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A comparative study on depression among working and non-working women in Rewa district

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Abstract
Depression is a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being. This mood disorder is becoming more common among middle aged female population and especially the factors associated are unique in this population. The results depicted in the table also highlight that one year and life time stress is also significantly correlated with ill health thus indicating the greater number of the life stress experienced by person the symptom score of health is also found to be greater in the person. Both life stress and symptom score of health are found to be positively related with each other. Depression and symptom score of health also yield a positive relationship (r= .31 p<.01). In summary, we report that the overall prevalence of depression was still high, so it is necessary to initiate and implement the health policy towards family and work place counselling services to overcome depression and to improve their quality of life among both working and non-working female population.

Keywords: depression, working and non-working women, work place problems, Rewa, comparison

1. Introductions
Life is full of emotional ups and downs, But when the "down" times are long lasting, they interfere with an individual's ability to function. Clinical depression affects physical well-being, resulting in chronic fatigue, sleeping problems and changes in appetite. It affects mood, with feelings of sadness, emptiness, hopelessness and dysphoria. It affects the way one thinks, interfering with concentration and decision making. It affects individual's behavior, with increased irritability and loss of temper, social withdrawal and a reduction in desire to engage in pleasurable activities. Research indicates that in the United States more then 17 million people experience depression each year. In India also people suffer from depression and it has become a serious psychological problem.

Women are almost twice as likely as men to experience depression. Research continues to explore how this psychological problem affects women. At the same time, it is important for women to increase their awareness of what is already known about depression, so that they seek early and appropriate treatment.

Depression is a serious mental health concern that will touch most people's lives at some point in their lifetime (either directly or through someone close they know). The suffering endured by people with depression and the lives lost to suicide attest to the great burden of this disorder on individuals, families and society. Improved recognition, treatment and prevention of depression are critical public health priorities. Organizations such as the National Institute of Mental Health (NIMH), one of the world's leading mental health biomedical organizations, conducts and supports research on the causes, diagnosis, prevention and treatment of depression in the United States.

Evidence from neuroscience, genetics and clinical investigation demonstrate that depression is a disorder of the brain. Modern brain imaging technologies are revealing that in depression, neural circuits responsible for the regulation of moods, thinking, sleep, appetite and behavior fail to function properly and that critical neurotransmitters chemicals used by nerve cells to communicate are perhaps out of balance. Genetics research indicates that vulnerability to depression results from the influence of multiple genes acting together with environmental factors. Studies of brain chemistry and of mechanisms of action of antidepressant medications continue to inform the development of new and better medical and psychotherapy treatments.

Depression is a 'whole-body" illness, involving body, mood and thoughts. It is the way one eats and sleeps, the way one feels about self and the way one thinks about things.

A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with depression cannot merely "pull themselves together" and get better. It is seen that without treatment symptoms can last for weeks, months or years.

The symptoms of depression vary from person to person and the intensity of the symptoms depends on the severity of the depression. Depression causes changes in thinking, feeling, behavior and physical well-being.

Studies show that individuals with certain characteristics pessimistic thinking, lo esteem, a sense of having little control over life events and proneness to excessive worrying are more likely to develop depression. These attributes may heighten the effect of stressful events or interfere with taking action to cope with them.

Major advances in the understanding of mood disorders over recent years have come from recognition of the often chronic and persistent course of depression over the life span (Belsher & Costello, 1988; Keller, 2003; Kennedy, Abbott & Paykel, 2003) [1-3]. Current widely publicized estimates suggest that at least 60% of individuals who have had one depressive episode will have another, 70% of individuals who have had two depressive episodes will have a third and 90% of individuals with three episodes will have a fourth episode (American Psychiatric Association, 2000; Solomon *et al.* 2000; Revati R Dudhatra, Yogesh A Jogsan (2012) [4-6].

2. Hypothesis

The hypotheses formulated for the present study are as follows:

1. Women possessing good health status would be low on depression in comparison to low health status women.
2. There would be significant differences found between life stresses mean scores of high and low health status of working and non-working women.
3. There would be significant differences found between depression mean scores of high and low health status of working and non-working women.

