THE PSYCHOSOCIAL FACTORS FOR DEPRESSION IN UPPER AND UPPER-MIDDLE CLASS URBAN WOMEN OF KARACHI

Unaiza Niaz, Sehar Hassan

ABSTRACT

Objective: To estimate the frequency of depressive disorder in upper and upper-middle class urban women in Karachi and to identify the psychosocial factors of depressive disorders in these women.

Design: Cross-sectional descriptive survey.

Place and duration of study: The study was conducted at the Psychiatric Clinic and Stress Research Centre, which is a private practice clinic located in Defence, a high socioeconomic status area. The duration was from January 2000 to December 2004.

Subjects and Methods: The data for study was obtained from patients who came to the clinic for psychiatric consultations. Complete information about the patients was obtained from their case history files. This information consisted of the patient's demographic characteristics, diagnosis and biological or psychosocial factors of depressive illness. Only patients from upper and upper-middle class were selected in the study.

Results: A total of 835 patients were diagnosed with depressive disorders. 33% were male patients and 67% were female patients. In single women, parental conflicts (4.3 %), conflicts with boyfriends (3.3 %), adjustment problems (2.3 %), and father's alcohol abuse were the basic factors linked with their depression. In married women, marital conflicts (31%), bereavement (9.8%), domestic violence (3.6%), work stress (3.2%), daughter's marriage (1.3%), traumatic experiences (.7%) were found to be associated with their depression.

Conclusion: The results that women in upper and middle class presenti ng to a private facility suffer from depressive disorders twice as much as the males. The psychological factors associated with depression in this group are mainly related to the marital and role conflicts in domestic sphere of life.

Key words: Psychosocial factors, Depressive disorders, Upper class, Women.

INTRODUCTION

Various studies clearly identify depression as a major health problem[1]. The standardized mortality rates for unipolar depression is 1.4[2]. The World Bank publication on the global burden of disease provides a true picture of global impact of depression. The social and economic burden of depression on the individual, family members and society at large are very significant and this underlies the importance of identification of various factors associated with depressive disorders. Women are constantly exposed to specific risk factors which greatly contribute to threaten their mental health throughout their life[3]. A study done in France showed that 46% of the study population had experienced mental disorder in their lifetime. Lifetime prevalence for major depression was 26.5%. Both life time and current prevalence rates were twice as high in women than men[4]. Recognition of specific psychosocial factors associated with depressive illness has strong clinical implications since it helps in meeting the specific treatment needs of the patients. Some cross-cultural longitudinal studies of depression have identified few relevant factors. One of such studies showed that urban/rural and male/female differences in prevalence of depressive disorder are likely to be related to differential exposure to life event or different levels of social support networks[5]. Present survey is conducted to estimate the prevalence of depressive disorders in upper and upper-middle class urban women in Pakistan and to identify psychosocial factors associated with depressive disorders.

Unaiza Niaz M.D. DPM F.R.C., Psych (Eng)
Consultant Psychiatrist and Psychotherapist
Executive Director

Sehar Hassan M.Sc (Behavioral Sciences)
Counselor
The Psychiatric Clinic & Stress Research Center,
6C, 7th, Commercial Lane, Zamzama Boulevard,
Phase V, D.H.A. Karachi, Pakistan.

Correspondence
Dr. Unazia Niaz

SUBJECTS AND METHODS

A cross-sectional descriptive study was conducted at The Psychiatric Clinic and Stress Research Centre in Karachi. It is a private practice clinic and most of the patients come

from higher socioeconomic starta. The data about patients was obtained through case history files. Case history files keep the record of each patient in detail. It includes socio-demographic characteristics, diagnosis, factors associated with morbidity (biological/psychosocial), family history and treatment details of patients. For the study, patients diagnosed with depressive disorders on DSM IV criteria were selected. An inclusion criterion was defined to include patients from upper and upper-middle class only. Patients with family's monthly income range from 30,000 to 50,000 & above, with 4-6 family members, and having their own residence in Defence, Gizri, Clifton and Gulshan areas (all the areas have very costly property and the population is predominantly rich) were included in the study. SPSS was used for data analysis.

RESULTS

A total of 835 patients were diagnosed with depressive disorders based on DSM-IV criteria. 85% of patients had diagnosis of major depression, 8.0% were diagnosed with manic depressive psychosis and 6.4% with depressive neurosis. 33% were male patients and 67% were female patients. 54% of patients in middle-age group i.e. 30-45 years. The overall data showed that 66.9% of patients were married, 27% were single and 6% were either divorced/separated or widowed. Most of the patients were literate. 35% were graduates, 18% studied up to intermediate level, 13% had done there Masters and 12% had completed professional education. Minor differences were observed between the education level of male and female patients. 18-20% of female patients studied up to the Matric and Intermediate levels (including students). 37% of female patients were graduates and 20% had studied further. 85% of male patients were employed. Of these, 32% were business men, and rest were working in various other fields. 12% of male patients were students and 3% were retired/unemployed supported by their families. 61% of women were housewives, 17% were students and 0.5-5% women were employed, working as teachers, doctors, business (boutiques/parlors), personal assistants etc.

