Marriage and other psychological stressors in the causation of psychiatric disorder

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Article Info

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Received: 12 April 2016
Accepted: 25 July 2016
Available Online: 5 September 2016

ISSN: 2224-7750 (Online)
2074-2908 (Print)

DOI: 10.3329/bsmmuj.v9i3.29423

Cite this article:
Mullick MSI, Algin S, Ahmed HU, Majumder AH. Marriage and other psychological stressors in the causation of psychiatric disorder. Bangabandhu Sheikh Mujib Med Univ J. 2016; 9: 129-134.

Available at:
www.banglajol.info

A Journal of Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh

Abstract

The aim of this study was to compare the specific psychiatric diagnosis, frequency, and types of stressors, and the level of awareness about marriage law between married (cases; n=80) and unmarried girls (control; n=80) with one or more psychiatric disorders below the age of 18 years. The psychiatric diseases were diagnosed according to Axis One of ICD-10 clinical diagnoses of multi-axial classification of childhood and adolescent psychiatric disorder. Psychosocial stressors were considered on the basis of Axis Five of this classification. Of the cases, major depressive disorder was the highest (n=47) and next was a dissociative (conversion) disorder (n=24). Among the controls, generalized anxiety disorder (n=31) was the most prevalent followed by obsessive-compulsive disorder (n=17). The difference was highly significant (p>0.001). The cases reported a significant excess of psychosocial stressors than that of the controls to the onset of the psychiatric disorder. All the cases had associated stressors. In contrast, 77 out of 80 control patients had stressors. Marriage itself played as a stressor in the 78 cases. Beside this, other highly frequent stressors were marital discord followed by drop out from study and trouble with in-laws. Among the controls, the highest reported stressor was increased academic workload and next two commonest stressors were poor academic performance and discord with peers. Interestingly, 52.5% of the cases were having knowledge about the law on the age of marriage and that was 32.5% among the controls. It was significant that most of the girls breached their continuity of education after marriage (p>0.001). In conclusion, psychosocial stressors including marriage have a causal relationship with depressive and conversion disorder.

Introduction

Early marriage, otherwise known as child marriage, is the marriage of a young person (typically a girl) before the onset of adulthood as defined by the 1989 Convention on the Rights of the Child. Not only do many females marry while they are still legally children, but these girls often marry men who are considerably older. Males are generally not encouraged to marry while they are still adolescents; thus, males, unlike females, rarely marry before reaching adulthood.[1] The vast majority of married adolescent girls do not choose their husbands: their parents did. Most are informed of the marriage at the last moment, some not until the day of the event. Child marriage is significant and burning problems throughout the globe. A research report of UNFPA, it was found that in the developing countries, about 80.2 million girls marry at the age between 10-17 years. They suffer from mental and physical problems including damaging of sexual life. The dropout rate from school among them is increasingly higher and the opportunity of social communication is decreasing for them. About 55% of these girls dropped out from school after their marriage due to engaging with physical labor in household work in husband's house. The International Center for Research of Women Advocacy Toolkit reported the highest rate of child marriage (below 18 years) in many countries. This rate is the highest in Niger (76.6%) followed by Chad (71.5%).[1]

According to UNICEF, the highest rate of child marriage is in Bangladesh (two out of every three girls marry before the age 18) followed by India, Nepal and Afghanistan.[2] Investigators claimed that main cause of this problem is the absence of birth register or tendency of not registering newborn in the birth register. The marriage of women under the age of 18 years is a criminal offense and punishable under the law. Unfortunately, it is not working to prevent an underage marriage. This low is not considerably plasticized and implemented in Bangladesh. In a survey of the Ministry of Child and Women Affairs, Government of Bangladesh in 2007, it has been reported that 33% girl got married before the age of 15 years and that

was increased to 74% before 18 years. Rural-urban distribution of this child marriage is 48.4 and 65.4% respectively.[3] The incidence is more than this in the non-governmental survey. In a recent report on health population survey done by National Institute for Population Research and Training (NIPORT) revealed that 66% of Bangladeshi girl got married before the age of 18 years and the rate is nearly static for the last two decades.[3] According to a report of Bangladesh Demography and Health Survey 2009, this rate is 70% and mean age of such marriage is 15.3 years. Most prevalent age group of underage marriage is 13-15 years. This tendency is not decreasing despite providing free education for girls up to the secondary education and stipends for them from the Government. The tendency of conception is more among the married women with younger age. About 27% of the married women between the age group of 15-19 years become the mother. Girl mother is more in the rural area than that of an urban area. The underage marriage of women is also one of the main reasons for the failure of population control program.[3]

In the UNFPA survey, it is reported that social insecurity, parents believe of increasing dowry with the increasing the ages of girls are the main cause of underage girl marriage and the tendency of conception and childbirth.[1] Studies have demonstrated that girls who marry as adolescents attain lower schooling levels, have lower social status in their husband's families, report less reproductive control, and suffer higher rates of maternal mortality and domestic violence.[4] Another study revealed that conjugal stressors including marriage precipitated depression in Bangladeshi women.[5]

No study on the role of child marriage in the causation of psychiatric disorder has yet been reported in Bangladesh. In the present study, it is hypothesized that marriage itself acts as a stressor which is one major cause for developing the psychiatric disorder among the girl's age below 18 years.

