Mind and Society, ISSN 2277-6907
Vol.08, No. I & II, March & June 2019, Page No.13 to 17

Depression and Perceived Quality of Life in Youths

*** Ram Prasad sonakar**,
****Jay Singh**

Received	Reviewed	Accepted
26 June 2019	27 June 2019	28 June 2019

Today depression is a major problem of human life which produced various adjustment related problems in day to day life. 5% depressive patients are in India (Indian academy of clinical psychology, 2000) and Depression will be most factor of death un till 2020 (Marray & Lopez, 1996). Present study examined the depression level is effected perceived quality of life of male and female adults. Sample consists of 60 adults (30 males & 30 females) for the age range of 21-40 years. Sample was selected across Varanasi district by purposive sampling technique. The subjects were selected from middle socio-economic status that was decided by their monthly income and they were educated at least high school level. All the subjects were assessed on Depression Scale (Karim and Tiwari, 1986) and P.G.I Quality of Life Scale (Moudgil, Verma and Kaur, 1998). On the bases of data analysis it was found that male perceived high depression as comparison to female and there is no significant difference between male and female on quality of life. It is also found that there is significant negative correlation between depression and quality of life of male and female adults.

Key Words- Depression, Quality of life

Introduction:

Depression is one of the most common and expensive disorders worldwide (World Health Organization, 2005. Around 1997, depression was considered as second greatest cause of disability in the world the by WHO (Murray and Lopez, 1997) It was proved by major research led by the WHO and published in 20072 in this study the burden of depression was compared with many chronic illnesses including angina, arthritis, asthma and diabetes. This research includes nearly a quarter of a million people in 60 countries. Results show that, over the effect of socioeconomic factors and other health conditions, depression had the largest effect on declining health, and people with depression in addition to another chronic health complaint had the worst wellbeing measures of all disease states. Depression that are chronic or follow a pattern of reduction and deterioration are linked with illness-related burdens that fall into two major categories. Previous is the burden of illness experienced by affected person, including uneasiness, pain or distress, or problems in the activities of daily life. The latter is the large economic load which includes the expenditure of providing health and social care, defeat of productivity and time off work, the burden on caregivers,

* *Assistant Professor (Psychology), VKM PG College, Varanasi*
* **Assistant Professor (Psychology), BPD Govt. PG College, Kanker (CG)*

and loss of earnings or confidence on state benefits. In this perspective, depression has been described as a situation that is "chronic and recurrent in nature, impairs family life, reduces social adjustment, and is a burden on the community" (Klerman and Weissman, 1992). Persons with depression may not find it easy to fit into place like social activities as well as family life and work. In addition to high healthcare expenses, the disability associated with depression can limit the performances and productivity of affected individuals than persons reported with other chronic physical illnesses (Wells *et al*., 1989; Hays *et al*., 1995). Research has shown that the effect of depression on quality of life (QOL) is associated with severity of depression. Some aspects of depression can be considered as intangible and are difficult to quantify. These comprises hurt, suffering and stress on family, friends, caregivers and other relations, which may observable as disturbance in daily activities, family relation or marital breakdown, and even homelessness. There are many researches to establish the relation between depression and QOL.

A review by Demyttenaere, DeFruyt and Huygens (2002) has summarizes that depression has significant effects on quality of life, comparably chronic medical disorders, but right treatment is associated with significant improvement in quality of life. The review try to make conceptual clarity and rationales behind assessing quality of life in depression and the influence of clinical intervention on quality of life of depressed patients.

There are numerous earlier systematic reviews that have evaluated facts on the association between depression and quality of life. For example, some examinations have focused on definite age categories (Creighton, Davison and Kissane, 2017; Sivertsen, *et al*., 2015), or samples with specific diseases (Blakemore et al., 2014; Schram, Baan and Pouwer, 2009). Specifically, Creighton, *et al.* (2017) as well as Sivertsen, *et al*. (2015) have investigated the association of anxiety or depression with quality of life in older people. Regarding reviews of disease-specific samples Blakemore, et al. (2014) have analyzed the connection between anxiety, depression and quality of life in patients of chronic obstructive pulmonary disease (COPD), and Schram *et al*. (2009) have focused on depression and quality of life in patients of diabetes.

When come across longitudinal studies in particular, generally reviews show more or less negative association. For example, the meta-analysis of Blakemore *et al* [15] for patients with COPD shows that reduced health-related quality of life were significantly related to depression and anxiety with moderate to large effect sizes. But in contrast, Schram *et al* [16] have reported insignificant to very small negative effects of depressive symptoms on domain-specific quality of life in patients of diabetes.

