SURVEY REPORT

Knowledge of Depression Among Community Members and Health Care Providers in Two Selected Areas of District Rawalpindi

Mahmood Ali Jafri, Fareed A. Minhas, Asad Tamiz-ud-Din, Munir A. Slatch and Faiza Mujeeb

ABSTRACT

Objective: To determine the level of knowledge about depression in two selected areas of district Rawalpindi.
Study Design: Cross-sectional survey report.
Place and Duration of Study: Union council Rehmatabad and mohalla Sultanpura, Rawalpindi, from June to December 2007.
Methodology: Strata of community were interviewed regarding the knowledge about depression using an indigenously developed questionnaire. To determine any association between difference of level of knowledge and different strata of community Chi-square $(X)^2$ tests was applied at 5% level of significance and p-value less than 0.05 was considered significant.
Results: Most of the respondents (63%) thought that diabetes was the major health problem in our country. Most of participants thought that drug abuse and addiction (74.3%), adolescent emotional and behavioral problems (66.8%) followed by alcohol abuse (50.3%) and personality disorders (49.2%) were the common mental illnesses. Chi-square $(X)^2$ statistics showed a highly significant association between difference of level of knowledge and the two strata of community i.e. health care providers and community members ($p < 0.001$).
Conclusion: People in the selected areas of district Rawalpindi had a poor knowledge about depression.

Key words: *Knowledge. Mental health. Depression.*

INTRODUCTION

The global burden of disease (GBD) study launched by the World Health Organization illustrated that among the mental health problems, unipolar depressive disorder places an enormous burden on society and ranked as the fourth leading cause of burden among all diseases.[1,2] More than 150 million persons suffer from depression at any point in time.[3]

Pakistan, with an estimated population of 152 million,[4] is the sixth most populous country in the world. The overall mean prevalence of depressive disorders in men and women is 33.62%, with the point prevalence varying from 28.8% to 66% for women (overall mean 45.5%) and from 10% to 33% for men (overall mean 21.7%).[5-8] Early detection and treatment have been shown to improve long-term outcomes and reduce the risk of future episodes of illness.[9,10] Barriers to seeking early help early for mental health problems include accessibility and availability of services and limited "mental health literacy" (defined as knowledge and beliefs about mental disorders) which aid their recognition that promote appropriate help-seeking, management or prevention.[11,12] It has been argued that help seeking will improve with better recognition and labelling of mental disorders.[13]

This study was conducted to determine the baseline knowledge towards depression which can be utilized to bring a positive change in the community towards depression.

METHODOLOGY

This study was a cross-sectional survey using an indigenously developed questionnaire. It was conducted in the Rehmatabad and mohalla Sultanpura union councils from June to December 2007.

The inclusion criteria were age above 18 years and health care providers working for the last 6 months in the same facility.

Exclusion criteria were any organic brain disease, acute psychotic illness and inability to understand the instrument question due to sensory deficit or language problems.

The indigenous questionnaire was developed after conducting small focus group discussions with the members of the community in both the rural and urban areas. The sessions were then analyzed to generate

Institute of Psychiatry, Shaheed Benazir Bhutto Hospital, Rawalpindi.

Correspondence: *Dr. Mahmood Ali Jafri, House No. 06, Lane No. 07, Sector G, DHAI, Islamabad.*
E-mail: mahmoodalijafri@yahoo.com

Received July 06, 2009; accepted October 25, 2011.

items for the questionnaire. Items in the questionnaire have been broadly categorized into two different categories like demographics, knowledge of major health problems and depression.

A list of common health problems in Pakistan were told to the participants and they were required to give four options that they thought were the major health problems in Pakistan. These lists were based on the top 13 'health problems' causing the most death or disability in Disability Adjusted Life Years (DALYs) in the world as determined by World Health Organization.[14] A scoring system was devised for their knowledge and score 01 was given for every correct response so maximum score in this question was 04. Knowledge of depression was checked through respondents selecting from lists what they believed were the most typical symptoms and common experiences with depression and the prevalence of depression.

