ORIGINAL ARTICLE

Prevalence of Depression and Associated Risk Factors in patients belonging to low Socio-Economic Status

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ABSTRACT

Aim: To find out the prevalence of depression and associated risk factors in patients belonging to low socio-economic status.
Study design: Cross sectional descriptive design.
Settings: The study was done at Out-patient Department of Psychiatry of Bahawal Victoria Hospital Bahawalpur.
Duration of study: The duration of our study was 2 months that is 1st April to 31st May 2014.
Methodology: We collected the data through pre-tested and pre-formed questionnaire. The questionnaire consisted of two parts. The first part comprises of demographic data that includes name, age, sex, occupation, religion, marital status, number of family members and bread earners. The second part consisted of variables under study which were psychosocial factors including financial problems, marital conflicts, major life trauma and social failure. The data for study was obtained from the patients of low socio economic status who came to clinic for psychiatric consultations. After taking an informed consent, the questions were translated in Urdu by the researcher and answers by the patient were translated in English and entered in the questionnaire by the researcher.
Results: A total 200 of the diagnosed patients of depression were taken under study, 24% subjects were male and 76% subjects were female. Major life trauma was leading cause of depression in 46.5% subjects, social failure in 22.5% subjects, marital conflicts in 19.5% subjects and financial problems in 11.5% subjects. Most of the patients presenting to psychiatric outpatient department were from low socio-economic status with age group of 18-65 years.
Conclusions: The findings of present study suggest that depression was more frequent in females than males. Major life trauma being the most prevalent psychosocial risk factor.
Keywords: Depression, psychosocial, socioeconomic stressors, traumatic events.

INTRODUCTION

Globally, depressive disorder (DD)is very common[1].By the year 2020, depression will be the 2nd most common cause of disability[2].It is a very complex disordershowingmarked clinical variability influenced by interacting genetic, cultural and social factors[3]. Theeconomic and social burden of depression on an individual, members of family and society at large are very important and this underlines the significance of identification of different factors which arecorrelated with DD[4].

The identified psychosocial risk factors associated with DD are economic constraints, marital conflicts, major life trauma and social failures including absence of confiding relationships, professional and educational failures. More concentration should be given to socio-demographic risk factors and intimate partner violence, since they are potential risk factors for the development of depression[5].

An increasing duration of un-employment was correlated with marked increase in the risk of all psycho-social outcomes. The data suggested that the correlation between un-employment and psycho-social outcomes was likely to involve a causal process in which un-employment led to increased risks of adverse psycho-social outcomes[6,7].

A recent epidemiological study of depression in large families in Pakistan did not find significant relationship between inbreeding, economic status, rural living and depression[7]. However, in another study;female gender, marital conflicts, traumatic experiences, bereavement, and work stress were found to be associated with depression[8].

A systemic review of studies in Pakistanconcluded that middle age, financial problems female sex, low level education, being a housewife and problems of relationship to be positively correlated with DD andanxiety[9].

Anxiety, depression and stress can intervene with learning; affect/impair practical and academic performance. Many studies reported a general

increase in the severity of and extent of problems of mental health among the students of university and college with increasing stress and competition to acquire higher education[10].

Nearly 150 million people suffer from anxiety and depression and about1million people commit suicide every year worldwide[11] In another study carried out by HaiderNaqvi about depression in Pakistan, the results were more alarming that every 3rd Pakistani is expected to be suffering from anxiety and depression and this has very serious implications for themental health care scenario of the country[12].

Background information and Statistical surveys show that Pakistan is sixth most populous country in the world with estimated population of about 200 million. Total number of psychiatrists for such a large population is only 300-350.So the prevailing mental health problems including depression should be considered with much concern to reduce morbidity and mortality associated with these issues in this community[13,14].

DD presents a particular challenge for developing countries like Pakistan where malnutrition and infectious diseases are still rife. So there is a crucial need to highlight this issue under study to figure out the most prevailing social risk factors among Pakistani population. Therefore we planned this study to work out the risk factors causally linked with major depression in our society; especially among the patients belonging to low socio-economic status.

RESEARCH METHODOLOGY

The study was conducted at psychiatric outpatient Department of Bahawal Victoria Hospital Bahawalpur while some subjects were also taken from a private clinical setup. The data of 200 patients of depression diagnosed by senior psychiatrist using ICD10 diagnostic research criteria[14] were included during 1st April to 31stMay 2014 with non-probability convenient sampling technique for this cross sectional descriptive study.The patients of age ranging 18-65 years of low socioeconomic class were included. Whereas, the patient of middle and high classes and depression due to general medical conditions like thyroid dysfunction, head injury or drug abuse were excluded.