The objective of the study is to delineate and compare the specific psychiatric diagnosis, to see the frequency and types of stressors and to compare the socioeconomic characteristics tools and relevant variables between married and unmarried girl patients.

Table I

Sample characteristics

	Case (n=80)	Control (n=80)	p value
Age (Year)			
<12	5 (6.3)	5 (6.3)	NS
13-14	10 (12.5)	11 (13.7)	NS
15-16	24 (30.0)	28 (35.0)	NS
17-18	41 (51.2)	36 (45.0)	NS
Occupation			
Housewife	51 (63.7)	0 (00)	>0.0001
Student	29 (36.3)	79 (98.8)	>0.005
Others	0 (00)	1 (1.2)	NS
Habitat			
Rural	38 (47.5)	35 (43.7)	NS
Semiurban	12 (15.0)	8 (10.0)	NS
Urban	30 (37.5)	37 (46.3)	NS
Monthly income (US$)			
<140	30 (37.5)	26 (32.5)	NS
140-280	33 (41.3)	31 (38.8)	NS
>280	17 (21.3)	23 (28.8)	NS

Data within the parenthesis are the percentage; Chi square test was done to measure the level of significance; NS= Not significant

Materials and Methods

It is a cross-sectional descriptive and case-control study. The study was conducted from July 2010 to June 2011. A purposive sample of 80 married girls (cases) was matched with an equal number of unmarried girls (control) ages under 18 years from a child and adolescent consultation center in Dhaka city. Table I shows sample characteristics of the cases and controls. For the cases, age was ranged between 10 and 18 years with the mean of 16.9 (SD=1.96) years. For the controls, the age range was between 10 and 18 years with the mean of 15.6 (SD=1.97) years. Regarding the occupation, only 36.3% were students among the cases but 98.8% respondents were students among the controls. It is significant that most of the girls breached their continuity of education after marriage ($p<0.001$). The definition of income group was operationalized for the study following the concept of household income provided by the Bangladesh Bureau of Statistics. A monthly income of Taka less than 10,000 (US$ 140), between Taka 10,000 and 20,000 (US$ 140-280), and over Taka 20,000 (US$ 280) were considered low, middle and high-income group.[6] For the cases, minimum family income was US$

Table II

Specific psychiatric diagnosis

Psychiatric disorder	Case (n=80)	Control (n=80)	p value
Major depressive disorder (MDD)	47	5	<0.001
Bipolar mood disorder, manic	4	0	NS
Bipolar depression	2	6	NS
Adjustment disorder	3	1	NS
Post traumatic stress disorder (PTSD)	4	2	NS
Dissociative (conversion) disorder	24	7	<0.001
Obsessive compulsive disorder (OCD)	3	17	<0.001
Panic disorder	3	6	NS
Somatoform pain disorder	1	5	NS
Generalized anxiety disorder (GAD)	3	31	<0.001
Somatoform disorder undifferentiated	11	6	NS
Specific phobia	1	7	>0.05
Social phobia	0	7	>0.05
Conduct disorder	1	0	NS
Oppositional defiant disorder	0	8	>0.05
Substance dependence	1	0	NS
Dysthymia	0	1	NS
ADHD	0	3	NS

*More than one diagnosis in axis 1 among some subjects (32 cases and 36 controls)

33.3 and the maximum was 285.7 (mean 337.2, SD= 45.7). Of the controls, minimum and maximum family income were US$ 47.6 and 258.1 (mean 391.1, SD= 44.3) respectively. Therefore, it can be said that the case and control group were fairly matched.

The cases were diagnosed by the first author on the basis of ICD-10 clinical diagnoses of multiaxial classification of childhood and adolescent psychiatric disorder.7 Only Axis One of this classification was considered which comprises clinical psychiatric syndromes. Psychosocial stressors were recorded on the basis of Axis Five of this classification that contents associated abnormal psychosocial situation. This axis provides a means of categorizing those aspects of child's psychosocial situation that are significantly abnormal in the context of the child's level of development, past experiences, and prevailing socio-cultural circumstances. The assessment was carried out on the basis of the guidelines for the categories.

