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Predictors of Major Depressive Disorder among Pakistani Women: A Case Study

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Abstract

Social and cultural pressures play a significant role in the development of depressive disorders. Women are at a greater risk of developing depressive disorders because they always become the subject of social and cultural pressures. This paper presents the case of a 23-year-old female who developed symptoms of Major Depressive Disorder (MDD) due to cultural constraints. Initial pre-testing and therapist observation of the client's verbal and non-verbal attitude / behaviour confirmed the diagnosis of MDD. Diagnosis was made according to DSM-5. After initial intake interview, psychological tests including House-tree-person (HTP), Thematic Apprehension Test (TAT), Rotter's Incomplete Sentence Blank (RISB), Beck Depression Inventory (BDI), Raven's Standard Progressive Matrices (SPM) and Clinical Structured Interview (CIS-R) were administered on the client. After exploring the causal factors of her problem and conducting diagnostic sessions, therapeutic sessions were also conducted. Some techniques from cognitive behavioural therapy were selected for the client based on the strong empirical evidence available which advocates for their usage in effectively treating depressive disorders. After achieving the goals of psychotherapy set at the first session with the help of the client as well as achieving satisfactory results of post-testing and therapist observation of the client progress, psychotherapy was terminated. Follow-up sessions were conducted to monitor the progress of the client. Our research has clinical and community implications.

Keywords: cognitive behavioural therapy, Major Depressive Disorder (MDD), social and cultural pressures

Introduction

According to DSM-5, the symptoms of major depression include feelings of sadness, loss of interest in daily activities, feelings of guilt and sleep disturbance. People suffering from Major Depressive Disorder (MDD) often experience a significant change in their weight. Depression can be diagnosed throughout the lifespan of a person and is more frequent among girls and women. Several effective

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treatment options exist but when not treated, MDD can lead to suicide (American Psychiatric Association, [2013](#)).

Throughout the course of their life, women are three times more likely to experience MDD as compared to men. In the United States, the prevalence of MDD is about 7% among the general population (American Psychiatric Association, [2013](#)).

In Pakistan, the prevalence of MDD is 28%–57% among women (Husain et al., [2000](#); Mumford et al., [2000](#); Ali et al., [2002](#)). The major determinant of depression among Pakistani women is the prevailing social environment (Rabbani & Raja, [2000](#); Niaz, [2001](#); Riso et al., [2002](#)). Social environment was found to be more hostile towards women in Pakistan (Husain et al., [2011](#); Mumford et al., [2000](#); Mumford et al., [1996](#); Mumford, Saeed, Ahmad, Latif, & Mubbashar, [1997](#)). Women are encouraged to be subservient and wife battering as well as conflict with spouse and in-laws are common problems in Pakistan (Niaz, [2001](#)).

Many studies have measured social setting variables in terms of income, education, occupation and the number of social supports (Koniak, Lominska, & Brecht, [1993](#)). These variables define social conditions which include socioeconomic status (SES), major life events, relatives' health status, household responsibilities and supports (Nilsson, Engberg, Nilsson, Karlsrose, & Lauritzen, [2003](#)). Additionally, a woman's social relations should be based on the quality of relationship with her husband, in-laws, parents and children (Barnet, Joffe, Duggan, Wilson, & Repke, [1996](#); Stuchbery, Matthey, & Barnett, [1998](#)). Concerns related to pregnancy are an added burden during pregnancy and may include signs and symptoms of pregnancy, changes due to pregnancy and concern for the baby (Huizink, Robles de Median, Mulder et al., [2002](#); Stotland, [1995](#)).

According to the existing literature, South Asian women face circumstances which are responsible for their poor mental health. Antenatal depression was estimated to be found at the rate of 16%–33% among South Asian women (Chandran, Tharyan, Muliyl & Abraham, [2002](#)). Violence inflicted by the husband, lack of support from in-laws and family preference for a male child are factors strongly associated with depression among pregnant women in the entire South Asian region (Chandran et al., [2002](#)).

