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Original Research Article

Marital and family relationships among women with severe mental illness during perinatal period admitted to a mother baby psychiatric unit, India

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ABSTRACT

Background: Pregnancy and transition to parenthood is often a stressful event and brings about more profound changes than any other developmental stage of the family life cycle. Consequently, pregnancy and post-partum are times of increased vulnerability for the onset or relapse of a mental illness. The current paper aimed at understanding the marital and family relationships among women with severe mental illness during the perinatal period in India.
Methods: The study included a retrospective chart review of mothers admitted to a mother-baby unit between the years January 2015 to March 2020. We included all mothers who were married and had onset of SMI in the perinatal period. Details of socio-demographic, clinical profile and descriptive understanding of relationships were collected.
Results: The total sample was 149, mean age of women in years was 25.27 (SD=4.97). The clinical diagnosis included non-affective psychosis (45.5%), affective psychosis (42.2%) with 130 (87.24%) women having their first episode of SMI during the postpartum period. More than half of the women admitted to the ward reported having problems in their marital relationship, with 25% experiencing violence from their spouses and in-laws. Interpersonal issues with their in-laws in the context of violence, household chores and poor support.
Conclusions: This study highlights the importance of routine assessments of the quality of marital and family relationships including domestic violence. There is a need to provide interventions aimed at helping women deal with difficulties in intimate and social relationships.

Keywords: Marital and family relationships, Severe mental illness, Perinatal

INTRODUCTION

Pregnancy and transition to parenthood is often a stressful event and brings about more profound changes than any other developmental stage of the family life cycle. Pregnancy and delivery bring many physiological and psychosocial changes, and both mothers and fathers are required to face several new challenges during the transition period. Consequently, pregnancy and post-partum are times of increased vulnerability for the onset or relapse of a mental illness.[1] The prevalence of postpartum psychosis, a form of severe mental illness (SMI) is consistently estimated to be 1-2 per 1000 women who have recently given birth.[2-4] These episodes represent some of the most severe forms of postpartum mood disorders, which, as psychiatric emergencies, can have devastating consequences for the mother, baby and wider family.[3] In low and middle-income countries, the cumulative incidence of peripartum severe mental disorders ranged from 1.1 to 16.7 per 1000 births.[5]

The relationship between marriage and mental illness is complex. Marriages in India are usually arranged by parents and are influenced by several factors such as astrological compatibility, caste regulation, geographic proximity, socio-economic equivalency, prescribed values, and expectations of dowry, it is not just a tie of two human beings but establishes as a constellation of many other relationships surrounding the couples.[6,7] In Indian marriage, the husband is considered the head and principal earner of the family; sexual fidelity and monogamy of both husband and wife are represented as marital ideals.[6] For most women in India, marriage is a one-time event in life, which is glorified and sanctified and is associated with much social approval. If this is endangered or broken by mental illnesses like psychoses, the lives of these women are severely affected.[8] The lifetime prevalence of intimate partner violence (IPV) in women with SMI was 22% with a past one-year prevalence of IPV being 20%. Control and emotional violence were the most commonly reported form of violence, followed by physical violence, and sexual violence was the least reported.[9] The current study aimed at understanding the marital and family relationships among women with SMI during perinatal period. Our study focused on understanding the socio-demographic and clinical profile, and descriptive understanding of relationships in the context of marital and family life of women with SMI during perinatal period.

METHODS

The current study is a retrospective chart review that included charts of women who were admitted to the mother-baby unit (MBU) between January 2015 to March 2020. The MBU is a five bedded facility that caters to mothers with perinatal mental illness. The multidisciplinary team (MDT) consists of psychiatrists, psychiatric social workers, clinical psychologists, developmental psychologists, and psychiatric nurses. Mothers and infants are admitted with a family member (usually a woman) in keeping with local cultural traditions where a postpartum mother receives extra care from the family and is seldom left alone.[10] The team routinely carries out a comprehensive assessment of clinical details, marital and family relations, violence and psychosocial factors for all the women admitted to the MBU by gathering information from multiple sources. In some instances, the MDT was unable to obtain detailed information, where the husband was unavailable during the IP care, paid attendees, and early/premature discharges.

