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ORIGINAL ARTICLE

Frequency of Depression in Patients with Religious Inclination

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ABSTRACT

Objective: To assess the frequency of depression in patients with religious inclination.

Materials & Methods: It was a cross sectional survey conducted in outpatients' department of Psychiatry of Sughra Shafi Medical Complex, Narowal over the period of 6 months. Sample size of 160 cases is calculated having age 40 to 75 years with 95% confidence level, 6% margin of error and taking expected percentage of depression was as 17% in subjects with religious inclination. Non-probability consecutive sampling was used. Depression was assessed according to HADS scale for depressive disorder of any severity.

Results: Frequency of depression in patients with religious inclination was recorded in 19.38% (n=31) while 80.62% (n=129) had no findings of the morbidity.

Conclusion: However, in observation of the above, we concluded that the frequency of depression in religiously inclined participants is not higher and some other factors i.e. socioeconomic was considerably greater, it may be the associated factor of depression in our study, further research in this field is necessary to validate our findings.

Keywords: Depression, morbidity, religious inclination, socioeconomic status

INTRODUCTION

Depression has been recognized as a major public health problem. It is the fourth largest contributor towards global burden of diseases and is believed to ascend two positions by the year 2020[1]. The prevalence of depressive disorders appears to be particularly high in Pakistan[2]. Depression is as serious mental disorder associated with both morbidity and mortality[3]. It is recognized by persistent low mood which is more than two weeks and also related with anhedonia or lack of concern in previously pleasurable activities. Other associated features comprise significant weight reduction when not dieting or weight gain (e.g., a alteration of more than 5 % of body weight in a month), or change in appetite nearly every day, sleeplessness or over sleepiness nearly every day, psychomotor excitement or retardation, tiredness or loss of drive, feelings of worthlessness or extreme or inappropriate guilt, reduced capability to think or concentrate, or uncertainty, recurring feelings of death[4,5]. The symptoms cause clinically important suffering or deficiency in social, occupational or other significant areas of functioning[6,7].

Natural course of depression is quite variable as it can be relapsing and remitting and in some cases it may take chronic course[8]. It usually strikes in age brackets of 14-65 but it can occur in any age[9]. Following factors have been implicated in etiology of depression: Genetics[10,] Psychological aspects, Psychodynamic[11], Cognitive, Behavioral[12,] Temperament, Childhood[13,] Personality, Neurochemical, HPA axis, Immunological theories, Structural, Blood flow /functional studies, Neurotransmitters and neuromodulator [14-16]. Treatment of depression is based on following principles Detection, recognition and referral[17], Assessment and co- ordination of care[18], Aim, and non-specific effects of treatment and the placebo[19]. Model of treatment based on bio psychosocial model[20].

Sudden cessation of any antidepressant can lead to constellation of symptoms traditionally called discontinuation syndrome. The condition frequently comprises flulike symptoms such as sickness, myalgia, vomiting, giddiness, and headache, and might even contain neurologic symptoms such as unstable gait, dysesthesias such as strange shock- like perceptions, tremors, or lightheadedness. Management includes prior psycho education, switching to longer acting drugs and to prescribe symptomatic treatment for example benzodiazepine and NSAIDs for insomnia and body aches respectively[21].

New researches have shown that risk of suicide associated with antidepressants is low and does not warrant withholding active treatment[22-24.] It is estimated that approximately 10-20% of all people will experience at least one episode of clinical depression during their lifetime. Currently best treatments for depression, which the latest data suggesting, are antidepressant medicines and organized forms of psychotherapy such as cognitive- behavioral therapy (CBT) and interpersonal therapy[23]. These interventions are proven to ensure good efficiency in randomized controlled trials, outdoing no treatment or placebo controls. Subcategories of depression include bipolar depression, melancholic depression, atypical depression, Seasonal mood disorder, postpartum depression**,** Spirituality is philosophically defined as the search for ultimate answers of life and how individuals are connected with transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community[25.] Religion is an systematized scheme of dogmas , practices, ceremonies and codes intended a) to assist intimacy to the sacred or transcendent (Divinity, greater power, or final truth/reality) and b) to raise an understanding of one's relationship and accountability to others in living together in a community[26.] Religion and spirituality are therefore used interchangeably but it is imperative to define both construct. And for that matter the measuring tools must be separately established. Although it is suggested that religiosity and spiritualism are protective factors but when we analyze it in detail then it becomes clear that evidence is poor and it is marred with multiple confounders[27-29].

