

A Study to Assess the Quality of Life in Persons with Mood Disorder Attending OPD of LGBRIMH TEZPUR, Assam

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Abstract: *Mood disorders are brain disorder that causes changes in a person's mood, energy and ability to function in their daily life. This condition may make work and other day to day activities difficult, and also may cause people to abuse alcohol or drugs, and make it harder for people to take care of their health. And therefore this disorder can have serious effects on a person's quality of life. A descriptive non - experimental research method was used to achieve the objectives of the study. The study was conducted in the outpatient department of LGBRIMH with 100 participants and they were selected by purposive sampling technique. The investigator assessed the quality of life by administering WHOQOL - BREF scale which has 26 items. The data were collected using questionnaire and confidentiality was maintained throughout the study. Data were analyzed using descriptive and inferential statistics with SPSS 20 version. Result shows that the mean score of quality of life of persons with mood disorder on physical health, psychological health, social relationships and environment domains were 11.98 ± 1.370 , 12.14 ± 1.421 , 11.20 ± 1.392 and 12.83 ± 1.247 respectively. The mean and standard deviation of total quality of life of the persons with mood disorder was found to be 76.53 ± 5.753 which ranges from 48 to 90. And also there was significant association found between age ($\chi^2 = 4.000$, $p = 0.046$), marital status ($\chi^2 = 6.832$, $p = 0.009$) and the social relationship domain. Also there was a significant association found between domicile ($\chi^2 = 6.238$, $p = 0.013$) and environmental health domain. There was also a significant association between physical health domain and the age of onset of illness ($\chi^2 = 5.473$, $p = 0.019$). And there was also a significant association found between the physical health domain and the total duration of treatment of the person with mood disorder ($\chi^2 = 9.304$, $p = 0.002$). The study result further showed that there was no significant association between the selected socio demographic & clinical variable with the four domains of quality of life of the persons with mood disorder.*

Keywords: Quality of life, Mood disorders, Descriptive research, WHOQOL - BREF scale, Statistical analysis.

1. Introduction

Quality of life is a concept that refers to an individual's general well - being, including physical, emotional, and psychological parameters. It is defined as "The degree to which a person enjoys the important possibilities of his or her life" [1]. Quality of life has a wide range of contexts: physical, psychological and social health. Quality of life should not be confused with the concept of standard of living, which is based primarily on income. Instead, standard indicators of quality of life include not only wealth and employment but also the built environment, physical and mental health, education, recreation and leisure time and social belonging [2].

WHO defines Quality of life as " the individual's perceptions of their position in life in the context of the culture value systems in which they live and in relation to their goals, expectations, standards and concerns. " This definition reflects the view that quality of life refers to a subjective evaluation which is embedded in a cultural, social and environmental context. Because this definition focuses upon respondent's "perceived" quality of life, it is not expected to provide any means of measuring in any detailed fashion symptoms, disease or conditions but rather effects of diseases and health interventions on quality of life [3].

2. Literature Survey

Lima & Fleck [4] conducted a prospective cohort study with the objectives to describe the demographic and clinical characteristics, adequacy of antidepressant treatment, and

changes in quality of life of patients with major depression receiving follow - up care from primary care centers. The study was carried out in the primary care units in the south of Brazil in the year 2011. The evaluation instruments used were the World Health Organization Quality of Life and the Quality of Life - Depression, Centers for Epidemiologic Studies - Depression questionnaires. This study used a cohort obtained from the longitudinal Investigation of Depressive Outcomes study. Sample collection for the study was done by screening interview which was performed with 2, 475 users of 3 primary care services in Porte Alegre. For analysis of the data chi - square test was used and mixed models were used for repeated - measures analysis. The total sample was 179 individuals, where most were female i. e.73%, with a mean age of 38 years and mean education of 9 year and the result further showed at the end of the follow - up period, 42% of the individuals still presented with major depression, 25% had complete symptom remission, and only 9% were properly treated with antidepressants. In relation to quality of life, there were significant differences especially between baseline and after nine months in almost all measures at the beginning it was found that 54.2% were considered to be good or very good, 50.3% were good or very good at the end of the follow up period. The average World health organization scores were greater for the physical domain i. e.55.6to 64.9 and least for environmental domain i. e.50.30 to 54.14. This concluded that depressive symptoms are poorly recognized and that treatment is often inadequate for patients followed - up in primary care units in the south of Brazil. Most of the patients continued to have symptoms of depression over the nine - month period which were associated with impaired quality of life.

