

Research Article

Psychiatric morbidity in married females living away from their spouses attending the psychiatry clinic in a tertiary care, teaching hospital

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ABSTRACT

Background: In India economic problems like dowry and related issues play a major role in the problems of marriage and separation. The aim of the present study is to assess the psychological impact on married females who living away from their spouses, and comparison of the psychiatric morbidity with the married women who are living with their spouses.

Methods: A total of 35 subjects were included in the study. Intake proforma was specially designed for study and the questions were divided into 4 subscales (somatic complaints anxiety/insomnia social dysfunction and severe depression).

Results: The study clearly revealed that the occupational separation has a significant negative impact on the marital quality of the women spouses of men working abroad or living away. Comparison with the marital quality of the control group, the group does not have the separation; the study group differs significantly in marital quality.

The factors such as social support from family and friends, the stay of the study group with parents or in-laws, and duration of pre-separation, the study proved that there is no significant difference exists on the marital quality of the study group based on these factors.

Conclusions: The numbers of females who were separated from their spouses are more likely to have psychiatric illnesses due the additional work load of looking after the children and managing the household activities. The study also found that the females staying with their parents after the separation from their spouses were less likely to have a severe psychiatric morbidity as they felt comfortable due the cooperation from their parents.

Keywords: Psychiatric morbidity, Marriage, Females, Management

INTRODUCTION

Marriage is one of the most important events of life affecting social status as well as the psyche of an individual. It not only serves to satisfy the fundamental biological need of sexual gratification through a socially acceptable way but also helps the individual to achieve a higher level of personality maturation. Historically marriage existed in one form or another in every culture, ensuring social sanction to a physical union between man

and woman and laying the foundation for building up of one family.¹ According to William Stephen, marriage is a socially legitimate sexual union, beginning with a public announcement, and undertaken with some idea of permanence, with a more or less explicit contract, which spells out the reciprocal rights and obligations between the spouses and their future children. There are four basic components that go together to create a marriage: social legitimizing, public acknowledgement, an assumption of permanence, and reciprocal rights and obligations.

Marriages in almost every culture of the world, both pre literate and modern, appear to have most of these basic components.² Urban societies is highly heterogeneous as well as individualistic. The urban attitude is one of non-interference in the affairs of other people. Thus, the social life of urban people also exposes them to a variety of situations that can retract from the bond of attachment to the family. These situations therefore make separation much easier. Since marriage is the stepping stone in family life, its incompatibility leads to separation.

Marital separation usually occurs as a result of husbands' occupational transfers. There are an increasing number of married men who are transferred by their employers and who do not take their families, primarily in order to maintain educational continuity for the children. However, for the past few decades due to the westernization, modernization and emergence of the nuclear family etc. the problems of marriage lead to separation. In most of the Western countries, problems are linked mostly to sexual compatibility and health of the partners. However, in India economic problems like dowry and related issues play a major role in the problems of marriage and separation. The respondents of the present study already confirmed that more than 75% percent of them faced the problem of separation from their husbands due to their overseas employment and, this is the most commonly reported reason for their separation.³ Besides, nearly 20% of the respondents stated the problem of husband's illegal contacts with other women and related problems and incompatibility in adjustments. Another 5% of the respondents accepted that they preferred separation because they were unable to bear the physical torture from their husbands and in-laws. Couple of respondents stated that they were not aware of the reason as just after few days of marriage they were separated without any reason.

The aim of the present study is to assess the psychological impact on married females who living away from their spouses, and comparison of the psychiatric morbidity with the married women who are living with their spouses.

METHODS

Subjects

A total of 35 subjects were included in the study conducted between August 2008 and October 2010, those are married females attending the psychiatry clinic at the two participating hospitals Owaisi Hospital and Research Centre, Kanchanbagh, Hyderabad and Princess Esra Hospital, Shah Alibanda, Hyderabad, attached to Deccan College of Medical Sciences, Kanchanbagh, Hyderabad and informed consent was obtained by the attending psychiatrist.

