

Original Research Article

Prevalence and role of social factors and personal attitude in occurrence of depression in married women in urban and rural areas of district, Amritsar, India

Ekta Arora*, Jasleen Kaur, Shyam Sunder Deepti, Tejbir Singh, Mohan Lal

Department of Community Medicine, Government Medical College, Amritsar, Punjab, India

Received: 29 November 2016

Revised: 09 December 2016

Accepted: 23 December 2016

*Correspondence:

Dr. Ekta Arora,

E-mail: aroraekta09@gmail.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Depression is not "one size fits all," particularly when it comes to the genders. Many factors contribute to the unique picture of depression in women-from reproductive hormones to social pressures to the female response to stress. It is estimated that by the year 2020, the burden of depression will be increased to 5.7% of the total burden of the disease.

Methods: A cross sectional study was conducted and 1000 married females were selected by systematic random sampling from rural and urban areas of District, Amritsar, India. Pretested and predesigned questionnaire and PHQ9 scale was used to obtain valid results.

Results: In this study, 269 women are found to be suffering from depression as per the scale applied. Respondents having no social involvement are more prone to depression (31.1%) and majority of those, who faced some problem in public places, were found to be depressed (28.8%). 11.2% women were depressed amongst those who act skilfully in response to a problem. 29.6% amongst those who got panic while 34.7% were found to be depressed amongst those who had an escapist attitude.

Conclusions: Awareness through public education, early detection and organized national mental health programs can curb the increasing epidemic of depression.

Keywords: Depression, Married women, Social Factors, Personal attitude of women, PHQ9 scale

INTRODUCTION

Modern civilization, technological complexity and rapidly changing social values contribute to changing pattern of health and disease in the society. Gradually changing life style, westernization, changing social support, changing relationships and family bonding could be factors contributing to this change. Depression is a serious condition that can impact every area of our life. The term depression describes a wide range of emotional

laws, from mere sadness to a pathological suicidal state.¹ Today, depression is estimated to affect 350 million people.¹ It is estimated that by the year 2020, the burden of depression will increase to 5.7% of the total burden of the disease and by 2030; it is expected to be the largest contributor to disease burden.^{2,3} Women are about twice as likely as men to suffer from depression. This two-to-one difference persists across racial, ethnic, and economic divides. One out of eight women will have an episode of major depression at some time in her life.⁴

A study on depression in married women revealed that 32.9% of study respondents had poor mental health and only about 10% of these women had sought any kind of mental health services.⁵

Social factors can play a part in causing depression in women, along with lifestyle choices, relationships, and coping skills. Friction, hostility, and a lack of affection are other major contributors.⁶

According to Diagnostic and Statistical Manual of Mental Disorder (DSM-5), depressive symptoms include feeling sad or empty, markedly diminished interest or pleasure in activities, weight gain or loss, insomnia or hypersomnia, psychomotor agitation, fatigue, feeling of worthlessness, diminished ability to think or concentrate and recurrent thoughts of deaths.⁷

The main treatment approaches are psychotherapy and antidepressant therapy. But most important approach is self-help. Regular exercise, practicing relaxation techniques, trying to keep up with social activities are other measures to keep ourselves feel better.

METHODS

A cross sectional study was done from: 1st January 2015 to 31st December 2015 with a sample size of 1000. The study was conducted under urban and rural field practice area of Department of Community Medicine, Government Medical College, Amritsar after approval from institutional thesis and ethics committee and informed consent of the patient was taken. Those married women who gave consent were included in the study while those women who refused consent, widows and married daughters who visited their parents' home at the time of interview were excluded.

The list of all villages and wards was procured from Municipal Corporation office. 5 villages and 5 wards were selected randomly from the list. From every selected area (village or ward), 100 houses were selected by systematic sampling technique for the study i.e. (total number of houses in the village/ total number of houses to be taken for study).

From every house one eligible person was enrolled. If more than one married women were present, then one member was selected by lottery method. In case, there was no eligible person in the selected house, the very next house was included in the study. The first part of the Questionnaire included socio- demographic information of the women and the second part included questions on various factors which could be deemed responsible for depression, designed specifically for the purpose of study. The third part of the Questionnaire was Patient Health Questionnaire- 9 (PHQ-9). After filling the predesigned and pretested Performa, the data collected was compiled and analysed statistically and valid conclusion have been drawn.

Criteria used in study

Patient health questionnaire-9 (PHQ-9) is multipurpose instrument for screening, diagnosing, monitoring and measuring severity of depression. PHQ-9 incorporates DSM- IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.

Interpretation of total score - Depression severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression

RESULTS

In the study, the prevalence of depression was found to be 24% in rural areas while 29.8% in urban areas (See Table 1).

Table 1: Distribution of respondents according to depression in rural & urban areas.

	Rural (%)	Urban (%)	Total
Depressed	120 (24)	149 (29.8)	269 (26.9)
Non- depressed	380 (76)	351 (70.2)	731 (73.1)
Total	500	500	1000

Out of total, 29.6% and 26.6% respondents were depressed belonging to General and Scheduled Caste respectively (See Table 2).

