

Depression Severity, Quality of Life, and Economic Burden: Informing Individualised Support for People with Psychosocial Disabilities

Aditya Parashar^{*1}, Piyush Mittal²

¹Department of Pharmacy Practice, Teerthankar Mahaveer College of Pharmacy, Teerthankar Mahaveer University, Moradabad, India, 244001, Corresponding Author E-mail: adityaparashar05@gmail.com

²School of Pharmacy, Sharda University, Greater Noida, India 201310

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Background: Depression is a leading cause of psychosocial disability worldwide, substantially affecting functioning, participation, health-related quality of life (HRQoL), and economic well-being. Beyond its clinical symptoms, depression limits individuals' ability to engage in education, employment, family life, and community participation. Understanding the relationship between depression severity, HRQoL, and economic burden is essential for developing individualised support strategies for people with psychosocial disabilities.

Methods: A prospective, observational, cross-sectional study was conducted among 357 adults diagnosed with clinical depression according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Participants were recruited from the Department of Psychiatry at Teerthankar Mahaveer University Hospital, Moradabad, India. Depression severity was assessed using the Patient Health Questionnaire-9 (PHQ-9). Health-related quality of life was evaluated using the WHOQOL-BREF and EQ-5D-5L instruments. Cost-of-illness data, including direct medical, direct non-medical, and indirect costs, were collected through patient interviews and medical records. Statistical analyses were performed using IBM SPSS Statistics version 31.0.

Results: Greater depression severity was significantly associated with poorer HRQoL across multiple domains. PHQ-9 scores showed a significant inverse correlation with the WHOQOL-BREF total score ($r = -0.212$, $p < 0.001$) and EQ-5D-5L utility values ($r = -0.311$, $p < 0.001$). Indirect costs demonstrated a significant positive correlation with WHOQOL-BREF total scores ($r = 0.120$, $p = 0.023$), while total cost of illness was also positively associated with HRQoL scores ($r = 0.126$, $p = 0.017$). Among the sociodemographic variables, only occupational status showed a significant association with EQ-5D-5L utility values ($p < 0.001$), indicating the importance of employment in functional well-being.

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Conclusion: Depression severity is closely associated with reduced health-related quality of life and increased economic burden among people with psychosocial disabilities. These findings highlight the importance of integrating routine assessment of symptom severity, functional outcomes, and economic burden to identify individuals requiring greater support. Individualised, multidisciplinary interventions that combine mental health care with psychosocial rehabilitation, educational and vocational support, and community-based services may enhance participation, improve quality of life, and promote inclusion for people living with depression.

Keywords: Depression; Psychosocial Disability; Health-Related Quality of Life; Cost of Illness; PHQ-9; WHOQOL-BREF; EQ-5D-5L; Individualised Support; Social Participation

Introduction: Depression is one of the most prevalent mental health conditions worldwide and a major contributor to disability, functional limitations, and reduced quality of life.^[1] According to the World Health Organisation (WHO), more than 280 million people live with depression globally, making it one of the leading causes of years lived with disability (YLDs) and a substantial contributor to the global burden of disease.^[2] In India, depression affects a considerable proportion of the population, with approximately one in twenty individuals experiencing the condition during their lifetime, representing a significant public health challenge with far-reaching social and economic consequences.^[3]

Beyond its clinical manifestations, depression is increasingly recognised as a psychosocial disability because of its profound effects on emotional regulation, cognition, interpersonal relationships, educational attainment, employment, and community participation.^[4] Persistent symptoms such as sadness, loss of interest, impaired concentration, fatigue, sleep disturbances, and reduced motivation often restrict individuals' ability to perform daily activities and participate fully in social, educational, and occupational settings.^[5] These limitations frequently result in social exclusion, stigma, reduced independence, and diminished opportunities for personal development, highlighting the importance of disability-inclusive approaches to mental health care.^[6]

The burden of depression extends beyond health outcomes to encompass substantial economic costs for individuals, families, healthcare systems, and society. These costs include direct medical expenditures, direct non-medical expenses, productivity losses, and informal caregiving, all of

which may increase with worsening symptom severity. Understanding this economic burden is essential for informing efficient allocation of healthcare resources and developing comprehensive support systems that address both clinical and social needs.^[7,8]

