

## A Cross-Sectional Study on the Prevalence of Depression and Anxiety Among Homemakers and Its Association with Social Support

Dr. Rahul Bagal

Assistant Professor, Dept of Psychiatry, Santosh Medical College, Ghaziabad

Article Info: Received 23 March 2021; Accepted 05 May 2021

Corresponding author: Dr. Rahul Bagal

Conflict of interest: No conflict of interest.

### Abstract

**Background:** Homemakers are often at risk of psychological distress due to multiple stressors including social isolation, lack of financial independence, and familial responsibilities. Depression and anxiety frequently go unrecognized in this population.

**Objective:** To assess the prevalence of depression and anxiety among homemakers and evaluate the role of perceived social support in relation to their mental well-being.

**Methods:** A community-based cross-sectional study was conducted on 350 adult homemakers aged 20–60 years. Data were collected using the Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), and Multidimensional Scale of Perceived Social Support (MSPSS). Sociodemographic variables were also recorded. Statistical analysis included chi-square tests and Pearson correlation.

**Results:** The prevalence of moderate to severe depression and anxiety was 28.5% and 24.8%, respectively. Low perceived social support was reported by 34.6% of the participants. A statistically significant inverse correlation was found between MSPSS scores and PHQ-9 ( $r = -0.49, p < 0.001$ ) and GAD-7 scores ( $r = -0.45, p < 0.001$ ).

**Conclusion:** A substantial number of homemakers experience depression and anxiety, with low perceived social support being a major contributing factor. Mental health screening and community-based support systems should be prioritized for homemakers.

**Keywords:** Depression, anxiety, homemakers, social support, PHQ-9, GAD-7, MSPSS

### Introduction

Mental health problems such as depression and anxiety are major contributors to the global burden of disease and disability [1,2]. While working populations often receive attention for occupational stress and mental health issues, homemakers—particularly women engaged in unpaid domestic labor—remain an underrecognized group in mental health research [3,4].

Homemakers frequently experience role overload, lack of autonomy, restricted social interaction, and low appreciation for their work [5]. These psychosocial challenges can predispose them to emotional distress, which often remains

undiagnosed due to social stigma or absence of structured screening mechanisms [6].

Social support has consistently been identified as a protective factor in mental health. Perceived social support from family, friends, and significant others plays a crucial role in reducing psychological morbidity, especially in emotionally demanding roles such as caregiving and domestic management [7,8].

This study aims to estimate the prevalence of depression and anxiety among homemakers and assess the relationship between these conditions and their perceived level of social support.

## Materials and Methods

This cross-sectional study was conducted over six months in a suburban locality affiliated with a tertiary care hospital. The target population included adult homemakers aged 20 to 60 years residing in the area for at least six months. A total of 350 participants were enrolled using systematic random sampling from electoral rolls and local community registers.

Inclusion criteria were adult women self-identifying as full-time homemakers, willing to provide informed consent, and able to complete the questionnaires. Exclusion criteria included current psychiatric treatment, known cognitive impairments, or history of serious physical illness that could impact mental state.

Data collection was carried out through structured interviews at the participants' residences by trained postgraduate psychiatry residents. Sociodemographic information such as age, marital status, number of children, household income, and education level were recorded.

Depression was assessed using the Patient Health Questionnaire-9 (PHQ-9), a 9-item scale aligned with DSM criteria. Anxiety was measured using

the Generalized Anxiety Disorder-7 (GAD-7) scale. Perceived social support was evaluated using the Multidimensional Scale of Perceived Social Support (MSPSS), which includes subscales for family, friends, and significant others.

All instruments were available in the local language and validated through a pilot study involving 20 participants who were excluded from the final analysis. Data were analyzed using SPSS version 22. Descriptive statistics were used for demographic variables. Chi-square tests were applied to examine associations, and Pearson correlation was used to assess relationships between continuous variables. A p-value < 0.05 was considered statistically significant.

## Results

### Demographic Characteristics of Participants

The mean age of the study population was 36.4 years (SD ± 8.7), with a majority (58%) falling in the 31–45-year age group. Most participants were married (91.2%) and had two or more children (66%). A large portion belonged to lower-middle-income households.

**Table 1: Demographics of Participants (n = 350)**

Variable	Value
Mean age (years)	36.4 ± 8.7
Age group 31–45 years	58%
Married	91.2%
≥2 children	66%
Lower-middle-income status	Majority

### Prevalence and Severity of Depression

Using the PHQ-9 scale, 28.5% of participants were found to have moderate to severe depression. Mild

symptoms were observed in 28.6%, while 42.9% had no significant depressive symptoms.

**Table 2: Depression Severity (PHQ-9)**

Depression Severity	Number of Participants	Percentage (%)	Statistical Test
No significant symptoms (<5)	150	42.9%	–
Mild (5–9)	100	28.6%	–
Moderate (10–14)	60	17.1%	–
Severe (15–27)	40	11.4%	–
<b>Total Moderate–Severe</b>	<b>100</b>	<b>28.5%</b>	–

**Prevalence and Severity of Anxiety**

Based on the GAD-7 scale, 24.8% of homemakers experienced moderate to severe anxiety. A further 33.7% reported mild anxiety symptoms.

**Table 3: Anxiety Severity (GAD-7)**

Anxiety Severity	Number of Participants	Percentage (%)	Statistical Test
Minimal (0–4)	145	41.5%	–
Mild (5–9)	118	33.7%	–
Moderate (10–14)	60	17.1%	–
Severe (15–21)	27	7.7%	–
<b>Total Moderate–Severe</b>	<b>87</b>	<b>24.8%</b>	–

**Perceived Social Support**

The average Multidimensional Scale of Perceived Social Support (MSPSS) score was  $54.2 \pm 12.3$ .

