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Mental Disorders: A Glance at its Socio-Economic Pushing Factors in Peshawar

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Abstract

This paper examines various social and economic factors promoting neurotic mental disorder in Peshawar, capital of the Frontier Province. Data were collected at psychiatric wards of the two biggest hospitals of Peshawar city: Lady Reading Hospital (LRH) and Khyber Teaching Hospital (KTH). The sample size includes 31 male and female admitted patients. They were interviewed through interview schedule under purposive sampling technique. The study findings reveal that respondents had joint family system with low monthly income. Male patients developed mental disorder for, lack of social contacts, broken family and low economic profile. Whereas female patients faced gender disparity in important decisions like mate selection, property share/transaction and domestic matters. They were also put to mental agony by giving them no part in authority matter; and exposed to cultural restrictions hampering their access to desired life style. Depression and anxiety were common among male and female patients respectively. To address the mental problems, the study recommends the prevalence of social contact, state patronage of children deprived of parental supervision and income generating opportunities for people of low placed economic status.

Key words: Family tension, social contact, broken family, gender disparity and low economic profile

Introduction

Mental disorder has been springing out in diverse shape for different reasons across the world. The growing rate of mental disorder has become a matter of grave concern and attracted the attention of the concerned quarters to play multidimensional role in addressing the problem. Mental disorder is as old as human history is. Bootzin (1985) classifies mental disorder into two types: neurosis and psychosis.

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Neurosis is defined as a mild form of mental disorder including anxiety, phobia, depression, obsession and hysteria etc, whereas psychosis contains schizophrenia, manic depression and organic disorder (Spencer, 1991). A brief description of various types of neurosis and psychosis will help the readers better understand mental disorder. *Anxiety* is a feeling of fear and apprehension by an anxious person like difficulty in decision-making, extreme sensitivity, discouragement, sleeps disturbance and excessive sweating. *Phobia* is an irrational and exaggerated fear of some object or situation. Phobia disorders are persistent fears of objects and situations that are disproportional to the threat posed by them. *Depression* appears in the form of all time exhaustness or pain in any part of body or insomnia or worries stem out of financial inconvenience, marital dissatisfaction and excessive drug use. Sad mood and loss of interest/pleasure are the diagnostic features of a depressed man. *Hysteria* appears in two positions: conversion reaction and dissociative reaction (Spencer, 1991).

Psychotic mental disorder has three types such as Schizophrenia, Manic depression and Organic disorder. *Schizophrenia* is common among male teenagers at greater frequency while childhood schizophrenia, simple schizophrenia, paranoid schizophrenia, catatonia, and hebephrenic are its various types (Kanner, 1943). *Manic depression* is relatively an extreme stage such as more talking, restlessness, aggressiveness and destruction. *Organic disorder* is the latest stage of mental disorder in which brain gets damaged (Kagan and Havemann, 1968). Mental disorder can be viewed from two standing perspectives: somatogenic hypothesis (maintaining physical disease as a reason of abnormal psychology) and psychogenic hypothesis (maintaining environmental stress and inappropriate learning as causes, (Kanner, 1943). Perhaps no one will disagree with this ground reality that ‘as society is getting more complex over the time the magnitude of mental illness would concomitantly enhance’; this is why that mostly industrialized societies are the main victims. It is a fact that industrial revolution adversely affected family organization and the major

inspiration behind the emergence of sociology as subject in the menu of social sciences was to address mainly the problem of family disorganization. The founding father of sociology August Comte and his associates thought that family disorganization had become a serious threat to the mental functioning of people engaged at various industrial units. Industrialization, sociologically speaking, has bulldozed certain social values such as social cohesion, cooperation, affectionate behaviour, sharing individual problems with family members and social contact with relatives on regular basis which compelled the members on isolated life and resultantly caused various mental illnesses. Thus, the Social and economic dynamics multiply the list of psychological and physical factors responsible for mental disorder.

