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Research Article

MENTAL HEALTH OF URBAN BENGALI WOMEN WEST BENGAL-INDIA

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A B S T R A C T

Depression is a state of low mood and aversion to activity that can hurt a person's thoughts, behavior and feelings. Poverty, low social status, lack of education, and domestic violence are issues that tend to be more common among women. Pertinent studies in Eastern Indian Bengali women are unavailable with special reference. The present study was therefore conducted to evaluate the mental depression in sedentary Bengali women of the urban region of West Bengal, India. Sedentary women of 20 to 35 years of age were selected from different regions of West Bengal, India. The Hopkins Symptom Checklist (HSCL-10) was used. 40% of women could not pass the school final. 20% of women passed the school final and 10% of women completed their master's degree. Low income, poverty, and education are the main important factors of Bengali women's mental depression. It seems to be not only a method for mental health assessment study but also a good method that can offer health promotion and a consequential medical professional for improving mental health among women.

INTRODUCTION

Depression is a state of low mood and aversion to activity that can hurt a person's thoughts, behavior, feelings, world view, and physical well-being. (Almotiry *et al*., 2022; Kuruvilla A and Jacob K.S. 2007) Depressed people may feel sad, anxious, empty, hopeless, worried, helpless, worthless, guilty, irritable, hurt, or restless. They may lose interest in activities that once were pleasurable, experience loss of appetite or overeating, have problems concentrating, remembering details, or making decisions, and may contemplate or attempt suicide (Kuruvilla A and Jacob K.S. 2007; Elder *et al*., 1992). Insomnia, excessive sleeping, fatigue, loss of energy, or aches, pains, or digestive problems that are resistant to treatment may also be present. (Almotiry *et al*., 2022). Women were more likely than men to have a potential psychological disorder (24% and 17% respectively) (Potuchek, J. L. 1992). Depression often causes increased irritability and a tendency to lose control more quickly (Teachman *et al*., 1994; Jacob K.S. 2007; Elder *et al*., 1992). Poverty, low social status, social isolation and the experiences of child sexual abuse and domestic violence are issues which tend to be more common amongst women than men (Mumford *et al*., 1997; Potuchek, J. L. 1992). Poverty and social disadvantage are common features amongst these different groups of women (Potuchek, J. L. 1992; Elder *et al*., 1992). The complex interplay of these factors can impact adversely upon the women's mental health (Almotiry *et al*., 2022; Potuchek, J. L. 1992). Socio-economic factors such as low income and poor housing conditions cause depression and feelings of powerless amongst women. Educational factors such negative school experiences often result in a lack of confidence and self-esteem later in life. Long term dependency on prescription drugs (for depressive and sleeping disorders) often leads to anxiety. Living in unsafe neighbourhoods and other environmental factors (such as crime and anti-social behaviour) are further factors causing depression and anxiety among women (Elder *et al*., 1992 Potuchek, J. L. 1992).

The relationship between poor mental health and the experience of poverty and deprivation has been well studied and an association between the two factors has been established in different population (Kuruvilla A and Jacob K.S. 2007; Elder *et al*., 1992). Pertinent studies in Eastern Indian Bengali women are unavailable with special reference. The present study was therefore conducted to evaluate the mental depression in sedentary Bengali women of Eastern Region of India.

METHODS AND PROCEDURE

Sample

Participants were recruited from urban region of West Bengal, India. Two hundred (200) sedentary women of 20 to 35 years of age were selected from different Urban region of West Bengal, India. They were not under any mental medication during the study period. Due to common illiteracy in the West

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Bengal rural population, the questionnaires were presented for participants in interview form.

Data sampling procedure: (Strand *et al*., 2003)

Before the data collection phase of the study, these field assistants were informed about the purpose of the study and explained to the questionnaire and data registration technique. We were familiar with Bengali, the main written language of the West Bengal. The local health authorities were also informed and permission was obtained from them to conduct the survey. Verbal consent was taken from all the participants in the study before conducting their interviews. Participants were also consulted individually for the purposes of clinical examination.

