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INTERVENTION STRATEGY FOR ENHANCING GENERAL WELL BEING AND QUALITY OF LIFE IN SEVERE DEPRESSIVE MALE PATIENTS

Dr. R. Kannappan, Ph.D, D.Litt.
Associate Professor of Clinical Psychology, Department of psychiatry, Vinayaka Mission University, Salem, Tamilnadu.

Abstract
***Background**: The impact of psychosocial rehabilitation of depressive patients with and without psychotic syndromes which are often reoccurring psychiatric conditions was assessed.*

***Objective:** Outcome as measured by psychosocial functioning was examined in a one and half year follow-up study of 32 patients with severe depressed disorder with psychotic syndromes, and 32 depressed patients without psychotic syndromes were participated in an intensive psychosocial program.*

***Methods:** pre-post research design was used in the study. Level of functioning was determined at baseline (before) and after and follow-ups by using the following scale 1. Psychological General Well Being schedule (PGWB), 2. Quality of Life scale (QOL) and 3. The reports of functionality which assessed the patient's ability to stay out of the problem at home, the frequency and depth of social relationships, function in work, the reappearance of symptoms, etc.*

***Results:** The sample was divided into two diagnostic groups of severe depressive patients with psychotic syndromes (N=32), and severe depressive patients without psychotic syndromes (N=32). Scores on the level-of-functioning measure were significant between baseline and five months, between five months and ten months, and between five and fifteen months. Statistical tests indicated a substantial and significant increase in level of functioning from baseline to 15 months for all groups.*

***Conclusions:** The results provided more evidence for the effectiveness of the intensive psychosocial intervention for the severe depressive male patients without psychotic syndromes than the severe depressive patients with psychotic syndromes. Remarkable improvement in the latter group in the areas of functioning such as ability to stay out of the problem at home, the frequency and depth of social relationships, dysfunction in work, the appearance of symptoms, the ability to take self care, and participate in leisure activities.*

Key Words: Psychosocial Intervention, Severe Depressive Patients, Psychosocial Functioning.

Introduction

Human beings have disturbance in their state of mental well being or the psyche. Many mental health problems have started attacking them; one such common problem is depression which affects person's physical health, feeling, thinking, and acting toward others and manifests various symptoms such as change in sleep patterns, feelings of worthlessness, hopelessness, or inappropriate guilt, fatigue, difficulty in concentrating or making decisions, overwhelming and intense feelings of sadness or grief, disturbed thinking and physical symptoms like stomach aches or headaches. These symptoms are treatable. (Johnstone et al, 2004; Sarason, & Sarason, 2002; Kaplan, & Sadock, 1999) and the new episode appears abruptly with the same symptoms or more severe symptoms (Hales Yudofsky & Talbott, 2003). Further the general services are also sought more by the depressive patient's services (Weissman et al, 1988). The treatment of depression is done by medical and psychological means (Johnstone et al, 2004). This disorder affects all people, young or old, regardless of sex, race, ethnicity, and socio economic status.

Depression results from an interaction between a stressful event and life a person's biological and psychological vulnerabilities. Men are less likely to suffer from depression than women and they tend to commit suicide. Genetically identical twins are three times more likely to have depressive disorder than fraternal twins, and they are five times more likely to have bipolar disorder (Ladwig, Marten-Mittag, Erazo, & Gündel, 2001). They might manifest hallucinations or delusions that are either mood-congruent (content coincident with depressive themes) or mood- non-congruent (content not coincident with depressive themes).

The present study attempts to examine the remission of depressive symptoms in depressed men with and without psychotic syndromes by Psycho Social Intervention (PSI).

Objectives
They were i) to use psychosocial intervention strategy for the management of male patients who have severe depressive disorder with and without psychotic syndromes and ii) to assess the qualitative changes in the two groups of depressive patients with and without psychotic syndromes after the intervention and at follow-ups.

Method
Design: The Pre and post research design was used for the study. Data were collected before, after (5 months), and follow-ups (10 &15 months) by using 1. Psychological General Well Being schedule (PGWB), 2. Quality of Life scale (QOL) and 3. The reports of functionality by family member. After the intervention, follow-ups were conducted twice times and with a period of five month gap.