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Michalak et al [5] conducted a review of literature study on Quality of life in bipolar disorder. A literature search was conducted in a comprehensive selection of databases including MEDLINE up to November 2004. The samples were collected through the literature search which initially yielded 790 articles or abstracts. Of those, 762 did not meet the inclusion criteria, leaving a final total of 28 articles. Those were sub - divided into four categories (assessment of QoL in patients with BD at different stages of the disorder, comparisons of QoL in Patients with BD with that of other patient populations, QoL instrument evaluation in patients with BD and treatment studies using QoL instruments to assess outcome in Patients with BD) and described in detail. The review indicated that there is growing interest in QoL research in bipolar populations. Although the scientific quality of the research identified was variable, increasing numbers of studies of good design are being conducted. The majority of the studies identified in this study indicated that QoL is markedly impaired in patients with BD, even when they are considered to be clinically euthymic. This study identified several important avenues for future research, including a need for more assessment of QoL in hypo/manic patients, more longitudinal research and the development of a disease - specific measure of QoL for patients with BD. Norholm et al [6] conducted a comparative study with the objectives to examine to what extent depressive symptoms are associated with reduced quality of life in schizophrenia in the year 2009. The sample included in the study were the general population which were taken as control group and were compared with the patients with ICD - 10 schizophrenia stabilized during hospitalization with antipsychotics. The tool used for the study are the WHO Quality of Life Short Form, 9WHOQOL - BREF) and for depression the Major Depression Inventory, (MDI). The results showed that within the group of schizophrenic patients, no association was seen with the types of antipsychotic medication prescribed. Both in the group of schizophrenic patients and in the general population sample, those persons scoring on the Major Depressive Inventory, who have depressive symptoms, had reduced quality of life significantly. The researcher concluded that approximately 70% of the schizophrenic patients stabilized during hospitalization with antipsychotics are able to validly complete self - report scales measuring quality of life and depressive symptoms. These study results have found that the depressive symptoms have association with reduced quality of life.

Objectives

- 1) To assess the socio - demographic and clinical variables of the persons with mood disorder.
- 2) To assess the quality of life of the persons with mood disorder.
- 3) To assess the association of quality of life with the selected socio - demographic and clinical variables.

3. Methodology

A descriptive non - experimental research method was used to achieve the objectives of the study. The study was conducted in the outpatient department of LGBRIMH with 100 participants and they were selected by purposive

sampling technique. The investigator assessed the quality of life by administering WHOQOL - BREF scale which has 26 items. The data were collected using questionnaire and confidentiality was maintained throughout the study. Data were analyzed using descriptive and inferential statistics with SPSS 20 version.

Tools used:

The tool for collecting data was in three parts - Part I: A: Young Mania Rating scale (YMRS), Part I: B: The Hamilton Rating Scale for Depression (HDRS), Part II: The socio - demographic Performa sheet, it includes: Part II - A (socio demographic variables) age, gender, religion, marital status, educational status, occupation, family income, patient's income, domicile, types of family Part II -B (Clinical variables) includes: diagnosis, total duration of illness, total episode of illness, regularity of medication intake, age of onset, any history of hospitalization, Part III: The world health organizational quality of life (WHOQOL) - BREF.

