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"Psychosocial Functioning in Women with Depression"

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Abstract

Introduction:

The World Health Organization (WHO) rated depression as the third leading cause of disease burden in 2008, with the disorder expected to rise to first place by 2030. Depression is not only the most common women's mental health problem but more persistent in women than men, as reported by World Health Organization and Indians are reported to be the highest affected population in the world (WHO, 2005). The biomedical perspective posits that psychological, hormonal, and reproductive processes render women more prone to developing depressive symptoms (Ussher, 2010). In India, the prevalence of depression is 9%, a major depressive episode is 36%, and the average age of depression is 31.9 years (World Health Report, 2001). Approximately 20% of Indian women experience depression at some time in their lives (Bhattacharya, 2019). Depression affects individuals physically and psychologically and it often results in impairment in their quality of life and relationships. The present study aims to find out the psychosocial functioning of women with moderate depression.

Methodology:

The aim of the study was to assess psychosocial functioning of women with moderate depression. Descriptive study design was employed with total 40 women diagnosed with depression who were taking treatment from outpatient department of LGB Regional Institute of Mental Health. A random sampling method was adopted to obtain the sample that satisfied the ICD 10 criteria for moderate depressive disorder. This study included married women with the age of 18 – 45, and who speak Assamese. Women with IDD and co- morbid psychiatric illnesses were excluded. To measure the socio-demographic details, a semi-structured socio-demographic data sheet was used. Psychosocial functioning was measured through disability and quality of life. World Health Organization Quality of Life- Bref (WHOQOL-Bref) and World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) tools were administered to obtain the data. This study was conducted in the outpatient department of Lokopriya Gopinath Bordoloi Regional Institute of Mental Health. Results indicated substantial changes in the daily functioning and quality of life of these patients. The limitations and suggestions for future perspective are discussed.

Findings:

The results show that social involvement was the most affected area, followed by routine activities and the patient's comprehension and communication. These resulted in disability in the areas of interpersonal relationships, disruption in regular work and cognitive processes such as

attention and concentration, learning new skills etc. Similarly, the various domains in quality of life revealed comparable results, indicating that social relationships are most negatively impacted by depression, followed by psychological health and physical health.
Key words: Women with depression, Psychosocial functioning, Disability, Quality of life.

INTRODUCTION

Depression is a prevalent condition that has a significant impact on psychosocial functioning and quality of life. The World Health Organization (WHO) rated depression as the third leading cause of disease burden in 2008, with the disorder expected to rise to first place by 2030. This underlines the severity of the disability that results from depression. The biomedical perspective posits that psychological, hormonal, and reproductive processes render women more prone to developing depressive symptoms (Ussher, 2010). Depression affects a person's physical activities such as psychomotor agitation or retardation, fatigability and psychological activities such as low mood, and decrease interest in previously pleasurable activities. These symptoms often results in impairment in their psychosocial functioning. Psychosocial functioning refers to a person's ability to perform daily activities and ability to create and maintain meaningful relationships in ways that are satisfying to the individual and others while also meeting the needs of the community in which s/he lives. Thus, the consequences of depression manifested in terms of impairment, and disability can have a significant impact on the lives of both the depressed individual and significant others in their environment. It has a severe impact on physical health, daily functioning, self-care, productivity and social functioning can all be adversely affected (Steger, 2012). The lifetime prevalence of Major Depressive Disorder is 10–25% for women and 5–12% for men (Rihmer, 2004). According to Bhattacharya (2019), approximately 20% of the Indian women experience depression at some time in their lives. Over the last decade, researchers have paid more attention to the connection between depression and disturbances in intimate interpersonal functioning. Descriptive studies have found a strong link between marital conflict and concurrent depression (Bohra et al., 2015; Srinivasan et al., 2020). Dalkou et al. (2019) also found that married women had significantly higher levels of depression than non-married women. Hence the present study is aimed to find out the psychosocial functioning of married women diagnosed with depression.

In the context of the northeastern part of India, there is paucity of literature which highlights the psychosocial functioning of women with moderate depression. Considering the other Indian literature based on the impact of depression on women, the current study was considered to be important to explore the various affected psychosocial functioning areas of women. To understand the psychosocial needs of this group of women, one must first identify the areas of psychosocial functioning that are impacted by depression in order to develop a psychosocial management strategy for them.