Health-related quality of life (HRQoL) has emerged as an important patient-centred outcome in depression research because it captures the broader impact of the condition on physical, psychological, social, and environmental well-being.^[9] Individuals with greater depression severity consistently report poorer HRQoL across multiple domains, reflecting the interaction between mental health symptoms and participation restrictions.^[10] Assessing HRQoL alongside economic burden provides a more comprehensive understanding of the lived experiences of people with depression. It supports the design of individualised interventions that extend beyond symptom reduction alone.^[11]

The COVID-19 pandemic further intensified the global burden of depression through prolonged social isolation, bereavement, financial insecurity, educational disruption, and reduced access to mental health services.^[12] Although India has strengthened mental health services through the integration of mental healthcare into primary care and national mental health initiatives, substantial treatment gaps, particularly in underserved and rural communities, continue to limit early diagnosis, continuity of care, and psychosocial rehabilitation. Persistent stigma surrounding mental illness also remains a significant barrier to help-seeking and sustained treatment adherence.^[13,14]

Reliable assessment of depression severity is fundamental for planning individualised care. The

Patient Health Questionnaire-9 (PHQ-9) is a validated, widely used instrument that classifies depression severity and supports clinical decision-making. In parallel, standardised measures such as the EuroQol Five-Dimension Five-Level questionnaire (EQ-5D-5L) and the World Health Organisation Quality of Life-BREF (WHOQOL-BREF) provide complementary assessments of health-related quality of life.^[15,16] The EQ-5D-5L, recommended by the Health Technology Assessment in India (HTAIIn), facilitates health utility measurement for economic evaluation. In contrast, the WHOQOL-BREF provides a multidimensional assessment encompassing physical health, psychological well-being, social relationships, and environmental factors that are particularly relevant to understanding psychosocial disability.^[17]

Despite increasing recognition of depression as a disabling condition, limited evidence from India has simultaneously examined the relationship between depression severity, HRQoL, and the economic burden of illness within the context of psychosocial disability. Understanding these interrelationships is essential for identifying individuals with greater support needs and for developing person-centred, individualised interventions that promote functional recovery, social participation, and inclusion. Therefore, the present study aimed to examine the association between PHQ-9 depression severity, health-related quality of life, and cost of illness among individuals with clinical depression, to inform individualised support strategies for people experiencing psychosocial disabilities.

2. Material and Methods

A prospective observational cross-sectional study was carried out in the psychiatry department at Teerthanker Mahaveer University Hospital, Moradabad, India, to assess the cost of illness and health-related quality of life among patients with depression.

2.1 Ethical approval- The research study was approved by the Institutional Ethics Committee, Teerthanker Mahaveer University, Moradabad, India, with reference no. TMU/IEC-INT/954-965/141.

2.2 Participants- We enrolled adult patients (18+ years) who had an affirmed diagnosis of persistent depressive disorder by a psychiatrist using the DSM-5. The exclusion criteria involve patients other than those with depression who come to the outpatient department, such as severe Cognitive deficits, as

guided by the clinicians. The participants were involved using a consecutive sampling approach.

2.3 Patient's consent- The participants, as well as caregivers, were notified about the study through a patient information sheet, and written informed consent was collected from them before initiation of the interviews.

2.4 Sample size- Sampling size was calculated using a standard two-step method. First, the opening sample size for an unknown or large population (n_0) was computed using the formula for proportions:

$$n_0 = \frac{(Z^2 \times p(1 - p))^2}{E^2}$$

Standard assumptions were applied, with a $Z = 1.96$ corresponding to a 95% confidence level (CI), p set at 0.5 to represent maximum variability, and a margin of error (E) of 0.05. Substituting these values into the formula gave

$$\begin{aligned} n_0 &= \frac{(1.96^2 \times 0.5 \times 0.5)}{0.05^2} \\ n_0 &= \frac{(3.8416 \times 0.25)}{0.0025} \\ n_0 &= \frac{0.9604}{0.0025} \\ &= 384.16 \end{aligned}$$

which was rounded to 384 as the initial required sample size.