Measures
a) Psychological General Well Being schedule (PGWB)
The PGWB scale was developed in 1970 for the National Center for Health Statistics by Dupuy. The scale assessed how the individual could feel about his inner personal state rather than about external conditions. The scale had 22 items covering anxiety, depressed mood, positive well- being, self control, general health, and vitality. The last four questions used a 0 to 10 rating. The reliability ranged from 0.68 to 0.85 (Dupuy, 1984).

b) Quality of Life Scale (QOL)
The QOL assessed an individual's quality of life through self-report of the importance they attached to each of the five conceptual domains of quality of life: material and physical well-being, relationships with other people, social, community and civic activities, personal development and fulfillment, and recreation. The QOL scale was scored by adding up the score on each item to yield a total score for the instrument and then these scores determined an overall current quality of life for each individual. The scores ranged from 16 to 112. This measure was very quick to complete, and had been normed in a community sample of adults. It had also been used to track changes in individuals over the course of therapy. Higher scores indicated a higher overall quality of life (Burckhardt et al, 1989).

c) Report of functionality by family member.
This report of functionality included the following patient's ability to stay out of the problem at home, the frequency and depth of social relationships, dysfunction in work, the presence of symptoms, the ability to maintain personal hygiene, and the ability to participate in leisure activities.

Sample: Thirty two men who had the symptoms of severe depressive disorder with psychotic syndromes, and thirty two men who had the symptoms of severe depressive disorder without psychotic syndromes were subjects to the study. Both groups received drugs and participated in an intensive psychosocial intervention. To highlight on the care taken in process of the study is that the patients were exposed to adequate duration of therapy.18 sessions were given and the time taken for each session was 50 minutes. The data collections were done at before, after, and follow-ups with an interval of five months.

Psycho Social Intervention (PSI)
The psychiatrists of the department of psychiatry prescribed drugs to the patients of the two groups. The patients also responded to the treatment and the symptoms such as pain, insomnia, and loss of appetite, were decreasing in the patients. The patients attended the program that three days a week in a predominantly for three months and later on once in month with their informants.

Psychosocial intervention was used for the caregivers to understand the depressive features and related problems. In this intervention, the anxieties and the worries of the caregivers were addressed. It was found very important that they had to cope up and also follow up the needs of the patients. The treatment of the individuals merged with the observation and the problems of the caregivers.

At the beginning the patients and caregivers were assigned reading material on coping with depression and a weekly activity schedule (self-report) of home work assignment emphasizing on active learning approach. The main focus of the therapy was directed to clinically relevant dimensions of family functioning such as problem solving, communication, roles, affective responsiveness, involvement and behavior control as well as occupational functioning.

The therapeutic principles were designed to the individual family's problems. The specific problems of the family were

determined by the therapist and the family together. The stages of the therapy included assessment, contracting, treatment and termination. The number of sessions varied depending on the needs of the family ranging from 10 to 15 (fifty-minute per session). Caregivers became skilled to cope with depression and they observed the patients while engaging in selected activities like problem solving, communication, and occupational functioning (Vieta, 2005a, and Gutirrez, 2004).
Statistical analysis: SPSS package was used for analysis and comparing the means of different groups.

Results

Table 1: shows demographic variables of the depressed male patients with and without psychotic syndromes.

S.No	Demographic variables		*D w PS group*		*D w PS group*	
			N	%	N	%
1	Age	25- 30 years	16	50	14	44
		31-40 years	16	50	18	56
2	Education	<5th standard	10	31.3	8	25
		8th standard	12	37.5	10	31
		10th standard	10	32.2	14	44
3	Religion	Hindu	24	75	22	69
		Christian	4	12.5	6	19
		Muslim	4	12.5	6	19
4	Income	Rs.>2000	14	44	10	31.3
		Rs.>3000	16	50	12	37.5
		Rs.>4000	4	12	10	31.2
5	Number of children	0	2	6	4	12.5
		1	2	6	4	12.5
		2	16	50	14	44
		3	12	38	10	31
6	Occupation	weaver	18	56	14	44
		Coolie	10	31.5	14	44
		Construction worker	4	12.5	4	12

D w PS –Depression without psychotic syndrome; *D wo PS* –Depression without psychotic syndrome
Table 1 showed the socio demographic variables of the two groups of depressed male patients with and without psychotic syndromes. Majority of patients with and without psychotic syndromes belonged to the age group of 25-30 years & 31-35 years (each 50%), and 31-35 years (56%), and belonged to Hindu (75%) and (69%) respectively. Majority of them had education 8th standard (37.5%) & 10th standard (44%), income Rs.>3000 (50%) & (37.5%) and they worked as weaver (56%) and (44%) respectively. Most of them had 2 children (50%) & (44%) respectively.

Table 2: shows Mean, standard deviation, and t-value for the scores of Psychological General Well Being schedule (PGWB) of the depressed patients with and without psychotic syndromes

Groups	Sample	Scale	Assessment	Statistics		
				Mean	S.D.	t-value
D w PS	n=32	PGWB	Before	29.23	4.84	
			After	55.75	4.52	16.78*
			Follow-up1	61.36	5.02	3.46*
			Follow-up2	63.08	5.63	1.06
D wo PS	n=32		Before	34.37	3.61	
			After	58.25	4.36	16.94*
			Follow-up1	70.19	4.26	7.86*
			Follow-up2	73.27	3.81	10.36*

*$p < 0.01$;
D w PS –Depression with psychotic syndrome group, *D wo PS* –Depression without psychotic syndrome group
Mean and standard deviation were calculated for each of the groups i.e. with and without psychotic syndromes to facilitate the comparison of repeated assessments by Psychological General Well Being schedule (PGWB) and Quality of Life Scale (QOL). The main analysis of the data was to determine the significance of mean differences between before and after, after

and follow-up1, and after and follow-up2 assessments of each group i.e. Depression with psychotic syndrome (*D w PS*) and Depression with psychotic syndrome (*D wo PS)* groups.

