## **Research Article**

DOI: http://dx.doi.org/10.18203/2394-6040.ijcmph20161401

# A study on social factors and magnitude of mental health problem among women with marital disharmony

# Sudhir Prabhu<sup>1</sup>, Delma D'Cunha<sup>2</sup>\*

<sup>1</sup>Department of Community Medicine, <sup>2</sup>MBBS Intern, Father Muller Medical College, Kankanady, Mangalore, India

Received: 15 March 2016 Revised: 13 April 2016 Accepted: 19 April 2016

\*Correspondence: Dr. Delma D'Cunha,

E-mail: demi.elmo@gmail.com

**Copyright:** © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

#### **ABSTRACT**

**Background:** Marital disharmony is a widespread phenomenon that is largely hidden. The single most important factor that determines the quality of the family is the quality of marriage that supports it. Rapid socio-economic transitions in our society have led to increasing trends in marital disharmony thus emerging as an important social problem with grave consequences. This study was undertaken to identify the key social factors which contributed towards development of mental health problems among the affected women.

**Methods:** The present cross sectional study was conducted at a family counselling centre located in Davangere city where a total of 53 participants, who registered and availed the short term stay facility in the centre and who consented to participate in the study were administered a questionnaire to assess socio-demographic factors and were interviewed using Goldberg's 12 item general health questionnaire (GHQ) as a screening tool for the presence of psychiatric morbidity. Hamilton's rating scales for anxiety and depression were then used for confirmation.

**Results:** Each of the female subjects mostly in the age group 22-26 years (35.8%) were facing some degree of marital discord; the largest proportion (47.2%) facing problems for periods greater than a year. The commonest reasons for discord were found to be physical harassment (32.1%) and dowry-seeking (20.8%).56.6% of the women suffered from mild to moderate degree of depression. Among the spouses, addictions were seen in 60.4 %. After counseling, 81% were willing for a compromise, with the remaining 19% strongly rooting for separation from their spouses. Using univariate and multivariate analyses, it was seen that there was a strong correlation between social and familial factors and psychiatric morbidity.

**Conclusions:** In our study we found that the overall psychiatric morbidity rates were very high; depression being the commonest. Dowry and physical harassment from the husband were the most common reasons leading to disharmony. We found that counselling works as an effective measure to sort out the issues affecting the marriage. Post personality assessment of the spouse, which could be beneficial in solving such matters should be implemented. Also, establishment of social support centers for socially dependent women could be a useful approach in managing cases of marital disharmony.

Keywords: Marital disharmony, Depression, Addictions, Partner violence, Dowry, GHQ

#### INTRODUCTION

Marriage is an institution, the foundation of family life which in turn is the basic unit of a society. In India, arranged marriages stay put as the most favored option for most sections of society owing to cultural and religious beliefs.<sup>1,2</sup> Even then, in the recent changing times, a few cases of liberal mindedness are also seen. Marriage being the union of two people and more so, two families, requires a lot of adjustment from both sides.

This by itself may be quite stressful for some individuals. To add to this, certain familial, social and financial factors lead to the growth of mental health problems.

Mental health disorders may be seen in any individuals, yet it could be due to the effect of marital disharmony. High prevalence of psychiatric morbidity has been reported among couples with marital discord.<sup>3</sup>

Time and again studies show greater misery among individuals following a separation, divorce or death of a spouse. According to some studies in other parts of the world, distress is seen more among married women than married men, and more in single women than single men. These studies also show that affected women are more symptomatic than their male counterparts.<sup>4</sup>

Marriages stipulate a continued level of understanding, adjustment and trust from both partners. This is complicated by certain social practices such as dowry. Further, the process of child birth, financial instability, an abortion or miscarriage, job transfers, sicknesses, or any such circumstance can lead to demanding or taxing periods in a relationship. Other problems related to sexuality, infidelity and trust issues can also trigger marital disturbances.

There also exists a lot of stigma associated with mental illnesses and broken families in Indian society leading to under-diagnosis of such cases. Alcohol addiction is seen to be a major causative or associative factor leading to broken families.

This study was undertaken to identify the key social factors which contributed towards development of mental health problems among the affected women.

The objective of this study was to study the social factors contributing to marital disharmony. And to study the magnitude of mental health problem among women affected with marital disharmony. And to study the social factors contributing to the development of mental health problem among these women.

