Psychosocial factors associated with depression in women

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ABSTRACT
Depression is a condition characterized by unhappy feelings of hopelessness. It can be a response to stressful events, hormonal imbalances, biochemical abnormalities, or other causes. The study was conducted to find the extent of depression among women as per their socio-economic characteristics. The sample of 100 depressed women in the age group of 20-68 years was taken at random from Psychiatry Hospital of Srinagar. The study reveals significant relation of women’s age with their levels of depression. Women with better socio-economic indicators have shown less risks of depression. The major cause of depression among women is seen as their menopause or death in their family and broken family. This has adversely affected their social and family relations.

Keywords: Women, Depression, Socio-economic Characteristics

1. INTRODUCTION
Depression is more common in women than men and is especially common during the teen years. Men seem to seek help for feelings of depression less often than women. Therefore, women may only have more documented cases of depression. Depression is a highly prevalent condition, as confirmed by many national (Kessler et al., 1994; Angst, 1997; Lépine et al., 1997) and international studies (Ustun & Sartorius, 1995), with many possible outcomes. Predicting outcome at the time of diagnosis can have a strong clinical impact, since it can help to distinguish people in need of specific treatment from those likely to recover spontaneously. Nevertheless, studies of predictors of outcomes in depression show mixed results (Bagby et al., 2002). Research challenges include the need to determine if any specific predictor is independent of other predictors, and to know whether predictors identified in the USA and Europe are also valid in other settings. Brown and Moran (1997) conducted a study to examine the relationship between marital...
Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. True clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for an extended period. Depression is generally ranked in terms of severity—mild, moderate, or severe. The degree of your depression, which your doctor can determine, influences how you are treated. Symptoms of depression include trouble sleeping or excessive sleeping, dramatic change in appetite, often with weight gain or loss, fatigue and lack of energy, feelings of worthlessness, self-hate, and inappropriate guilt, extreme difficulty concentrating, agitation, restlessness, and irritability, inactivity and withdrawal from usual activities, feelings of hopelessness and helplessness, recurring thoughts of death or suicide. Low self-esteem is common with depression. So are sudden bursts of anger and lack of pleasure from activities that normally make you happy, including sex. Depressed children may not have the classic symptoms of adult depression. Watch especially for changes in school performance, sleep, and behaviour.

Major Depression
Symptoms tend to continue for at least 6 months.

Minor Depression
Depression is classified as Minor Depression if symptoms continue for at least 2 weeks.

Mild Depression
Depression accompanied by unusual symptoms, such as hallucinations (for example, hearing voices that are not really there) or delusions (irrational thoughts).

