

## Social and Cultural Pressures and Depression in Pakistani Women: A Case Report

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**Abstract:** This study shows a case of young girl of 19 years of age. She was brought Fouji Foundation hospital with the symptoms of loss of appetite, dry mouth, insomnia, suicidal thoughts, loss of pleasures, feeling of guilt and low self-esteem. Diagnoses was made according to DSM-5. Through detail investigation it was known that her symptoms were not due to any biological cause rather they were due poor social condition and cultural pressures in which she living. Psychotherapies including cognitive behaviour therapy, interpersonal and couple therapy were applied in this case. The patient showed significant improvement in her condition.

**Keywords:** symptoms, suicidal thoughts, social condition, cognitive behaviour therapy.

### 1. INTRODUCTION

The DSM-5 describes that major depressive disorder as a state or condition manifest by feelings of unhappy or sadness, guilt or emptiness; sleep problems and loss of interest in daily activities. In many cases, individuals exhibiting the sign and symptoms of major depressive disorder also experience considerable change in weight. Major depressive disorder can be diagnosed across the lifespan and is most common among girls and women (American Psychiatric Association, 2013).

Some patients with major depressive disorder experience recurring episodes, but many patients experience only a single episode. The sign and symptoms of depression cannot be related to substance use or other medical illness. If symptoms of depression are related to a trauma or loss, they are considered signs of grief, not major depressive disorder (American Psychiatric Association, 2013).

According to DSM-5 there are many causes of major depression. Negative thinking style in response to stress is the major cause of depression. Environmental risk factors can also play important role in the development of depression. People with the memories of difficult or abusive childhood are particularly at the high risk of developing depression. The DSM-5 estimates that heritability is around 40%. Individuals with an family members who suffer from depression are two to four times

more likely to exhibit depressive symptoms than the general population (American Psychiatric Association, 2013). Bierat et al., (1999) suggested that genes play important role in the development of depression among women. It has been suggested that women may be more vulnerable to depression because of the neuroendocrine rhythmicity engendered in menstrual cycle or reproduction (Dunn & Steiner, 2001; Steiner, 1992).

The biological maturation that occur during puberty along with intensification of the social roles also make women more prone to depressant (Kovas, Summit, 2000). Freud and Bowbly suggest that relationships problems appear to have particular cause of depression among women.

Interpersonal stressful events and circumstances trigger depressive episodes in women and low peer and parent support are risk factors that continue after the episode resolves, presumably creating vulnerability for recurrence of depression among women (Beevers, Rohde, Stice & Nolen-Hoeksema, 2007).

Golding (1999) and Mccauley et al., (1995) suggested that depression is more common in women who suffer from violence. Many biological and psychological perspectives on depression have develop a stress diatheses model that explain the women vulnerability to developing sign and symptoms of depression. This stress diatheses model relate the depression

with other factors like learned helplessness, poor coping styles and biology of women that make women more prone to depression (Abramson, Alloy & Matasky, 1989).

Past research has suggested that as compared to men women experience higher rates of depression and anxiety (Aneshensel, 1992; Gove & Tudor, 1973; Kessler & McRae, 1981; Mirowsky & Ross, 1989). According to the WHO Global Burden of Disease 1996 statistics, the major cause of disease burden for women in 1990 was unipolar depression.

In our country women literacy rate is low that is i.e. 24% and majority of women are housewives and Pakistani women are not economically independent rather they are dependent on men and they do not have awareness about their legal rights. Throughout the life span Pakistani women face many psychosocial stresses. Many researchers have found high rate of depression in Pakistani women (Mumford, Nazir, 1996; Naiz, 2000).

Many important predisposing factors for mental illness in Pakistani women have been identified and these are low socioeconomic conditions, unemployment or poor job conditions, illiteracy, social discrimination, denial of justice or lawlessness, loosening of cohesion in society and violations of human rights (Gadit & Khalid, 2002).

As compared to men the diagnosable depressive disorders are extraordinarily common in women, who have lifetime prevalence for major depressive disorder of 21.3%, compared with 12.7% in men (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993).

Social relationships are thought to be ubiquitous part of life, serving important psychological, behavioural and social functions across the lifespan. Both the quantity and quality of social relationships have been reliably related to having influences on morbidity and mortality (Blazer, 1982; Broadhead et al, 1983; Cassell, 1976; Cobb, 1976; Cohen & Syme, 1985; and House, Landis & Umberson, 1988).

