

## **SOCIO-DEMOGRAPHIC FACTORS OF DEPRESSIVE DISORDERS IN INDIA : A COMPARATIVE APPRAISAL**

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### **SUMMARY**

Socio-demographic study of 173 cases of depression was carried out prospectively over one year's period from January 1977 to December 1977, at the psychiatric out-patient department of Kasturba Medical College Hospital, Manipal, Karnataka. The findings are compared with the data reported from other centres in India and the results are discussed.

It is widely recognised that depressive disorders belong to the commonly occurring psychiatric disturbances in the Indian sub-continent. Millions of people today are exposed to a host of stressful factors that could foster a variety of psychological disturbances. The introduction of E.C.T., a variety of antidepressant drugs, and lithium have brought relief to the depressives. However, when we are questioned about socio-demographic factors of depressive disorders in the Indian population, we often find ourselves at a loss as different investigators have reported different findings at different times. Hence we thought it worthwhile to undertake this study and compare our findings with the data reported from other centres to see if any comprehensive picture emerges.

### **MATERIAL AND METHOD**

All the adult cases of depression seen for the first time during the period January to December 1977 at the psychiatric out-patient department of Kasturba Medical College Hospital, Manipal, Karnataka constituted the material. The diagnostic terms used were the ones in line with ICD-9 (1975). Depression associated with organic illness and schizophrenia, adjustment reaction with depressive symptoms, and doubt-

ful cases of depression were excluded from the study. Out of one year's total attendance of 645 new cases there were 173 (26.7%) of depression. Of these 130 were of depressive neurosis (20.1%) and 43 were M.D.P.—depression (6.6%). The frequency of depression at our clinic has been described elsewhere (Raju, 1979). The data obtained prospectively regarding socio-demographic factors in depressives at our clinic have been compared with the pertinent data reported from other centres in India.

### **OBSERVATIONS**

The findings of our study are presented first, followed by the data from other centres. The data in the present study, was categorized into two groups namely depressive neurosis and M.D.P.-depression (as per ICD-9) and the two groups were compared with each other, while some of the previous investigators reported their findings, treating depression as one entity (this study does not address itself to the controversies regarding classification of depressive illness). It must be pointed out, that in most of the studies the data has not been subjected to statistical treatment and hence the findings are only of relative importance.

A significant difference was noticed in the age distribution of two groups of

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depressives. Depressive neurosis was found to be more frequently occurring below 40 yrs. of age (20-39 yrs.) whereas M.D.P.-depression was more commonly noticed in the age group of 40 yrs and above (Table 1).

TABLE 1

Age (Yrs.)	Depressive Neurosis		M.D.P. Depression	
	No.	%	No.	%
15-19	03	2.3	..	..
20-29	36	27.7	04	9.3
30-39	38	29.2	08	18.6
40-49	28	21.5	14	32.6
50-59	18	13.9	08	18.6
60-69	05	3.8	09	20.9
70-79	01	0.8	..	..
80-89	01	0.8	..	..

15-39 Yrs. VS 40-89 Yrs.  
 $X^2=12.69$ , d.f.=1,  $P<.01$

Sex distribution in depressive neuroses was found to be significantly different from that of M.D.P.-depression, the former showing a marked male preponderance (Table 2).

TABLE 2

Sex	Depressive Neurosis		M.D.P. Depression	
	No.	%	No.	%
Male	85	65.4	19	44.1
Female	45	34.6	24	55.9

$X^2=6.06$ , d.f.=1,  $P<.02$ .

TABLE 3

Religion	Depressive Neurosis		M.D.P. Depression	
	No.	%	No.	%
Hindu	98	75.4	38	88.4
Muslim	16	12.3	02	4.7
Christian	16	12.3	03	6.9

Hindu VS Others.  
 $X^2=3.24$ , d.f.=1, N.S.

TABLE 4

Marital Status	Depressive Neurosis		M.D.P. Depression	
	No.	%	No.	%
Married	99	76.1	33	76.7
Unmarried	24	18.4	04	9.4
Separated	01	0.8	..	..
Divorced	01	0.8	..	..
Widowed	05	3.9	06	13.9
Remarried	..	..	..	..
Other	..	..	..	..

Married VS Others.  
 $X^2=0.006$ , d.f.=1, N.S.

TABLE 5

Domicile	Depressive Neurosis		M.D.P. Depression	
	No.	%	No.	%
Rural	99	76.1	31	72.1
Urban	17	13.1	08	18.6
S. Urban	14	10.8	04	9.3

Rural VS Others.  
 $X^2=0.29$ , d.f.=1, N.S.

