Socio Demographic and Clinical Profile of Indoor Female Patients of RINPAS

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ABSTRACT

Background: The role of women is very crucial in our society. She cares for her parents, partner, children and other relatives. She performs all types of duties in family and also in the society without any expectations. Because of playing many roles, women often face many challenges in their life including both physical and mental. Mental health problems affect women and men equally, but some problems are more common among women including both physical and mental health problems. Aim of the study - The present study is aimed to describe and compare the clinical and socio-demographic correlates of female mentally ill patients. Methods and Materials: The study includes 180 female mentally ill patients based on cross sectional design and the sample for the study was drawn purposively. A semi structured socio-demographic data sheet was prepared to collect relevant information as per the need of the study. Result: The present study reveals that the socio-demographic factors contribute a vital role in mental illness. Findings also showed that majority of patients had mental problems in the age range of 20-30 have high rate. Illiterate and primary level of education and daily wage working women as well as low and middle socio-economic status women are more prone to have mental illness. Other factors like marital status, type of family and religion etc also important factors for mental illness.

Keywords : Socio demographic profile, female, psychiatric patient

INTRODUCTION

"The hand that rocks the cradle rules the world"

- Roman Catholic.

"A woman is the full Circle. Within her is the power to create, nurture and transform"

- Diane Mariechild.

Females are creature of this world. They have capacity to give birth and nurture for all living things. We can't imagine this world without women. It is very surprising that women are essential to all aspects of society yet their status is not up to the mark in our society as they deserve. Women have to face many types of problems from childhood due to established code of conduct in our society like economic condition, deficit in education, caste, religion, and dowry system etc. Besides this females have to perform multiple duties in the society. She is also oppressed by antisocial elements. So they are more vulnerable to mental problems. The mental health of women must be considered in the context of women's life and can be understood only if their biological, social, cultural, economical and personal context is considered. Therefore it is necessary to consider all the socio demographic factors which affect the mental health of women. Studies have shown that various socio-demographic variables influence the general health of both gender specifically health of women. Marital status, family type, socio-economic status, education, occupation etc are some of the important variables which help in mental health of the individual. These socio-demographic variables also play a contributing and maintaining role in mental illness. There are various social theories and models of mental disorders which explain how socio-demographic and psychosocial factors lead to mental illness.

It has been reported that women are at higher risk for the development of mental disorders, especially for depressive and anxiety disorders. It has been argued that women's multiple roles in society and heavier

burden of social and household responsibilities puts them at higher risk for developing common mental disorders such as anxiety and depression. Patel et al.[1] identified a particular effect of rising income inequality on women's risk of common mental disorders. More so, in many traditional societies women bear additional burden in the form of gender discrimination and gender violence. Abused women are more likely to suffer from anxiety and depression than non-abused women.[2]

If higher rates in mental disorders in women are due to a universal biological vulnerability the sex ratio ought to be unaffected by, for example, sociodemographic attributes. There is no convincing evidence for this, however.[3] Thus, biological explanations alone are not sufficient. This inevitably moves the focus of interest to psychosocial hypotheses for gender differences in mental Disorders.

Women face many injustices and inequalities globally, both in terms of economic factors and human rights. An often overlooked aspect of this phenomenon is their health. For example, the World Health Organization points out that "maternal mortality has barely changed since 1990." This fact points to the great need for a specific focus on women's health issues.[4]

Need for the Study

This study was undertaken due to paucity of Indian studies on socio demographic correlates of female patients. The aim of this study was to explore those socio-demographic factors which might be a causative factor for mental illness as poverty, malnutrition, economic hardship, family environment, marital status, lack of social support, lack of education etc. This study was conducted to know the clinical factors which lead to psychiatric illness.

METHOD AND MATERIALS

Aim of the study: To find out the socio demographic and clinical factors contributing to mental illness.

Objective of the study: To assess the socio demographic & clinical factors which are causative and maintaining factors of mental illness.

Hypothesis

– There will be no significant role of socio cultural factors in psychiatric illness.

– There will be no significant role of clinical variables in psychiatric illness.

Research Design: The present study adopts hospital based cross sectional survey design.

Population of the study: Total 180 patient were included in the study who were admitted at RINPAS.

Venue: This study was conducted in In-patient department of the Ranchi Institute of Neuro-Psychiatry and Allied Sciences, (RINPAS) Kanke, Ranchi.

