



The mental health status and associated factors affecting underprivileged Iranian women



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ABSTRACT

Purpose: The prevalence of mental disorders in Iran approximates to that of other countries. This study evaluates mental health status and its related factors among underprivileged women in Shiraz, Iran.

Methods: This research was conducted between June, 2010 and November, 2012, and comprised 2108 women who participated in the Shiraz Women's Health Cohort Study. The questionnaire used in the study was completed by trained general practitioner and included demographic information and the 28-item version of the General Health. The *t*-test, chi-square test and multivariate logistic regression model were used for statistical analysis. A *P*-value <0.05 was considered significant.

Results: The mean age of the participants was 49.7 ± 10.6 years. According to the General Health Questionnaire, the most prevalent mental disorder was social dysfunction observed in 1643 (77.9%) participants followed by somatic symptoms found in 1308 (62%) subjects. Mental disorders were most prevalent among married women (63.8%, $P = 0.004$). Participants holding high school diploma or university degree (141; 52.4%) comprised the smallest proportion of subjects with mental disorders ($P = 0.01$). Of a total 265 participants whose husband were in prison, 171 (64.5%) exhibited mental disorders, presenting the greatest proportion of women with mental disorders. Logistic regression analysis showed an association between mental health status and participants' level of education, number of children and marital status, based on the General Health Questionnaire total score.

Conclusions: The results of this study showed a considerably higher prevalence of mental disorders among Iranian women in comparison with the general population. Therefore policymakers should pay greater attention to the mental health status of underprivileged Iranian women.

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1. Introduction

Mental disorders have been found to adversely impact the mental health more than any other chronic diseases, including diabetes, and hypertension (Lubetkin et al., 2003). These disorders

affect communities by undermining social and occupational relationships as well as fulfilling the need for physical, emotional and financial support (Ahmadvand et al., 2012).

According to a World Health Organization (WHO) report, psychiatric disorders would be the most common causes of disability and premature death over the next three decades (Noorbala et al., 2012). Recently, WHO has performed a study in seventeen countries from Africa, Asia, the Americas, Europe, and the Middle East and clearly documented that mental disorders are common occurrences (Kessler et al., 2007).

In Iran, the prevalence of mental disorders increased from 11% in 1963 (Noorbala, 2004) to 21.5% in 1998 (Noorbala et al., 2012), 23.8% in 2000 (Noorbala, 2004) and 34.2% in 2007 (Ahmadvand et al., 2012). A review article of mental disorders has shown that

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the prevalence of these disorders in Iran is not less than other countries (Ahmadvand et al., 2012). The incidence of mental disorders varies according to the target population and geographic regions (Ahmadvand et al., 2012; Noorbala et al., 2012; Noorbala, 2004; Padyab et al., 2012; Naderi et al., 2012). Also, studies have proved that women from low socio-economic class are at higher risk of developing for mental disorders (Noorbala et al., 2012). Since we found no study in Iran that specifically focused on mental health status of women from low socio-economic background, this study was designed to evaluate both the mental health status and its associated factors among underprivileged women in Shiraz, Iran.

2. Methods

2.1. Setting and sample

A total of 2108 socioeconomically disadvantaged women participated in the Shiraz Women’s Health Cohort Study (SWHCS) between June, 2010 and November, 2012 (Maharlouei et al., 2012). Inclusion criteria in the SWHCS were household women insured by Imam Khomeini Relief Foundation (IKRF), a governmental charity organization. Weekly, 30 invitation letters were sent to eligible participants. Invitation letters explained the study objectives,

advantages and disadvantages of participation, and the study consent form. Next, subjects were contacted by telephone and invited to visit SWHCS. Ethics Committee approval was obtained from Shiraz University of Medical Sciences Research Ethics Board before starting the study. All information was kept strictly confidential.

2.2. Data collection

One section of SWHCS evaluated participants’ mental health status by a standard questionnaire, the General Health Questionnaire (GHQ). This questionnaire is a psychiatric screening instrument for mental disorders designed by Goldberg and Hillier (1979). The GHQ was translated into Persian, the official language of Iran, virtually comprehensible to all Iranians. This questionnaire has an estimated sensitivity of 84.7%, specificity of 93.8% and overall misclassification rate of 8.2% (Noorbala et al., 2009), the validity and reliability of which for Iranian population had been confirmed by Noorbala et al. (Noorbala et al., 2009). Additionally, frequent use of GHQ by researchers makes comparison between our results and other studies much easier and more comprehensible (Noorbala et al., 2012; Noorbala, 2004; Naderi et al., 2012). The standard GHQ version 28 consists of four sub-scales, each containing seven questions as follows: (I) somatic symptoms

Table 1
General Health Questionnaire (GHQ-28) score based on participants’ demographic variables.