TABLE 6

Education	Depressive Neurosis		M.D.P. Depression	
	No.	%	No.	%
0 Nil	25	19.2	11	25.6
1 3 R's	02	1.5	02	4.6
2 Primary	35	26.9	14	32.6
3 Middle	20	15.4	04	9.3
4 Secondary	28	21.6	08	18.6
5 Pre-university	03	2.3	03	6.9
6 Degree	15	11.6	01	2.4
7 Post-graduate	02	1.5	..	..
8 Other	..	..	..	..

Lower Education VS Higher Education.  
 (Categories 0 to 4) (Categories 5 to 7)  
 $X^2=1$ , d.f.=1, N.S.

Depression both neurotic and M. D. P. was found more commonly amongst people of lower educational status (Table 6),

and in both the groups of depressives a preponderance of housewives was noticed, farmers being the next commonly affected ones (Table 7).

At Manupal income levels showed no significant differences. Majority of both the groups of depressives belonged to lower income levels (this in part reflects the relatively lower income levels of most of our patients mainly drawn from rural areas).

TABLE 7

Occupation	Depressive, Neurosis		M.D.P. Depression	
	No.	%	No.	%
Farmer ..	22	16.9	08	18.6
Business ..	11	8.5	04	9.3
Professional ..	08	6.2	04	9.3
Service (Non-Prof.) ..	17	13.1	..	..
House Wife ..	44	33.9	20	46.6
Labour ..	14	10.8	01	2.3
Student ..	04	3.1	01	2.3
None ..	07	5.4	02	4.7
Other ..	03	2.1	03	6.9

(Frequencies in M.D.P.—dep. are too small for meaningful application of  $X^2$  test).

TABLE 8

Family Income (Rs. per month)	Depressive Neurosis		M.D.P. Depression	
	No.	%	No.	%
Lower income group (up to 300) ..	41	31.5	17	39.5
Lower middle income group (301—700) ..	59	45.4	14	32.6
Upper middle income group (701—1000) ..	14	10.8	7	16.3
Upper income group (1001 and more) ..	16	12.3	5	11.6

$X^2=2.69$ , d.f.=3, N.S.

For family structure the definitions given by Omran *et al.* (1976) have been used—"A nuclear family consists of a father and mother and their children, who are unmarried at the time of the study. If in-laws, married children and/or other blood relatives live in the same family unit the family is described as an extended one". In our study, a preponderance of nuclear families was noticed in both the groups of depressives (Table 9).

TABLE 9

Family type	Depressive Neurosis		M.D.P. Depression	
	No.	%	No.	%
Extended	39	30.0	13	30.3
Nuclear	91	70.0	30	69.7

$X^2=0.0$

Depressive disorders were encountered in all the twelve months of the year and no statistically significant differences were found between depressive neurosis and M.D.P. depression when the results were analysed seasonwise—'summer' (March-June), 'monsoon' (July-Oct.), 'winter' (Nov.-Feb.)—(Table 10). Bagadia *et al.* (1973d) too, found no significant seasonal variations.

TABLE 10

Season	Depressive Neurosis	M.D.P. Depression
'Summer' (March-June)	36	12
'Monsoon' (July-Oct.)	41	17
'Winter' (Nov.-Feb.)	53	14

$X^2=1.23$ , d.f.=2, N.S.

## DISCUSSION

The comparison of data from different centres offers only a profile of socio-

demographic factors of depressive disorders in India and cannot be regarded as all-embracing in view of the differences in methodology and parameters involved in the analysis.

The available data from different centres suggest that depression occurs commonly between 20 to 65 years of life. Our study, however, indicates that depressive neuroses is more frequent below 40 years of age, whereas M.D.P.-depression is more commonly encountered from 40 years onwards. The stresses and strains of life may be more common in the former age group like the problems related to adolescence, education, occupation, financial responsibilities, marital and sexual life, child bearing, child rearing and parting of adult family members with division of assets, which might contribute to the occurrence of a neurotic depressive illness. M.D.P.-depression due possibly to genetic implications might be more common in the latter age group.

