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Prevalence And Sociodemographic Correlates Of Common Mental Disorders In Urban Areas Of West Bengal: A Cross-Sectional Study

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Abstract
Introduction: *Common Mental Disorders (CMDs) such as depression, anxiety, and somatoform disorders contribute significantly to the mental health burden in India. Urban populations in West Bengal face unique socio-economic and psychosocial stressors; however, community-based prevalence data are scarce.*
Objectives: *To estimate the prevalence of CMDs among adults in selected urban areas of West Bengal and identify associated sociodemographic and psychosocial factors.*
Methods: *A community-based cross-sectional study was conducted among 45 adults (>18 years) attending the General OPD at UHTC Hindol, Kolkata, during August 2025. Complete enumeration was used. Data were collected using a pretested schedule and validated tools—GHQ-12, PHQ-9, and GAD-7. Statistical analysis included descriptive measures and multivariate logistic regression; $p<0.05$ was considered significant.*
Results: *Of the 45 participants, 75.3% had at least one CMD. Depression (24.4%), obsessive-compulsive disorder (20.0%), and generalized anxiety disorder (15.5%) were most common. Significant risk factors included age 18–25 years (AOR=2.671, p=0.001), experience of abuse (AOR=3.462, p=0.045), low marital satisfaction (AOR=3.186, p=0.012), chronic illness (AOR=2.572, p=0.001), alcohol abuse (AOR=2.961, p=0.032), and financial debt (AOR=2.843, p=0.026). Comorbidity between depression, anxiety, and OCD was frequent. Higher education, nuclear family arrangement, family support, and religious participation were not significant predictors.*
Conclusions: *A high prevalence of CMDs was observed, with strong links to younger age, psychosocial adversity, chronic illness, substance use, and debt. Findings highlight the urgent need for targeted mental health screening, counselling, and integrated care in urban primary health settings of West Bengal.*
Keywords: *Common mental disorders, Depression, Anxiety, Risk factors, Urban health, West Bengal*

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I. Introduction

Common mental disorders (CMDs), encompassing depressive and anxiety disorders, constitute a significant public health burden worldwide. Characterized by symptoms such as fatigue, irritability, insomnia, somatic complaints, and emotional distress, CMDs are among the leading contributors to disability-adjusted life years (DALYs) globally. According to the Global Burden of Disease Study 2019, mental disorders accounted for approximately 5% of total DALYs and nearly 14% of years lived with disability (YLDs) across the world, underscoring their widespread impact and long-term consequences [1].

In India, mental health issues represent a growing concern. The National Mental Health Survey (NMHS) 2015–16 estimated that nearly 10.6% of the Indian adult population suffers from some form of mental illness, with CMDs being the most prevalent, affecting 10% of the adult population [2]. Despite these high rates, the detection and treatment of CMDs in India remain alarmingly low, attributed largely to social stigma, limited access to mental healthcare services, and lack of awareness, especially in urban low- and middle-income communities [3].

Urbanization, while often associated with better health infrastructure, paradoxically contributes to increasing mental health stressors. Overcrowding, pollution, poor housing conditions, socioeconomic disparities, work-related stress, and reduced social support systems in urban settings have been consistently associated with higher prevalence of CMDs [4]. A recent systematic review of studies across urban India confirmed higher levels of anxiety and depression among urban dwellers compared to their rural counterparts, particularly among socioeconomically vulnerable groups [5].

West Bengal, a densely populated state with substantial urban-rural divide, has seen a rapid pace of urbanization in recent decades. However, mental health surveillance in the state, particularly in its urban settings,

remains patchy. Existing studies from West Bengal have largely focused on institutional data or rural populations, thereby creating a notable knowledge gap in understanding the mental health landscape of its urban residents. For example, while a few small-scale surveys have been conducted in Kolkata or its suburbs, there is a dearth of population-based data on the prevalence and sociodemographic determinants of CMDs in urban West Bengal [6].