Total score was calculated from sections that were basically meant for knowledge about major health problems, mental health problems, depression, symptoms and behaviour associated with depression and its prevalence. The total score was 20 which was further divided into three categories. Level of knowledge as poor was assigned for score 0-7; adequate level were given to score 8-15 and good knowledge to 15-20.

To determine any association between difference of level of knowledge and gender like male and female, age group like young and middle aged, literate and illiterate, rural or urban resident or community and health care provider Chi-square $(X)^2$ tests was applied at 5% level of significance.

RESULTS

A total of 600 respondents were interviewed with 362 participants (60%) residing in the rural areas and 238 (40%) in the urban areas. Another division was that community members were 500 and 100 were health care providers (HCPs).

A total of 288 respondents (48.0%) were males and 312 were females (52.0%). The mean age of study participants was 38.85 $\pm$ 9.86 years.

Most of the respondents were literate; 130 (22%) having completed or partially completed tertiary education and 97 (16%) having completed or partially completed secondary education. Two hundred and twenty four participants (37%) had completed or partially completed primary education. One hundred forty nine (25%) had no formal education.

Most of the respondents (63.0%) thought that diabetes was the major health problem in our country (Table I).

The majority of participants (53.7%) got one answer correct. A further comparison between community members and health care professionals was done and this showed slightly good response of health care providers.

When the participants were asked about common mental illnesses, most of participants thought that drug abuse and addiction (74.3%) are the common mental health problems.

When respondent were asked to choose three most common symptoms of depression the following trend was seen; most of the participants chose “being irritable” (33.7%) as the most common symptom of depression (Table II). The exact response was decided on the basis of criteria of International Classification of Diseases version 10.[15]

Table I: Major health problems in Pakistan.

Common health problems	Yes Frequency (%)	No Frequency (%)
Cancer (e.g. lung, liver, breast)	328 (54.7)	272 (45.3)
Heart disease and stroke	325 (54.2)	275 (45.8)
Diabetes (high blood sugar)	378 (63.0)	222 (37.0)
Stomach, bowel and liver disease (e.g. stomach ulcer)	137 (22.8)	463 (77.2)
Infectious diseases (e.g. HIV/aids, diarrhoea)	340 (56.7)	260 (43.3)
Suicide or self-harm	75 (12.5)	525 (87.5)
Complications of pregnancy or childbirth	136 (22.7)	464 (77.3)
Muscle or joint diseases (e.g. arthritis)	227 (37.8)	373 (62.2)
Brain, behavioural and mental health disorders	98 (16.3)	502 (83.7)
Lung and chest diseases (e.g. asthma, emphysema)	140 (23.3)	460 (76.7)
Lung and chest infections (e.g. pneumonia) accidental injuries	202 (33.7)	398 (66.3)
(e.g. road traffic accidents, falls)	67 (11.0)	533 (88.8)
Vision or hearing impairment or loss	07 (1.2)	593 (98.8)

Table II: Knowledge of symptoms of depression.

Symptoms of depression	Yes (%)	No (%)
An upset stomach	6.7	93.3
Being indecisive	18.5	81.5
Being irritable	33.7	66.3
Being sad, down or miserable	32.7	67.3
Being unhappy or depressed	11.3	88.5
Feeling disappointed	25.5	74.5
Feeling frustrated	10.5	89.5
Feeling guilty	2.0	98.0
Feeling overwhelmed	11.2	88.8
Feeling sick and run down	11.3	88.7
Feeling tired all the time	12.7	87.3
Headaches and muscle pains	23.0	77.0
Having no confidence	19.7	80.3
Poor appetite	22.8	77.2
Thinking "i'm a failure"	16.5	83.5
Thinking "nothing good ever happens to me"	10.3	89.7
Thinking "it's all my fault"	4.7	95.3
Thinking "i'm worthless"	9.3	90.5
Thinking "life is not worth living"	2.0	98.0
Sleep disturbance	14.0	86.0
Weight loss	4.2	95.8

When participants were asked about the common behaviour of patients suffering from depression most of them (68.3%) thought that they did not take care of themselves and only 27.5% could think about suicidal thoughts or behaviours. Experiencing stigma was the most frequent answer (73.2%) when the participants were asked about the most likely outcome of depression.