Second, because the target population was finite, the finite population correction (FPC) was applied using the formula

$$n_0 = \frac{n_0}{[1 + (n_0 - 1) / N]}$$

where $n_0 = 384$ and N represents the total population size. Based on this correction, if the population size (N) was 500, the adjusted sample size became

$$\begin{aligned} n_0 &= \frac{384}{[1 + 383/500]} \\ n_0 &= \frac{384}{1.766} \\ &\approx 217 \end{aligned}$$

For a population of 1,000, the adjusted sample size was

$$\begin{aligned} n_0 &= \frac{384}{[1 + 383/1,000]} \\ n_0 &= \frac{384}{1.383} \end{aligned}$$

≈ 278

When the population was estimated to be 5,000, the corrected sample size was close to 357. For huge or effectively infinite populations, the required sample size remained close to the initial maintained proximity of 384.

$$n_0 = \frac{384}{[1 + 383/5,000]}$$

$$n_0 = \frac{384}{1.076}$$

$$\approx 357$$

2.5 Data collection: Conducted in-person interactions with the participants suitable for the study. Data collection came about over a 1 Year 3-month time frame from June 10, 2024, to Aug 10, 2025. The interaction was performed in the local language (Hindi) through a semi-structured patient

data collection form. It took approximately 10 to 20 minutes to make every interaction. Clinical information regarding participants was obtained through the interaction, complemented by patient medical records, which incorporated details on clinical history, diagnosis, and recommended treatment. This medical information in the data collection tools was indicated by clinicians during the data collection process.

The details of expenditure on direct medical (medicine, diagnostics, hospital bills), direct non-medical (associated travel, food), and indirect costs (loss of income of patients and caregivers) on outpatient as well as inpatient care were elicited for a month of treatment. The participants were newly diagnosed as well as previous patients with depression. STROBE Flow Diagram of Participant Recruitment and Selection for the Study, as mentioned in Figure 1.

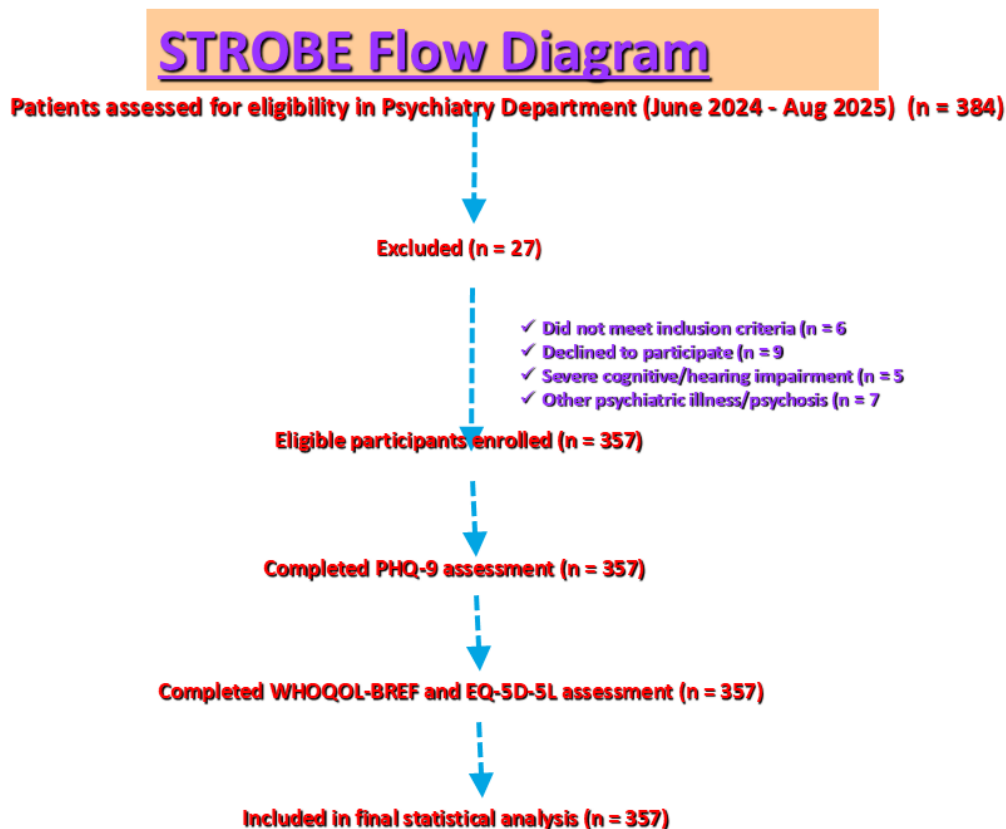


Figure 1 STROBE Flow Diagram of Participant Recruitment and Selection for the Study

2.6 Statistical analysis- Outcomes were evaluated after the study, and statistical analyses were done using IBM SPSS Statistics (31.0). Continuous variables were illustrated as mean ±SD, while categorical variables were provided as proportions. The level of

significance (α) was set at 0.05 for detailed assessments, and two-tailed tests were applied.