Table 2: Distribution of respondents according to caste.

Caste	Depressed (%)	Non-depressed (%)	Total (%)
General	101 (29.6)	240 (70.4)	341(100)
OBC	7 (14.6)	41(85.4)	48 (100)
SC	161 (26.6)	443 (73.3)	604 (100)
Others	0	7(100)	7 (100)
Total	269	731	1000

Chi - 7.58; P>0.06.

Table 3 shows that out of total, 45.5% Hindus were depressed whereas only 24.7% Sikhs were depressed. Table 4 show that equal number of respondents were found to be depressed from nuclear and non-nuclear families and this association is not found to be significant statistically. Women performing religious rituals are more depressed (29.04%) as compared to those who are not involved in any religious rituals (25.8%) (See Table 5). Out of 946 women, who had first marriage, 28.4% were depressed while out of 54 women who had remarriage, none was found to be depressed. This

association was found to be significant statistically (See Table 6).

Table 3: Distribution of respondents according to the religion.

Religion	Depressed (%)	Non –depressed (%)	Total (%)
Hindu	55 (45.5)	66 (54.5)	121(100)
Sikh	196 (24.7)	595(75.2)	791(100)
Others	18 (20.5)	70 (79.5)	88 (100)
Total	269	731	1000

Chi - 24.85; P<0.05.

Table 4: Distribution of respondents according to the type of family.

Type of family	Depressed (%)	Non-depressed (%)	Total (%)
Nuclear	185 (26.9)	503(73.1)	688 (100)
Non-Nuclear	84 (26.9)	228 (73.1)	312 (100)
Total	269	731	1000

Chi – 0; P>0.05.

Table 5: Distribution of respondents according to the religious involvement.

Perform religious rituals	Depressed	Non – depressed	Total
Yes	97 (29.04)	237 (70.9)	334 (100)
No	172 (25.8)	494(74.2)	666 (100)
Total	269	731	1000

Chi – 1.17; P>0.05.

Table 6. Distribution of respondents according to the Marital Status.

Marital Status	Depressed (%)	Non - depressed (%)	Total (%)
First Marriage	269 (28.4)	677 (71.6)	946 (100)
Re-marriage	0	54 (100)	54 (100)
Total	269	731	1000

Chi -21.006; P<0.05.

Out of 1000, 492 women had a friend circle, of which 22.6% were depressed. While out of 508 women, who didn't have a friend circle, 31.1% were found to be depressed (See Table 7). This association was found to be significant when analyzed statistically.

337 women have faced a problem in market or other place and amongst them, 28.8% were depressed. While out of 663 women who hadn't faced any problem in market or public place being a women, 25.9% were depressed as per the scale applied (See Table 8).

11.2% women were depressed amongst those who act skillfully in response to a problem. 29.6% amongst those who got panic were found to be depressed whereas 34.7% were found to be depressed amongst those who had an escapist attitude (See Table 9). This is also a significant association as determined statistically.

Table 7: Distribution of respondents on the basis of friend circle.

Friend circle	Depressed (%)	Non depressed (%)	Total (%)
Yes	111 (22.6)	381 (77.4)	492(100)
No	158 (31.1)	350 (68.9)	508(100)
Total	269	731	1000

Chi-9.273; P<0.05.

Table 8: Distribution of respondents on the basis of social problem being faced.

Faced problem in market or public place	Depressed (%)	Non depressed (%)	Total (%)
Yes	97 (28.8)	240 (71.2)	337(100)
No	172 (25.9)	491(74.1)	663(100)
Total	269	731	1000

Chi – 0.917; P>0.05.

Table 9: Distribution of respondents on the basis of attitude towards problems.

How you react to problems?	Depressed (%)	Non Depressed (%)	Total (%)
Act skillfully	22 (11.2)	175 (88.8)	197(100)
Panic	133 (29.6)	316 (70.4)	449(100)
Seek help from others	13 (14.7)	76 (86.4)	88(100)
Escapism	68 (34.7)	128 (65.3)	196(100)
Others	34 (48.6)	36 (51.4)	70(100)
Total	269	731	1000

Chi – 56.002; P<0.05.

DISCUSSION

A study by Bohra et al found that the prevalence rates of depression from India range from 1.5/1000 to 37.74/1000. The lifetime prevalence of Depression is 10–25% for women. WHO states that the burden of depression is 50% higher for females than males and Indians are reported to be among the world's most depressed.⁸ In the present study, the prevalence of depression was found to be 24% in rural areas while 29.8% in urban areas, while overall prevalence came out to be 26.9%. This is in concordance with the above mentioned study.

Studies have suggested that individuals with no religious affiliation are at greater risk for depressive symptoms and disorders, while people involved in their faith communities may be at reduced risk for depression⁹. Women with a diagnosis of major depression before 18 years of age were significantly more likely to stop attending religious services as an adult than women with no diagnosis of major depression or a diagnosis after the age of 18. There were no significant associations between religious involvement and men¹⁰. In this study, performing religious rituals are associated with depression and this is a non-significant finding.

