# INCREASING DEPRESSION IN INDIAN WOMEN: A SOCIOLOGICAL STUDY

**Charumitra Anand and Lajwant Singh**
Department of Sociology, Faculty of Social Sciences
Dayalbagh Educational Institute, Deemed University, Agra (U.P), India
charumitra91@gmail.com

## Abstract

Depression is a common, complex mental illness of person across gender, race, ethnicity, religion, age, and socioeconomic status. Though depression has been observed in most countries of the world, some countries or cultures do not have a word for depression. Epidemiologic data from around the world demonstrate that major depression is approximately twice common in women than men. Progress has been made in understanding the epidemiology of depression and in developing effective treatments. The rates of depression for females have been consistently higher as compared to rates for males. However, the greater numbers of depressed women may reflect referral and treatment biases, social roles and expectations, specific biological and reproductive differences, higher rates of victimization and poverty, and the under diagnosis of males. In India Women have very negligible access to mental health care and the only setting where there is gender parity in access to health care is the community setting. Lack of education, superstitions and reluctance on the part of the womenfolk and the social stigma and bleak chances of matrimonial placement in our culture are significant determinants. In general, two perspectives are most often discussed in the explaining gender differences in rates of depression: (1) the reproduction, and (2) women's roles, status, and life situations. Trans-cultural stability of gender ratio (more women than men) makes logical hypothesis more reasonable. It may be likely that sex differences in rates of depression more to do with culturally defined gender differences in symptom help seeking, social support, coping styles, treatment utilization, stress than with differences in neurobiology. Symptoms of depression may be unduly considered intensification what are traditionally considered normal female characteristics, dependency, helplessness, hopelessness, passivity, and lack of confidence. Study actually found that depressed persons were described as stereotypically female and normal persons as stereotypically male. My study is a secondary analysis. The present study aims to identify the factor responsible for depression in Indian women and how to obtain an accurate diagnosis of it, the area of women and mental health needs immediate attention from health researchers, social scientists, women's organizations, professional organizations, health planners and other administrators.

**Keywords:** Depression, Mental illness, Awareness, NMHS

## INTRODUCTION

According to a World Health Organization Indians are among the world's most depressed population and the burden of depression is 50% higher for females than males while around 9% of people in India reported having an extended period of depression within their lifetime, nearly 36% suffered from what is called Major Depressive Episode (MDE).MDE is characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration, besides feeling depressed. WHO ranks depression as the fourth leading cause of disability worldwide and projects that by 2020, it will be the second leading cause of disability.

In India Women have very negligible access to mental health care especially in a rural setting? The higher rates of depression have been reported in the rural compared to the urban population. Lack of education, superstitions and reluctance on the part of the womenfolk and the social stigma and miserable chances of matrimonial placement in our culture are significant determinants. Most people in India attach mental ailments to superstitions which worsens the scenario to a great extent. Patients are often tied to chains, put in an unhealthy environment and often go without food for days. Even in the urban society, people would not mind visiting the doctor for a common flu or cold, but when it comes to visiting psychologists, hesitation grips them hard. In India factors like gender biasness, culturally defined gender differences, women's roles, status, and life situations are the major cause of Depression. Symptoms of depression may be improperly considered strengthening what are traditionally considered normal female characteristics, dependency, helplessness, hopelessness, passivity, and lack of confidence. Study actually found that depressed persons were described as stereotypically female and normal persons as stereotypically male. Depression to be extremely common among rural women in India speculated to be directly related to cultural including early marriage, an associated loss of contact with close kin, relationship, and the perception of helplessness. In fact, women's work roles are not considered as important as their roles as mothers and wives; therefore, employment outside the home is not significantly protective against depression.The roles of culture and condition in the expression of depression illustrate the complexity of the interaction between cultural norms and emotional expression, specifically regarding the female expression of depression or other distress. Certainly, there are numerous cultures, where an individual is not

encouraged express thoughts or feelings of depression. Throughout much of the world, women have higher rates of poverty higher rates of victimization when compared to men. These rates contribute to higher rates of depression and other mood disorders. Women often have been treated for mood disorders, eating disorders, and substance abuse in isolation and without diagnosing an underlying disorder thus overemphasizing the depression and neglecting the rather significant effects of a trauma.

