Clinical and Sociodemographic Characteristics of Depressive Disorders in Kirkuk Governorate

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Abstract

Depression has been recognized as a major public health evidenced by its ranking of fourth position among the global burden of diseases. The aim of the study was to determine the clinical and sociodemographic characteristics of depressive disorders in Kirkuk Governorate. 231 depressed patients included 78 male patients and 153 female patients who were attending psychiatric unit were participating in this study. Diagnosis was made according to the Diagnostic Statistical Manual of Mental disorders-IV (Text Revision) (DSM-IVTR). It was observed that a significant number of depressed patients were females 153(66%), unemployed140 (61%), come from rural area142 (61.5%). The highest rate is seen in widowed 70 (30%) and divorced 65 (28%) while the lowest rate is seen in married 40 (17%). The most frequent depression subtypes are major depression 140 (61%) followed by dysthymia 35(15%), while the lowest subtype is bipolar depression 14(6%). The frequency of depression subtypes among patients are major depression 61%, dysthymia 15%, psychotic depression9.5%, postpartum depression 8.6%, bipolar depression 6%.The sociodemographic characteristic factors are consistent with some previous finding.

Key word: clinical characteristic, sociodemorgaphic characteristic, depressive disorder, Kirkuk governorate

Introduction

Depression, a term used to mean a reduced functioning in other medical disciplines, come to be associated with mental depression[1]. It was adopted because it implied a physiological change, and was defined as a condition characterized by sinking of the spirits, lack of courage or initiative and a tendency to gloomy thoughts[1]. Depression has been recognized as a major public health evidenced by its ranking of fourth position among the global burden of diseases[2]. Many believe it will occupy second position by the year 2020[2].A large study conducted by WHO in fourteen countries showed 24% of primary care attenders worldwide received an ICD-10 psychiatric diagnosis, the most common of which was current depressive episode[3].Rates of depression are increasing rapidly, particularly in developing countries[4].Over the intervening years there has been much debate as to whether a biological type of depression exists separate from a neurotic type[1] . Terminology has fluctuated around 'endogenous', vital, autonomous, endomorphic, and melancholic depression, characterized by distinctive symptoms and signs, genetic basis, and running an independent course unrelated to psychosocial factors. In contrast,' neurotic' or 'reactive' depression could manifest in multiple forms, showed clear responsiveness to the environment ,and ran a more variable course[1].Non-melancholic(DSM-IV) or without somatic symptoms(ICD-10) essentially defined as absence of psychotic or marked somatic symptoms, this subtype captures the clinical picture historically described by 'neurotic depression'(in those with certain premorbid personality traits and /or high levels of anxiety) and 'reactive depression'[1]. Melancholic (DSM-IV) or with somatic symptoms (ICD-10). The presence of 'somatic symptoms' define ,what is regard as a more 'biological' or 'endogenous' depressive episode, which is more sever[1]. Major depression disorder (also known as unipolar depression) must last at least 2 weeks[5]. An episode with psychotic features commonly referred to as psychotic depression[5].If the patient has had an episode of mania or markedly elevated mood, a diagnosis of bipolar is made in stead[5]. Atypical depression refers to fatigue superimposed on a history of somatic anxiety and phobia, together with reverse vegetative signs(mood worse in the evening, insomnia, tendency to oversleep and over eat), so that weight gain occurs rather than weight loss[5].The term dysthymia, which means 'ill hammered' was introduced in 1980[6]. Before that time, most patients now classified as having depressive neurosis (also called neurotic depression)[6]. Subthreshold forms of depression is a relatively new but faster growing area of study in psychiatry commonly known as minor depression or subsyndromal depression, these depressive spectrum disorders are typically characterized by the presence of depressive symptoms at least two weeks duration[7].These levels of depression are significantly more common than major depression[8,9]. The aims of the study are to determine the clinical and sociodemographic characteristics of depressive disorders.

Methods

231 depressed patients included 78 male patients and 153 female patients who were attending psychiatric unit at Azadi general hospital in Kirkuk governorate between January 2008 and March 2009 were participate in this study .Ages of the patients were

between(22-62) years. Diagnosis was made according to the Diagnostic Statistical Manual of diseases-Fourth Text Revised (DSM-IVTR)[10] . Patients who were filling the criteria of depressive disorder, included in this study. A specifically designed data sheet was developed. Data sheet included, sex, age, marital status, education level, residence and mental state examination. Patients who were diagnosed depression were interviewed with this sheet after they gave verbal consent to participate in this study. Statistical analysis was done by, mean ± standard deviation (SD) or number (%).Categorical data was compared using chi-square test. P value < o.o5 was considered significant

Results

A total of 231 depressed patients were reviewed of which 78(34%) were male patients while 153(66%) were female patients. The mean age of the patients is 39±8.8.The sociodemographic characteristics of patients with depressive disorders are shown in table(1).It was observed that a significant number of depressed patients were females 153(66%), with intermediate and secondary schools levels 120(52%), unemployed 140 (61%), and come from rural area142(61.5%). The highest rate is seen in widowed 70(30%) and divorced 65(28%) while the lowest rate is seen in married 40 (17%). Table (2) shows depressive subtypes. The most frequent depressive subtypes are major depression 140(61%) followed by dysthymia 35(15%), while the lowest subtype is bipolar depression 14(6%). Table (3) shows the frequency of psychological and somatic symptoms of the patients. The highest frequent symptoms are loss of energy/easily feeling of tiredness or fatigue (77%), depressed mood (73%),sleep disturbance (70%) anxious ,fearful ,nervous (65%),and loss of libido (65%) while the lowest frequent symptom is suicidal idea(25%). Table(4) shows psychiatric comorbidity. The highest comorbidity rates are anxiety disorders (male14%, female46%), drug abuse (male5%, female 0%) and alcohol abuse (male3%, female 0%) with significant differences between male and female patients in all of them.