Part I: A: Young Mania Rating scale (YMRS) - It is developed by Vincent E Ziegler and popularized by Robert Young, is an eleven item multiple choice diagnostic questionnaire which psychiatrists used to measure the severity of manic episode in children and adults. The items have five defined grades of severity. The scale was modeled on the Hamilton Rating Scale for Depression (HAM - D). The scale is intended for use by clinically experienced raters. Inter - rater reliability reported was adequate for total score (0.93) and for individual items ranged from 0.67 to 0.95. In the scale 4 items scored up to 8 the rest up to 4 and the cutoff of 20 for inclusion in bipolar disorder is used [46].

Part I: B: The Hamilton Rating Scale for Depression (HDRS) - The Hamilton Rating Scale for Depression was written in the late 1950s by Max Hamilton, a psychiatrist at Leeds University and originally designed to evaluate the performance of first group of antidepressants, but in 1990s its use began tool is also called as Hamilton Depression Rating scale, is a multiple 21 item questionnaire used to provide an indication of depression, and as a guide to evaluate recovery the questionnaire is designed to be used by a health care professional during a clinical interview. The scale is widely available and has two common versions with either 17 or 21 items and scored between 0 to 4 points. Scoring is based on the 17 - item scale and scores of 0 - 7 are considered as being normal, 8 - 16 suggest mild depression, 17 - 23 moderate depression and scores over 24 are indicative of severe depression, the maximum score being 52 on the 17 - point scale. A major view of 70 studies suggested that the internal, inter - rater and retest reliability estimates are adequate for global score but are weaker for individual items [47]. In the current study 21 items scale was used.

Part II: The socio - demographic Performa sheet - It includes: Part II - A (socio demographic variables) age, gender, religion, marital status, educational status, occupation, family income, patient's income, domicile, types of family

Part II -B (Clinical variables) includes: diagnosis, total duration of illness, total episode of illness, regularity of

medication intake, age of onset, any history of hospitalization, if yes total duration of hospitalization, total duration of treatment whether on monotherapy or polytherapy medicine, if on polytherapy type of medication being taken, regularity of medication and any persons with mental illness in the family at present.

Part III: The world health organizational quality of life (WHOQOL) - BREF

The WHOQOL - BREF is a short version of the WHOQOL - 100 1996 which is a self administered tool and has 26 items. It contains 2 questions on overall quality of life and general health and 24 questions (one for each facet) used to produce scores for four domains related to quality of life. These are as follows

- Physical health domain
- Psychological domain
- Social relationships domain
- Environmental domain

It produces a quality of life profile and the items in the WHOQOL - BREF are rated on a point scale. It produces scores for four domains related to quality of life (physical health, psychological, social relationships and environment). Domain scores are scaled in positive direction (i. e. higher scores denote high quality of life). It also includes one facet on overall quality of life and general health. An overall, quality of life score can be obtained by summing up the individual scores on each of 24 items the response the instrument would give raw scores which need to be transformed. Raw domain scores are calculated by straight ward summative scaling of constituent items. Three negatively - worded items need to be reversely scored. Reliability is found to be Cronbach's alpha ≥ 0.7 [48].

4. Results/ Discussion

Table 1: Frequency (f) and percentage (%) distribution of selected Socio - demographic variables of the persons with mood disorder

Variables	Category	Frequency (f)	Percentage (%)
Gender	Male	51	51%
	Female	49	49%
Religion	Hindu	47	47%
	Islam	53	53%
Marital status	Married	77	77%
	Unmarried	14	14%
	Widowed	3	3%
	Divorced	3	3%
	Separated	3	3%
Educational status	Primary	50	50%
	Secondary	34	34%
	H. S	11	11%
	Graduate	3	3%
	Above	2	2%
Occupation	Private	3	3%
	Government	2	2%
	Cultivator	21	21%
	Daily labor	16	16%
	Business	8	8%
	Others	50	50%
Domicile	Urban	36	36%
	Rural	64	64%