Next question was about the life time prevalence of depression. The exact answer to this question was 26-50%.[16] Most of the participants underrated the chances of developing depression.

The Chi-square $(X)^2$ statistics was calculated to be 61.332 with (df = 2) and a p-value of < 0.001. This showed a highly significant association between difference of level of knowledge and these two strata of community i.e. health care providers and community members. But when health care providers were taken out and any association between the difference of level of knowledge and other strata of community (like gender, age and education) was calculated, no significant association was found. The results are shown in Table III.

Table III: Association between level of knowledge and different study groups.

Respondents	Category	Poor (%)	Adequate (%)	Good (%)	p-value
Whole study population	Community members	65.1	34.9	0.0	0.0
	Health care providers	46.0	43.0	11.0	
Gender	Male	48.6	38.9		0.154
	Female	51.4	61.1		
Age	Young	37.3	62.7		0.65
	Middle age	34.3	65.7		
Education	Illiterate	31.2	25		0.21
	Literate	68.8	75.0		
Residence	Urban	31.2	39.8		0.184
	Rural	68.8	60.2		

DISCUSSION

This survey was conducted to assess the knowledge of community members and health care providers towards common physical and mental illnesses generally and towards prevalence, symptoms, and outcome of depression specifically.

Respondents showed a great interest in this research and asked different questions about psychiatric illnesses. One thing was realized just at the start of research that there was a communication gap between the mental health professionals and community members. Both urban and rural population were well aware and familiarized about the names of physical illnesses like heart attack, cancer, asthma and tuberculosis but did not know much about the mental illnesses and their names. This finding has also been seen in previous local studies.[17] Schizophrenia, bipolar affective disorder and anorexia nervosa were new names for them. This fact was opposite to the trend seen in western societies where people know much about the mental illnesses and its terminology.[18,19]

Most participants did not know about the major health problems in Pakistan. They did not rate the mental health problems as a main cause of disability. They did not have any idea that how much burden these illnesses carried. Again a finding replicated from previous studies.[20,21] A small number of participants thought that depression was a real health problem. This finding was in accordance with previous studies carried out in this country.[20,21] They were not able to recognize its core symptoms. Even most of the health professionals were not able to tell about the symptoms of depression again the finding which has been seen in both national and international studies.[22,23] The participants did not have a clear idea about the outcome of depression. Most of the participants did not think that attempted or completed suicide could be an outcome of depressive illness. Apart from psychiatrist and medical specialist other doctors did not know about the prevalence and incidence of depression. This finding was consistent with the international studies carried out recently in developed countries.[19,24]

CONCLUSION

The main finding of this study was that people in two selected rural and urban areas of district Rawalpindi had a poor knowledge of major health problems, specific illnesses, mental illnesses and depression.

REFERENCES

1. Lopez AD, Mathers CD, Ezzati M, Jamison DT, Murray CJ, editors. Global burden of disease and risk factors. Washington (DC); *World Bank*: 2006.
2. Murray CJ, Lopez AD, Black R, Mathers CD, Shibuya K, Ezzati M, *et al*. Global burden of disease 2005: call for collaborators. *Lancet* 2007; **370**:109-10.
3. World Health Organization (WHO). The world health report: working together for health. Geneva: *World Health Organization* Press; 2006.
4. Syed HR, Zachrisson HD, Dalgard OS, Dalen I, Ahlberg N. Concordance between Hopkins symptom checklist (HSCL-10) and Pakistan anxiety and depression questionnaire (PADQ), in a rural self-motivated population in Pakistan. *BMC Psychiatry* 2008; **8**:59.
5. Zuberi SI, Syed EU, Bhatti JA. Association of depression with treatment outcomes in type-2 diabetes mellitus: a cross-sectional study from Karachi, Pakistan. *BMC Psychiatry* 2011; **11**:27.
6. Luni FK, Ansari B, Jawad A, Dawson A, Baig SM. Prevalence of depression and anxiety in a village in Sindh. *J Ayub Med Coll Abbottabad* 2009; **21**:68-72.
7. Gadit AA, Mugford G. Prevalence of depression among households in three capital cities of Pakistan: need to revise the mental health policy. *PLoS One* 2007; **2**:e209.