3. Methodology

3.1 Sample: The study was conducted on a sample of 400 women of Rewa district out of which 200 women comprised of working women group and 200 non working group (simply housewives) who were classified into two subgroups high and low on health status i.e. 100 working women high on health status and 100 working women low on health status. On the other hand 100 non working women high on health status and 100 non working low on health status.

All the subjects were matched on age sex, education and socio economic status. The age of the subjects ranged from 25 to 45 years with a mean of 32.6 years. They were all females and literate and hailed from middle class families. The working group consisted of University and College teachers of Rewa. The sampling undertaken was purposive sampling.

The working women group consisted of women who were employed as permanent teachers in higher education. They were Government and Private College teachers as well as University teachers. The non working group consisted of women who were not employed in teaching or engaged in any other profession but were simply housewives.

3.2 Method and Procedure

First and foremost Vyaktigath Prasnavali and PGI Health Questionnaire was administered on a sample of 300 working women and 300 nonworking women (N=600).

The data was collected on working and nonworking women on individual basis in home and workplace setting respectively. Standard instructions were read aloud by the investigator. As instructed the subjects filled the personal data sheet and PGI health questionnaire. They were thanked for their cooperation and informed that they would again be approached if required. Scoring was done by counting the numbers checked by the subject.

On the basis of their symptom scores they were classified into high and low health status groups (100 high health status working women, 100 low health status working women, 100 high health status non-working women and 100 low health status non-working women).

The high health status group compared of women who showed less symptom score. The low health status group comprised of women who showed more symptom scores i.e. scored high on PGI health questionnaire (N=200).

The subjects who scored below score 9 were labeled as good health status group whereas those who scored above 9 were labeled as ill health status group. This cut of point was suggested by Wig and Verma (1973) [7]. Therefore it was taken into consideration.

The final sample of 400 women i.e. 200 working women and 200 non working women out of which 100 of good health and 100 ill health status) were administered the stressful life events scale and depression scale with on interval of five minutes in one session by the investigator personally. The subjects were informed about the purpose of the study and were requested to participate. Proper rapport was established and each subject was tested individually. The instructions were printed on the scales. They were read aloud by the investigator and the subjects were also asked to read on their own. If there were any doubts, they were cleared. They were informed about the confidentiality of their responses and the information given by them would be used only for research purpose. The subjects followed the instructions and gave their responses for the items stated in PSLE scale and depression scale.