Description of tools used:

Intake proforma

It was specially designed for study and it includes:

1. Socio demographic data.
2. Past illnesses
3. Physical examination
4. Psychiatric history and examination

Master score sheet:

This was prepared to score the general health questionnaire (GHQ).

General health questionnaire: This was developed by David Goldberg at Institute of Psychiatry for use in London as a screening instrument in community settings, primary care, and medical out-patients. Now it is being used in many different countries/cultures and has been translated into 38 different languages. It is derived from various existing scales, such as Cornell Medical Index. The original version consists of 60 items (GHQ-60). Shorter versions were subsequently developed (GHQ-30; GHQ- 28 (with four sub-scales and GHQ-12).

Rationale and development: Despite its title, GHQ is designed to assess mental health, not "general health". GHQ is based on features which differentiate psychiatric patients as class from individuals in the community who consider themselves healthy. It is not concerned with differences between psychiatric patients.

The threshold for psychiatric case identification: There is no clear demarcation between cases and normal individuals; rather, there is a graded increase in severity. Thus, if to be used in a clinical context, some criterion is needed for selection as a case.

If the results of a set of GHQ scores are compared with the results of an independent psychiatric assessment, it is possible to state the number of symptoms (or, the GHQ score) at which the probability that an individual will be assessed as being a case exceeds 0.5. This is the threshold score.

Scoring

There are several alternative methods for scoring the GHQ:

GHQ scoring: 0 0 1 1:

(Usual way when it is to be used for case identification; effectively counts number of symptoms present; also avoids problems of middle users)

CGHQ scoring:

Negative items: 0 1 1 1

Positives items: 0 0 1 1

(More likely than GHQ to detect long-standing disorders; score distribution even less skewed than Likert)

Likert scoring: 0 1 2 3

(Produces less skewed score distribution than GHQ; marginal advantage if sub-scale scores are required)

Modified Likert: 0 0 1 2

(Simpler than Likert, rationale being that little is gained by discriminating between first two columns: “Less than usual”, “No more than usual”)

Reliability

1. Internal consistency (Split-half): During development, “the split half reliability was computed on the 853 completed questionnaires that were used in all the other studies, and was shown to be 0.95”. Later, Sheik (1987) reported a split-half reliability coefficient for 2150 Chinese students given the GHQ-30 of 0.78.
2. Internal consistency (Cronbach’s alpha): Values for GHQ-60, GHQ-30, and GHQ-12 range from 0.82 to 0.93.
3. Test-retest Depending on category of patient, scores six months apart, correlated between 0.51 and 0.90.

Validity

1. Content validity Method of test construction ensures that each test item is known to be highly discriminating between groups with and without mental illness.
2. Construct validity is best assessed by examining the factor structure (see Ch. 2 and 4 of GHQ Manual) which reveals a large general factor corresponding to the construct of “dysthymia”.
3. Criterion validity: Most appropriate approach would be to correlate GHQ scores with some measure of the severity of psychiatric illness derived from a criterion interview such as the Clinical Interview Schedule (CIS).
4. Predictive validity: Since it was intended as a state measure rather than a trait measure, the GHQ would not generally be used for predictive purposes, although there are studies that have attempted this.

The questions were divided into 4 subscales (somatic complaints anxiety/insomnia social dysfunction and severe depression).

RESULTS

The mean age of the respondents who were living away from their spouses was 25.35 years. Among the total 35 respondents, only 1 woman was 19 years of age (2.85 %) Further it has been found that 13 women, around 37.14 % of them belong to the age group of 20 to 25 years followed by 17, around 48.58% of them in the age group of 25 to 30 years. It is also noticed that 4 (11. 43%) of the respondents belong to 30- 35 years of age (Figure1A). The control groups consisting of 35 married females who are living with their husbands were taken. Among the controls the mean age of the married females was 27.98 years (Figure 1B).

