CODEN [USA]: IAJPBB ISSN: 2349-7750

INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES
http://doi.org/10.5281/zenodo.3382852

Available online at: http://www.iajps.com *Research Article*

PREVALENCE OF DEPRESSION AND ASSOCIATED RISK FACTORS IN PATIENTS BELONGING TO LOW SOCIO-ECONOMIC STATUS

[1]Dr. Ahsan Farooq, [2]Dr. Muhammad Faisal Hayat, [3]Dr. Maryam Shahid.

[1]Extern Department of Psychiatry, Nishtar Hospital Multan; [2]Medical officer, Basic health Unit Lagar, Sheikhopura; [3]Women Medical Officer, Basic health Unit Panwan, Nankana Sahib.

Article Received: June 2019 **Accepted:** July 2019 **Published:** August 2019

Abstract:

Objectives: *The purpose of this study was to find out the prevalence of depression and associated risk factors in patients belonging to low socio-economic status.*

Material and methods: *This cross-sectional study was conducted at Department Psychiatry Nishtar Hospital, Multan from February 2018 to August 2018 over the period of 6 months. A total 200 diagnosed patients of depression were selected for this study and depression & associated risk factors were assessed in selected patients.*

Results: *A total 200 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.*

Key Words: *Depression, psychosocial, socioeconomic stressors, traumatic events.*

Corresponding author:

Dr. Ahsan Farooq,

Extern Department of Psychiatry, Nishtar Hospital Multan.

QR code

Please cite this article in press Ahsan Farooq et al., ***Implications Of Lipid Profile Dosages In Fasting And Postprandial Status.,*** *Indo Am. J. P. Sci, 2019; 06[08].*

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 disorder showing marked clinical variability influenced by interacting genetic, cultural and social factors.[3] The economic 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 are correlated 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 Pakistan concluded that middle age, financial problems female sex, low level education, being a housewife and problems of relationship to be positively correlated with DD and anxiety.[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 Haider Naqvi 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 the mental 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:

This cross-sectional study was conducted at Department of Psychiatry Nishtar Hospital, Multan from February 2018 to August 2018 over the period of 6 months. Total 200 diagnosed patients of depression by using ICD10 diagnostic research criteria[14] having age range from 18-65 years either male or female were included during study period. 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 of Beck'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 (Table.1)

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. (Table.2).

Out of 200 patients 59% study subjects were married, 29.5% were single, 5% widowed, 3.5% separated and 3% were divorced (Figure. 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% (Figure.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

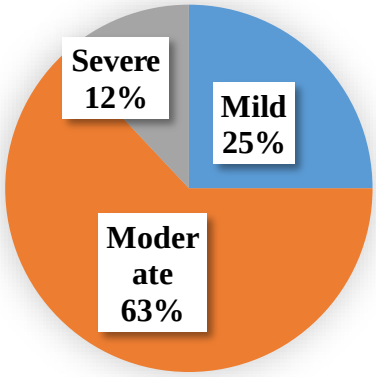


Table: 1: Gender distribution of the study patients (n=200)