status, poverty, and depression in a sample of inner-city women. Single and married mothers were followed up over a 2-year period during which time rates of psychosocial risk factors, onset of depression and experience of chronic episodes were measured. Risk of onset was double among single mothers. Single mothers were twice as likely as their married counterparts to be in financial hardship, despite being twice as likely to be in full-time employment. Both of these factors were independently associated with onset in single mothers. The link between them and onset was via their association with humiliating or entrapping severe life events. Single parents were at a much-raised risk of experiencing these events. Onset was also more likely to follow such an event when women had poor self-esteem and lack of support, both of which were more common among single mothers. These risk factors were more frequently found among those in financial hardship. Financial hardship was also related to risk of having a chronic episode (lasting at least a year), of which single parents were also at greater risk. The majority of chronic episodes among single mothers had their origins in prior marital difficulties or widowhood and rates of chronicity reduced with length of time spent in single parenthood. Results are discussed in terms of an aetiological model of onset in which financial hardship probably influences outcome at a wide variety of points. Chermas (1997) presented descriptive study on depression, as perceived by 10 women. Guided by symbolic interactionism and feminist theory this qualitative study used semi-structured interviews, self-report measures, observations and participant self-reflective journals to elicit women’s views on depression and its affect on, and meaning in, their lives. The theme of loss of self was the central feature in their experiences that characterized depression and, in turn, affected their efforts in recovery and healing. Six other themes reflected their experiences in living with depression including: the transformed self, wanting and monitoring, the self as healer, revealing verses, concealing, acceptance and belonging, and making sense of depression—meaning and understanding. Miller et al. (1997) examined maternal religiosity as a protective factor against depression in offspring. Sixty mothers and 151 offspring were independently assessed over the course of a ten-year follow-up. Maternal and offspring religiosity were assessed based on self-report of the importance of religion, the frequency of attendance of religious services, and religious denomination. Depression was assessed using the Schedule for Affective Disorders-Lifetime version. Maternal bonding style was assessed through offspring report on the Parental Bonding Instrument. A series of logistic regressions were run to predict offspring depression status, taking into account maternal religiosity, offspring religiosity, and mother-offspring concordance of religiosity. Maternal religiosity and mother-offspring concordance of religiosity were shown to be protective against offspring depression, independent of maternal parental bonding, maternal social functioning, and maternal demographics. Maternal religiosity and offspring concordance with it may protect against depression in offspring. Kendler and Prescott (1999) obtained by telephone interview, a lifetime history of Major Depression (MD), defined by the DSM-III-R, from 3790 complete male-male, female-female, and male-female twin pairs, identified through a population-based registry. Results were analyzed using probandwise concordance, odds ratios, and biometrical twin modeling. The odds ratios (plus tetrachoric correlations) for lifetime MD were as follows: (1) male-male monozygotic, 3.29 (+0.37); (2) male-male dizygotic, 1.86 (+0.20); (3) female-female monozygotic, 3.02 (+0.39); (4) female-female dizygotic, 1.59 (+0.18); and (5) male-female dizygotic, 1.39 (+0.11). In the best-fitting twin model, the heritability of liability to MD was the same in men and women and equal to 39%, while the remaining 61% of the variance in liability was due to individual-specific environment. We rejected, with only modest confidence, the hypothesis that the genetic risk factors for MD were the same in men and women. The best-fitting model estimated the genetic correlation in the liability to MD in the 2 sexes to be +0.57. While we found no evidence to suggest a violation of the equal environment assumption, MD was less common in women from opposite-sex versus same-sex twin pairs. Major depression is equally heritable in men and women, and most genetic risk factors influence liability to MD similarly in the 2 sexes. However, genes may exist that act differently on the risk for MD in men versus women. Bifulco et al. (2002) examined adult attachment style in a high-risk community sample of women in relation to clinical depression. It utilized an interview measure of adult attachment, which allowed for an assessment of both type of attachment style and the degree of insecurity of attachment. A companion paper examines its relationship with other depressive vulnerability. The sample of 222 high-risk and 80 comparison women were selected from questionnaire screenings of London GP patient lists and intensively interviewed. A global scale of attachment style based on supportive relationships (with
Many women feel somewhat down after having a baby, but true postpartum depression is rare.

Postpartum Depression

Many women feel somewhat down after having a baby, but true postpartum depression is rare.

partner and very close others) together with attitudes to support seeking, derived the four styles paralleling those from self-report attachment assessments (Secure, Enmeshed, Fearful, Avoidant). In order to additionally reflect hostility in the scheme, the Avoidant category was subdivided into ‘Angry-dismissive’ and ‘Withdrawn’. The degree to which attitudes and behaviour within such styles were dysfunctional (‘non-standard’) was also assessed. Attachment style was examined in relation to clinical depression in a 12-month period. For a third of the series this was examined prospectively to new onset of disorder. The results show that the presence of any insecure style was significantly related to 12-month depression. However, when controls were made for depressive symptomatology at interview, only the ‘non-standard’ levels of Enmeshed, Fearful or Angry-dismissive styles related to disorder. Withdrawn-avoidance was not significantly related to disorder.

