FREQUENCY AND DISTRIBUTION OF DEPRESSION AMONG OCCUPATIONAL WORKERS AND THEIR FAMILIES

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ABSTRACT

Background: Depression is highly frequent and in 2020, it will become the second leading cause of disability. The objective of the study was to determine the frequency & distribution of depression among occupational workers and their families.

Material & Methods: This cross-sectional study was conducted in Punjab Employees Social Security Hospital (PESSI), Rawalpindi, Pakistan from July to September 2013. Sample size was 80 subjects selected by convenient sampling technique. Demographic variables were; gender, age, education, income and family type. Research variable was presence of depression. We used a standardized and validated questionnaire to collect data named as "Hospital Anxiety and Depression Rating Scale (HADS)". The scale was translated in urdu. Scores for each item in the questionnaire ranged from 0 to 3. The categorical variables were expressed as frequency and percentages whereas numeric variable such as age was expressed as mean and SD by using SPSS version 16.

Results: The mean age of the patients was 33.85 ±10.67 years ranging from 18 to 70 years. Out of 80 subjects, 31.25% were having depression. Out of 25 patients, Eight percent were males and 92% were females. Twenty four percent were illiterate, 8% were primary, 24% were middle, 28% were matric and 16% were graduates. Thirty six percent were having income Rs. <10,000, 40% were having income 10,000-20,000 whereas 24% were having income >20,000. Out of 25, 52% were from joint family whereas 48% were from nuclear family setup.

Conclusion: Frequency of depression was 25(31.25%). It was more common in poor and illiterate females from joint families.

KEY WORDS: Depression; Anxiety; Patients.

INTRODUCTION

Depression is prevalent mental illness that occur with desperation, low mood, unhappiness, sorrow or feeling of low self dignity, fatigue or low energy, and feeling of hopelessness. Depression shows physical and mental features of anxiety.[1]

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Date Submitted: 23-08-2017
Date Revised: 28-08-2017
Date Accepted: 12-09-2017

These problems can become long lasting or periodic and reduces the quality and strength of a person and he cannot perform his daily work in proper way. At this stage the worst effect of depression can lead to suicide. Due to suicide almost 1 million lives are lost per year, which translates that 3000 people expire per day due to suicide All over the world abnormal gloomy or unhealthy state of mind (morbidity) is a major contributor to depression.[2]

Clinically presenting depression is more intense than typical sadness. Studies shows that effects of depression are more in women as compared to men. After cardiovascular illness it is more common and it is related to poor outcomes.[3] The Global Burden of Disease study shows that in the developing countries depression will be leading cause of disability by the year 2020.[4]

Mental illness is also associated with poor outcomes of diseases such as diabetes, hypertension, heart attacks and cancers etc. Depression is a world health issue that will lead to morbidity and mortality .[5] Depressive disorder is characterized by depressed mood, reduced self-esteem, suicidal thinking, guilt and pessimism. Depression also effects productive and social life of a person.[6]

Published data reveals under-recognition and inadequate treatment of Generalized Anxiety Disorder (GAD) and depression in primary care.[7] Most of the studies on depression (epidemiological) in primary care were held at single sites. Many local factors and methodological differences made these studies unavailable for the comparability.[8]

According to latest statistics in 2015 from WHO, 322 million people, of about 4.4% of the whole population were suffering from depression. The frequency was higher in women (5.1%) than men (3.6%).[9]

Studies have shown that there is high frequency of depression among people. Almost every individual has depression in any stage of life and depression causes negative impact on personal and social life.[10] There are many types of depression that include: biological depression, situational, bipolar depression, unipolar depression, postpartum depression, psychotic depression and premenstrual dysphoric disorder.[11]

The objective of the study was to determine the frequency & distribution of depression in among occupational workers and their families.

MATERIAL AND METHODS

This cross-sectional study was conducted in Punjab Employees Social Security Hospital (PESSI), Rawalpindi, Pakistan from July to September 2013. Sample size was a total of 80 subjects from routine OPD, selected by convenient sampling technique. Demographic variables were; gender, age, education, income and family type. Research variable was presence of depression. Gender has 2 attributes (male and female), education has 5 attributes (illiterate, primary, middle, matriculate, graduate & above), income has three attributes (<Rs.10000, 10000-20000, >20000), family type has two attributes (joint, nuclear). Presence of depression has two attributes of yes and no. We used a standardized and validated questionnaire to collect data named as "Hospital Anxiety and Depression Rating Scale (HADS)". The scale was translated in urdu for convenience of the patients. It consisted of fourteen items. Scores for each item in the questionnaire ranged from 0 to 3 showing no depression and maximum depression respectively. The categorical variables were expressed as frequency and percentages whereas numeric variable such as age was expressed as mean and SD. SPSS version 16 was used for descriptive statistics.

