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A CROSS SECTIONAL STUDY ON ASSESSMENT OF QUALITY OF LIFE IN SUBJECTS WITH COMMON MENTAL DISORDERS IN AN URBAN SLUM OF M.P

KEY WORDS: Common mental disorder, Urban slum, WHOQoL

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ABSTRACT

Background: *Mental disorders are on the increase due to changing life styles.*

Materials and Methods: A cross sectional study was conducted in which 423 people were screened with the help of a pretested questionnaire by SRQ-20. All the subjects who scored 7 and more in SRQ-20 were further evaluated using WHOQOL (WHO Quality of life-BREF Questionnaire)

Result: Out of total subject 60.28% showed satisfaction with their life. 30.49% of the population was neither satisfied nor dissatisfied with their life. 9.21 % of the population was dissatisfied with their life. Out of 39 female were 33(84.61%) showed dissatisfaction with their quality of life and in males 6 (15.38%) showed dissatisfaction which was found to be statically significant. Out of 423 subject 76.12% reported typical response within 7 in SRQ-20 scoring. Common mental disorder was found in 16.07% with SRQ-20 scoring between7-13. Severe distress was found in 7.80 % of the population with SRQ-20 score >14. Among psychological distress group females scored higher with 10.63%. In the severe distress group again females scored higher with4.96 %.this is statically not significant.

Total 101 subjects was found to have CMD after screening the population and its prevalence come to 238.77 per thousand. Quality of life among people with common mental disorders13.86% reported satisfied and 62.37% reporting neither satisfied nor dissatisfied and 23.76% was dissatisfied. Also shows predominantly females being dissatisfied with the quality of life. This is statically significant.

Introduction

The definition of QoL adopted by the WHOQoL Group is:

"An individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns. It is a broad-ranging concept, incorporating in a complex way the person's physical health, psychological state, level of independence, social relationships, and their relationship to salient features of their environment".[1] Indian literature considers health as a broad and global concept represented by from independent dimensions of physical, psychological, social and spiritual well being (Charak Samhita, 1949). Till the turn of last century the main focus of treatment was on saving the lives but with the development of medicine as a science there has been a conceptual shift from simply treating the symptoms and prolonging life to improving the QOL of the patients. [2] The concept of quality of life is not so new. However, in its current form it was launched by late American president, Lyndon B. Johnson, during his presidential campaign in 1964, when he gave the idea that people were entitled to "a good quality of life". Thereafter quality of life has been recognized as one of the fundamental needs.[2]

The concept of QOL is quite new to mental illness and has gained significance as a consequence of shift towards deinstitutionalization and practice of community mental disorder. It is believed that the QOL of mentally ill would be greatly enhanced by living with family and in his community rather than within the cold and impersonal walls of a mental hospital. Long term mental disorders are more vulnerable to stress, are more dependent, have greater problems in employment, and in relationship to their social environment.[3] Mental and behavioral disorders cause massive disruption in the lives of those who are affected and their families. Though the whole range of unhappiness and suffering is not measurable, one of the methods to assess its impact is by using quality of life (QOL) instruments. QOL measures use the subjective ratings of the individual in a variety of areas to assess the impact of symptoms and disorders.[1] A number of studies have reported on the quality of life of individuals with mental disorders, concluding that the negative impact is not only substantial but sustained. It has been shown that quality of life continues to be poor even after recovery from mental disorders as a result of social factors that include continued stigma and discrimination [4]. Results from QOL studies also suggest that individuals with severe mental disorders living in long-term mental hospitals have a poorer quality of life than those living in the community.[5] Few studies clearly demonstrated that unmet basic social and functioning needs were the largest predictors of poor quality of life among individuals with severe mental disorders. The impact on quality of life is not limited to severe mental disorders. Anxiety and panic disorders also have a major effect, in particular with regard to psychological functioning .[5,3] Most QOL studies have been conducted in developed countries, but very few published studies from developing countries. In developing countries, differences due to cultural factors influencing the prognosis of mental disorders (especially in schizophrenia) have been documented by Kulhara. In India, most mentally ill patients live with their families in the community. There is evidence to suggest that the perception of QOL by Indians differs from that of persons living in developed countries. [4] According to Saxena et al, Indians gave priority to peace of mind and spiritual satisfaction over physical and psychological functioning, while in developed countries the highest priority is physical functioning.[6] there was a need to carry out rigorously implemented general population surveys to assess the prevalence of mental disorders among the urban slum community at Indore M.P and no such study has been done in these region. The study was undertaken to estimate the 12-month prevalence rates of specific mental disorders (as per ICD-10 of WHO-1993 edition) among the urban slum community. The study attempted to know the quality of life in people with common mental disorder.