Variables	Frequency (%) ^a	GHQ score				
		GHQI ^{b,d} Mean ± SD	GHQII ^{b,e} Mean ± SD	GHQIII ^{b,f} Mean ± SD	GHQIV ^{b,g} Mean ± SD	GHQ-28 ^{c,h} Mean ± SD
Age (years)						
≤30	66 (3.2)	8.9 ± 4.8	9.5 ± 5.2	7.7 ± 2.8	6.5 ± 5.5	32.6 ± 14.6
31–45	790 (38.2)	8.2 ± 4.7	8.2 ± 4.9	7.3 ± 2.9	5.5 ± 5.5	29.2 ± 14.1
46–64	1102 (53.3)	8.6 ± 4.5	7.9 ± 4.8	7.3 ± 2.6	5.2 ± 5.1	29 ± 13.2
≥65	109 (5.3)	8.2 ± 4.7	6.6 ± 4.8	7.2 ± 2.3	4.4 ± 3.8	26.4 ± 13.2
Marital status						
Single	55 (2.6)	8.3 ± 5.5	8.3 ± 5.7	6.9 ± 2.9	4.9 ± 3.9	28.4 ± 16.1
Married	621 (29.4)	8.8 ± 4.6	8.6 ± 5.2	7.5 ± 2.8	5.8 ± 5.4	30.8 ± 13.9
Divorced	834 (39.4)	8.1 ± 4.5	7.4 ± 4.6	7.2 ± 2.6	4.9 ± 3.5	27.6 ± 13.1
Widowed	598 (28.4)	8.9 ± 4.7	8.3 ± 4.9	7.3 ± 2.8	5.5 ± 5.5	29.7 ± 13.9
Educational level						
Illiterate	695 (33)	8.4 ± 4.3	7.4 ± 4.6	7.4 ± 2.3	5.3 ± 4.9	28.5 ± 12.7
Primary school	607 (28.8)	8.3 ± 4.8	8.1 ± 4.9	7.5 ± 2.9	5.5 ± 5.4	29.5 ± 14.1
Secondary	537 (25.5)	9 ± 4.7	8.8 ± 5.1	7.4 ± 2.9	5.5 ± 5.3	30.7 ± 14.4
Diploma	252 (12)	7.7 ± 4.6	8 ± 5.1	6.7 ± 2.6	5 ± 4.5	27.3 ± 13.8
University degree	17 (0.7)	8.7 ± 5.7	8.1 ± 4.3	5.2 ± 3	2.6 ± 2.1	24.6 ± 12.4
Insurance status						
One insurance	2067 (98.1)	8.4 ± 4.6	8.1 ± 4.9	7.3 ± 2.7	5.4 ± 5.3	29.2 ± 13.7
Two insurances	41 (1.9)	7.3 ± 4.3	7 ± 4.8	6.7 ± 2.2	4.4 ± 4.1	25.4 ± 12.7
Occupation status						
Worker	193 (9.1)	8 ± 4.8	8 ± 5	7.1 ± 2.5	7.1 ± 6	30 ± 14
Student	25 (1.1)	6.3 ± 3.1	6 ± 3.2	6.9 ± 1.9	3.1 ± 2.3	22.3 ± 8.5
Self-employed	52 (2.5)	8.8 ± 5.4	8.8 ± 5.4	7.2 ± 3.2	4.5 ± 3.3	29.3 ± 15.3
Unemployed	1863 (87.3)	8.5 ± 5	8.1 ± 4.9	7.4 ± 2.7	5.2 ± 5.2	29.1 ± 13.7
Reasons for being head of the household						
Widowed	849 (40.3)	8.1 ± 4.5	7.4 ± 4.6	7.2 ± 2.6	4.9 ± 3.5	27.6 ± 13.1
Disabled	391(18.5)	9.8 ± 4.8	8.5 ± 5.5	7.4 ± 2.8	5.6 ± 5.6	32.9 ± 15.1
Prisoner	256 (12.1)	8.3 ± 4.5	8.9 ± 4.8	7.8 ± 2.8	6 ± 5.8	31 ± 13.3
Divorced	583 (27.7)	8.5 ± 4.7	8.3 ± 4.9	7.3 ± 2.8	5.5 ± 4.7	29.6 ± 14
Single	29 (1.4)	7.8 ± 5	7.3 ± 4.9	7.4 ± 1.8	4 ± 2.6	26.5 ± 13.1

^a %: Percent is derived from frequency divided by total study population (2108).

^b Score ranged between 0 (perfect condition) to 21 (worst condition).

^c Score ranged between 0 (perfect condition) and 84 (worst condition).

^d GHQI: somatic symptoms (items 1–7).

^e GHQII: anxiety/insomnia (items 8–14).

^f GHQIII: social dysfunction (items 15–21).

^g GHQIV: severe depression (items 22–28).

^h GHQ-28: General Health Questionnaire (items 1–28).

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