The inclusion criteria include women who were married and had onset of mental illness during pregnancy till one year of childbirth. We excluded women with primary neurological conditions and women who have had a pre-existing mental illness. A data extraction form was prepared by the authors that included socio-demographic details of the women, clinical details of the women and spouse, marital details, details of the families- both family of origin (FOO) and procreation (FOP), support systems as well relationships within the family. Details such as experiences of violence, type of relationship between the couple, and type of relationship between women and in-laws' families were also included. The nature of a marital and family relationship was understood either as a cordial relationship or as having interpersonal relationship issues. The problems in marital/family relationships were understood as different from marital/ family discord on the grounds of less severity and intensity. In this study, descriptive analyses were carried out using SPSS version 20.0, Descriptive statistics mean, median and standard deviation were used.

RESULTS

A total of 149 case records of women with SMI during perinatal period were included in this study. The mean age of the women in the study was 25.27 years. (SD=4.97).

Clinical profile

Of 149, sixty-eight women (45.6%) were diagnosed with non-affective psychosis (psychosis NOS, schizophrenia, acute psychosis, delusional disorder), 63 women (42.2%) with affective psychosis (Mania, BPAD, mixed affective, severe depression) and 18 (12.07%) others. A family history of mental illness was recorded in 60 charts (40.9%), 130 (87.2%) women who were seeking inpatient treatment had their first post-partum episode of SMI, 14 (9.39%) women had an earlier perinatal episode, and 5 (3.35 %) women had two earlier perinatal episodes. Regarding age of marriage, 52 (34.8%) of the women married below the age of 18, 80 (53.6%) married between the ages of 19 and 25, 17 (11.4%) after 26 years and above. Four spouses had a history of mental illness. 17 spouses were diagnosed with alcohol dependence syndrome, 9 had occasional alcohol use. Of the 149 charts, 108 had documentation of the nature of marital relationship of which 44 (40.74%) couples were recorded as having a cordial relationship, 47 (43.51%) women reported having some problems in their marital relationships and 17 (15.74%) were recorded to have marital discord in the chart. Details about the nature of the marital relationship were not available in 41 charts.

Context of marital problems or discord

Of 64 charts which reported marital problems or discord, twenty-seven charts documented interpersonal issues secondary to poor support from their spouses: husband not spending time with the wife, lack of involvement in the treatment of the patient, poor financial support, and experiences of feelings that the husband does not care for and understand them. Five charts recorded interpersonal issues in the context of the patient's illness. The reasons documented included women's behavior during the period of illness, in the form of abnormal behavior, anger, and disrespect. Further, during the course of the illness if the patient was unable to do household chores such as cleaning, washing dishes, cooking etc, had led to critical comments. Six charts recorded information about IPR issues in the context of personality-related factors. Before

the onset of the illness, husbands reported issues in the form of demanding behavior, sensitivity to criticism, insecurity about their relationship, and being suspicious and short-tempered. Whereas for the women, the issues noted were anger outbursts of the husband, and violence towards wives and children. Another four charts recorded the husband's alcohol use as one of the main reasons for interpersonal problems in their relationship.

Table 1: The sociodemographic profile of women with SMI during perinatal period.

