To Determine the Link Between the Main Presenting Symptoms of Depressive Disorder and the Level of Stigma

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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: Seventy-five adult patients with Major Depressive Disorder (MDD) who are attending psychiatry OPD for the first time have been chosen. The study used proforma for socio-demographic and clinical characteristics, as well as the Hamilton depression rating scale, distress questionnaire, and stigma scale from the Eplanatory Model Interview Catalogue (EMIC).

Results: Pains or other somatic symptoms were identified as the most distressing symptom by nearly half of the patients, but sadness was mentioned by just 27% of the patients. When compared, somatic problems were perceived as less stigmatizing; the difference in mean stigma scores was statistically significant. The intensity of depression was found to be linked to stigma ratings. Unmarried status, as well as a family history of psychiatric illness, were perceived as more stigmatizing.

Conclusion: The majority of patients with serious depression cited somatic issues as the most worrisome, which could make early detection more difficult. Because 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

Depression is a significant public health concern worldwide and has been ranked as one of the illnesses having the greatest burden for individuals, families, and society. [1, 2] 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. [3] 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. [3]

Depressive disorders are currently a major public health issue. They are common, and their prevalence is likely to rise in the coming years as a result of socio-demographic changes in most countries around the world, which are increasing the number of people at high risk for depressive disorders, the longer life expectancy of people with chronic illnesses who frequently suffer from depressive disorders, iatrogenic depression, and the effects of certain forms of prolonged stress. [6, 7]

It is therefore disturbing that a large proportion of people with depressive disorders do not get treatment. The general population is unaware of the frequency and ubiquity of the disorder and does not realize that effective treatment is possible. Therefore, many do not come forward seeking help from health care services, and unfortunately even those who utilize health care services are not always appropriately treated. It is estimated that in even in developed countries nearly half of those who have depressive disorders do not come forward asking for help from their doctors, and of those who do, half remain unrecognized as suffering from depressive disorders. [7]

Symptomatology of any illness is not only the expression of a pathological process in an individual, but also depends on a variety of circumstances, including the environment, socioeconomic status, and cultural background, and the same is true for depression. One of the main reasons for the lack of recognition of depressive illnesses is that they frequently manifest as somatic symptoms. In previous years, it was thought that patients with somatic symptoms were mostly from developing nations and had minimal education. Today, it is apparent that this is not the case, and that somatic symptoms and complaints are common in all demographics and among people of various educational levels. [8]

Several cultural characteristics make diagnosing and treating depression more difficult. These include the perception and expression of social and emotional issues as aches, pains, and other somatic sensations, exhibiting the somatization process. The failure to recognize these bodily symptoms as a sign of depression results in missed diagnoses and treatment opportunities. Patients may reject the diagnosis and fail to cooperate with recommended treatment because the relationship between somatic and emotional symptoms is not clear. [8] The reasons for this trend are many. The stigma attached to mental illness makes patients reluctant to speak about their psychological problems. 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.[8]

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, Darbhanga Medical College & Hospital, Laheriasarai, Darbhanga, Bihar, India for 12 months. Seventy-five (75) cases of Major Depressive Disorder

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

Tools used:

1. Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (APA, 2000).[9]

2. Kuppuswamy's Socioeconomic Status Scale - Updated for 2007 (for urban population).[10]

3. Pareek's Socio-economic Status Scale[11]

4. Hamilton Depression Rating Scale (HAM-D) to assess severity of depression.[12]

Methodology:

60 subjects; presenting for the first time to the outpatient clinic at the Department of Psychiatry, Darbhanga Medical College & Hospital, Laheriasarai, Darbhanga, Bihar, India 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.

The objectives of the study were explained to them and if they agreed, informed consent was taken. Then, a research interview was conducted using the specified tools for this study before any treatment was initiated.

Their age, sex, residence, marital status, family structure, family history of psychiatric illness, educational qualification, were noted using the semi-structured proforma designed for this study, and socio-economic status were determined using Kuppuswamy's Socioeconomic Status Scale-Updated for 2007 (for urban population) and Pareek's Socio-economic Status Scale (for rural population).

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). The socio-demographic and clinical variables (both continuous & discrete) were summarized in terms of frequency, percentage, mean & standard deviation as per applicability. 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. To measure the relationship among continuous clinical and socio-demographic variables; Pearson's correlation test and for discrete variables; spearman's correlation test 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). To measure the significance of difference among the groups; in terms of various socio-demographic variables, chi square for discrete variables & for continuous variables, t-test was applied.

Results:

Socio-demographic and clinical characteristics of patients with Major Depressive Episode in this study have been shown in table 1, 2, 3. The study population is made up of 30.0 percent men and 69.3% women. The average age was 40.12 11.09. 51 (68.0 percent) were married, 15 (20.0 percent) were single, and nine (12.0 percent) were widows. The majority of them were religious, and the majority of them had only received secondary education (30.6 percent). 53 (70.6%) of them came from a joint family background, and the majority of them were from urban families in the lower middle class.

30 percent of the participants in the study had a positive family history of psychiatric disease; 20 percent complained of sorrow (26.6 percent). The mean HDRS and stigma score were 28.76 6.76 and 20.11 7.65, respectively, with 48 (64.0%) having a stigma score of 16 or higher and 27 (36.0%) having a stigma score of less than 16.

This table 4 shows comparisons of mean HDRS and Stigma scores across different patterns of distress in the research sample.