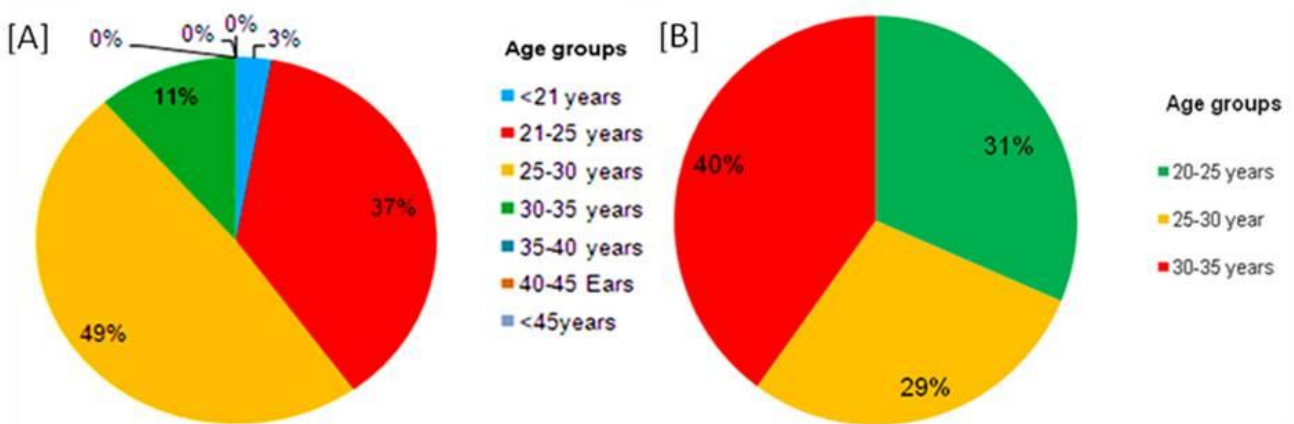


Figure 1: Age of the [A] respondents and [B] control group.

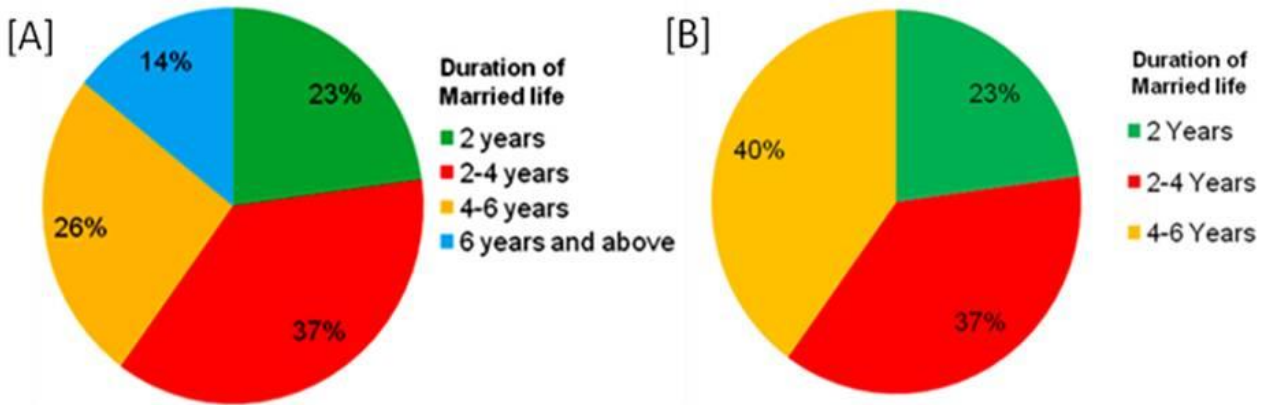


Figure 2: Duration of married life of the [A] respondents and [B] control group.

Among the 35 interviewees recruited in the study 88.58% belonged to the Urban areas and 11.42 % belonged to the rural areas.

Among the 35 females recruited for the study the duration of married life was as follows: 8 women (22.86%) were married for 2 years, 13 women (37.14%) were married for 2-4 years, 9 women (25.70%) were married for 4-6 years and only 5 women (14.30%) were married for more than 6 years (Figure 2A). Among the control group of 35 women, 8 women (15%) were married for 2 years period, 13 women (40%) were married for 2-4 years and 14 women (45%) were married for 4-6 years (Figure 2B).

