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Original Article

Psychiatry Section

The Correlation Between Psychiatric Disorders and Women's Lives

FUSUN SEVIMLI BURSALIOGLU, NAZAN AYDIN, ESRA YAZICI, AHMET BULENT YAZICI

ABSTRACT

Objective: Psychiatric disorders are important factors which affect the quality of life: employment rates, interpersonal and intrafamilial communications, marriage, child-bearing, parental skills and many other social – cognitive areas in different ways. Psychiatric disorders like schizophrenia, bipolar affective disorder and depressive disorder have a negative impact on women's lives. This study has compared the relationship between these mental illnesses and the liabilities of women's lives.

Methods: For the purpose of this study, 61 schizophrenics, 35 bipolar and 40 unipolar female patients and 60 healthy controls from a university hospital of eastern Turkey were evaluated with SCID- I, a family environmental scale and a personal information questionnaire.

Results: The women with psychiatric disorders had higher rates of unemployment, shorter durations of marriage and lower numbers of parity, as compared to their healthy counterparts, especially after the onset of their illnesses. The schizophrenia and bipolar groups are at risk due to the psychotropic medications which they take during pregnancy. The onset or the exacerbations of illnesses during the postpartum period are also seen more in the schizophrenia and the bipolar groups. However, the patients did not use medicines more than the healthy controls during lactation. The schizophrenia and bipolar groups seem to be failing in using reliable methods of contraception. This data is important due to the traditional and the socio-economical structure of eastern Turkey, which may interrelate with the results.

Conclusion: Women have to play various roles in life and they have various challenges which are related to these roles. The female psychiatric patients should be evaluated in the special perspective of 'being women', along with other clinical parameters. The evaluation of the social, cultural and the economic aspects and the collaborative teams of different clinical disciplines which are related to women's mental health would be beneficial.

Key Words: Woman, Psychiatry, Disorder, Marriage, Pregnancy, Mental health, Parent

INTRODUCTION

A psychiatric disorder is an important factor which affects the quality of life. People who live with mental illnesses often face higher rates of unemployment, lack of a stable housing, and social isolation. It has been shown that mental disorders, except alcoholism and antisocial personality disorder, are more frequently seen in women [1,2]. Women are one and a half to two times more likely to suffer from "Common Mental Disorders" as compared to men. Gender plays a major role in determining the socio-economic position, the access to resources and the social status, which in turn influence the mental health [3].

Psychiatric diseases such as schizophrenia, bipolar affective disorder and recurrent depression are chronic diseases which involve repetitive attacks and hospitalization, in which the follow-up and treatment can continue for years, even for the lifetime, thereby affecting the lives of the patients as well as of their family members.

Marriage, pregnancy, child-rearing, lactation, contraception, career and intra-familial communications take important places in the life cycles of women. These periods are shaped under the effect of many biological, environmental, genetic, financial and socio-cultural titles. The pressures which are created by these multiple roles, gender discrimination and the associated factors of malnutrition, overwork, domestic violence and sexual abuse, combine to account for the poor mental health of women [4]. Although it is hard to determine the direct effect of psychiatric diseases once and for all, it may be useful to draw a preliminary profile which provides comparative information regarding the life cycles of psychiatrically ill women. This profile can serve in providing a versatility for the treatment and protective approaches with regards to the women who carry the weight of being both psychiatry patients and women under traditional roofs. This study looked for the answer to the question in eastern Anatolia in Turkey, where the traditional structure was in the foreground.

MATERIALS AND METHODS

This study was performed on 15-49 years-old women, who were admitted to the Ataturk University Hospital during one year, who were diagnosed with schizophrenia, bipolar affective disorder and depressive disorder and were randomly selected for the study by using a simple accidental sampling method. 75 female patients who were diagnosed with Affective Disorder (35 Bipolar, 40 Unipolar), 61 female patients who were diagnosed with Schizophrenia and 60 female patient accompanists without mental disorders who served as the controls, were selected for study.