It has already been pointed out that most of the community surveys in India found female preponderance in depressive illness, whereas majority of the reports from psychiatric clinics including ours indicated relative male preponderance. Hence it is possible that in the community there is higher frequency of depression amongst females but actually more males seek psychiatric help, possibly because depression in the latter group causes more hardships for the family as they are the prime breadwinners. In addition to well recognized reasons, responsible for female preponderance in depression (Weissman & Klerman, 1977), certain other factors seem relevant in our setup. Though theoretically women in our country are regarded as equals in practice they are not so meted out—like male issues are more welcome; women get little share of property; they only need to bring dowry; and they only need to leave the parents' home and get a new identity associated with husband. In addition they are supposed to mould their ways as deemed proper by

the husbands and in-laws too in extended or joint families. It is beyond doubt that women in India in general face more problems in getting a suitable alliance as compared to men. And of course question of remarriage is still a taboo for most Indian women even today. In this era of relative sex permissiveness, if a woman has pre-marital or extramarital sex and if she conceives, it has a direct bearing on the woman's psyche, whereas a man is free from this 'side-effect'. In our setup, tacitly, women are not supposed to give free vent to certain emotions like anger, hostility and aggression, as much as men do, which can result in a cumulative effect. Added to it alternative sources of emotional or physical gratification outside the family are scarce for Indian women.

It is obvious that a Hindu preponderance might reflect the distribution of religion in general population in many Indian centres and the additional finding that Parsees, Christians, Muslims and Sikhs were well represented in some of the studies seem to denote that no religious group is immune to depressive illness.

Most studies found that married individuals formed the greater part of depressive population. Depressives in the premorbid self may not be apparently unstable and by the usual age of onset of depression, one might be already married. Depressive illness in mild to moderate intensity may not be recognized or perceived as a serious mental illness and as it often culminates in remission, poses no serious threat towards getting married. Marriage is more often arranged by the parents (in our culture) irrespective of the mental status of their children. And finally marital life and related responsibilities might lead to depressive illness. To sum up, the possibility that depressives in our culture are commonly found to be married seems to be more pertinent than the probability that married ones are more prone to depressive illness.

Majority of the studies reported higher

occurrence of depression in the urban population whereas in our centre, being one of the very few located in a rural surrounding, a marked preponderance of rural people was noticed. It is possible, as most hospitals with attached psychiatric clinics are situated in the urban setup, a preponderance of the urbans may be encountered. Sethi and Gupta (1970) summed up that "urbanised areas produce more noise, more pollution, more contamination, more friction, more challenges and more depressions". However rural people too are exposed to a myriad of stressful factors. For most urbanites a certain monthly income is assured. For a villager nothing is definite. His crop may fail him, thus robbing him of both investment and often the only source of income. He bears the brunt of floods, famines, and vagaries of weather. Educational facilities and career opportunities are limited in the rural setup. Many Indian villages are not easily accessible by road, rail or air and in the case of unforeseen exigencies like fire-accidents, dacoities, communal riots, outbreak of epidemic diseases or even for general medical and surgical emergencies, by the time, attention is paid, it may prove to be too late in many instances. Due to ignorance, superstitions, poverty and lack of proper medical facilities timely treatment is not sought even for treatable illnesses, thus causing untold misery to the afflicted individuals and their near and dear ones. Arranged marriages are the rule in rural areas, often between two persons unacquainted with each other, which may have some advantages. However if the relationship is incompatible, there is no other option except to accept it, as divorce and separation are usually not a part of rural life. If a rural woman gets widowed, she has much less chance of remarrying than her urban counterpart. And recreational facilities for the villagers are scarce as compared to urban people.

Most Indian studies found an association of lower educational status with de-

pressive illness while some studies found no correlation of education to depression. In our study, preponderance of lower educational status partly reflects the literacy of rural population. These findings suggest that educational and (possibly consequent) psychological sophistication is not a prerequisite to get depressed.

A preponderance of housewives was noticed in several of the studies, amongst depressives. What could be the possible reasons? Housework is monotonous. In spite of prolonged years of housekeeping, no constructive rewards are forthcoming and they continue to remain housewives throughout their life. Gove and Tudor (1973) among other reasons implicated the unstructured role of housewife, which allows time for brooding. Girls in our culture get married relatively early and have considerably less freedom to choose their husbands, which could lead to adjustment problems. Housewife is expected to do justice to the multifarious duties of a wife, daughter-in-law, mother, organizer of household activities and later a mother-in-law. However the last mentioned task is said to cause problems to another housewife. Housewives, consequent to their sex are subjected to several other stresses, as already pointed out.

In the Indian setup, upper, middle as well as lower social classes have been found to be evenly distributed by different workers in different locales. Hence it is possible that depression too is more or less evenly distributed through the diverse socio-economic groups and the heterogeneous results may reflect the economic status of the population studied. For instance higher representation of upper class reported by Marfatia (1973) and Davis (1973) may indeed be due to more frequent utilization of private psychiatric facilities by affluent ones whereas lower income range reported by us and Davis (1973) again in a different setup might reflect the prevailing economic status of the respective populations.