Mental Illness, Depression and Coping Pattern in Women

S.A. Kudachi
Public Relation Officer (PRO), Al-ameen Medical College and Hospital, Bijapur, Karnataka, India

Abstract

Mental illnesses affect women and men differently — some disorders are more common in women, and some express themselves with different symptoms. Scientists are only now beginning to tease apart the contributions of various biological and psychosocial factors to mental health and mental illness in both women and men. In addition, researchers are currently studying the special problems of treatment for serious mental illness during pregnancy and the postpartum period. The patients belonging to <25years of age group have higher coping pattern about mental illness scores as compared to patients belonging to 26-50years and >50years of age group. The unmarried patients have higher coping pattern about mental illness scores as compared to married patients. Depressive illnesses, even the most severe cases, are highly treatable disorders. As with many illnesses, the earlier that treatment can begin, the more effective it is and the greater the likelihood that a recurrence of the depression can be prevented. The recent growth in the development of needs assessment measures in mental health care provides a good basis for further examination of the extent to which these measures work for women, and if necessary, for the development of specific measures to address women's needs. These can be epidemiologically based, with attention to gender differences in different settings. In addition to the development of needs assessment measures, the increasing use of routine performance monitoring and clinical audit, together with increasing participation of service users in service evaluation, is likely to give us more information on the needs of women with mental health problems.

KEYWORDS: Women health, Depression, Remedial measures, Caretakers, Coping pattern

INTRODUCTION

Mental illnesses affect women and men differently — some disorders are more common in women, and some express themselves with different symptoms. Scientists are only now beginning to tease apart the contributions of various biological and psychosocial factors to mental health and mental illness in both women and men. In addition, researchers are currently studying the special problems of treatment for serious mental illness during pregnancy and the postpartum period.

The mental disorders affecting women include the following:

- Anxiety Disorders, including OCD, panic, PTSD, social phobia, and generalized anxiety disorders.
- Attention Deficit Hyperactivity Disorder (ADHD, ADD)
- Bipolar Disorder
- Borderline Personality Disorder
- Depression
- Postpartum depression
- Eating Disorders
- Schizophrenia

WHAT IS DEPRESSION?

Everyone occasionally feels blue or sad, but these feelings are usually fleeting and pass within a couple of days (Kessler, 2003). When a woman has a depressive disorder, it interferes with daily life and normal functioning, and causes pain for both the woman with the disorder and those who care about her. Depression is a common but serious illness, and most who have it need treatment to get better.

Depression affects both men and women, but more women than men are likely to be diagnosed with depression in any given year.[1] Efforts to explain this difference are ongoing, as researchers explore certain factors (biological, social, etc.) that are unique to women.

Many women with a depressive illness never seek treatment. But the vast majority, even those with the most severe depression, can get better with treatment.

DIFFERENT FORMS OF DEPRESSION

There are several forms of depressive disorders that occur in both women and men. The most common are major depressive disorder and dysthymic disorder. Minor depression is also common.

Major depressive disorder, also called major depression, is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life.

Dysthymic disorder, also called dysthymia, is characterized by depressive symptoms that are long-term (e.g., two years or longer) but less severe than those of major depression. Dysthymia may not disable a person, but it prevents one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.

Minor depression may also occur. Symptoms of minor depression are similar to major depression and dysthymia, but they are less severe and/or are usually shorter term.

Some forms of depressive disorder have slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression. They include the following:

- **Psychotic depression** occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality; seeing, hearing, smelling or feeling things that others can't detect (hallucinations); and having strong beliefs that are false, such as believing you are the president (delusions).
- **Seasonal affective disorder** (SAD) is characterized by a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy also can reduce SAD symptoms, either alone or in combination with light therapy.[2]

Bipolar disorder, also called manic-depressive illness, is not as common as major depression or dysthymia. Bipolar disorder is characterized by cycling mood changes – from extreme highs (e.g., mania) to extreme lows (e.g., depression).

