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Epidemiology of Mental Health and Mental Health Issues of Women in India: A Literature Review

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ABSTRACT

Worldwide 450 million (12%) people suffer from disability and this will be increased up to 15% in the year 2020, as per WHO estimation. Psychiatric Epidemiological studies in India from 1964 to 2001, shows increasing trends of mental health morbidity prevalence from 9.5 to 102.8 per 1000 population and new incidence cases were over 16.0 per 1000 population. A study reported that overall life time prevalence of mental disorder to be around 5%. Depression, anxiety, and unspecified psychological distress are 2–3 times more common among women compare to men. Common Mental Disorders is common among poor women and the causes may be hormonal factors (reproductive cycle may play a role of increased vulnerability to depression), other factors are excessive partner, alcohol use, sexual, physical violence by the husband, being widowed or separated, having low autonomy in decision making, and low levels of support from one's family. Illiteracy and women mental health is significantly associated in India. Suicide and rape also related to mental health issues in Indian women. In 2012, National Crime Records Bureau reported 24,923 rape cases and among them 98% being committed by someone known to victims. Studies found that girls from nuclear families and women married at a very young age are in higher risk for committing suicide. To reduce these problems, Indian Constitution made several articles and acts to safeguard the disabilities/issues including women. Several NGO's and VO's are also working for the development of this section.

Keywords: *Epidemiology, Mental Health*

The World Health Organization's Ottawa Charter for Health Promotion in 1986, sees health as multidimensional and espouses a social model of health. It defines health as 'a positive concept emphasizing social and personal resources, as well as physical capacities (World Health Organization, 1986).

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WHO report on the social dimensions of mental health, which states that: 'Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities involves cognitive, affective and relational, the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality (World Health Organization, 1981). This definition does not mention gender, but gender can and does impact on the production of mental health at every level - the individual, the group and the environment- and is critically implicated in the differential delivery of justice and equality. Gender configures both the material and symbolic position women occupy in the social hierarchy as well as the experiences which condition their lives.

Women and men differ in the way they communicate, deal in relationships, express their feelings, and react to stress. Thus, the gender differences are based in physical, physiological, and psychological attributes. There are psychological theories that present a gender sensitive viewpoint called as alpha bias, and there are others that are gender neutral representing beta bias. Alpha bias proposes that men and women are different and opposite, and in beta bias differences between men and women are ignored. Alpha bias is seen in psychodynamic theories and therapies where according to Freudian viewpoint, male anatomy and masculinity is the most desired and cherished goal and female anatomy and femininity are seen as a deviation. In contrast, the cognitive theories, behavioral theories, and humanistic-existential theories have beta bias (Hare-Mustin and Marecek, 1988). It is necessary to understand and accept that women and men differ in biological attributes, needs, and vulnerabilities.

The importance of gender differences in mental health is most graphically illustrated in the significantly different rates of major depression experienced by women compared with men. A recent comprehensive review, Gender Differences in the Epidemiology of Affective Disorders and Schizophrenia, found that women predominated over men in lifetime prevalence rates of major depression in all the general population studies conducted so far (Piccinelli and Homen, 1997).

Beginning with the Second World War, epidemiology has grown by leaps and bounds all over the world, even though gross disparities are noticed even today, both between and within countries in its development and application. This branch of community and clinical medicine, means literally 'on the people', indicating study of populations. Epidemiology as a branch of public health has also grown in principles, methods and applications over a period of time (Park, 2002). Epidemiology is defined as 'the study of distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems' (Last, 1988). Psychiatric epidemiology is the study of the distribution and determinants of mental illness frequency in human beings, with the fundamental aim of understanding and controlling the occurrence of mental illness. Psychiatric epidemiology deals

with important components such as disease/disorder, distribution and frequency of disease/disorder, determinants of disease/disorder, human population and methods employed to control the occurrence of illness (Aschengrau and Seage, 2003).

METHODS

Secondary data collection method was followed for this review study. The authors searched articles and reports from several journals which were published in PubMed, Google Scholar, CrossRef, Google, etc. from the year 1964 to 2012. The authors accepted both published and unpublished works. Out of 86 searched publications, a total 49 articles were included for this review. The search engine consists of both research papers and review papers.