Seeking to explain the fact that women are overwhelmingly the victims of depression, feminist theorists and researchers have argued that its incidence is tied to normative femininity rather than to aspects of women's biological makeup as the medical model asserts While not denying a biological basis to depression, feminist scholars focus on the social realities that have largely been underappreciated and under theorized in the etiology of such mental distress. Thus, in the silencing paradigm, much attention is placed on prevailing standards of feminine goodness. That is, normative expectations for women insist that they be overly attuned to others' needs, often at great cost to their own goals, desires, and feelings. In the process of living up to these cultural images, women may engage in self-silencing as they keep important aspects of their experiences hidden from those around them. They fear that significant others will not accept their discourse-discrepant feelings, thoughts, and needs The silencing paradigm maintains that depression is a psychosocial process in which women "mourn" a self that has become "submerged, excluded, or weakened" under relationships that they are socialized to view as central to their social acceptance and critical to their personal well-being .The paradigm further asserts that while standards of goodness "vary by gender, ethnicity, and social context," they typically are drawn from cultural discourses that, once internalized, exert a moral force that judges and condemns those thoughts and feelings that women experience as authentic and grounded in their actual experiences. The onset of depressive episodes, then, is essentially a period in which women become voiceless or fractured from doubting and repressing private thoughts that are at odds with the forms of femininity that they are pressured to take on to be considered good women .Within the silencing paradigm, recovery from depres sion becomes a process of redefinition, and resistance during which women critically examine through cultural messages to determine which they will embrace and which others they will reject as “the not me”. Mental health and

Wellness therefore depend on a woman's realizing that the discursive socio-cultural representation of her womanhood fails to fit in her reality.

**HERE'S A LIST OF INDIAN CELEBRITIES**

**1. Manisha Koirala-**One of the most established actresses of Bollywood; Manisha Koirala suffered from clinical depression.

**2. Deepika Padukone -**Who was diagnosed with depression during the peak of her career, is the Founder of **LIVE LOVE LAUGH** Foundation which helps people to come out from depression. She decided to come out and speak about her own personal struggle to encourage people to come out and openly talk about mental health/depression.

**3. Anushka Sharma**

**4. Ileana D'Cru**

**WHAT IS DEPRESSION?**

According to common misunderstandings, the word “depression” conveys a normal everyday emotional reaction and expresses itself as feelings of unhappiness, sadness and frustration but Depression is an illness entity, which can be most severe and even life threatening.

Depression is characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks. Depression is a common mental disorder that affects people of all ages, from all walks of life, in all countries."Depression not only affects your emotions, but can also change the way you think, how you behave, and how you function physically, it can impact on people’s ability to carry out even the simplest everyday tasks, with sometimes devastating consequences for relationships with family and friends. In severe cases it can lead to suicide. Depressive illness affects not only the individual but also those around in the family and in the workplace.

**STATEMENT OF THE PROBLEM**

Mental disorders contribute to a significant load of morbidity and disability, even though few conditions account for an increasing mortality Previous reviews, meta analysis, studies and independent reports have indicated that nearly 100 million persons in India are in need of

systematic care based on data3 that are a few decades old and have serious methodological limitations. Conditions related to the brain and mind are acknowledged to be on the increase in recent times. This is probably due to the growing awareness in society, improved recognition, variations in disease patterns, changing lifestyles and biological vulnerabilities. Consequently, depression, anxiety, alcohol use, suicidal behaviours, drug use, sleep disorders and several others are on the increase.

## SIGNIFICANCE OF THE STUDY

National Mental Health Survey examined the prevalence and patterns of mental problems along with treatment gap, disability nature and socioeconomic impact based on the primary data collected from 12 states. Mental health system components on several domains (based on available secondary data and opinion of experts, administrators and professionals) were examined to understand current systems of care; certainly, limitations exist in this approach. It would help in learning from each other and the need to invest in different areas within each state to strengthen existing systems

## REVIEW OF LITERATURE

**Davar V. Bhargavi** (1995) Mental Illness among Indian women.

In this paper researcher focused on the mental health needs of Indian women. He found planning for women's health have altogether neglected the question of the mental health of women and that's why researcher cull out gender relevant data and re-analyses them from them the gender perspective. This paper attempts and tries to provide some information on the occurrence of mental illness among women. In order to fill a noticeable lacuna in women health studies information about mental illness in Indian women has been obtained from the primary data available from this studies. This work is a secondary analysis. Researcher found women married in her reproductive years, divorced, widowed or separated is a housewife in low or middle level occupations in unpaid jobs or illiterate. She is high risk of mental illness.