In a survey conducted in Lahore, 807 married women who used to visit the clinic of their private family physician were approached and among them 658 agreed to be interviewed. The researchers used International Classification of Diseases (ICD) diagnosis for depressive episodes and other psychiatric ailments.

The results of the study suggested that 30.35% of married women were experiencing depressive episodes and it was the most common diagnosis among other psychiatric ailments assessed (Ayub et al., [2009](#)).

In another case control study, which was conducted to investigate the association of various reproductive rights, domestic violence and marital rape with depression among Pakistani women, it was found that the age of less than 18 years at marriage and decision for marriage by parents could also contribute to depression among women in Pakistan (Ali, Israr, Ali & Janjua, [2009](#)).

Another study conducted on pregnant women of rural areas of Sindh determined that social conditions, as compared to social relations, were more important determinants of depression among women. The results of this study showed that for each unit increase in poor social conditions, there was 0.57 unit increase in depression scores (Zahidie, Kazi, Fatmi, Bhatti, & Dureshahwar, [2011](#)).

Despite immense diversity in the sociocultural environment of Pakistan, there is overall a very high prevalence of anxiety and depression in the rural areas of the country. A study conducted in rural Punjab to investigate stress and psychiatric disorders showed that 66% of women and 25% of men suffered from anxiety and depressive disorders (Mumford et al., [1997](#)). This study in rural Punjab imitated the findings of a previous study carried out in Chitral in northern Pakistan and it found high levels of emotional distress and psychiatric morbidity among women in the rural areas of Pakistan. Another research carried out in Gilgit, in the Northern Areas of Pakistan, found that 50% of women had anxiety and/or depression (Mumford, Nazir, Jilani, & Baig, [1996](#)). Another study carried out in a village in KP, which in some aspects resembles our rural setting, showed that 60% of women and 45% of men scored 9 or more on the Self Reporting Questionnaire (SRQ) (Husain, Chaudhry, Afridi, Tomenson, & Creed, [2007](#)).

Agency / Setting

Case was taken from Foundation University, Rawalpindi Campus.

Background of the Client / Demographic Details

Name:	XYZ
Age:	24
Gender:	Female
Education:	Bachelors in Science
Siblings:	3
Marital Status:	Single
Occupation:	Student

Residence: Rawalpindi
Birth order: Middle

Reasons / Mode / Source of Referral

Client was self referred.

History of Present Illness

The client had been unwell for the past nine months. She was experiencing symptoms of sad mood, suicidal ideation, loss of appetite, sleep disturbance and concentration problems. She was in a relationship with a boy and her parents did not accept his proposal. Afterwards, she started experiencing these symptoms and attempted suicide twice by taking too many sleeping pills.

Past Psychiatric History

Not found.

Past Medical History

She was suffering from hormonal problems, infection in uterus and had an irregular menstrual cycle. Currently, she was taking medication for these problems.

Family History

The client belonged to a conservative and religious family. She had one sister and one brother. She was the middle born child. Her father was a retired army officer and her mother was a housewife. According to her, her family was not supportive at all. Her parents had a conflicting relationship with each other and with herself. Her father wanted her to marry his brother's son but she was not willing to marry him.

She also reported during sessions that her relationships with her relatives were very conflicting and her relationship with her siblings was also conflicting. She did not like them at all and they were jealous of her.

Personal History

The client was born after nine months of pregnancy. Her birth was normal and she and her mother did not suffer any medical complication at the time of her birth. Her weight at birth was 4 pounds. She passed all the significant milestones at the appropriate age.

The client reported herself as a very talkative child in her childhood. She had many friends in her childhood and she was an average student. She had a conflicting relationship with her father since her childhood.

Pre-morbid Personality

The client reported herself to be very social, friendly and responsible before the onset of her disease. She had many friends and some were very close to her.