METHODOLOGY

The aim of the study was to assess psychosocial functioning of women with moderate depression. Descriptive study design was employed and random sampling method was adopted to obtain the sample that satisfied the ICD 10 Criteria for moderate depressive disorder. Total 40 patients were selected between the age group of 18 – 45, and who speak Assamese. Women with IDD and co- morbid psychiatric illnesses were excluded. To measure the socio-demographic details, a semi-structured socio-demographic data sheet was used. The psychosocial functioning of the patients was defined through social (social relationship, self-care and participation), family (relationship with family members) and occupational functioning (relationship with colleagues, working ability, satisfaction) of the patient. The other areas of psychosocial functioning include physical health, psychological state, and environment of the patient. These areas were measured through World Health Organization Quality of Life- Bref (WHOQOL-Bref) and World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0). This study was conducted in the outpatient department of Lokopriya Gopinath Bordoloi Regional Institute of Mental Health. The outpatient department of the hospital was the setting for this study. The main language in and around the site of study is "Assamese" and the researcher is conversant in the local language. Ethical approval was obtained from the Institutional Ethical Committee of LGBRIMH.

RESULTS

The sociodemographic characteristics of the patients were documented through a socio-demographic data sheet. Socio-demographic details of patient are shown in table 1 and table 2. Table 1 depicts the age distribution of the patients.

Table 1

Distribution of age

Age	Mean+SD	Total patients (N)
	34.47+ 7.2	40

The findings of the socio-demographic variables show that the mean age of the patients was 34.47. The other socio-demographic details are shown in table no 2.

Table 2

Distribution of other socio-demographic details

Variables	Total no. of patients	Percentage (%)
Religion		
Hindu	26	65%
Islam	14	35%
Family Type		
Nuclear	26	65%
Joint	14	35%
Domiciles		
RURAL	19	47.5%
URBAN	13	32.5%
SEMI URBAN	8	20%
Education		
Graduation	12	30%
Higher	16	40%

secondary		
Primary	12	30%
Occupation		
Housewife	30	75%
Self employed	8	20%
Government employee	2	5%
Socio-Economic Status		
Low	2	5%
Upper low	1	2.5%
Low middle	8	20%
Upper middle	12	30%
Upper	17	42.5%

In the religion it was found that majority of the respondents were Hindus, i.e., 65%, followed by Islam (35%). Majority of the patients (65%) were from nuclear family followed by joint family type (35%). A significant number of patients were from rural background (47.5%) followed by urban (32.5%) and semi urban (20%) areas. The hospital is the only tertiary care center in the area for mental health problems and so gets referrals from the whole region. Also, the hospital is situated at a semi-urban area and easy accessible to the people. The education of the patient in the present study was 40% were high school passed, 30% were graduates and another 30% were primary school passed. Occupation wise majority (75%) patients were housewives, followed by self employment (20%) and government employees (5%). Socio-economic status of the patients found that majority of the patients (42.5%) was from upper-socio economic status, followed by middle (30% -upper middle and 20% -low middle) and low socio economic status (2.5%-upper low and 5% -low).

Table 3
Distributions of domains of WHODAS

WHODAS Domains	Mean	Std. Error	SD	Minimum	Maximum
Understanding & Communicating	8.42	0.53	3.41	1.00	15.00
Getting around	6.62	0.40	2.57	3.00	12.00
Self care	3.55	0.40	2.54	0	8.00
Getting along with people	7.92	0.54	3.44	0	16.00
Life activities	9.27	0.61	3.88	1	18.00
Participation in society	**14.77**	0.63	3.40	4.00	22.00

Note. *N*=40.

The results presented in table 3 revealed that the participation in society category had the highest mean score (14.77), followed by life activities (9.27), understanding and communication (8.42). As a result, the patients' societal involvement, daily activities, and cognitive processes such as comprehension and communicating with others were affected.

