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A Community Study on Mental Health among Rural Women

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Abstract
Introduction: Good mental health is a sense of wellbeing, confidence, and self-esteem. It enables one to fully enjoy and appreciate other people, cope with day to day life and with his/her environment. Mental health problems affect women and men equally. But women are particularly exposed to some of the factors that increase the risk of poor mental health because of the role and status that they typically have in society.
Methodology: The aim of the study was to assess the mental health status (minor mental health problems) among women. The study was descriptive cross sectional. Fifty randomly selected respondents in a village were interviewed using Clinical Interview Schedule-Revised (CSIR) and substance abuse questionnaire developed by World Health Organization (WHO).
Result: The study found that 18% of respondent had sub threshold psychotic symptoms, 6% had common mental health disorder diagnosable as per ICD 10 criteria especially in minor mental health problems. About 44% fulfilled the criteria for dependence primarily on tobacco. Suggestions: The findings clearly describes that there is a need to create health awareness and enhance wellbeing among women especially in rural areas. The policy and social scientists intervention is required in many dimensions. Conclusion: The study report the major health problems and an increase in substance abuse among women.
Key words: women, common mental health, mental illness, assessment, substance abuse.

I INTRODUCTION

Good mental health is a sense of wellbeing, confidence, and self-esteem. It enables one to fully enjoy and appreciate other people, cope with day to day life and with his/her environment. Mental health problems affect women and men equally. But women are particularly exposed to some of the factors that increase the risk of poor mental health because of the role and status that they typically have in society. Mental health has been reported as an important factor influencing an individual's various behaviors, activities, happiness and performance. Gender considerations in health promotion and healthcare have to highlight the mental health risks and the socioeconomic and cultural determinants of mental health. Apparently, economic independence, physical, sexual, and emotional safety and security are primarily needed for good mental health. Unfortunately, same are supposedly denied to some women by virtue of their status as women. Such gender-based discrimination is not only a gross violation of human rights but directly contributes to the growing burden of disability caused by poor mental health [1].

Mental pressure is a vital cause of the mental health problems which arise due to various conditions. If the mental condition is good, a woman can take various responsibilities of family, herself, understand the complications, try to solve them, plan for future and adjustment with others by becoming mentally strong. Mental health can be defined as the ability to make adequate social and emotional adjustments to the environment, on the plane of reality. In other words it is the ability to face and accept the realities of life [2].

World Health Organization (2001) defines "Mental health is a state of well-being in which every individual realize his/her own potential, can cope with the normal stresses of life, can work productively and is able to make a contribution to his/her community [3]". WHO has estimated that globally over 450 million people suffer from mental disorders, currently mental and behavioral disorder account for about 12 per cent of the global burden of disease. This is likely to increase to 15 per cent by 2020.

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Studies reported that depression, Schizophrenia, Perinatal illness, eating disorders and substance abuse are the possible effects of gender [4]. There is a strong relationship between women's social roles and mental health. Women whether single or partnered, having children had a higher risk of personal stress. Single, unemployed mothers were significantly more to experience financial stress. For partnered mothers, rate of personal stress and chronic stress were significantly lower among unemployment partnered mothers. Married and partnered mothers reported better mental health than single partnered [5]. A study surveyed 9938 women, among them 40% reported poor mental health, women violence were at increased risk of poor mental health and indicated a strong association between domestic spousal violence and poor mental health, and underscore the need for appropriate interventions [6]. A study reported that physical health and nutritional status is not associated with common mental illness whereas married or divorced or separation or widowed, gynecological are associated with common mental illness [7]. Studies described that mentally healthy person is not having worries, tension in their life and physically healthy as bold and confident. Commonest stressors were conflict with husband and mother-in-law, domestic violence and poverty. The study highlighted the need to reduce discrimination based on sex, caste, disability and illness, and promoting individual and community mental health. Violence induces suicidal tendencies among women [8,9].