Gender	Frequency	Percentage
Male	48	24.0
Female	152	76.0
Total	200	100

Table No: 2: Age distribution of the patients

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

Figure: 2: Marital status of the patients

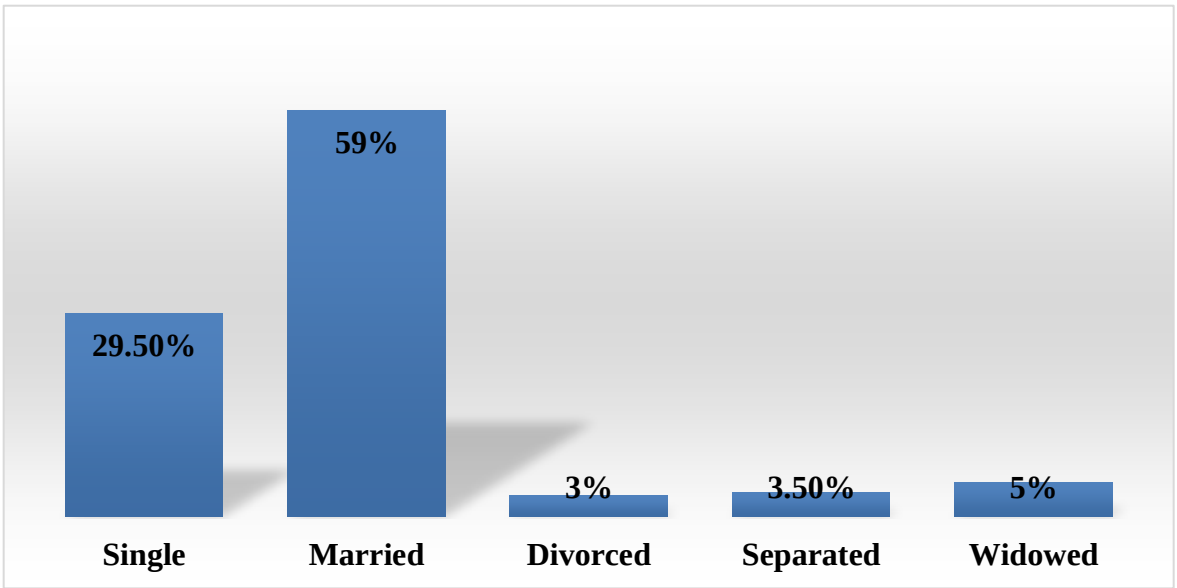


Figure: 3: Life events causally related to depression

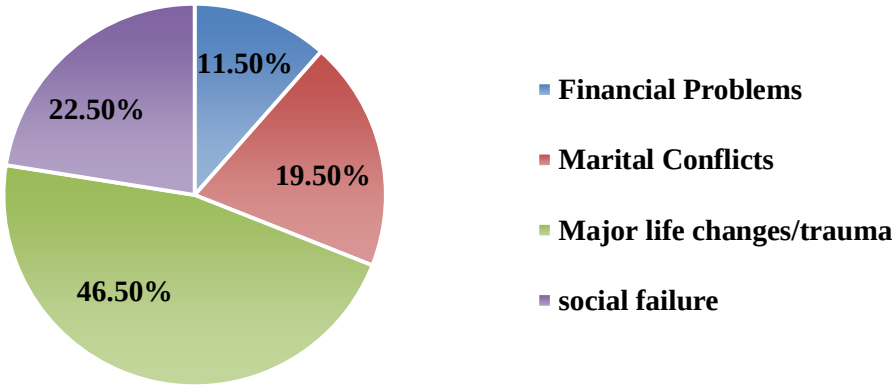


Figure No. 4: Kind of traumatic event

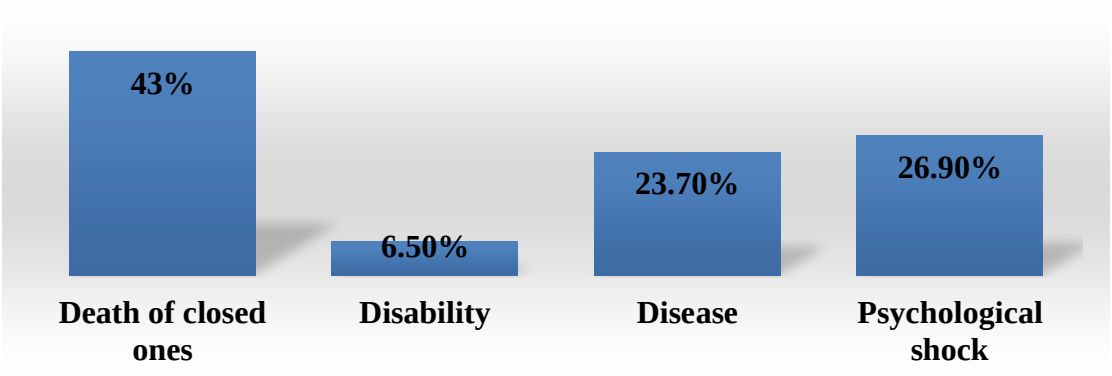


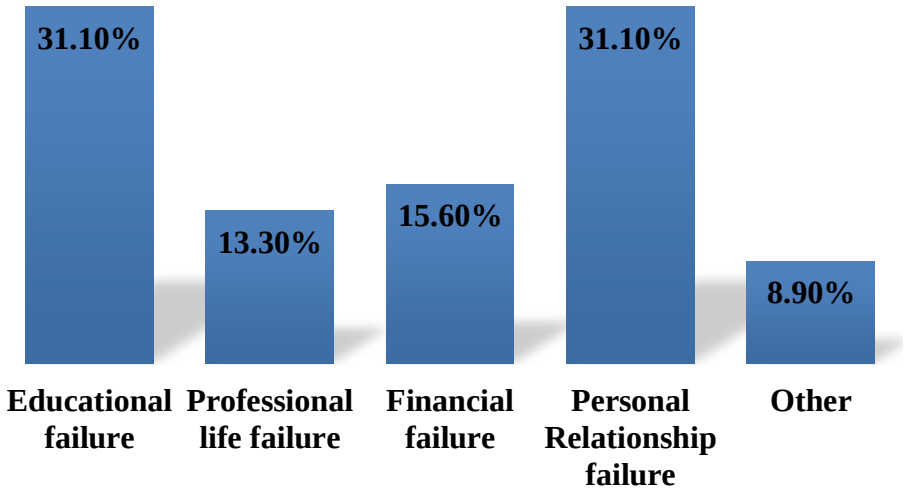
Table: 3: Distribution of patients according to their profession

