Original Research Article

A Study to Address the Link Between the Main Presenting Symptoms of Depressive Disorder and the Level of Stigma Associated with Them

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Abstract

Aim: To determine whether there is a link between the main presenting symptoms of depressive disorder and the level of stigma associated with them, taking into account the patient's socioeconomic and demographic background.

Material & Methods: One hundred adult patients with Major Depressive Disorder (MDD) who are attending psychiatry OPD for the first time have been chosen. All subjects were rated with Hamilton depression rating scale to assess severity of their depression. Selected portion of EMIC Questionnaire (Distress questionnaire & Stigma scale) were used to assess the most troubling patient-specified symptoms with reference to four broad categories of symptoms (sadness, pain and other somatic, mental tension and others) and total perceived Stigma (illness experience) with reference to 13 items directly related to stigma.

Results: The study population is made up of 33% men and 67% women. Table 1 shows basic sociodemographic details of the study participants. 48 percent of the participants in the study had a positive family history of psychiatric disease; 31 percent complained of sadness. The statistical significance of the difference in means is strong (one way ANOVA; df 3, F=15.92, p<0.001). There is no significant relationship between age and total stigma score, but there is a positive association between HDRS score and total stigma score, which is highly significant at the p<0.001 level.

Conclusion: Stigma is linked to the severity of depression; it may function as a deterrent to getting care. The presence of depression is unrelated to socio-demographic factors.

Keywords: Presentation of depression, Stigma, Sociodemograhic Variables, Somatization.

Introduction

Mental disorders are often been neglected because of its non-specificity in diagnosis, indefinite clinical presentations, long term and varied treatment, various myths and belief systems associated with social stigma. [1] Around 20% of the world's

children and adolescents have mental disorders or problems. [2] There has been an age-old quest for achieving mental health. "Chitta vritti nirodha" is a yogic sutra which means bringing the mind to the state of tranquility[3]. Mental health is an integral part of well-being as evident from the WHO definition of health [4]. Mental illnesses follow the iceberg phenomenon, impart no immunity, negatively affect almost every aspect of patients' life and are emerging as a challenge to public health. This silent threat was highlighted by the World Health Day theme of 2001 (mental health: stop exclusion - dare to care) [5].

Depression is one of the most prevalent mental disorders of public health importance affecting mental, physical as well as social well-being and can lead to dolor and torment. It is a mood disorder characterized by a multitude of symptoms like feeling of sadness, guilt, worthlessness, tiredness, low self-esteem, difficulty in concentrating, loss of interest along with altered sleeping and eating behaviors. It can be mild, moderate or severe and may lead to suicide [6]. The mechanism of depression is the synergy between various biological, psychological and social factors. It affects more than 300 million people globally. Between 2005 and 2015, the prevalence of depression has increased by 18%. In India, approximately 5% of the population or 1 in every 20 Indians suffers from this condition [7, 8]. Once a stigma swept under the rug, depression has morphed to be tabbed as the theme of World Health Day 2017 by the World Health Organization (WHO) [9].

Prevalence for depression has also been found to vary considerably based on gender [10]. Consistently, women have nearly double to triple the prevalence rates for 12- month depression compared to men [11]. There are also gender differences in both the use of outpatient treatment and response to antidepressants [12].

The reasons for this trend are many. The stigma attached to mental illness makes patients reluctant to speak about their psychological problems.2 Physicians are often reluctant to treat people with mental illness and therefore may be rather superficial in their exploration of the psychological state of their patients. Unless these physicians were given additional training during their service, they may not see much point in recognizing diseases for which they think there is no adequate treatment. [13]

So, this study aims to determine whether there is a link between the main presenting symptoms of depressive disorder and the level of stigma associated with them, taking into account the patient's socioeconomic and demographic background.

Materials and Methods:

This was a cross-sectional study conducted at the outpatient department (OPD) of Department of Psychiatry, Department of Psychiatry, Vardhman Institute of Medical Sciences, Pawapuri Nalanda, Bihar, India for 12 months. All cases showed Major Depressive Disorder were taken into the study.

Inclusion criteria:

a. Subjects aged between 18 years and 60 years.

b. Consecutive subjects diagnosed as Major Depressive Episode according to DSM-IV-TR.

c. Subjects with reliable informants.

d. Subjects who will be able to communicate properly.

e. Subject who will give informed consent.

f. Subjects who can understand and speak Bengali.