MATERIAL AND METHOD

This cross-sectional study was conducted at Department of Psychiatry of Sughra Shafi Medical Complex, Narowal over the period of 6 months. Sample size of 160 cases is calculated with 95% confidence level to define the frequency of depression in patients with religious inclination. The nature of study was explained to each patient and informed consent to take part in study was taken. Each patient was interviewed in a comfortable setting ensuring privacy. Demographic details like name, age, gender was noted.

Depression was assessed according to HA DS scale for depressive disorder of any severity. Total score was 28. A score of > 8 was labeled as depression. Question 2, 4, 6, 8 (even numbers) was assessed depression. The spiritual well-being scale (SWBS) was used Range 20-120. Score above 60 was labeled as religiously inclined.

Non-probability consecutive sampling was used. Age criteria were 40- 75 years either male or female were included for this study.

Patients who were not willing to participate in the study and those who already diagnosed with depression were excluded.

Data was analyzed by using SPSS version14.0. Age was presented as mean and SD. The qualitative variables like gender and presence of depression in subjects with religious inclination was presented as frequencies and percentages. Data was stratified for age, SWBS score, socioeconomic status, educational level and gender to control the effect modifier. Post stratification p value <0.05 chi square test was applied, p value <0.05 was considered as significant.

Descriptive Statistics: Some descriptive statistics are calculated to explore the distributional properties of the data

Table 1:

Mean	Median	Std. Dev.	Skewness	Kurtosis	Jarque-Bera	Probability
57.88	62.31	6.42	0.072	1.786	14.82	0.21

The values of skewness & kurtosis indicated the normality of data consequently,on the basis of Jarque-Bera test of normality the null hypothsis of the normality accepted at 5% level of Significance.So, the data is normally distributed.

H_o: The data follow normal Distribution

H_1: The data does not follow normal distribution

Table 2:

Test of Normality					
Kolmogorov Smirnov Test			Shapiro-Wilk Test		
Statistics	d.f	Sig.	Statistics	d.f	Sig.
0.937	160	0.786	1.23	160	0.079

P value of Kolmogorov Smirnov Test & Shapiro-Wilk test is <0.05 so we accept H_o and conclude data is normally distributed.

RESULTS

This consisted on 160 patients fulfilling the inclusion/exclusion criteria were enrolled to determine the frequency of depression in patients with religious inclination. Patients were distributed according age showing that 33.12 % (n=53) were between 40-55 years and66.88%(n=107) were between 56-75 years of age, mean + SD was calculated as 57.88

± 6.42 years. Patients were distributed according to gender showing that 54.37% (n=87) were male and 45.63% (n=73) were females.

Frequency of depression in patients with religious inclination was recorded in 19.38 % (n=31) while 80.62% (n=129) had no findings of the morbidity. Stratification for frequency of depression with regards to age, gender, socioeconomic status, educational status and SWBS were recorded and presented in Table No. 2 respectively.

Table 1: Frequency of depression in patients with religious inclination (n=160)

Depression	No. of patients	%
Yes	31	19.38
No	129	80.62
Total	160	100

Table 2: Stratification for frequency of depression with regards to age, gender, socioeconomics status, educational status, SWBS

Age	Depression		P value
(in years)	Yes	No	
40-55	10	43	0.92
56-75	21	86	
Gender			
Male	19	68	0.38
Female	12	61	
Socio economic status			
High	2	5	0.74
Middle	9	44	
Low	20	80	
Educational status			
Under Matric	15	70	0.55
Matric	16	59	
SWBS			
60-90	11	42	0.75
91-120	20	87	