Type of family	Nuclear	51	51%
	Joint	49	49%
	Extended	0	0

Table 2: Mean and Standard deviation of the selected socio - demographic variables of the persons with mood disorder, n=100

Variables	Minimum	Maximum	Mean	Standard Deviation
Age (years)	18	60	37.88	10.06
Family income (in rupees)	2000	100000	13220	14976.47
Patient's income (in rupees)	0	28000	3653	4821.091

Table 3: Frequency and percentage distribution of the selected clinical variables of the persons with mood disorder. n=100

Category	Variables	Frequency (f)	Percentage (%)
Diagnosis	F30.0 - F30.9	3	3%
	F31.0 - F31.9	44	44%
	F32.0 - F32.9	51	51%
	F33.0 - F33.9	2	2%
Whether on monotherapy or polytherapy	Monotherapy	18	18%
	Polytherapy	82	82%
Types of medication being taken	Antipsychotics	7	7%
	Antidepressant	11	11%
	Mood stabilizer	2	2%
	Anti-anxiety & hypnotics	1	1%
	2types & more	60	60%
	3types & more	19	19%
Regularity of medication intake	Yes	43	43%
	No	57	57%
Any persons with mental illness in the family at present	Yes	8	8%
	No	92	92%

Table 4: Mean and standard deviation of the selected clinical variables of persons with mood disorder n=100

Variables	Minimum	Maximum	Mean	Standard Deviation
Age of onset of illness (in years)	14	57	33.09	10.145
Total episode of illness	1	9	1.92	1.338
Number of hospitalization	0	5	0.56	1.166
Total duration of hospitalization (in months)	0	11	0.91	2.165
Total duration of treatment (in years)	1	20	6.45	4.700

Table 5: Mean and standard deviation of quality of life of persons with mood disorder n=100

Domain Of WHOQOL - BREF	Range	Mean	Standard Deviation
Physical Health	6 - 15	11.98	1.370
Psychological Health	4 - 15	12.14	1.421
Social relationships	8 - 15	11.20	1.392
Environment	10 - 16	12.83	1.247
Total score of quality of life	48 - 90	76.53	5.753

Table 6 Showed that there was no significant association between physical health domain and selected socio demographic variables i. e., gender, religion, marital status, educational status, occupation, family income, patient’s income, domicile and family types. But there was a significant association found between age, and physical health domain ($\chi^2=5.473$, $p=0.019$). And there was a significant association found between domicile with physical health domain ($\chi^2=4.675$, $p=0.031$).

n=100

Socio - demographic variable of persons with mood disorder	Physical health domain		Calculated χ^2 value	df	P value	S*/NS	
	≤12	>12					
Age (in years)	<37	28	22	5.473	1	0.019	S*
	≥37	39	11				
Gender	Male	34	17	0.005	1	0.942	NS
	Female	33	16				
Religion	Hindu	32	15	0.047	1	0.828	NS
	Muslim	35	18				
Marital status	Married	52	25	0.043	1	0.836	NS
	Others	15	8				
Educational status	<HSLC	57	27	0.174	1	0.676	NS
	≥HSLC	10	6				
Occupational status	Private & government job	3	2	0.117	1	1.000 (Fisher’s Exact value)	NS
	Others	64	31				
Family income	<13220	47	24	0.071	1	0.789	NS
	≥13220	20	9				
Patient’s income	<3653	45	22	3.243	1	0.072	NS
	≥3653	16	17				
Domicile	Urban	29	7	4.675	1	0.031	S*
	Rural	38	26				
Types of family	Nuclear	38	13	2.655	1	0.103	NS
	Joint	29	20				

Significant at <0.05 level

*S=Significant

NS=Not significant

(Cells have expected count less than 5, Fisher’s exact p value was considered)

Table 7: Chi - square values showing association between selected socio demographic variables with the psychological domain of WHOQOL - BREF of the persons with mood disorder, n=100