Mental Status Examination (MSE)

The client was well dressed. Her appearance was neat and clean. Her hair was well managed. Her attitude was friendly during the session. She was well oriented to time, place and setting. She was alert and had an insight into her problems. Her speech was pressured. Initially, her mood was good but with the progression of the session her mood changed and she became depressed. She was well aware about her condition and remained cooperative throughout the session. Her short term memory and long term memory were well preserved. She successfully recalled an address after five minutes and she also shared some of her childhood experiences which showed that her long term memory was well preserved.

Assessment

1. House-tree-person (HTP)
2. Thematic Apperception Test (TAT)
3. Rotter's Incomplete Sentence Blank (RISB)
4. Beck Depression Inventory (BDI)
5. Raven's Standard Progressive Matrices (SPM)
6. Revised Clinical Interview Schedule (CIS-R)

House-tree-person (HTP)

Her HTP interpretation indicated that she had an extrovert personality type. Her test revealed that she was having difficulties in social relationships. Her test also revealed anxieties in her life. Strong sexual concerns were also indicated by HTP. Feelings of immaturity, inferiority, and insecurity were also indicated by her drawing. HTP also indicated that she was feeling hostile towards other females.

Thematic Apperception Test (TAT)

TAT was administered on the client. She took one and a half hour while responding to TAT cards. Her non-verbal behaviour was also noticed during TAT administration process. Some common themes were identified in the cards. Her responses to stories indicated interpersonal issues. The main hero of most of her stories was male. She presented a distorted self-image in stories. Love and support were her behavioural needs as depicted by her stories. Her conception of the environment was hostile, rejecting and non-supportive. Significant conflicts were revealed in the areas of her social and interpersonal domains. The nature of

anxieties revealed by her responses on TAT cards was physical and caused by disapproval and deprivation. Isolation, denial and regression were the defence mechanisms used by her. Her thought processes were stereotypical and inappropriate. The ending of her stories on TAT cards was pessimistic which revealed her negative approach towards life.

Rotter's Incomplete Sentence Blank (RISB)

Her score on RISB was 145 which suggested that she was not socially well adjusted. Her responses on social and familial dimensions were pessimistic, while her responses on sexual and general dimensions were satisfactory.

Beck Depression Inventory (BDI)

Her score (35) on BDI indicated that she was suffering from a severe level of depression.

Raven's Standard Progressive Matrices (SPM)

She completed SPM in 65 minutes. Her total score on SPM was 30 and her age was 23 which fell within the 40th percentile which indicated that she was average intellectually.

Revised Clinical Interview Schedule (CIS-R)

CIS-R was administered on her to screen out the co-morbidity of other psychological conditions. Her score on CIS-R was 26 which indicated that she was suffering from a moderate level of psychological distress. She scored high in the domains of somatic complaints, sleeping problems, depression, depressive ideas and obsessions. She did not score on phobias, panic and delusional domains of CIS-R. Special attention was paid to her non-verbal behaviour during the interview. She showed resistance while responding in certain domains of CIS-R including obsessions and depressive ideas. She took 35 minutes to complete CIS-R.

Diagnosis

296.12(F32.2). Major Depressive Disorder

Case Conceptualization / Theoretical Orientation

The biopsychosocial model developed by renowned cardiologist Dr. George Engel is widely accepted by mental health professionals at present. According to this model, biological, psychological and social factors are all interlinked and important with regard to promoting health or causing disease. In other words, the mind and the body are independent but connected and are not independent and

separate. What affects the body will have an effect on the mind and vice versa, what affects the mind will also end up affecting the body. Now, wellness or illness includes a person's social status and psychological state and it is not just the matter of someone's physical state.

The biopsychosocial model helps mental health clinicians to explain phenomenon such as depression by examining all relevant biological, psychological, and social factors which may have a significant impact in its development. With regard to biological factors, it is well-known that depressed individuals are often significantly disturbed in terms of endocrine (hormone), immune, and neurotransmitter system functioning. Moreover, depression can make a person more vulnerable to develop a range of physical disorders, as we saw in this case where the affected lady also had headaches and body pains due to her mental state. Similarly, a person who has a physical disorder is often more likely to develop depression and this disorder may become a factor which increases the severity of that person's depression. Psychological factors behind her case were her low tolerance and lack of social support. Research also suggested that genes can influence the transmission of depression from one generation to the next generation.

