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Social Stresses in Relation to Psychiatric Morbidity in Menopause.

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ABSTRACT

129 menopausal women from the psychiatric outpatient clinic were compared to 100 menopausal women from the gynaecology outpatient clinic at Assiut University Hospital. The occurrence and severity of psychiatric illness was found to be associated with several factors which showed statistical significance and acted independently. These factors are : (1) Disturbed family life, being widowed, divorced, or having no living children. (2) Living with children without the husband , with husband without the children or living alone. (3) Life problems related to children, husband or other relatives. (4) History of previous psychiatric illness. (5) Negative attitude towards menopause.

The difference between the two groups as regards the presence of one or more of the above factors was found to be statistically significant.

INTRODUCTION

The menopause usually occurs between the age of 45 and 52 years, the average age is 47 years (Jeffcoate, 1975).

Slater and Roth (1969) state that the life situation is more important than endocrinal changes in producing psychiatric symptoms at the menopause. Marital status whether single, separated, divorced or widowed may influence the occurrence and severity of psychiatric morbidity in menopausal women (Mitchell, 1971; Ballinger, 1975; Jeffcoate, 1975).

In two studies, Ballinger (1975, 1977) found that psychiatrically ill menopausal women in a general population sample and among gynaecology outpatient clinic attendence reported problems about their children varying from minor misbehaviours up to troubles with the police and marital problems of their offspring. In her opinion,

these problems seem to contribute to maternal psychiatric illness at the time of menopause. However she postulated another possibility that mothers who are depressed or anxious are likely to make more intense and pessimistic view of their children's behaviour and discover or magnify problems.

A child having recently married or left home was associated with increased psychiairic morbidity in the mother as reported by Ballinger (1975) and Brown (1975).

From the general practice notes at least 61 % of psychiatrically ill menopausal women in a general population sample screened by the G.H.Q. (General Health Questionnaire) were more likely to have had previous contact with local psychiatric services or have had a previous episode of illness identified as psychiatric in nature by general practitioners (Ballinger, 1976).

The aim of this work is to explore the social factors reported above by different investigators in menopausal women suffering from psychiatric illnesses in Upper Egypt as those factors may contribute to the occurrence of the illness in such a critical period of the female life and also to check the psychiatric past history of those females and investigate other life stresses.

MATERIAL AND METHOD :

Two groups of menopausal females constituted the sample of the present study. In both groups, the age was between 40 and 55 years, women reported cessation of menstruation for at least two months prior to inclusion in the study and pregnancy, of course, was excluded.

Group A included 129 cases attending the psychiatric outpatient clinic of Assiut University Hospital with psychiatric morbidity, while group B were 100 women attending gynaecological outpatient at the same hospital with different complaints. All were selected randomly.

The different social variables as marital status, number of dead and living children, with whom she is living now in the house, whether they experience at present any social problems and the nature of the problem if present; all of these were reported in both groups A and B.

Women's reaction to menopause was reported, that is, whether accepting or rejecting (e.g. got depressed or anxious). In addition,

any previous psychiatric illness before menopause was reported and its probable nature (whether neurosis, depression or psychosis) was assessed.

RESULTS :

In group B (100 cases) 10 women (10 %) were found free of any psychiatric morbidity, 52 cases (52 %) showed clear manifestations of anxiety and/or depression while the other 38 cases (38 %) were found to have mild psychosomatic complaints with no appreciable mood change. All cases of group A (129 cases) had manifestations of anxiety and/or depression.

TABLE I

Distribution of the group A and B

Regarding Marital Status

	Married		Widowed		Divorced		Unmarried	Total
	+ve*	– ve	+ve	– ve	+ ve	– ve		
Group A No	91	4	30	2	0	2	0	129
%	70.5%	3.1%	23.3%	1.55%	0%	1.55%	0%	100%
Group B No	82	2	10	4	1	1	0	100
%	82%	2%	10%	4%	1%	1%	0%	100%

Distribution of group A and B cases according to marital status is shown in table (I). This table shows that the total number of cases manifesting family stresses as regards marital status is 38 cases in group A (29.5 %) compared to 18 cases in group B (18 %) The difference is statistically significant ($P < 0.01$).

The present life situation :

* + ve & — ve = That is having or not havi ngchildren.

TABLE II

Distribution of Cases in Groups A and B Regarding Present Life Situation. *

		living with husband and children	liviug alone	living with children without husband	living with husband without children	living with others
group A	No	85	7	27	7	3
	%	65.9%	5.42%	20.93%	5.42%	2.33%
group B	No	74	6	10	8	2
	%	74%	6 %	10 %	8 %	2 %

By this item we mean with whom the woman is living at the time of examination. Table (II) shows that 44 cases in group A (34.1 %) have life stresses (not being in the natural family life with husband and children) compared to 26 cases in group B (26 %). The difference is statistically significant ($p < 0.05$).

Life problems :

TABLE III

Distribution of cases in groups A and B Regarding the Presence or Absence of Life Problems.