8. Taqui AM, Itrat A, Qidwai W, Qadri Z. Depression in the elderly: does family system play a role? A cross-sectional study. *BMC Psychiatry* 2007; **7**:57.
9. Khan H, Kalia S, Itrat A, Khan A, Kamal M, Khan MA, *et al*. Prevalence and demographics of anxiety disorders: a snap shot from a community health centre in Pakistan. *Ann Gen Psychiatry* 2007; **6**:30.
10. Graham AL, Julian J, Meadows G. Improving responses to depression and related disorders: evaluation of a innovative, general, mental health care workers training program. *Int J Ment Health Syst* 2010; **4**:25.
11. Kronmüller KT, Victor D, Schenkenbach C, Postelnicu I, Backenstrass M, Schröder J, *et al*. Knowledge about affective disorders and outcome of depression. *J Affect Disord* 2007; **104**:155-60. Epub 2007 Mar 23.
12. Mbatia J, Shah A, Jenkins R. Mental health literacy as a function of remoteness of residence: an Australian national study. *Int J Ment Health Syst* 2009; **3**:5.
13. Gabriel A, Violato C. The development of a knowledge test of depression and its treatment for patients suffering from non-psychotic depression: a psychometric assessment. *BMC Psychiatry* 2009; **9**:56.
14. Barney LJ, Griffiths MK, Christensen H, Jorm AF. Exploring the nature of stigmatising beliefs about depression and help-seeking: Implications for reducing stigma. *BMC Public Health* 2009; **9**:61.
15. WHO. International Statistical Classification of Diseases and Related Health Problems ICD-10. 2nd ed. Geneva: *World Health Organization*; 2005.
16. Nishtar S, Minhas FA, Ahmed A, Badar A, Bile KM. Prevention and control of mental illnesses and mental health: national action plan for NCD prevention, control and health promotion in Pakistan. *J Pak Med Assoc* 2004; **54**:S69-77.
17. Gadit AA. Psychiatry in Pakistan: 1947-2006: a new balance sheet. *J Pak Med Assoc* 2007; **57**:453-63.
18. Griffiths MK, Christensen H, Jorm AF. Predictors of depression stigma. *BMC Psychiatry* 2008; **8**:25.
19. Hickie A M IB, Davenport TA, Luscombe GM, Rong Y, Hickie ML, Bell MI. The assessment of depression awareness and help-seeking behaviour: experiences with the international depression literacy survey. *BMC Psychiatry* 2007; **7**:48.
20. Zafar AM, Jawaid A, Ashraf H, Fatima A, Anjum R, Qureshi SU. Psychotherapy as a treatment modality for psychiatric disorders: perceptions of general public of Karachi, Pakistan. *BMC Psychiatry* 2009; **9**:37.
21. Minhas FA, Mubbashar MH. Attitudes of medical students towards psychiatry in Pakistan. *J Coll Physicians Surg Pak* 2000; **10**: 69-72.
22. Kelly CM, Jorm AF, Wright A. Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Med J Aust* 2007; **187**:S26-S30.
23. Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, Evans DB, *et al*, editors. Disease control priorities in developing countries. 2nd ed. Washington (DC): *World Bank*; 2006.
24. Fitch K, Molnar FJ, Power B, Wilkins D, Man-Son-Hing M. Antidepressant use in older people: family physicians' knowledge, attitudes, and practices. *Can Fam Physician* 2005; **51**:80-1.

.....☆.....