When the means of the group with psychotic syndromes was compared, there had significant differences between before and after, and between after and follow-up1, but not between after and follow-up 2. When the means of the group without psychotic syndromes was compared, there had significant differences between before and after, and between after and follow-up1, and between after and follow-up 2.

The noticeable differences between these two groups showed that depression without psychotic syndrome group is significantly more effective than the group with psychotic syndrome group. These findings imply that therapist/clinician could use PSI for enhancing individual's psychological well being and making changes in social rehabilitation of the male depressive patients.

Table 3: shows Mean, standard deviation, and t-value for the scores of Quality of Life Scale (QOL) of the depressed male patients with and without psychotic syndromes

Groups	Sample	Scale	Assessment	Statistics- Quality of Life Inventory		
		QOLI		*Mean*	*S.D.*	*t-value*
D w PS	n=32		Before	30.65	3.74	
			After	38.72	3.38	6.40*
			Follow-up1	41.86	2.96	2.80*
			Follow-up2	42.02	2.89	2.97*
D wo PS	n=32		Before	32.63	3.82	
			After	51.07	4.47	12.54*
			Follow-up1	56.46	4.92	3.25*
			Follow-up2	58.20	4.08	4.78*

*$p < 0.01$;
D w PS –Depression with psychotic syndrome group, *D wo PS* –Depression without psychotic syndrome group

Table 3 showed that Mean and standard deviation were calculated for each of the group i.e. with and without psychotic syndromes for determining the significance of mean differences of the two groups.

When the means of the group with psychotic syndromes was compared, there had significant differences between before and after, and between after and follow-up1, and between after and follow-up 2. When the means of the group without psychotic syndromes was compared, there had significant differences between before and after and between after and follow-up1, and between after and follow-up 2.

The noticeable differences between these two groups showed that depression without psychotic syndrome group is significantly more effective than the group with psychotic syndrome group at follow levels. These findings imply that therapist/clinician could use PPSI for enhancing individual's quality of life such as material and physical well-being, relationships with other people, social, community and civic activities, personal development and fulfillment, and recreation in the male depressive patients.

Family member report

The family member reported that none of the depressed patients with and without psychotic syndromes were re-hospitalized during the study and the patients had more medication compliance in the group of depressed patients without psychotic syndromes. The former group spent more money for medications than the group without psychotic syndromes. In relationships and burden in the family, the depressed patients without psychotic syndromes had more good relationships, the ability to participate in leisure activities, less burden for the family, and minimum level of problem while staying out of home. The performance of the two groups showed that the depressed patients with psychotic syndromes had less performance in work and had increased levels of worry when compared to the patients without psychotic syndrome group pertaining to addiction and illness. Member from non-governmental organizations (NGOs) visited their homes, motivated and suggested solving their problems during the study. This could reinforce them to have healthy atmosphere at homes.

Discussion

A number of studies have examined the usefulness of psychosocial interventions as an adjunctive treatment for mood disorders. Some outcomes are not directly clinical, for instance, focusing on the illness outcome itself. Other outcomes are not directly linked to any modification in the manifestations or evolution of the disease, such as the patients' and their family members' knowledge of the disease. But in the present study, the symptoms such as loss of appetite, change in sleep patterns, feelings of worthlessness, hopelessness, or inappropriate guilt, fatigue, difficulty in concentrating or making decisions, overwhelming and intense feelings of sadness or grief, disturbed thinking and physical symptoms like stomach aches or headaches are decreased .

Family members or caregivers could play a very important role in detecting subtle mood fluctuations of the patient, and could act therapeutically if properly prepared. It is possible that improving the environment, in which family functioning plays a major role, may be one kind of help for the patients. On the other hand, stressful conditions in the family context, such as excessive hostility or over involvement i.e., "expressed emotion", could result in increased risk for the patients. Among psychosocial interventions, family intervention could be as promising as other psychosocial interventions in improving therapeutic outcomes, and perhaps even more so, because they involve the patient's immediate world.