DISCUSSION

In various countries, people religiously inclined are happier and having less depression and it is considered that religion delivers a happiness boost and it protects against depression [28,29]. The current study was planned with the view that no study is published on this issue before in Pakistan, however, we intend to conduct this to determine the frequency of depression in subjects with religious inclination. In our study, 33.12%(n=53) were between 40-55 years and 66.88%(n=107) were between 56-75 years of age, mean+SD was calculated as 57.88+6.42years, 54.37%(n=87) were male and 45.63% (n=73) were females, frequency of depression in patients with religious inclination was recorded in 19.38%(n=31) while 80.62%(n=129) had no findings of the morbidity.

King M also found associations between a spiritual or religious understanding of life and psychiatric symptoms and diagnoses andrecorded that of the participants 35% had areligious understanding of life, 19% were spiritual but not religious and 46% were neither religious nor spiritual[30]. Religious people were similar to those who were neither religious nor spiritual with regardto the prevalence of mental disorders, except that the former were less likely to have ever used drugs (odds ratio (OR) = 0.73, 95% CI 0.60-0.88) or be a hazardous drinker (OR = 0.81, 95% CI 0.69-0.96).

Spiritual people were more likely than those who were neither religious norspiritual to have ever used (OR = 1.24,95% CI 1.02-1.49) or be dependent on drugs (OR = 1.77, 95% CI 1.20-2.61), and to have abnormal eating attitudes (OR = 1.46, 95% CI 1.10-1.94), generalized anxiety disorder (OR = 1.50, 95% CI 1.09- 2.06) any phobia (OR = 1.72, 95% CI 1.07-2.77) or any neurotic disorder (OR = 1.37, 95% CI 1.12-1.68). They were also more likely to be taking psychotropic medication (OR = 1.40, 95% CI 1.05- 1.86). They concluded that the people whohave a spiritual understanding of life in the absence of a religious framework are vulnerable to mental disorder.

Waqas Ahmed and co-workers in a previous study 99.7% believed that leading an Islamic way of life (abstaining from forbidden things e.g. fornication, alcohol, cigarettes, illicit drugs etc.) leads to a healthier life. 95% of the patients believed that praying five daily prayers (salat) will keep them healthy. 98% believed that listening to the holy Qur'an would help in their healing. 98.8% believed in the intercessory role of prayers by others. 82% believed that giving charity (sadaqa) assists in healing. The most important findings were that 93% wanted to see their physicians pray for their health out-load in front of them and 88% believed that having a physician, who is also a God-fearing person, will have a positive impact on their health. In view of the current social/cultural practices, 76% believed thatwearing emulets (religious inscriptions) also helps in healing.

On the other hand, Saleem et al. found out the impact of Spirituality on Well-being among old age people and recorded that the correlation was computed between Spirituality and Different dimensions of Well-being i.e. Physical, Mental, Social, Emotional and Spiritual[31]. It was found to be 0.542, 0.592, 0.524, 0.527 and 0.451 respectively. Further, Correlation was applied between Overall Well-being and Different dimensions of Spirituality i.e. Sense of Purposeness and Maintenance of Discipline which was found to be 0.696 and 0.534. Well-being is concern for an individual by which he can live a better life on which the happy life of the society is based. In order to be living long an individual should be involve in religious practices throughout his/her life.

However, in view of the above, we concluded that the frequency of depression in religiously inclined participants is not higher and some other factors i.e. socioeconomic was significantly higher, it may be theassociated factor of depression in our study.

CONCLUSION

In view of our study and those considered in review of literature it become clear that relationship between depression and religious inclination may not be straightforward. There needs to be more vigorous studies which consider confounding factors. For example, one study concluded that the people who have a spiritual understanding of life in the Absence of religious framework are vulnerable to mental disorder. we concluded that frequency of depression in religiously inclined participants is not higher and other factors of socioeconomics were considerably contributing in this outcome. Likewise other factors may be contributing and religiosity may be associated secondary factor. Therefore, it is important to conduct further studies in this area to establish the relationship in unequivocal terms.

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