Lifestyle Changings and Depression among the Married and Unmarried Nurses of Multan

Syed Muzaffar Hussain
Psychology & Counselling Program, School of Applied Psychology, SocialWork and Policy, College of Arts and Sciences, Universiti Utara Malaysia
Email: syedbzu@gmail.com

Saralah Devi Mariamdaram Chethiyar
Psychology & Counselling Program, School of Applied Psychology, SocialWork and Policy, College of Arts and Sciences, Universiti Utara Malaysia
Email: devi@uum.edu.my

Nabisah Binti Ibrahim
Psychology & Counselling Program, School of Applied Psychology, SocialWork and Policy, College of Arts and Sciences, Universiti Utara Malaysia
Email: nabisah@uum.edu.my

ABSTRACT

Purpose: The current research was directed to examine the association between lifestyle changings (age, marital status, duty hours) and depression among the married and unmarried nurses of Multan. Methodology. Data was taken from (n=150) nurses through stratified proportional sampling method. Hamilton Depression Rating Scale, Independent Sample T-Test and A Generalized Linear Regression Model studied relations between lifestyle aspects and depression. Main Findings: The result showed that lifestyles changings (age, marital status and duty hours) have significant positive relationship with depression. Regression findings revealed lifestyles changings (age, marital status and duty hours) were the significant predictors of depression. However, results also showed that mean score of depression was high in married nurses as compared to unmarried nurses. Application of this Study: The present study will help to understand the consequences of depression especially among nurses. Existing policies and coping strategies could be inquired and could probably to improve to better help this population. Nurses should make therapeutic lifestyle variations to improve their work-life balance and protect their functioning at work and individual well-being. Novelty/Originality of this Study: Based on this study, it is not only particular for professionals or nurses to be aware of depression toward better life in the Pakistani society but also to be educated the culture itself and clinical area.

Keywords: Life Styles Changings, Depression, Nurses, Multan.
Introduction

It is clearly valuable for grant to examine the relationship of neuropathological illnesses such as depression or certainly of emotional conditions like happiness with lifestyle aspects, yet to do this, there is a need first for a practical definition of “lifestyle”. Three eras ago, lifestyle was defined as “any distinctive and recognizable mode of living” Sobel and Rossi, (1984). We can also realize the term as including the main aspects making up a person’s health and well-being. Swarbrick (1997) describes another term, “wellness”, as “a conscious, deliberate process that requires a person to become aware of and make choices that help promote a more satisfying lifestyle”. Well individuals, for Swarbrick (1997), have healthy, stable habits. They sleep efficiently, they eat well, they exercise, and they are productive at work and have meaningful leisure pursuits and social relations. These things keep them in good physical and psychological health. Individuals who fail to sustain a healthy lifestyle can come to suffer from physical illness and risk their balance of mind (Paris et al. 2014).

It is often nurses who encourage patients to change their behavior in the sense of adopting a healthier lifestyle by Duffield et al. (2007). The clinical effectiveness of these interventions has been proven. So far, there have been few studies of ethnically Chinese nurses’ psychological well-being by Gao et al. (2012), especially in connection to lifestyle. Interestingly, interventions into patients’ lifestyles have rarely been tested on nurses themselves by Chan and Perry (2012). With the HKSAR population growing by over 7 million since 2014, nurses have to deal with the increasingly complex care of greater numbers of patients in hospitals. Unfortunately, nursing in Pakistan tends to be short-staffed and badly remunerated (Jasper et al. 2012). Nurses, further, often work under serious time pressure with inadequate resources and fractious colleagues (Xianyu & Lambert, 2006), and can sometimes encounter workplace violence (Lamont et al. 2012). With advances in medical technology, the public may have higher expectations of nurses’ professional behavior, putting nurses at higher risk of developing occupational stress and associated forms of psychiatric morbidity (Chung et al. 2012; Letvak et al. 2012). The main objective of the study to check the association between life style and depression.

Literature review

The World Health Organization (WHO) evaluations that, by 2030, depression will become one of the three leading causes of illness burden worldwide (Mathers & Loncar, 2006). The WHO also project that by 2020, the similar illness will be the second directing cause of poor health and mortality (WHO, 2012).
Depression is one of the closest relations with suicide in China (Peipins et al. 1997), and suicide is itself among the top five causes of death in all nurses, from the newly capable to retirees (Andersen et al. 2010).

In numerous countries, female nurses’ factors among the work-related groups recognized as being at raised risk of suicide. This risk may reflect work-related stresses with heavy workload, lack of autonomy and job discontent (Bakker & Demerouti, 2007). Current study has also highlighted how shift work is a major aspect causing stress and burnout among nurses (Stimpfel et al. 2012) two aspects closely related to depression. More meaningfully, nursing is mostly a female profession; depression is further more prevalent in females (Meeks et al. 2011). The present research examines possible relations between lifestyle and depression in nurses. Current study (Tanaka et al. 2011) outlines causal associations between lifestyle and depression in the overall population.