Variables	Sub categories	N (%)
Religion	Hindu	134 (89.9)
	Muslim	14 (9.4)
	Christian	1 (0.7)
Education	No formal education	10 (6.7)
	Primary	29 (20.2)
	Secondary	65 (43.6)
	Degree & above	36 (24.2)
Occupation	Home maker	105 (70.9)
	Unskilled jobs	6 (4.1)
	Semi-skilled job	4 (2.7)
	Professionals	3 (2)
Annual income (Indian Rupee)	0-19000	45 (30.2)
	20000-39000	81 (54.4)
	40000 and above	23 (15.4)
Marital status	Married	146 (97.9)
	Separated	2 (1.3)
	Widow	1 (0.7)
Type of marriage	Arranged	75 (50.3)
	By Personal choice	19 (12.8)
Type of family	Joint	72 (49.0)
	Nuclear	24 (16.3)

Family relationships

Relationship with FOP: Sixty-eight charts documented the relationship between women and their in-laws, of which 58 charts recorded having interpersonal problems with in-laws' families and 10 charts reported having cordial relationships with in-laws. Based on the documentation of family issues in the case files, the main themes around which women and in-laws had interpersonal relationship issues were derived. Violence: 38 charts reported incidents of domestic violence by spouses and in-laws. The violence occurred on the following occasions: the husband and father-in-law were intoxicated with substances, the husband was asking for a divorce from the woman, according to the husband and in-laws, poor household work performance by women, not involving themselves adequately in the everyday tasks at home, and when the performance of household tasks was obstructed by drowsiness due to medications during the day, demands of dowry. It was also recorded that 16 (10.73%) women were constantly threatened by in-laws and spouses with divorce and separation. Household chores: it was documented that the patient was expected by in-laws to complete all household work independently and the stress associated with completing household chores, led to interpersonal issues with in-laws' families. Criticism due to her illness: women faced criticism regarding their mental illness, their performance in doing household chores, and their appearance and clothing. Her in-laws constantly compared her with other women in the family. In-laws and relatives often complained about her illness and how they regret their son marrying an unwell lady.

Gender concerns

Thirty charts (20.1%) recorded that there were concerns present about the gender of the baby. The families and spouses had expressed their wish to have a male child, and patients had reported that they experienced stress about the same 'what if a female child was born?' The husband wanted male children, and upon discovering the birth of a female child, it led to problems between the couple.

Relationship with family of origin (FOO)

Out of 54 charts, 32 (59%) were recorded to have a cordial relationship and 22 (41%) reported having problems in relationships with their family of origin. The nature of interpersonal problems with the family of origin are mentioned below: FOO forced the woman to go back to live with her in-laws despite her telling them that she had been uncomfortable at in-laws' house. Marrying against FOO's wishes resulted in relationship problems. IPR issues between FOO and in-laws as a stressor for patients. The patient's right to property was denied by her parents or her brothers disagreeing over property matters in FOO.

DISCUSSION

The study aimed at understanding the marital and family relationships among women with SMI. Most women with an episode of perinatal illness were in the age range of 21-28 (mean age 25.27) years similar to findings reported in a study earlier done in our centre.[11] All women were married, a majority had an arranged marriage and lived in a joint family set up with their in-laws. In India, most couples are married through arranged marriages, where family members are primarily responsible for choosing their spouse. However, the couple's involvement in choosing their spouse is also increasing.[12-13] It is observed that a woman's life begins as a daughter-in-law in a joint family where she resides with her husband and in-laws.[14] The couple experienced relationship problems or marital discord in the context of the woman's illness, lack of perceived support from the husband, substance use in the husband, and gender preferences. An earlier study from India, reports after marriage when the husband comes to know about mental illness in the wife, he conveys his resentment, neglects the wife and wants to abandon her, while the wife and her parents make all efforts to ensure that she stays in the matrimonial home. During her stay in the matrimonial home, she faces ill-treatment from her husband and in-laws.[15] Women with mental illnesses mostly encounter broken marriages in India and only 30%