In Pakistani women pressure is generated because of women's multiple roles, gender discrimination and associated factors of poverty, hunger and domestic violence make women prone to depression.

In Pakistan social problems are a leading cause of anxiety and depression and have an overall prevalence of 34% (Mumford, Nazir, 1996; Naiz, 2000). Findings from studies conducted

in rural areas of Pakistan show higher of depression among rural women and suggest low social support to women suffering from mental illness (Husain & Chaudhry, 2007).

Low social support has been associated with sign and symptoms of depression (Klineberg et al., 2006). In a cross sectional study by Miller et al. (2004), social support was found to be the most important risk factor for clinically depressive symptoms. Women who were more likely to display sign and symptoms of depression also showed that they are receiving less social support by their family and friends. Lack of social support that make individual more prone to greater depressive symptoms has also been linked to heart diseases (Taylor, Washington, Artinian, & Lichtenberg, 2008).

Brown and Harris (1989) showed that women who have a close and strong relationship with her husband, relatives and friends are less likely to develop the sign and symptoms of depression as compared to woman who does not receive social support from their friends and family. Disappointment in the family relationships, marriage disputes, financial issues, a change of the place of residence or working place, a disease or the death of a family member are considered important factors for developing sign and symptoms of depression.

## **2. DIAGNOSTIC CRITERIA OF MAJOR DEPRESSION**

The DSM-5 requires that at least five symptoms be present for a two week period or longer to make a diagnosis. The most common symptoms of major depressive disorder are feeling unhappy most of the time and losing interest or pleasure in most activities, emptiness, guilt or hopelessness. In children and adolescents, irritable mood is commonly observed by parents and teachers.

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- Depressed mood most of the day.
- Markedly diminished interest or pleasure in most of the daily activities.
- Significant changes in weight.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation nearly every day.

- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or inappropriate guilt.
- Diminished ability to think and concentrate.
- Recurrent suicidal
- The symptoms may cause clinically marked distress or impairment in social, occupational.
- The episode is not attributable to the physiological effects of a substance or to another medical condition.

### 3. A CASE STUDY

#### 3.1. Presenting Complaints

Miss X came to the Fauji Foundation Hospital with her mother for getting psychological help. Miss X was presented in Fauji Foundation Hospital with having complains like irritability, diminished interest in daily activities, insomnia, suicidal ideation, feeling of worthlessness and concentration problems. She was the young girl of 19 years of age and came with her mother.

#### 3.2. History of the Patient

According to miss X her whole life was full of troubles. She was very young of 7 years of age when her father died. She reported her father a very nice. After the death of her father she left her education and at the age of 18, she got married. According to her at that time she was not mentally prepared for marriage. After marriage she faced many problem created by her in-laws and her husband. She was the only member of family who has to take care of the whole family. Initially her husband's behaviour was very good with her but with the passage of time due to continuous pressure from his family, his behaviour with her started turning into bad. After having many quarrels with her husband, she went to her mother house but there her brothers didn't accept her presence and forced her to go back to her husband's house where she didn't want to live. Due to this family atmosphere, she started to develop the symptoms of diminished interest, insomnia, concentration problems and feeling of worthlessness 4 months ago. She wanted to end her life because she felt that she had no purpose to live any more.

#### 3.3. Family History of the Patient

No family history of any disease was found. Her parents were a happy married couple. Her parents were cousins and there was no history of

mental illness was found in her family. Her family was very religious and all of her family members strictly followed religious traditions. No physical disability was found in her family her all the siblings were mentally and physically healthy. Her father was the head of family and he used to set the rule and regulation for all the family members. After her marriage she faced many problems created by her in-laws, initially her relationship with her husband were good but her relationship with her mother in law and sister in law were very disturbing. These disturbed relations contribute to her signs and symptoms.

She was born with full term pregnancy and her delivery was vaginal. Nor she neither her mother faced any complications at the time of her birth. When she was born her weight was 5 pounds. She was very healthy from her childhood. In her infancy and early childhood her relationship with her parents specially with her mother were very strong. She got her significant milestones at proper age.

She got married when she was 18 years of age. She got married with her cousin. Her marriage was arranged marriage and didn't see her husband before marriage. Her husband was already married and it was his second marriage with her. His husband divorced his first wife and then got married with her. According to her, her husband's behaviour with her was not satisfactory.