Table (1):- Sociodemographic of patients

Variables	No.	%	p-value
Sex			
Male	78	34	S
Female	153	66	
Marital state			
Single	55	24	
Married	40	17	s
Divorced	65	28	
Widowed	70	30	
Age(years)			

22-32	47	20	
33-42	68	29	
43-52	59	26	
53-62	57	25	
Education level			
Illiterate and primary school	80	35	
Intermediate and secondary schools	120	52	
University	31	13	
Employment			
Employed	91	39	S
Unemployed	140	61	
Residence			
Rural	142	61.5	S
Urban	89	38.5	

S: significance difference (p-value <0.01)

Table (2):- Depressive disorders subtypes

Depression subtypes	Males (%)	Females (%)	Total (%)
*Major depression (included atypical depression)	52(22.5) (atypical=30)	88(38) (atypical=50)	140(61) (atypical=80)
Dysthymia	12(5)	23(10)	253(15)
Psychotic depression	8(3.5)	14(6)	22(9.5)
Bipolar depression	6(2.6)	8(3.5)	14(6)
Postpartum depression	-	20(8.6)	20(8.6)
Total	78(33.8)	153(66)	231(100)

*significance difference between male and female (p-value <0.01)

Table (3):- Presenting of psychological and somatic symptoms

Symptoms	% of patients
Psychological symptoms	
Depressed mood	73
Emotional –want to cry	40
Anxious, fearful, nervous	65
Poor concentration	57
Worthless	42
Loss of interest/ or decreased interest	30
Guilt feeling	30
Hopelessness	42

Suicide idea	25
Wishes of death	45
Somatic symptoms	
Loss of energy\easily feeling of tiredness or fatigue	77
Sleep disturbance	70
Change in appetite	43
Loss of libido	65

Table (4):- psychiatric Comorbidity

Psychiatric disorders	Males (%)	Females (%)
*Anxiety disorders	36(14%)	116(46%)
*Drugs abuse	13(5%)	o
*Alcohol abuse	8(3%)	o

*significance difference between male and female (p-value <0.01)

Discussion

This study shows significantly more depressive disorder among female patients 153(66%) than male patients 78(34%) and this is similar to the study of Ai-Nakkas [(11)]. The prevalence of depression varies with the marital status. The highest rates are seen in widowed 70(30%).This highest rates may be due to the psychological trauma of loss. Female patients feel helplessness when their husbands died or killed, loss of their husbands usually associated with poverty as the husband in our society is the main source of income and change of their roles in society specially if they have children, they should take full responsibility for rearing their children. The prevalence of depression, according to the educational level, the highest rates are among patients with intermediate and secondary schools level with significant difference than patients with university level. This difference may be due to the sample of the study, and in our society the population with intermediate and secondary schools levels is much higher than population with the university level. The study shows higher rates of depression among unemployed patients 140(66%) with significant difference than employed patients 91(39%) and this is may be due to poverty and low income of the patients. There is an inverse relation between income and the prevalence of depression [(12).] The highest and the lowest rates of depression are seen among patients living in rural 142(61.5%) and urban 89(38.5%), respectively. These high rates in rural area may be due to many factors such as poverty of the patients, low income, and some of them and/or their families are the victims of wars. Depression among our patients is manifested mainly by somatic symptoms (loss of energy 77%, sleep disturbance 70%, loss of libido 65%, change in appetite 43%) and depressed mood 73%.This may be because of the greater social acceptance of physical complaints than of psychological complaints, which are either not taken seriously or are believed to be cured by rest or extrapraying, and likely to evoke caring response than vague complaints of psychological symptoms, which can be either disregarded or considered a stigma of being soft or even worse insane[(13,14)] .For these reasons Iraqi who are depressed either resort to the general physician, rheumatologist, who are likely to request unneeded and costly investigations, or ask traditional healers to alleviate their

suffering. considerable number do not ask for help at all, especially in rural populations, among which absenteeism from work or inability to face day to day affairs is largely tolerated by the community and their attended families. The coexisting of psychological comorbidities among our patients are anxiety disorders, drugs abuse, alcohol abuse, with statistically significant between male (14%, 5%, 3%) and female (46%, 0%, 0%) patients respectively, is consistent with other studies [15,16]

Conclusion

The frequencies of depression subtypes among patients are major depression 61%, dysthymia 15%, psychotic depression 9.5%, postpartum depression 8.6%, and bipolar depression 6%. The sociodemographic characteristic factors are consistent with some previous finding. The coexisting a higher frequency of anxiety disorders among depressed patients may be due to situational factors in Iraq, as Iraqi population were exposed to wars and their subsequent psychological trauma.

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