of women with schizophrenia live, at least temporarily, with spouses. They are often subjected to domestic violence and neglect and exhibit a strong gender preference for a male child, this discrimination or prejudice continues despite socioeconomic development and higher growth rates.[16-18] Most women in our study reported interpersonal problems with their in-laws and spouse in the context of their mental illness, their inability to carry out household chores, caring for the baby, and violence at home. The findings are similar to a study [19-20] where they found intimate partners were not the only ones involved in the abuse; in most cases, the in-laws also abused the women (their daughters-in-law). Differences in daily routines, cooking and cleaning styles were common causes of conflict between mothers-in-law and daughters-in-law. Domestic violence in the Indian context is unique, as it is perpetrated not only by intimate partners but also by in-laws. In our study, we also found the interpersonal relationship issues between patients and her own family. The context of the interpersonal issues was because of the marriage of the patient against FOO's wishes, family forcing the patient to go back to live with her in-laws despite her telling them, that she was unhappy there. Interpersonal issues between FOO and FOP/in-laws as a stressor for patients and property issues, where either the patient's right to property is denied by her parents or her brothers was also recorded. An earlier study reported, self-arranged marriages continue to be perceived as a blot on family honour (izzat) and result in a range of adverse reactions, ranging from limited natal family support to ostracism of the girl.[21] In India, The Hindu succession (amendment) act, 2005 (39 of 2005) was enacted to remove gender discriminatory provisions in the Hindu succession act, 1956. However, many women cannot or are not able to access property due to legal illiteracy and the societal patriarchal mindset.[22] The study has an important contribution to the scant literature on marital and family relationships among women with SMI during the perinatal period in a patriarchal culture like India. The study highlights the importance of family relationships beyond the marital couple, broadening the discussion from marital quality to family relationship quality. The presence of a joint family system highlights the importance of the relationship between women and their in-laws and the need to widen the scope of interventions. The other contribution is the significant presence of domestic violence, perpetrated by the spouse and in-laws.

The traditional joint family that exists in India is seen as a source of social and economic support and allows for diffusion of burden in families caring for the mentally ill and could be responsible for mediating the good course and outcome of major mental disorders. On the other hand, in the 'restrictive' environment of the joint family, women are expected to observe more restraint, and all must be subject to the command of the 'elders', which leads to interpersonal maladjustment.[23] The National family health survey (NFHS)-5, reported that 29% of women aged 18-49 have experienced physical violence since age 15, and three percent of ever-pregnant women have experienced physical violence during any pregnancy.[24] Thirty-two percent of ever-married women aged 18-49 have experienced physical, sexual, or emotional spousal violence. As domestic violence is a sensitive issue, under-reporting due to fear of stigma or fear of escalation of violence cannot be ruled out, though routine assessment and interviews were conducted with privacy and ensuring confidentiality. The issues of IPV or DV are taken seriously, addressed and acknowledged by the MDT at MBU. Expressing empathy, and validation, providing education about the impact of violence on survivors' health and mental health, her safety plan, psychosocial intervention, referrals to resources and organizations offering support to abused women and a close follow-up are routinely carried out. Although our study is a retrospective chart review, patients at MBU, NIMHANS undergo comprehensive assessment, intervention and documentation. The incomplete data can be secondary to discharges against medical advice, abrupt discharges due to some life events/familial context, husband unavailability during inpatient care secondary to job, geographical locations or pre-existing interpersonal issues with wife. This would have compounded the non-recorded data of the marital and family relationship. The sample was drawn from a tertiary care centre in India. Thus, generalizing the results to other populations without similar contextual factors (e.g., urban, low-income backgrounds, cultural context) is limited.

CONCLUSION

The perinatal period brings various changes for women and families. But having an episode of perinatal mental illness can add to various other stressors and existing issues for women and their families. The findings of this study bring to our attention that domestic violence from spouses and in-laws and interpersonal difficulties with them play a significant role in maintaining the distress of women who are admitted for IP care. Hence, it is essential to assess domestic violence as a part of routine care for women with perinatal mental illness. The study highlights the need for assessing and intervening in the couple relationships focussing on preparedness for parenthood.

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