This knowledge gap is concerning, given that urban environments are not homogenous, and the sociodemographic determinants such as age, gender, education, marital status, employment status, and socioeconomic class interact differently across urban populations to influence mental health outcomes. The role of these determinants in modulating risk for CMDs has been well documented globally [7], but localized data are crucial to informing policy and planning interventions at the state and municipal levels.

Another important consideration is the ongoing mental health transition in India, with increasing awareness and policy attention to community mental health. The Mental Healthcare Act of 2017 advocates for the rights-based approach to mental health and emphasizes decentralized, community-based mental health services [8]. To support this mandate, region-specific epidemiological data on the burden and determinants of CMDs are essential to ensure equitable and efficient service delivery.

Thus, there exists an urgent need to investigate the prevalence of CMDs and their relationship with sociodemographic variables in urban regions of West Bengal. This study attempts to fill that void by conducting a cross-sectional community-based survey among adults residing in urban areas, using standardized screening tools and validated sociodemographic profiling.

The findings of this study are expected to contribute toward better understanding of the mental health burden in urban settings, assist in identifying high-risk groups, and provide data to guide public health planning, mental health resource allocation, and preventive strategies.

Objectives of the Study:

1. To estimate the prevalence of common mental disorders among adults residing in urban areas of West Bengal.
2. To identify the sociodemographic factors associated with common mental disorders in the study population.

II. Methods

This was a community-based, cross-sectional observational study conducted in urban training center of Calcutta National Medical College and Hospital, Hindol. The study was designed to assess the prevalence of common mental disorders (CMDs) and evaluate their sociodemographic correlates among adults residing in that urban location. Data collection was carried out over a period of one month. The study population consisted of adult residents (aged ≥18 years) of urban field practice area of CNMCH, Kolkata which is catchment area of UHTC, Hindol in Kolkata.

Individuals were included only after providing informed written consent. Those with known psychiatric illnesses currently under treatment, with severe cognitive or communication impairment, or unwilling to participate were excluded from the study.

The sample size was determined using the standard formula for prevalence studies: $n = Z^2pq/l^2$, where Z = 1.96 for 95% confidence level, p = 13.5% based on the prevalence of CMDs from previous literature [9], q = 1 – p, and l = 10% of p (relative error). This yielded a required sample size of 45. Participants were enrolled through a complete enumeration technique, whereby all individuals meeting the inclusion criteria within the study area were approached consecutively until the required number was achieved.

Data were collected using a predesigned, pretested, and semi-structured questionnaire that included a sociodemographic information schedule along with three validated mental health screening tools. These included the General Health Questionnaire-12 (GHQ-12) to screen for general psychiatric morbidity, the Patient Health Questionnaire-9 (PHQ-9) for assessing depressive symptoms, and the Generalized Anxiety Disorder 7-item scale (GAD-7) for evaluating anxiety symptoms. The tools were translated into Bengali following standard translation and back-translation procedures to ensure linguistic accuracy and conceptual equivalence.

Participants were interviewed face to face by trained personnel using the structured schedule and mental health scales. Each interview lasted approximately 30 to 45 minutes and was conducted in a private setting to maintain confidentiality and comfort. Written informed consent was obtained prior to participation, and the purpose of the study was clearly explained to all participants in their preferred language.

The study received prior approval from the Institutional Ethics Committee of Calcutta National Medical College and Hospital, with the ethical clearance number [EC-CNMC/2025/633 dated 12.07.2025]. Participants found to have moderate or severe symptoms of depression or anxiety were appropriately counselled and referred to mental health professionals or community health resources for further evaluation and care.

All data were coded and entered into Microsoft Excel, and statistical analysis was performed using Jamovi software version 2.5.6. Descriptive statistics were used to summarize the data, and associations between CMDs and various sociodemographic variables were examined using appropriate inferential statistical tests. A p-value of less than 0.05 was considered statistically significant in all analyses.

III. Results

A total of 45 participants were included in the study. The age distribution showed that the largest proportion of respondents belonged to the 18–25-year age group (26.7%), followed by 26–35 years (22.2%) and 36–45 years (17.8%). Participants aged 65 years and above constituted the smallest group (4.4%). Males comprised 55.6% of the study population, while females accounted for 44.4%. Regarding marital status, 64.4% were married and 35.6% were unmarried.