### **METHODS**

The present cross sectional study was conducted at a family counseling centre located in Davangere city. A total of 53 women who registered and availed the short term stay facility in the centre during the study period of 6 months were included in the study as study subjects. Necessary permission from the concerned authorities was obtained. Ethical clearance was taken from the institutional ethics committee at JJM medical college Davangere. The purpose of the study was explained and a written informed consent was taken in a consent form (annexure A) from the participants willing to participate in the study. Only those women with past history of any psychiatric disorders were excluded from the study.

The participants were administered a predesigned, pretested questionnaire (Annexure B) validated for local setting, to assess socio-demographic factors and Goldberg's 12 item general health questionnaire (Annexure C) was used as a screening tool for the presence of psychiatric morbidity. Hamilton's rating scales for anxiety and depression (Annexure D) was used for confirmation.

Data was collected through face to face interviews. Each respondent was made to complete a short questionnaire containing socio-demographic questions and questions related to marital life. The general health questionnaire (GHQ) which is a determinant of mental health was used to assess whether the respondent had experienced a particular symptom, behavior or activity recently. Each item was rated on a four-point scale (always, usually, occasionally, never) and was scored with points ranging from 0 to 3. A total score of greater than 24 was considered as significant.<sup>5</sup>

The Hamilton anxiety scale (HAM-A) which is a questionnaire used to measure the severity of anxiety symptoms was used in our study. The questionnaire had 14 items regarding certain somatic (physical factors related to anxiety) and psychiatric symptoms (psychological stress). Each item was scored on a scale of 0 (not present) to 4 (severe), with a total score range of 0-56, where <17 indicated mild severity, 18-24 mild to moderate severity and 25-30 moderate to severe severity.

The Hamilton depression rating scale (HAM-D) was used to confirm anxiety and assess depression in the subjects. The questionnaire comprised 17 items related to symptoms of depression experienced by the individual in the recent past. Scoring was ranged from 0 to 3 or 0 to 4 based on the type of question. A score of 0-7 was taken to be normal, while a score of 20 or more was considered to be significant for depression. 9,10

Data was entered into Microsoft excel sheet and analyzed using SPSS software. The statistical tests used were descriptive statistics like frequency, percentages, measures of central tendency, measures of dispersion and inferential statistics like the chi-square test/ Fisher exact test and multiple logistic regressions.

#### **RESULTS**

The study population constituted 53 women; 19 (35.8%) of them belonged in the age group 22-26 years.

There was equal number of subjects from urban as well as rural set up. 42 (79.2%) of them were arranged marriages and the remaining 11 were love marriages.

Each of the subjects were facing some degree of marital discord with the duration varying from less than 6 months to more than a year as shown in Table 3; the largest

proportion; 25 (47.2%) of them facing problems for periods of greater than a year. Varied reasons were cited for reasons for quarrel as shown in (Table 4) with the commonest being physical harassment as stated by 17 (32.1%) and dowry-seeking by 11 (20.8%).

Table 1: Age wise distribution.

Age group	Frequency	Percentage (%)
< 18 years	2	3.8
18-22 years	13	24.5
22-26 years	19	35.8
26-30 years	12	22.6
30-34 years	6	11.3
>34 years	1	1.9
Total	53	100

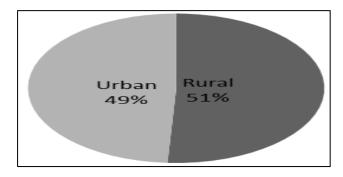


Figure 1: Location.

Table 2: Addictions in the husband.

Duration	Frequency	Percentage (%)
<6 months	13	24.5
6 months-1 year	15	28.3
>1 year	25	47.2
Total	53	100

**Table 3: Duration of the problem.** 

Problems	Frequency	Percentage (%)
Dowry	11	20.8
Physical harassment	17	32.1
Mental harassment	1	1.9
Physical and mental harassment	2	3.8
Sexual harassment	3	5.7
Illegitimate relations	8	15.1
Marriage/children	5	9.5
Suspicious husband	6	11.3
Total	53	100

Among the spouses, addictions were seen in 32 (60.4%), even though a significant proportion i.e. 11 (20.8%) had no addictions with alcohol or tobacco at all.