The patients whose disease symptoms started at least 6 months ago and were in remission, were included in the study. Healthy vol-

unteers of the same age group and of the same region, who were without any psychiatric disease or history, were selected randomly from among the visitors who came to the hospital as the control group. The patients with mental retardation, drug/alcohol dependence and other psychiatric symptoms or organic diseases which could affect the quality of the patients' answers, were excluded from the study.

This study was approved by the ethical committee of Ataturk University. Written approvals were obtained from all the study subjects.

SCID-I: A clinical which is structured for the DSM-IV Axis I disorders (SCID-I) [4]. This structured interview was developed to enable the standard practice of the diagnostic evaluation, to facilitate the reliability of the diagnosis and scanning of the DSM-IV diagnostic criteria, to increase the validity of the diagnosis and to investigate the symptoms systematically. The adaptation and reliability studies of the SCID-I for Turkey were done by Corapcıoglu et al., [5].

The Personal Information Questionnaire: A questionnaire which was collected under 4 different titles in addition to the general illustrative characteristics that questioned the employment/financial status, the family and marriage characteristics and the pregnancy and lactation characteristics of the subjects, as well as their opinions and behaviour in relation to family planning through closed-ended questions, was prepared for the study.

The Family Environment Questionnaire: This questionnaire was developed by Fowler (1982), and the Turkish validity and reliability study of the questionnaire was done by Usluer [6]. The questionnaire, which consisted of a total 26 items, had two subtests, which were: interpersonal relations (16 items) and the control (10 items). This was a paper-and-pencil test which was given to the family members of the patients [6,7].

The interviews were taken by an experienced psychiatry physician, and the questionnaires and the scales were filled in by interviewing the patients, and their relatives if necessary.

STATISTICAL EVALUATION

The Minitab Statistical Package Program (Main Frame Computer with an IBM 4381 VM/SP operating system), the Chi-square test, variance analysis (ANOVA) and the inter-ratio difference test were applied for the statistical analysis of the data.

RESULTS

The average age (in years) of the schizophrenic group (n: 61) was 29.74±9.82, that of the bipolar group (n: 35) was 28.58±9.07, that of the depressive disorder group was (n: 40) 32.15±9.23 and that of the control group (n: 60) was 30.85±8.60, and there were no significant age differences between the groups.

The Study and Financial Characteristics

The difference in the education levels of the study subjects was statistically insignificant. However, elementary school graduates constituted a majority in all the groups.

More women with psychiatric diseases were unemployed than those in the control group (p<0.05) [Table/Fig-1].

The financial status and the familial structure (extended, alone and small) were statistically not different from each other.

The Family and Marriage Characteristics

Statistically, no significant difference was observed in the average marital age of the various groups of the study subjects. However, the average age of onset of the illness was significantly low in singles than in married women in each of three groups (p<0.05) [Table/Fig-2].

	Schizophrenic Group		Bipolar Group		Depressive Group		Control Group	
	%	N	%	N	%	N	%	N
Unemployed	78.68	48	80.00	28	85.00	34	63.33	38
Employed	11.47	7	17.14	6	10.00	4	33.33	20
Student, Retired, other	9.84	6	2.86	1	5.00	2	3.33	2
kk=12. SD=6								p<0.05

[Table/Fig-1]: Employment status of groups

	Schizophrenic Group		Bipolar Group		Depressive Group	
	N	Age of Onset	N	Age of Onset	N	Age of Onset
Married	26	28.46	15	24.07	26	33.19
Single	28	19.54	17	18.12	12	17.50
Widowed	2	37.50	1	28.00	2	32.00
Divorced	5	21.20	2	21.00	0	00.00
F=11.39 p<0.01, F= 5.29 p<0.01, F=21.82 p<0.001						

[Table/Fig-2]: Relationship between marital status and age of onset of illness

	Unity and Cohesion Subtest		Control Subtest	
	N	Average Score	N	Average Score
Schizophrenia Group	61	30.33	61	22.82
Bipolar Group	35	32.17	35	23.40
Depressive Group	40	31.45	40	23.00
Control Group	60	37.12	60	25.73
	F= 9.41 p<0.01		F= 4.40 p<0.01	

[Table/Fig-3]: Average Scores Of Unity - Cohesion And Control Subtests Of Family Environment Scale

Psychiatric disorders affected the marital lives of the patients too. The patients with depressive disorder had the shortest married lives while the healthy volunteers had the longest married lives. (depressive group: 8.61 years, schizophrenic group: 9.38 years, bipolar group: 8.85 years, , control group: 9.62 years) (F:5, p<0.05). It was also observed that the duration of marriage for those whose age of onset of illness was early, was shorter as compared to those whose age of onset was at a later age (F:7.65, p<0.01).