**Norman Judith** (2004) Gender bias in the Diagnosis and treatment of Depression.

In this paper researcher suggests that the rate of depression are increasing in many parts of the world. Greater number of depressed women may reflect referral and treatment biases, social

roles and expectations, specific biological and reproductive differences, higher rate of victimization and poverty and under diagnosis of man. The methodology is a review of recent literature summaries regarding unipolar depression internationally more important for assessment and early intervention explanations and possible bias in gender analysis will be examined. Finally conceptualization of an assessment and intervention strategy for depression sensitive to gender as well as culture is described.

**Lafontant-Beauboeuf Tamara** (2007) You have to show Strength: An Exploration of Gender, Race, Depression.

In this paper researcher investigated the possible overlap between depressed and presumably strong black women.The past decade has witnessed a growing autobiographical and clinical literature focused on the experiences of depressed women .This literature has taken both medical and psychosocial approaches to conceptualizing depression among black women.Researcher undertook interview study with non clinical convenience sample of 44 working and middle class black women between 2000 and 2005.Analysis suggests that the researcher should interrogate the rhetoric of being strong and empirically investigate whether or under what circumstances it becomes a productive way of managing life and emotional distress for black women.

**Roxbrgh** (2009) Untangling Inequalities: Gender, Race, and Socio-economic difficulties in Depression .

Link and Phelan (1995)argue that socioeconomic status is a fundamental cause of variation is well being and that the social resources associated with socio economic status constitute the fundamental cause of variation in well being.Author oversamples for race/ethnicity and employs nationally representative of the U Spopulation for analysis include respondents who defined themselves as no hisparic black or non hisparic white excluding respondents from the analysis who identified as mixed race.Researcher find that the black and white men are signifacntly less depressed than black and white women.

**Bluhm Robyn**(2011)Gender differences in depression :Explanations from feminist ethics.

In this article the author draws on feminist analyses of personhood and of autonomy to explain the greater prevalence of depression among women. Depression is a mental disorder but it is more common in women than in men To provide a more nuanced explanations of how social

factors can affects women health by emphasizing that women with depression are not merely passive victims of oppressive social practices but actively responding to their environment and interpreting their own experiences. Author has done brief survey of the epidemiology of depression. Emphasized that the value that guide our decisions the way in which we expresses ourselves and our understanding of the situations in which we find ourselves are all shaped by social practices.

**OPERATIONALIZATION OF CONCEPTS**

DEPRESSION- Depression is characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks.

MENTAL DISORDER-A wide range of conditions that affects mood ,thinking and behavior.

AWARENESS- Knowledge or perception of a situation or facts.

NMHS- The National Mental Health Survey is a joint collaborative effort of nearly 500 professionals, comprising of researchers, state level administrators, data collection teams and others from the 12 states of India and has been coordinated and implemented by NIMHANS.

**OBJECTIVES**

1. Estimate the prevalence and pattern of various mental disorders in Indian women.
2. Identify treatment gap health care utilization,
3. Identify the disability and impact of health care treatment.
3. Assess the current mental health services and system.

**WHAT IS NHMS.**

The National Mental Health Survey is a joint collaborative effort of nearly 500 professionals, comprising of researchers, state level administrators, data collection teams and others from the 12 states of India and has been coordinated and implemented by NIMHANS. The results and implications point to a need for a strong public health approach and a well-functioning mental health systems within larger health system. The response needs to be integrated, coordinated and effectively monitored to appropriately address the growing problem.

## DATA AND METHOD

The data used for the analysis are from the 2014-2016 (National center for health statistics,2004).The NMHS is an annual cross sectional household survey of the non-institutionalized population of the United states carried out by the national center for health statistics. Secondary data is used from National mental health survey of India 2015-2016 supported by Ministry of Health and Family welfare government of India. Implemented by National Institute of Mental Health and Neuro Sciences Bengaluru, in collaboration with partner institute.