Progression of Therapy (Number of Sessions)

The total number of sessions conducted with the client XYZ was 9.

During the first session, intake interview was conducted with the client. During the initial interview, she shared her problems and the therapist tried to explore the causal factors behind her problems. Consent was taken from her and she was ensured that all the information gleaned from her was to be kept confidential. However, confidentiality could be breached if the situation arose and information could be shared with the supervisor for the purpose of case consultation. The therapist observed that the source of her problematic thoughts and behaviour was her problematic and non-supportive environment. Too much conservativeness and the rigid attitude of her family were the sources of her problems.

During the second session, the causal factors of her problematic behaviour were further explored by the therapist. The client reported that she remained socially isolated for 9 months after her breakup from her boyfriend. According to her, the sole reason behind her breakup was her father. She revealed that her parents' especially her father's attitude had been very harsh with her since her childhood. She further said that she was too careless these days because she was not feeling any interest in life. During the second session, she also revealed that she attempted suicide twice by taking too many sleeping pills. She made her last attempt three

months before and she was hospitalized for three days. On further probing, she revealed that currently she did not have any close friend. Moreover, she felt much burden on her shoulders and she was performing poorly in her studies.

During the third session, different psychological tests were administered on the client to identify her problems. Her non-verbal behaviour was also observed during the test administration process. TAT was administered on her during the fourth session. Cards of TAT were selected keeping in view her present complains and the therapist observation of her thoughts and behaviours. Some common themes which the therapist identified in all the stories on TAT cards were emotional instability, strong need for affiliation, power, nurturance and fear of rejection.

After the completion of the initial intake and assessment interviews, therapeutic interview was started in the fifth session. Since psychological testing had revealed that the client was having interpersonal issues and depression, so psychotherapeutic suggestion was aimed at overcoming these problems. The goals of psychotherapy were set with the help of the client. Since she had a religious orientation, so she was encouraged to incorporate religious beliefs in all aspects of her life including her relationship with her father and her ex-boyfriend. Her maladjusted coping mechanism was attempted to be replaced by positive coping strategies. She was encouraged to focus on her potential and capabilities instead of her shortcomings. During the fifth session, she was encouraged to get rid of her negative memories (break up from her boyfriend) as they were harming her. At the end of session, she was given the homework assignment of writing five pros and five cons of holding negative memories and their impact on her present and future life.

The sixth session was started with a positive approach and therapeutic suggestions were continued. The client looked happy but she did not reveal any particular reason behind her happiness. After some time, she was asked about the homework assignment she was given last week. She had written five negative points of holding negative memories and she had not written any plus point of living in negative memories. She was made cognitively aware of the consequences of living in the past. Cognitive restructuring was done in the sixth session. She was given some positive statements about herself and was asked to repeat them as many times as possible.

After successfully employing the cognitive aspects of CBT, the seventh session centred on the implications of the behavioural aspects of CBT. During this session, the client was taught muscle relaxation and deep breathing techniques to calm her physical and mental states whenever she felt worried. She was also taught thought stopping techniques to stop the flow of negative thoughts to her mind. Modelling

was also applied during the seventh session. She was asked to think about the person whose behaviour she would like to adopt and she was encouraged to adopt that person's behaviour.

During the eighth session, the client rated the effectiveness of psychotherapy at point 6 out of 10. During this session, she was taught the self-dialogue technique to rationalize all her irrational thinking. She was also taught empty chair technique for effectively expressing her unsaid feelings to her father who was the actual cause of her problems. For diverting her attention from negative to positive aspects of life, she was taught techniques from art therapy so that she might utilize her energy in a positive direction.

The last session was that of termination. When the client and the therapist both felt that psychotherapy had achieved most of its goals set by them mutually, it was terminated. Follow-up sessions were recommended to the client.

Therapist / Client Orientation Dynamics

No issue of transference and counter transference happened in the entire course of psychotherapy.

