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Depression: A Sociological Perspective

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Abstract: Depression, which affects lives of millions of people, is commonly known to be a subject matter of psychology. But very few people are aware of the fact that the term depression is commonly used in the field relating to many branches of social science and behavioral science, especially in the area of Medical Sociology, Psychology and Social Psychology. As an illness of isolation and disease of disconnection, depression involves factors which are matter of serious concern for the discipline of sociology. This paper attempts to bring in to fore various aspects of depression by going beyond the boundary of psychology and takes measures to analyse them sociologically. In order to do so it reviewed many of available literatures extensively and attempted to demonstrate how this disorder of disconnection is actually related to multiple social factors.

Key words: Depression, mental health, mental illness, mental disorder.

Depression, a term which is used to refer to melancholic state of mind of individuals, is an important global public health issue. Approximately 280 million people in the world have depression according to the estimate of World Health organization in 2023 (WHO; 2023). Mental disorders account for 13% of the global disease burden, and major depression alone is expected to be the major contributor by 2030 (Hock et al.; 2012). WHO states that depression is a prevalent mental ailment that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or reduced self-worth, disturbed sleep or appetite, and poor concentration. In addition, depression often comes with symptoms of anxiety. These problems can become chronic or recurrent and cause considerable harm to an individual as the sufferer loses the capacity to take care of his or her everyday tasks and responsibilities. At its worst, poor self-care resulting from depression can lead to suicide. More than 700 000 people die due to suicide every year. Being a significant contributor to the global burden of disease, depression affects people in all communities across the world (WHO; 2023).

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Depression is a disorder marked by persistent sadness, discouragement, loss of self-worth, and loss of interest in usual activities. A defining feature of depression as a clinical disorder is the presence of dysphoric mood, consisting of feeling sad, blue, "down-in-the-dumps" or depressed. However, such feelings are common in a normal population and do not necessarily indicate clinical impairment. Clinical conceptions of depression involve something more than the presence of a depressed mood. A major depressive episode (MDE) is characterized by a minimum 2-week history of alteration of the patient's previous level of functioning as well as at least five of the following nine symptoms, which must include either of the first two: (1) depressed mood; (2) markedly diminished interest or pleasure in all, or almost all, activities; (3) significant weight loss or gain or decrease or increase in appetite; (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation that is observable by other people; (6) fatigue or loss of energy; (7)feelings of worthlessness or excessive or inappropriate guilt; (8)diminished ability to think or concentrate or indecisiveness; and (9) recurrent thoughts of death or suicidal ideation or attempts (Abbey and Garfinkel; 1991). Thus the presence of other symptoms that together with the dysphoric mood suggests a clinical syndrome by virtue of their number, persistence, and interference with normal functioning. These typically include a loss of interest in normal activities; feelings of worthlessness, self-reproach, or excessive guilt; a pessimistic outlook or sense of hopelessness about the future; suicidal thoughts or acts; and other signs of impaired functioning, such as sleep or appetite disturbances. For the depressed person, suicide appears to be the only way of escaping the state of hopelessness and despair and if a person is full of hopelessness, suicidal risks increase significantly.

Beyond Psychology: Depression with social roots

Depression is commonly viewed as a matter of psychology. But this disease hardly remains limited to that, as numerous studies revealed. But every person's tale of depression inevitably speaks to questions of isolation, withdrawal, and lack of connection (Karp; 1994). The pain of depression arises in part because of separation from others; from an inability to connect, even as one desperately yearns for just such connection. Whenever we talk about connection, we talk about a person's attachment with various relationships found in society-- family, friends, neighbors, workmates and larger community as a whole. Karp; (1994) further states, As an illness of isolation, a disease of disconnection, depression has critical implications for person's ongoing self-definitions. The related themes of disconnection, isolation, and withdrawal coincide with the most basic issues of sociology itself. Classical sociological theorists shared a common interest in the changing nature of the social bond as agrarian societies were being transformed into urban, industrial societies. Nearly all were disturbed by the progressive weakening of persons' ties to society, and Durkheim, writing on issues

immediately central to this research, explored the linkage between integration and suicide (Aron; 1979). Following this tradition, Karp (1994) discussed how recent sociologists have considered the ill effects of a society characterized by radical individualism. In all of this, the presumption is that the emotional health of individuals, and ultimately society itself, is related to how firmly individuals feel embraced by and connected to communities large and small.