The review shows that many studies have been conducted on women's mental health. They focused on socio- economic status, socio- cultural and environmental factors, domestic violence and abuse among women. Available evidences indicates that women are prone to a number of health impacting conditions due to, family condition, environmental influences and working condition. Working environment also influence women in consuming substances in different way (tobacco, alcohol, etc.) and at same time their belief influence them to use substance. Women are likely to experience some form of mental illness such as worry, somatic disorder, depression, mood disturbances, substance abuse, suicidal behaviors, obsession and others. Most strongly associated factors with mental disorders are deprivation, poverty; women with lower level of education, low household income, lack of access to basic amenities are at high risk of mental disorder. Lifetime risk of affective disorders, panic disorders, generalized anxiety disorder, specific phobia and substance use disorders is found to be highest among illiterate and unemployed women. Suicidal behavior was found to have relation with female gender, working condition, independent decision making, premarital sex, physical abuse and sexual abuse. Female are more predisposed to mental disorders due to rapid social change, gender discrimination, social exclusion, gender disadvantage like marrying at young age, concern about the husband's substance misuse habits and domestic violence. Divorced and widowed women are at slightly elevated risk of mental disorders. Psychological factors such as headache and body ache, sensory symptoms and nonspecific symptoms such as tiredness and weakness also makes people vulnerable to mental disorders. Biological factors affecting mental disorders are genetic origin, abnormal physiology and congenital defect. Various studies had shown that the prevalence of mental disorders is high in female gender. The present study made an attempt to study the mental health among women and based on the need assessment interview schedule was developed. The study provided insight into the women regarding important of mental health and mental illness. This is a community based study and differs in terms of diagnosis and implications. There is a need to look into the epidemiology of the mental health problems among women in the community in order to understand this. As the study was conducted in the community, this adds to the scientific literature that what

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would be the mental health status of women in the community. Based on the present study findings, appropriate interventions would be tailored to the particular population concerned.

Women are traditionally suppressed to express their notions, problems, and deprived of economic independence particularly in rural areas. Hence they are unable to surpass and are expected to adjust the prevailing environment in their families. Thus it results in dumping their stress and anxiety within themselves. As a result, the smooth functioning of the family was severely disturbed and has negative repercussions on family and marital relationships. The present study reveals the causing factors affect the neurosis among the women. It also reveals the how the neurosis inflicted women are being treated in the society. Moreover, this study provides a platform for promoting mental awareness and suggests measures for alleviating mental health problems.

II METHODOLOGY

The aim of the study was to assess the mental health status (minor mental health problems) among women. Objectives were to study the socio economic details of the respondents, assess the mental health status of the women in a particular community, assess the level of substance use and abuse among women and study the relationship among socio-demographic variables and mental health domains including substance use.

The study was descriptive cross sectional. Universe of the study was Suntanoor village in Kalaburagi district, India. In Suntanoor village about 2897 population was recorded in 2015. Among them 1461 are women. All women at Suntanoor village are considered as Universe of the study. Out of which 700 were in the age group of 36-65 years. It was decided to take 7% of the total population as sample. Hence, the researcher decided to collect the data of about 50 respondents. From 18th February to 29th February every day the researcher used to visit the village for data collection. Fifty randomly selected respondents in a village were interviewed after obtaining informed consent. Average 8-10 interviews were conducted in a day. Each interview lasted for about 30-40 minutes. The following tools were used for the study. Socio-demographic schedule: The socio demographic schedule was prepared by the researcher itself and it includes: Age, Religion, Caste, Education, Type of family, marital status, Occupation, Income and Economic status. Clinical Interview Schedule Revised (CISR) [7]: The clinical Interview Schedule-Revised is a fully structured diagnostic instrument that was developed from an existing instrument, the Clinical Interview Schedule (CIS), which was designed for the use of clinically experienced interviewers such as psychiatrists in 2006. The CISR was revised and developed into a fully structured interview in order to increase standardisation and to make it suitable to be used by trained lay interviewers in assessing minor psychiatric morbidity in the community, general hospital, occupational and primary care research. The scale has 14 domains which assess: a. somatic symptoms, b. fatigue, c. concentration and forgetfulness, d. sleep disorder, e. irritability, f. worry about physical health, g. depression, h. depressive ideas, i. worry.