Some studies are revealed that, severity of depression is correlated with QOL impairment, (Judd, et al., 2000) but changes in QOL are not fully accounted for changes in depression (Hirschfeld, et al., 2002) and changes in QOL are more slower than symptoms of depression (Trivedi, 2006). Furthermore, treatments that reduce symptoms of depression do not necessarily result in better QOL. Moreover, a meta-analysis examining the effectiveness of antidepressants for depressed youths confirmed that regardless of improvement in clinician-rated depression symptoms, patients did not show improvement in overall well-being and QOL (Spielmans and Gerwig, 2014).

On the bases of above reviews and our existing knowledge, we can say that there are no clear recent studies specifically analysing evidence on the association between depression and quality of life in youths and focusing on samples without specific diseases or disorders. In this research paper we are about to see that depression is negatively correlated with quality of life.

Many researches are done on this topic and on the basis of these the researcher has decided to do this study. The main point that will be tried to check is, if the quality of life is good then depression will be less but if the quality of life is bad then depression will be experience more.

Objectives

1- To assessed the level of depression and quality of life of male and female adults.

2- To assessed the relation between depression and quality of life of male and female adults.

Hypothesis

1- There would be significant deference in depression and quality of life of male and female adults.

2- There would be significant negative correlation between depression and quality of life of male and female adults.

Method and procedure

Design

According to the purpose of study and type of variables of co-relational design was used to a certain the answer of proposed hypothesis.

Sample

Sample consists of 60 adults (30 males & 30 females) for the age range of 21-40 years. Sample was selected across Varanasi district by purposive sampling technique. The subjects were selected from middle socio-economic status that was decided by their monthly income and they were educated at least high school level.

Tools

Depression scale

This scale has been developed by Shamim Karim and Rama Tiwari (1986). The scale comprising of 96 items, related to twelve aspects or dimensions (apathy, sleep disturbance, pessimism, fatigability, irritability, social withdrawal and self centeredness, dejection or sadness, self dislike, self acquisition, self harm, somatic reoccupation and indecisiveness. Eight items of each dimension of depression. Each item has five alternatives (not at all, little bit, moderately, quit a bit and extremely). Scoring is 0 to 4 for five responses respectively. Interpretations separately for males and females in five levels (very high depression, high depression, moderate depression, low depression and very low depression). Reliability of the test is very satisfactory and validity of the test is moderate.

P.G.I Quality of Life Scale

This scale has been developed by A. C. Moudgil, S. K. Verma and Kuldip Kaur (1998). The scale comprising of 26 items. Each item has five lavels of responses (strongly agree, agree, indefinite, disagree and strongly disagree). Scoring is 1 to 5 for five responses respectively. Ranging from low to high degree. Reliability of the test is very satisfactory and validity of the test is moderate.

Results and discussion

Table-1

Mean, SD and t-value of adults (male & female) on Depression (N=60)

Sex	Mean	SD	t -value
Males	111.33	37.35	2.47*
Females	94.03	39.25	

*p<.05

Table-1 shows the mean, SD and t-value of males and females on depression. Mean value of male is 111.33 and SD is 37.35 and mean of females is 94.03 and SD is 39.25, and t-value for these two group is 2.47, that is show the significant difference (.05, p<.05). It is evident that there is significant difference in male and female subjects on depression scale.

In this competitive time people have try to become carrier concerned, level of achievement, adjustment, occupation and marital life its results in high level of tension. Racing with others autonomically resulted in depression. As we are well known that males are more carrier concern than females, depression caused by this reason will be found higher in males. And it is found in present result.

Table-2

Mean, SD and t-value of adults (male & female) on Quality of life (N=60)

Sex	Mean	SD	t -value
Male	93.03	10.22	1.75
Female	96.77	10.22	

Table-2 shows the mean, SD and t-value of male and female participants on quality of life scale. Mean of males is 93.33 and their SD is 10.22 and mean of females is 96.77 and SD is 10.65 and t-value is 1.75 ($p>.05$). It shows that there is no significant difference between male and female on quality of life.

This result of present study may occur because in the modern world male and female both want to live a standard life. And today education, employment opportunities for carrier and selective life style is equally provided to males and females.