Table 1: Socio-demographic profile of the study subjects (n=45)

Socio-demographic variables	Categories	Frequency	Percentage
Age group (years)	18-25	12	26.7
	26-35	10	22.2
	36-45	8	17.8
	46-55	6	13.3
	56-65	7	15.6
	65+	2	4.4%
Gender	Male	25	55.6
	Female	20	44.4
Marital status	Married	29	64.4
	Unmarried	16	35.6
Education level	Illiterate	2	4.5
	Primary	8	17.7
	Middle	5	11.3
	Secondary	9	20
	Higher Sec	12	26.5
	Graduate	9	20
Occupation	Unemployed	5	11.1
	Student	6	13.3
	Self employed	9	20
	Govt sector	8	17.8
	Pvt sector	17	37.8

In terms of education, 4.5% of participants were illiterate, 17.7% had completed primary education, 11.3% had studied up to middle level, 20% had completed secondary level, 26.5% had attained higher secondary level, and 20% were graduates. With respect to occupation, 11.1% were unemployed, 13.3% were students, 20% were self-employed, 17.8% were employed in the government sector, and 37.8% were working in the private sector (Table 1).

Table 2: Prevalence of different CMDs in study population: (multi-response table)

Type of CMDs (n=34)	Number of cases	Percentage
1. Depression	11	24.4
2. Somatoform Disorders	2	4.4
3. Obsessive-Compulsive Disorder (OCD)	9	20
4. Generalized Anxiety Disorder (GAD)	7	15.5
5. Panic Disorders	2	4.4
6. Substance Use Disorders (SUD)	3	6.6
Total	**34**	**75.3**

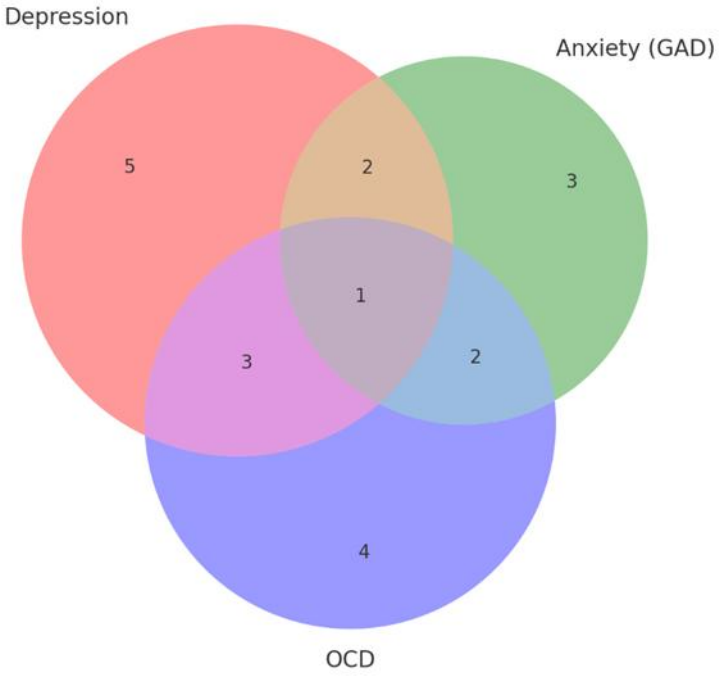
Out of the 45 participants, 34 (75.3%) were found to have common mental disorders. Depression was the most prevalent condition, affecting 24.4% of the total study population, followed by obsessive-compulsive disorder (20%) and generalized anxiety disorder (15.5%). Somatoform disorders and panic disorders each affected 4.4% of participants, while substance use disorders were present in 6.6% of the study population (Table 2).

