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## Socioeconomic determinants of depressive symptoms in a Polish population



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### ABSTRACT

Previous community research has shown a relationship between the incidence of depression and demographic and socio-economic factors in various countries, however, data on Polish population are scarce. The aim of this study was to assess the severity of depressive symptoms and their relationship with selected demographic and economic variables among adult residents of Poland. Determinants of prevalence of depressive symptoms were based on the results of a cross-sectional study of a random sample of the Polish population (647 women and 579 men). The presence of depressive symptoms was assessed based on the Beck Depression Inventory questionnaire. The relationship between presence and severity of depression and demographic and socioeconomic parameters (such as marital status, education, income level, economic activity, self-declared health status) was assessed. Symptoms of depression were found in nearly 40% of respondents, more often among women (47.76%) than men (31.78%). High scores on depressive tendencies were associated with low level of education, low personal income, precarious job situation, low health self-evaluation. The lowest rates of depression were among the unmarried and the highest among the widowed and divorced. Depressive episodes were highly prevalent in the studied group. The study showed the association between depressive tendencies and demographic and socioeconomic variables, thus identifying predictors which might be used to identify individuals at higher risk of developing depression, e.g. women with low socioeconomic status.

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## 1. Introduction

Mental health is perceived not only as a condition for individual welfare, but also as a factor allowing for effective fulfilment of social and economic roles. Depression is one the most common mood disorders which affects nearly 6.9% of the population of Europe, more often women than men (Wittchen et al., 2011). People with depression take seven times more days off work than healthy controls and more than patients with cardiovascular disease and diabetes (Alonso, Angermeyer, & Bernert, 2004). The costs of treating depression in Europe were estimated in 2004 at 250 euros per capita. Over 65% of this sum is associated with lost productivity, early retirement and mortality (also from suicide) (Sobocki, Jönsson, Angst, & Rehnberg, 2006). Depressive disorders such as depressed mood and low self-esteem, a tendency to isolate

oneself from the outside, withdrawal from daily activities and responsibilities, impaired concentration and memory, decision-making and motivational difficulties contribute significantly to the reduction of the quality of life and generate a lot of social costs (Puzyński, 1987).

Psychological factors have significant impact on the incidence and course of many somatic afflictions (Kennedy, Lam, Nutt, & Thase, 2004). The risk of suicide is significantly higher in people with depression, especially when it co-occurs with other somatic diseases (Harris & Barraclough, 1994). Depression has a negative effect on the course of treatment and prognosis of chronic diseases, including coronary heart disease, obesity and diabetes (Szczepańska-Sadowska & Sikora, 2009; Anda et al., 1993). Patients chronic conditions and concomitant depression are three times more likely to be hospitalized than those without depressive symptoms (Kartha et al., 2007).

Demographic and economic factors are important risk factors for depression development. Symptoms of depression are often found in subjects of lower economic status (Mikolajczyk et al.,

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2008), which is also associated with increased risk of alcoholism and suicidal behaviour.

Moreover, marital status is significantly related to the risk of depression (Bracke, 2000). A positive impact of a successful marriage on mental and physical health is scientifically proven, and so is the fact that long-term marriage problems, a breakdown or demise of a partner result in chronic stress and decrease quality of life. (Strohschein et al., 2005; Berkman, 1995; Gove, Hughes, & Style Briggs, 1983). However, as much being in a successful relationship allows to achieve mental comfort, people who remain in unsatisfactory marriages more often complain of somatic symptoms of stress, even compared to single people. Apparently more fact of being married does not guarantee benefits, as it is more about having satisfying relationships based on mutual support (Holt-Lunstad, Birmingham, & Jones, 2008). Chun and Lee found that staying in a relationship also ensures greater financial comfort (Chun and Lee, 2001) as marriage is associated with a more stable financial situation. It also reduces the stress of job loss by one of the partners. Marriage can also build a larger network of social support and offers benefits of belonging to a larger community (Hurlbert and Acock, 1990; Nock, 1998).

Early diagnosis of depression and professional help for those affected by mood disorders is a major public health problem. Identification of risk factors for depression and thus helping early intervention can contribute significantly to improving the quality of life of many people.

The aim of this study was to determine the prevalence of symptoms of depression among Polish population aged 20–74 depending on gender, education level, income, employment status, marital status and assess their own health. Participants were residents of the provinces of Lodz and Lublin.

## 2. Material and methods

Determinants of prevalence of depressive symptoms were assessed based on the results of a WOBASZ study—a cross-sectional study of a random sample of the Polish population. Study design and method of sampling was described previously (Rywik et al., 2005).