Socio - demographic variable of persons with mood disorder	Psychological health domain		Calculated χ^2 value	df	P value	S*/NS	
	≥12	<12					
Age	<37	36	14	0.421	1	0.517	NS
	≥37	33	17				
Gender	Male	37	14	0.613	1	0.434	NS
	Female	32	17				
Religion	Hindu	36	11	2.392	1	0.122	NS
	Muslim	33	20				
Marital status	Married	54	23	0.200	1	0.655	NS
	Others	15	8				
Educational status	<HSLC	59	25	0.376	1	0.540	NS
	≥HSCL	10	6				
Occupational status	Private & government job	4	1	0.98	1	1.000 Fisher’s exact value	NS
	Others	65	30				
Family income	<13220	47	25	1.666	1	0.197	NS
	≥13220	22	6				
Patient’s income	<3653	62	30	1.391	1	0.429 Fisher’s exact value	NS
	≥3653	7	1				
Domicile	Urban	24	12	0.143	1	0.705	NS
	Rural	45	19				
Types of family	Nuclear	40	11	0.020	1	0.887	NS
	Joint	10	39				

Table 8: The data presented in Table 8 Showed that there was no significant association between social relationship domain with selected socio demographic variables i. e. gender, religion, educational status, occupation, family income, patient’s income, domicile and family types. But there was a significant association found between age ($\chi^2= 4.000$, $p= 0.046$), marital status ($\chi^2=6.832$, $p=0.009$) with the social relationship domain respectively

n=100

Socio - demographic variable of persons with mood disorder		Social relationship domain		Calculated χ^2 value	df	P value	S*/NS
		<11	\geq 11				
Age	<37	14	36	4.000	1	0.046	S*
	\geq 37	6	44				
Gender	Male	12	39	0.810	1	0.368	NS
	Female	8	41				
Religion	Hindu	13	34	3.252	1	0.071	NS
	Muslim	7	46				
Marital status	Married	11	66	6.832	1	0.009	S*
	Others	9	14				
Educational status	<HSLC	15	69	1.507	1	0.220	NS
	\geq HSLC	5	11				
Occupational status	Private & government job	4	1	1.329	1	0.375 Fisher's exact value	NS
	Others	51	44				
Family income	<13220	15	56	0.194	1	0.659	NS
	\geq 13220	5	24				
Patient's income	<3653	11	50	0.378	1	0.539	NS
	\geq 3653	9	30				
Domicile	Urban	5	31	1.313	1	0.252	NS
	Rural	15	49				
Types of family	Nuclear	7	44	0.679	1	0.410	NS
	Joint	13	36				

Table 9: The data presented in Table 9 showed that there was no significant association between environmental health domain with the selected socio demographic variables i. e., age, gender, religion, marital status, educational status, occupation, family income, patient's income, and family types. But there was a significant association found between domicile ($\chi^2=6.238$, $p=0.013$) with the environmental health domain.

n=100

Socio - demographic variable of persons with mood disorder		Environmental domain		Calculated χ^2 value	df	P value	S*/NS
		\leq 13	$>$ 13				
Age	<37	33	17	1.214	1	0.271	NS
	\geq 37	38	12				
Gender	Male	39	12	1.512	1	0.219	NS
	Female	32	17				
Religion	Hindu	34	13	0.077	1	0.781	NS
	Muslim	37	16				
Marital status	Married	57	20	1.489	1	0.222	NS
	Others	14	9				
Educational status	<HSLC	59	25	0.148	1	1.000 Fisher's exact value	NS
	\geq HSLC	12	4				
Occupational status	Private & government job	3	2	0.309	1	0.629 Fisher's exact value	NS
	Others	68	27				
Family income	<13220	50	21	0.040	1	0.842	NS
	\geq 13220	21	8				
Patient's income	<3653	44	17	0.097	1	0.755	NS
	\geq 3653	27	12				
Domicile	Urban	31	5	6.238	1	0.013	S*
	Rural	40	24				
Types of family	Nuclear	37	14	1.387	1	0.239	NS
	Joint	34	15				