## THE NATIONAL MENTAL HEALTH SURVEY (NMHS)2014-2016

The data used for the analyses are from the2014-2016 NMHS(The national mental health survey ).The NMHS was conceptualized to cover a representative national population examine all priority mental disorders ,focus on the treatment gap, service utilization disability and impact along with an assessment of resource and system in a sample of Indian states simultaneously and with uniform methodologies .The population selected and interviewed was drawn based on scientific sampling method by including individuals aged 18 years and above.

## UNIVERSE AND SAMPLE

The states selected were North : Punjab and Uttar Pradesh, South: Tamil Nadu and Kerala, East: Jharkhand and West Bengal, West: Rajasthan and Gujarat, Central: Madhya Pradesh and Chhattisgarh and, North-East : Assam and Manipur. States covered in National Mental Health Survey -2015-16 The overall study design of the NMHS was multi-stage, stratified, random cluster sampling technique, with random selection based on Probability Proportion to Size at each stage (MSRS-PPS). A multi stage sampling was adopted (District g Taluka g Village / Ward g HH) in each state and each selected state of India constituted the sampling frame.

## STATISTICAL METHOD

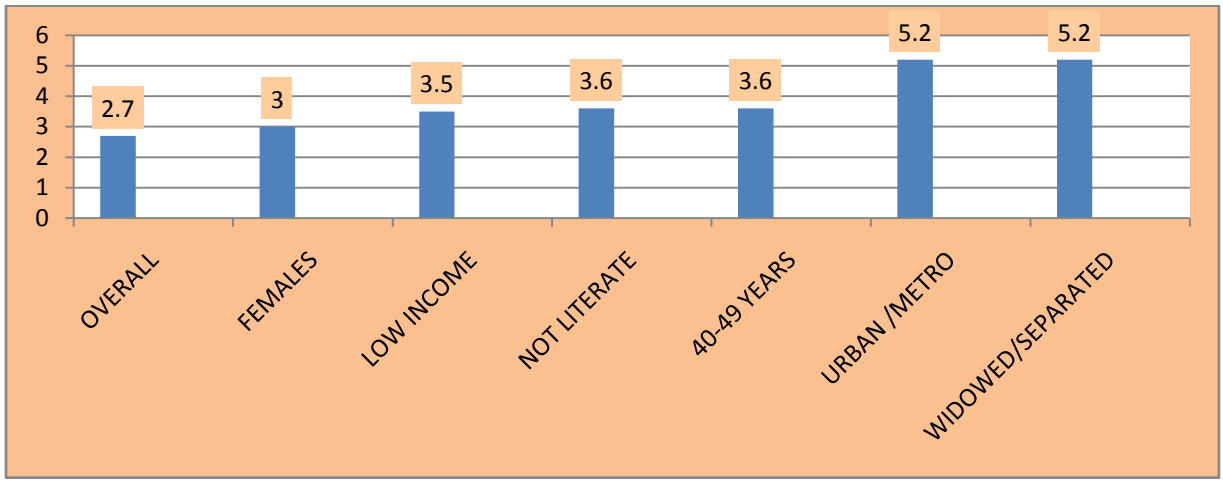
Column and Bar graph used to represent the data.

## SURVEY POPULATION WAS REPRESENTATIVE OF THE SOURCE POPULATION

The National Mental Health Survey of India-2016 was conducted on a nationally representative sample of 34802 individuals, sampled from 12 states of India. The response rate at households

was 91.9%,while individuals interviewed were 88%, with some variations across the surveyed population. One out of every three respondents in the survey was a young adult (aged 18-29 years). The age distribution of study subjects in the sample was closely similar to that documented in the Census of India-2011 in all age-groups, except for a slightly higher proportion of elder respondents (more than 60 years). This pattern was similar in all states . Females comprised 52.3% of all respondents in the NMHS. The proportion was slightly higher in the states of Kerala, Assam and Manipur (57%). Rural, urban and metro respondents were proportionately distributed across all age-groups and both sexes. Three-fourths of the study subjects were currently married. The percentage of widowed / separated / divorced respondents (6.2%) were higher among females (9.8%) and in Kerala, Tamil Nadu, and Gujarat (13- 14%). The literacy status in the total sample was similar to the national literacy levels.