After taking informed consent from each patient, the data was collected on the questionnaire consisted of two part; the first part to gather demographic data and the second part to register the psychosocial variables to be studied. Depression was rated by using Urdu version ofBeck's depression inventory.[15] SPSS version 17 was used for statistical analysis.

RESULTS

Out of 200 patients, mild depression was found in 25% patients followed by moderate depression in 63% and severe depression in 12% patients. (Fig. 1)Out of total 200 study subjects 24% were male and 76% female (Table1).In our study the age group of 26-40 years, proved to be the most vulnerable with percentage of 41% followed by age group of 18-25 years with the prevalence of 30.5%. Next frequent pray are the age groups of 41-50 years and 51-65 years with percentages of 19% and 9.5% respectively(Table2).Out of 200 patients 59% study subjects were married, 29.5% were single, 5% widowed, 3.5% separated and 3% were divorced (Fig. 2).

Major life trauma turned to be the leading cause of depression in most of the study subjects; 46.5%, social failure in 22.5%, marital conflicts in 19.5% and financial problems in 11.5% (Fig. 3).

Out of 93 subjects, who had major traumatic life event as main precipitating factor of depression, 43% had their closed ones died in the recent past, 26.9% had some psychological shock, and 23.7% were diseased and the rest 6.5% had some disability (Fig.4).Overall data showed that 38% subjects were housewives, 24% subjects did not work, 15.5% subjects were students, 8.5% subjects were self-employed, 7.5% were private employees, 5,5% were working in Government sector and 1% were seasonal employees(Table 3).

Out of 39 subjects, who had marital conflicts as major precipitating factor of depression, 79% had arrange marriages, 10.3% had love marriages, 5.1% had both arrange and love marriages and 5.1% had forced marriages(Table: 4).Out of 45 subjects, having depression due to some social failure, educational and personal relationship failures had percentage of 31.1% each. Subjects with financial loss were 15.6%, those with professional life failure were 13.3% and 8.9% of the subjects were having depression due to some other life failures (Fig. 5).

Fig. 1: Severity of depression

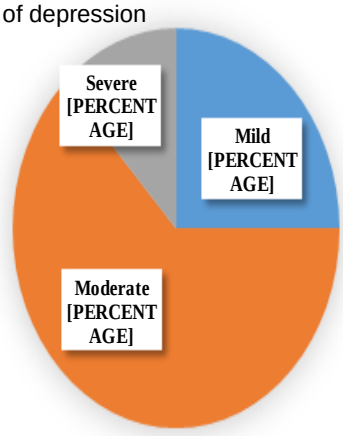


Table 1: Gender distributionof the study patients (n=200)

Gender	Frequency	%age
Male	48	24
Female	152	76
Total	200	100

Table 2: Age distribution of the patients

Age (years)	Frequency	%age
18-25	61	30.5
26-40	82	41.0
41-50	38	19.0
51-65	19	9.5
Total	**200**	**100**