RESULTS AND DISCUSSION

Epidemiological studies of mental health in India

WHO estimated that globally over 450 million people suffer from mental disorders and currently mental and behavioral disorders account for about 12 percent of the global burden of diseases. This is likely to increase to 15 percent by 2020. Major proportions of mental disorders come from low and middle income countries (World Health Organization, 2001). So, globally the issues of mental health considered one of the health issues that people suffers. Descriptive epidemiological studies have provided data about the prevalence of mental disorders in the community. However, many researchers have expressed reservations about the comparison of various epidemiological studies because of methodological differences. Varying prevalence rates have been reported in international studies like the Epidemiological Catchment Area Program and the National Co-morbidity Survey (Regier *et al.,* 1998, Murphy *et al.,* 2000).

Psychiatric epidemiology has kept its place with the general growth of psychiatric research in India. (Wig and Akhtar, 1974) mentioned that psychiatric research itself has grown by leaps and bounds in India since the time of independence. Wig clearly classifies this during the periods 1947–1960 (a slow phase of growth due to the lack of researchers and clarity issues) and 1960–1972 (a period of psychiatric epidemiological surveys and some focused studies). (Kessler, 1999) expressed about global developments of psychiatric epidemiology. (Murthy, 1987) mentioned that, India has not lagged behind in the growth of psychiatric epidemiology.

Epidemiological studies divided into several types i.e., prevalence study, incidence study, and follow up study. Prevalence studies can be simply defined as total number of persons in the population who have disease/problems at a point or period in time. It refers to both old and new cases. If the observational period is at a given point in time it is called as 'point prevalence' and if it is at a given specific period in time it is called as 'period prevalence'(Park, 2007). Most of the community-based Indian epidemiological studies are on point prevalence which summarizes the prevalence of psychiatric morbidity in the general population. These community-based

epidemiological studies (Table 1) conducted in India on mental and behavioral disorders report varying prevalence rates, ranging from 9.5 to 102.8 per 1000 population.

Table 1: Prevalence of psychiatric morbidity and incidences from Indian Epidemiological studies

Investigator/s	Centre	Sampling	Tool used	Population	Prevalence per 1000	Incidence per 1000
Surya, 1964	Pondicherry	H-H	MHSQ(P)	2731	9.5	
Dube, 1970	Agra	H-H	DCP	29,468	18.0	
Elnager et al, 1971	Hoogly	H-H	CHM and DCP(2)	1393	27.0	
Sethi et al, 1972	Lucknow	H-H	CHQ and CHM	2691	39.4	
Verghese et al., 1973	Vellore	SRS	MHIS and DCP	1887	66.5	
Sethi et al, 1974	Lucknow	3SPS	PSQ and DCP	4481	67	
Thacore et al., 1975	Lucknow	H-H	PHQ and DCP	1977	81.6	
Nandi et al., 1975	West Bengal	H-H	HS, QS and CRS	1060	102.8	
Nandi et al.,2000	West Bengal	H-H	HS, QS and CDS	1060		17.6
Nandi et al., 1976	West Bengal	H-H	HS, CDS and CRS	2230		16
Nandi et al., 1979	West Bengal	H-H	HS, SESS, CDS, & CRS	3718	102	
Shah et al., 1980	Ahmedabad	H-H	MHSQ and DCP	2712	47.2	
Mehta et al., 1985	Vellore	S-S	IPSS and DCP	5941	14.5	
Sachdeva et al., 1986	Faridkot	H-H	HS, SESS and CDS	1989	22.12	
Premrajan et al., 1993	Pondicherry	RS	IPSS and DCP	1115	99.4	
Shaji et al., 1995	Erankulam	H-H	IPSS, SESS, CRS & DCP	5284	14.57	
Sharma and Singh, 2001	Goa	SRS	RPES and DCP	4022	60.2	