METHODOLOGY

Ethical clearance – Institutional Research and Ethical Committee approval of SAMC and PGI, was obtained before starting the study by explaining them about the aim and importance of the study.

Study Area - It was a community- based, cross sectional study carried out in an urban slum community in the field practice area of Urban Health Center, Pardeshipura of SRI AUROBINDO MEDICAL COLLEGE & P.G. INSTITUTE INDORE (M.P).

The study was recorded in a pilot tested pre-designed validated semi-structured questionnaire about all the family members. A

total of 467 people were visited out of which 44 were below 16 years of the age and were excluded from the study. The remaining 423 people were included in the study. Each house was visited and head of the family was informed about the purpose of the study. The head of the family was interviewed to start with the information, followed by individual interview, during the period from March 2014 - March 2015. The core design of the study was door to door enquiry of each family as a unit and each individual member of the family separately. The present study was done in two phases

First phase

The first phase was the screening phase in which history, general examination, demographic profile along with Self Reporting Questionnaire (SRQ-20) [7] was administered in order to measure the presence of mental illness .SRQ-20 consists of 20 yes and no questions with a reference period of the preceding 30 days. (SRQ comprises question related to cognitive symptoms, anxiety, depression and manifestation as somatic symptoms.)

SECOND PHASE

All the subjects who scored 7 and more in SRQ-20 were further evaluated using M.I.N.I. Plus (Mini International Neuropsychiatric interview plus). 101 people were observed to have CMD for the second phase. WHO QOL BREF [8] Questionnaire rating scale was administered on the subjects.

Statistical Methods Applied

Results were tabulated and statistical analysis was done using Microsoft excel. The statistical evaluation included descriptive statistics, frequencies and percentages were calculated for the data. The chi-square test and fisher's exact test was carried out find the significant value. As this is a prevalence study the results were converted into per thousand populations.

RESULTS

Table1: Distribution of screened subjects according to quality of life.

Quality of life	Male		Female		Total	
	(n=423)					
	N	%	N	%	N	%
Dissatisfied	6	1.14	33	7.80	39	9.21
Neither satisfied nor dissatisfied	42	9.92	87	20.56	129	30.49
Satisfied	150	35.46	105	24.82	255	60.28
Total	198	46.81	225	53.19	423	100.00

X^2=40.8, p value 0.00*

Table2: Distribution of common mental disorders among screened study subjects.

SRQ-20	Male		Female		Total	
	(n=423)					
	N	%	N	%	N	%
Disorder absent	163	38.53	159	37.58	322	76.12
Distress	23	5.4	45	10.63	68	16.07
Severe distress	12	2.83	21	4.96	33	7.80
Total	198	46.81	225	53.19	423	100.00

X^2=7.93, p value = 0.019

Table 3: Distribution of quality of life among people with common mental disorders

Quality of life	Male		Female		Total	
	(n=101)					
	N (35)	%	N (66)	%	N (101)	%
Dissatisfied	3	2.97	21	20.79	24	23.76
Neither satisfied nor dissatisfied	23	22.77	40	39.60	63	62.37
Satisfied	9	8.91	5	4.95	14	13.86
Total	35	34.66	66	65.34	101	100.00

X^2 =10.7257 , p value=0.0046*

The WHO QOL BREF Questionnaire was administered to all the subjects. 60.28% of the people showed satisfaction with their life. 30.49% of the population was neither satisfied nor dissatisfied with their life. 9.21 % of the population was dissatisfied with their life. Out of 39 female was 33(84.61%) showed dissatisfaction with their quality of life and in males 6 (15.38%) showed dissatisfaction. This is statically significant.

Table2 shows 76.12% reported typical response within 7 in SRQ-20 scoring. Common mental disorder was found in 16.07% with SRQ-20 scoring between 7-13. Severe distress was found in 7.80 % of the population with SRQ-20 score >14. Among psychological distress group females scored higher with 10.63%. In the severe distress group again females scored higher with4.96 %.this is statically not significant.

Total 101 subjects were found to have CMD after screening the population and its prevalence come to 238.77 per thousand. And the prevalence of male comes to 176. 76 were as in female it was 293.33 per thousand.