Questionnaire

The questionnaire was compiled in Bengali. This questionnaire was used to collect socio-demographic information including age, sex, education, marital status, income and number of family members. The Hopkins Symptom Checklist (HSCL-10) was used for this study (Strand *et al*., 2003; Derogatis *et al*. 1974). Also included in the questionnaire to obtain information regarding the anxiety and depression level of participants in the study. Participants reported their age in years, Education was reported primary, secondary education, and intermediate, university education. Participants reported total annual income of their families in rupees per year. This figure was categorized into four levels: 15000-25000/- per annum, 25000-35000/- per annum, 35000-45000 per annum, 45000-60000/- per annum medium. In forming these income categories, detailed information regarding the per capita income, family structure and socio-economic conditions included in the study. Marital status was recorded.

Participants were also asked to report the total number of family members in their household. This variable included all the persons living in the same house and sharing the same kitchen.

Hopkins symptoms checklist (HSCL-10)

The ten-item Hopkins Check List (HSCL-10) was used to measure psychological depression. HSCL-10 demonstrate good sensitivity and specificity for detecting psychological symptomatology and mental depression. Participants were asked to response to the following items according to their experience during the previous week: (Strand *et al*., 2003)

1. I become senseless
2. Terrified without any cause
3. I blame myself for different purpose
4. Always I feel mental tension
5. Blaming yourself for things
6. Difficulty in falling asleep or staying asleep
7. I think sufficient effort is need to do something
8. Always a feeling of fear working
9. I forget everything
10. Feeling hopeless about future

Out of the 10- items described above, the first 4-items were related to anxiety and the remaining to depression. Each item was rated on a scale from 1 (not at all) to 4 (extremely). Only those participants who answered at least 5 of the 10 items were included in the analysis and data for unanswered items was imputed using the mean value of the items responded to by the participant. In this way out of total 1040 participants only 5 were not included in the present study.

Statistical analysis

The Statistical Package for the Social Sciences 14.0 (SPSS for Window 14.0) was used for statistical analysis.

RESULTS

The mean age of participants was 28.84 years (SD± 10.56) and 60% women between 20 to 35 years age range. Table 1. represents educational qualification and income status. The overall education level of the participants was poor. 40% of women could not pass school final, 20% of women passed school final, only 20% women passed H.S.,10% women completed graduation, 10% women completed master degree. The higher qualified women had better financial condition than less qualification. That is given below (Fig-1). From this present study it is shown that the lower income group (25000 to 35000/-) was highly terrified without any cause (Fig :1), they feel mental tension about the future (Fig 4). They feel they are useless (Fig 8).

Table 1 Educational Qualification and income status

Qualification	Education (%)	Average income per head (per annum)
Up to Madhyamik	40	24,000
Madhyamik	20	31,000
H.S.	20	33,500
Graduation	10	40,000
M.A.	10	59,000

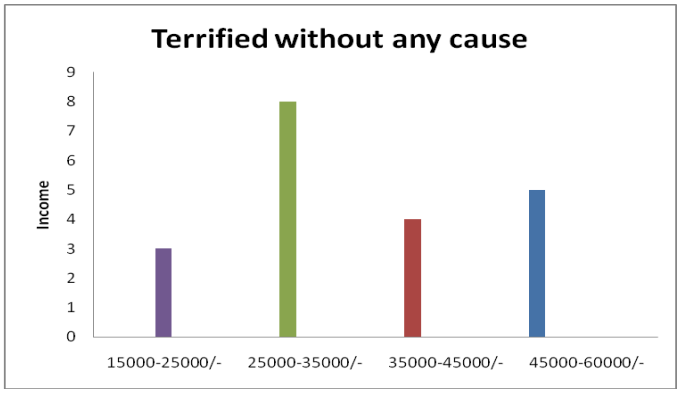

Fig 1 The relationship between annual income and experimental parameter (terrified without any cause)