All continuous variables were tested for typically using the Shapiro–Wilk test and homogeneity of variances using Levene’s test to in order that assumptions of parametric analysis were met.

Regression analysis was used to establish the predictive influence of socioeconomic and demographic variables (e.g., age, gender, and education) on HRQoL as measured by the WHOQOL-BREF instrument, justifying its use for identifying significant factors of HRQoL among patients with depression.

Pearson's correlation analysis was used to appraise the magnitude and direction of linear relationships between continuous variables, specifically, depression severity (PHQ-9 scores), cost-of-illness parameters, and QoL domains. This method was chosen because the data met normality assumptions, taking into account a valid interpretation of linear associations.

One-Way ANOVA was conducted in order to figure out mean differences in QoL scores across groups with varying depression severity (mild, moderate, moderately severe, and severe). This test was appropriate use it determines whether statistically significant differences exist between the mean values of more than two independent groups when assumptions of normality and homogeneity of variance are satisfied.

The study aimed at investigating the association between depression severity, HRQoL and COI among patients diagnosed with depression. Further, an extensive understanding of the financial results of

clinical depression and its implications for resource allocation, decision-making, and the development of cost-effective interventions.

The utility value corresponding to the remarks on each participant was evaluated using the EQ-5D-5L Indian value set. The mean QoL in different domains of the WHOQOL-BREF was derived using the standard methods of analysis. The cost of illness on direct medical and direct non-medical components and indirect costs for outpatient consultation, as well as inpatient, was calculated on a per-visit basis to calculate the total non-medical cost of illness, while the medical cost of illness for outpatient care was calculated every month

3 Result:

A descriptive observational cross-sectional study was conducted in the psychiatry department of Teerthankar Mahaveer University Hospital, TMU, Moradabad, India. A total of 357 participants were in the study. The results were analysed descriptively to assess the characteristics of the study participants, along with their quality of life and cost of illness. The findings are presented across these domains to provide a comprehensive overview of the study outcomes. Results were analysed on the Characteristics of the study participants, quality of life and cost of illness.

Table 1: Characteristics of the study participants (n =357)

Characteristics	n=357	Percentage
Gender		
Female	191	53.50%
Male	166	46.50%
Educational qualification		
Illiterate	28	7.84%
Primary school	42	11.76%
Secondary school	186	52.10%
Graduate	83	23.25%
Postgraduate	18	5.04%
Age		
954-965 Year	217	60.78%
954-965 Year	110	30.81%
954-965 Year	27	7.56%
81 and Above Years	3	0.84%

Mean	36.89	
Range	954-965	
SD	14.38	
Marital Status		
Married	216	60.50%
Unmarried	102	28.57%
Divorced	9	2.52%
Separated	14	3.92%
Widow/Widower	16	4.48%
Occupation		
Service	81	22.69%
Professional	10	2.80%
Student	48	13.45%
Labour	39	10.92%
Business	67	18.77%
House wife	47	13.17%
Unemployed	19	5.32%
Farmer	9	2.52%
Non-Working/ Retired Personnel	11	3.08%
Dependent	26	7.28%
Comorbidity		
Anxiety Disorders	310	86.83%
Chronic Medical Conditions	220	61.62%
Obesity	212	59.38%
Eating Disorders	57	15.97%
Personality Disorders	30	8.40%

In Table 1, among 357 participants, the females consistently have a slightly higher proportion (53.5%). This study also indicates that economically active individuals (mean age 36.89 years) are more affected. This study considered key sociodemographic and clinical characteristics of participants to comprehensively understand the background factors that may influence the study outcomes. Study results demonstrated that the female gender predominance in the study population, with a greater number of

participants (more than 50%) being female. Gender was included to assess demographic variables for potential biological and social impact. Education is also a significant derived measure in the case of depression; like neuronal or psychiatric disorder, level of education plays a vital role, at least educated up to secondary level, and only a few participants are illiterate (7.84%). This also helps to identify the population. Age was considered in this study for the

evaluation of age-related or developmental, social, and psychological variables.

