ABSTRACT

Depressive disorders are a group of prevalent, disabling, often chronic or recurrent illnesses, causing a high economic burden globally. General population surveys conducted in many parts of the world, including some South-East Asian countries, have revealed a high rate of depression with a lifetime prevalence of 7-12 % for men and 20-25 % for women. Community surveys in Sri Lanka, in the past, have revealed very low prevalences (point prevalence of 0.13% and 6-month period prevalence of 0.19%). Concept of depression for Sri Lanka has not been well defined from previous research. There is also a view among anthropologists that the concept of depression in Sri Lanka has a cultural specificity.

The objectives of the study were to determine the prevalence and correlates of depression in adults of 25-45 years in the Kalutara Divisional Director of Health Services (DDHS) area and to describe the conceptualization of depression among depressed patients and psychiatrists. Study instruments were Composite International Diagnostic Interview (CIDI - Core lifetime version 2.1) which assesses lifetime depression and Center for Epidemiologic Studies Depression Scale (CES-D), which measures the depressive symptoms during the last week. They were translated into Sinhala using rigorous qualitative methods and were validated in the Psychiatric Clinic, General Hospital, Kalutara, against the consultant psychiatrist's diagnosis made using ICD-10 Diagnostic Criteria for Research. Trained public health midwives and public health nursing sisters collected data. The sample consisted of 960 adults selected by a two-stage cluster sampling method.

The Sinhala versions of CIDI and CES-D were found to be valid and reliable instruments based on validation against the consultant psychiatrist's diagnosis. CIDI had the following validity and reliability measures: sensitivity 92.7%; specificity 85.7%; positive predictive value 86.7%; negative predictive value 92.3%; reliability between psychiatrist's diagnosis and CIDI diagnosis (kappa)

0.786; internal consistency (Cronbach alpha reliability coefficient) 0.7936; Guttman split-half reliability 0.8281; inter-rater reliability (kappa) from 0.846 to 1.00; test-retest reliability (kappa) from 0.761 to 0.894.

CES-D had the following validity and reliability measures: sensitivity 91.43%; specificity 90%; positive predictive value 90.14%; negative predictive value 91.30%; reliability between psychiatrist's diagnosis and CES-D diagnosis (kappa) 0.814; cutoff value 15/16 according to the ROC curve; internal consistency (Cronbach alpha reliability coefficient) 0.7936; Guttman split-half reliability 0.7592; inter-rater reliability from 0.831 to 0.894.

The overall response rate for the prevalence survey was 97.8%. The adjusted prevalence of life-time depression of depressive episode using CIDI and current depression of depressive symptoms using CES-D were 7.8% (CI 6.1% - 9.5%) and 11.2% (CI 9.2% - 13.2%) respectively. Concurrent life-time and current depression was seen in 3.9% (CI 2.7-5.1%). The prevalence of dysthymia was 0.43% (CI 0.0% - 0.8%). Either life-time or current depression was seen in 15.7% (CI 13.4% - 18.0%). Majority of current depression (68.9%) were severe while a majority of life-time depression (78.2%) were mild and moderate.

As found in the prevalence survey, the predictors of life-time depression in the logistic regression analysis were: female gender; poor educational attainment of the respondent; unemployment status or economic inactivity; being in debt; having a chronically ill child; poor relationship with the partner; past history of deliberate self harm ever in lifetime; not having a natural father figure; being fifth or more in the childhood family; facing >3 major life events during the last 5 years; not taking 3 meals a day regularly; less than 7 hours of sleep during the last month; poor perceived social support and poor self assessed health status.

The predictors of current depression in the logistic regression analysis were: female sex; poor educational attainment of the respondent; unemployment status or economic inactivity; being a samurdhi recipient; being in debt; presently living in a rent house; abuse of self by partner; paternal antipathy; being fifth or more in the childhood family; not taking 3 meals a day regularly; not undertaking exercises regularly; poor perceived social support and poor self assessed health status.

Female sex, poor educational attainment of the respondent, unemployment status or economic inactivity, being in debt, being fifth or more in the childhood family, not taking 3 meals a day regularly, poor perceived social support and poor self assessed health status were predictors for both types of depression. These correlates are mainly related to social disadvantage and it is seen that depression in the community may have some social origins.

The concept of ICD-10 depressed mood is existent in the Sri Lankan community according to the psychiatrists' views and experience and the findings in the prevalence survey. This is in contrast to the findings in past surveys in Sri Lanka. However, there are cultural presentations in Sri Lanka, which may be poorly detected by the instruments based on ICD-10 criteria alone according to the some psychiatrists.

The conceptualization of depression among the depressed patients is not based on Western concept of depression. Depressed people and some sections of the general public don't have basic allopathic medical knowledge even when resorting to allopathic health care. Appropriate agreed terminology to communicate the concept of depression between psychiatrists and patients was not present. However, there are local lay terms and concepts which signify depression such as '*Peretha Doshaya*'.

It is concluded that depression is an important public health problem in Sri Lanka. Depression in the community has some social correlates.