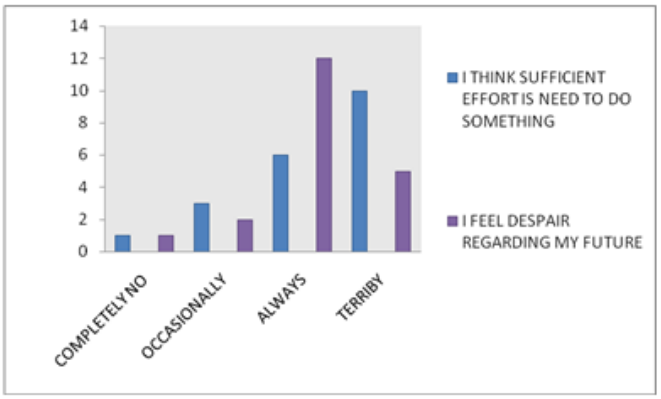

Fig. 2 Think sufficient effort is need to do something

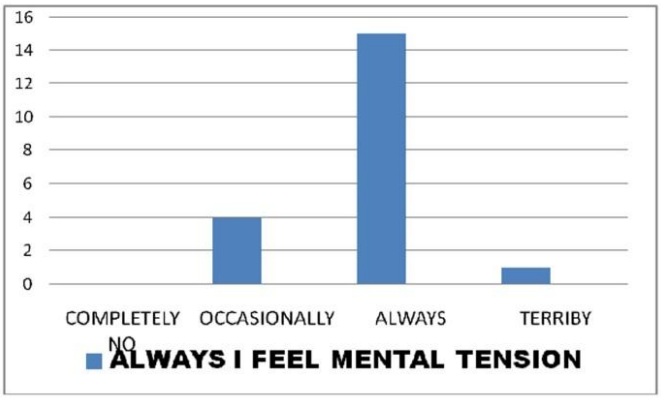

Fig.3 I Become Senceless

Fig 7 I forget everything

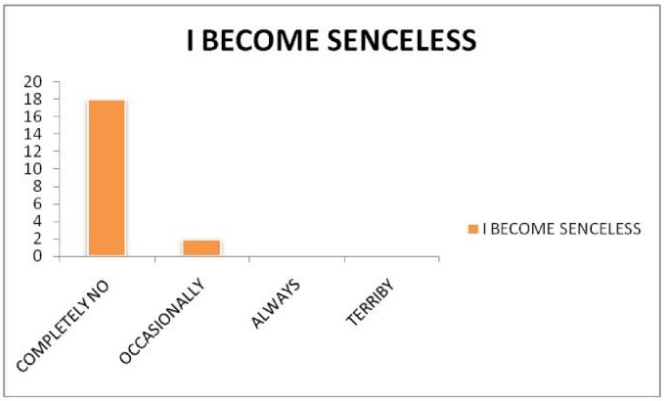

Fig.4 Always I Feel Mental Tension

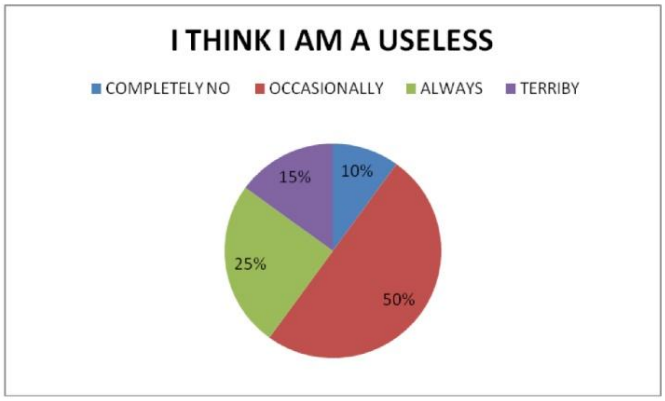

Fig 8 I think I am a Useless

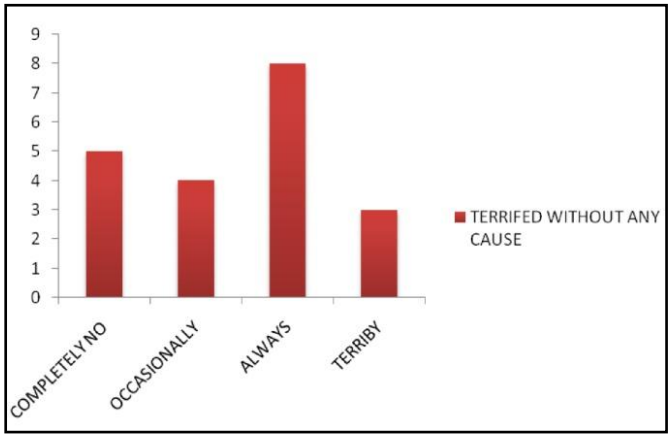

Fig 5 terrified without any cause

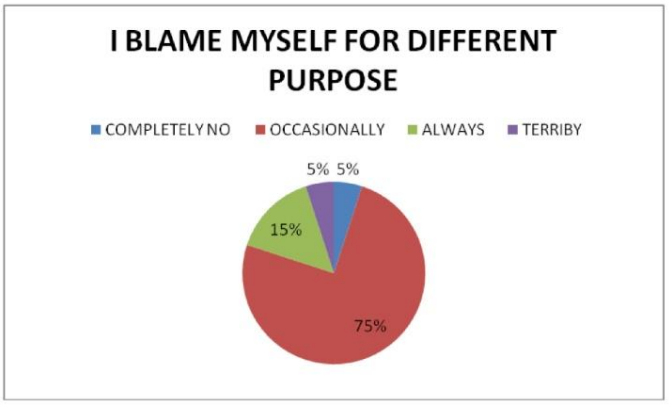

Fig 9 I am blame myself for different purpose

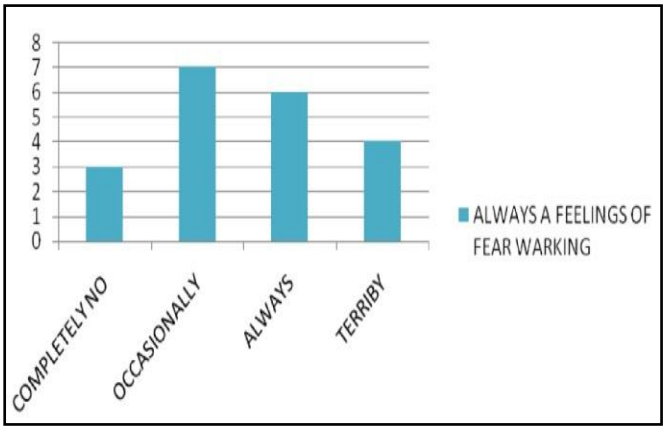

Fig 6 always a feeling of fear working

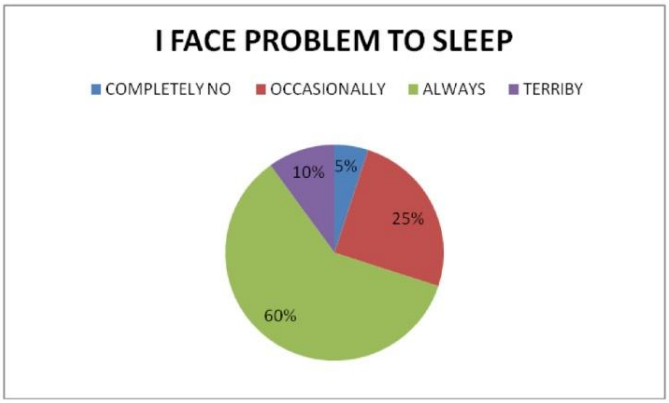

Fig 10 I face problem to sleep

DISCUSSION

Social inequality and poverty have demonstrable adverse effects on health (Jacob K.S. 2007; Elder *et al*., 1992). Low educational score had a big impact on Panjab women population (Mumford *ET AL* 1997). Present study depicted similar observation in Bengali women (Figure:1). Poverty, low social status, social isolation and domestic violence are issues which tend to be more common amongst women (Kuruvilla A and Jacob K.S. 2007; Elder *et al*., 1992). Mental depression also found Russian immigrating women (Hoffmann *et al*., 2006;. Similar finding also reported in Bosnian refugees (Sundquist *et al*., 2005; Dalgard *et al*.,). These earlier studies also collaborated with the present study. The complex interplay of these factors can negatively impact adversely upon women's mental health. Female was reported to be a risk factor for common mental disorders