Demography of mental health among young married women in a rural setting in India

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Introduction: Mental health disorder is one of the most important public health concerns at present as it accounts for a large proportion of the global burden of non-communicable diseases. Most mental disorders often have their foundation in the younger years of life and there are evidence that rates of mental disorders in young people have increased during the past few decades. Mental health disorders in young people have multifactorial causes; biological and genetic factors, interact with various social, familial and community level factors to modify the risk of mental disorders. Social disadvantage, disruptive familial environment and cultural factors have major influence on mental health. The key challenges in addressing people's mental health needs, especially in rural areas, are the sensitive nature of the issue, stigma & discrimination associated to it, lack of quality mental health services and mental health professionals. On the other hand, mental health problems among women are specifically hard to reach. In societies like India where women are domesticated and caught within marriage, family and procreation, their communication with outer world is limited and expression of emotion is limited, increasing their vulnerability to common mental disorders like anxiety, depression, stress and so on. However, mental disorders among women is till date a shadowy subject in India and little is known about its pattern, severity and confounding factors. Studying women's mental health is important as it is often linked to various other health outcomes and can affect the well-being of their children and families.

Therefore, our aim in this paper was to assess the mental health status of young women, examine its prevalence and socio-cultural disparities within a rural setting in India.

Data & Methods: We used data from a population based primary survey of 500 young married women (18-30 years) conducted during April-August, 2015 in 10 villages of North-Dinajpur district of West Bengal, India. A multistage sampling design was followed: firstly, two out of nine CD Blocks were selected based on the dominant religious group; in the second stage, villages were identified based on their religious composition and at the final stage equal numbers of households were selected through systematic random sampling.

Women's mental health status was measured by symptom based depression.

Outcome variable:

Depression, as defined by WHO, is a common mental disorder characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, poor concentration and thoughts of death. It can be long lasting or recurrent, substantially impairing a person's ability to function/cope with daily life.

Respondents, in the present study, were asked about their experience of various symptoms of depression persisting in the last 12 months preceding the survey, adopting WHO-SAGE survey (2012) depression module. A score of '1' (having depression) was given to those reporting 4 or more numbers of symptoms and '0' as otherwise (no depression).

Covariates:

Mother's experiences of any spousal violence, respondents' socialization experiences during childhood, status of women in terms of decision making power and experience of domestic violence, marital life satisfaction, overall life satisfaction and satisfaction with social support network were major explanatory variables.

Results:

Prevalence of depression: Descriptive results reveals that, around 17% of the women reported having experienced any depressive symptom such as feeling sad/empty/depressed for several days (15.4%), losing interest in most things she usually enjoyed (11.2%) and feeling tired or lack of energy/tired all the time (9.8%) in the last 12 months preceding the survey. The period of sadness/loss of interest/low energy lasted most of days/nearly every day and for more than 2 weeks for a large number of women (more than 80%). During this period, a considerably higher proportion of women (more than 70%) reported having experienced loss of appetite, problem in sleeping and felt anxious/worried in most days; over 50% of the respondents expressed that they felt negative about themselves and felt hopeless. Another significant proportion of women (30-40%) reported having difficulties in concentrating and moving around, slowing down in thinking and felt restless. Around one third of the women reported losing interest in sex. Most importantly, nearly 40% of the women thought of death or wished to die and around 10% ever tried to end their lives. Combining all, prevalence of symptomatic depression was 13% among the study population.

Determinants of women's mental health: Results from bivariate analysis revealed that married women in the younger age group (18-21 years) reported more depression compared to older ones. Working women and those belonging to nuclear families were more depressed. Depression was more among women who witnessed parental violence during childhood. Women who had love marriages, were childless or had more number of daughters reported more depression. Women who experienced any marital control and any form of spousal violence reported more depressive symptoms. On the other hand, depression was less among those having high marital satisfaction and overall life satisfaction. Bivariate results did not show any significant association of women's mental health with religion and economic status of family.

