

# Clinical Presentation and Abuse Seen in Females Presenting to A Tertiary Care Center in Kashmir, India

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## Abstract

**Background:** Gender has an important bearing on one's mental health and well-being. The pattern of presentation and the forms of stress differ between males and females. Females usually present with bodily symptoms and internalizing disorders as compared to males. Due to abuse seen in females, rates of mental illnesses are higher in females than in males. We wanted to find out whether abuse is seen in females in our population and find out its relationship with various psychiatric disorders. Belief systems also shape the way psychiatric symptoms manifest. Muslims fast for almost a month every lunar calendar year. We thus wanted to assess our patients' fasting status and understand the importance of fasting in their recovery. **Material and Methods:** We employed convenience sampling for our patients. All female patients presenting to the general outpatient department at IMHANS, Kashmir, during the month of Ramadan were interviewed after providing consent to the study. Confidentiality was maintained in all cases. Only females aged 18 years or older were included in our study. A total of 130 patients were included in our study. After taking the socio-demographic details, the female patients were screened for mental disorders using the MINI-PLUS scale. **Results:** The most common psychiatric disorder seen in our patients was major depressive disorder (37.7%), bipolar disorder (30%), obsessive compulsive disorder (8.5%), schizophrenia (6.9%), dementia (4.6%), and others. Abuse was seen in 27.7% of females, with emotional forms of abuse seen in 14.6%. About 26.2% of patients were fasting during Ramadan despite having to take multiple medicines in a single day. **Conclusion:** The most common psychiatric illness seen was depression. Among our patients, emotional abuse was more common than other forms of abuse. Most of our patients were fasting despite having to take multiple medicines in a single day, and they believed that fasting would help with recovery as well.

**Keywords:** Depression, abuse, fasting, and bipolar disorder.

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## INTRODUCTION

Gender has an important bearing on one's mental health and well-being. The patterns of presentation and the forms of stress differ between males and females. Females usually present with bodily symptoms and internalising disorders as compared to males. Around two-thirds of married women in India have been victims of domestic violence. Social factors and support systems determine the course of illnesses seen in female sufferers. Women's mental health has been worse than men's all across the globe. According to the World Health Organisation (WHO, 2023, March 31), depression is currently 50% more common in women than in men.<sup>[1]</sup> By improving the support networks and providing a congenial environment, most of the females who have a mental illness will have a good prognosis. A landmark study by the WHO, which collected data from over 24,000 women in 10 countries about the extent of domestic violence they experienced, found that, depending on the country and context (e.g., rural versus urban locations), the physical or sexual violence by a partner was seen to be present between 15 and 71% during their lifetime.<sup>[2]</sup> Other than violence, women suffer from discrimination at various places in their lives, which increases the burden of mental illnesses in females. Also, due to multiple social roles played by females during their lifetime, they face a lot of stress, which results in increased mental distress seen in females

worldwide. Belief systems and customs also shape the way mental illnesses present in various populations across the globe. Muslims follow fasting for a single month every lunar calendar year, but a certain subgroup of people, such as the sick, pregnant women, or small children, are excluded from fasting. Fasting, being a religious ritual, is also followed in India by Muslims for almost one month in a single lunar year. It has an important bearing on our patients' mental health as well. Due to their strong belief system, they continue taking their medicines at dawn or dusk despite fasting for 14 to 16 hours per day.

## MATERIALS AND METHODS

We employed convenience sampling for our patients. All female patients presenting to the general outpatient department at IMHANS, Kashmir, during the month of Ramadan were interviewed after providing consent to the study. Confidentiality

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was maintained in all cases. Only females aged 18 years or older were included in our study. A total of 130 patients were included in our study. After taking the socio-demographic details, the female patients were screened for mental disorders using the MINI-PLUS scale. They were asked questions about abuse, the type of abuse, and their fasting status.

