Mental Health, Are We at Risk?

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ABSTRACT

Background: Mental health is an important component of the total positive health and is interwoven closely with the physical and physiological dynamics of the human body. Worldwide, about 500 million people are believed to be suffering from neurotic, stress related and psychological problems. In India, surveys on mental morbidity in various parts of the country suggest a prevalence rate of 18-20 per 1000. Materials and Methods: A community-based, cross-sectional descriptive study was carried out amongst married women in the age group 18-45 years in an urban community of South Mumbai. Self-reporting questionnaire of 20 items (SRQ 20) developed by the WHO was administered. Statistical analysis was carried out to estimate the prevalence of psychiatric disturbance. Result: The prevalence of psychiatric disturbance was found to be 27.27% for the total sample. The study results indicate that somatic symptoms were reported more commonly which could be a manifestation of underlying/burgeoning mental disorders. Conclusions: The results imply a high prevalence of 27.27% of psychiatric disturbance in our community. However, defining mental disorder from a clinical standpoint necessitates identification of the dividing line between despair and depression. It is recommended that women be encouraged to approach counsellors and thus enable further diagnosis and management of Common Mental Disorders in the community.

Keywords: Common mental disorders, depression, women

Introduction

India shines today with a whopping one billion army of its own, the dazzle, however, is marred by a myriad health problems. Urbanization, industrialization and technological advancement have established India as a force but the price the society is paying is a tremendous load of “Non-Communicable diseases”.(1)

Consequent to socio-demographic changes, media revolution and epidemiological transition, lifestyle diseases have come to the forefront of medical arena. The social, biological and psychological strengths of the past are slowly being replaced by a consumer-driven lifestyle, leaving people more vulnerable to social, mental and psychological problems at all ages.

Mental health is an important component of the total positive health, and it is interwoven closely with the physical and physiological dynamics of the human body. The WHO expert committee defines mental health as ‘the capacity in an individual to form harmonious relations with others and to participate in or contribute constructively to change in the social environment’.(2)

Worldwide, about 500 million people are believed to be suffering from neurotic, stress-related and psychological (somatoform) problems.(3) In India, surveys on mental morbidity in various parts of the country suggest a prevalence rate of 18-20 per 1000.(4)

A substantial number of Indian women suffer from Common Mental Disorders (CMD) which are characterized by symptoms such as fatigue, forgetfulness, insomnia, irritability, difficulty in concentrating, headaches, and psychosomatic complaints.(5) Both community-based studies and studies of treatment seekers indicate that women are, on an average, two to three times, at greater risk to be affected by CMD.(6)

Everyone occasionally feels blue or sad, but these feelings are usually fleeting and pass within a couple
of days. When a woman has a depressive disorder, it interferes with daily life and personal functioning, causing considerable stress to her own self as well as to those looking after her. We have a real problem in distinguishing depression as an illness from the despair of everyday life. Depression is a common but serious illness, asking for a targeted intervention. The propensity to be chronic, sometimes unresponsive to treatment, the resultant disability in various spheres of functioning, stigmatization and the social sequel make it a public health issue. Thus, information on the prevalence of mental disorders can prove useful for the development of large-scale health-intervention programs designed toward its prevention.

In view of the above, the present study was carried out to ascertain the prevalence of CMDs among married women in an urban community, within the age group 18-45 years residing in Mumbai.

Materials and Methods

This study used a community-based, cross-sectional descriptive epidemiological design, and was carried out in an urban community of south Mumbai. The reference population was all married women in the age group 18-45 years residing in a common residential area. In order to measure the presence of mental illness, the self-reporting questionnaire of 20 items (SRQ20) developed by WHO was administered. This consists of 20 yes/no questions with a reference period of the preceding 30 days. The questionnaire was translated in Hindi as shown in Figure 1 and administered to a group of 50 women having similar socio-demographic profile for validation. It has acceptable levels of reliability and validity in developing countries and is recommended by the World Health Organisation (WHO) as a screening tool.

SRQ comprises questions related to cognitive symptoms, anxiety, and depression and manifestation as somatic symptoms. The questions of the instrument are written in a simple, easy to understand language which encompassed many important areas of psychopathology. Its administration took 5-10 minutes per individual.