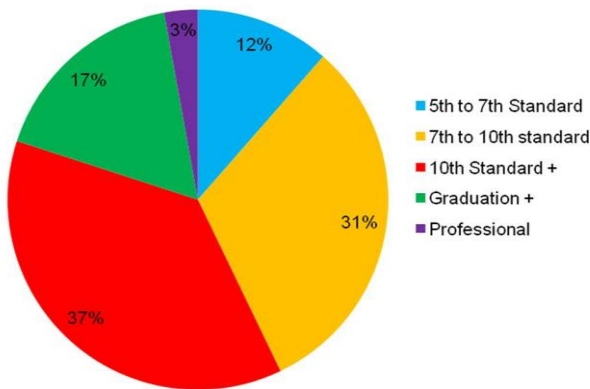


Figure 3: Educational level of respondents.

Education is one of the social variables that influence the status of women in societies. The present study analyzed the educational status of the separated women and noticed a progressive trend in education among the separated women. Nearly 11.43% (4) of the respondents had education up to 7th standard, 31.43% (11) had education up to 10th, 37.14% (13) had been educated up to intermediate, 17.14% (6) had graduation and above level and only one respondent was professional (Figure 3).

Almost 60% (21) of respondents belong to the housewife category; 22.84% (8) were working as vocational or skilled personnel and only one was working as professional. However, 14.3% (5) of the separated women were students, mostly doing vocational/graduate courses and only one woman was computer engineer by profession (Figure 4). Some of them reported that they discontinued their education when they got married. Further, once they were separated they started their education mainly for obtaining job and in turn economic independency. However, a few of them stated that they have joined the course to avoid mental stress and isolation. The participation of women in diverse fields of occupation may have a bearing on their separated status by improving their economic independency.

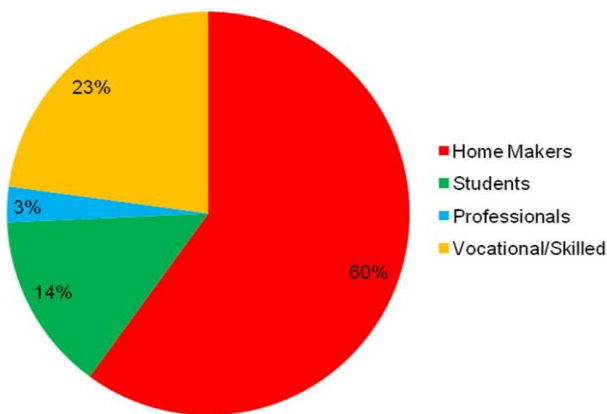


Figure 4: Occupation of the respondents.

The respondents of the present study were asked whether the marriage is arranged by parents or self-selection. It has been reported 32 women (more than 91.4%) of them, had arranged marriages, barring 3 respondents who had love marriages (8.6%).The control group all had their marriage arranged.

Persons who seem to be anxious about almost everything, however, are likely to be classified as having generalized anxiety disorder. The text revision of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines generalized anxiety disorder as excessive anxiety and worry about several events or activities for most days during at least a 6 month period. The worry is difficult to control and is associated with somatic symptoms, such as muscle tension, irritability, difficulty sleeping, and restlessness. The anxiety is not focused on features of another Axis I disorder, is not caused by substance use or a general medical condition, and does not occur only during a mood or psychiatric disorder. The anxiety is difficult to control, is subjectively distressing, and produces impairment in important areas of a person's life.

In the study it was found that 19 (54.28%) of the females were suffering from Generalized Anxiety Disorder, 11 (31.44%) were suffering from Major Depressive Disorder and only 5 (11.28%) of the females had Somatoform Disorder, Conversion Disorder (Figure 5A). It was noted that the percentage of women who are living away from their spouses had more generalized anxiety disorder than the control group. It was found that 19 women (54.28%) who are living away from their spouses had generalized anxiety disorder than those who were staying with their spouses 3 (8.57%) (Figure 5B). In the study it was also found that the control group females who are living with their spouses have less major depressive episode than the study group. The number of females in the control group having M.D.D is 1 (2.85%) and the number of females in the study group who had M.D.D is 11 (31.44%) (Figure 5C).