A greater number of middle-aged participants are in the study, which may indicate midlife crisis-like symptoms of a life stage. Conditions like marital status are also important social determinants. A maximum number of participants are married (60.50%), which also supports regression analysis, and in general terms, depression is not due to marital problems in our population. Occupation is a significant variable that contributes to measuring risk factors, as workplace-

related stress leads to the existence of other chronic health conditions considered. Participants have very variable occupations, so there is no clear predominance. Some dependents were also included in the study. Comorbidity in this study, including psychological and medical conditions, may modify the severity, progression and management of the primary condition. Anxiety disorder and chronic medical conditions are major contributors in our study population. One participant may have more than one comorbidity, as shown in the results.

Table 2: Analysis of association between sociodemographic status of participants and Quality of Life Instruments Transformed Scale, n=357

Demographic Characteristics	WHO QoL BREF					EQ5D5L				
	R	F	B	T	Sig	R	F	β	t	Sig
Gender	0.006	0.330	-0.033	-0.624	0.533	0.024	1.438	0.019	0.367	0.714
Education			-0.019	-0.350	0.727			0.021	0.386	0.700
Age			0.015	0.259	0.796			-0.025	-0.452	0.651
Marital Status			0.036	0.640	0.522			-0.004	-0.078	0.937
Occupation			0.040	0.724	0.470			0.146	2.661**	0.008
Comorbidity			0.029	0.536	0.593			0.009	0.167	0.867

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

In Table 2, Association Between Sociodemographic Factors and Health-Related Quality of Life Outcomes, assessed using the WHOQOL-BREF and EQ-5D-5L instruments, indicated that most demographic variables, such as gender, educational level, age, marital status, and presence of comorbid conditions, did not have a significant association with participants' perceived quality of life.

Regression analysis further supported these findings, demonstrating that sociodemographic characteristics were generally weak predictors of quality-of-life outcomes. For the WHOQOL-BREF domains, none of the demographic factors contributed significantly to variations in quality of life, suggesting that perceived well-being in this population was largely independent of basic demographic background.

Similarly, when quality of life was evaluated using the EQ-5D-5L instrument, most variables again failed to show any significant relationship. However, only occupational status emerged as an exception, showing a significant association with EQ-5D-5L outcomes. This finding suggests that employment-related factors such as job security, work environment, income stability, and functional independence may play an important role in shaping health-related quality of life.

Overall, the results indicate that while sociodemographic variables were largely unrelated to quality of life in this study population, occupation appears to be a potentially important determinant of perceived health status and well-being.

Table 3: Associations of depression severity and domain-specific quality of life among depressive patients.

Severity	Mild n=75	Moderate n=94	Moderately Severe n=117	Severe n=71	Overall n=357	Correlation (r)	p Value
WHO QOL BREF DOMEN							
Physical Health	49.52±24.32	48.33±13.34	36.48±9.32	43.51±28.37	43.74±19.65	-.140**	0.008

Psychological Health	45.56±19.43	51.95±14.85	22.90±8.70	40.43±29.64	38.80±21.73	-.181**	0.001
Social Relationships	46.11±16.74	42.99±10.17	25.14±9.41	38.50±24.45	36.90±17.47	-.180**	0.001
Environment	38.50±21.53	43.61±13.23	22.97±7.18	33.05±24.11	33.67±18.49	-.160**	0.002
WHO QOL BREF Total	44.43±14.70	46.99± 9.58	27.16±4.56	38.63±19.84	38.29±14.89	-.212**	<0.001
EQ5D5L							
Mobility	0.093±0.082	0.142±0.102	0.166±0.135	0.145±0.124	0.140±0.118	0.152**	0.004
Self-care	0.098±0.066	0.117±0.080	0.140±0.109	0.135±0.090	0.124±0.091	0.154**	0.004
Usual activity	0.099±0.066	0.143±0.124	0.165±0.094	0.141±0.087	0.138±0.088	0.159**	0.003
Pain/discomfort	0.133±0.134	0.133±0.083	0.128±0.107	0.193±0.161	0.146±0.131	0.147**	0.005
Anxiety/depression	0.055±0.057	0.073±0.064	0.068±0.058	0.083±0.062	0.070±0.061	0.138**	0.009
EQ5D5L Index Value	0.521±0.217	0.391±0.228	0.334±0.203	0.304±0.260	0.382±0.237	-0.311**	0.000