		Cases reporting life problems	Cases reporting no particular life problems
group A	No	70	59
	%	54.3	45.7
group B	No	24	76
	%	24 %	76 %

* By the term life situation we mean with whom the woman is living at the time of examination.

Table (III) shows the distribution of cases A and B regarding the presence or absence of present life problems. In group (A) 70 cases (45.3 %) reported current life problems which they considered to be distressing, while only 24 cases in group B (24 %) reported such problems. The difference is statistically significant ($P < 0.01$).

The problems reported were mostly related to the children and to a lesser degree to husbands and few women related their problems to other relatives. Problems related to children were mostly being recently married and left home to live in a far place, immigrated recently outside the country or left the locality calling for better chance for working or recently called for military service. Sickness or recent death of children was sometimes reported. Divorce or widowing for daughters was also mentioned.

Problems related to husbands were mostly related to ill health, aging, husband working and living in a far place or a husband who wishes to have children and even threatening to divorce his wife or to marry another woman if she fails to get children.

Many women reported every day trouble with their young children, daughters - in - law, mothers - in - law, other wives of their husband, brothers, sisters or parents considering these troubles distressing for them.

Previous psychiatric history :

TABLE IV

Distribution of Cases in Groups A and B According to the Presence or Absence of a History of Previous Psychiatric Illness

		History of neurosis	History of depression	History of psychosis	Total
group A	No	6	12	zero	18
	%	4.7 %	9.3 %	zero	14 %
group B	No	4	1	zero	5
	%	4 %	1 %	zero	5 %

18 cases (14 ٪) out of the 129 cases of group A reported a history of previous psychiatric illness compared to 5 cases (5 ٪) out of the 100 women in group B (Table IV). The difference is statistically significant ($P < 0.01$).

Reaction to menopause :

TABLE V

Distribution of Cases in Groups A and B According to the Attitude Towards the Menopause

		accepting	rejecting	Total
group A	No	115	14	129
	%	89.1 %	10.9 %	110%
group B I	No	36	16	52
	%	69.2 %	30.8 %	100%
group B II	No	34	4	38
	%	89.5 %	10.5 %	100%
group B III	No	10	zero	10
	%	100 %	zero	100%

The results are presented in table (V). Women in group B can be divided into three subgroups :

I — 52 cases showing clear psychiatric illnesses.

II — 38 cases showing mild psychosomatic complaints without appreciable mood changes.

III — 10 women were psychiatrically free.

It is evident that 30.8 ٪ of the psychiatric cases in group B (subgroup I) had negative attitude towards menopause which is higher than group A cases (10.9 ٪), and subgroups II and III in group B (10.8 ٪) and (zero) respectively ($P < 0.01$).

To Sum up the results :

101 cases out of the 129 cases of A (78.3 ٪) compared to 54 cases out of the 100 cases of group B (54 ٪) were found to have one or more of the following stressful situations :

(1) Family stress being widowed, divorced or having no living children ($P < 0.01$).

(2) Living with children without her husband, with husband without the children, with others or living alone ($P < 0.05$)

(3) Life problems related to children, husband or other relatives ($P < 0.01$).

(4) History of previous psychiatric illness ($P < 0.01$).

(5) Negative attitude towards menopause (rejecting) ($P < 0.01$)

The last factor can be considered a risk factor of the same importance as the above four factors but it motivates women to consult a gynaecologist to regain their periods, rather than consulting a psychiatrist for their anxiety and / or depression.

DISCUSSION :

The results of the present study are in accordance with the findings of Mitchell (1971) and Ballinger (1977) regarding the role of marital status in the occurrence and severity of psychiatric illness in menopausal women.

It is also in accordance with the findings of Ballinger (1975), 1977) about the frequency of reported problems about children in menopausal women, although Ballinger did not stress the aetiological importance of such life problems. The present study clarifies this association and, in addition, we found reported problems related to husbands or other relatives (mothers - in - law, daughters - in - law or other wives of the same husband) as the cultural pattern in Upper Egypt allows such relatives to live in the same house within the extended family.

Also past history of psychiatric illness was found to play a role in the occurrence and severity of the illness, the same was reported by Ballinger (1976).

Counting the different variables together , as it was stated by Bebbington (1980) that vulnerability factors and life stresses act independently, it was found that 78.3 % of group A cases reported one or more of these factors (all showing clear psychiatric morbidity) compared to 54 % of group B cases of which 52 % were showing clear psychiatric morbidity and 38 % were showing only mild psychosomatic complaints. The difference between both groups was statistically significant. This clarifies the association between the presence of one or more of these factors and the occurrence and severity of the illness.

Brown et al., (1977) clarified the large association between loss of sibling, child or a husband and type and severity of depressive symptoms in women whether this loss was due to death or other reasons. They state that it is not only loss that brings about depression, but also a long term difficulty quite often does so and sometimes the threat of loss. They, therefore, place more weight on an aetiological mechanism whereby a person deprived of important sources of value (derived from a person , a role or an idea) can develop a feeling of hopelessness, from this specific feeling related to a particular event or difficulty a more general feeling of profound hopelessness may develop which may form a central feature of the depressive disorder itself. As three of their vulnerability factors concern the present rather than the past, they concluded it is the current environment that most powerfully influences the risk of depression.