Table3 shows the distribution of quality of life among people with common mental disorders. 13.86% reported satisfied with their quality of life. 62.37% reporting neither satisfied nor dissatisfied and 23.76% were dissatisfied. Table also shows predominantly females being dissatisfied with the quality of life. This is statically significant.

DISCUSSION

Epidemiology is the study of the distribution and determinants of mental disorders frequency in human beings, with the fundamental aim of understanding and controlling the occurrence of common mental disorder. In majority of the studies the researchers were able to assess major mental disorders accurately, but minor mental disorders were not assessed adequately. Indian researchers made attempts to overcome the difficulty of diagnosis by assessing the positive cases on screening [115] for final diagnosis by using their clinical judgment and available diagnostic guidelines at that time, thus avoiding clinician bias in diagnosis. This raises a query whether the findings can be generalized to even one State in a country like India, which is well known for its geographical, linguistic and ethnic diversity. Mental health care priorities need to be shifted from psychotic disorders to common mental disorders like depression, anxiety disorders, somatoform disorder, etc., which are also associated with high disability in all measures[9]. The available evidence suggests that though there has been increase in prevalence rate of psychiatric disorders in the past few decades in India, the changing health scenario has led to imminent epidemic of non-communicable diseases[10] and psychiatric co-morbidity being common in non communicable diseases and chronic medical conditions provides indirect evidence of rise in psychiatric disease prevalence[10].

The study was undertaken in an urban slum of Indore city, M.P with a population of 4219 predominantly belonging to Hindu religion. In our study a total of 423 people were included among 423 people, 101 people were found to be suffering from common mental disorders giving an overall prevalence rate of 238.7 /1000 which is high in accordance with the other studies. The rate of CMD found in females was 293.33/1000 and in males it was 176.76/1000.

Prevalence of people found to be suffering from CMD was 24% by T. S. Sathyanarayana Rao [4]study in south India population in 2011, Ganguli H.C. et al. [11] in year 2000 in Bangalore Pooled data from 15 selected studies with the prevalence of 73.0/1000, Another study by Premarajan et al.[12] in 1993 reported a prevalence of 9.94% (99.4/1000). A trend of continuous increase in the prevalence of psychiatric disorders with time can be noted by the above study findings. Substantiating the above observation Murray and Lopez[13] from their study in 1996 found mental and behavioral disorders to be increasing in the population and Even World Health Organization has published similar reports of increase in incidence of psychiatric disorders with time.[14]

Quality of life with common mental disorders Income and other

factors, we identify stress specific to the slum environment are strongly associated with CMDs. The qualitative findings enrich our understanding of the connection between these stress and mental illness. In addition, the qualitative findings highlight a few community-level slum adversities broadly affecting the entire slum population that could potentially contribute to the high overall burden of CMDs in the population. Recent review articles have come to conflicting conclusions about the association between poverty and mental illness in developing countries, with one review suggesting no association done by J. Das, Do, Friedman, McKenzie, & Scott, 2007 and another review suggesting a strong association (Patel & Kleinman, 2003), Ramnath Subbaraman et al 2012 our findings support the latter conclusion. Quality of life of the screened people

Our study reported that out of 423 people screened 9.21% of the people reported poor quality of life. Poor quality of life was found more among females. In the socioeconomic class, poor quality of life reported in lower class and lower middle class. Illiterates reported poor quality of life compared to educated group. Unemployed and unskilled laborers reported dissatisfaction and quality of life was poor in people with general medical conditions and substance use. The findings are suggestive of influence of education, occupation, socioeconomic status, illness (both physical and mental) and other factors on the quality of life needs further evaluation. Our study reported an overall assessment of quality of life of people of urban slum. As our main objective was to find the prevalence of common mental disorders and overall quality of life, each domain of quality of life was not assessed in the present study.

CONCLUSION

Our study conclude that there is a need to consider wider impact of common psychological health problem that urban slum community is facing today which is largely a neglected part of today's modern society CMD (Common mental disorders) can be a major contributor to slum's overall burden of functional impairment. Almost one third of total population dwelling in urban slum community suffered from CMD which is evident by prevalence which came out to be 238.7 per thousand indicating high prevalence of common psychological health problem. As on today these urban slum community is facing major health problem both mental and physical , based on the prevalence of CMD, we conclude that their mental health requires attention, which is an essential part of individual's health.

("Health is a state of complete physical, mental and social well –being and not merely an absence of disease or infirmity"). Hence it is essential to design intervention that aim at allaying their distress which can improve their mental health and overall quality of life, being a descriptive nature of this study and only one slum study the above mentioned finding cannot be generalized.

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