Unity and Cohesion in the Family Environment

The Family Environment Questionnaire cohesion subtest score averages were found to be significantly high in the control group and to be lowest in the group with schizophrenic disorders [Table/Fig-3].

The Pregnancy, Natal, Postnatal and Lactation Characteristics

The first natal age average was found to be more in the depressive patients as compared to that in others (F:3.17, p<0.05). While there were no significant differences between the total number of parities of the study subjects, after the onset of their illnesses, the parities in the schizophrenia and the depression groups were determined to be significantly lower than those in the bipolar group [Table/Fig-4].

	N	Number of Total Parity	Number of Children Alive	Parity After Onset of illness
Schizophrenia Group	34	2.971	2.324	0.4118
Bipolar Group	18	2.667	2.389	1.5556
Depressive Group	28	3.321	3.321	0.1429
Control Group	38	3.026	2.605	Not applicable
		F= 0.29 p>0.05	F= 1.68 p >0.05	F= 5.07 p<0.01

[Table/Fig-4]: Average no of Parity And Alive Children in Groups

The administration of psychotropic medications during pregnancy, was determined to be highest in the schizophrenic group, it was medium in the bipolar group and it was lowest in the depressive disorder group (kk=12.917, SD=6, p<0.05). Based on the information which was taken from the patients, no difference was found among the groups, for the postnatal problems in babies, due to the psychotropic medication which was taken by their mothers, during pregnancy. (kk=1.428, SD=2, p= insignificant).

When the postnatal course of the mental disease was investigated, the onset, increase and the persistence of the disease, were found to be significantly higher in the bipolar and schizophrenic patients as compared to those in the women with depressive disorders (kk=25.759, SD=8, p<0.001).

No significant difference was seen among the patient groups with respect to the psychotropic drug use during their lactation periods. Also, no significant difference was determined with respect to the presence of problems in the babies as a result of the drug use of their mothers during lactation. Only three babies were reported to have problems such as crying, refusal of sucking and respiratory problems as their mothers had used psychotropic medicines during lactation.

When all patient groups were asked, "Do you think you could sufficiently look after your child?" postnatally, the women with bipolar and schizophrenic disorders expressed that they could look after their babies less as compared to the women with depressive disorders (kk=29.874, SD=8, p<0.001).

There were no significant differences between the total number of miscarriages before and after the mental disease and the opinions of the patients with respect to abortion in the whole sampling. But when the number of abortions were investigated in the patient groups for the purpose of resuming the psychiatric treatments, it was determined that 5 patients had 7 abortions in the schizophrenic group, 3 patients had 5 abortions in the bipolar disorder group, and there were no abortions in the depressive disorder group. When the difference between the ratios was evaluated (Z=2.95, p<0.01), the difference was found to be significant among the groups with bipolar and depressive disorders.

Family Planning

No statistically significant difference was found between the patients and the control groups when their opinions about family planning (contraception) were asked, but the negative and no opinion answers were found to be higher in number in the schizophrenia group as compared to those in the other groups.

	Schizophrenic Group		Bipolar Group		Depressive Group		Control Group	
	%	N	%	N	%	N	%	N
None	35.29	12	44.44	8	10.71	3	17.14	6
Reliable	29.42	10	44.44	8	44.29	18	40.00	14
Unreliable	35.29	12	11.11	2	25.00	7	42.85	15
kk=16.05 SD=6 p<0.05								

[Table/Fig-5]: The family planning methods of groups with active partnership

When the use of family planning- contraception methods was asked to the patients who were living with their partners; the number of the ones who did not use any contraception method was higher in the schizophrenia and bipolar groups and the use of unreliable methods was higher in the schizophrenia and the control groups [Table/Fig-5].