After controlling for all socio-economic and cultural characteristics, the final multivariate model found a significant religious disparity in prevalence of depression; Muslim women were nearly 3 times more likely to report symptomatic depression than Hindus (OR=2.90, $p<0.01$). Working women were 2.7 times more likely to be depressed than non-working women (OR=2.69, $p<0.05$). Interestingly, depression was more among women having education up to primary and above primary levels. Women experiencing spousal control were more likely to report depression (OR=2.04, $p<0.05$). On the other hand, depression was less among women having more number of sons (OR=0.32, $p<0.10$), higher marital satisfaction (OR=86, $p<0.05$) and higher satisfaction with life (OR=0.65, $p<0.01$).

Conclusion: Despite the sensitive and hard to reach nature of the issue, mental disorder was found to be prevalent in the study population. There is a significant religious disparity with Muslims being more at risk. Educational attainment, work status and sex composition of children were other socio-demographic factors having significant association with mental health status. The study established a strong relationship between the marital well-being and women's mental health. Policies must explicitly address strengthening the capacity to provide mental health services to young women especially in rural settings where mental disorder is a shadowy subject. In conclusion, our single most important recommendation is to integrate mental health interventions with all women's health sectors like maternal and child health programmes, sexual and reproductive health programmes to get a wider coverage and larger service potentiality.

Table 1 Prevalence of various symptoms of depression among young married women.

Symptoms of depression	**Percentage of young married women**
During the last 12 months, R felt sad, empty or depressed for several days	15.4
During the last 12 months, R lost interest in most things she usually enjoyed	11.2
During the last 12 months, R felt her energy decreased/she was tired all the time	9.8
Respondents experiencing any of the three symptoms in last 12 months	**17.2**
Among those reporting any of the 3 symptoms:	
Period [of sadness/loss of interest/low energy] lasted for more than 2 weeks	88.4
Period [of sadness/loss of interest/low energy] lasted most of the day/nearly everyday	76.7
During this period, R lost appetite	70.9
R noticed any slowing down in thinking	41.9
R noticed any problems falling asleep	70.9
R noticed any problems waking up too early	23.3
During this period, R had any difficulties concentrating	34.9
R noticed slowing down in moving around	34.9
During this period, R felt anxious and worried most days	73.3
During this period, R was so restless or jittery nearly every day that she paced up and down and couldn't sit still	39.5
During this period, R felt negative about herself or like she had lost confidence	55.8
R frequently felt hopeless - that there was no way to improve things	53.5
During this period, R's interest in sex decreased	31.4
R thought of death, or wished she was dead	39.5
During this period, R ever tried to end her life?	9.3
Respondents had symptom based depression:	
No	86.8
Yes	13.2
Total, N=	**500**

Table 2 Factors influencing symptomatic depression among young married women.

		Percentage of women reporting depression	**Exp. β** (Results from Binary logistic regression)
Religion	Hindu (ref.)	13.2	
	Muslim	13.2	2.897**
Current work status	Not working (ref.)	10.6	
	Working	28.0	2.686*
Household wealth index	Lower (ref.)	12.7	
	Middle	11.7	0.766
	Upper	15.0	0.871
Type of family	Nuclear (ref.)	13.8	
	Joint	12.6	1.118
Age group	18-21 (ref.)	15.0	
	22-25	12.4	0.951
	26-30	12.7	0.960
Years of schooling	No schooling (ref.)	9.1	
	Primary	15.0	3.064+
	Above primary	14.4	3.310*
Mass media exposure	No (ref.)	11.9	
	Yes	14.2	1.984
Type of marriage	Arranged	12.1	-
	Love	19.4	-
Family composition	No children (ref.)	19.4	
	More sons	8.4	0.322+
	More daughters	21.0	0.876
	Equal no of son & daughters	8.1	0.358
Social support number (SSN)	Low	13.7	-
	High	12.5	-

Ever experience of any spousal violence	No (ref.)	10.1	
	Yes	19.5	0.537
Relationship control (RCI)	No control (ref.)	6.7	
	Any control	17.9	2.043*
Witnessing parental violence	No	12.0	-
	Yes	22.8	-
Marital satisfaction (MSS)	Low (ref.)	26.5	
	High	7.4	0.863*
Satisfaction with life (SWLS)	Low (ref.)	24.4	
	High	5.9	0.652**
Constant			1.272
R-square			0.167

Note: 'ref.' - Reference category; (-) – Variable not included in logistic regression; ** $p<0.01$, * $p<0.05$, $^{+}$ $p<0.10$