The presence of depressive symptoms was evaluated with the Beck Depression Inventory questionnaire. The BDI is a Likert scale consisting of 21 statements that describe the most commonly observed symptoms of depression: depressed mood, pessimism, sense of failure, loss of satisfaction, guilt, expectation of punishment, lack of self-acceptance, self-incrimination, death wish, cry for help, irritability, withdrawal from social contacts, inability to make a decision, distorted body image, problems at work, sleep disturbances, fatigue, loss of appetite, weight loss, somatic complaints, low energy levels (Beck and Beamesderfer, 1974). Responses are assessed on a 0–3 scale and the final result of the test is the sum of all points. The severity of depression is calculated as follows: 0–9 – no symptoms of depression, 10–19 – mild depression, 20–25 – moderate depression, more than 26 – severe depression. The BDI focuses on subjective symptoms, putting less emphasis on the somatic ones. The presence and severity of depression was compared with demographic and socioeconomic variables such as marital status, education, level of income, economic activity and health self-evaluation. A chi-square test, chi-square test with Yates correction and adjusted Pearson's contingency coefficient  $C$  was used for the analysis of the relationship between the severity of depression and the variables applied. The impact of the features to develop depression was evaluated using univariate and multivariate logistic regression.  $P$  value  $\leq 0.05$  were considered significant. The study group consisted of 1226 residents of Lodz and Lublin provinces (647 women and 579 men).

**Table 1**  
Structure of the study group with regard to socio-economic variables.

Variable	Variable value	No.	%	No. of depression	%
<b>Sex</b>	Men	579	47.2	184	31.8
	Women	647	52.8	309	47.8
<b>Age</b>	20–39	447	36.5	83	18.6
	40–59	534	43.5	252	47.2
	60–75	245	20.0	158	64.5
<b>Marital status</b>	Married	859	70.2	342	39.8
	Widow/widower	85	6.9	61	71.8
	Unmarried	226	18.5	58	25.7
	Divorced	54	4.4	30	55.6
<b>Education</b>	Higher	139	11.3	38	27.3
	Incomplete higher	35	2.9	2	5.7
	Post-secondary school	41	3.3	16	39.0
	Secondary school	402	32.8	155	38.5
	Incomplete secondary school	23	1.9	9	39.1
	Professional	325	26.5	112	34.5
	Primary school	220	18.0	135	61.4
	Incomplete primary school	40	3.3	25	62.5
<b>Income level</b>	> 1500	44	4.0	13	29.5
	1001–1500	70	6.4	41	44.3
	701–1000	193	17.6	65	33.7
	501–700	233	21.3	98	42.1
	301–500	337	30.8	145	43.0
	< 300	217	19.9	96	44.2
<b>Employment status</b>	Full-time job/self-employment	427	34.9	103	24.1
	Part-time job	44	3.6	13	29.5
	Pupil/student	56	4.6	10	17.9
	Farmer	105	8.6	35	33.3
	Housewife	23	1.9	9	39.1
	Retired	404	32.9	164	65.3
	Unemployed—on relief	39	3.2	10	25.6
	Unemployed—no benefits	127	10.3	49	38.6
<b>Self-declared health status</b>	Very good	90	7.3	12	14.4
	Good	696	56.8	166	23.8
	Mediocre	355	29.0	241	67.9
	Poor	84	6.9	72	85.7

## 3. Results

In the studied population the following variables' relationship with depression incidence were analyzed: gender, age, level of education, marital status, employment status, income level and personal health perception (Table 1).

Depression was significantly more often found in the elderly than in the younger subjects ( $=161.775$ ;  $C=0.418$ ;  $p < 0.001$ ), with depression risk increasing by 6% per every year of age (OR=1.06, 95%CI: 1.05–1.07;  $p < 0.001$ ).

Symptoms of depression were found in over 40% of respondents (47.8 % women and 31.8% men,  $=32.454$ ;  $C=0.227$ ;  $p < 0.001$ ). The risk of depression in women was almost twice higher than in men (OR=1.96, 95%CI: 1.55–2.48;  $p < 0.001$ ). Mild symptoms of depression were observed in 26.9% of men and 37.2% of women ( $=14.822$ ;  $C=0.155$ ;  $p < 0.001$ ), and moderate in 2.6 % of men and 6.7% of women ( $=11.150$ ;  $C=0.134$ ;  $p < 0.001$ ), while

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