RESULTS

The mean age of the patients was 33.85 $\pm$10.67 years ranging from 18 to 70 years Out of a total of 80 patients, 20 (24.25%) were males and 60 (75.75%) were females (Table 1).

Twenty two (27.5%) were illiterate, 10 (12.5%) were primary, 11 (13.8%) were middle, 18 (22.5%) were matriculate and 19 (23.8%) were graduate or above (Table 2).

Table 1: Gender of the OPD patients in PESSI, Rawalpindi (n=80).

Gender	Frequency	Percent
Male	20	24.25
Female	60	75.75
Total	80	100.0

Table 2: Education of the OPD patients in PESSI, Rawalpindi (n=80).

Education	Frequency	Percent
Illiterate	22	27.5
Primary	10	12.5
Middle	11	13.8
Matriculate	18	22.5
Graduate or above	19	23.8
Total	80	100.0

Thirty four (42.4%) were having income Rs.<10,000, 23 (28.75%) were having income between 10,000 - 20,000, whereas 23 (28.75%) were having income >20,000 (Table 3).

Table 3: Income of the OPD patients in PESSI, Rawalpindi (n=80).

Income	Frequency	Percent
Rs. <10000	34	42.4
Rs. 10000-20000	23	28.75
Rs. >20000	23	28.75
Total	80	100

Out of 80 patients, 32 (41.4%) were living in joint family system and 46 (56.6%) were living as nuclear families (Table 4).

Table 4: Family type of OPD patients in PESSI, Rawalpindi (n=80).

Family type	Frequency	Percent
Joint	34	42.5
Nuclear	46	57.5
Total	80	100

Out of 80 subjects, 25 (31.25%) were having depression. Out of 25, 2 (8%) were males and 23 (92%) were females. Six (24%) were illiterate, two (8%) were primary, six (24%) were middle, seven (28%) were matric and four (16%) were graduates. Nine (36%) were having income <10,000, 10 (40%) were having income 10,000 – 20,000 whereas six (24%) were having income >20,000. Thirteen (52%) were from joint family whereas 12 (48%) were from nuclear family setup.

Table 5: Socio-demographic wise frequency of depressed patients (n=25).

Gender			
Males	2(8%)	18	20
Females	23(92%)	37	60
Education			
Illiterate	6(24%)	16	22
Primary	2(8%)	8	10
Middle	6(24%)	5	11
Matric	7(28%)	11	18
Graduated	4(16%)	15	19
Total income			
<10000	9(36%)	25	34
10,000-20,000	10(40%)	13	23
>20,000	6(24%)	17	23
Family system			
Joint	13(52%)	21	34
Nuclear	12(48%)	34	46

DISCUSSION

Sometimes, depression remain unnoticeable and it can creep up on the patient's life. The general prevalence of depressive disorder in our study was (31.25%) and it is closed to studies that were conducted in Saudi Arabia (18.2%) and Kuwait (37.1%).[12,13]

According to study held in Kuwait in Primary Health Care settings the depression rate was high among females 21.7% than males 15.3% like our studies there is high association of depression in females 23 (92%) than males 2 (8%) because women are highly sensitive to seasonal changes /stressful life events and are more likely to experience guilty feelings and attempt suicide. Similar study was held in Saudi Arabia which also shows higher depression rate in female (22.2%) than males (13.7%). In Kuwait depression rate was reported higher in individuals with elementary schooling (19.9%) and less in well educated person (8.9%) but in our studies, depres-

sion rate is high among matriculate (28%) than well educated person (16%).[13] While the statistic of depression regarding level of education in Saudi Arabia was similar to our study.[12] In another study conducted in Saudi Arabia it is shown that matric people have 40% unemployment rate so they have higher rate of depression.[14] Jobless people having higher frequency.[12,13]

On the same way, people whom pay is 10,000 to 20,000 are more depressed 7 (40%) than having pay <10,000 9 (36%) because middle class family is trying to increase the standards of living, it is recognized that the middle classes are normally inclined toward modernity than other classes.

People living in a joint family system have higher percentage of depression 13 (52%) than of nuclear families 12 (48%) because of social and individual problems.

Our study revealed that the highest rate of depressive disorders is explained by medical and socio-demographic factors. Some philosophers state that depression is commonly seen in children and young adults, but it is unrevealed.[15,16] Individuals having large family size and less income are more depressed probably because they cannot meet the usual requirements of life due to less income. So number of children affects the rate of depression.[17] Social problems have also an impact on the frequency of depression such as unfavorable circumstances, imperfect marital status, jobless person and having a big family.[18]

CONCLUSION

Frequency of depression was 25 (31.25%). It was more common in poor and illiterate females from joint families.

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AUTHORS' CONTRIBUTION

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