A. *Total scores are classified as:*

1. No common mental disorder (<6 and no ICD 10 diagnosis). There are 70% of the respondents are not having no neurotic disorder.

2. Sub threshold psychiatric symptoms (CIS-R score 6 -11 and no ICD - 10 diagnosis). There are 18% of the respondents are having initial stage of neurotic disorder.

3. Common mental disorders (CIS-R score 12 and above and or an ICD 10 diagnosis). There are 12% of respondents are having common mental disorder.

Substance use checklist (2004) which has 10 item, was developed by World Health Organization (WHO) [10]. Analysis has been done using statistical package for Social Sciences. (IBM, 21 Versions). Limitations of the study: In this study researcher only assessed women's mental health

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status, because of time limitation the researcher could not able to identify the cause for the mental illness. And even because of time limitation researcher has taken small sample size of women. Hence, the generalization cannot be done. Due to lack of time researcher could not able to interview more number of respondents.

III RESULTS AND DISCUSSION

Descriptive statistics shows (table 1) that mean age is 43.66 $\pm 7.57\ years$. Age of the respondent show that (48%) of the respondents were under 36 to 40 years, 22% of the respondents were under 41 to 45 years, 12 % of the respondents were under the age of 46 to 50 years, 6 % were under the age of 51 to 55 years and remaining 12% were under 56 to 65 years. Religion of the respondents shows that 90% of them Hindu by religion and remaining (10%) of them belongs to Islam. Caste of the respondents shows that 18% of the respondents belongs to general category, 28% belongs to OBC and SC 30% and ST Category is 14% and remaining 10% belongs to minority. Education of the respondents shows that 38% were Illiterate, 38% educated upto primary and upper primary, and 20% did secondary and higher secondary. Occupation of the Respondents shows that 40% are coolie, 10% agriculture, and 16% engaged in Government job or self-employment and remaining 34% are housewives. Types of Family of the respondent's shows that 78% of the respondents are having Nuclear Family and 22% of the respondents are belong to Joint family. Marital status of the respondents shows that 90% of the respondents are married and remaining 10% of the respondents are widow. Annual income of the Respondents shows that 28% of the respondents are having below 10,000 annual incomes, 46% of the respondents are having Rs 11,000 to 25,000 annual incomes, and 26% of the respondents are having annual incomes of Rs.26,000 to 50,000. Economic status of the respondents shows that 84% belongs to BPL card holder whereas 16% are APL card holder.

Table No. 1 Social Demographic details of the Respondents

Sl no	Variable	Category	Frequency (N=50)	Percentage (100%)
1	Age	36 – 40	24	48.0
		41 – 45	11	22.0
		46 – 50	6	12.0
		51 – 55	3	6.0
		56 and above	6	12.0
2	Religion	Hindu	45	90.0
		Muslim	5	10.0
3	Caste	GM	9	18.0
		OBC	14	28.0
		SC	15	30.0

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		ST	7	14.0
		Minority	5	10.0
4	Education	Illiterate	19	38.0
		Upper primary	19	38.0
		Secondary	10	20.0
		Graduation and above	2	4.0
5	Occupation	Coolie	20	40.0
		Agriculture	5	10.0
		Government employee and self-employment	8	16.0
		Housewife	17	34.0
6	Types Of Family	Nuclear Family	39	78.0
		Joint Family	11	22.0
7	Marital Status	Married	45	90.0
		Widow	5	10.0
8	Annual Income	10000 and below	14	28.0
		11000 to 25000	23	46.0
		26000 to 50000	13	26.0
9	Ration card	BPL	42	84.0
		APL	8	16.0

Table: 2 Category of mental health status of the respondents

Category	**N=50**	**%**
No common mental disorder (<6 and no ICD 10 diagnosis)	35	70.0
Sub threshold psychiatric symptoms (CIS-R score6 -11 and no ICD - 10 diagnosis)	9	18.0
Common mental disorders (CIS-R score 12 and above and or an ICD 10 diagnosis)	6	12.0

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Table 2 describes the mental health status of the respondents. About 70% of the respondents did not have any common mental disorders as per ICD- 10 classification, 18% had sub-threshold of psychiatric symptoms and 12% met the criteria for common mental health disorders basically on neurotic disorders.