BASIC SIGNS AND SYMPTOMS OF DEPRESSION

Women with depressive illnesses do not all experience the same symptoms. In addition, the severity and frequency of symptoms, and how long they last, will vary depending on the individual and her particular illness. Signs and symptoms of depression include:

- Persistent sad, anxious or “empty” feelings
- Feelings of hopelessness and/or pessimism
- Irritability, restlessness, anxiety
- Feelings of guilt, worthlessness and/or helplessness
- Loss of interest in activities or hobbies once pleasurable, including sex
- Fatigue and decreased energy
- Difficulty concentrating, remembering details and making decisions
- Insomnia, waking up during the night, or excessive sleeping
- Overeating, or appetite loss
- Thoughts of suicide, suicide attempts
- Persistent aches or pains, headaches, cramps or digestive problems that do not ease even with treatment

CAUSES DEPRESSION IN WOMEN

Scientists are examining many potential causes for and contributing factors to women's increased risk for depression. It is likely that genetic, biological, chemical, hormonal, environmental, psychological, and social factors all intersect to contribute to depression.

Genetics: If a woman has a family history of depression, she may be more at risk of developing the illness. However, this is not a hard and fast rule. Depression can occur in women without family histories of depression, and women from families with a history of depression may not develop depression themselves. Genetics research indicates that the risk for developing depression likely involves the combination of multiple genes with environmental or other factors.

Chemicals and hormones: Brain chemistry appears to be a significant factor in depressive disorders. Modern brain-imaging technologies, such as magnetic resonance imaging (MRI), have shown that the brains of people suffering from depression look different than those of people without depression. The parts of the brain responsible for regulating mood, thinking, sleep, appetite and behavior don't appear to be functioning normally. In addition, important neurotransmitters-chemicals that brain cells use to communicate-appear to be out of balance. But these images do not reveal WHY the depression has occurred.

Scientists are also studying the influence of female hormones, which change throughout life. Researchers have shown that hormones directly affect the brain chemistry that controls emotions and mood. Specific times during a woman's life are of particular interest, including puberty; the times before menstrual periods; before, during, and just after pregnancy (postpartum); and just prior to and during menopause (perimenopause).

Premenstrual dysphoric disorder: Some women may be susceptible to a severe form of premenstrual syndrome called premenstrual dysphoric disorder (PMDD). Women affected by PMDD typically experience depression, anxiety, irritability and mood swings the week before menstruation, in such a way that interferes with their normal functioning. According to Dreher (2007) Women with debilitating PMDD do not necessarily have unusual hormone changes, but they do have different responses to these changes. They may also have a history of other mood disorders and differences in brain chemistry that cause them to be more sensitive to menstruation-related hormone changes. Scientists are exploring how the cyclical rise and fall of estrogen and other hormones may affect the brain chemistry that is associated with depressive illness.

Postpartum depression: Women are particularly vulnerable to depression after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming. Many new mothers experience a brief episode of mild mood changes known as the "baby blues," but some will suffer from postpartum depression, a much more serious condition that requires active treatment and emotional support for the new mother. One study found that postpartum women are at an increased risk for several mental disorders, including depression, for several months after childbirth.

Some studies suggest that women who experience postpartum depression often have had prior depressive episodes. Some experience it during their pregnancies, but it often goes undetected. Research suggests that visits to the doctor may be good opportunities for screening for depression both during pregnancy and in the postpartum period.

Menopause: Hormonal changes increase during the transition between premenopause to menopause. While some women may transition into menopause without any problems with mood, others experience an increased risk for depression. This seems to occur even among women without a history of depression. However, depression becomes less common for women during the post-menopause period, Freeman (2007)

Stress: Stressful life events such as trauma, loss of a loved one, a difficult relationship or any stressful situation-whether welcome or unwelcome-often occur before a depressive episode. Additional work and home responsibilities, caring for children and aging parents, abuse, and poverty also may trigger a depressive episode. Evidence suggests that women respond differently than men to these events, making them more prone to depression. In fact, research indicates that women respond in such a way that prolongs their feelings of stress more so than men, increasing the risk for depression. However, it is unclear why some women faced with enormous challenges develop depression, and some with similar challenges do not, Cohen L, (2006).