Patients who reported of melancholy had a mean HDRS score of 32.15 7.65, whereas those who complained of pain and other somatic symptoms had a score of just 21.77 2.58, while those who complained of tension had a score of 29.87 6.55, and others had a score of 29.00 4.71. The statistical significance of the difference in means is strong (one way ANOVA; df 3, $F=14.76$, $p<0.001$). The mean stigma score for those who complained of sadness was 24.44 3.98, while it was 18.51 7.21 for those who complained of somatic complaints. This distinction is extremely significant (one-way ANOVA; df 3, $F=13.13$, $p<0.001$).

There is no significant relationship between age and total stigma score ($r=0.17$, $p=0.25$), but there is a positive association between HDRS score and total stigma score ($r=0.43$), 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=75).

Variables		N (%)
Sex	Male	23 (30.0%)
	Female	52 (69.3%)
Marital status	Married	51 (68.0%)
	Unmarried	15 (20.0%)
	Widow	09 (12.0%)
Religion	Hindu	59 (78.6%)
	Muslim	16 (21.3%)
	Illiterate	05 (6.6%)
	Read and write	07 (9.3%)

Education	Primary	15 (20.0%)
	Secondary	23 (30.6%)
	Higher secondary	11 (14.6%)
	Graduate	14 (18.6%)
Family structure	Joint	53 (70.6%)
	Nuclear	22 (29.3%)
Residence	Urban	60 (80.0%)
	Rural	15 (20.0%)
Socioeconomic Status	Upper middle	07 (9.3%)
	Lower middle	35 (46.6%)
	Lower	10 (13.3%)
	Poor	23 (30.6%)

Table 2: Showing clinical variables (discrete) of patients with major depressive episode (N=75)

Variables		N (%)
Most prominent Symptoms (Pattern of Distress)	Sadness	20 (26.6%)
	Pain and other somatic	33 (44.0%)
	Tension	14 (18.6%)
	Others	08 (10.6%)
Family history of psychiatric illness	Positive	16 (21.3%)
	Negative	59 (78.6%)
Stigma score	> 16	48 (64.0%)
	< 16	27 (36.0%)

Table 3: Showing Socio-demographic and clinical variables (continuous) of patients with major depressive episode (N=75)

Variables	Mean ± SD
Age	40.12 ± 11.09
HDRS score	28.76 ± 6.76
Total Stigma score	20.11 ± 7.65

Table 4: Showing group difference in total stigma and HDRS score among patients with major depressive episode, presenting with different pattern of distress (N=75)

Variables	Pattern of Distress				
	Sadness	Pain & other somatic	Tension	Others	p
HDRS score	32.15 ± 7.65	21.77 ± 2.58	29.87 ± 6.55	29.00 ± 4.71	<0.001**
Total Stigma score	24.44 ± 3.98	18.51 ± 7.21	20.11 ± 6.54	23.61 ± 9.12	<0.001**

Table 5: Correlation of socio-demographic & clinical variables (continuous) with total stigma score in patients with major depressive episode (N=75)

Variables	Total Stigma score	
	r	P
Age	0.176	0.254
HDRS Score	0.432	<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=75)

Variables	Distress patterns	
	P	P
Sex	0.097	0.431
Marital status	0.028	0.867
Religion	0.060	0.701
Education	0.145	0.410
Family structure	0.164	0.288
Residence	0.081	0.589
Socio-economic status (SES)	0.178	0.271
Family h/o psychiatric illness	0.190	0.177

Table 7: Showing difference in terms of clinical variables (discrete) between patients with major depressive episode having stigma >16 (n=48) and stigma <16 (N=27)

Description		Stigma>16	Stigma<16	P-value
		N (%)	N (%)	
Distress patterns	Sadness	21(43.7%)	00(00%)	
	Pain & other somatic	11(22.9%)	17(62.9%)	
	Tension	09(18.7%)	08(29.6%)	
	Others	07(14.5%)	02(7.4%)	<0.001**
F/H of psychiatric illness	Positive	22(45.8%)	07(25.9%)	
	Negative	26(54.1%)	41(74.1%)	<0.055*

Discussion:

It is a well-known fact that somatization plays a role in many parts of the world, where it frequently accounts for "common presenting features of depression," and it is now clear that somatic symptoms and complaints are common in all populations suffering from depression, as well as people with various levels of education. [13,14]

Many research have focused on the role of somatic symptoms in recognizing depression, however there is no agreement on which scale to employ. The majority of studies used rating scales that were mostly patient rated (such as the CES-D, SSI, SRQ,

and others), [11-13] but a few studies used patient's account of symptoms, symptom checklists, and self-reported questionnaires that were specially prepared for, which may lack psychometric property and may also ignore the patient's experiences of distress, which eventually lead to seeking help. [15-17]

There are no statistically significant relation exists between distress patterns and sex, marital status, religion, education, family structure, residence, SES, family history of psychiatric illness. But there was significant difference when compared across family history of psychiatric illnesses (p<0.055), persons having positive

family history of mental illnesses were experienced high stigma than patients did not have such history.

When the groups were compared in terms of mean HDRS scores and patterns of distresses, a strong statistically significant difference were noticed (p<0.001) that means patients having high depression severity and who complained sadness as their main distressing complaint experienced high stigma compared to patients with less severe depression and somatic complainers.[6]

Conclusion:

The majority of patients with serious depression rated somatic issues as the most troublesome, which could make early detection more difficult. Despite meeting the criteria for a major depressive episode, aches or other somatic symptoms were the most distressing symptom for nearly half of the patients. We may expect all patients with a depressive episode to highlight sadness if the professional medical and local experience were the same, but only about 27% of the patients we analyzed here did.

Although stigma is linked to the severity of depression, it may function as a deterrent to getting care. When compared to sadness, somatic problems were perceived as less stigmatizing; the difference in mean stigma scores was statistically significant. The presence of depression is unrelated to socio-demographic factors.

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