Table I
Prevalence of Depressive Disorder (N=835)

		Major Depression	Manic Psychosis	Depressive Neurosis	Total
Sex	Male	226 (27%)	36 (4.3%)	13 (1.5%)	275 (33%)
	Female	488 (58%)	31(3.7%)	41(4.9%)	560 (67%)
	Total	714 (85%)	67 (8.0 %)	54 (6.4%)	835

The case history files of female patients were further analyzed and various psychological factors reported by the patients as cause/precipitant for their depressive illness were recorded. A variety of psychosocial factors were identified in single and married/divorced or separated women. In single women, parental conflicts (4.3 %), conflicts with boyfriends (3.3 %), adjustment problems (2.3 %), father's alcohol abuse (1.7 %), and displeasure with academic choices due to parents forcing them into taking them (1.5 %), living far from parents (1.5%) were the central factors linked with their depression. Different psychosocial factors were reported as major precipitant for depressive illness by married/divorced or separated women. (See Table II).

Table II
Psychosocial Factors associated with Depressive Disorder in married/ divorced/ separated women

Factors	Frequency (n= 560)	Percent
Marital Conflicts/ Interpersonal Conflicts	173	31
Bereavement	55	9.8
Domestic violence	20	3.6
Loss in Husband's or Self Business	18	3.2
Work Stress	13	2.3
Daughter got divorced	7	1.3
Worried about daughter marriage	6	1.1
Traumatic Experience (Robbery, Bad Accident)	4	.7
Divorce	3	.5
Far from children	3	.5
Away from husband	3	.5

The reasons for of marital or interpersonal conflicts in 30% of the cases were role limitation, cultural restrictions, lack of choice and restricted mobility as expressed by these women. They expressed that they felt useless and bored by doing only the household chores.

Gynaecological issues were also found to be significantly associated with depressive disorders in married women. 2.3% women had postpartum depression, 1.5% had depression during pregnancy, 1.4% of women had depressed related to abortion or birth of abnormal child, 0.5% of women had depression associated with infertility while in 22 (3.9%) it was associated with menopause.

Depression was found to be co morbid with other conditions. Psychotic illness was found in 31 (4.3%) patients, physical illnesses in 20 (3.4%) cases, drug dependence was found in 10 (1.8%) and personality disorder were associated in 4 (0.7%) cases.

DISCUSSION

Epidemiological studies suggest that there is high rate of depression in women in general[6,7,8]. In this study, we estimated the proportion of depressive disorder in upper and upper-middle class urban women presenting to a private clinic in Karachi. This was found to be significantly high.(Female Vs Male N=560; 67% Vs N=275; 33%).

It is established that psychosocial stress precedes the onset of depression[9,10]. The prevalence, incidence and morbidity of depressive disorders are higher in females than males, beginning at mid-puberty and persisting through adult life. In present study results, we also found a wide age range (13-89 years) for female patients diagnosed with depressive disorders, with 54% in middle-age group. Critical review by Marco Piccinelli and Gerg Wilkinson (2000)[11] identified certain social roles and cultural norms are the risk factors for depression in women. These include functional limitation with associated lack of choice, role overload and competing social roles. In our study we also found that highly educated women, who have also studied certain professional courses before marriage, couldn't use their qualifications and skills after marriage. Their role was mainly limited to household chores. These women may have been depressed as they felt useless and likely to develop low self-esteem. The results of our study suggest, 77% of women were literate enough to have income generating jobs but 61% of them were living as housewives.

Detailed review of epidemiological findings suggests that marriage may have detrimental effects in females. Possibly due to gender specific demands posed by marriage and the resulting limited number of roles available to females[12,13]. Both home-making and child care reduce the likelihood of females being in paid employment or put additional responsibilities on those who are employed. In our study 66% of patients were married; marital/interpersonal conflict was present in 30% and work stress in 2.3% of women was associated with depression. Married females with no paid employment have to rely for their identity and self-esteem on their role as a housewife, a role that carries many frustrating elements and has been increasingly devalued in modern societies.