Mortimer (1990) has referred to social stratification depicting differentiated groups of race, age, sex and diverse occupations in society. In such circumstances, they have described the unjust role of society as a source of creating mental discomfort. Barry *et al*. (2008) have described a great association in the parameters of social support, higher education and positive mental health. They have referred to a study carried out by Slain in 2007. Murray and Lopez (1996) have declared that depression among women could be found at double rate as compared to men. Kessler *et al*. (1994) have referred to a report of the US National Co morbidity Survey, depicting a picture of major depressive episode at the rate of 21.3% among women against 12.7% of men (long time). American Medical Association (1992) has reported that subordination, inferiority and humiliation are correlated to various mental illnesses. A report from Italian National Public Health has negated the active role of women's reproductive system in mental disorders. American Psychiatric Association (1952) has quoted parental deprivation as a significant causative factor in development of mental malfunctioning, particularly among people of below 20 years of age. In Pakistan, particularly in the province of North West Frontier, socio-economic environment is too harsh that persistently irritates human mind. The present study is an attempt to investigate those social and economic hazards of life which disturb smooth mental functioning.

Materials and Methods

The Psychiatric Wards of Lady Reading Hospital and Khyber Teaching Hospital, two major hospitals of Peshawar, were selected for the study. Both male and female patients constitute the universe. The study was delimited to neurotic cases only because psychotic patients were unable to be interviewed for their serious mental condition. There are many dimensions around mental disorder but the existing study focused only on the socio-economic ones. Neurotic patients were more in number in both the study units but the researchers approached only those who were able to understand and respond to the queries. Resultantly, 31 patients including 18 males and 13 females from the sampled hospitals were selected for interview under the purposive sampling technique. To ensure the accuracy of data, its cross checking in case of dubious answers was made from attendants staying with them. They were interviewed through interview schedule and maximum questions were semi closed as the researchers prompted questions sensitizing the varied temperament of patients at the time of interview. Sometimes in-depth interview was also exercised in order to get close to achieving the study objectives and by this way access to the required information on the topic was ensured. Keeping in view ethical consideration respondents were assured about their names not to be disclosed to any one. The researchers faced numerous problems while acquiring data from the target patients, as each one question was put many times in a tactful manner. The services of female students were utilized for data collection from female patients. These students were briefed on all-important information regarding the topic and mechanism of data acquisition from the respondents. Statistical Package for Social Sciences (SPSS) was used for analyzing data obtained from both the male and female patients in target hospitals. Secondary data on various types of neurotic patients admitted in both the target hospitals were also utilized.

Results and Discussion

As stated above, data were collected on parameters related to various socio-economic dimensions of mental disorder. Different types of neurosis and associated factors are presented along with related discussion.

Socio-Demographic Profile of Respondents

Dwelling units, marital status and age group have a vital role in mental instability in every human society. These situations are associated to mental abnormality at different magnitude of affordability and then the resultant outcomes in the form of multiple diseases.

Family Pattern, Marital Status and Age Group of the Patients

Table 1 is a multivariate table including data on family pattern, marital status and age groups of both male and female neurotic patients. Majority of the male respondents (56%) and female respondents (69 %) had joint families. It is evident from data that female respondents had joint families at maximum and they felt discomfort at the hands of in laws for

many reasons such as authority, gender based differences and dictated patterns of life. The second part of table of Table 1 indicates that majority of male patients (61%) and female patients (54%) had meager monthly income, which was up to Rs. 5000. They had different occupations and mostly were engaged in laborious works. Since, majority of male respondents were from urban areas and to live in the demanding life of city with such lowest income is quite impossible. Such situation remained irritating their mind about fulfilling the high-spirited needs and demands of city life. The third part of Table 1 is about the placement of respondents in different groups of age. Majority of female patients (69%) were in the age group of 21-30 years and maximum male patients (39%) were in the age group of 31-40 years. As for the age group of female respondents is concerned, it is the bloom of youth and people in this group can be found at emotionally charged position who sensitize, even, over petty issues such as consideration of superiority, no warm welcome among family members, bickering etc. This situation has a great relevance to their mental functioning. Mortimer (1990) has also observed the correlation of mental disorder and social stratification particularly differentiated age groups and occupations.