Discussion

This article utilized many scholarly works to reveal social origin of the disease. In order to do that, various aspects of the disease have been unfolded.

i) Mental illness: holistic approach

The idea of mental disorder is not something universal or static. Lefley (2009) discussed how concepts of mental illness and mental health, mental and physical disorder vary across cultures. An overview of three leading sociological approaches about mental illness was provided by Thoits (2009) — namely, Stress theory, which holds that social stressors give rise to mental health problems, Structural strain theory, which locates the origins of distress in the larger social structure, and finally labeling or social reaction theory, which shows people who are labeled as mentally ill, eventually become mentally ill. Horwitz (2009) further discussed various sociological approaches that consider mental health and illness as dimension of social situations. Of course, there is difference in the perspectives of various schools. One type of sociological study investigates the types of social conditions, such as negative life experiences, ongoing stressful events, demand of social roles, presence or absence of social support that influence mental health. Another type of study focuses on how social and cultural factors shape the definitions of and responses to mental disorders. These studies include medicalization, increasing tendency to consume prescription drugs to deal with mental illness, to treat emotional suffering as mental disorders that require professional help.

History of mood disorder has been discussed by Marneros (2006). Hippocrates was the first physician to recognize that mood disorders are caused by brain disease, in the 5th century BC. Melancholia and mania were also conceptualized in this early stage of scientific medicine by him. In the article by Radden (2003) the relationship between today's depression and melancholia of previous era has been discussed. Though both of them share features such as, sadness, dejection, fear, anxiety, they differ in lot of aspects too. The latter was viewed as the characteristic of intellectually brilliant men, a sign of genius. But today depression is not viewed as such glamorous condition and it is associated with both genders.

Following WHO's definition of health, as not merely the absence of disease and infirmity, but also the presence of various forms of well-being, Keyes and Michalec (2009)

highlight the need of the government to adopt the policy, not only for the prevention and treatment of mental illness but also for the protection and promotion of flourishing mental health. Schwartz and Corcoran (2009) highlighted the part sociologists can play in researching the factors that affect the study of mental illness in order to strengthen our knowledge of the relationship between social and biological factors. Lee (1967) wrote how health is defined to include not only freedom from physical disease and pain, but also social well-being. Significant improvement in the health of the people or achievement of specific health objectives cannot be achieved by the fragmented efforts of separate health professions, institutions, and agencies working alone. An integrated effort by all agencies is mandatory.

ii) Studies about emotion

Depression is described as an illness of isolation, a disease of disconnection and is always accompanied by a dysphoric mood. Therefore, it is important to have knowledge about the emotion of those suffering from this disease. Keeping this point in mind, the researcher has reviewed studies discussing about emotion.

Francis (2006) argues that sociology of emotion is the ideal field where the biological and the social can connect, thereby overcoming the duality of Western thought, in which self and society are viewed as different and biology is not related to the social structure. Goodwin and Jasper (2006) argue how study of emotion has been neglected in sociology so far, though in the matter of collective behavior, such as movements, research on this issue can be really useful. Fields, Copp and Kleinman (2006) showed how emotions can be studied using symbolic interactionist approach to enhance one's knowledge about the reproduction of inequality in day-to-day life. Kemper (1991) discussed how emotions are responsive to social incentives and environmental outcomes. Social relations are prime instigators of emotions. Correspondingly, emotions are responses to environmental events and arguably the most important aspect of the environment in modern society is social. Emotions (within limits) conduce to personal and group survival. Fear removes one from potentially destructive conditions. Anger helps the organism mobilize to resist deprivation of vital resources. Sadness, suffered after ineluctable loss, adjusts the organism to the new state of lowered benefits. Guilt stays one's hand from acting destructively toward others. Shame helps to maintain a balance between one's performance and one's claims to reward. Joy and its correlates of caring and loving, lead to solidarity with others in the group. Thompson (1998) described emotional competence as the capacity for self-efficacy in emotion-eliciting social transactions. Its constituents include an awareness of one's emotions and those of others, a capacity to use emotion vocabulary and expressions, empathy, the differentiation of internal subjectivity from outward expression, emotion regulation and coping skills, and adaptive emotional communication within relationships. The ability to