Prognosis

Initially, her prognosis did not seem favourable due to her resistance, lack of insight about her problem and destructive self-beliefs. Later on, the prognosis improved with the progression of psychotherapy.

Termination

After achieving psychotherapeutic goals set by the client and the therapist during the first psychotherapeutic session, it was decided to terminate psychotherapy. During the ninth session, the therapist checked the progress of the therapy. The client told the therapist that she was feeling relieved of problematic thoughts and behaviours. She also told the therapist that her signs and symptoms were getting low in frequency and intensity and therapist observation also supported this stance.

Before termination, the client was asked to rate her problem on a scale of 1-10. She rated her symptoms at 5 out of 10. Post-testing was done during the last session. BDI was administered on the client and her score on BDI indicated that the intensity of her depression had become moderate. After achieving the targeted goals of psychotherapy (as described by the client, post-test result and therapist observation), psychotherapeutic sessions were terminated and the client was recommended for follow-up sessions and to monitor her own progress.

Discussion

Pakistan is a developing country and presently the Pakistani people are facing political, economic and social crises in addition to security threats. It was found that political, economic and social instability and feelings of insecurity in general are the causes of mental distress among the Pakistani people. During the last two decades, electronic and print media have created awareness about psychological problems and psychiatric disorders in the general public. It was reported in 'Pakistan Today' that psychological disorders are on the rise and mental illnesses are reaching alarming proportions. 50 to 60 patients visit the psychiatry department in the country's hospitals on a daily basis. Moreover, the report of Human Rights Commission of Pakistan (HRCP) indicated that 34% of the country's population is suffering from some form of mental illness (Andrade et al., [2003](#)).

Depression as a serious mental health problem is causing an enormous burden in Pakistan where the health budget comprises less than 1% of Gross National Product (GNP), of which only 0.4% is allocated to the mental health sector, which is a meagre amount compared to the enormity of the situation (Gadit, [2004](#)).

In the Pakistani society, females face a greater amount of stress because they are considered solely responsible not only for household affairs but also for the upbringing of children. Further, it is also expected of them to take care of all other family members. The lady in our case was also the victim of social and cultural pressures which led her to exhibit the symptoms of depression. She belonged to a lower class family. Her father's attitude with her was very harsh but his attitude with her brother was very polite and this developed an inferiority complex in her. She wanted to marry by her own choice but here too social bystanders troubled her. Low S.E.S and lack of social support were the causal factors of her problem.

Previous research showed how stressful life events are positively correlated with psychiatric morbidity. Whereas education and social support were found to have a negative correlation with depression. Moreover, low educational status, having four or more children, overcrowding of household and lack of confidence were the variables most closely associated with a raised SRQ score (Pearson correlation=0.24, p=0.004) (Ali et al., [2009](#)). In our case, the client was not educated and she was not receiving social support. Her relationship with her family was also conflicting. All these factors nourished her depression.

We can conclude that depression in women is due to their gender specific roles and responsibilities which actually result from cultural and social factors prevalent in the surrounding. All these factors generate stress because of their multiple social

roles and gender based discrimination, while associated factors of poverty, hunger, malnutrition and domestic violence combine to account for their poor mental health, especially in the low resource settings of Pakistan. Indigenous studies have also found that social problems are a major cause of anxiety and depression in Pakistan and have an overall prevalence of 34% (Dodani & Zuberi, [2000](#)).

Limitations of the Study

- ❖ The researchers tried their level best to access all published statistics about depression among Pakistani women. However, time constraints and limited resource availability hindered our search for indigenous literature available on depression among Pakistani women.
- ❖ The researchers tried to highlight the major researches conducted on depression among Pakistani women in this paper but the selection of studies may be subject to biasness, which can't be ruled out completely from qualitative studies.
- ❖ The focus of the current study was to review indigenous literature on depression associated with social pressures which contribute to the development of depression. Other parameters causing depression among Pakistani women including biological, hormonal and neurological parameters were ignored by the researchers.
- ❖ For next level researches, cross-cultural comparative studies should be the matter of choice.

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