Tools: Socio- Demographic Data Sheet was prepared to collect basic information about the participants. Clinical Data Sheet was prepared to study the maintaining factors of the illness.

Analysis of data : The data obtained was analyzed using the statistical package for social sciences version 16.0(SPSS-16.0)

RESULT

Age range : A major portion of patients for all the disorder were centered in the age range of 20-30 years like in schizophrenia (48.1%) from 52 patients, In Bipolar affective disorder (58.5%) from 41 patients, in mania patients (46.2%) from 13 patients, in Psychosis NOS (55%) from 20 patients, in depression (51.2%) from 21 patients, in epilepsy (50%) from 10 patients and in other mental disorder (39.1%) from 23 patient. Further it was also evident that the percentage of mental illness decreased with subsequent age range.

Education level: In present study majority of the patients were educated up to primary level or had no formal education. Percentage of patients with primary level of education such as patients of schizophrenia was (48.1%), in total mania patients was (39%) , among mania patients was (30.8%), psychosis NOS (30%), in persons with depression was (52.4%), among epilepsy cases was (70%), in other disorder was (60.9%), and no formal education was found in schizophrenia was 30.8%, BPAD was 39%, in depression 52.4% and in other cases (43.4%), in mania (46.2%), in psychosis NOS was (30%) and in epilepsy (60%).

Socioeconomic status: Almost half of the total sample of patients belongs to lower socioeconomic status as the treatment facilities provided are free of cost. In schizophrenia, lower (51.9%), middle (44.2%), BPAD and mania patients the percentage is almost equal in

Table
1 Socio-demographic factors of female patients

Variables	Level	Schizophrenia N=52	BPAD N=41	Mania N= 13	Psy NOS N=20	Depression N= 21	Epilepsy N=10	Other N=23
Age Range	20-30	25(48.1)	24 (58.5)	6(46.2)	11(55.0)	10(47.6)	6(60.0)	14 (60.9)
	31-40	12(23.1)	5 (12.2)	4(30.8)	5(25.0)	8(38.1)	2(20.0)	5 (21.7)
	41-50	11(21.2)	6 (14.6)	3(23.1)	3(15.0)	2(9.5)	2(20.0)	4 (17.4)
	51-60	4(7.7)	6 (14.6)	0(00)	1(5.0)	1(4.8)	0(00)	0(00)
Education	primary	25(48.1)	16 (39.0)	4(30.8)	6(30.0)	11(52.4)	1(10.0)	10 (43.5)
	Matric	8(15.4)	12 (29.3)	2(15.4)	1(5.0)	3(14.3)	3(30.0)	6 (26.1)
	Inter	3(5.8)	4(9.8)	1(7.7)	4(20.0)	1(4.8)	0(0.0)	2(8.7)
	graduation	0(0.0)	0(0.0)	0(0.0)	1(5.0)	0(0.0)	0(0.0)	0(0.0)
	Illiterate	25(48.1)	16 (39.0)	4(30.8)	8(40.0)	11(52.4)	1(10.0)	10 (43.5)
SES	Low	27(51.9)	21 (51.2)	7(53.8)	7(35.0)	14(66.7)	7(70.0)	14 (60.9)
	Middle	23(44.2)	20 (48.8)	6(46.2)	12(60.0)	6(28.6)	2(20.0)	9 (39.1)
	High	2(3.8)	00(0)	00(00)	1(5.0)	1(4.8)	1(10.0)	00(00)
Occupation	House wife	5(9.6)	3 (23.1)	3(7.3)	1(5.0)	2(9.5)	2(20.0)	0(0.0)
	Domestic work	33(63.5)	8 (61.5)	21(51.2)	10(50.0)	12(57.1)	5(50.0)	0(0.0)
	Service	14(26.9)	2 (15.4)	3(7.3)	1(5.0)	7(33.3)	1(10.0)	0(0.0)
	Student	0(0.0)	0(0.0)	14(34.1)	8(40.0)	0(0.0)	2(20.0)	0(0.0)
Marital status	Married	35(67.3)	25(61.0)	9(69.2)	13(65.0)	13(61.9)	7(70.0)	14 (60.9)
	Unmarried	7(13.5)	13 (31.7)	2(15.4)	2(10.0)	2(9.5)	1(10.0)	2(8.7)
	Divorce	1(1.9)	1(2.4)	1(7.7)	2(10.0)	1(4.8)	0(0.0)	1(4.3)
	Widow	5(9.6)	1(2.4)	1(7.7)	3(15.0)	1(4.8)	2(20.0)	6 (26.1)
	Separated	4(7.7)	1(2.4)	0(0.0)	0(0.0)	4(19.0)	0(0.0)	0(0.0)
Total no family members	1-5	24(46.2)	18 (43.9)	9(69.2)	9(45.0)	9(42.9)	4(40.0)	13 (56.5)
	5-10	23(44.2)	22 (53.7)	4(30.8)	9(45.0)	11(52.4)	6(60.0)	9 (39.1)
	Above 10	5(9.6)	1(2.4)	0(0.0)	2(10.0)	1(4.8)	0(0.0)	1(4.3)
Family type	Joint	27(51.9)	19(46.3)	19(46.3)	12(60.0)	11(52.4)	5(50.0)	11 (47.8)
	Nuclear	25(48.1)	22 (53.7)	22(53.7)	8(40.0)	10(47.6)	5(50.0)	12 (52.2)
Religion	Hindu	36(69.2)	31 (75.6)	13(100.0)	13(65.0)	17(81.0)	5(50.0)	18 (78.3)
	Muslim	10(19.2)	4(9.8)	0(0.0)	4(20.0)	1(4.8)	3(30.0)	3 (13.0)