Table 4
Distributions of domains of WHOQOL Bref scale

WHOQOL Domains	Mean	Std. Error	SD	Minimum	Maximum
Physical Health	19.80	.36	2.27	15	25
Psychological	15.85	1.00	6.33	10	49
Social relationships	**7.67**	.35	2.26	3	12
Environment	25.25	.75	4.77	15	35

Note. N=40.

The table 4 depicts the distribution of four of the quality of life domains. The lowest mean score is found in social relationships (7.67), indicating that social relationships are the most affected aspect of quality of life, followed by psychological health (15.85) and physical health(19.80).

DISCUSSION

The main focus of the study was to examine the psychosocial functioning of women with moderate depression. It was measured in the domains of understanding and communicating, getting around and getting along with people, self care, life activities, daily activities, participation in society, physical health, psychological health, social participation and environmental health. The tools used to assess these areas were the WHODAS 2.0 version and WHOQOL Bref measures. The highest affected area in the WHODAS showed as participation in society (mean 14.77) and WHOQOL-Bref was social relationship (mean 7.76). The results of both of the measures from the current study showed that the social relationship, i.e., interpersonal relationship was found as the highest affected, confirming the highest affect area as patient's intimate relationship with significant family members such as spouse, children and others. Earlier work has suggested that relationship with family members tended to oscillate with severity of depression; patients diagnosed with depression, displayed a great deficit in emotional closeness, avoided seeing their family and found contact with them to be unpleasant (Altshuler et al., 2006). Nezlek et al. (2000) mentioned that patients with depression find their interactions to be less pleasurable and personal than non-depressed patients, and they have less control over their interactions.

The findings showed that the life activities (mean 9.27) such as taking care of household responsibilities, doing most important household tasks, getting all the household related work done as quickly as needed etc were found to be affected in the patients. This finding is consistent with previous findings, which suggest that depression has a significant effect on the quality of life and various functional areas of the affected person (Steger, 2012). Zimmerman et al. (2018) explored in their study that married women's depressive symptoms were associated with physical pain, poor sleep, reduced working capacity, and impaired learning and memory. In the

present study also patient's understanding and communication were found to be affected (mean 8.42), by depressive symptoms. Present study also found patient's ability of getting along with others (mean 7.92) and getting around (mean 6.62) were also disrupted. It was observed that self care was least affected (mean 3.55) area in the women patients with moderate depression.

Psychological domain (mean 15.85) such as positive feelings, self esteem, thinking, learning, memory concentration, bodily image and acceptance, self satisfaction and negative feelings were found as impacted by depression in the patients. Strine et al. (2009) also found a clear link between depression, poor health-related quality of life, insufficient social and emotional support, and disability in their investigation. An Indian study also found that patients experienced moderate to severe deficits in their work, interpersonal relationships, and life satisfaction (Mehta et al., 2014). The next affected area was physical health (mean 19.80), which includes pain and discomfort, medical treatment, energy, sleep, discomfort, ability to perform daily activities, capacity for work. Barge et al. (1999) also found a substantial link between depression and a lower quality of life, as well as a negatively affected mood and enjoyment of activity, and increased physical pain. Another similar study by El-Sheikh et al. (2013) reported that depression in married individuals leads to physical disturbances; mainly appetite and sleep were grossly affected. The least affected area was environmental health (mean 25.25). It is well established that depression results in poor health conditions, role limitations, poor social relationships and a reduction in psychosocial well-being (Goldney et al., 2000). All these studies support the findings on the psychosocial functioning of women in the present study. So, it can be inferred that depression disrupts the psychosocial functioning of patients irrespective of any culture.

LIMITATIONS

However, the findings should be interpreted with caution, because of the study's limitations. More research with bigger sample size and a longitudinal study design is needed to see how psychosocial functioning changes over time, as the illness progresses alongside with change in severity. Also, the population from other settings such as community samples could be considered for comparison for further generalization of the study.

SUGGESTION

Thus, the study confirms the impact of depression on the overall psychosocial functioning of patients including quality of life. The assessment of various spheres of psychosocial functioning namely occupation, interpersonal connections, and life satisfaction is required. This will be used as a guide to suggest appropriate psychosocial interventions for women diagnosed with depression to improve the overall quality of life and can specifically structure psychosocial interventions by psychiatric social workers towards building evidenced based practice.

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