DISCUSSION

There are a great number of studies which have investigated the relationships between psychiatric diseases and the general socio-demographic data of the patients, and there is a need for studies which have to be done on the 'edge points of being a woman'. This study has researched the relationship of the psychiatric disorders with many important areas of a woman's life such as her profession, marriage, pregnancy, lactation, childrearing and familial relationships.

Our study found that women with psychiatric disorders had higher rates of unemployment than the healthy counterparts with the same education levels. This was in accordance with the known characteristics of psychiatric patients which had resulted in challenges in the physical and mental activity and the use of one's skills for job hunting, recruitment and job continuation [8,9]. A study which was done in Ghana reported that education and employment were strong protective factors for the mental health [10]. Another study which was done in Norway emphasized that being employed contributed to a positive treatment outcome in the antidepressant and psychotherapy efficacy trials for major depressive disorder [11].

When the age of marriage was evaluated, the average age at marriage was not found to be different between the healthy volunteers and the psychiatry patients. However, the psychiatric patients had a difficulty in continuing with their marriages. The prospects for marriage were decreased for those with premarital mental disorders. In their study, Dilbaz et al., reported that the percentage of marriages for schizophrenic women was less and that 86.7% of the patients were single, particularly those with an early onset of schizophrenia [12]. In her study, Pehlivan presented that in the major psychiatric disorders -particularly in schizophrenia- the rate of being single/ divorced/ separated was frequently high as compared to that in the normal population [13]. Similarly, Breslau et al reported that mental disorders were positively associated with divorce [14].

In this study, the scores in the cohesion of the family were less in the patients with mental disorders, especially among the schizophrenic patients, than among the healthy controls. The data of this study and that of the study of Tüzer et al., which evaluated the family environment adaptation of the schizophrenic patients in Turkey, are parallel [15]. A study which was done in Ghana,

pointed out that a good relationship in marriage had an effect on the mental health of women, rather than the status of being married or not married [10].

The relationship between pregnancy and mental disease has been investigated for years. It can be considered that the disruption of regular medication, irregular sleep and the potential hormonal interactions during pregnancy, make the psychiatric patients more vulnerable [16]. Although the risk seems to be less in depression, the emotional and the social load of being a parent may result in a resolution, particularly in the schizophrenic and the bipolar groups [17,18]. In this study, the amount of medicine utilization in pregnancy was found to be the most in schizophrenics, it was medium in the bipolar group and it was the least in those with depressive disorders. It was stated in one study, that one-third of the women with psychotic symptoms had used psychotropic drugs at least once during their pregnancies [19]. No significant difference could be found among the patients and the healthy controls in their drug utilization during the lactation period in this study.

This study found that the sense of inefficiency of the schizophrenic and bipolar mothers in parenting was more intense as compared to that of depressive mothers. A study which was done in the Massachusetts, USA, reported that 44 percent of the children lived with their mothers or with their mothers and their partners. It also stated that the women with mental illnesses were the victims of stigma and societal attitudes which had undermined their normal desire to bear and raise children [20,21]. A study which was done in Turkey reported that female patients with major psychiatric disorders lacked the necessary parenting skills to various extents and that they tended to rely on their close relatives and institutions for childrearing. This was significantly higher in the schizophrenic and the bipolar groups as compared to that in the control and depressive groups [13]. It is actually known that schizophrenia and bipolar disorder result in a loss of empathy, a difficulty in understanding and expressing feelings and in a lack of impulse control and cognitive functions, which are necessary skills for parenting [22].

When we looked at the total parities, the total parities of the psychiatry patients were found to be similar to those of the healthy volunteers; however, the parities of the schizophrenics and the depressives were found to be less than those of the bipolar group after the onset of the disease. Here, the relationship between the number of parities in the bipolar group, their increased sexuality in the manic-hypomanic period, their unwillingness in schizophrenia, and depression and the side effects of the medicines should be investigated [13,17,22].