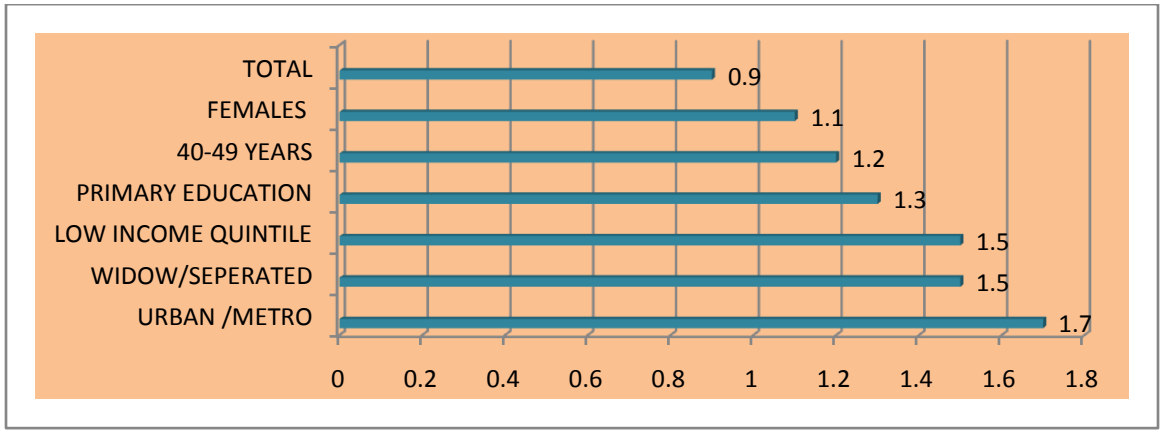
**Figure.1 Prevalence of depression in females (unmarried, widow ,separated)**




**1 IN 20 PEOPLE IN INDIA SUFFER FROM DEPRESSION**

The weighted prevalence of depression for both current and life time was 2.7% and 5.2%, respectively, indicating that nearly 1 in 40 and 1 in 20 suffer from past and current depression, respectively. Depression was reported to be higher in females, in the age-group of 40-49 years and among those residing in urban metros.

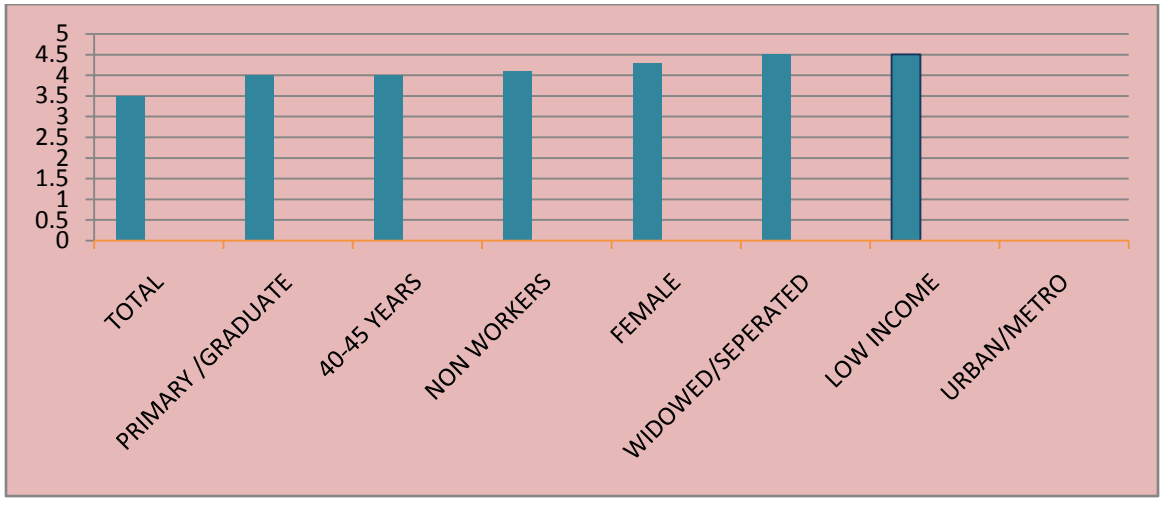
**Figure 2. Prevalence of high suicidal risk in women: Socio-demographic differentials**