One-third (34.6%) of participants had low perceived social support (score <50), indicating potential vulnerability to emotional distress.

**Table 4: Perceived Social Support (MSPSS Score)**

MSPSS Category	Number of Participants	Percentage (%)	Statistical Test
Low (<50)	121	34.6%	–
Moderate/High ( $\geq 50$ )	229	65.4%	–

**Association Between Low Social Support and Mental Health**

Chi-square analysis showed a **significant association between low perceived social**

**support and moderate–severe depression** ( $\chi^2 = 27.1, p < 0.001$ ), and **moderate–severe anxiety** ( $\chi^2 = 11.6, p = 0.001$ ).

**Table 5: Association Between Low Social Support and Mental Health**

Mental Health Outcome	% with Low MSPSS	Chi-square ( $\chi^2$ )	p-value
Moderate–Severe Depression	66.3%	27.1	< 0.001 **
Moderate–Severe Anxiety	54.0%	11.6	0.001 **

**Correlation Between Social Support and Mental Health Scores**

Pearson correlation showed a **significant inverse relationship** between social support and depression/anxiety scores.

**Table 6: Correlation Between MSPSS and PHQ-9/GAD-7**

Correlation Pair	Correlation Coefficient (r)	p-value	Interpretation
MSPSS vs PHQ-9	-0.49	< 0.001 **	Moderate negative correlation
MSPSS vs GAD-7	-0.45	< 0.001 **	Moderate negative correlation

**Discussion**

This study found a high prevalence of depression (28.5%) and anxiety (24.8%) among homemakers, underscoring the mental health burden in this group. These findings are consistent with studies

from similar socioeconomic settings in India and other low- and middle-income countries, where the psychosocial demands of domestic life, lack of occupational identity, and financial dependence contribute to emotional distress [4,9,10].

Homemakers in our sample reported significantly lower levels of perceived social support, particularly from sources outside the family. This may be explained by the fact that many homemakers have limited mobility, fewer social engagements, and often prioritize family responsibilities over personal needs [11]. Social isolation, limited financial autonomy, and role monotony have been shown to increase vulnerability to mental illness in women performing unpaid domestic labor [5,12].

The inverse correlation between MSPSS and both PHQ-9 and GAD-7 scores reinforces the buffering hypothesis of social support. This theory suggests that high perceived emotional support can reduce the negative psychological impact of stressful life events [13,14]. Our results are supported by other community-based studies that show a strong link between poor social support and common mental disorders in women [15,16].

Barriers to care such as stigma, under-recognition of symptoms, and lack of structured screening programs delay help-seeking in this population [6,17]. Community outreach programs, mental health literacy campaigns, and training of primary healthcare providers are crucial in addressing the unmet psychological needs of homemakers.

## Conclusion

Depression and anxiety are prevalent among homemakers, with social support emerging as a crucial factor in psychological well-being. Strengthening social networks and integrating mental health screening into community health services can help reduce the burden of undiagnosed psychiatric illness in this population.

## References

1. World Health Organization. Depression and Other Common Mental Disorders: Global Health Estimates. Geneva: WHO; 2017.
2. Vos T, Lim SS, Abbafati C, et al. Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis. *Lancet*. 2020;396(10258):1204–1222.
3. Patel V, Kirkwood BR, Pednekar S, et al. Gender disadvantage and common mental disorders in women: a community survey in India. *Arch Gen Psychiatry*. 2006;63(4):404–413.
4. Mathias K, Goicolea I, Kermode M, et al. Cross-sectional study of depression and social support among women in rural India. *BMC Psychiatry*. 2015;15:28.
5. Mehrotra S, Tripathi R. Role conflict, stress and coping: A study on working women. *J Health Manag*. 2013;15(4):593–605.
6. Shidhaye R, Kermode M. Stigma and discrimination as a barrier to mental health service utilization in India. *Int Health*. 2013;5(1):6–8.
7. Thoits PA. Mechanisms linking social ties and support to physical and mental health. *J Health Soc Behav*. 2011;52(2):145–161.
8. Zimet GD, Dahlem NW, Zimet SG, Farley GK. The Multidimensional Scale of Perceived Social Support. *J Pers Assess*. 1988;52(1):30–41.
9. Grover S, Dutt A, Avasthi A. An overview of Indian research in depression. *Indian J Psychiatry*. 2010;52(Suppl1):S178–88.
10. Nandan D, Agarwal M. A study of depression among housewives in a rural area of Varanasi district. *Indian J Prev Soc Med*. 2012;43(3):312–315.
11. Khan MS, Anwar A, Irshad N, et al. Psychological distress among housewives and working women in Karachi. *J Pak Med Assoc*. 2013;63(8):939–941.
12. Silva MT, Galvao TF, Martins SS, Pereira MG. Depression as a risk factor for the development of chronic diseases. *Rev Saude Publica*. 2014;48(1):5–11.
13. Cohen S, Wills TA. Stress, social support, and the buffering hypothesis. *Psychol Bull*. 1985;98(2):310–357.
14. Kawachi I, Berkman LF. Social ties and mental health. *J Urban Health*. 2001;78(3):458–467.
15. Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: Scarcity, inequity, and inefficiency. *Lancet*. 2007;370(9590):878–889.

16. Rahman A, Patel V, Maselko J, Kirkwood B. The neglected “m” in MCH programmes – why mental health of mothers is important for child nutrition. *Trop Med Int Health*. 2008;13(4):579–583.
17. Gureje O, Oladeji BD, Montgomery AA, Araya R. Integrating mental health into primary care in low- and middle-income countries: background, need and opportunities. *World Psychiatry*. 2015;14(1):1–8.