***Abbreviation** - H-H - House to house survey, S-S - Systematic sampling, SRS - stratified random sampling, 3SPS - 3-stage probability sampling, RS - random sampling, ICD - International classification of diseases, DSM-II - diagnostic and statistical manual of mental disorders. Tools: MHSQ = Mental health screening questionnaire, DCP = Diagnosis confirmed by a psychiatrist (S), CHM = Case history method, CHQ = Case history questionnaire, IPSS = Indian Psychiatric survey schedule, SFQ = Social functioning questionnaire, MHIS = Mental health item sheet, PSQ = Psychiatric screening questionnaire, PHQ = Psychiatric health questionnaire, HS = Household schedule, QS = Questionnaire schedule, CRS = Case record schedule, CDS = Case detection schedule, SESS = Socioeconomic status schedule, RPES = Rapid psychiatric examination schedule*

Source: Math et al., 2007

A study conducted in Pune in 2012 reported the overall life time prevalence of mental disorders to be nearly 5 percent (Deswal and Pawar, 2012). Only two studies conducted on incidence which shows that the incidence was over 16 per 1000 population. In India, less numbers of incidence studies conducted and the result shows an increasing trend compare to WHO

prediction of 2020. India is a developing country and increasing trend of mental health disorders/issues may lead its health and economy.

Understanding mental health issues and disorders in India

Worldwide, gender is a critical determinant of mental health and mental illness. Symptoms of depression, anxiety, and unspecified psychological distress are 2–3 times more common among women compare to men (World Health Organization, 2001). From the various literature reviews it has found that majority of women in India, during their life-span faces several problems like domestic violence, particularly spousal violence, dowry related stressors, and poor family support.

Females 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 (Patel and Kleinman, 2003). Poorer women are more likely to suffer from adverse life events, to live in crowded or stressful conditions, to have fewer occupational opportunities and to have chronic illnesses; all of these are recognized risk factors for common mental disorders (Kermode *et al*., 2007). A study on National Literacy Mission in Northern India shows there is an association between female illiteracy and poor mental health (Cohen, 2002). Community-based studies and studies of treatment seekers in India indicate that women are on average, 2–3 times, at greater risk to be affected by common mental disorder (Thara and Patel, 2001). This may be due to hormonal factors related to the reproductive cycle may play a role in women's increased vulnerability to depression (Parry, 2000). Another factor may be include excessive partner alcohol use, sexual, and physical violence by the husband, being widowed or separated, having low autonomy in decision making, and having low levels of support from one's family (Patel *et al*., 2006, Shidhaye and Patel, 2010, Nayak *et al*., 2010). There are a number of potential factors, which increase vulnerability of women to common mental disorder. The reproductive roles of women, such as her expected role of bearing children, the consequences of infertility and the failure to produce a male child, have been linked to wife battering and female suicide (Davar, 1999, Dennerstein *et al*., 1993). Suicide is another serious mental health problem of women in India. The common causes for suicide in India are disturbed interpersonal relationships followed by psychiatric disorders and physical illness (Rao, 2004). A study found that girls from nuclear families and women married at a very young age, to be at a higher risk for attempted suicide and self-harm (Biswas *et al*., 1997). Indian women are also facing the problems of rape and it is the fourth most common crime in India against women (Kumar, 1993). National Crime Records Bureau, 2012, reported that in India there were 24,923 rape cases in the year 2012, and among them 98% being committed by someone known to the victim.

Indian constitution made several articles and acts to deal with such disabilities from our society and these were implemented in national, state, district, and block levels. Several non-

governmental organizations (NGOs) and voluntary organizations (VOs) in India are also working for the development of women and their associated mental disorders/issues.

CONCLUSION

Epidemiology of mental health in India shows that there is an increasing trend of mental health morbidities from 9.5 to 102.8 per 1000 persons. Generally women were facing issues of common mental disorders (CMD) which includes depression, anxiety, domestic violence, suicide, rape, etc. These types of disorders/issues female have 2-3 times more compare to males. So, these are the matter of concern and accordingly for preventive measures Indian constitution made several articles and acts. Apart from this several NGOs and VOs are working and also need to work for the development of women in respect of problems of their mental disorders/issues.

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