SOCIOECONOMIC FACTORS OF DEPRESSION AMONG FEMALES VISITING OUTPATIENT CLINIC IN DISTRICT GHIZAR, GILGIT-BALTISTAN, PAKISTAN: A PILOT STUDY

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ABSTRACT

OBJECTIVE: This pilot study was conducted to find out the socioeconomic factors leading to depression in married females of district Ghizar, Gilgit Baltistan, Pakistan.

METHODS: The study was conducted at District Headquarter Hospital Gahkuch, Ghizar from November 2015 to February 2016. Depression was diagnosed using Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criterion and socioeconomic status was assessed by a self-designed questionnaire. Analysis was performed with SPSS version-23.

RESULTS: Out of 73 females, 53 (72.6%) were depressed according to DSM-IV. Majority of women were uneducated (n=23; 31.5%). Most females were married (n=50; 68.5%) followed by divorced females (n=8; 11%). Sixty-one (83%) women had arranged marriage. Majority of women (n=43; 58.9%) were housewives. Most females (n=37; 50.7%) had non-cordial relations with in-laws. Domestic violence was reported by (n=41; 56.2%) women. Sixty-one (83.5%) women had land ownership of some kind. Women who were married within the family (OR 1.386, CI .837-2.292), presence of depression in husband (OR 3.530, CI .933-13.359), non-cordial relation of women with in-laws (OR 3.657, CI 1.979-6.755) and domestic violence (OR 3.584, CI 0.717-17.921) were significantly associated with depression.

CONCLUSION: Majority of the females had no cordial relations with in-laws, more than half had history of domestic abuse. Marriages outside family had inverse relation with depression. Depression in husband and bad relationship of women with in-laws were strong predictors for depression in married females of district Ghizar, Gilgit Baltistan. Small sample size and hospital-based study were the main limitations of the study.

KEY WORDS: Depression (MeSH); Socioeconomic Factors (MeSH); Domestic Violence (MeSH).

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INTRODUCTION

Depression is affecting 350 million people worldwide annually; and projected to be the second commonest cause of disability by the year 2020.[1] Symptoms of depression encompasses sadness, loss of interest or pleasure, feelings of guilt, low self-worth, disturbed sleep, appetite, tiredness, and poor concentration with mild, moderate and severe depression as its main categories, depending on the number and severity of symptoms.[2]

As far etiological factors are concerned, social factors causing depression have been studied extensively. A United Kingdom research demonstrated that common mental disorders including depression were significantly associated with poor standard of living, low house hold income and economic disparities.[3]

Studies looking at depression in Pakistan demonstrated staggering statistics. In an affluent urban setting of Pakistan Niaz U, et al. found that 72% women and 44% men were suffering from depression.[4] Similarly a community-based study in the Hindu Kush region of Pakistan revealed that 46% of women had depression as compared to 15% of men, it also showed that illiteracy and lower socioeconomic status were associated with higher levels of distress.[5]

Gilgit Baltistan (GB) is an administrative territory of Pakistan, previously known as the Northern Areas of Pakistan.[6] GB has a total population of 1.3 million; no data on gender population breakdown is available. District Ghizar is one of the ten districts of GB with total population of 0.19 million.[7] According to GB Demographic and Health Survey 2008, it has a population of 20% with the lowest socioeconomic status index and 15% with the highest socioeconomic index, rest of the population resides in the wealth quintiles between these two. About one fourth (23%) of women with age between 15 to 49 years are literate.[8] As research on depressive illness in women residing in this area is very limited, this pilot study was conducted to find out the socioeconomic factors leading to depression in married females of district Ghizar, Gilgit Baltistan, Pakistan.

METHODS

In this cross-sectional study, 73 non-pregnant, married females with depression were interviewed, from November 2015 to February 2016. The study was conducted at female outpatient department; District Headquarter Hospital Gahkuch, Ghizar.

TABLE I: DESCRIPTIVE ANALYSIS OF THE STUDY PARTICIPANTS

Variable		Frequency (n=73)	Percentage
Depression	Depressed	53	72.6
	Non Depressed	20	17.4
Education	Uneducated	23	31.5
	Primary	10	13.7
	Secondary	17	23.3
	Higher Secondary	2	2.7
	Graduation or more	21	28.8
Marital Status	Married	59	80.8
	Widowed	5	6.8
	Divorced	9	12.3
Type of Marriage	Arrange Marriage	61	83.6
	Love Marriage	12	16.4
Occupation	House Wife	43	58.9
	Other	30	41.1
Relation with laws	Non Cordial	37	50.7
	Cordial	36	49.3
Ever Faced Domestic Violence	Yes	41	56.2
	No	32	43.8

Informed consent was taken from all patients prior to the interview. The research was approved by institutional review board of University of Peshawar, Peshawar, Pakistan.