Sample size of 81 was worked out based on prevalence of mental disorders in developing countries between 20 and 30% with an error of margin of 10% at 95% confidence interval. Complete confidentiality was maintained for the sample drawn and even the names of individuals were not asked. Statistical analysis was carried out by using SPSS 14 software. The demographic information showed that all women had attained primary education and none of the women were illiterate. The living conditions and socio-economic status of all women was similar.

Respondents were chosen by simple random sampling from women between 18 and 45 years who could both read and write. The mean age of women was 31.60 years. However, we were able to administer SRQ to 132 subjects. A limitation of the study was the relatively small sample size. For this reason, these findings cannot be generalized to the broader community based on this study alone.

Results

At the cut-off point of 7, we identified 36 cases of mental distress, yielding a prevalence of 27.27% for the total sample. If lower cut-off points were used, the prevalence of mental distress would increase by 1.5 times at each lower threshold score. Most common symptoms from among 132 women who responded were being easily tired (61.36%) and feeling tired (36.36%) all the time, as shown in Table 1.

From Table 1 it is observed that ‘Being easily tired’ was the maximally reported (61.36%), symptom by respondents followed by ‘Often having headache’ and ‘Poor digestion’ cited by 31.81% and 31.80% respondents, respectively.
The symptoms reported less commonly ranged from poor appetite to feeling worthless as shown in Table 2.

From Table 3 it is observed that 34.09% women exhibited feelings of nervousness and indecisiveness. There were 32% women who got easily frightened and 30% who felt they were not playing a useful part in life.

Discussion

The meta-analysis by Reddy(4) revealed high prevalence of mental disorders in urban area i.e., 80.60%, whereas it was 48.90% in rural area. The model of cultural transformation especially from rural to modern society, is considered to be one of the reasons of psychological disorder as applicable to the sample in the study.

The prevalence of mental distress found in this study is higher than the WHO estimates of the lifetime prevalence of mental or behavioral disorders in both developed and developing countries which has been estimated as 25%. (11-13) The prevalence is also more than that obtained for mental distress in developing countries. (9) Another study using SRQ at the cut-off of 7/8 among 400 female caregivers of children under 1-year old in a province in North Vietnam found a lower prevalence of mental distress of 20%. (8) A survey carried out in Delhi, among women where average age of sample was 36.30 years revealed that women were highly stressed out. The survey used the general Health questionnaire and also evaluated subjective wellbeing. (14)

They found that rates of anxiety, hysteria, and phobia had fallen dramatically while those of depression, learning disability, and dementia had risen significantly from 1972 to 1992. (15)

In the present study, somatic symptoms among the sample were more prevalent than ‘emotional’ symptoms. Several studies have found that somatic symptoms are the most common clinical expression of psychological distress. (9,10) In Indian context, the higher prevalence of somatic symptoms can be explained by the prevailing cultural notion that a person is considered ill only when he or she has some physical ailment and it is easier for to remember an abnormal event. In addition, a person with mental distress might dislike reporting psychiatric symptoms because mental illness is still stigmatized in our culture unlike other countries. Instead, somatic symptoms may be used to express psychological symptoms. This study confirmed earlier studies showing that depressive disorders with predominantly somatic presentation were likely to be the most common form of depression.

Conclusions

This study was undertaken as a survey in a close knit, urban community. It was aimed at an early identification of the most commonly seen disorders amongst Indian women. The results imply a high prevalence of 27.27% of CMDs in our community. However, defining mental disorder from a clinical standpoint necessitates identification of the dividing line between despair and depression.

Mental distress in women can affect their normal functioning and eventually disturb the equanimity at home, thus affecting all members. Such an issue seeks serious attention in the public health domain. This calls for courage, acceptance of the problem and a vibrant spirit of innovation. Also, the awareness in the community about mental health problems should be increased. The stigma attached to being labelled should be addressed and dealt with through a multipronged strategy. The need for counsellors and clinical psychologists to be able to reach the target population is of prime importance. Understanding how cultural dynamics articulate with adaptation to urban life may facilitate proper management of mental disorders in cities.

Larger studies including role of spouse and association with factors such as household work overload or lack of leisure time need to be undertaken. The need for renewed vigor in the provision of community-based mental healthcare services is thus self-evident. There is hence a need for serious introspection and radical reordering of priorities. “It’s time we admitted that there’s more to life than money and it’s time we focused not just on GDP but on GWB-general well being. (16) The significance of this study also lies in forming a groundwork for future research in identifying the causal relationships in CMD.”