The participants with psychotic syndromes attending for psychosocial intervention have higher anxiety. This could be considered a side-effect, which might be accounted for by the discomfort induced by the knowledge of the difficult aspects of the disorder, such as chronicity. In general, there is increased acceptance of the need for adjuvant psychosocial intervention added to standard medications in the treatment of depressive disorder. It is suggested that the addition of psychosocial intervention reduces symptoms and hospitalizations and enhance social functioning, leisure time activities, adherence to the treatment of mood disorder for rehabilitation. Baker & Thompson (1999); Deegan (1988); Kannappan (2005 & 2008) Vieta et al, (2005b) have had similar findings.

Family interventions might be an important means of increasing the effectiveness of treatment for the patients, and helping relatives and clinicians in the task of better dealing with the illness and its consequences.

Limitation

The present study did not have control group to compare with the two groups as the patients need immediate care and treatment due to their suffering of depressive disorder. The sample was limited to N= 64 focusing only on male depressed patients.

Conclusion

The results provided evidence for the effectiveness of Psycho Social Intervention (PSI) program for depressed males with and without psychotic syndromes. The symptoms of the depressive disorder were arrested significantly in the two groups, i.e., D *wo PS and D w PS. T*he men who had depressive features benefited more than the men who had depressive features with psychotic syndromes as the group had more psychological well being covering improvement in anxiety, depressed mood, positive well- being, self control, general health, and vitality and the quality of life such as material and physical well-being, relationships with other people, social, community and civic activities, personal development and fulfillment, and recreation in the depressed group rather the group with psychotic syndromes. Besides the functioning included in the group without psychotic syndromes was the patient's ability to stay out of the problem at home, the frequency and depth of social relationships, dysfunction in work, the presence of symptoms, and the ability to participate in leisure activities.

The implication of the findings is that the psycho social intervention (PSI) program could be used to change the depressive patients in order to enhance individual's psychological well being and improve the quality of life in depressed male patients.

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References

1. Baker, F.M., Thompson, J.S., Davis, O.A., Gonzo, R. and Hishinuma, E.S. (1999). Two-Year Outcomes of Psychosocial Rehabilitation of Black Patients With Chronic Mental Illness, *Psychiatr Serv,* 50, 535-539.
2. Burckhardt, C.S., Woods,S.L., Schultz, A.A., and Ziebarth, D.M. (1989). Quality of life of adults with chronic illness: a psychometric study, *Research in Nursing and Health*, 12, 347-354.
3. Deegan, P.E. (1998). Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11, 11-19.

4. Dupuy, H,J.(1984). *The Psychological General Well Being index, Assessment of quality of life in clinical trails of cardiovascular therapies*, Wenger NK. Mattson ME. Furberg CD, Elinson ,J. eds, Newyork: LeJacq, 170-83.
5. Gutierrez, M. J., and Scott, J. (2004). Psychological treatment for bipolar disorders, *European Archives of Psychiatry and Clinical Neuroscience*, 254, 92-8.
6. Hales, R.E., Yudofsky, S.C .and Talbott, J.A. (1999). *Text book of psychiatry*, 3rd Ed, New Delhi: Jaypee Brothers Medical Publishers (p) Ltd.
7. Johnstone, E.C., Cunningham Owens, D.G., Lawrie, S.M., Sharpe, M. and Freeman, C.P.L. (2004).*Companion to psychiatric studies*, London, Churchill Livingstone.
8. Kannappan, R. (2005).*Efficacy of intervention strategies for the management and care of psychiatric patients*, Mumbai: Institute of Psychotherapy and Management Sciences (IPMS), M.Phil. thesis.
9. Kannappan, R. (2008).Outcome of psychosocial rehabilitaion of depressed female patients with and with out psychotic syndromes, M*aking a Difference*, New Delhi: Execl publishers, 504-512.
10. Kaplan, H.J. and Sadock, B.J.,(1999). *Concise Text Book of Clinical Psychiatry*, London: Williams and Wilkins.
11. Ladwig, K., Marten-Mittag, B., Erazo, N., and Gündel, (2001). Identification Somatization disorder in a population-based health examination survey; Psychosocial burden and gender differences, *Psychosomatics*, *42,511-518,*
12. Sarason, I.G.and Sarason, B.R. (2002). *Abnormal psychology;* The Problem of Maladaptive Behavior, 3rd Ed, Delhi: Pearson Education.
13. Vieta, E., Pacchiarotti, .I, Scott, J., Sanches-Moreno, J., Di Marzo, S., and Colom, F. (2005a).Evidence-based research on the efficacy of psychological interventions in bipolar disorders: a critical review, *Current Psychiatry Reports*, 7(6), 449-55.
14. Vieta E. (2005b).Improving treatment adherence in bipolar disorder through psycho education, *Journal of Clinical Psychiatry*, 66 Suppl 1:24-29.
15. Weissman, M.M., Leaf, P. J. and Bruce, M. L. (1998).The epidemiology of dysthymia in five communities: rates, risks, comorbidity, and treatment, *American journal of psychiatry*, 145, 815-19.