Another research was conducted on 9201 persons, aged between 40 and 69, revealed relations between physical inactivity, poor self-perceived health, chronic disease and depression (Tanaka et al. 2011). The research revealed that members of both genders with poor self-perceived health and chronic disease were more likely to become depressed. Multivariate analyses showed this increased risk of depression in male members who were physically inactive and had chronic illness, and in female members with a body mass index of 25 or more and poor self-perceived health. However, factors of both lifestyle and health status appeared as risk aspects for depression (Tanaka et al. 2011).

In these conditions, it is expected that nurses may have failed to establish actual stress-coping methods, in fact, take higher lifestyle risks with their health as compare to the population at large (Schluter et al. 2011). Current study on lifestyle generally emphasizes on clients. The experimental indication for nurses’ lifestyles over the last period is limited. This means little is known regarding the effect of unhealthy lifestyles on the working-age nursing people. There is a requirement for a recent study to fulfill this gap. Therefore, the present research was conducted to examine the association between lifestyle changing and depression among the married and unmarried nurses of Multan, Pakistan.

However, no local research has examined relations between lifestyle and depression among nursing professionals in Multan, Pakistan. Whereas some health professionals may have strong lifestyles in terms, of nutrition, they may undervalue how this can be weakened through unhealthy habits like not training or sleeping well. This study reporting correlation between lifestyle aspects and depression, highlighting a general conception of health as the basis for sustaining nurses’ psychological health.
METHODOLOGY

Participants
It is correlational research directed with nurses of Multan. Correlational research design was used. We recruited (n=150) nurses through nurses through stratified proportional sampling method in Multan, Pakistan. The sample consisted of 150 nurses in which (50% unmarried, 50% married). The research was approved by the Human Research Ethics Committee at the Children Hospital Multan.

Measures

Demographic Questionnaires
A set of queries were established to capture appropriate personal information regarding nurses. Nurses details included age, marital status and duty hours were the demographic variables of the current research. These demographic variables also used to consider and measure life styles of nurses.

Hamilton Depression Rating Scale (HDRS; Hamilton, 1960)
Hamilton Depression Rating Scale was originally developed by (Hamilton, 1960). Also measures signs of the previous week and contains of nine questions rated 0 to 4 and eight items rated 0 to 2, for a score range of 0-52 (Hamilton, 1960). HDRS is utilized to rate the severity of depression through assessing mood, insomnia, feelings of guilt, anxiety, suicide ideation, weight loss, retardation or agitation, and somatic symptoms. Participants with a score of 0 to 7 points considered normal, 8 - 13 as mild depression, 14 - 18 as moderate depression, 19 - 22 as severe depression and > 23 as very severe depression (Hamilton, 1960; Sarfo, 2019). The Cronbach’s alpha reliability of this scale is (α=.95).

Procedure
This research was accepted by the Institutional Review Board of the Psychology & Counselling Program, School of Applied Psychology, SocialWork and Policy, College of Arts and Sciences, Universiti Utara Malaysia. Before data collection could start, consent to select participants was required from school administrators and once consent was taken nurses were approached. Nurses were systematically informed about the aim of the research and those who permission were given the form to anonymously complete. Meanwhile this research employed paper-and-pencil scales for data collection. Those who agreed to the participate in research were given a set of the forms to fill. Questionnaires that were completed were concurrently ready for data analyses.

Analysis
Statistical analyses were conducted using the IBM SPSS Statistics: version 22 with significance set at (P=.05). The demographic variables showed participants were drawn from the ongoing working hospital and
nursing hostel, who were aged 21-30 (M= 25.58, s= 6.42) =120, duty hours (M=12.79, s=3.21). The participants were belonging to city 98 (64.9%), town 29 (17.2%) and from village 27 (17.9%). The sex split was 150 (100%) females. For the main study variables to ensure easy analysis and understanding, Pearson product moment correlation analysis, hierarchal regression analysis and Independent Sample T-Test were used.

RESULTS

Pearson Product Moment Correlation Analysis

The outcomes of the correlation analyses are described in Table 3. A significant positive relationship was observed between total score of age (r = .38, P = .05) with depression, total score of marital status (r = .86, P = .05) with depression and duty hours has also significant positive relationship (r = .68, P = .05) with depression. See Table 2 for summary.

Hierarchal Regression Analysis

A hierarchical regression was showed with age entered at the first step, marital status entered at the second step and duty hours entered at the third step. The results for the regression analysis are in 3. Findings revealed that models were significant. In the first step (ΔR² = .40, F (1, 147) = .20, P = .01) age was a statistically significant predictor (β = .26, P =.01), suggesting that age predicted depression. In the second model (ΔR² = .41, F (2, 146) = 17.8, P =.05) marital status (β = .30, P =.05) was significant predictor of depression. In the last model (ΔR² = .34, F (3, 145) = 17.8, P =.01) duty hours (β = .35, P =.01) was significant predictor of depression. In sum, the results showed that age, marital status and duty hours were significant predictors of depression.