Occupation	Frequency	Percentage
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
Total	**200**	**100**

Table: 4: Distribution of patients according to type of marriage

Type of Marriage	Frequency	Percentage
Arranged	31	15.5
Love	4	2.0
Forced	2	1.0
Arranged & love	2	1.0
Total (n)	39	19.5

Figure: 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.[03] Our study supports this fact as our results showed 24% were the male subjects suffering from depression and 76% were female subjects.

According to the results of a research conducted in Karachi in 2005, 54% women diagnosed with DD belonging to middle age group.[04] 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 association between psycho-social, socio-economic, 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, as our 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 with entrapment or humiliation and with other 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. Other factors including distressful events such as accidents/robbery, business loss, dysfunctional families, history of childhood abuse and trauma play vital role in precipitating depression.

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 Pakistan financial problems, relationship problems and level of low education are positively correlated with depressive and anxiety disorders[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 the 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.

REFERENCES:

1. Institute of Medicine. Neurological, psychiatric, and developmental disorders: meeting the challenge in the developing world. Washington, DC: National Academy Press, 2001.
2. Murray C, Lopez A. The global burden of diseases: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Boston: Harvard School of Public Health, WHO and World Bank, 1996
3. Ayub M, Irfan M, Naeem F. Major Depression in a large family In Pakistan: No Relationship to Inbreeding, Economic Status or Rural Living. JPPS. 2012; 09(01):37.
4. Niaz U, Hassan S. The Psychosocial Factors for Depression in Upper and Upper-Middle Class Urban Women of Karachi. JPPS. 2005; 02(02):76.
5. Rieder H, Elbert T. The relationship between organized violence, family violence and mental

health: findings from a community-based survey in Muhanga, Southern Rwanda. Eur J Psychotraumatol, 2013; 4.
6. Knobloch-Fedders LM, Critchfield KL, Boisson T, Woods N, Bitman R, Durbin CE. Depression, relationship quality, and couples' demand/withdraw and demand/submit sequential interactions. J Couns Psychol. 2014; 61(2):264–79.
7. Chernomas WM, Shapiro C. Stress, depression, and anxiety among undergraduate nursing students. Int. J. NursEducScholarsh, 2013; 10.
8. The World Health Report: 2001: Mental health: New Understanding, New Hope. World Health Organization 2001. (Online) (Cited 2010 Aug 25). Available from URL: http://www.who.int/whr/2001/en/whr01en.pdf.
9. Mirza I, Jenkins R. Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. BMJ. 2004 Apr 3; 328(7443):794.
10. Naqvi H. Depression in Pakistan: An epidemiological critique. JPPS. 2007; 04(1):10.
11. Luni FK, Ansari B, Jawad A, Dawson A, Baig SM, Prevalence of Depression and Anxiety in a Village in Sindh. J Ayub Med Coll Abbottabad. 2009; 21(02):5.
12. Ali BS, Rahbar MH, Naeem S, et al. Prevalence of and risk factors associated with anxiety and depression among women in a lower middle class semi urban community of Karachi. Pak J Med Sci 2002; 52:513-5.
13. Bebbington PE. The origin of sex differences in depressive disorders, bridging the gap. International Review Psychiat 1996; 8: 295-332.
14. Bebbington PE. Sex and depression. Psychological Medicine 1998; 28: 1-8.
15. NailaAyub, Leiden Universty, NAyub@leidenuniv.nl. Published online before print, February 1, 2008,doi:10.1177/107312240 Assessment September 2008 vol.15 no.3 287-293.
16. Fergusson DM, McLeod GF, Horwood LJ. Unemployment and psychosocial outcomes to age 30: A fixed-effects regression analysis. Aust N Z J Psychiatry. 2014.
17. Broadhead J, Abas M. Life events, difficulties and depression among women in an urban setting in Zimbabwe. Psychol Med 1998; 28: 29-38.
18. Keyes KM, Pratt C, Galea S, McLaughlin KA, Koenen KC, Shear MK. The Burden of Loss: Unexpected Death of a Loved One and Psychiatric Disorders Across the Life Course in a National Study. Am J Psychiatry. 2014 May 16;
19. Chernomas WM, Shapiro C. Stress, depression, and anxiety among undergraduate nursing students. Int J Nurs Educ Scholarsh. 2013 Jan;10.