Table 3: Multivariate logistic regression analysis of factors influencing the CMDs (n=45)

Variables	AOR	P	95 % C.I. Lower	95 % C.I. Upper
Age (18-25 years)	2.671	**0.001**	1.545	6.653
Nuclear family arrangement	0.398	0.08	0.380	2.273
Experiencing abuse	3.462	**0.045**	1.151	4.339
Low marital satisfaction	3.186	**0.012**	1.129	6.835
Presence of chronic illness	1.572	**0.001**	1.163	5.764
Alcohol abuse	1.961	**0.032**	1.384	7.869
Higher Education level	0.745	0.86	0.644	1.667
Family support	0.529	0.72	0.474	1.982
Religious participation	0.783	0.09	0.694	7.475
Presence of debt	2.843	**0.026**	1.295	4.358

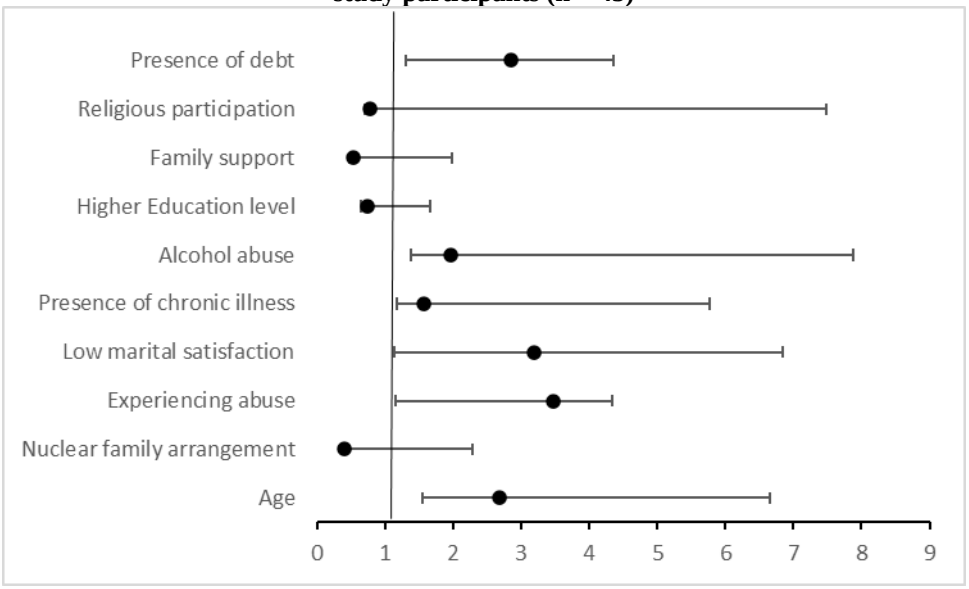
Multivariate logistic regression analysis identified several factors significantly associated with the presence of CMDs. Participants aged 18–25 years had higher odds of CMDs (AOR = 2.671, p = 0.001). Experiencing abuse (AOR = 3.462, p = 0.045), low marital satisfaction (AOR = 3.186, p = 0.012), presence of chronic illness (AOR = 1.572, p = 0.001), alcohol abuse (AOR = 1.961, p = 0.032), and presence of debt (AOR = 2.843, p = 0.026) were also found to significantly increase the risk of CMDs. Other factors such as nuclear family arrangement, higher education level, family support, and religious participation were not found to have statistically significant associations (Table 3).

Figure 1: Venn Diagram showing overlapping of different CMDs



The Venn diagram depicting the distribution of depression, anxiety (GAD), and obsessive-compulsive disorder (OCD) among participants revealed substantial comorbidity between these conditions. While a proportion of participants had each disorder in isolation, overlaps were observed, with several individuals experiencing two or more conditions concurrently. Depression and OCD showed a notable degree of co-occurrence, and a smaller subset of participants had all three conditions simultaneously (Figure 1).

Figure 2: Forest plot showing AOR for factors associated with common mental disorders (CMDs) among study participants (n = 45)



The forest plot visually summarized the strength and direction of associations between different factors and the presence of common mental disorders in the study population. Variables plotted to the right of the reference line indicated an increased likelihood of CMDs, while those on the left suggested a possible protective influence. Younger age emerged as a clear risk factor, with its marker positioned far to the right of the reference line. Experiences of abuse, low marital satisfaction, chronic illness, alcohol use, and financial debt also showed a distinct shift toward higher risk. In contrast, factors such as higher education, strong family support, and regular religious participation clustered closer to the reference line, indicating weaker or negligible associations with CMDs in this sample (Figure 2).