Fig. 2: Marital status of the patients

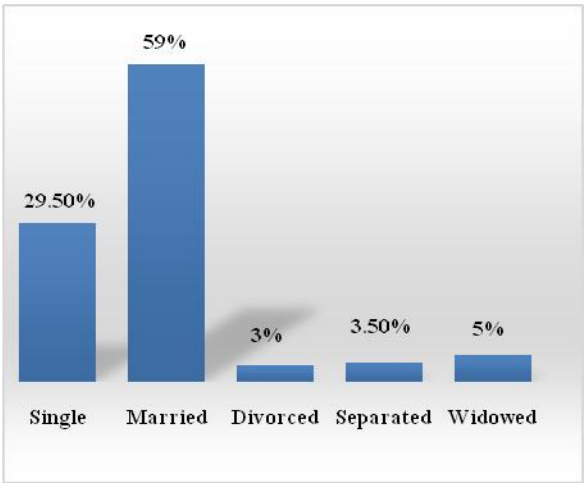


Fig. 3: Life events causally related to depression

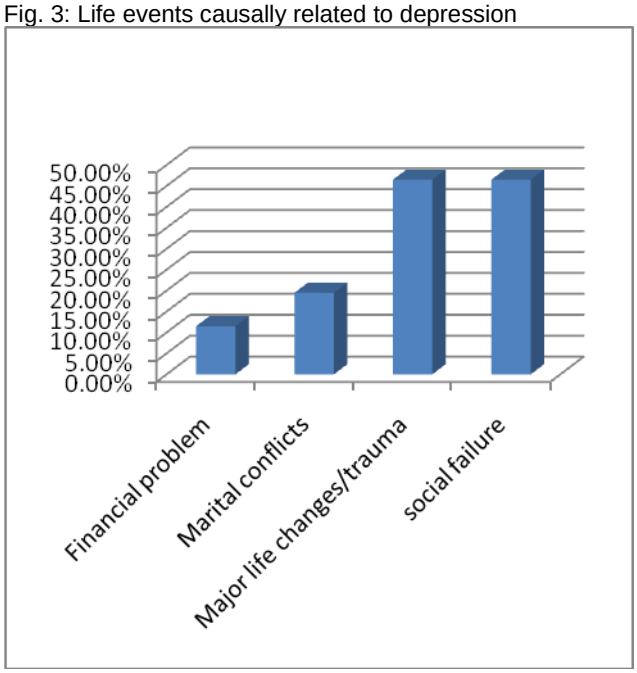


Fig. 4: Kind of traumatic event

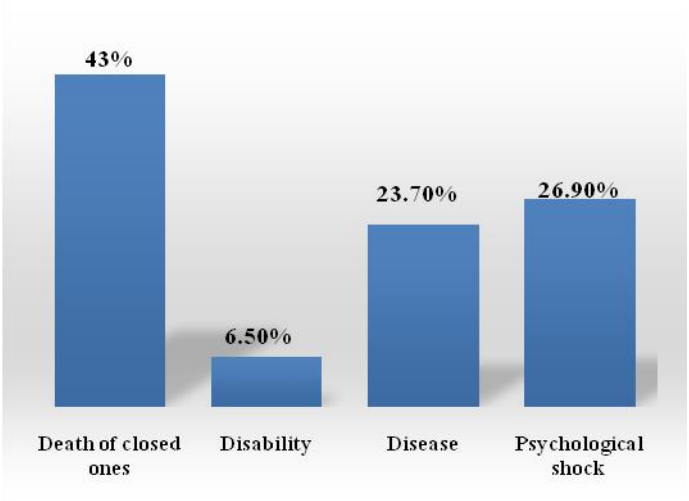


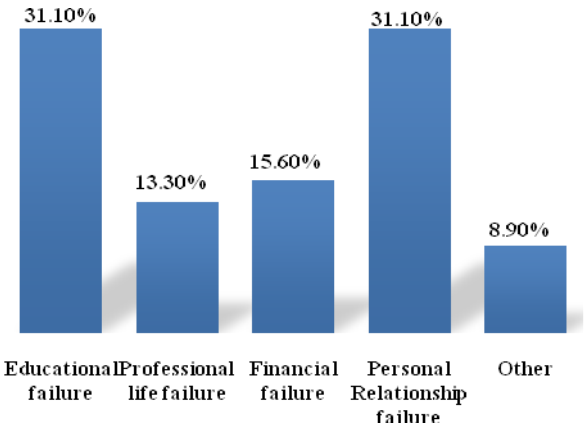
Table 3: Distribution of patients according to their profession

Occupation	Frequency	%age
Govt. Servant	11	5.5
private	15	7.5
self-employed	17	8.5
housewife	76	38.0
student	31	15.5
Does not work	48	24.0
seasonal	2	1.0

Table 4: Distribution of patients according to type of marriage

Type of marriage	Frequency	%age
Arranged	31	15.5
Love	4	2.0
Forced	2	1.0
Arranged & love	2	1.0

Fig. 5: Distribution of patients according to type of Social failures



DISCUSSION

It is established that psycho-social/socio-demographic/socio-cultural stressors precede the onset of depression. Available evidence suggests social problems as a major cause of anxiety and depression in Pakistan securing an overall prevalence of 34 %[11].

Statistical surveys and studies suggest that there is very high prevalence of depression in females in general[12]. In a co-twin control design, which matches brothers and sisters on genetic and familial-environmental background, failures in interpersonal relationships and personality played a stronger etiologic role in major depression for women as compare to men[3]. Our study supports this fact as our results showed 24% were the male subjects suffering from depression and 76% were female.