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Table 2: Responses to various questions on the SRQ

| Questions                          | Response type (Yes) | Percentage |
|------------------------------------|---------------------|------------|
| Poor appetite                      | 27                  | 20.45      |
| Having trouble thinking clearly    | 27                  | 20.50      |
| Daily work suffering               | 27                  | 21.00      |
| Lost interest in things            | 24                  | 18.00      |
| Daily activities hardly found       | 21                  | 15.90      |
| Having thought of ending life       | 21                  | 15.90      |
| Feeling unhappy                    | 15                  | 11.00      |
| Feeling worthless                  | 9                   | 06.81      |

Table 3: Manifestations of psychiatric disturbance

| Response                          | Number | Percentage |
|-----------------------------------|--------|------------|
| Feeling nervous, tense, worried   | 45     | 34.09      |
| Difficulty in making decisions    | 45     | 34.09      |
| Easily frightened                  | 42     | 32.00      |
| Unable to play a useful part       | 39     | 30.00      |
| Crying more than usual             | 33     | 25.00      |
References

1. Lopez AD, Mathers CD, Ezzati M. In Lopez AD, editor. Global burden of disease and risk factors. Book on Global Burden of Disease and Risk Factors 2006. Available from: http://www.ncbi.nlm.nih.gov/books/NBK11812/ [Last cited on 2013 May 4].

2. World Health Organisation. Mental Health Tech Report Series No 31. World Health Organization. 1951. Available from: http://whqlibdoc.who.int/trs/WHO_TRS_58 [Last cited on 2013 May 5].

3. World Health Organisation. Annual Report of the Director General for the year 1995. Available from: http://www.who.int/whr/1998/en/whr98_en [Last cited on 2013 May 5].

4. Reddy MV, Chandrasekhar CR. Prevalence of mental and behavioural disorders in India: A meta-analysis. Indian J Psychiatry 1998;40:149-57.

5. Goldberg D, Huxley P. Common mental disorders: A bio-social model. London: Tavistock; 1992. Available from: www.kumj.com.np/issue/35/213-7 [Last cited on 2013 May 6].

6. Patel V, Araya R, de Lima M, Ludermir A, Todd C. Women, poverty and common mental disorders in four restructuring societies. Soc Sci Med 1999;49:1461-71.

7. Shirala KA, Kanwar S. Mental illness and hill women: A demographic study. J Pers Clin Stud 1987;3:103-8.

8. Beusenberg M, Orley J. A user’s guide to the self reporting questionnaire (SRQ). Edited by Health DoM. Geneva: WHO; 1994. Available from: http://whqlibdoc.who.int/hq/1994/WHO_MNH_PSF_94.8 [Last cited on 2013 May 6].

9. Lives Y. Young lives preliminary country report. Int J Epidemiol 2012;1:25-6.

10. Patel V, Kleinman A. Poverty and common mental disorders in developing countries. Bull World Health Organ 2003;81:609-15.

11. Almeida-Filho N, Marie Jde J, Coutinho E, Franca JF, Fernandes J, Andreoli SB, et al. Brazilian multicentric study of psychiatric morbidity. Methodological features and prevalence estimates. Br J Psychiatry 1997;171:524-9.

12. Regier DA, Boyd JH, Burke JD Jr, Rae DS, Myers JK, Kramer M, et al. One-month prevalence of mental disorders in the United States. Based on five Epidemiologic Catchment Area sites. Arch Gen Psychiatry 1988;45:977-86.

13. Wells JE, Bushnell JA, Hornblow AR, Joyce PR, Oakley-Browne MA. Christchurch Psychiatric Epidemiology Study, Part I: Methodology and lifetime prevalence for specific psychiatric disorders. Aust NZ J Psychiatry 1989;23:315-26.

14. Prevalence of psychiatric morbidity, subjective well being and patterns of help seeking behaviour. State of mental health in Delhi 2008. Available from: http://www.manas.org.in [Last cited on 2013 May 8].

15. Nandi DN, Banerjee SP, Mukherjee SP, Ghosh A, Nandi PS, Nandi S. Psychiatric morbidity of a rural Indian community: Changes over a 20-year interval. Br J Psychiatry 2000;176:351-6.

16. Bulletin of World Health Organisation 2011;89:246-7. Available from: http://www.who.int/bulletin/volumes/89/4/11-020411/ [Last cited on 2013 May 8].

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