Exclusion criteria:

a. Subjects aged below 18 years and more than 60 years.

b. All subjects with a past history of established manic, hypomanic or mixed episode.

c. Subjects who have been suffering from - Disorders usually first diagnosed in infancy, childhood and adolescence (e.g. Mental retardation, ADHD), Delirium, Dementia, Amnesic and other Cognitive disorders, Schizophrenia and other psychotic disorders, Mood disorders other than major depressive disorders

Methods:

A total of one hundred subjects; presenting for the first time to the outpatient clinic at the Department of Psychiatry, Vardhman Institute of Medical Sciences, Pawapuri were included as per inclusion criteria by purposive sampling. They were screened for any features that meet exclusion criteria listed before. Patients fulfilling any exclusion criteria, those patients were excluded.

All subjects were rated with Hamilton depression rating scale to assess severity of their depression.

Selected portion of EMIC Questionnaire (Distress questionnaire & Stigma scale) were used to assess the most troubling patient-specified symptoms with reference to four broad categories of symptoms (sadness, pain and other somatic, mental tension and others) and total perceived Stigma (illness experience) with reference to 13 items directly related to stigma.

Statistical analysis

The statistical analyses were done using Statistical Package for the Social Sciences, version 13 (SPSS-13). To compare difference in terms of mean stigma and HDRS scores across different most prominent presenting complaints (patient specified) of study population; one way ANOVA was done. The relationship between depression and stigma scores were examined with simple linear regression and computation of Pearson's correlation coefficient. As the mean stigma score of the sample was 16.10; a median split of the data was done to make two groups (patients having stigma score ≥ 16, considered high and < 16, considered low).

Results:

The study population is made up of 33% men and 67% women. Table 1 shows basic sociodemographic details of the study participants. 48 percent of the participants in the study had a positive family history of psychiatric disease; 31 percent complained of sadness. The mean HDRS and stigma score were 26.56 ± 5.81 and 19.73 ± 7.30, respectively, with 75% having a stigma score of 16 or higher and 25% having a stigma score of less than 16. (Table 2,3)

Table 4 shows comparisons of mean HDRS and Stigma scores across different patterns of distress in the research sample. The statistical significance of the difference in means is strong (one way ANOVA; df 3, F=15.92, p<0.001). The mean stigma score for those who complained of sadness was 23.84 ± 2.91, while it was 17.72 ± 6.71 for those who complained of somatic complaints. This distinction is extremely significant (one-way ANOVA; df 3, F=12.42, p<0.001).

There is no significant relationship between age and total stigma score, but there is a positive association between HDRS score and total stigma score, which is highly significant at the p<0.001 level. (Table 5)

Table 6 depicts the relationships between discrete socio-demographic and clinical characteristics. There is no statistically significant link between distress patterns and sex, married status, religion,

education, family structure, residence, SES, or psychiatric illness in the family.

Distress patterns (p<0.001), family history of psychiatric disease (p<0.05), and HDRS scores (p<0.001) were all statistically significant variations between groups as shown in table 7.

Table 1: Showing socio-demographic variables (discrete) of patients with major depressive episode (N=100).

Variables		N%
Sex	Male	33
	Female	67
Marital status	Married	65
	Unmarried	30
	Widow	05
Religion	Hindu	51
	Muslim	49
Education	Illiterate	05
	Read and write	07
	Primary	27
	Secondary	47
	Higher secondary	09
	Graduate	10
Family structure	Joint	71
	Nuclear	29
Residence	Urban	77
	Rural	23
Socioeconomic Status	Upper middle	10
	Lower middle	41
	Lower	13
	Poor	36

Table 2: Showing clinical variables (discrete) of patients with major depressive episode (N=100)

Variables		N%
Most prominent Symptoms (Pattern of Distress)	Sadness	31
	Pain and other somatic	48
	Tension	19
	Others	02
Family history of psychiatric illness	Positive	34
	Negative	66
Stigma score	> 16	59
	< 16	41

Table 3: Showing Socio-demographic and clinical variables (continuous) of patients with major depressive episode (N=100)

Variables	Mean ± SD
Age	35.81 ± 9.01
HDRS score	26.56 ± 5.81
Total Stigma score	19.73 ± 7.30