Patients with depressed mood experience a loss of energy and interest, feelings of guilt, difficulty in concentrating,

loss of appetite, and thoughts of death or suicide. Other signs and symptoms of mood disorders include change in activity level, cognitive abilities, speech, and vegetative functions (e.g., sleep, appetite, sexual activity, and other biological rhythms). These disorders virtually always result in impaired interpersonal, social, and occupational functioning.

A major depressive episode must last at least 2 weeks, and typically a person with a diagnosis of a major depressive episode also experiences at least four symptoms from a list that includes changes in appetite and weight, changes in sleep and activity, lack of energy, feelings of guilt, problems thinking and making decisions, and recurring thoughts of death or suicide.

The somatoform disorders are a broad group of illnesses that have bodily signs and symptoms as a major component. These disorders encompass mind and body interactions in which the brain, in ways still not well understood, sends various signals that impinge on the patient's awareness, indicating a serious problem in the body. Additionally, minor or as yet undetectable changes in neurochemistry, neurophysiology, and neuroimmunology may result from unknown mental or brain mechanisms that cause illness

Conversion disorder is an illness of symptoms or deficits that affect voluntary motor or sensory functions, which suggest another medical condition, but that is judged to be caused by psychological factors because the illness is preceded by conflicts or other stressors. The symptoms or deficits of conversion disorder are not intentionally produced, are not caused by substance use, are not limited to pain or sexual symptoms, and the gain is primarily psychological and not social, monetary, or legal.

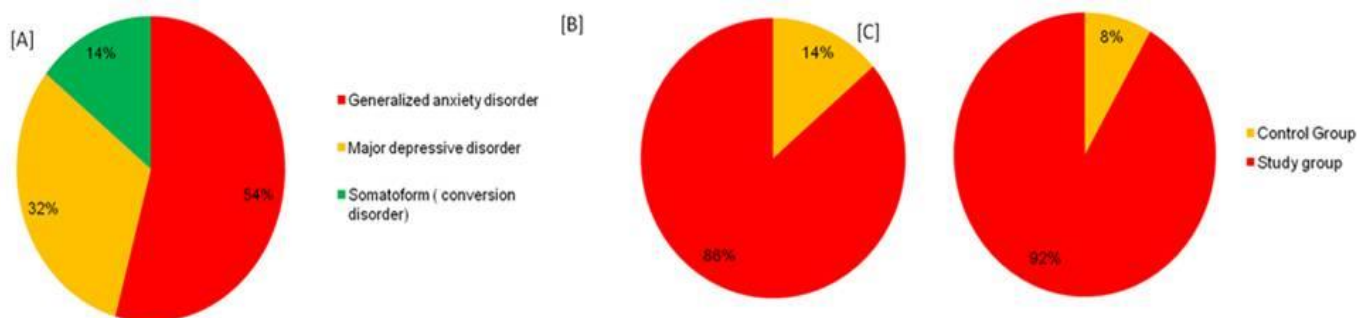


Figure 5: [A] Disorders Observed in the Study [B] Generalized Anxiety Disorder Comparison [C] Major Depressive Disorder Comparison.

DISCUSSION

One of the major objectives of the present study was to analyze the impact of separation on the marital quality of the women spouses left behind. The study clearly

revealed that the occupational separation has a significant negative impact on the marital quality of the women spouses of men working abroad or living away. Comparison with the marital quality of the control group,

the group does not have the separation; the study group differs significantly in marital quality.

The factors such as social support from family and friends, the stay of the study group with parents or in-laws, and duration of pre-separation, the study proved that there is no significant difference exists on the marital quality of the study group based on these factors.

Among the 35 respondents, only 1 woman (around 2.85%) belonged to the age group below 20 years. Further it has been found that 13 women (around 37.14%) belong to the age group of 20 to 25 years followed by 17 women (48.58%) in the age group of 25 to 30 years. It is also noticed 4 (11.43%) of the respondents belong to 30-35 years of age.