and Pakistani women faced some mental disorders (Elder *et al*., 1992; Mumford *et al*., 2005). The present study also depicted the same observation (Figure:5), they feel always mental stress without any reason. Studies from India have shown that poverty and deprivation are independently associated with the risk for common mental disorders in women and add to the sources of stress associated with womanhood (Kuruvilla A and Jacob K.S. 2007; Patel *et al* 2006 ; Elder *et al*., 1992). This present study also agreed with this same observation (Figure:4).

Present study depicted low monthly income and they were suffered from different mental trouble. I earlier study in case of Punjab, women were also suffering from mental disorder due to low income (Mumford *et al*., 1997). This study is similar to Elder *et al*. study (Kuruvilla A and Jacob K.S. 2007; Elder *et al*., 1992). In this present study corroborated with same think (Figure: 5).

Poverty, low social status, social isolation and the experiences of child sexual abuse and domestic violence are issues which tend to be more common among women than men (Mumford *et al*., 1997). The complex interplay of these factors can negatively impact adversely upon the women's mental health (Kuruvilla A and Jacob K.S. 2007). These all things also similar in this present observation (Figure; 1,2,3,4,5). It is estimated that 66% of women suffered from anxiety and depressive disorders. Levels of emotional distress increased with problem to sleep etc (Mumford *et al*., 1997). This study genuinely reflected the present research (Figure: 6,7,8,9,10). Similar observation also noted in Pakistani women (Mumford *et al*., 2000). Same report also published in western population in earlier (Patel *et al*., 2006). Above finding also noted in urban Rawalpindi population (Husain *et al*., 2004)

Having a doctorate or master's degree may offer career advancement, but it may also have negative effects on one's mental health (Robert and Matano 2003). This study is dissimilar of our study.

CONCLUSSION

Low income, poverty and education are the main important factors of Bengali women of mental depression. Poor education and illiteracy are the issues which tend to be more depression among women. These findings suggested that Bengali women who were suffering in depression can lead to suicide.

Practical Implication

It seems to be not only a method for mental health assessment study but also a good method which can offer health promotion and a consequential medical professional for improving mental health among young adults. Thus psychiatric, medical professionals may consider this data for treatment purpose to promote mental fitness and for preventing suiciding tendency to a greater extent.

Limitation of the study

Although the dietary practice and fluid intake patterns influence the mental fitness profile parameters, but it is a shortcoming of the study that these parameters were not evaluated in the present study.

Conflict of Interest Statement

The authors declare that they have no conflicts of interest.