Table2 presents data on various kinds of neurotic diseases of the sampled respondents. Data on these diseases were taken from hospital records. Majority of respondents i.e. 51 % had depression, 29% had anxiety, and 10 % each had phobia and hysteria. It indicates that two third of male respondents (66.6%) had depression and they had poor economic condition showing relevance in the two variables. Since, in patriarchal society male members are allocated with duty to meet the needs and demands of their families, starting from bread earning to unjustified demands of city life. Whereas female respondents mainly suffered from anxiety as they developed fear in joint families.

Table 1. Family Pattern, Marital Status and Age Group of the Patients

Patients	**Joint Family**	**Nuclear Family**	**Below Rs. 5000**	**From Rs. 5000 to 10000**	**Above Rs. 10,000**	**Upto 20**	**21-30**	**31-40**	**Above 40**
Male	10	08	11	05	02	03	06	07	02
Female	09	04	07	04	02	02	09	02	-
Total	19	12	18	09	04	05	15	09	02

Table 2. Various Neurotic Mental Disorder of Sampled Respondents

Patients	**Anxiety**	**Depression**	**Phobia**	**Hysteria**	**Total**
Male	04	12	02	-	18
Female	05	04	01	03	13
Total	09 (51%)	16 (29%)	03 (10%)	03 (10%)	31 (100%)

Socio-economic Forces at the back of Mental Disorder of Male Patients

Male and female patients suffering from various neurotic mental disorders were asked on differently presented questions as given in two portions of Table 3. Results and discussion on social and economic factors are given as under.

Social Factors

Social Contact: Part (a) of table 3 depicts that 66.7 % respondents complained of no social contact and even ignorable attitude of relatives, neighbors and friends in social domain of life. Since more than half of the male patients were from the urban areas, and it has been observed that in urban areas there is less social cohesion and people preferably live an isolated life. Here, the study findings of berry et al. (2008) are also evident that lack of social support and isolation are significantly associated with mental distress.

Broken Family: Table 3 (a) shows that a considerable number of male patients (44.5%) hailed from broken families and in most of cases their parents experienced either divorce or separation. Such patients were mainly ruralites as their male parents had authoritative behaviour that resulted in broken homes and ultimately affected process of their personality development. Their close relatives did not fulfill moral obligations to extend any patronage, guidance and counseling, and socio-economic support to the members of broken homes. Broken family, constituted by separation, divorce and death

of either life partner, is exposed to different kinds of crime and disturbed life usurping mental satisfaction. The finding of the existing study is identical to a report of American Psychiatric Association, published in 1952, that includes parental deprivation in the list of major causative factors behind mental distress.

Gender Disparity: Table 3 (b) indicates that 62.2 % women patients replied that they were ignored in property matter, mate selection and other important decisions. The Pukhtun culture does not allow women to be consulted when important decisions are taken. Though Islam has entitled women for their share at a defined ratio and allowed them also to have a glimpse of husband (to be) prior to settle matrimony etc., but the existing local culture has its own sanctions keeping in tact the fabrics of society. Apart from it, majority of such women were uneducated and resultantly exploited in acquisition of their rights.

They had a silent protest against such cultural restrictions and even manifest feelings to consider these curbs as a blow to basic human rights, but they did not dare to voice against such situation and ultimately resorted to live suffocated lives. Such situation compelled them to develop inferiority complex and humiliation leading to mental agony. American Medical Association (1992) has held subordination, humiliation and inferiority of women as major reasons behind their mental discomfort. We, at the same time, can also not discard this reality that they are a tender sex and are relatively more victims to mental illness. Murray and Lopez (1996) are of the view that mental disorders can be found at double rate among women.