IV. Discussion

The present study revealed a remarkably high prevalence of common mental disorders (CMDs) among participants, with 75.3% found to have at least one CMD, substantially exceeding the rates reported in most prior epidemiological studies from similar urban Indian settings. For instance, while the current estimate stands at 75.3%, Singh et al [10] reported a prevalence of 18.5% in an urban resettlement colony in Delhi, highlighting a striking difference likely attributable to differences in sampling, screening tools, and perhaps underlying population vulnerability. The National Mental Health Survey of India [11] also reported lower rates, with an overall mental morbidity prevalence of 13.5% in urban metros, emphasizing how context, method, and possibly pandemic-related stressors may influence observed rates. Such high prevalence in this sample may underscore the compounding effects of socioeconomic instability, urban stress, or selection bias toward individuals seeking care, as seen with the sample drawn from a health facility.

Notably, depression emerged as the most common CMD in the present study, affecting 24.4% of participants. This figure is substantially higher than the national estimates; for example, the National Mental Health Survey [11] found a current prevalence of depression at 2.7% and a lifetime prevalence at 5.2%. Barsisa et al [12] similarly documented lower depression rates, highlighting the importance of localized risk factors. Interestingly, obsessive-compulsive disorder (OCD) was the second most prevalent at 20.0%, followed by generalized anxiety disorder (GAD) at 15.5%. The observed co-occurrence and overlap of depression, anxiety, and OCD within this urban population aligns with findings from Plana-Ripoll et al [13], who demonstrated that comorbidity is pervasive in mental disorders, with certain disorder pairs leading to absolute comorbidity risks of 30–40% over five years. Comorbidity rates for depression and OCD, specifically, have been reported to exceed 50% in clinical and community samples, resonating with the Venn diagram in this study that shows substantial overlap among these conditions. This pattern mirrors the work of Veisani et al [14], where 23% of individuals with comorbid psychiatric disorders reported suicide ideation, emphasizing the heightened clinical significance of such co-occurrences.

The multivariate regression analysis in this study identified several factors significantly associated with CMDs. Age emerged as a strong correlate; participants aged 18–25 years had significantly higher odds of CMDs (AOR = 2.671, p = 0.001) compared to older age groups. This is consistent with observations by Habtamu et al [15], who noted increased CMD risk among younger adults and particularly among women. Singh et al [10] also identified socio-demographic vulnerabilities such as younger age and female gender. The present study, however, did not find significant gender-related differences in risk. Another salient finding was the strong association between experiencing abuse and CMDs (AOR = 3.462, p = 0.045). This result is echoed in the multivariable findings by Barsisa et al [12], where victims of physical abuse had more than double the risk (AOR = 2.36, 95% CI: 1.49–3.74) of developing CMDs, highlighting the trans-contextual impact of psychosocial trauma.

Low marital satisfaction also emerged as a robust predictor for CMDs in the present study (AOR = 3.186, p = 0.012), paralleling findings in other settings where poor perceived marital relationships have been significantly associated with higher CMD burden (Barsisa et al, AOR = 3.64, 95% CI: 1.47–8.99 for single/divorced/widowed individuals). Chronic illness was another significant risk factor (AOR = 2.572, p = 0.001), a result in alignment with Engidaw et al [16], who reported that those with a chronic physical illness had more than threefold increased odds of CMDs (AOR = 3.48, 95% CI: 2.10–5.04). Similarly, Barsisa et al [12] observed increased CMD risk among those with chronic illness (AOR = 3.25, 95% CI: 2.10-5.04), reinforcing that the burden of physical morbidity is a major contributor to adverse mental health outcomes across diverse populations.