Table: 3 Dependence level on substance use among women

Category	Frequency	Percent
Dependence (3 or more of the symptoms	22	44.0
No dependence < than 2 symptoms	28	56.0

The table 3 describes dependence on substances use shows that 44% met the dependence majorly on tobacco products and remaining 56% are not dependent on substance use.

Table: 4 (t – test) Neurotic symptoms and other variables

Variable	Category	N	Mean	Std. Deviation	t	df	Sig. (2-tailed)
Neurotic symptoms and marital status	Married	45	4.15	4.58	-1.305	4.419	.256 NS
	Widow	5	8.20	6.76			
Neurotic symptoms and religion	Hindu	45	4.71	5.00	.756	5.388	.481 NS
	Muslim	5	3.20	4.14			
Neurotic symptoms and types of family	Nuclear family	39	5.05	5.25	1.342	48	.186 NS
	Joint family	11	2.82	3.02			
Neurotic symptoms and ration card	BPL	42	4.62	5.09	.193	48	.848 NS
	APL	8	4.25	4.06			

*significant at 0.05level, NS=Not significant

The table 4 explains the mean differences (t test) between neurotic symptoms and other variables. It shows that there is no significant difference between married and unmarried (t=1.305, df=4.419, p>0.256), Hindu religion and Muslim religion (t=.756, df=5.38, p<0.48)., nuclear family and joint family (t=1.342, df=48, p<0.186) and APL and BPL families (t=.193, df=48, p<0.848). Hence, it is concluded that that these variables do not affect neurotic symptoms/mental health.

Table: 5 One way Anova for neurotic symptoms and demographic variables

Variable	Category	N	Mean	SD	df	F	Sig
Age	36 – 40	24	3.7500	4.85	4	.809	.526 NS

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	41 – 45	11	4.8182	4.40			
	46 – 50	6	3.6667	5.57			
	51 – 55	3	8.0000	6.24			
	56 and above	6	6.5000	5.21			
	Total	50	4.5600	4.91			
Occupation	Coolie	20	3.7000	3.78			
	Agriculture	5	7.8000	5.93			
	government employee and self employment	8	4.1250	4.45	3	.965	.418 NS
	Housewife	17	4.8235	5.92			
	Total	50	4.5600	4.91			
Education	Illiterate	19	4.7895	3.72			
	upper primary	19	4.6316	6.03			
	Secondary	10	4.9000	5.11	3	.590	.624 NS
	graduation and above	2	.0000	.00			
	Total	50	4.5600	4.91			
Income	10000 and below	14	5.5714	5.27			
	11000 to 25000	23	2.9130	3.17			
	26000 to 50000	13	6.3846	6.31	2	2.654	.081 NS
	Total	50	4.5600	4.91			

To check the mean differences on neurotic symptoms and socio-demographic variables, one-way Anova was done. It shows that there is no statistically significant difference in mental health among various categories of age (F.809, df=4,p>0.5). But the mean scores clearly mentions that above 51 years respondents are having high mean scores. The larger samples would give clear picture. Hence, it is concluded that all the age groups are having same mental health status. The null hypothesis has been accepted. Occupation of the respondents shows that statistically there is no significant difference among various occupation groups (F=.965, df=3, p>0.05). It shows that agriculture people are having more mean. Among various education groups there is no statistically significant different (f=.590, df=3, p>0.05). Hence it is concluded that the various education of the respondent is having same mental health status. Income of the respondents

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shows that there is no statistically significant difference among various incomes. (F=.590,df=3,p>0.05).