Family Related Tension: Table 3 (b) manifests that 61.5% female patients confronted family related tension at their respective homes. The unpleasant situation was created over many issues like authority, liberty-seeking behaviour/ life style of own choice and status gap. Majority of female respondents were from the rural areas and had joint families (as mentioned in table 2) restricting transference of authority to women after their marriages. The families' heads and other responsible people negated women's authority (61.5%) and life style of their own choice to women (38.5%) as deemed contradictory to the local culture. Women contracting hypogamous marriages (marriages with lower status persons), who were 23 %, did not compromise on lower status at in laws homes and tried to show their superiority that led to hamper the spirit of working relationship. It was observed that Denial to women in the domains of authority and preference to their choices in life style has mounted to stressful behaviour.

Economic Factors

Low Economic Profile: Table 3 (a) depicts that majority of male patients (55.5%) had low economic profile. They were mostly low paid and working in different capacities at different workplaces in urban areas of Peshawar city. They had incompatible economic position as their families' needs and requirements were hardly met. Earning, sky rocketing prices, high demands and desire to meet other responsibilities of the competitive age have multiplied the mental worries of male members who are assigned to do the needful in our patriarchal society. Such situation compelled them to feel inferior and at low standing in community, which resulted in their constant frustration and ultimate abnormal functioning.

The remaining sampled respondents (45%) described their unemployment as an embarrassing reason behind their distressed life. They were mostly from rural areas and the employment chances are scarce there. The rural environment is not physically suitable as well as inaccessible for industrialization, which has generated unemployment amongst other social, economic and psychological problems.

Table 3 (b) indicates various social and economic factors promoting mental disorder among female patients. 62.2 % affected women mentioned gender disparity as a cause behind their mental disorder. 61.5% Patients observed family tension and liberty as causing factors behind their mental illness. 38.5 % and 23.1% women mentioned their life style and status gap respectively as reasons behind their mental illness.

It is clear from the obtained data that attendants with patients both men and women supported what their patients told about the major questions of the study, which indicate that the patients presented genuine reasons for their mental discomfort. It was observed that traditional families boosted many unfavourable situations including tense in laws relations over the question of authority, teasing women of incompatible status, negating liberty even in moral premises to women to adopt life style, and promoting gender bias in no participation by women in important decisions like mate selection, no/less share in property etc. It was further observed that close social circles overlooked them in establishing any kind of social contact. Though it is an undeniable fact that frequent social contact diminishes mental agony when one is at the mercy of loneliness.

Conclusion

The data obtained reveal that male patients were mostly from the urban areas and in socially alienated atmosphere they got mentally distressed for lack of

social contact, broken homes and critical economic conditions. Female respondents associated their mental discomfort to prevalence of gender disparity and multifaceted family tensions. The study recommends that mentally upset people should be facilitated with an environment containing social proximity in order to relinquish sense of loneliness; bereaved members of parentally deprived children need to be furnished with state patronage; and poverty alleviation projects should be initiated at maximum on meritorious ground to strengthen the overall economic condition of people.

Table 3 (a). Socio-economic Factors at the back of Mental Disorder of the Male Patients (n=18)

Reasons	Yes	% age	No	% age
Broken Family	08	44.5	10	55.5
Social contact	12	66.7	06	33.3
Inferiority	09	73.2	05	27.8
Unemployment	08	44.5	10	55.5
Low Eco. Profile	10	55.5	08	44.5

Table 3 (b). Socio-economic Factors at the back of Mental Disorder of the Female Patients (n=13)

Reasons		% age	No	% age
Gender Disparity	09	62.2	04	30.8
Family Tension	08	61.5	07	38.2
Life Style	05	38.5	08	61.5
Status Gap	03	23.1	10	76.9
Authority	08	61.5	05	38.5

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