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

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

In Table 3, the analysis revealed a clear and consistent relationship between depression severity and health-related quality of life among participants. Across all domains of the WHOQOL-BREF, quality of life progressively worsened as symptom severity increased, demonstrating that individuals with more severe depressive symptoms experienced greater impairment in daily functioning and overall well-being. Physical and psychological health domains showed a particularly notable decline in quality of life. Social relationships and environmental well-being were also directly related to public communication, which also affects significant impact on quality of life. Overall quality of life, as reflected by the total WHOQOL-BREF score, showed a strong inverse relationship with depression severity, confirming a broad decline in life quality with increasing symptom burden.

Findings from the EQ-5D-5L further supported this pattern. Greater depression severity was associated with more pronounced difficulties across all dimensions, including mobility, self-care, routine activities, pain or discomfort, and emotional distress. The overall health index derived from the EQ-5D-5L similarly declined with worsening severity, reinforcing the conclusion that higher levels of depression are linked to poorer quality of life.

When we take it together, these results demonstrate that depression severity is a key indicator of health-related quality of life, with consistent evidence across two validated assessment instruments. The findings highlight the need for early identification and effective management of depressive symptoms to preserve functional ability and overall well-being.

Table 4: Correlation between QoL and cost metric n=357

Cost of illness	Mean ± SD	WHO QOL BREF		EQ5D5L	
		r	p Value	r	p Value
Cost of Illness (Direct Medical Cost)	1941.978±1560.63	0.53	0.315	0.0410	438
Cost of Illness (Direct Non-Medical Cost)	947.77±488.80	-0.25	0.643	022	672
Cost of Illness (Indirect cost)	5662.61±4162.61	0.120*	0.023	096	070
Cost of Illness (Total)	8552.35±4539.63	0.126**	0.017	100	059

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

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

The association between different components of the cost of illness and quality of life was examined using both WHOQOL-BREF and EQ-5D-5L measures. The findings indicated that direct medical and direct non-medical expenses were not meaningfully related to participants' perceived quality of life, as neither showed a significant association with outcomes on either assessment scale.

In contrast, indirect costs—reflecting productivity loss and functional impact—showed a significant, though weak, relationship with overall quality of life when assessed using the WHOQOL-BREF. Similarly, the total cost of illness was also significantly associated with WHOQOL-BREF scores, suggesting that the broader economic burden of the condition may influence individuals' overall perception of well-being.

However, when quality of life was evaluated using the EQ-5D-5L instrument, similar results were obtained, and the cost components—indirect and total costs, demonstrated a significant association.

Overall, the results suggest that the economic impact of illness, particularly costs related to loss of productivity, may influence subjective quality of life.

4. Discussion:

This study examined how depression severity influences HRQoL and economic burden in patients, assessed using the PHQ-9 and quality of life measures, the WHO QOL BREF and EQ5D-5L, as well as standard cost-of-illness components.

This result shows a clear, consistent pattern as increasing depression severity indicates lower or declining quality of life, and further, high indirect costs are also significantly associated with severe depression.

Sociodemographic characteristics presented in Table 1 show that among 357 participants, females consistently have a slightly higher proportion (53.5%). This study also indicates that economically active individuals (mean age 36.89 years) are more affected. Similar epidemiological studies conducted by Patel et al. (2018) and GBD mental health (2022) confirm that depression is more common in women and working-age groups, emphasising productivity losses [17,18,19]. The high prevalence of comorbid anxiety disorder 86.83% and chronic mental illness (61.62%) observed in this study is consistent. Kessler et al (2015) reported that depression rarely exists in isolation and commonly co-occurs with anxiety and lifestyle-related conditions. [20,21]

These comorbidities likely contribute to the observed decreases in QoL and higher indirect costs. In Table

2, none of the demographic variables, including gender, education, marital status or comorbidities, showed a significant association with the WHO QOL BREF score. These findings are consistent with Piccinelli et al (2000), who reported that psychological disorders have a stronger impact on QOL than demographic factors. [22] However, occupation showed a significant association with EQ5D5L score ($\beta=0.146$ and $P=0.008$), particularly affecting mortality due to working conditions or workplace stress. Similar associations were observed in the European DEPRES II survey, which reported that employment status influences health utility score more than other demographic variables. [20] This suggests that in developing countries, work-related functional impairment may reflect the true disability burden more effectively than demographic factors alone.