According to the results of a research conducted in Karachi in 2005, 54% women diagnosed with DD belonging to middle age group[4]. Whereas according to our research, age group of 26-40 years was more vulnerable with a percentage of 41%, however it includes both the genders.

Detail review of epidemiological finding suggests that marriage may have adverse effects in females. Possibly,because of gender specific needs posed by marriage and resulting limited number of roles available to Females[13,14]. We also found that married people were consistently reported with depression and 59% of our depressed subjects were also married.

Another study documented a positive correlation for problems of relationship with in-laws for females as compared to other social problems. Chronic difficulties with housing, health and finances were significantly correlated with depression[9]. Our analysis also showed that depression was more prevalent in people who had arranged marriages.

There was very strong association between mid-life adversities and depressive symptoms of post-retirement: poor living standards, high job strain, low occupational position and few close relationships. The strength of the associationbetween psycho-social, socioeconomic, work-related, or non-work related exposures and symptoms of depression was similar.

The results of our study suggested that the association between the un-employment and psycho-social outcomes was likely to involve a causal process in which un-employment led to increased risks of adverse psycho-social outcomes, asour data tells 38% of our subjects were housewives and 24% subjects had no work.This coincides with the study done by Fergusson and McLeod in 2014, which tells that an increase in duration of un-employment was associated with marked increase in the risk of all psycho-social outcomes[16].

Critical review by Broadhead and Abas, elaborated a significant association withentrapment or humiliation and withother loss or death[17]. Un-expected death of a loved one was the most common traumatic experience and most likely to be rated as the worst by the respondents, regardless of other traumatic experiences. Increased incidence after un-expected death was observed at nearly every point across the life course for major depressive episode,post-traumatic stress disorder and panic disorder[18]. Our survey showed that depression was linked to Psychic trauma due to traumatic life events as death of closed one, debilitating mental or physical disability and lingering illness.

The rigors of professional education can be demanding. Anxiety and depression may interfere with learning,impair clinical practice performance,and affect academic performance. Many studies documented a general increase in the severity of and extent of problems of mental health among college and university students[19].

In Pakistanfinancial problems, relationship problems and level of low education are positively correlated with depressive and anxietydisorders[9] whereas having a supportive relationship is negatively associated. In 31.1% of our subjects, the social factor behind their depression was educational and personal relationship failure.

CONCLUSION

The results of this study suggest that psychosocial factors have significant role in precipitating and perpetuating the depressive illness; traumatic life events being the most prevalent factor followed by social failure, marital conflicts and financial issues, respectively. The prevalence of depression was three times more in women than men.

RECOMMENDATIONS

- At current rates of 12%-20% among all depressed patients, treatment-resistant depression may present an annual added societal cost of $29-$48 billion, pushing up the total societal costs of major depression by as much as $106-$118 billion. These findings stress upon the need for research on the mechanisms of depression, new therapeutic targets, existing and new treatment combinations, and tests to improve the efficacy of and adherence to treatments for treatment-resistant depression.

- The psychiatric departments should work in collaboration with the social welfare department in order to prevent and minimize the expanding financial and social stressors triggering the depressive illnesses.
- As the population burden of Southern Punjab is increasing, there should be more appointments of psychiatrists and psychologists.
- Besides the support for families to cope with stress, awareness-raising initiatives challenging the current discourse of discipline toward children in schools or at home need to be fostered.
- In low socio-economic class, there must be women empowerment; they should be given right of education, employment and decision making.
- Workplace physical activity and yoga programs are associated with a significant reduction in depressive symptoms and anxiety, respectively. Their impact on stress relief is less conclusive.
- Depression and anxiety were strongly associated with common chronic medical disorders and adverse health behaviors. Examination of mental health should therefore be an integral component of overall health care.
- There should not be any delayed delivery of prognostic information to the family by ICU staff in order to prevent family ICU-staff conflicts and PTSD.
- Positive adjustment and social support are needed for the highest-risk population.
- There were strong associations between midlife adversities and post-retirement depressive symptoms: low occupational position.
- There is a need of establishment of rehabilitation centers for the old and retired people to make them realize that they can still play a productive role in society.
- Nationally representative psychiatric morbidity surveys and controlled treatment trials are needed to inform policymakers in order to control morbidity from anxiety and depressive disorders in Pakistan.

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