Table 10: showed there was no significant association between physical health domain with the selected clinical variables i. e., diagnosis, total episodes of illness, number of hospitalization, total duration of hospitalization, whether on monotherapy or polytherapy, types of medication being taken, regularity of medication intake, and any persons with mental illness in the family. But there was a significant association found between the physical health domain with the age of onset of illness of the person with mood disorder ($\chi^2 =5.473$, $p= 0.019$). And there was also a significant association found between the physical health domain with the total duration of treatment of the person with mood disorder ($\chi^2 =9.304$, $p= 0.002$).

n=100

Clinical variable of persons with mood disorder		Physical health domain		Calculated χ^2 value	df	P value	*S/NS
		\leq 12	$>$ 12				
Diagnosis	Manic episode	32	15	0.047	1	0.828	NS
	Depressive episode	35	18				
Age of onset of illness	<33	28	22	5.473	1	0.019	S*
	\geq 33	39	11				
Total episode of illness (in years)	<2episodes	32	14	0.254	1	0.615	NS

	≥2episodes	35	19				
Number of hospitalization	≤1times	56	27	0.049	1	0.825	NS
	>1times	11	6				
Total duration of hospitalization	≤1month	57	24	2.190	1	0.139	NS
	>1month	10					
Total duration of treatment	<6year	40	9	9.304	1	0.002	S*
	≥6years	27	24				
Whether on monotherapy or polytherapy	Monotherapy	13	5	0.271	1	0.603	NS
	Polytherapy	54	28				
Types of medication being taken	<2types	14	7	0.001	1	0.971	NS
	≥2types	53	26				
Regularity of medication	Yes	29	14	0.007	1	0.935	NS
	No	38	19				
Any persons with mental illness in the family	Yes	4	4	1.137	1	0.434	NS
	No	63	29				

Table 11: showed that there was no significant association between psychological health domain with the selected clinical variables i. e., diagnosis, age of onset of illness, total episodes of illness, number of hospitalization, total duration of hospitalization, total duration of treatment, whether on monotherapy or polytherapy, types of medication being taken, regularity of medication intake, and any persons with mental illness in the family

n=100

Clinical variable of persons with mood disorder		Psychological health domain		Calculated χ^2 value	df	p value	*/NS
		≥12	<12				
Diagnosis	Manic episode	35	12	1.240	1	0.266	NS
	Depressive episode	34	19				
Age of onset of illness	<33years	35	15	0.047	1	0.829	NS
	≥33years	34	16				
Total episode of illness (in years)	<2episode	28	18	2.633	1	0.105	NS
	≥2episode	41	13				
Number of hospitalization	≤1times	54	29	3.543	1	0.084 Fisher's exact value	NS
	>1times	15	2				
Total duration of hospitalization	≤1month	53	28	2.537	1	0.168 Fisher's exact value	NS
	>1month	16	3				
Total duration of treatment	<6year	31	18	1.477	1	0.224	NS
	≥6years	38	13				
Whether on monotherapy or polytherapy	Monotherapy	12	6	0.056	1	0.813	NS
	Polytherapy	57	25				
Types of medication being taken	< 2types	14	7	0.068	5	0.795	NS
	≥2types	55	24				
Regularity of medication	Yes	28	15	0.532	1	0.466	NS
	No	41	16				
Any persons with mental illness in the family	Yes	5	3	0.172	1	0.700 Fisher's exact value	NS
	No	64	28				