#### 3.4. Premorbid Personality

According to her before exhibiting these signs and symptoms she was a very responsible member of the family. She was quite social and was not having any anger outburst. She was very caring before exhibiting her signs and symptoms. The description of her premorbid behaviours was cross checked by her referral (mother).

#### 3.5. Treatment Process

Her score on the BDI was 33 which shows that she is suffering from major depression. Her score on the RISB was 145 which is above cut off score that means she is not well socially adjusted. The HFD of patient reveals that she had guarded personality and not very social. The patient seems to have the feelings of insecurity. Several features indicate his depressive behavior. She seems to have confused thinking, distorted self image and communication difficulty. The patient seems to have difficulty in interpersonal relationship. In drawing the person, feelings of inadequacy inferiority of

social intellectualization, aggressive tendency, need for increase in physical power. Projective analysis indicate that client has weak split personality. The test reveal that she has high need for love, affection, achievement and affiliation. And she has dominant need for dominancy difficulty in sexual areas.

### **3.6. Psychotherapies**

Miss X was cope up with 16 individuals psycho therapeutic sessions during which her those feelings, emotions and behaviours were discussed which were causing problem for her. Many therapies were administered on her. Cognitive therapy was used to change her pessimistic ideas, unrealistic expectations, and overly critical self-evaluations. Her way of perceiving reality was changed by her mutual cooperation. Behavioural therapies was applied on her to modify her maladaptive behaviours. She was taught muscle relaxant techniques to cope with stress. During sessions she was also taught stress management and anger management techniques.

Family and couple therapy and support group program were also applied on her. In couple therapy she with her husband was counsel to manage the issues in future. She was taught problem solving and coping skills during sessions and was taught to learn the greater sense of control over her troublesome emotions and behaviours.

In the final session Miss X reported of having less frequency of her symptoms. She was in good mood and was determined to improve her life. She was recommended the follow up session to check her progress of recovering.

## **4. DISCUSSION**

It has been reported that not only in Pakistan but also across many nations, cultures, and ethnicities, women are about three time more prone as compared to men to develop the symptoms of depression (American Psychiatric Association, 2013).

Miss X was brought by mother to the hospital for getting psychological help for her sign and symptoms. Miss X was 19 years old girls. Though a thorough and detail psychological examination it was concluded that she has become the victom of social pressures as she was not ready to live with her husband due to his and his family misbehaviours but she was forced to live with them. The feeling of helplessness and hopelessness was getting peak

in her case. She was not well educated to earn for herself and was dependent on her family members for her survival. After many sessions and informal interviews she herself felt decrease in the intensity of her symptoms.

She is not only single case of social injustice rather they are many women in developing countries and men dominating societies displaying her picture. Due to these social pressure women in the developing countries suffer more from depression than males. There are several causes for Pakistani women to exhibit more the sign and symptoms of depressions as compared to men. First, because in our country men are dominating everywhere and women have less power and social status than men, so they are more likely to experience traumas. They are more likely to experience social and cultural pressures like poverty, harassment, lack of respect, and limited choices. Second, even when women and men suffer from the same stressors, women may be more prone as compared to men develop the sing and symptoms of depression because of gender differences in biological responses to stressors and coping styles.

Because in Pakistan women lack of social power and they are dependent on others it makes them more vulnerable than men to exhibit the sign and symptoms of depression. Social pressures and traumas may contribute directly to depression, by making women feel they are powerless and helpless to control their own lives, and may also contribute in indirect ways, by increasing women's reactivity to stress. In our culture women's multiple social roles and responsibilities may also contribute to depression. In Pakistan women has to care only their husband but also children and they has to care their sick and elderly family members.

The dilemma of Pakistani people for poor mental health is that they give more importance to magic, evil eye, possession, as being the solely causes of mental problem and usually approach a shaman or a traditional healer rather than mental health professional for treatment (Gadit, 1995; Gadit, 1998).

## **5. CONCLUSION**

The purpose of the study was explore the causes behind increasing cases of depression among Pakistani women. Depression and other mental illness among Pakistani women are resulting from social dilemmas of our country. It is

concluded that social and cultural pressures play huge role in the development of depression among women. It has become the need of the hour to reduce these pressures from women otherwise it may become the serious threat to women's mental health in Pakistan. Women should make aware of their rights and they should make independent and policies at government and public level should be made solve the women issues and making them aware of their legal rights. More studies should be done to correlate the depression with other variables.

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