Table-3

Correlation between depression and quality of life of male participants

Variables	Mean	SD	Correlation
Depression	111.33	37.35	-0.12
Quality of life	93.33	10.22	

This table of correlation between depression and quality of life of male subjects shows a negative correlation (-0.12). It means that, if the quality of life will show good position then depression will be less, in other words, when depression will experienced be high the quality of life may results in bad conditions.

Table-4

Correlation between depression and quality of life of female participants

Variables	Mean	SD	Correlation
Depression	94.03	39.25	- 0.40
Quality of life	96.77	10.65	

Above table shows the correlation between depression and quality of life in female participants. It shows a negative correlation (-0.40), which means the good condition of quality of life will leads to the low level of depression in females. Another way of explanation may be that, high level of depression will associated with bad experience quality of life. Today's status of education, employment opportunities provided and infrastructure available for general life are factors to make artificial attitudes of human being that leads to demand of high level of quality in life. Although it is slowly become an attitudes that is why in the unfavorable conditions for quality life one can feel depressed. Therefore present investigation has a worth to understand the actual reason of depression in youths and will be useful to design strategy for their improved quality of life.

References:

Blakemore, A., Dickens, C., Guthrie, E., et al. (2014). Depression and anxiety predict health-re lated quality of life in chronic obstructive pulmonary disease: Systematic review and meta-analysis. *Int J Chron Obstruct Pulmon Dis, 9,* 501–12. doi:10.2147/COPD.S58136.

Creighton, A.S., Davison, T.E. & Kissane, D.W. (2017). The correlates of anxiety among older adults in nursing homes and other residential aged care facilities: A systematic review. *Int J Geriatr Psychiatry, 32,* 141-54. doi:10.1002/gps.4604.

Demyttenaere, K., De Fruyt, J. & Huygens, R. (2002). Measuring quality of life in depression. Current Opinion in Psychiatry, 15(1), 89-92.

Hays, R. D., Wells, K. B., Sherbourne, C. D., Rogers, W., Spritzer, K. (1995). Functioning and well-being outcomes of patients with depression compared with chronic general medical illnesses. *Archives of General Psychiatry*; **52**: 11–19.

Hirschfeld, R.M., Dunner, D.L., Keitner, G… et al. (2002). Does psychosocial functioning improve independent of depressive symptoms? A comparison of nefazodone, psychotherapy, and their combination. *Biological Psychiatry, 51,* 123–133.

Judd, L.L., Akiskal, H.S., Zeller, P.J… et al. (2000). Psychosocial disability during the long-term course of unipolar major depressive disorder. *Archives of General Psychiatry*. *57*, 375–380.

Karim, S., & Tiwari, R. (1986) depression scale.

Klerman GL, Weissman MM (1992). The course, morbidity, and costs of depression. *Archives of General Psychiatry*, **49**, 831–834.

Moudgil, A.C., Verma, S.K. and Kaur, K. (1986) P.G.I. quality of life scale: revised form. *Indian journal of clinical psychology*, 13, 175 – 184.

Murray, C.J.L., Lopez, A.D. (1997). Alternate projections of mortality and disability by cause 1990–2020: global burden of disease study. *Lancet*, **349**, 1498–1504.

Schram, M.T., Baan, C.A. & Pouwer, F. (2009). Depression and quality of life in patients with diabetes: a systematic review from the European Depression in Diabetes (EDID) Research Consortium. *Curr Diabetes Rev, 5,* 112–9. doi:10.2174/157339909788166828.

Sivertsen, H., Bjorklof, G.H., Engedal K , *et al*. (2015). Depression and quality of life in older persons: a review. *Dement Geriatr Cogn Disord, 40,* 311–39. doi:10.1159/000437299.

Spielmans, G. (2014). The efficacy of antidepressants on overall well-being and self-reported de pression symptom severity in youth: A meta-analysis. *Psychotherapy and Psychosomat ics, 83*, 158–164.

Trivedi, M.H., Rush, A.J., Wisniewski, S.R… et al. (2006). Factors associated with health-related quality of life among outpatients with major depressive disorder: A STAR*D report. *Journal of Clinical Psychiatry, 67*, 185–195.

Wells, K.B., Stewart, A., Hays, R.D., Burnam, M.A., *et al*. (1989). The functioning and well-being of depressed patients: Results from the medical outcomes study. *JAMA*, **262**, 914–919.

World Health Organization, WHO Press. The Global Burden of Disease: 2004 Update. 2005.

Retrieved from: http://www.who.int/healthinfo/global_burden_disease/2004_ report_update/en