STATISTICAL ANALYSIS:

Table No. 1: Distribution of Caretakers by Information About Mental Illness

Information about mental illness	No of care takers	Percentage
Chronic	84	84
Severe	16	16
Total	100	100

Table No. 1 shows the distribution of caretakers by information about mental illness, 84 caretakers knew what is chronic mental illness, whereas 16 patients caretakers knew what was severe mental illness as shown in the table. Thus, a maximum number of caretakers knew what is chronic about mental illness as shown in the table.

Table No. 2 : Mean And SD Values of Coping Pattern About Mental Illness of Patients by Age Groups

Group	n	Coping pattern about mental illness	
		Mean	Std.Dev.
<25years	27	24.2593	7.6791
26-50years	59	21.2881	6.7544
>50years	14	21.1429	7.0804
Total	100	22.0700	7.1127

Table No. 2 represents the mean and SD values of coping pattern about mental illness of patients by age groups. The mean self reporting scores on total sample is (12.8100±4.3361). In which, the mean coping pattern about mental illness scores on total sample is (22.0700±7.1127). In which, the patients belonging to <25years of age group have higher coping pattern about mental illness scores (24.2593±7.6791) as compared to patients belonging to 26-50years (21.2881±6.7544) and >50years of age group (21.1429±7.0804).

Table No. 3 : Mean And SD Values of Coping Pattern About Mental Illness of Patients by Marital Status

Marital status	n	Coping pattern about mental illness	
		Mean	Std.Dev.
Unmarried	15	27.2667	8.9480
Married	85	21.1529	6.3724
Total	100	22.0700	7.1127

Table No. 3 represents the mean and SD values of coping pattern about mental illness of patients by marital status. The mean self reporting scores on total sample is (12.8100±4.3361). In which, the mean coping pattern about mental illness scores on total sample is (22.0700±7.1127). In which, the unmarried patients have higher coping pattern about mental illness scores (27.2667±8.9480) as compared to married patients (21.1529±6.3724).

DIAGNOSTIC AND REMEDIAL MEASURES

Depressive illnesses, even the most severe cases, are highly treatable disorders. As with many illnesses, the earlier that treatment can begin, the more effective it is and the greater the likelihood that a recurrence of the depression can be prevented.

The recent growth in the development of needs assessment measures in mental health care provides a good basis for further examination of the extent to which these measures work for women, and if necessary, for the development of specific measures to address women's needs. These can be epidemiologically based, with attention to gender differences in different settings.

In addition to the development of needs assessment measures, the increasing use of routine performance monitoring and clinical audit, together with increasing participation of service users in service evaluation, is likely to give us more information on the needs of women with mental health problems. For example, a recent initiative to reduce the waiting list for an in-patient unit for the treatment of alcohol problems in part of our trust led to careful monitoring of referrals and admissions. Although not the focus

of this exercise, we discovered that women referred to the unit were less likely than men to take up a place, even though they were in contact with community services, were apparently appropriately referred and were offered admission. This sort of information can lead to further investigation of the needs of women patients and the potential barriers for women in making use of services that are available for them.

REFERENCES:

Cohen L, Altshuler L, Harlow B, Nonacs R, Newport DJ, Viguera A, Suri R, Burt V, Hendrick AM, Loughead A, Vitonis AF, Stowe Z (2006) Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *Journal of the American Medical Association*. Feb 1; 295(5): 499-507

Dreher JC, Schmidt PJ, Kohn P, Furman D, Rubinow D, Berman KF. (2007) Menstrual cycle phase modulates reward-related neural function in women. *Proceedings of the National Academy of Sciences*. Feb 13; 104(7): 2465-2470.

Freeman EW, Sammel MD, Lin H, Nelson DB. (2007) Associations of hormones and menopausal status with depressed mood in women with no history of depression. *Archives of General Psychiatry*. Apr; 63(4): 375-382.

Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Walters EE, Wang PS. (2003) The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *Journal of the American Medical Association*.; 289(3): 3095-3105