According to a study by Hiyoshi et al., remarriage following divorce is not associated with a reduced risk of depression. Interpersonal or financial difficulties resulting from remarriage may outweigh the benefits of marriage in terms of depression risk¹¹. The high prevalence of depression in separated or divorced individuals is due to both an increased risk of marital disruption in those with major depression, and also to the higher risk of this disorder in those with divorced or separated marital status. Thus a clinically significant interplay exists between major depression and marital status. Exposure to depression doubled the proportion of transitions from married to separated or divorced status (95% CI 1.4-2.9 $P < 0.001$). Conversely an increased proportion of non depressed individuals with separated or divorced status subsequently experienced major depression (95% CI 1.0-1.5 $P = 0.04$).¹²

It is found that those who have friends go through life smoothly as compared to others who are socially isolated. Depression is a disease of loneliness. Many untreated depressives lack friends and it becomes hard for them to speak or hear words of comfort.¹³ A study by Hou et al. revealed that prevalence of depressive symptoms was 12.4% in women with lower social support. Younger age and greater social support were negatively associated with depression.¹⁴ whereas in the present study, 22.6% women with no friend circle were depressed.

Numerous studies have documented associations between social problem solving and depressive symptoms. Depressed individuals often exhibit a negative orientation towards problems in living (e.g., appraising a problem as a threat, doubting one's own problem-solving ability) and deficits in specific problem-solving skills and performance-based measures¹⁵. The results of the present study are in concordance with the above mentioned statement.

CONCLUSION

- Women should have friend circle so that they can open their minds with them
- Practicing relaxation techniques like yoga, deep breathing, progressive muscle relaxation, or meditation, aiming for 8 hours of sleep, trying to keep up with social activities

- Indulging in rituals can be a reason for depression.
- If they are unable to handle real life problems, they should go for counselling by a professional trainer or they shouldn't hesitate to seek help from others
- But most important approach is SELF-HELP

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. Marcus M, Taghi YM, Van OM, Chisholm D, Sexsena S. Depression: A global public health concern. [Internet]. [cited 2016 Oct 19]; Available from: http://www.who.int/mental_health/management/depression/who_paper_depression_wf_mh_2012.pdf.
2. Grover S, Dutt A, Avasthi A. An overview of Indian research in depression. *Indian J psychiatry*. 2010;52(suppl 1):178-88.
3. World Health Organisation; Global Burden of Disease (2008): 2004 update. Geneva: World Health Organization. [Internet]. [cited 2016 Oct 19]; Available from: http://www.who.int/healthinfo/global_burden_diseases/GBD_report_2004update_full.pdf.
4. Depression in married women; [cited on 16 Oct 18]. Available from: http://www.health.harvard.edu/newsweek/women_and_depression.htm
5. Study of depression in married women in India; [cited on 16 Oct 19]. Available from: <http://www.hindawi.com/journals/bmri/2014/97982>.
6. Social causes of depression; [cited on 16 Oct 18]. Available from: <http://www.personality.org/papers/beattie.html>
7. Diagnostic and statistical manual of mental disorder text revision. 4th ed. American Psychiatric association; 2000.
8. Bohra N, Srivastava S, Bhatia MS. Depression in women in Indian context. *Indian J Psychiatry*. 2015;57(Suppl 2):S239-45.
9. Blazer D. Religion/Spirituality and Depression: What Can We Learn From Empirical Studies? *Am J Psychiatry*. 2012;169(1):10-2.
10. Maselko JI, Buka S. Religious activity and lifetime prevalence of psychiatric disorder. *Soc Psychiatry Psychiatr Epidemiol*. 2008;43(1):18-24.
11. Hiyoshi A, Fall K, Netuveli G, Montgomery S. Remarriage after divorce and depression risk. *Soc Sci Med*. 2015;141:109-14.
12. Bulloch AG, Williams JV, Lavorato DH, Patten SB. The relationship between major depression and marital disruption is bidirectional. *Depress Anxiety*. 2009;26(12):1172-7.
13. Depression is a disease of loneliness. *The Guardian* [Internet]. 2016 Aug 16 [cited 2016 Oct 14]; Available from: <https://www.theguardian.com/>

commentisfree/2014/aug/16/depression-disease-loneliness-friends.

14. Hou F, Cerulli C, Wittink MN, Caine ED, Qiu P. Depression, social support and associated factors among women living in rural China: a cross-sectional study. *BMC Womens Health*. 2015;15:28.
15. Klein DN, Leon AC, Li C, D’Zurilla TJ, Black SR, Vivian D, et al. Social Problem Solving and Depressive Symptoms Over Time: A Randomized Clinical Trial of Cognitive Behavioral Analysis

System of Psychotherapy, Brief Supportive Psychotherapy, and Pharmacotherapy. *J Consult Clin Psychol*. 2011;79(3):342-52.

Cite this article as: Arora E, Kaur J, Deepti SS, Singh T, Lal M. Prevalence and role of social factors and personal attitude in occurrence of depression in married women in urban and rural areas of district, Amritsar, India. *Int J Community Med Public Health* 2017;4:446-50.