Table 2
Clinical Factors of female patients

VARIABLES	Level	Schizophrenia N=52	BPAD N=41	Mania N= 13	Psy NOS N=20	Depression N= 21	Epilepsy N=10	Other N=23
Age of onset	0-10 years	2(3.8)	0(0.0)	0(0.0)	0(0.0)	1(4.8)	1(10.0)	0(0.0)
	10-20 years	17(32.7)	18 (43.9)	0(0.0)	4(20.0)	5(23.8)	4(40.0)	4(17.4)
	20-30 years	17(32.7)	9(22.0)	6(46.2)	11 (55.0)	9(42.9)	0(0.0)	14(60.9)
	30-40 years	10(19.2)	7(17.1)	6(46.2)	3(15.0)	5(23.8)	1(10.0)	3(13.0)
	40-50 years	4(7.7)	6(14.6)	1(7.7)	2(10.0)	1(4.8)	4(40.0)	2(8.7)
	50-60 years	2(3.8)	1(2.4)	0(0.0)	0(0.0)	0(0.0)	2(20.0)	0(0.0)
Course	Continuous	37(71.2)	27 (65.9)	8(61.5)	10 (50.0)	11(52.4)	6(60.0)	16 (69.6)
	Episodic	15(28.8)	14 (34.1)	5(38.5)	10 (50.0)	10(47.6)	4(40.0)	7(30.4)
DOI	1-5 years	28(53.8)	29 (70.7)	10 (76.9)	10 (50.0)	12(57.1)	7(70.0)	17 (73.9)
	6-10 years	15(28.8)	7(17.1)	2(15.4)	7(35.0)	6(28.6)	1(10.0)	6(26.1)
	11-15 years	6(11.95)	3(7.3)	1(7.7)	1(5.0)	1(4.8)	1(10.0)	0(0)
	16-20 years	2(3.8)	2(4.9)	0(0)	1(5.0)	2(9.5)	1(10.0)	0(0)
	21-25 years	1(1.9)	0(0)	0(0)	0(0)	0(0)	0(0)	0(0)
	25-30 years	0(0)	0(0)	0(0)	0(0)	0(0)	0(0)	0(0)
	30 above	0 (0)	0(0)	0(0)	1(5.0)	0(0)	0(0)	0(0)
Progress of illness	Static	5(9.6)	3(7.3)	4(30.8)	5(25.0)	2(9.5)	2(20.0)	2(8.7)
	Improving	30(57.7)	21 (51.2)	5(38.5)	8(40.0)	12(57.1)	4(40.0)	10 (43.5)
	Deteriorating	4(7.7)	10 (24.4)	3(23.1)	3(15.0)	2(9.5)	0(0)	4(17.4)
	Fluctuating	13(25.0)	7 (17.1)	1(7.7)	4(20.0)	5(23.8)	4(40)	7(30.4)
T.H	Physician	7(13.5)	9(22.0)	4(30.8)	3(15.0)	1(4.8)	1(10.0)	9(39.1)
	Psychiatrist	45(86.5)	32 (78.0)	9(69.2)	17 (85.0)	20(95.2)	9(90.0)	14 (60.9)
Substance	Yes	9(17.3)	5(12.2)	3(23.1)	6(30.0)	3(14.3)	1(10.0)	10(43.5)
	No	43(82.7)	36 (87.8)	10 (76.9)	14(70.0)	18(85.7)	9(90.0)	13(56.5)
FHPI	Yes	28(53.8)	32(78)	11(84.6)	15(75)	17(81)	6(60)	17(73.9)
	NO	24(46.2)	9(22)	2(15.4)	5(25)	4(19)	4(40)	6(26.1)