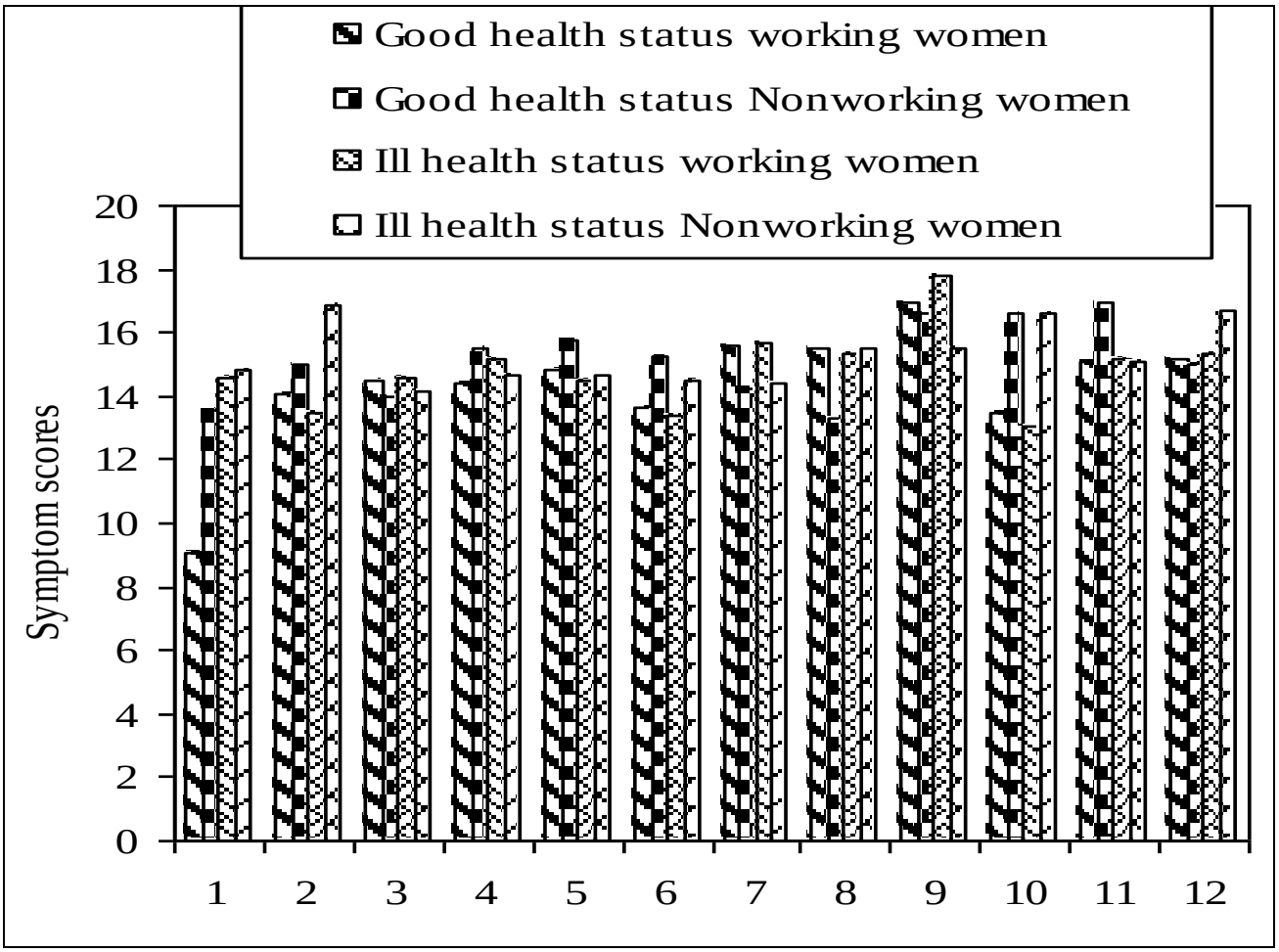
Data was collected on the working and non working high health status and 1000 health status women. Finally the investigator paid thanks to the subjects who gave their cooperation. The forms were scrutinized by the investigator and systematically scored according to the appropriate scoring procedure prescribed in the manuals of the scales and later subjected to statistical analyses. Means, standard deviations, correlations and t-ratios were computed to interpret the findings and to discuss the results at length.

4. Results and Discussion

For the descriptive analysis of the data, means and standard deviations were computed. As it is known to all that mean is the sum of the separate scores divided by the number whereas standard deviation (SD) is the most stable index of variability.

Table 1: Showing the mean scores and S.D. scores for 12 areas of depression and total depression of good and ill health status working and non working women.

S. No.	Areas of Depression	Good Health Status				ILL Health Status			
		Working women		Nonworking women		Working women		Nonworking women	
		Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
1.	Apathy	9.03	3.13	13.60	3.02	14.60	4.14	14.83	3.38
2.	Sleep Disturbance	14.07	4.31	14.99	4.76	13.49	4.01	16.85	4.67
3.	Pessimism	14.53	4.11	14.02	3.65	14.55	4.42	14.15	3.96
4.	Fatigability	14.38	3.97	15.48	4.35	15.15	4.77	14.64	4.32
5.	Irritability	14.84	4.02	15.78	4.20	14.52	4.08	14.69	4.15
6.	Social Withdrawal & Self Centeredness	13.65	4.04	15.28	4.52	13.40	4.20	14.46	4.68
7.	Dejected or Sadness	15.61	4.47	14.22	4.31	15.70	4.34	14.44	4.27
8.	Self Dislike	15.52	4.83	13.31	4.21	15.34	5.12	15.54	4.33
9.	Self Acquisition	16.93	4.99	16.58	3.30	17.80	5.23	15.51	4.70
10.	Self Harm	13.50	4.05	16.59	6.94	13.02	3.93	16.64	4.96
11.	Somatic Reoccupation	15.09	4.66	16.94	4.94	15.16	4.85	15.09	4.64
12.	Indecisiveness	15.19	4.91	14.99	4.04	15.32	4.75	16.66	4.05
	Total Depression	172.34	13.28	176.66	14.91	178.23	13.56	183.50	12.21