Schless et al. (1977) supported the notion that an increase in reported life stresses is in some way associated with increased psychiatric illness in a psychiatrically ill group compared with a community sample or a physically ill group.

According to Brown and Harris (1978) it is not only reasonably well established that certain types of life events are capable of producing affective disorders at least of a depressive nature but also that which person develops psychiatric disturbance is powerfully influenced by background factors that reflect the quality of a person's current social relationship.

Paykel et al. (1980) showed that the strongest associated factor with puerperal depression in women was the occurrence of recent stressful life events. Previous psychiatric history, poor marital relationship and absence of social support were also notable. Previous psychiatric history acted independently both with or without stressful life events.

In the present study, the psychiatric morbidity in menopausal women in both groups was found to be of affective nature either depression, anxiety or mixed states of anxiety and depression. So, we can conclude that the vulnerability factors that we tested in addition to the current distressing life problems contributed to the occurrence and severity of psychiatric morbidity in menopausal women.

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الموجـــــز

علاقة الضغوط الاجتماعية بحدوث المرض النفسى وشدته فى فتـــرة ســـن اليـــأس

قامت هذه الدراسة بالمقارنة بين ١٢٩ سيدة فى ســـن اليأس من مريضات العيادة النفسية بمستشفى أسيوط الجامعى و ١٠٠ سيدة أخرى فى سن اليأس من مريضات عيادة أمراض النساء بنفس المستشفى ، وذلك للكشف عن العوامل الاجتماعية المختلفة التى قد تكون لها علاقة بحدوث المرض النفسى وشدته فى فترة سن اليأس ، ولقد خلصت الدراسة الى ان حدوث المرض النفسى وشدته فى هذه الفترة يرتبط بعدة عوامل ثبت أن لكل منها دلالة احصائية وأن كل منها له تأثير مستقل عن العوامل الاخرى وهذه العـــوامل هى :

١ ـــ أن تكون السيدة أرملة أو مطلقة ، أو ليس لها أولاد أحياء .

٢ ـــ أن تكون السيدة مقيمة مع أولادها بدون الزوج ، أو مع زوجها بدون الاولاد ، أو تقيم مع آخرين غير الزوج والاولاد ، أو مقيمة بمفردها .

٣ ـــ أن تكون السيدة تعانى من مشاكل تزعجها مع أولادها أو زوجها أو الاقارب الاخرين .

٤ ـــ أن يكون قد سبق حدوث مرض نفسى للسيدة قبل سن اليأس .

٥ ـــ احساس السيدة بمشاعر الرفض لتوقف الدورات الشهرية وعدم تقبلها ما حدث لها عند بلوغها سن اليأس .

ABSTRAIT

Les Tensions Sociales Par Rapport à la Morbidité Psychiatrique Durant la Menopause.

129 femmes en ménopause, se présentant à la clinique psychiatrique, ont été comparées à 100 autres femmes se présentant à la clinique gynaecologique de l'hôpital universitaire d'Assiout.

L'occurence ainsi que la sévérité des maladies psychiatriques se trouvaient associées à plusieurs facteurs, ceux ont montré une signification statistique et ont agi indépendemment.

Ces facteurs sont les suivants :

(1) Vie familiale troublée, étant veuve, divorcée, ou n'ayant pas d'enfants vivants.

(2) Vivant avec les enfants sans le mari, avec le mari sans les enfants, ou vivant seule.

(3) Problèmes de vie concernant les enfants, le mari ou autres proches considérés

(4) Histoire de maladie psychiatrique précédente.

(5) Attitude négative envers la ménopause.

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Knowledge and Opinions of Families about Mental Illness and Mental Patients

By A. F. El-Sherbini, Mervat El-Gueneidy, Sanaa Abd El-Aziz and Sawsan Reda

ABSTRACT

Sixty families of first admitted psychiatric patients were interviewed to explore their knowledge about mental illness and their opinions about mental patients in general and their hospitalized ill member in particular.

The results showed a tendency of family members to reflect the general community view of mental patients, describing them as unreasonable, odd and bizarre. They also tend to deny psychotic illness among their patients. Their knowledge about mental illness is very limited and greatly influenced by the stigma attached to mental illness.

INTRODUCTION :

Nowadays, trends in psychiatric nursing are directed towards community care. Mental patients are no longer kept in the hospital to the same extent as they used to be. This policy of early discharge is principally based on the families' acceptance of their discharged patients and families' knowledge about mental illness. In fact, families affect the cause and outcome of mental disorders and have a definite important impact on treatment. They are considered the real primary care agents of patients discharged from mental hospitals. Literature showed evidence that knowledge and behaviour of families of formerly hospitalized patients have an effect on the relapse rate (Mechanic, 1977).

Fagin (1970) and Bentz and Edgerton (1971) have presented evidence that if people in a community know about and are accepting mental illness they can be more supportive to the mentally ill. Moreover they would be willing to recognize symptoms of mental illness in themselves and others, and would play an active role in the