Patients with severe mental and physical condition were excluded. Diagnosis was made based on Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) criterion. This criteria recognizes depression by identifying depressed mood for at least 2 weeks in a continuous pattern and with any five of the following symptoms present; decreased interest or loss of interest in daily activities (anhedonia), significant changes in weight or appetite disturbance, lack of concentration, sleep disturbances, fatigue and suicidal ideation.[9] Non-pregnant patients who fell into this category were selected for inclusion in the study and were then interviewed. Patients who gave history of being previously diagnosed with depression at a health care facility and were put on anti-depressant medication but later discontinued medicines on their own and did not undergo follow up visits were not included in the study.

Interviews were conducted by licensed medical practitioners. Patients, who did not understand Urdu and instead spoke the local language Shina, were interviewed by a licensed medical practitioner who was well versed in Shina.

A self-designed questionnaire with 35 items was used to interview patients. The questionnaire was in English and read out to the participants in local language. The questionnaire was designed after thorough literature search, focus group discussion and input from the experts.

The 35 items were ramified into personal profile, family structure, economic profile, and details of deliberate self-harm (where applicable). Each category had a detailed cluster of questions investigating the socioeconomic status of the patient's house hold.

Personal profile included questions probing age, marital status, education, occupation, age at the time of marriage, years of marriage, type of marriage (arranged, love, eloped, exchange, inter family, outside family), years since divorced or widowed (where applicable), history of infertility, number of male and female children, any personal disability (mental , physical), history of substance use, duration of depression (if previously diagnosed) and treatment of depression, and history of Deliberate Self Harm (DSH).

Details of family set up were retrieved by questions inquiring whether family structure was joint, nuclear or extended, relation of patient with head of the family, husband's history of polygamy, any physical or mental disability in family, history of intoxicating substance use and depression in family, history of domestic violence (verbal, physical, emotional) and the perpetrator of violence (husband, in-laws, relatives).

Economic profile included questions on monthly household income, freedom of spending of patient, if family is in financial debts, and is monthly expenditure within income range.

The last category of the questionnaire inquired about details of deliberate self harm (where applicable) with questions pertaining to reason of DSH (psychiatric illness, economic or family issues, academic, job problems or any other), method of DSH used (over dose, hanging, near drowning, jumping from height, slashing, gun, any other), number of DSH attempts and if treatment was undertaken after DSH.

Depression was taken as dependent variable and dichotomized with yes and no responses while socioeconomic factors were independent variables. A bivariate logestic regression was used to calculate the odds ratio. SPSS version 23 was used to analyse the collected data.

RESULTS

A total of 73 females were included in the study as shown in Table I. More than two third, 53/73 (72.6%) were depressed according to DSM-IV definition. A majority 23/73 (31.5%) was uneducated. Most females 50/73 (68.5%) were married followed by 8/73 (11%) who were divorced. A total of 61/73 (83%) had arrange marriages rather than love marriage. A greater share of women 43/73 (58.9%) were housewives. Most females 37/73 (50.7%) had non-cordial relations with in-laws. History of domestic violence was reported by 41/73 (56.2%) women. A great majority of women had land ownership of some kind in 61/73 (83.5%) cases.

Logistic regression model was applied to the available data to analyze if any predictors were significantly associated with the presence of depression. The model explained about 57% of the variation observed in the dependent variable (presence of depression). The model shows that if someone is married within family, they are more likely to

TABLE II: ASSOCIATION OF DEPRESSION WITH SOCIAL FACTORS

	Sig.	Odds Ratio	95% C.I. for odds ratio	
			Lower	Upper
Type of marriage (Arranged)	.303	.712	.373	1.359
Marital Status (Married)	.018	.160	.035	.733
Marital Status (Divorced)	.208	.228	.023	2.272
Years of marriage	.997	1.000	.978	1.023
Married within Family	.204	1.386	.837	2.292
No depression in family	.573	.842	.462	1.534
Depression in husband	.063	3.530	.933	13.359
Relation with in-laws (Non-cordial)	.000	3.657	1.979	6.755
Accommodation (Owned)	.279	2.103	.547	8.082
Accommodation (Rented)	.839	.861	.205	3.627
Domestic violence	.123	3.584	.717	17.921
Constant	.062	6.881		