**RESULTS**

The majority of our patients hailed from rural areas (64.6%), were married (67.7%), had no formal education (38.5%), and were homemakers (76.2%). The majority belonged to socio-economic classes III and IV (34%, 31%). The majority were from nuclear families (75%). Almost 38% of our patients were illiterate, and only 2% had a postgraduate degree. The majority were homemakers (75%). [Table 1]. The most common psychiatric disorder

seen was major depressive disorder (37.7%), bipolar disorder (30%), obsessive compulsive disorder (8.5%), schizophrenia (6.9%), dementia (4.6%), and others. Co-morbid medical illnesses were seen in almost 36% of our patients. [Table 2]. Abuse was seen in 27.7% of females, with verbal forms of abuse seen in 14.6%. Only 16% of patients had reported abuse to some authority or any other person in their life. [Table 3]. Almost 44% of patients had more than 10 years of psychiatric illness duration, 26% had less than 5 years, and 28% had between 5 and 10 years of illness duration. [Table 4]. 36% of patients reported critical comments from the caregivers regarding their mental illnesses. [Table 5]. In our sample, abuse was seen to have a significant association with socio-economic class and medical co-morbidity, being higher in classes III, IV, and patients with co-morbid medical illnesses. [Table 6].

**Table 1: Socio-demographic variables.**

Variable	Sub-types of variables	Number (Percentages)
Residence	Rural	84(64.6%)
	Urban	46(35.4%)
Socio-economic status:	I	0(0%)
	II	39(30%)
	III	45(34.6%)
	IV	41(31.5%)
	V	5(3.8%)
Marital status	Married	88(67.7%)
	Unmarried	42(32.3%)
Family type	Joint	32(24.6%)
	Nuclear	98(75.4%)
Educational status	Illiterate	50(38.5%)
	Upto 10th standard	42(32.3%)
	Upto 12th standard	17(13.1%)
	Graduate	19(14.6%)
Occupation	Post-graduate	2(1.5%)
	Housewife	99(76.2%)
	Student	28(21.5%)
	Professional	3(2.3%)

**Table 2: Psychiatric disorders and other co-morbid illnesses.**

Psychiatric Disorders	Number of patients	Percentage
MDD	49	37.7%
BPAD	39	30.0%
OCD	11	8.5%
GAD	5	3.8%
Schizophrenia	9	6.9%
Dementia	6	4.6%
Others	1	0.8%
Co-morbid medical illnesses		
Diabetes	13	10%
Hypertension	19	14.6%
Hypothyroid	16	12.3%
No medical illness	82	63.1%

MDD= Major depressive disorder, BPAD=Bipolar affective disorder, OCD= Obsessive compulsive disorder, GAD= Generalized anxiety disorder, PTSD= post-traumatic stress disorder, others= panic disorder, dysthymia.

**Table 3: Abuse and various forms of abuse.**

History of abuse	Present n (%)	36(27.7%)
	Absent n (%)	94(72.3%)
Form of abuse	Physical n (%)	3(2.3%)
	Verbal n (%)	19(14.6%)
	Emotional n (%)	4(3.1%)
	More than one form n (%)	10(7.69%)

Reporting of abuse	Present n (%)	6(16.6%)
	Absent n (%)	30(83.33%)

n= number, % =percentage.

**Table 4: Duration of psychiatric illness.**

Duration	Number of patients	Percentage
< 5 years	35	26.9%
≥ 5 years	37	28.5%
≥ 10 years	58	44.6%

**Table 5: Critical Comments.**

Critical comments	
Present	48(36.9%)
Absent	82(63.1%)

**Table 6: Association between abuse and socio-economic status, co-morbid medical conditions.**

	X2 value	p-value
Abuse and Socio- economic status	8.452	0.036
Abuse and Co-morbid medical conditions	9.306	0.025

p- value was significant when finding the association between socio-economic status and abuse, showing abuse to be more prevalent in classes III and IV (44.4%, 38.9%) as compared to class V (5.6%). Also, a higher rate of abuse was seen in psychiatric patients with co-morbid medical conditions (75%) as compared to those without co-morbid medical conditions.

## DISCUSSION

In our study, the majority of patients were from rural backgrounds, as our hospital, a tertiary care centre, serves an exceptionally large population. According to the 2011 census, 72% of the population lives in rural areas of Kashmir. Among our female patients, about 61% were literate, a figure that has been reported in census data as well, where female literacy was 56.43%. The slightly higher literacy rate seen in our study can be because females who are educated can get themselves treated for mental health issues, which otherwise get neglected. 76% of our female patients were homemakers, reflecting cultural practices that limit women's job opportunities and confine them to the role of homemakers.

