

Depression: A Major Public Health Problem Facing the Caribbean

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Epidemiological studies indicate that depression is a common disorder worldwide (1, 2). Estimates of the lifetime prevalence for this disorder range from 5–17% of the population in the USA (3–4). However a MEDLINE trawl of two hundred and seventy-five publications on mental health issues in Caribbean people revealed a paucity of written material on depression in the region.

In the Global Burden of Disease Report, it is estimated that depression was the fourth leading cause of burden among all diseases and that it accounted for 4.4% of the Total Disability Adjusted Life Years (5).

An important characteristic feature of the longitudinal course of major depression is the frequent co-occurrence with other illnesses. Numerous studies have examined the prevalence of co-morbid depression. Robin *et al* (3) and Wittchen *et al* (6) have shown that there is high co-morbidity between major depression and other psychiatric disorders. Much has been written on the risk factors; Blazer *et al* have shown that there was a stronger correlation with younger age, lower level of education and lower income in co-morbid depression in contrast to pure depression in which the major potential risk for pure depression was non-black race/ethnicity (7).

Studies have shown that in persons diagnosed with diabetes mellitus the prevalence of depression range from 6.1% – 60.7% (8). In a meta-analysis of 42 studies on co-morbid depression in adults with diabetes, Anderson *et al* concluded that the presence of diabetes increases the risk of depression they also concluded that the variation in prevalence estimates was due to clinical and methodological factors (9).

A number of epidemiological studies have established a clear relationship between depression and cardiovascular diseases (10–13) with the prevalence of major depression in post myocardial infarction ranging from 15%–20% (14, 15).

Depression, coexisting with other medical conditions, has poorer outcome in terms of quality of life and social and physical functioning (16, 17) and it is associated with increased morbidity and mortality (18, 19). In a study of

patients with myocardial infarction, Frasure-Smith *et al* showed that 17% of patients had died by six months compared with 3% for non-depressed patients (14). In patients with breast cancer depression is associated with a reduced 5-year survival (19).

Major criticisms on studies of co-morbid depression have identified methodological problems, inadequate control of confounding variables and weak or inappropriate comparison groups as major limitations. In a recent study by Scott *et al*, adjustments were made for confounding variables, socioeconomic status and health status and they showed that irrespective of gender, major depression was associated with increased mortality (20).

In Jamaica, to date, no large-scale population based studies have been done to estimate either the prevalence of depression or co-morbid depression and clearly there is an urgent need to do so in order to better inform policy and to facilitate the development of appropriate interventions.

In 1971, analysis of patients seen at the University of the West Indies indicated that 23% of new patients seen in the psychiatric service suffered from depression (21).

In a population based lifestyle survey conducted in Jamaica, Wilks *et al* reported that 49% of respondents reported “feeling down or depressed” and 28.7% of men and 36.6% of women reported, “having little interest or pleasure in activities”(22).

The conduct of significant epidemiological research on depression can be both difficult and expensive, for the last four years the Section of Psychiatry has been attempting to mount an epidemiological project on the incidence and prevalence of depression in Jamaica. Our research has shown that WHO-CIDI instrument would be the most appropriate instrument to use in any large scale epidemiological studies (23). This would require the training of personnel that is available only in the United States of America and that we have not been able to execute this up until the present. However it seems that this is the logical way forward for the future.

Notwithstanding, major depression needs to be properly studied as the diagnosis of this condition can sometimes be challenging and the understanding of the biologic determinants is at times elusive. Major depression can be complicated by personality and social factors which cannot be adequately addressed except by pharmacological intervention. A critical part of the management of this condition therefore involves psychotherapy.

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The Ministry of Health in Jamaica has made Major Depression a Public Health priority. Towards this end the Zung Depression Index has been validated for Jamaica (24) and a short four-item questionnaire has been developed as a screening tool to be used in primary care settings in Jamaica.

The Ministry of Health has mounted a major public education programme to increase the understanding and awareness of Major Depression and has developed and implemented in collaboration with The Section of Psychiatry, The University of the West Indies, a training programme in the recognition and treatment of Major Depression and other common mental disorders for health personnel.

There is still a need for greater emphasis to be placed in areas of research and the management of this common disorder which is associated with high levels of psychosocial and physical impairment and which results in significant socio-economic burden. Hence the timeliness of the papers in this issue of the Journal by Maharaj *et al* (25) on depression in patients in chronic disease clinics and Lowe *et al* (26) on depression in adolescents.

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