Table 12 Showed that there was no significant association between social relationship domain and selected clinical variables i. e., diagnosis, age of onset of illness, total episodes of illness, number of hospitalization, total duration of hospitalization, total duration of treatment, whether on monotherapy or polytherapy, types of medication being taken, regularity of medication intake, and any persons with mental illness in the family

n=100

Clinical variable of persons with mood disorder		Social relationship domain		Calculated χ^2 value	df	P value	S*/NS
		<11	≥11				
Diagnosis	Manic episode	10	37	0.090	1	0.764	NS
	Depressive episode	10	43				
Age of onset of illness	<33years	12	38	1.000	1	0.317	NS
	≥33years	8	42				
Total episode of illness (in years)	<2episode	7	39	1.218	1	0.270	NS
	≥2episode	13	41				
Number of hospitalization	≤1times	16	67	0.159	1	0.741 Fisher's exact value	NS
	>1times	4	13				
Total duration of hospitalization	≤1month	14	67	1.966	1	0.161	NS
	>1month	6	13				
Total duration of treatment	<6year	8	41	0.810	1	0.368	NS
	≥6years	12	39				
Whether on monotherapy or polytherapy	Monotherapy	5	13	0.830	1	0.362	NS
	Polytherapy	15	67				

Types of medication being taken	<2types	6	15	1.221	1	0.269	NS
	≥2types	14	65				
Regularity of medication	Yes	7	36	0.653	1	0.419	NS
	No	13	44				
Any persons with mental illness in the family	Yes	2	6	0.136	1	0.659 Fisher's exact value	NS
	No	18	74				

Significant at <0.05 level

*S=Significant

NS=Not significant

Table 13 showed the there was no significant association between environmental health domain and selected clinical variables i. e., diagnosis, age of onset of illness, total episodes of illness, number of hospitalization, total duration of treatment, whether on monotherapy or polytherapy, types of medication being taken, regularity of medication intake, and any persons with mental illness in the family.

n=100

Clinical variable of persons with mood disorder	Environmental health domain		Calculated χ^2 value	df	P value	S*/NS	
	≤13	>13					
Diagnosis	Manic episode	35	12	0.518	1	0.472	NS
	Depressive episode	36	17				
Age of onset of illness	<33years	35	15	0.049	1	0.826	NS
	≥33years	36	14				
Total episode of illness (in years)	<2episode	24	12	0.351	1	0.554	NS
	≥2episode	37	17				
Number of hospitalization	≤1times	59	24	0.002	1	1.000 Fisher's exact value	NS
	>1times	12	5				
Total duration of hospitalization	≤1month	60	21	1.957	1	0.162	NS
	>1month	11	8				
Total duration of treatment	<6years	37	12	0.949	1	0.330	NS
	≥6years	34	17				
Whether on monotherapy or Polytherapy	Monotherapy	13	5	0.016	1	0.900	NS
	Polytherapy	58	24				
Types of medication being taken	<2types	15	6	0.002	1	0.961	NS
	≥2types	56	23				
Regularity of medication	Yes	33	10	1.209	1	0.272	NS
	No	38	19				
Any persons with mental illness in the family	Yes	4	4	1.862	1	0.225 Fisher's exact value	NS
	No	67	25				

Significant at <0.05 level

*S=Significant

NS=Not significant

5. Conclusion

Quality of life is a concept that refers to an individual's general well - being, including physical, emotional, and psychological parameters. It is defined as "The degree to which a person enjoys the important possibilities of his or her life". Quality of life has a wide range of contexts: physical, psychological and social health. Quality of life should not be confused with the concept of standard of living, which is based primarily on income. Instead, standard indicators of quality of life include not only wealth and employment but also the built environment, physical and mental health, education, recreation and leisure time and social belonging. The present study was conducted to assess the quality of life in persons with mood disorder in the OPD of LGBRIMH, Tezpur, Assam. The total numbers of sample included in the present study were 100 persons with mood disorders. The purposive sampling technique was used to select the sample in considering the inclusion and exclusion criteria which were planned prior to the study. Descriptive research design was used for the current study.

6. Future Scope

The study can be done in different settings. The same study can be done on a large sample for more valid generalization.

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