Age at onset of illness and current age didn't have significant association ($p=0.761$) with occurrence of psychiatric morbidity.

Among the 35 respondents 31 (about 88%) were from an urban background and only 4 (12%) were from the rural background. These findings show the catchment area of this hospital. No significant difference among these groups was seen for occurrence of psychiatric morbidity.

More than half (19) of the respondents, 54.28% had GAD. The females with GAD reported of anxiety and restlessness, disturbed sleep, not able to concentrate on their work getting tired easily and had become irritable.

The number of females in the control group had only 3 females (8.57%) were suffering from G.A.D. This is also compared with the study done by Morrice and Taylor (1978)⁴ and (Zachariah et al., 2000).³

Major depression was seen in 11 of the respondents (31.43%). Those females who were found to have Depression complained of sadness of mood, easy fatigability, reduced sleep, feeling of guilt, reduced appetite and lack of interest in previously pleasurable activities. This is in comparison with the earlier studies done by Morrice and Taylor (1978)⁴ and (Zachariah et al., 2000).³

Somatiform disorders were seen in 5 of the respondents (14.28%). These females had more of bodily symptoms than the others. GHQ scores were significantly higher in Generalized Anxiety Disorder and in depressed patients.

The Anxiety, Social dysfunction, Depression Subscales of the GHQ also showed significantly higher scores in GAD & MDD. As expected, GHQ scores though not significantly higher in patients with Somatiform disorders, they were higher in the somatic complaints subscale of the GHQ. Scores of GHQ total score and that of its individual subscales was significantly higher for patients with psychiatric morbidity than those without.

The study found that the numbers of females who are separated from their spouses are more likely to have Psychiatric illnesses due to the additional work load of looking after the children and managing the household activities. It was also seen that they find it more difficult to be in their in-laws as they reported excess of pressure from the in-laws as they did not get full cooperation from them.

The study also found that the females staying with their parents after the separation from their spouses were less likely to have a severe psychiatric morbidity as they felt comfortable due to the cooperation from their parents. It was also noticed that these females were having less strenuous life than those staying with their in-laws. They were in a better position to bring up the children and manage the household activities comparing to the ones staying with their in-laws. According to Morrice and Taylor (1978) 4 study home and away occupations are characterized by a parting and reunion cycle providing a recurring crisis and a uniform pattern of feelings. This recurring cycle includes tension and tearfulness on a husband's departure, return to normal, followed by feelings of depression, sadness, anger and recrimination towards a husband during the cycle and on his return.

A response of three, four or five (that is, a report of experiencing a symptom, some, most or all of the time) to any item was considered equivalent to experiencing a particular symptom. On this basis, the most frequently occurring symptoms of anxiety included worrying about every little thing (44%) having a pain or tense feeling in the neck or head (32%) and being kept awake at night due to worry (23%). Five respondents or 14 percent of the sample reported experiencing four or more symptoms and can be considered to be experiencing high levels of anxiety, Morrice and Taylor (1978).⁴

There was no significant difference between the marital quality of the women in the study group with high social support and those with low social support. There was no significant difference between the marital quality of the women in the study group who are employed and those who are not employed. There was no significant difference between the marital quality of the women in the study group staying with in-laws and those staying with own parents.

Among the 35 control women who were living with their spouses only 4 (11.43%) had psychiatric morbidity and the remaining 31 (88.57%) did not have any psychiatric problems.

CONCLUSION

The study clearly revealed that the occupational separation has a significant negative impact on the marital quality of the women spouses of men working abroad. The numbers of females who were separated from their spouses are more likely to have psychiatric

illnesses due the additional work load of looking after the children and managing the household activities. The study also found that the females staying with their parents after the separation from their spouses were less likely to have a severe psychiatric morbidity as they felt comfortable due the cooperation from their parents.

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Conflict of interest: None declared

Ethical approval: The study was approved by Institutional Review Board (IRB) of Deccan College of Medical Sciences, Hyderabad

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