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References

1. Almotiry, O. M., Alomair, B. I., Alashgay, S. F., Binnheet, M. A., Alrasheedi, A. K., Alrashidi, K. S., Alruwaili, T. M. F., Alotaibi, A. G. D., Almatrafi, D. R. S., & Alotaibi, A. A. (2022). Depression among Addictive Patients. *International Journal of Medical Sciences and Dental*, 5, 9-18.
2. Kuruvilla, A., & Jacob, K. S. (2007). Poverty, social stress & mental health. *Indian Journal of Medical Research*, *126*, 273-278.
3. Elder, G. H., Conger, R. D., Foster, E. M., & Ardelt, M. (1992). Families under economic pressure. *Journal of Marriage and Family*, *54*(1), 5–37.
4. Potuchek, J. L. (1992). Employed wives' orientations to breadwinning: A gender theory analysis. *Journal of Marriage and Family*, *54*, 548–558.
5. Teachman, J. D., Call, V., & Carver, K. P. (1994). Marital status and the duration of joblessness among white men. *Journal of Marriage and Family*, *56*, 415–428.
6. Mumford, D. B., Saeed, K., Ahmad, I., Latif, S., & Mubbashar, M. H. (1997). Stress and psychiatric disorder in rural Punjab: A community survey. *The British Journal of Psychiatry*, *170*, 473-478.
7. Mumford, D. B., Saeed, K., Ahmad, I., Latif, S., & Mubbashar, M. H. (1997). Stress and psychiatric disorder in rural Punjab: A community survey. *The British Journal of Psychiatry*, *170*, 473-478.
8. Mumford, D. B., Minhas, F. A., Akhtar, I., Akhter, S., & Mubbashar, M. H. (2000). Stress and psychiatric disorder in urban Rawalpindi: Community survey. *The British Journal of Psychiatry*, *177*, 557-562.
9. Husain, N., Gater, R., Tomenson, B., & Creed, F. (2004). Social factors associated with chronic depression among a population-based sample of women in rural Pakistan. *Social Psychiatry and Psychiatric Epidemiology*, *39*, 618-624.
10. Patel, V., Kirkwood, B. R., Pednekar, S., Weiss, H., & Mabey, D. (2006). Risk factors for common

mental disorders in women: Population-based longitudinal study. *The British Journal of Psychiatry, 189*, 547-555.
11. Strand, B. H., Dalgard, O. S., Tambs, K., & Rognerud, M. (2003). Measuring the mental health status of the Norwegian population: A comparison of the instruments SCL-25, SCL-10, SCL-5 and MHI5 (SF-36). *Nordic Journal of Psychiatry, 57*, 113-118.
12. Halepota, A. A., & Wasif, S. A. (2001). Hopkins Symptoms Checklist 25 (HSCL-25) Urdu translation: An instrument for detecting anxiety and depression in torture and trauma victims. *Journal of the Pakistan Medical Association, 51*, 255-257.
13. Fabrigar, L. R., Wegener, D. T., MacCallum, R. C., & Strahan, E. J. (1999). Evaluating the use of exploratory factor analysis in psychological research. *Psychological Methods, 4*, 272-299.
14. Husain, N., Chaudhry, I., Afsar, S., & Creed, F. (2004). Psychological distress among patients attending a general medical outpatient clinic in Pakistan. *General Hospital Psychiatry, 26*, 277-281.
15. Hoffmann, C., McFarland, B. H., Kinzie, J. D., Bresler, L., Rakhlin, D., & Wolf, S. et al. (2006). Psychological distress among recent Russian immigrants in the United States. *International Journal of Social Psychiatry, 52*, 29-40.
16. Mumford, D. B., Ayub, M., Karim, R., Izhar, N., Asif, A., & Bavington, J. T. (2005). Development and validation of a questionnaire for anxiety and depression in Pakistan. *Journal of Affective Disorders, 88*, 175-182.
17. Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral Science, 19*, 1-15.
18. Sundquist, K., Johansson, L. M., DeMarinis, V., Johansson, S. E., & Sundquist, J. (2005). Posttraumatic stress disorder and psychiatric co-morbidity: Symptoms in a random sample of female Bosnian refugees. *European Psychiatry, 20*, 158-164.
19. Dalgard, O. S., Thapa, S. B., Hauff, E., McCubbin, M., & Syed, H. R. (2006). Immigration, lack of control and psychological distress: Findings from the Oslo Health Study. *Scandinavian Journal of Psychology, 47*, 551-558.

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