lower and middle socioeconomic status. In other disorders the percentages however differ like in psychosis NOS lower class shows (35%) and middle class shows (60%), in depression lower class shows (48.8%) and middle class shows , in epilepsy lower class is (50%), in other disorder (60%). However the percentages of patients belonging to higher socioeconomic status are very less.

Occupation: Majority of the patients did domestic work

because most of the patients belong to lower socioeconomic status. Patients doing domestic work, like in schizophrenia (63.1, 61.5%) in BPAD, (51.2%) in mania, (50%) in psychosis NOS, (57.1%) in depression and (50%) in epilepsy and in other disorder (69.6%) were house wife.

Marital status: In present study majority of the patients were married such as in schizophrenia was (67.3%). The ratio of unmarried patients was very less in comparison to the married patients, where as patients who were widow and divorces were even more less in comparison to the unmarried patients. However the percentage of widow and divorce patients was almost equal.

Total no of family members: In present study majority of the patients were found to be having 1 to 5 and 5 to 10 family members. It was found that 1 to 5 family members, (46.2%) patients with schizophrenia, (43.9%) patients having BPAD, (69.2) patients with mania, (45%) with psychosis NOS, (42.9%) with depression,(40%) with epilepsy and with other disorder (56.5%). And 5 to 10 members, (44.2%) with schizophrenia, (53.7%) patients with BPAD, (30.8%) patients with mania, (45%) patients with psychosis NOS, (52.4%) patients with depression, (60%) patients epilepsy, (39.1%) in other disorder.

Family type: In the present study, majority of the patients fall in joint family type like in schizophrenia (51.9%), in BPAD (46.3%), Mania (46.3%), Psychosis NOS (60.0%), Depression (52.4%), Epilepsy (50.0%) and others (47.8%). The remaining patients fall in nuclear family type like in schizophrenia (48.1%), in BPAD (53.7%), Mania (53.7%), Psychosis NOS (40%), Depression (47.6%), Epilepsy (50%) and others (52.2%).

Religion: In present study most of the patients belonged to Hindu religion. Patients from other religion also come for the treatment purpose like Muslim, Christian and local tribes.

Mother tongue: 90% of the patients of each disorder were Hindi speaking.

State : Majority of the patients belonged to Jharkhand state and to a lesser percentage belonged to Bihar state but there were patients from other state as well like Odisha, Bengal etc.

Age of onset: In present study most of the patients of each disorder had age of onset between 20-30 years. like in schizophrenia (32.7%, 46.2%) in mania, in psychosi NOS (55%), in depression (42.9%)and in other disorder (60.9%) and it was seen that the percentage of age of onset decreased with increase in age range where as very less patients were found in the age of onset of 0-10 years.

Course of illness : Majority of the patients of each disorder had continuous course of illness, such as schizophrenia was (71.2 %), BPAD was (65.9 %), Mania was (61.5 %) and other disorder (69.6 %), where as the disorders psychosis NOS, depression, epilepsy showed equal percentages of continuous and episodic course of illness.

Duration of illness: In present study most of the patients of each disorder had duration of illness from 1 to 5 years like in schizophrenia was (53.8%), In BPAD (70.7%). In mania (76.9%), in psychosis NOS (50%), in depression (57.1%), in epilepsy (70%) and in other disorder (73.9%). Again it is seen that duration of illness decreased from 5-20 years. Present study also showed that very few cases was found in the duration of 21 to 30 years.

Substance use: Majority of the patients had no history of substance.

Treatment history: All patients were receiving treatment from psychiatrist because they were admitted in RINPAS.

Family history of mental illness: Mostly all the psychiatric disorders have been found in families where psychiatric history has already been present (family history of psychiatric illness). Among the total population of the respective disorders, in mania (84.6%), depression (81%), BPAD (78%), psychosis NOS (75%).