Furthermore, the study identified financial debt (AOR = 2.843, p = 0.026) and alcohol abuse (AOR = 2.961, p = 0.032) as significant drivers of CMDs. Meltzer et al reported that adults in debt were three times more likely to have CMDs, consistent with the present study's findings and underlining the interplay between economic stress and mental health. The compounding effect of substance use was also evident in Meltzer et al [17], where debt and addictive behaviors conferred an approximate 50% prevalence of CMDs in such high-risk groups. This corresponds well with our own findings in which alcohol abuse substantially elevated the odds of CMDs, confirming the synergistic burden of financial hardship and substance misuse. These results underscore the need

for integrated public health and social interventions targeting both financial and behavioral domains to reduce CMD risk.

Non-significant variables in this study—such as family structure, higher education, family support, and religious participation—deserve discussion given their prominence in previous research. Unlike the protective effect observed for strong social support (AOR = 0.529, p = 0.72) and higher education in some reports, such as those by Habtamu et al and Engidaw et al [15,16], the current findings did not show significant associations. This might be attributable to unique contextual factors within the present study, including the relatively small sample size, characteristics of the urban health center setting, or unmeasured confounding variables. It is worthwhile noting that other large studies, such as Singh et al [10], sometimes find similar null results for certain socio-demographic factors, indicating that the association between education, family dynamics, and CMDs may be modulated by the local context.

Finally, regarding the pattern of comorbidity, the forest plot and the Venn diagram from the current study provide visual reinforcement of the high degree of overlap among depression, OCD, and anxiety observed within this sample. This finding is well aligned with the work of Forman-Hoffman et al [18], who found that approximately one-third of adults with a past-year mental disorder had a co-occurring condition, and Plana-Ripoll et al [13], who emphasized that comorbidity is the rule rather than the exception in psychiatric populations. The clinical and policy implication is the critical need for multidimensional screening, integrated care approaches, and tailored interventions that address not only primary symptoms but also the breadth of comorbid presentations. The high rates of comorbidity and their strong associations with psychosocial, economic, and health-related factors, as observed in this study and others, call for comprehensive and context-sensitive mental health strategies at the community and health system levels.

V. Conclusion

This study found a markedly high prevalence of common mental disorders in an urban population, with depression, OCD, and anxiety being most common and often co-occurring. Younger age, abuse, marital dissatisfaction, chronic illness, alcohol use, and debt emerged as key risk factors, underscoring the need for integrated, targeted mental health interventions in urban settings.

VI. Recommendations

Routine mental health screening should be integrated into urban primary and community health services to ensure early detection of CMDs, with special focus on high-risk groups such as young adults, individuals with a history of abuse, chronic illness, marital dissatisfaction, or financial debt. Accessible counseling and psychosocial support must be established within urban health centres to manage comorbidities, while community-based awareness programs should aim to reduce stigma, improve mental health literacy, and encourage help-seeking. Addressing underlying social determinants through coordinated efforts between health, social welfare, and legal sectors is essential to create a supportive environment that mitigates risk factors and promotes overall mental well-being.

VII. Limitations

The study was conducted in a limited urban field practice area with a relatively small sample size, which may restrict the generalizability of the findings to the wider urban population. Being cross-sectional in design, it captures associations but cannot establish causal relationships between risk factors and CMDs. Data collection relied on self-reported information, which may be subject to recall bias and social desirability bias, potentially leading to underreporting or overreporting of symptoms and risk behaviors. Additionally, the diagnosis of CMDs was based on screening tools rather than clinical interviews, which, while validated, may not fully substitute for comprehensive psychiatric assessment.

Declarations

Funding: Nil.

Conflict of Interest: Nil.

Ethical Approval: Approved by the Institutional Ethics Committee of Calcutta National Medical College and Hospital, IEC No. EC-CNMC/2025/633.

Consent to Participate: Written informed consent was obtained from all study participants after explaining the study objectives and ensuring confidentiality.

We confirm that the manuscript in whole or in part, has not been previously published or is under consideration for publication elsewhere.

We declare that there has been no use of Artificial intelligence in research, data analysis/manuscript drafting ensuring transparency in the research process.

Data Availability: The data supporting the findings of this study are available from the corresponding author upon reasonable request.

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