**High suicidal risk is an increasing concern in India**

Nearly 1% of the population reportedhigh suicidal risk. The prevalence of high suicidal risk was more in the 40-49 age group (1.19%), among females (1.14%) and in those residing in urban metros (1.71%). While half of this group reporting suicidal risk had co-occurring mental illness, the other half did not report any co-morbid mental disorder. This warrants the need for multi-sectoral actions. Suicide andsuicidal ideation are important public health problems (and have in recent times assumed extremely sensitive political and social ramifications).Apart from the loss of lives (predominantly young), the causes, risk factors and consequences are poorly understood in India and this calls for good quality research at the national and state levels as well as coordinated and comprehensive interventions

**Figure.3 Neurosis and stress related disorders in women**



**Neurosis and stress related disorders affect women disproportionately**

Neurosis and stress related disorders affected 3.5% of the population and was reported to be higher among females (nearly twice as much as males)**.** Neurosis and stress related disorders are commonly encountered in primary care settings where they are usually missed or misdiagnosed.

**TREATMENT GAP**

Despite prior and current efforts in enhancing mental health care delivery across the country, the study revealed that a huge treatment gap still exists for all types of mental health problems: ranging from 28% to 83% for mental disorders and 86% for alcohol use disorders. Except for epilepsy all the other mental disorders reported a treatment gap of more than 60% with the highest treatment gap being for alcohol use disorders.Most of those identified, had not sought care or were not able to access appropriate care despite seeking. Multiple factors ranging from lack of awareness, to affordability of care, which varied between rural and urban areas, appear to critically influence these wide treatment gaps. Our assessment of the economic cost of care of a person with a mental disorder, mainly as out of pocket expenditure, reveals a huge burden . Families had to spend nearly INR 1000 – 1500 a month mainly for treatment and travel to access care. The hidden and intangible costs are difficult to monetize and add to this burden. The burden was reportedly higher in middle aged individuals, where disability due to mental illness significantly affected their productivity resulting in a sizeable economic impact in a cumulative manner to the country. Poverty and disability catalysed by poor access to care and treatment significantly affect the quality of life of persons with mental illness as well as their families

**Persons with mental disorders continue to be stigmatized**

Stigma contributes to the huge burden of mental morbidity, being a road-block to treatment seeking. Nearly 80% of persons suffering from mental disorders, had not received any treatment despite the presence of illness for more than 12 months. Stigma associated with mental disorders affects access to work, education and marriage of those with a disorder and it also affects family members of those affected.

**Significantly, low levels of education and income are closely linked to mental disorders**

Poverty, low levels of education and working status are closely interlinked to mental disorders which in turn contribute to impoverishment. Data from the NMHS reveals that mental disorders were significantly higher in households with lesser income, poor education and limited employment. It is evident that these individuals have a greater vulnerability to mental disorders moderated by adverse social and economic determinants of health. These factors also limit their access to and their utilisation of mental healt services.

**Institutional care is still limited; needs capacity building and innovative use of resources**

Despite the acceptance of the fact that primary and community care is the need of the hour, some patients need institutional mental health care and rehabilitative services.

**Existing health care facilities should be engaged for mental health care**

**Mental health activities at the state level are not information driven**-

While the information available at the state level was grossly inadequate, even the available data was of limited help; decisions taken were rarely based on information. The current mental health programmes in India are hampered by the lack of valid, reliable, timely, sensitive and specific outcome indicators for mental health developed on routine data gathering methods.

## GOVERNMENT HEALTH PROGRAMS AND POLICIES

The delivery of mental health care to Indian citizens is the joint responsibility of the central and state governments. Mental health services should be comprehensive (promotion, care, management and rehabilitation), integrated (within and between different sectors) and delivered to the entire population (public health approach). To deliver good quality mental health care, several activities and programme

components should work effectively and efficiently together, and this is referred to as the systems approach. Though initiated nearly 3 decades back, the programme implementation under the National Mental Health Programme has been slow. Only lately, changes have been noticed in coverage, resource allocation, and other areas. The development of the **National Mental Health Policy (2014), a new Mental Health Bill (2016)**, recent judicial directives, initiatives by the National Human Rights Commission18 (2016), increase in resource allocation, expansion of the

**District Mental Health Programme** to nearly 200 districts, establishment of new Centers of Excellence, improvement of care in mental hospitals are a few examples in this direction. However, the implementation of programmes are expected to happen at the state level in terms of access to care, availability of services, utilisation by communities and awareness about mental health issues. In this context, the **State Mental Health Systems Assessment (SMHSA)** was conducted alongside estimating prevalence of mental disorders under the National Mental Health Survey.