A strong negative relationship was observed in Table 3 between PHQ-9 severity and WHO QOL BREF domains. Physical health ($r=-0.140$, $P=0.008$) psychological health ($r=-0.181$, $p=0.001$) social relationship ($r=0.180$, $p=0.001$) environment ($r=-0.160$, $p=0.002$) and overall quality of life ($r=-0.212$, $p<0.001$) decline domain scores as severity is increases. This pattern is like Gao et al. (2019), who demonstrate that even moderate depressive symptoms lead to significant physiological impairment. [23]

The EQ5D5L reconfirm that finding in all domains – mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Worsening trends with a higher PHQ-9 severity score. A moderately strong negative correlation with severity ($r=0.311$, $p<0.001$), suggesting a decline in health utility. Furukawa et al. (2021) found moderate correlations ($r \approx 0.4-0.5$) between PHQ-9 and EQ-5D-3L scores in a Japanese general population sample, and similarly, Kolovos et al. (2017) reported a monotonic decrease in EQ-5D utility across depression severity levels. [24,25]

Together, these results confirm that HRQOL decreases are not only a psychological symptom but also extend deeply into social functioning, physical well-being, and environmental support.

Relationship between QOL and COI as discussed in Table 4, which highlights the indirect cost (mean $5662.61=-4162.39$) showed a significant positive correlation with ($r=0.120$, $p=0.023$) and borderline correlation with EQ5D5L ($r=0.096$, $p=0.070$). The total cost is also statistically significant ($r=0.126$, $p=0.017$). This suggests that a decline in QOL results in greater productivity loss and broader economic impact. This aligns with Luppá et al (2007) and Chisholm et al (2016), who estimated that 60% to 80%

of the cost of illness arises from indirect costs. Primarily due to absenteeism and functional impairment.^{26,27}

Direct medical and direct non-medical costs did not correlate significantly with QOL. This finding is expected in LMIC areas where health care utilisation is low, treatment gaps are exceeded by 70%, and patient cost remains limited to economic losses.

Overall analysis of the study clearly indicates that depression severity is a primary driver for both quality-of-life impairment and economic burden, while sociodemographic values show limited or non-significant predictive values. The dominance of indirect costs highlights that depression is a major burden in society that contributes more to productivity loss than to healthcare costs.

5. Limitations-

There are several limitations of this study. Firstly, being of a cross-sectional nature, this research does not permit the investigation of the causal relationship between the levels of depression and the studied HRQoL indicators and cost of illness. Secondly, the data on costs were obtained from patient self-reports, which could lead to a recall bias. Thirdly, being held in one specific hospital only, this study may lack generalizability as it can be specific to that particular institution and the population that was served there, rather than all patients with depression. Moreover, various factors such as treatment compliance, economic level, and social support system were not taken into account in this investigation, but could influence the results.

6. Conclusion-

The present study demonstrates that increasing depression severity is associated with poorer health-related quality of life and a greater economic burden among people with psychosocial disabilities. As symptom severity increases, impairments extend beyond clinical manifestations to affect physical

functioning, psychological well-being, social relationships, participation in daily activities, and financial stability. These findings highlight the multidimensional impact of depression and reinforce the need to evaluate outcomes beyond symptom reduction alone.

The combined assessment of depression severity, health-related quality of life, and cost of illness provide valuable evidence for identifying individuals with greater support needs and guiding person-centred care. Incorporating validated assessment tools such as the PHQ-9, EQ-5D-5L, and WHOQOL-BREF into routine clinical practice can facilitate early identification of functional limitations and enable timely, individualised interventions.

From a special education and disability perspective, the findings support the development of multidisciplinary, individualised support strategies that integrate mental health care with psychosocial rehabilitation, educational accommodations, vocational support, family engagement, and community-based services. Such approaches can enhance participation, improve quality of life, reduce the broader social and economic consequences of depression, and promote inclusion for people with psychosocial disabilities.

Further multicentre longitudinal studies are warranted to evaluate the long-term effectiveness of integrated support models and to inform policies that strengthen disability-inclusive mental health services and improve functional outcomes across diverse populations.

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Conflicts of interest

The authors declare that they have no conflicting interests.

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