Bifulco et al., (2002) in another study found that whilst insecure attachment style has been shown to relate to major depression in women, its relationship to depression associated with childbirth is largely unknown. A new UK-designed measure (Attachment Style Interview for Adoption/Fostering: ASI) utilized across European and US centres allowed for an assessment of its wider utility as a risk marker for maternal disorder. The aim of this study was to establish the reliability of the ASI across European/US centres, its stability over a 9-month period, and to test associations of insecure attachment with characteristics of the social context and with DSM-IV major or minor depression. The ASI was used by nine centres antenatally on 204 women, of whom 174 were followed-up 6 months postnatally. Inter-rater reliability was tested on 35 cases and the ASI was repeated at 6-months postnatally on a subset of 96 of the 174 women. Affective disorder throughout pregnancy and to 6 months postnatally was assessed by means of the SCID. Satisfactory inter-rater reliability was achieved with relatively high stability rates at follow-up. Rates of insecure attachment for the total group were similar to previously published London rates despite significant variability across study centres. Insecure attachment related to lower social class position and more negative social context. It also related to DSM-IV major or minor depression both antenatal and postnatal. A specific association of Avoidant style (Angry-dismissive or Withdrawn) and antenatal disorder and anxious style (Enmeshed or Fearful) and postnatal disorder was found. The ASI can be used reliably in European and US centres as a measure for risk associated with childbirth. Its use will allow for theoretically underpinned preventative action for disorders associated with childbirth. Imura et al. (2005) examined the effect of aroma-massage (full body massage under the diffusion of aroma) among normal postpartum mothers. A quasi-experimental between groups design was used. Mothers who received aroma-massage were compared to a control group who received standard care on the maternity ward. Forty first-time normal postpartum mothers who have full-term healthy infants participated in this study. Twenty mothers received a 30-minute aroma-massage session on the second postpartum day, and gave saliva and completed four standardized questionnaires before and after the intervention: 1) Maternity Blues Scale; 2) State-Trait Anxiety Inventory (STAI); 3) Profile of Mood States (POMS); and 4) Feeling Toward Baby Scale. Findings showed that scores significantly decreased in the Maternity Blues Scale and each subscale of the POMS except the POMS-Vigor. Moreover, scores significantly increased in POMS-Vigor. The scores on Feelings toward Baby tended to increase more in the aroma-massage group. Salivary cortisol tended to decrease more in the aroma-massage group, but did not show significant decrease between two groups. Figueiredo et al. (2006) compared the experience of pregnancy in teenage years and later adulthood and to examine insecure attachment style as a risk factor for depression during pregnancy. The Attachment Style Interview (ASI; Bifulco, Moran, Ball, & Bernazzani, 2002) and the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) were administered to 66 pregnant adolescents and 64 adult women. Pregnant teenagers were found to be nearly three times more likely to have an insecure attachment style of Enmeshed, Angry-Dismissive, or Fearful style than adults, all at high levels of impairment. Logistic regression showed, when all risk factors were entered, highly Enmeshed style and poor partner support provided the best model for depression with age at pregnancy no longer adding. Insecure attachment style should be addressed in prevention and intervention strategies with teenage mothers.

2. OBJECTIVES OF THE STUDY

The study is carried out with following objectives:
1. To find the extent of depression among women
2. To assess depression among women as per their socio-economic characteristics
3. To observe the cause and effect of depression on women

3. MATERIALS AND METHODS

The primary data was collected from Jammu and Kashmir State in India. The study was based on 100 women suffering depression. The sample women in the age group of 20-68 years were selected randomly from Psychiatry Hospital of Srinagar. In order to achieve the objectives of the study, the detailed interview schedule was constructed to get the
intricacies of the problem. All statistical analyses were conducted using the Statistical Package for the Social Sciences (SPSS) for Windows 10.1. The data was systematically analyzed computing row and column percentages, chi-square ($\chi^2$), levels of significance and degrees of freedom (d.f). The three levels of significance were obtained at $p<0.01$ i.e., highly significant; $p<0.05$ i.e., significant and $p\geq 0.05$ i.e., insignificant; where $p$ indicated probability values. Age of the sample was divided into three categories, i.e., young adulthood (20-30 years of age), middle adulthood (30-40 years of age) and late adulthood and old age (40-68 years of age). Family status was obtained as per sample’s family income. Low-income group depicted a family earning up to Rs 3000 per month, medium income group presented earning of Rs 3000-7000 per month, and high-income group comprised earning of Rs 7000 per month.

## 4. RESULTS

Depression (and even sub-syndromal depression) is highly associated with disability (Wells et al., 1989) and future relapse or recurrence (Keller et al., 1986), the low prevalence of complete remission at follow-up (from 25% in Porto Alegre to 48% in Barcelona) is an important finding. Mynor-Wallis et al. (2000) in the UK found higher proportions (56–66%) of complete remission at 1-year follow-up in a non-naturalistic study in a primary care setting. Simon (2000) found 45% remission from a 6-month follow-up period in a naturalistic primary care study in the USA. Differences between studies in overall remission rates may reflect differences in screening, selection procedures or levels of treatment. In any case, major depression is not a benign condition for the majority of primary care patients.

**Table 1** shows extent of depression among women as per their age and family status. It is observed that women generally have depression in their middle adulthood (30-40 years) by 42 per cent. Majority of women suffer major depression by 42 per cent. However, 48 per cent women suffer dysthymia during their late adulthood or old age (after 40 years). Depression is observed more in women belonging to high-income group by 42 per cent than only 25 per cent women in low-income group. In addition, 54 per cent women in high-income group suffer major depression than only 11 per cent women belonging to low income group. Dysthymia is found more among women in middle-income group by 36 per cent. Highly significant relation ($p<0.01$) is found between age of women and the type of depression suffered by them. Similarly, significant relation ($p<0.05$) is seen between family status of women and the type of depression suffered by them.