DISCUSSION

Present study was conducted to assess the socio demographic factors contributing to mental illness in females. Assessment was done in the following areas such as age range, education level, socioeconomic status, occupation, marital status, religion, age of onset, duration of illness, course of illness, total no of family members, state, substance use, mother tongue and treatment history, family history of mental illness. The effect of age on mental disorders was same for all the disorders mentioned, although lower socio-economic status did seem to affect the incidence of disorders especially schizophrenia and depression. A study done by K. Amore, P.L. Howden-Chapman,[5] describes that

rates of mental illness are disproportionately high among the homeless, with up to one-third suffering severe mental illness. Co-morbidity with more than one mental health problem, substance use disorders, and other health concerns are common. A study done by Patel,[1] explains that female gender, low education and poverty were strongly associated with common mental disorders. Illiteracy and lower education was prevalent in most disorders which was in conjugation with the study of Winkleby et al [6] suggesting that education has been widely perceived as one of the most important socio economic determinants of health and mortality. There is considerable evidence that low educational attainment is strongly correlated with diseases, health risks and mortality. The women in Indian societies have no respite from their family and household duties even if she is working, which creates more stress especially in the lower socio-economic status. In another study done by Mazaic et al.[7], showed that mental distress is common among low income women, who are also in risk of the contributing factors like physical harassment and abusing, women's education, polygamy, residence, age and age of marriage. Hindus were more in all the disorders as compared to other religions but this may be due to the dominance of it in this region. In a study conducted in Arab countries by Douski in [8], on Muslim women showed that culture, religion, gender does play a crucial role in the emergence of mental disorders, They also revealed that there are culture-related risk factors such as education, work, sexuality, marriage, and infertility, which significantly contribute to triggering mental disorders in females, or to worsen their course and outcome. Many of the previous researches also correlated mental illness with structure of the family. It has been widely noted by Sethi and Manchanda [9] and by Verghese et al[10] that mental distress is greater in nuclear families where as Dube[11] found more distress in joint family but in present study there has been dominance of mental illness in joint families. The reason for this may be that in this study the sample has been mostly available from rural background, and in rural background people continue to live in joint family. Therefore it has been difficult to get clear observation between joint and nuclear family. Married women were more in all the mentioned disorders. It was observed that there was prominence of family history in patients suffering from schizophrenia, bipolar affective disorder, mania and in depression whereas other mental disorders were also affected by family history of psychiatric illness. This is similar to the study given by Borba, et. al.[12] that the most common severe mental illness is depression and explained that the salient features may be social isolation, experiencing loss, and having a lack of control over one's own life decisions. Another study by Zauszniewski and Bekhet[13] summaries that depression and anxiety are greater in those with a recently diagnosed family member. Duration of illness took its role on all the psychotic disorders. Similar finding is reported in Chakraborty's[14] study notes that psychiatric disorder increased with age, whereas women who worked as domestic help for a living came under greater risk of a mental health disorder according to this study. May be the reason for this is the economical as well as family burden that the working women has to suffer in the Indian society. Substance abuse was less except in the other disorder category. A study done by Meng and Carl D'Arcy[15] states that women reported more mood and anxiety disorders whereas men more substance dependence. It was found that age of onset was mainly in the range of 10-30 years was more in number because may be there was some care taker to bring them for treatment. In present study course of illness was found to be continuous. Treatment was mostly taken from psychiatrist highlighting the findings by Borba,[16] that utilizing medical healthcare services requires a trusting relationship with a mental health provider and a women's social network. In a study reported by Patton et al.[17], showed that widows and women lacking social support such as network and family and social power were in more danger of developing critical condition of mental illness.

A study by Lyon and Parker [8] described that rural women with severe psychiatric mental illness had many gender-related issues, including unresolved grief over loss of children, isolation from family members, lack of sexual partners, diminished sexuality, and bodily changes secondary to medication side-effects S. Women with mental illness felt like their roles as women were superseded by their role as mentally ill individuals. They have unmet needs for women's health. The findings from this study revealed varied experiences among these women as well as the complexity of their situation. The enhanced understanding of women's situation will allow mental health professionals to

improve the quality of life for women with an severe mental illness by taking a contextual approach to the treatment of their mental illness.

CONCLUSION

It has been found from the study that socio-demographic factors are very important for every individual. Every member of society gets influenced by the socio-demographic parameters, which affect the whole life of an individual. Females are easily affected from mental illness because they are sensitive to different stressful and challenging events which move her towards mental illness. Present study also revealed that there are risk factors such as education, work, marriage, lack of support etc. which oppresses the women and significantly contribute to triggering mental disorders in females, or to worsen their course and outcome.

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