This approach is unique as it provides a dual assessment of the prevalence of mental disorders and systems available to address the same at the state level, in the same time period. The 12 states chosen for the SMHSA were diverse with regard to their administrative and economic characteristics like the number of districts, talukas and villages, per capita income and mental health issues.

## RECOMMENDATIONS

Based on the study results, interactions with stake holders, views of community respondents and a review of past lessons, to improve mental health systems in India, the following ecommendations are placed herewith.

1. The existing National Mental Health Programme, and its key implementation arm, the District Mental Health programme needs significant strengthening. In consultation with entral and state stakeholders, there is an urgent need for formulating explicit written action plans, increasing compliancetowards implementation by supportive supervision, enhancing mechanisms of integration, developing dedicated – ring fenced financing, devising mechanisms for accelerating human resources development, improving drug delivery and logistics mechanisms and devising effective monitoring frameworks so as to provide the widest possible coverage to affected citizens.

2. Broad-basing of priorities and planning of services to address the triple burden of common mental disorders, substance use disorders and severe mental disorders is required through focused as well a integrated approaches .

3. All Indian states should be supported to develop and implement a focused"Biennial mental health action plan" (covering severe mental disorders, common mental disorders and substance use problems) that includes specified and defined activity components, financial provisions, strengthening of the required facilities, human resources and drug logistics in a time bound manner. It should include implementing legislations, coordinated IEC activities, health promotion measures, rehabilitation and other activities. These action plans should indicate responsible agencies or units for each defined activity component, their budget requirements and time lines along with monitoring indicators. Monitoring and evaluation should be an inbuilt component of this action plan and could be revised once in five years to measure progress.

4. Capacity strengthening of all policy makers in health and related sectors (education, welfare, urban and rural development, transport, etc.,) at the national and state levels should be givenpriority. Furthermore, human resource development for mental health in health and all related sectors should be systematically planned and implemented over the next 5 years. Based on their roles and responsibilities, these strategies

should focus on (i) sensitisation of policy makers and professionals in education, welfare, women and child development, law, police and others, (ii) training all existing and new state mental health programme officers in programme implementation, (iii) training all district mental health programme officers in delivery of services (iv) building skills and knowledge of doctors (modern and traditional), health workers, ANMs, ASHAs and USHAs, Anganwadi workers and others5. Human resource development at all levels requires creating mechanisms by identifying training institutions – trainers – resources – calender of activities – financing at the state level.

6. Minimum package of interventions in the areas of mental health promotion, care and rehabilitation that can be implemented at medical colleges, district and sub-district hospitals, and primary health care settings should be developed in consultation with state governments and concerned departments and an action plan formulated for its implementation in a phased manner.

7. Upgradation of existing facilities to treat and rehabilitate persons with mental illness, will require further strengthening of existing mental hospitals as mandated by the National Human Rights Commission and provided by other previous schemes of the Health ministry.

## CONCLUSION

The multiple roles played by Indian women contribute to stress, thereby making her susceptible to depression. The influence of female hormones during the reproductive years contributes to depression during pregnancy, postpartum depression. Interventions that attempt to alter cultural and social norms to prevent violence are among the most widespread and prominent. Although the effect of mass media interventions, aimed at whole societies While it is difficult to ascertain the effectiveness of laws and policies in changing social attitudes, legislation that is enforced can send clear messages to society that violent behavior is not acceptable. in addressing other public health issues The study also identified a group with a new set of values: that is most reliable and consistent means of deciding of what is good for our life. In summary, concerted efforts at social, political, economic, and legal levels can bring change in the lives of Indian women and contribute to the improvement of the mental health of women. In this context, the State Mental Health Systems Assessment (SMHSA) was conducted alongside estimating prevalence of mental disorders under the National Mental Health Survey. This approach is unique as it provides a dual assessment of the prevalence of mental disorders and systems available to address the same at the state level, in the same time period. To understand its importance the World Health Organization (WHO) has declared Depression as the theme for the next World Health Day (7th April 2017). The campaign slogan is 'Depression: Let's Talk', and was released on the World Mental Health Day.