In the patient and the control groups, no significant differences were found between the average number of miscarriages as well the number of miscarriages before and after the disease. In a study which was done in the USA, it was determined that one-third of the women experienced at least one miscarriage [23], and Miller (1996) determined a 44.4% presence of miscarriages in his study on schizophrenic patients [24]. In this study, the presence of a miscarriage was determined to be 21.21% in the schizophrenic group, it was 16.66% in the bipolar group and it was 32.12% in the depressive group. The lower number of miscarriages in our study than in other studies was associated with the fact that the pregnancies were within the marriages in our community. Thus the pregnant women and their pregnancies were well protected.

In this study, the abortions which were done due to mental disease were found to be more in bipolar women than in others. An increased sexual desire and the presence of an unintended pregnancy (during a continuous medicine use), based on the activity in the group with bipolar disorder [25] could be ended by doing an abortion due to the potential teratogenic risks on the baby. However, this may be reduced in schizophrenics due to irregular drug use, and it can be considered that fewer abortions may be done in order to resume the psychiatric treatment, due to the length of the periods when there is no continuous drug use in women with depressive disorders.

There were no significant differences between the groups with respect to the information on the birth control and it was found to be less in all the groups as compared to those in the study of the population and the health survey which was previously performed in our country [26]. This was considered to be related to the geographical and the educational conditions of the eastern Anatolia region where our study was performed.

A significant difference with respect to the birth control methods was found between the patient and the control groups. Most of the bipolar and the schizophrenic groups did not use any methods or they used unreliable methods, whereas the depressive and the control groups were often observed to use reliable methods. A study which was done by Coverdale observed that 33% of the patients with chronic psychiatric disorders did not use any contraceptive methods, though they did not want to become pregnant [27]. In a study which was one in Turkey, Pehlivanoglu reported that the awareness and attitudes of schizophrenic and bipolar female patients on family planning and contraceptive use were unsatisfactory. The lower rates of use of the family planning methods may be related to a disruption in the skills which evaluate the reality, delusions and the lack of knowledge on the family planning practice and living in lower socioeconomic conditions of the schizophrenia and the bipolar disorder groups [22].

This study focused on female psychiatric patients and it was concluded that teams of psychiatrists, gynaecologists, family planning staff and social consultants should be created, who could co-operate with the patients and their families in the matters of marriage, pregnancy and family planning. These subjects are particularly challenging for the women who are on continuous psychotropic medicines due to their chronic psychiatric diseases, and even for healthy women from time to time, and these teams may help in reducing the financial and emotional challenges of these women in the future.

This study was conducted in a cross-sectional manner on a young patient group and the small sample size was a limitation of this study. Therefore, there is a need of comprehensive large sample follow-up studies which evaluate the special conditions of the life cycles of the women in Turkey and in the world.

CONCLUSIONS

Mental diseases affect women adversely in Turkey as well as in the rest of the world, and this study pointed out the relationship between women and their mental health. Women play important roles in the consistence of the social structure and the economic condition of the community. The failure in considering the factor of being a woman while planning the treatment and rehabilita-

tion studies of mental health policies, will result in a reduction of the effect and validity of the job which is performed. Women's life cycles constitute an important topic in the evaluation of their psychiatric diseases.

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AUTHOR(S):

1. Dr. Fusun Sevimli Bursalioglu
2. Dr. Nazan Aydin
3. Dr. Esra Yazici
4. Dr. Ahmet Bulent Yazici

PARTICULARS OF CONTRIBUTORS:

1. Department of Psychiatry, Izmir Katip Celebi University, Training and Research Hospital Izmir, Turkey.
2. Professor, Department of Psychiatry, Ataturk Universty, Erzurum Turkey.
3. Department of Psychiatry, Kocaeli Derince, Training an Research Hospital, Kocaeli ,Turkey.
4. Department of Psychiatry, Izmit Seka State Hospital, Kocaeli ,Turkey.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Esra Yazici,
Department of Psychiatry,
Kocaeli Derince Training and Research Hospital
Kocaeli Turkey.
E-mail: dresrayazici@yahoo.com

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