Data analysis was performed by the statistical package for social science (SPSS), version-17. Two-tailed t-tests and Pearson's chi-square test was used to find out the significance. Regarding the chi-square test, p value <0.05 was taken as significant. Individual variables were married and unmarried.

Results

Table II shows the specific psychiatric diagnosis among case and control patients. Within the cases, the major depressive disorder was the most common diagnosis (n=47, 58.7%) and next common was a dissociative (conversion) disorder (n=24, 30.0%). Among the control patients, most prevalent was generalized anxiety disorder (n=31, 38.7%) followed by obsessive-compulsive disorder (n=17, 21.3%). The difference was highly significance (p>0.0001).

All the 80 cases had associated psychosocial stressors and in controls, 77 respondents out of 80 had associated stressors. The cases reported a total of 221 stressors to the onset of psychiatric disorder with a mean of 2.8 (SD=0.56) for each case. In contrast, the control patients reported a total of 111 stressors to the onset of psychiatric disorder with a mean of 1.1 (SD=0.64). This difference was highly significant (t=11.48, p<0.001). This reveals that the cases reported two times as many stressors as the controls. The number of stressors varied from 2 to 7 among the cases and controls. Comparing the number of stressors between two group it was found that of the cases, 16.3% had <2 stressors, 70.0% had 3-4 stressors, 12.5% had 5-6 stressors and 1.3% had >7 stressors. Among the controls, 82.5% had <2 stressors, 16.3% had 3-4 stressors, 1.3 had 5-6 stressors and none had >7 stressors.

Seventy eight (97.5%) cases reported marriage as a stressor. Individual other stressors were analyzed among the cases and controls and presented in Table III. It reveals that overall increased frequency of stressors in the cases was paralleled by increased frequency of the most individual stressors. Among the cases, marital discord was the highest stressor reported by the respondents and next was trouble with in-laws followed by drop out from the study. Among the controls, the highest reported stressor was increased academic pressure and next was poor academic performance. These differences were significant.

Individual stressors collapsed into groups by types of stressors according to the social area of activities that have been presented in Table IV to further explore the implication of generally increased frequency of most of the individual stressors in the cases and controls. Six types were found to be present. Of these, conjugal, family, financial and other stressors were significantly higher in cases than controls. In contrast, academic and other stressors were reported higher in controls than cases.

Table V shows the knowledge of cases and controls and their parents on the current law about the age of marriage. Overall, more than half of the participants of both groups did not know the law of the age of marriage. Nearly half (52.5%) of the cases

Table III

Specific psychiatric diagnosis

Stressors	Case (n=80)	Control (n=80)	p value
Marital discord	41	0	<0.001
Trouble with in-laws	28	0	<0.001
Dropout from study	22	2	<0.001
Sexual difficulties	14	0	<0.01
Husband lives abroad	14	0	<0.01
Discord between own and in-laws family	11	0	<0.01
Change in family responsibilities	10	11	NS
Dowry	9	0	<0.02
Lack of school attendance	9	7	NS
Forceful marriage	9	0	<0.02
Victim of domestic violence	8	0	<0.05
Poor academic performance	8	18	<0.05
Pregnancy	7	0	NS
Discord with parents	7	13	NS
Abortion	5	0	NS
Increased academic pressure	5	31	<0.001
Extramarital relationship	3	0	NS
Harsh schooling	3	4	NS
Serious illness of a parent	2	2	NS
Litigation	2	0	NS
Parental divorce	2	0	NS
Sexual harassment	2	1	NS
Bullying	1	1	NS
Serious financial loss of family	1	2	NS
Involved with drug addiction	1	0	NS
Broke up with boy friend	0	4	NS
Death of a close family member	0	5	NS
Discord with friend/peer	0	9	NS
Parental separation	0	1	NS

were having knowledge about the law of the age of marriage and despite knowing, the early marriage happened. Knowledge about this law was significantly lower (32.5%) among the controls. More than half of the parents from both groups had the knowledge about the current law about the age of marriage. Despite knowing the current law of marriage the parents of the cases gave their daughters' marriage. Further asking to them about the reason of giving marriage, most of them mentioned that it was due to poverty, insecurity of daughters, sexual harassment, considering daughter as a burden of parents, fear of victim of acid burn violence by the man if girl or and her family does not agree with the marriage, liability of the family prestige as the main causes.

Discussion

In this study, major depressive disorder was the most common diagnosis followed by conversion disorder in the cases. Representative studies reported that conjugal stressors including marriage precipitated depression in Bangladeshi women.[4,7] It can be assumed that this would be higher in girls who married in their underage. The cases in this study perceived marriage as a stressor and significant other stressors were proved to be related to marriage. This can explain the excess of dissociative (conversion) disorder (30%) in cases than that of the controls (only 9%). Overall, internalizing disorders were found higher among the cases than that of controls in this study. As there are no available comparable similar studies, it would be somewhat difficult to judge the findings. Further clinic and also community-based studies on this issue are necessary to evaluate the present findings.