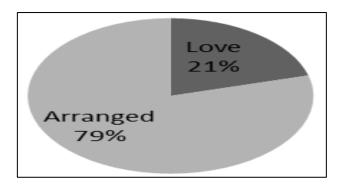


Figure 2: Type of marriage.

Table 4: Reasons for quarrel.

<b>Type</b>	Frequency (n)	Percentage (%)
None	14	26.4
Mild depression	17	32.1
Moderate depressi	on 13	24.5
Severe depression	2	3.8
Anxiety	2	3.8
Anxiety and depre	ession 5	9.4
Total	53	100

43 (81%) of our study participants were willing for a compromise after multiple counseling sessions, with the remaining 10 (19%) strongly rooting for separation from their spouses.

Prevalence of psychiatric morbidity was high with 30 (56.6%) of the women suffering from mild to moderate degree of depression as shown in (Table 5).

Table 5: Psychiatric morbidity.

Type	Frequency (n)	Percentage (%)
None	14	26.4
Mild depression	17	32.1
Moderate depression	13	24.5
Severe depression	2	3.8
Anxiety	2	3.8
Anxiety and depressi	on 5	9.4
Total	53	100

Table 6: Univariate analysis of income of the woman with psychiatric morbidity.

		Income			Total
Psychiatric		0	< 5000	>5000	
morbidity	morbidity Yes		5	11	39
	No	10	4	0	14
	Total	33	9	11	53

X<sup>2</sup> value 5.71, DF=2, P=0.06

Table 7: Univariate analysis of frequency of quarrel with psychiatric morbidity.

	Frequency of quarrel Total					
Psychiatrc	Dai	ily >1	l week	< 1 we	ek	
morbidity	Yes	20	16	3	39	
	No	1	13	0	14	
	Total	21	29	3	53	

X<sup>2</sup> value 11.2; DF=2; P=0.0038.

In our study, using univariate and multivariate analysis, we assessed the linkage between mental health and various factors which could have a likely impact.

Correlation between psychiatric morbidity and income of the woman (Table 6) highlights the statistical significance (X2 value 5.7, P=0.06) in that, financial stability of the women led to more disagreements and fights at home, as the male wasn't allowed to be dominant in terms of finances.

It was also found that more the frequency of quarrels, greater the incidence and degree of psychiatric morbidity and depression ( $X^2$  value 11.2, P=0.0038 and  $X^2$  value 6.76, P=0.028 respectively). The incidence of depression

faced by the woman was found to be associated with her husband's educational status ( $X^2$  value 8.82, P=0.010).

Using the multivariate model, we noticed significance at one level (psychiatric morbidity with husband's educational status) with a P value of 0.48 as shown in (Table 10).

Table 8: Husband's education.

	Total					
Depr- ession	Illi	Illiterate Pry/mid/ College/				
ession			high	graduate		
	Yes	6	12	19	37	
	No	2	12	2	16	
	Total	8	24	21	53	

 $X^2$  value 8.82; DF=2; P=0.010.

Table 9: Frequency of quarrel.

		Frequency of quarrel					
Depres-		Daily	> 1 week	< 1 week			
sion	Yes	18	16	3	37		
	No	3	13	0	16		
	Total	21	29	3	53		

 $X^2$  value 6.76; DF=2; P=0.028.

Table 10: Factors associated with depression.

Factors		Odd's ratio	Lower C.I.	Upper C.I.	Significance
O-4	Compromise	0.700	0.106	4.6	P = 0.69
Outcome willing	Separation	1	-	-	
Dowry	Taken	0.83	0.21	3.2	P=0.78
Dowly	Not taken	1	-	-	
Family type	Nuclear	0.61	0.12	3.3	P= 0.54
raining type	Joint	1	-	-	
Husband's education	Illiterate	2.40	0.195	29.6	P= 0.48
	Pry/mid/high school	8.06	1.14	56.57	P= 0.034
	College/graduate	1	-	-	

#### **DISCUSSION**

In our study we found that marital disharmony was equally prevalent in both rural and urban localities. In our study sample, arranged marriages were more compared to love marriage.