## References

1. Bluhm Robyn (2011)Gender differences in depression :Explanations from feminist ethics. Vol 4 No 1 Special issue.Feminist perpective on ethics in psychiatry pp 69-88 Toronto Press.
2. Burt VK, Stein K. Epidemiology of depression throughout the female life cycle. J Clin Psychiatry. 2002;63(Suppl 7):9–15.
3. Davar V. Bhargavi (1995)Mental Illness among Indian women.Economic and Political Weekly Vol:30,No.45 pp 2879-2886

4. Gable, S. L., & Nezlek, J. B. (1998). Level and instability of day-to-day psychological well-being and risk for depression. Journal of Personality and Social Psychology, 74, 129-138.
5. Gotlib, I. H., & Hammen, C. L. (1992). Psychological aspects of depression: Toward a cognitive-interpersonal integration. New York: Wiley.
6. Hammen, C., & Brennan, P. A. (2001). Depressed adolescents of depressed and nondepressed mothers: Tests of an interpersonal impairment hypothesis. Journal of Consulting and Clinical Psychology, 69, 284-294.
7. Hankin, B. L., Abramson, L. Y., Moffitt, T. E., Silva, P. A., Mcgee, R., & Angell, K. E. (1998). Development of depression from preadolescence to young adulthood: Emerging gender differences in a 10-year longitudinal study. Journal of Abnormal Psychology, 107, 128-140.
8. Jenkins, J.H., Kleinman, A., & Good, B.J. ( 1 99 1 ) Cross-cultured studies in depression. In J.Becker and A. Kleinman (Eds.), Psychological aspects of depression , 67-98. Mahwah, NJ: Lawrence Erlbaum Associates.
9. Joiner, T. E., Alfano, M. S., & Metalsky, G. I. (1992). When depression breeds contempt: Reassurance seeking, self-esteem, and rejection of depressed college students by their roommates. Journal of Abnormal Psychology, 101, 165-172.
10. Kenney-Benson, G. A., & Pomerantz, E. M. (2005). The role of mothers use of control in childrens perfectionism: Implications for the development of childrens depressive symptoms. Journal of Personality, 73, 23-46.
11. Lafontant-Beauboeuf Tamara(2007)You have to show Strength:An Exploration of Gender,Race ,Depression.Gender and Society vol21 No 1 pp 28-51.Sage Publication Inc.
12. Lewinsohn, P. M., Gotlib, I. H., & Seeley, J. R. (1997). Depression-related psychosocial variables: Are they specific to depression in adolescents? Journal of Abnormal Psychology, 106, 365-375.
13. Martire, L. M., Lustig, A. P., Schulz, R., Miller, G. E., & Helgeson, V.S. (2004). Is it beneficial to involve a family member? A meta-analysis of psychosocial interventions for chronic illness. Health Psychology, 23, 599-611.

14. McCullough, J. P. (2003). Treatment for chronic depression: Cognitive Behavioral Analysis System of Psychotherapy (CBASP). Journal of Psychotherapy Integration,13, 241-263.
15. Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. Journal of Abnormal Psychology, 100, 569-582.
16. Nolen-Hoeksema, S., & Girgus, J. S. (1994). The emergence of gender differences in depression during adolescence. Psychological Bulletin, 115, 424-443.
17. Norman Judith(2004)Gender bias in the Diagnosis and treatment of Depression International Jornal of mental health Vol 33 No2 pp 32-43 Taylor and Francis Ltd.
18. O'Hara, M. W., Lewis, D. A., Schlechte, J. A., & Varner, M. W. (1991). Controlled prospective study of postpartum mood disorders: Psychological, environmental, and hormonal variables. Journal of Abnormal Psychology, 100, 63-73.
19. Robins LN, Regier DA. New York: The Free Press; 1990. The Epidemiologic Catchment Area Study. Psychiatric Disorders in America.
20. Rihmer Z, Angst A. Mood disorders: Epidemiology. In: Sadock BJ, Sadock VA, editors. Comprehensive Textbook of Psychiatry. 8th ed. Baltimore: Lippincott Williams and Wilkins; 2004.
21. Roxburgh(2009)Untangling Inequalities :Gender,Race,and Socio-economic difficultie in Depression .Sociological Forum Vol 24 No.2 pp 357-381.Wiley.
22. The World Health Report. 2001. [Last accessed on 2014 Jun 30]. Available from:http://www.who.int/whr/2001/en/