**Table 2** observes depression among women as per their marital status, dwelling and economic status. It is found that widows and divorcees are more in depression by 39 per cents respectively than married and unmarried women (8 per cent and 14 per cent respectively). About 38 per cent divorcees and 33 per cent widows have major depression; whereas only 11 per cent married and 16 per cent unmarried women suffer major depression. Unmarried women are more in depression than married women. Widows and divorcees equally suffer Dysthymia by 41 per cents respectively. However, such differences between extent of depression and marital status of women is observed statistically insignificant ($p>0.05$). Urban women by 65 per cent are suffering depression than only 35 per cent of rural

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**Table 1**

Depression among Women as per their Age and Family Status (n=100)

<table>
<thead>
<tr>
<th>Indices</th>
<th>Age of Women **</th>
<th>Family Status of Women *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Young Adulthood (20-35 Years)</td>
<td>07</td>
<td>16.66</td>
</tr>
<tr>
<td>Middle Adulthood (35-40 Years)</td>
<td>21</td>
<td>50.00</td>
</tr>
<tr>
<td>Late Adulthood and Old Aged (&gt; 40 Years)</td>
<td>14</td>
<td>33.33</td>
</tr>
<tr>
<td>Women of All Ages (20-68 Years)</td>
<td>42</td>
<td>42.00</td>
</tr>
</tbody>
</table>

**Family Status of Women *  

- Low Income Group
- Middle Income Group
- High Income Group

**Dysthymia**

A generally milder form of depression that lasts as long as two years.

**Premenstrual dysphoric disorder (PMDD)**

Depressive symptoms occur one week prior to menstruation and disappear after they menstruate and Seasonal affective disorder (SAD)—occurs during the fall-winter season and disappears during the spring-summer season, likely to be due to lack of sunlight.

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women, though there may be unreported cases of depression among women in rural areas. About 78 per cent women in urban areas suffer major depression as compared to only 21 per cent rural women. About 53.65 per cent urban and 46 per cent rural women suffer Dysthymia. However, such differences between dwelling of women and the type of depression suffered by them are statistically found insignificant (p<0.05). As far as economic activity of women is concerned, non-working women are found more in depression by 83 per cent than only 17 per cent working women. Among non-working women, 88 per cent of them have major depression, followed by 82 per cent Mild Depression and 78 per cent dysthymia. However, among working women, 11 per cent have major depression, followed by 21 per cent dysthymia and 17 per cent Mild Depression. Such differences between various types of depression and economic activity of women are found highly significant at 0.01 level.

For most people a steady and rewarding job can really help to reduce the risk of depression. People who have recently been made redundant, or who have been out of work for many months, are more likely to become depressed than those who are able to carry on working. Work, therefore, has a largely beneficial impact on mental health, but there are circumstances in which it can be less helpful. Although there is little evidence that poor working conditions can directly cause depressive illness, undue pressure and stress at work can combine with other problems, such as difficulties at home or recent unhappy events, and contribute to the development of depression. Work is generally good for mental health. However, there are times when it can be harmful. There is little evidence that poor working conditions can directly cause depressive illness. However, pressure and undue stress at work combined with other problems, such as difficulties at home can make depression more likely to occur. Many surveys have shown that certain kinds of work are more likely to make people unhappy in their workplace. Jobs in which an employee cannot use his or her skills, or which are repetitive, and are the same every day, seem particularly likely to make people fed up with their work.

Certain symptoms can give a clue that someone is suffering from the kind of depression that will need help. These may include sadness which does not change from day to day, crying for no apparent reason, anxiety, worrying, irritability or tension, disturbed sleep, reduced appetite and change in weight, tiredness, lethargy and lack of motivation, loss of interest in normal activities, forgetfulness and poor concentration and thoughts of worthlessness and hopelessness. Figure 1 presents major symptoms of depression among women and the causes of depression among them. It is found that 33 per cent depressed women have disturbed sleep, followed by poor concentration (20%

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per cent), lethargy (17 per cent), irritability (16 per cent) and reduced appetite by 14 per cent. Depression often runs in families. This may due to genes (inherited), learned behavior, or both. Even if genes make more likely to develop depression, a stressful or unhappy life event usually triggers the onset of a depressive episode. Depression may be brought on by:

- Alcohol or drug abuse;
- Childhood events like abuse or neglect;
- Chronic stress; death of a friend or relative;
- Disappointment at home, work, or school (in teens, this may be breaking up with a boyfriend or girlfriend, failing a class, or parents divorcing);
- Drugs such as sedatives and high blood pressure medications;
- Medical conditions such as hypothyroidism (underactive thyroid), cancer, or hepatitis;
- Nutritional deficiencies (such as a lack of folate and omega-3 fatty acids);
- Overly negative thoughts about one’s self and life, self blame, and ineffective social problem solving skills;
- Prolonged pain or having a major illness;
- Sleeping problems; and
- Social isolation (common in the elderly)

Figure 1 shows that death in family is the major cause of depression among 30 per cent women. Menopause is also seen as a leading cause of depression for them by 28 per cent. Failure in career (10 per cent) and heavy workload (10 per cent are other causes of depression among women. Moreover, broken family is the cause of depression for 22 per cent women. If a person is depressed for 2 weeks or longer, she should contact doctor, who can offer treatment options. Regardless of whether she has mild or major depression, the following self-care steps can help:

- Get enough sleep
- Follow a healthy, nutritious diet
- Exercise regularly
- Avoid alcohol, marijuana, and other recreational drugs
- Get involved in activities that make you happy, even if you don’t feel like it
- Spend time with family and friends
- Try talking to clergy or spiritual advisors who may help give meaning to painful experiences
- Consider prayer, meditation, tai chi, or biofeedback as ways to relax or draw on your inner strengths
- Add omega-3 fatty acids to your diet, which you can get from cold-water fish like tuna, salmon, or mackerel
- Take folate (vitamin B9) in the form of a multivitamin (400 to 800 micrograms)

Women suffering from depression can start to behave out of character, both at home and at work. The common effects of depression are working slowly, making mistakes more often, unable to concentrate, forgetful, late for work or meetings, not turning up, getting into disputes and arguments with colleagues, unable to delegate tasks and working, or trying to work, much too hard. Figure 2 shows effect of depression on women. Depression has led to disputes and arguments with family members and/or colleagues for 28 per cent women. About 25 per cent women are not about to concentrate properly on their work due to depression. Moreover, 10 per cent women work slowly and 17 per cent women go late for work due to their depression. Forgetfulness is another effect of depression on 20 per cent women. Depression can seriously affect women’s ability to work effectively. It may be so bad that she will have to stop work completely for a time. When it is not quite that bad, most women try to soldier on, painfully aware

![Figure 2](image_url)

**Figure 2**
Effects of Depression and Home Care
that they are not doing their job as well as they usually do. If women’s depression can be recognised and helped, they will get back much more quickly to their normal performance at work. Much needless unhappiness and suffering can be avoided.

Many women with mild depression start to feel better once they have talked over their problems with someone. The majority of women with more severe depression can be helped by a number of treatments which can be provided by doctors or other trained professionals. Which treatment is best depends both on the type of depression and on the particular needs of the women concerned. There are two main types of treatment: talking treatments (such as problem solving), Cognitive Behavioural Therapy, or other forms of psychotherapy, and antidepressant tablets. All of these are given as a course of treatment over a period of months. They can be used on their own or together. Many women worry that antidepressant tables can be addictive, but there is no evidence for this. As with most other common illnesses, most women with depression will recover completely and will be able to start working again as usual. Figure 2 presents home care for the prevention and treatment of depression, initiated by women, in addition to proper medical treatment. About 30 per cent women consider prayer and meditation as best measure to relieve their depression. Nearly per cent depressed women initiate avoidance of alcohol and other recreational drugs. Moreover, 20 per cent depressed women prefer to spend their time with friends and relatives. About 26 per cent depressed women exercise regularly and 10 per cent of them follow nutritious dietary pattern.

5. CONCLUSION
Depression is found mostly among women in middle adulthood. Non-working women are more prone to depression than working women. Moreover, women from higher and middle-income group families suffer depression more than women from low-income group. Depression is also seen more common among urban women than rural women are. Widows and divorcee women are also at high risks of depression than married and unmarried women. The most common symptom of depression among women is disturbed sleep and poor concentration. They have disputes and arguments with their family members and colleagues. Most of the women consider prayers and meditation in order to relieve their depression.

SUMMARY OF RESEARCH
1. Depression mostly occurs among women in their middle age.
2. Depression has adversely affected their family and social life.
3. The major cause of depression is menopause, followed by death in family, broken family, workload and failure in career.

FUTURE ISSUES
Depression among women is increasing day by day and is a very serious concern for study. It is important to go in-depth study in order to find out the roots causes of depression among women and eliminate them.

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