Indirect evidence for the strong effect exerted by social and cultural factors is provided by those studies showing none or limited gender differences in depression rates, in samples where males and females are matched for putative social determinants of depression[14,15] and in cultural groups where high value is attached to the female role, such as in Mediterranean countries[16,17]. In order to understand the factors associated with depression and other psychiatric illnesses among females in Pakistan it is important to understand the scenario of female status. Tradition and culture has direct impact upon the identity of women who live in multiethnic society. Urban women in Pakistan are also under lot of pressure as they have to fulfill the cultural, religious and modern socioeconomic and social demands of time. Stressors like conflict with in-laws and poor relationship with husbands are still the major factors contributing to increased prevalence of depression in women. We also found in our survey that educated women from upper and upper-middle class also face the problems of domestic violence (3.6%).

Stressful life events retain a substantial causal relationship with the onset of depressive episode[18]. The present study findings also showed that in 9.8% of women, depression was linked to bereavement, 0.7-3.2% were depressed because of traumatic incidents like robbery/accidents or loss in business, 1.3% cases had depression because of daughter's divorce or problems in marriage, and 0.5% were depressed due to their own separation/divorce.

A study of couples reported that the excess of depression onset among females following adverse life events was entirely restricted to crises involving children, housing or reproductive problems[19]. A study done in South Africa showed that the point prevalence of post-partum depression (DSM IV) to be 34.7% and in 18% of women, depression had been since delivery and in 17% the onset was at some point antenatally[20]. In our study, we found that depression was significantly associated with reproductive life events, as 2.3% women had postpartum depression, 1.5% had antenatal depression, 1.4% of women were depressed because of abortion or birth of abnormal child. This underlies the importance of providing adequate supportive network to control rising rates of depression during or after pregnancy.

The findings of present study suggest that psychosocial factors have a significant role in the depressive illness in women. Highly educated, professional women keen to pursue their profession or jobs after marriage should be encouraged by husbands, family and society at large as these were the major reasons for conflicts with husbands and in-laws.

REFERENCES

1. Greenberg P, Stiglin L, Finkelstein S. The economic burden of depression in 1990. J Clin Psychiat 1993;54: 405-18.
2. Ustun T. Global burden of mental disorder. Am J Public Health 1999; 89:1315-8.
3. Attia A, Douki S, Haffan E. Condition feminine en Tunisie. Evolution socio-culturelle et psychopathologie. Evolution Psychiatrique 1981; 46:109-27.
4. Ritchie K, Artero S, Beluche I. et al Prevalence of DSM-IV psychiatric disorder in the French elderly population. Br J Psychiat 2004;184:147-52.
5. Dowrick C, Ayuso-Maeteos J. et al From Epidemiology to intervention for depressive disorder in general population; The ODIN study. World Psychiatry 2002;1:169-78.
6. Ali BS, Rahbar MH, Naeem S, et al. Prevalence of and risk factor associated with anxiety and depression among women in a lower middle class semiurban community of Karachi. Pak J Med Sci 2002; 52:513-5.
7. Abas M A, Broadhead JC. Depression and anxiety among women in an urban setting in Zimbabwe. Psychological Med 1997; 27:59-71.
8. Mumford D, Saeed K, et al. Stress and Psychiatric disorders in rural Punjab. Br J Psychiat 1997;170:473-8.
9. Brown GW, Harris TO. Life events and illness. The Gulliford Press. London, 1989.
10. Bifluco A, Brown GW, Movan P. et al. Predicting depression in women: the role of past and present vulnerability. Psychological Med 1998; (28);39-50.

11. Piccinelli, M, Wilkinson G. Gender differences in depression. Critical Review. Br J Psychiat 2000;17: 486-92.

12. Bebbington PE. The origin of sex differences in depressive disorder, bridging the gap. International Review Psychiat 1996; 8:295-332.

13. Bebbington PE. Sex and depression. Psychological Medicine 1998; 28:1-8.

14. Jenkin R. Sex differences in minor psychiatric morbidity. Psychological Medicine Monograph Supplement 1985; (7) 1-53.

15. Wilhelm K, Parker G. Hadzi-Pavlovic D. Fifteen years on: evolving ideas in researching sex differences in depression. Psychological Medicine1997; 27:875-83.

16. Mavreas VG, Beis A, Mouyias A. et al Prevalence of psychiatric disorders in Athens, a community study. Social Psychiatry 1986; 21:172-81.

17. Vazquez-Barquero JL, Diez-Manrique JF, Pena C. et al A community mental health survey in Cantabria : a general description of morbidity. Psychological Medicine 1987; 17:227-42.

18. Kendler KS, Prescott CA. A population-based twin study of lifetime major depression in men and women. Archives of General Psychiatry 1999; 56:39-44.

19. Nazroo JY, Edwards AC, Brown GW. Gender differences in the onset of depression following a shared life event: a study of couples. Psychological Medicine 1997; 27: 9-19.

20. Cooper PJ, Tomlinson L, Woolgal M, Murray L, Moltono C. Post-partum depression and the mother-infant relationship in South African peri-urban settlement. Br J Psychiat 1999; 175:554-8.