In this study, cases reported two times as many psychosocial stressors as of controls before the onset of the psychiatric disorder. These stressors along with marriage itself have certainly played an etiological role in developing psychiatric disorders since they occurred before the onset and thereby independent of the disorders. Though overall increased the frequency of the individual, stressors were found in the cases than controls, seven events: marital discord, trouble with in-laws, sexual difficulties, husband lives abroad, discord between own & in-laws family, dowry, and forceful marriage, had significant differences. All these events can happen only in a married girl that was true for the cases in this study, and therefore the differences were not unexpected. Further, these stressors are primarily related to marriage. Marriage itself played stressors in 78 (97.5%) cases. Drop out from the study was highly significant among the cases and certainly is one of the consequences of marriage in Bangladeshi society. A similar finding was reported in a research of UNFPA in Bangladesh.[4] Considering these findings, it can be assumed the widespread and severe impact of underage marriage. Therefore, it is obvious that cumulative effect of the marriage and related stressors on girls may result in the development of psychiatric disorders among them. Further exploration of this area including better understanding of the complex psychopathology is needed.

Table IV

Stress group by type

Type	Case (n=80)	Control (n=80)	Stress included in type	X^2 Significance
Conjugal	78	0	Marital discord Sexual difficulties Forceful marriage Husband lives abroad	p<0.001
Family	65	32	Trouble with in-laws Death of a close family member Serious illness of a parent Parental divorce Parental separation Discord with parents Discord between own & in-laws family Change in family responsibilities Victim of domestic violence	p<0.001
Financial	10	2	Dowry Serious financial loss of family	p<0.05
Academic	48	63	Lack of school attendance Increased academic pressure Poor academic performance Dropout from study Harsh schooling Bullying	p<0.05
Other interpersonal	3	13	Discord with friend/peer Broke up with boy friend Extramarital relationship	p<0.05
Other stressors	17	1	Sexual harassment Pregnancy Abortion Involved with drug addiction Litigation	p<0.05

daughter as a burden of parents, fear of victim of acid burn violence if girl or and her family do not agree with the marriage, liability of the family prestige were the main reason of underage girl marriage as mentioned by the parents. Therefore, it can be viewed that girl child marriage is rooted in social norms as well as in social factors. Moreover, lack of common family law in Bangladesh is possibly one of the important reasons for underage marriage. Despite having the rule of compulsory birth registration, the reluctance of parents and authority in implementing birth registration caused difficulties in proving the actual age of girls that encourage underage child marriage.

Table V

Knowledge of current law about the age of marriage

	Case (n=80)	Control (n=80)
Among participants		
Yes	42	26
No	9	25
No response	29	29
Among parents		
Yes	67	58
No	8	16
No response	5	6

Overall, more than half of the participants in this study did not know the law of the age of marriage. Creating awareness of the parents and caregivers could play a great role to minimize the tendency of underage girl marriage. The components of such awareness program should include an adverse impact on their daughters' health including the risk of mortality, increasing age will not create the problem for their daughters' marriage and will not increase the amount of dowry, and rather good education will minimize these issues. Creating opportunity for free higher secondary study for girls and more job opportunity for women particularly for the rural women can help in preventing the underage marriage.

The study is the first to explore the effect of marriage in developing psychopathology among under-aged girls. However, the study has some limitations. We did not use the structured instrument for assessing the psychiatric morbidity; instead, clinical assessment procedure was used. Psychosocial stressors were considered on the basis of Axis Five of the ICD-10 classification that contents associated abnormal psychosocial situation. This was made on the subjective experiences of the cases using guidelines for the categories as part of the clinical assessment and therefore has some limitation. It would be better to use a scale for measuring stressful life events. There is non-existence of such culturally valid scale. Though great care has been taken during interview of the cases to consider the stressors, caution should be taken to draw conclusion from the related findings.

Conclusion

The results of this study point that psychosocial stressors including marriage have a definite causal relationship with psychiatric disorder especially with depressive disorder and dissociative (Conversion) disorder. Whether marriage before 18 years of age precipitates the psychiatric disorder or not must depend on other factors which require further exploration. Though knowing the current law of marriage most of the parents dominated by socio-cultural 'convention'. Initiatives should be taken to increase general awareness and education towards the girls in Bangladesh. Developing the orthopsychiatry and public psychiatry as a basic wing of mental health services and providing community mental health services could be another strategy. Training on mental health for religious leaders and Quazi (marriage registrar) is necessary. Conducting a community-based comparative survey among married and unmarried girls is necessary to know the actual magnitude of the problem.

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