Sig: Level of significance

suffer from depression. The model shows that if someone is married within the family, they are more likely to suffer from depression (OR 1.386, CI .837-2.292). Similarly if the husband is suffering from depression, the wife is 3.53 times more likely to suffer from depression (OR 3.530, CI .933-13.359). A very obvious relationship was found between those women who had non cordial relation with in-laws and presence of depression (OR 3.657, CI 1.979-6.755). Similarly there was significant association of domestic violence and depression (OR 3.584, CI 0.717-17.921) [Table 2].

DISCUSSION

This research is one of the few studies which have analysed the conduit between depression and socioeconomic multiplicities that lead to depression in females in GB. Despite of being a pilot research it has revealed an intriguing pattern of association of depression with socioeconomic in female population.

The results of this study show that disharmonious relations with in-laws are a major risk factor for depression in females of Ghizar. Almost 50% females reported to have been negatively affected by the antagonistic behaviour of their in-laws. These results are also consistent with previously reported findings that strained relationship with husband and extended family has a strong association with depression in women.[10] Similar association was reported earlier in women having discordant relationship with their husbands and those who are facing the daily life challenges of living in an extended family system.[11]

Another finding was three times more likelihood of depression among wives when their husband had depression. It is well established fact that when either spouse is depressed the whole family unit is depressed. Depression has a great toll on emotional and sexual aspect of the couple's life, leading to anger and isolation.[12]

Our finding lend support similar researches conducted elsewhere, where the investigators found that living with depressed spouse caused significant more depressed moods in other partner.

There is ample of literature looking at this causal relationship. For example, some researchers have demonstrated that conflicts in marital relation have a unique relationship with depression in either spouse and depression in partner leads to over all distortion in relationship.[13]

Furthermore, our study demonstrated a strong relationship between depression and domestic violence. This finding confirmed the results of a similar study conducted in women belonging from the lower socioeconomic set ups of Karachi, showing that most of the women had been victims of intimate partner violence either in the form of verbal or physical abuse.[14] In Pakistan generally and rural settings in particular our culture is collectivistic in nature; where women have little liberty to make major decisions. This situation eventually bears down its deleterious strain on the couple, making them highly vulnerable to heightened strife. These stressors are triggering factors for psychiatric morbidity in females. Additionally another study reported the causal relationship of emotional and verbal abuse of women with depression in lower middle class communities which is in accordance with our findings.[12]

According to Human Rights Commission of Pakistan, the incidence of domestic violence ranges from 70% to 90% in the female population of the country.[15] The variegated forms of violence consist of domestic violence which includes acid attack, beating, edged tool attack, setting on fire; sexual violence which includes sexual harassment, rape and honour killings. In spite of the alarming nature of violence against women, the attention given to this crucial zone of human rights by political establishment and civil society is unsatisfactory to say the least.

One of the primary causes of many forms of violence against women is dowry related which has unfortunately not been given due attention and recognition in scientific literature. Dowry related form of violence is now declared as a "socially endorsed form of violence in Pakistan", which creates a significant psychological quandary for the girl and her family.[16] This practice imposes a large economic burden on the family of the girl with deep seated social consequences like people being reluctant to embrace the possibility of having a girl child. Though in recent years, dowry related violence has received attention from electronic media but a lot more needs to be done on the platform of legislation and social reform to aptly address this issue.

Limitations of the study

This research was conducted to run as a pilot project for a PhD research with a small sample size therefore, the results cannot be generalised. Since it was a hospital-based study hence may not reflect true socioeconomic status of women in the community.

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AUTHOR'S CONTRIBUTION

Following authors have made substantial contributions to the manuscript as under:

SB: Concept & study design, acquisition of data, drafting the manuscript, final approval of the version to be published

AFA: Acquisition of data & drafting the manuscript, final approval of the version to be published

SS: Analysis & interpretation of data, drafting the manuscript, final approval of the version to be published

NM: Critical review, drafting the manuscript, final approval of the version to be published

Authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

CONFLICT OF INTEREST

Authors declared no conflict of interest

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