Culture and societal responses determine the type of psychiatric disorders seen in a certain population. In developing countries, females present with depression twice as often as seen in males. The ratio of female to male depression has remained constant at 1.7:1 in almost all countries.<sup>[3]</sup>

Many factors, like abuse, educational status, and economic inequality, contribute to this difference in the rates of depression. Women more often present with internalising symptoms, and men present with externalising symptoms most of the time.<sup>[4]</sup>

Recent research suggests that biological factors, such as variations in ovarian hormone levels and particularly decreases in estrogen, may contribute to the increased prevalence of depression and anxiety in women.<sup>[5]</sup> Women have been studied to be suffering from atypical or “reverse vegetative” symptoms of depression, such as increased appetite and weight gain. In case of anxiety disorders, females have greater severity of symptoms, have more often co-morbid depression, and usually run a complicated course of illness.<sup>[6]</sup> Due to the cultural and religious influences, women in our part of the country manifest depression in the form of somatic complaints, which are actually due to

psychological conflict.

Women have been more sensitive to interpersonal relationships, whereas men have been more sensitive to external career- and goal-oriented factors.<sup>[7]</sup> Major depression is growing in overall disease burden in Canada and around the world, and it is predicted to be the leading cause of disease burden by 2030.<sup>[8]</sup> Major depression was seen in approximately 38% of our patients. Studies done among patients attending primary care settings in India have shown the prevalence of common mental disorders ranging between 15 and 44%. Among these patients, 33 to 83% were found to be depressed.<sup>[9-11]</sup> A few studies done in South India have shown the prevalence of depression in females as around 16.3% to 16.7%, respectively.<sup>[12]</sup> The different rates in prevalence of depression can be due to the use of different instruments to screen for depression, and another reason is that Kashmir, being a politically unstable area, has higher rates of common mental disorders, including depression. In another study done in Bangladesh among pregnant females, the prevalence of depression was found to be 18%, and anxiety was found to be 29%.<sup>[13,14]</sup> Another study involving 316 pregnant women in a rural district in the southwest part of Bangladesh found a 33% prevalence of depression.<sup>[15]</sup> Depression has the third-highest global burden of disease worldwide.<sup>[16]</sup>

There is a gap between the age of onset of depression and the intake of antidepressants for many years. In most of the studies, the peak age of onset is somewhere between 20 and 25 years, while the peak age of intake of antidepressants is around 45 years. Due to multiple social roles, gender inequality, inaccessibility to mental health, and hormonal changes, women are more prone to depression than men. Unipolar depressive disorder is the fourth most common cause of disability in females, across all ages, as per the Global Burden of Disease, 2000.<sup>[17]</sup>

The prevalence rates of depression in India range from 1.5/1000 to 37.74/1000. The higher rates of depression have been reported in the rural compared to the urban population.<sup>[18,19]</sup>

Adverse life experiences such as trauma, loss of a loved one, or a difficult relationship can act as a precipitating factor for a depressive episode. Additional work and home responsibilities, caring for children, and any form of abuse in the family may also trigger a depressive episode in women.

Bipolar affective disorder affects almost 1 % of the general population, and it affects males and females equally. However, females present more often with depression and rapid cycling as compared to males.<sup>[20]</sup> Females present with less severe symptoms and do not warrant admission; also, psychotic features are not seen so commonly in females as compared to males.<sup>[21]</sup> Many studies estimate higher prevalence rates, 3.7% to 6.4%, for bipolar spectrum disorders.<sup>[22]</sup> In our study, the prevalence of bipolar disorder was seen to be about 30%, which is quite high compared to the national prevalence. The socio-political instability contributes to the higher rates of all psychiatric disorders in the Kashmir Valley. A study conducted by MSF in collaboration with IMHANS, Kashmir, showed that 41 per cent of people exhibit symptoms of probable depression, 26 per cent show symptoms of probable anxiety, and 19 per cent show symptoms of probable Post-Traumatic Stress Disorder. This is quite high as compared to national prevalence, due to a seasonal increase in rates of depression and anxiety seen in Kashmir, and the reason cited above. They also have frequent co-morbid illnesses like diabetes, thyroid disorders, migraine, and obesity. The overall prevalence of migraines in BD is 13% to 25.9%.<sup>[23]</sup> In our patients, hypertension was the most common co-morbidity seen in 14%, followed by hypothyroidism in 12%, and diabetes in 10%, which is in accordance with the above prevalence rates.