The most common causes for harassment of women were dissatisfaction with the dowry received at marriage, demanding the women and their families for more of it, addictions in the partner and alcoholism of the husband were found to be major factors of marital disharmony and thus, psychiatric morbidity among these women. This is in agreement with a study done by Batra et al in which it

was found that psychological distress and divorce rates were higher among the spouses of alcohol-dependants.<sup>3</sup>

Among women coming from urban areas a few additional factors came into play, for instance, more income or financial stability of a working woman than her husband, working late hours, asking for help in household chores, being more actively involved in social events etc. In our study, a correlation between psychiatric morbidity and income of the woman showed a statistical significance in that, financial stability of the women led to more disagreements and fights at home.

It was also found in our study that a large proportion i.e. 43 (81%) of our study participants were willing for a

compromise after multiple counseling sessions i.e. the women had an inclination to put up with the harassment, anxiety and depression they faced, as also seen in a study by Nayar et al, mostly for the sake of their children as the mothers feared that it would hamper their children's social and emotional growth. This is a proven fact as confirmed by other studies in the past such as the one done by Weindrich et al, Reid et al and Caplan et al. 12-14 Also the cultural, traditional and religious norms of the society made them tolerate the sufferings without seeking help for long periods of time.

#### **CONCLUSION**

#### The following observations were made during this study

- Overall psychiatric morbidity rates were very high, among them depression was most common.
- Dowry and physical harassment by the husband were the most common reasons for disharmony.
- Counselling, post personality assessment of the spouse should be implemented for prevention and management of cases of marital discord.
- Establishment of social support centres for socially dependent women affected by marital disharmony would be a beneficial step towards this social problem.

Funding: No funding sources Conflict of interest: None declared

Ethical approval: The study was approved by the

Institutional Ethics Committee

#### REFERENCES

- 1. Marriage NS. Mental health and the Indian legislation. Indian J Psychiatry. 2005;47(1):3-14.
- Frieze IH, Schumm JA, Williams SL. Violence in the family as a public health concern. In: Wallace RB, editor. Maxcy-Rosenau-Last: Public health and preventive medicine.15<sup>th</sup> ed. New York: McGraw Hill; 2008:1329.
- 3. Batra L, Gautam S. Psychiatric morbidity and personality profile in divorce seeking couples. Indian J Psychiatry. 1995;37(4):179-85.

- Jablensky A, Sartorius N, Ernberg G, Anker M, Korten A, Cooper JE, et al. Schizophrenia: manifestations, incidence and course in different cultures: A world health organization ten-country study. Monograph. Psychol Med. 1992;20:1-97.
- 5. Goldberg DP, Blackwell B. Psychiatric illness in general practice. A detailed study using a new method of case identification. Br Med J. 1970;1:439-43.
- 6. Hamilton M. The assessment of anxiety states by rating. Br J Med Psychol. 1959;32:50-5.
- 7. Maier W, Buller R, Philipp M, Heuser I. The Hamilton anxiety scale: reliability, validity and sensitivity to change in anxiety and depressive disorders. J Affect Disord. 1988;14(1):61-8.
- 8. Borkovec T, Costello E. Efficacy of applied relaxation and cognitive behavioral therapy in the treatment of generalized anxiety disorder. J Clin Consult Psychol. 1993;61(4):611-9.
- 9. Hamilton M. Development of a rating scale for primary depressive illness. Br J Soc Clin Psychol. 1967;6(4):278-96.
- 10. Williams JB. A structured interview guide for the Hamilton depression rating scale. Arch Gen Psychiatry. 1988;45(8):742-7.
- 11. Nayar M, Muralidhar D, Vranda MN, Murthy P, Gangadhar BN, Jagadish A. Narratives of wives living with persons with alcohol dependence-why do they stay in violent marital relationships? Indian Journal Of Clinical Psychology. 2010;37(1):37-45.
- 12. Weindrich D, Laucht M, Esser G, Schmidt MH. Marital disharmony of the parents and child development in infancy and early childhood. Prax Kinderpsychol Kinderpsychiatr. 1992;41(4):114-8.
- 13. Reid WJ, Crisafulli A. Marital discord and child behavior problems: a meta-analysis. J Abnorm Child Psychol. 1990;18(1):105-17.
- 14. Caplan HL, Cogill SR, Alexandra H, Robson KM, Katz R, Kumar R. Maternal depression and the emotional development of the child. Br J Psychiatry. 1989;154:818-22.

Cite this article as: Prabhu S, D'Cunha D. A study on social factors and magnitude of mental health problem among women with marital disharmony. Int J Community Med Public Health 2016;3:1298-302.