Table 4: Showing group difference in total stigma and HDRS score among patients with major depressive episode, presenting with different pattern of distress (N=100)

Variables	Pattern of Distress				p-value
	Sadness	Pain & other somatic	Tension	Others	
HDRS score	30.61 ± 6.81	20.72 ± 3.81	27.53 ± 5.92	26.92 ± 3.84	<0.001 **
Total Stigma score	23.84 ± 2.91	17.72 ± 6.71	19.74 ± 5.82	21.95 ± 7.03	<0.001 **

Table 5: Correlation of socio-demographic & clinical variables (continuous) with total stigma score in patients with major depressive episode (N=100)

Variables	Total Stigma score	
	r	p
Age	0.208	0.271
HDRS Score	0.392	<0.001**

** Correlation is significant at the 0.001 level (2-tailed)

Table 6: Correlation of Socio-demographic and clinical variables (discrete) with distress patterns in patients with major depressive episode (n=100)

Variables	Distress patterns	
	P	P
Sex	0.091	0.334
Marital status	0.027	0.792
Religion	0.051	0.691
Education	0.121	0.502
Family structure	0.178	0.392
Residence	0.093	0.682
Socio-economic status (SES)	0.184	0.301
Family h/o psychiatric illness	0.192	0.181

Table 7: Showing difference in terms of clinical variables (discrete) between patients with major depressive episode having stigma >16 (n=75) and stigma <16 (N=25)

Description		Stigma>16	Stigma<16	P-value
		N (%)	N (%)	
Distress patterns	Sadness	38	00	<0.001**
	Pain & other somatic	24	17	
	Tension	07	04	
	Others	06	04	
F/H of psychiatric illness	Positive	37	06	
	Negative	38	19	<0.050*

Discussion:

A large sample survey in southern part of India reported an overall prevalence of depression of 15.9% among general population. [14] In a similar study from Brazil using DASS scale, 34.6%, 37.2%, and 47.1% of medical students suffered from depression, anxiety, and stress, respectively.[15] A study from Turkey found that 27.1% of students were depressed, 47.1% from anxiety, and 27%

students were stressed. In a study from Nepal, depression was reported to be 29.9%, anxiety 41.1%, and stress 27% among medical students.[16]A study based in the United States found 24% of medical students to be depressed while another study from the US reported 12% of medical students to be diagnosed with probable major depression using DSM III criteria.[17]In a study from Egypt, 43.9% of students were suffering from anxiety.[18] Similar alarming statistics have been corroborated by our study also. Studies conducted in various regions of India reflect diverse situation depending on the use of study instruments. In a study from Bhubaneswar (Odisha), the prevalence of depression, anxiety, and stress among medical students was 51.3%, 66.9%, and 53%, respectively, using DASS scale.[19]

The prevalence of mild depression was lower than that found in a study by Dighe et al. (51.5%) [20] and severe depression was lower as compared to that in a study by Radhakrishnan et al. (21%) [21]. In urban group, the prevalence of depression was 75.5% with mild depression being 69.1% and severe depression 6.4%. As special groups were involved in socially productive activities and had better access to health care, depression was found to be least among this group, accounting to only 25.9% with majority in milder form and only 1.4% severe depression. Studies done in old age homes by Chalise and Goud et al. have found the prevalence of depression to be 57.8% and 53.75% respectively [22].

According to Raghuram and Weiss[23] through qualitative analysis of patients' narratives, we also demonstrated that patients viewed depressive, but not somatic, symptoms as socially disadvantageous. Somatic symptoms were considered to be less stigmatizing since they resembled illness experiences that most people could expect to have from time to time.[24] It is important to address the issue of stigma related personal and social context with reference to local cultural perspective to improve recognition of depression at earliest; even in milder form as it also causes significant distress along with loss of productivity and to prevent wastage of resources in search of organic cause. It is also relevant from clinical point of view as Angst et al reported that among people with depressive disorders, those who received antidepressant treatment had lower mortality rates than those who did not receive treatment, due in part to the lower suicide rates of those treated and in part to the lower mortality from cardiovascular and other physical disorders.[25,26]

Conclusion:

The results show significant relationships between depression and different sociodemographic factors. Stigma is linked to the severity of depression, it may function as a deterrent to getting care. The presence of depression is unrelated to socio-demographic factors.

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