Pregnancy and postpartum are considered critical periods of relapse, and these need to be taken into consideration while deciding about the treatment of mood disorders. Also, it has been seen that early life stresses predispose to early onset of bipolar affective disorder, rapid cycling course of bipolarity, and poor prognosis in female patients. Women's mental health holds special importance due to these factors, and we need to consider different physiological states in females while prescribing medicines.

It has been said that abuse in females leads to increased rates of psychiatric illnesses in females as compared to males. Violence against women has a long history. It has been present throughout history and has been justified as tolerance among female sufferers. Violence in any form has been seen in about 35% of females throughout the world.<sup>[24]</sup> The United Nations has defined 'violence against women' as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women."<sup>[25]</sup> In a study done in India, about 26% of females reported experiencing physical abuse from their spouses.<sup>[26]</sup> In our study, abuse was seen in about 36% of females, which is quite similar to the prevalence seen in other states. It is disheartening to find abuse of pregnant women as well. This, in turn, results in poor care of the child once the pregnancy concludes due to the trauma suffered by females during pregnancy. Also, abuse during

pregnancy gets transmitted to the unborn child through maternal hormones, resulting in problems in the development of vital brain structures in the foetus. Abuse in any form leads to a lot of distress in females with related psychiatric disorders like depression, anxiety, post-traumatic stress disorder, sleep disturbances, and self-harming behaviours. It has been seen that among survivors of abuse, almost 40% have mental health issues like depression, anxiety, and PTSD.<sup>[27]</sup> Sometimes, patients present with somatic symptoms, which are mostly seen in developing countries, were patients with depression manifest as somatic complaints. At least, psychosocial, and psychological first aid should be made available for victims of domestic abuse at all levels of health care. Women with disabilities are more vulnerable to all types of abuse, especially in intellectually disabled females, other than hearing, visual, or locomotor disability. It has been seen that most of the time, females do not reveal abuse, and they keep on lingering in the vicious cycle of abuse and depression. In a survey done on abuse in females, it was seen that about 33% never told anyone about the abuse they suffered.<sup>[28]</sup> In our study, abuse was seen in almost 28% of patients, but among those, only 6% reported abuse. The most usual form of abuse seen was verbal abuse, seen in 15% of patients. Sometimes, they blame themselves for the negative events in their personal lives. This, in turn, leads to suicidal thoughts and behaviours seen in victims of abuse. Some females have suicidal thoughts due to abuse, and in 3% of females, documented suicidal attempts have been seen.<sup>[29]</sup> Besides providing psychological support to survivors of abuse, there is a need to provide legal aid to them, and child protection and women's welfare departments need to have liaison amongst themselves for better management of such cases. It has been seen that a longer duration of illness leads to increased caregiver burden and more negative outcomes. Most of the cases seen in our patients had an illness of more than 10 years duration. This explains the high rate of critical comments observed in about 37% of patients, which may be due to the long duration of illness in our patients. In our study, abuse was seen significantly higher in upper and lower-middle socio-economic classes, and also in patients with co-morbid medical illnesses. This can be because these sub-sections of society have a lot of financial and domestic issues, which disturb the family dynamics and result in higher rates of abuse. In patients with co-morbid medical illnesses, taking multiple medicines and having multiple illnesses puts a lot of strain on family members, which increases the prevalence of abuse in such cases. Muslims worldwide fast during the month of Ramadan for a specific period from dawn till dusk as part of their religious obligation. Despite having to take medication, our patients were fasting because of a strong religious belief that fasting would help them recover. Among our patients, 26% were fasting despite being on multiple medications. Fasting has a positive psychological and physical impact on psychiatric patients, and they feel better after fasting. The reasons for non-fasting were taking multiple medications and getting side effects like sedation and dry mouth because of the medicines. Although exempted, many individuals refuse to take this concession as they feel psychologically and spiritually inclined to fast along with other Muslims.<sup>[30]</sup>

## CONCLUSION

To summarise, major depressive disorder was the most common psychiatric disorder seen in our patients, followed by bipolar disorder. A high percentage of our patients had a history of abuse, but only a few patients had reported it. Emotional abuse was the most ordinary form of abuse seen in our patients. Because of strong religious beliefs, many of our patients fasted and took medicines at dawn and dusk.

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## Conflicts of interest

There are no conflicts of interest.

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