Independent Sample T-Test Analysis

An equal variances t test shows a statistical reliable difference between the mean of marital status for married nurses’ depression (M=42.51, s=8.89) and mean score of unmarried nurses’ depression (M=34.52, s=10.64), t (67) =3.24, p=.00, α=.05. Findings showed that married nurses have higher level of depression as compare to unmarried nurses.

Table 1: Psychometric Properties of Questionnaires (n=150)

| Variables                        | K | M     | SD  | α   |
|----------------------------------|---|-------|-----|-----|
| Hamilton Depression Rating Scale | 09| 60.40 | 16.0| .85 |

Note: k= Number of Items in the subscales, M = Mean, SD=Standard Deviation, α = Reliability Co-efficient.
Table 2: Pearson Product Moment Correlation Analysis between Study Variables (n= 150)

| Variables        | Δ R²   | β     |
|------------------|--------|-------|
| **Predictors**   |        |       |
| Age              | .40**  | .26** |
| Marital Status   | .86**  | .30*  |
| Duty Hours       | .34**  | .35** |
| Total R²         | 44%    |       |

*. Correlation is significant at the 0.05 level (2 tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

Table 3: Hierarchal Regression Analysis Predicting Depression on Age, Marital Status and Duty Hours (n=150)

Note: *p < .05, **p < .01, ***p < .001.

Dependent Variable: Depression

Predictors in the Models: Age, Marital Status, Duty Hours.
Table 4: Independent Sample t-test between Demographic Variable Marital Status and Study Variables (n=150)

| Marital Status | t  | df | p   | Confidence Internal |
|----------------|----|----|-----|--------------------|
| Depression     | 3.24 | 67 | .00 | 3.06               | 12.92            |

Note: t= Statistical Difference, df= Degree of Freedom, p= Significance Value, LL= Lower Limit, UL= Upper Limit.

**DISCUSSION**

In various areas of the world, individuals are affected through their health like a result of inappropriate behaviors about their health care, that is to about, daily lifestyles that in the standard or long term will cause worsening of their health (Fincham et al. 2015). On the contrary, psychological health issues need primary exposure, particularly at an initial age, for better treatment and management, which is why this study intentions to provide detailed information regarding this population by its outcomes.

The initial detection of psychological issues and the purpose of lifestyles in nursing students are significant for what can make as a significance at the educational level and the need to develop timely management and decrease the effect of these states on the environment of the university (Ansari et al. 2014).

Unhealthy lifestyles were revealed in the majority of nursing students from 20 to 29 years of age, female, single, who did not have children, and those who only considered. There was also a substantial difference in lifestyles with the gender and an OR = 1.661. In relative to these outcomes, Hosseini et al. (2016) revealed that students who were married had a better health promotion behavior, though, Almutairi et al. (2018) showed that sex was a predictive aspect for unhealthy styles in students from Saudi Arabia. There are also coincidences with the research by Baeza et al. (2014) who shown moderate lifestyles in students. On the conflicting, Daesy et al. (2015) revealed that students had risk behavior that comprised alcohol consumption, inappropriate diets, and poor physical activity. Likewise, they vary from that found by Mak et al. (2018) who revealed students did not involve in dangerous behaviors about their health.

About depression, the majority of students showed a regular state though levels of mild, moderate, severe, and extremely severe depression were revealed in a lower amount in those students between 20 and 29 years of age, female, single marital status without kids, and who only devote themselves to research. A relationship was revealed between the students’ age and depression, and it was also statistically shown that it establishes a risk aspect for suffering depression. The findings associated to depression are similar to the research by Shamsuddin et al. (2013) because they revealed among their results that depression and anxiety
were higher in students 20 years and older; similarly, Abebe et al. (2018) found that depression (19.1%) and anxiety (23.6%) were related with the gender of the students. Likewise, Hamaideh et al. (2014) revealed in their research that the levels of depression were mild and that those who suffered were females, unlike Cheung et al. (2016) who found that depression levels were moderate to extremely severe in 24.3% of nursing students.

LIMITATIONS OF STUDY
The research is limited through its reliance on self-reported assessment of lifestyle aspects and depressive signs, which were anyway limited to a normal week before the research duration. Objective assessment of depressive signs (e.g., by clinical interviews) may yield diverse outcomes. Yet, our results persistently clinically applicable meanwhile self-reported depressive indications effect health and can specify the future onset of depression. The structure of our survey with self-selecting members may make it difficult to infer statistical results to the overall population. Moreover, the study’s cross-sectional design can only define statistical relations between lifestyle features and depression. A randomized control design or other experimental method would be essential to draw causal conclusions. A longitudinal survey research may, though, be a first significant step in this way.

CONCLUSION
The efforts of the nursing staff were an important factor in the extent to which the lifestyle habit changes succeeded. The present study measures the correlation between lifestyle and depression. Three lifestyle features (age, marital status and job hours) were related with lower levels of depression. The research study how lifestyle selections were associated to self-rated depression in the nursing profession. Depression is discouraging and can make it tough for sufferers to persistently active or make healthier lifestyle selections. The present research suggests improvements in both social and physical domains of health. However, to better determine the efficacy and sustainability of the intervention, larger studies over a longer period should be conducted.
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