Hence it is concluded that the various income of the respondent is having same mental health status. The null hypotheses have been accepted.

Table: 6 Chi-square for category for mental health status and category for dependence on substance use

		category for dependence		Total
		Dependence (3 or more of the symptoms)	No dependence (Less than 3 symptoms)	
Category of mental health status	no common mental disorder(<6 and no ICD 10 diagnosis)	17	18	35
	subthreshold psychiatric symptoms (CIS-R score6 -11 and no ICD - 10 diagnosis)	3	6	9
	common mental disorders (CIS-R score 12 and above and or an ICD 10 diagnosis)	2	4	6
Total		22	28	50

χ^2 =0.989, df=2, p=>0.05

To check the difference between level of mental health disorders and dependence Chi-square test was computed. It shows that there is no difference between these (χ^2 =0.989, df=2, p=>0.05).

Hypothesis testing:

Hypothesis 1: There are no mental health problems among women

Explanation: It shows that 12% of the respondents are having some type of common mental disorder. Hence the null hypothesis has been rejected and alternative hypothesis has been accepted.

Hypothesis 2: Women do not use any substances. Hence, do not have addiction.

Explanation: It shows that 44% of the respondents are dependence on substance use. Hence the null hypothesis has been rejected and alternative have been accepted.

Hypothesis 3: There is no difference between mental health status and substance use

Explanation: It shows the difference between level of mental health disorders and dependence on substance use. It shows that there is no difference between these. Hence the null hypothesis is accepted and alternative hypothesis is rejected.

IV DISCUSSION

Although women are generally considered healthy during adulthood of life, several important public health and social behaviours and problems either start or peak during these years. Most of these problems are linked with social determinants and lifestyle operating and interacting in complex environments that precipitate or trigger these conditions or behaviors. Developmental transition of people makes them vulnerable particularly to environmental, contextual or surrounding influences. Environmental factors including family, neighborhood, policies, and societal cues can both support or challenge women health and well-being.

In the present study, on the 14 domains of common mental health symptoms like somatic symptoms, fatigue, concentration and forgetfulness, sleep problems, irritability, worry about physical health, depression, depressive ideas, anxiety, phobias, panic, compulsions and obsessions the status of mental health were assesses on women of age group 36 - 65 years. The result shows that 35 respondents are not having ant mental disorders, 9 respondents are having sub threshold psychiatric symptoms and remaining 6 respondents are having common mental disorders. The category for dependence

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shows that 22 respondents are dependent on substance abuse like tobacco, smoking etc. and 28 respondents are not having any substance abuse.

Thus the hypothesis made by researcher that there are no mental health problems among women. The null is rejected and the alternative hypothesis is accepted, there are mental health problems among women in a particular community is accepted.

Second null hypothesis that women do not use any substances is rejected and alternative hypothesis women do use substances and will have addiction is accepted.

The Risk Factors for common mental disorders in Women study by Vikram Patel, 2006 [6] has reported that prevalence of common mental disorders among women to be rate 1.8%, (95/1000 population). William Pickett, 2015 [11] in a study of Factors related to self – perceived health in Rural Women has reported that 17.5% of substance abuse consuming among women there is strong relations indicated with tobacco and smoking.

V CONCLUSION

The present study states that some of the major health problems are impacting women's behaviors and it causes common mental disorders among women including stress and anxiety, and it increased consumption of tobacco, and other substance use. There is also problem of increase in invisible or sub threshold mental disorder such as worry, anxiety, irritability, depression.

In our country women are facing more mental health problems because of abuse, negligent and domestic violence etc which they can't cope with their own problems or situations. There is a strong need for public health community to identify, prepare, integrate and implement mechanisms for delivery of population based intervention along with measuring its impact. Strategic investments in health, nutrition, education, employment and welfare are critical for healthy growth of women and these programmes need to be monitored and evaluated for their efficacy and effectiveness using public health approaches. So therefore, development of interventions to strengthen communities may also promote mental health and well-being.

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