Graph 1: Showing the means of 12 areas of depression of good and ill health status working and non working women.

By looking at Table 1 it is evident that the total depression mean scores are found to be higher for ill health group of working/nonworking women in comparison to good health status group. The nonworking ill status group of women have reported highest depression mean scores M = 183.50 followed by working women (178.23) then nonworking women of good health status women (176.66) and lastly working women of good health status group (172.34).

The highest score regarding the areas of depression has been found for self acquisition in working women of ill health status M= 17.80 whereas for good health status M = 16.93. The results, depicted in Table 1 show that for non working ill health status women the sleep disturbance area means core is found to be highest than the other areas of depression (M=16.85) whereas for somatic reoccupation the good health status non working women have reported highest depression mean score (16.93) than the other areas of depression (See graph 1).

It was hypothesized that there would be significant relationship between life stress and mean scores of good and ill health status working and nonworking women. The results did support this prediction. Further more significant difference were found between the depression mean scores

of good and ill health status working and nonworking women.

Coefficients of correlations were also computed to see the significant relationships between the variables. They are presented in Table 2.

Table 2: Showing coefficient of correlation amongst the variables.

S. No.	Variables	Past one year life stress	Life time stress	Health symptom score	Depression
1.	Past one year life stress	–	0.18**	0.23**	0.16**
2.	Life time life stress	–	–	0.36**	0.27**
3.	Health symptom score	–	–	–	0.31**
4.	Depression	–	–	–	–

Showing ** p<.01 level.

By looking at Table 2 it is evident that the life stress and depression coefficient of correlation is found to be significantly positively related with each other thus indicating that greater life stress experienced by a person, higher is the score for depression. The results depicted in the table also highlight that one year and life time stress is also significantly correlated with ill health thus indicating the greater number of the life stress experienced by person the symptom score of health is also found to be greater in the person. Both life stress and symptom score of health are found to be positively related with each other. Depression and symptom score of health also yield a positive relationship (r= .31 p<.01). The hypothesized predictions regarding the relationships of the variables taken care off in the present study are proved.

It was hypothesized, that women possessing good health status would be low on depression in comparison to low health status women (H_1). The mean scores for high health status working women for depression is found to be 172.34 whereas for non-working women of the same group is found to be 176.66. They results also revealed that for low health status working women the depression scores were found to be 178.23 and for non working women the mean score for total depression was greatest i.e. M = 183.50. The results support this hypothesized prediction.

The results revealed significant differences among the life stress mean scores of high and low health status working and non working women. Significant differences were also found between the depression mean scores of high and low health status working and non working women. Hence, the results supported H_2 and H_3 formulated for the present study.

Rusli, Edimansyah and Naing (2008) [8] assessed the relationship between working conditions (job demand, job control and social support); stress, anxiety and depression and perceived quality of life factors (physical health, psychological wellbeing, social relationships and environmental conditions) using a sample of 698 male automotive assembly workers in Malaysia. The validated Malay version of the Job Content Questionnaire (JCQ), Depression Anxiety Stress Scales (DASS) and the World Health Organization Quality of Life-Brief (WHOQOL-BREF) were used. A structural equation modeling (SEM) analysis was applied to test the structural relationships of the model using AMOS version 6.0, with the maximum likelihood ratio as the method of estimation.

5. Conclusion

The implications of the study show that the women working in home and outside homes have justified the work engagement and disengagement theory. The health status of working and nonworking women is an important variable. Life stress and depression are crucial variables which have an impact on the health status of working and nonworking women.

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