handle emotional crises determines plays a crucial role in determining one's mental wellbeing. Blanchard-Fields (2007) holds that young and older adults differentially approach problems because they focus on different goals related to their stage in life. Thamm (2006) presented a formal classification of emotions. A number of social dimensions proposed by psychologists and sociologists were combined in this formulation of structure of emotions. Peterson (2006) has demonstrated how culture shapes our definition of emotions everyday as emotion management is an ongoing process. The relevant cultural norms are usually learned during socialization on emotional level. Turner and Stets (2006) discussed how moral emotions are an integral part of social life. The list of this emotion includes not only sympathy, empathy, shame, guilt, but also joy, remorse, happiness, awe, veneration over certain issues. We are socialized to act morally, even if we do not do it consciously. Charmaz (2006) discusses the way grief is socially constructed as this particular emotion is related to losing valued social attachments. Scheiman (2006) analysed various aspects of anger as an emotion, its social causes, its distribution according to age, gender. Schmitt and Clark (2006) demonstrated how sympathy is used in various types of social exchanges. Davis (2006) has done the similar job with empathy as this emotion promotes sharing and connects isolated individuals.

iii) Influence of life-style

Nowadays we often hear how a fit body requires regular physical activity and a properly balanced diet. Studies reveal these factors contribute to the development of a fit mind too. Dietary practice, as many researchers suggest, predicts one's psychological health. Study by Jacka et al. (2010) reveal that a dietary pattern comprising vegetables, fruit, beef, lamb, fish, and whole-grain foods (traditional) was associated with a lower likelihood of depressive and anxiety disorders, whereas a dietary pattern comprising processed and "unhealthy" foods (western) was associated with a higher likelihood of psychological symptoms and disorders. Popa and Ladea (2012) discussed some of the most significant findings about the role of nutrition in major depressive disorder. The Mediterranean diet is associated to a low prevalence of depression while fast-food consumption has been found to increase the risk of developing and aggravating this disorder. The authors concluded that the low quality ofthe diet is linked to the high risk of depression. Study by Taylor, Sallis and Needle (1985) reviews the validity of the claim that vigorous physical activity positively affects mental health. Psychological benefits include improved confidence, well-being, sexual satisfaction, reduction in anxiety, and positive effects on depressed mood and various intellectual functioning. These effects can also produce preventive benefits by making people less vulnerable to other factors that might produce mental illness and could also have secondary preventive effects in improving functioning in people with mental illness. The strongest evidence reviewed by this study suggests

that physical exercise can alleviate some symptoms related to mild and moderate depression. Physical activity can be helpful in the treatment for alcoholism and substance abuse programmes too. On the other hand, physical inactivity is a primary risk factor for psychological and physical ill health, as suggested by Higgins et al. (2003), including many disease states that often originate during paediatric years yet only manifest during adulthood. Physical activity may offer protective, buffering effects on mental health for youth prior to the onset of emotional problems, independent of many other risk factors, by raising levels of self-esteem, body image and self- concept. The goal-setting orientation to physical activity can offer a feeling of self-accomplishment, and together with the development of new physical, social and mental skills, may reduce the sense of loss of control frequently linked to depression.

Having a fit mind is also prerequisite to have a fit body. Galson (2009) showed how mental health and wellness are essential to overall health. Individuals who suffer from a chronic condition such as cardiovascular disease or diabetes have a greater risk of developing a mental disorder such as depression. Individuals with depression have a greater risk of developing chronic diseases such as cancer. While mental illness can be an isolating and personal struggle, it is also a public health issue. Mental illness can weave itself through all aspects of one's life: physical health, parenting, work, childbearing, finances, care giving, and common daily activities.

iv) Role of Social Surrounding

Support from social surrounding is a crucial factor for people suffering from any form of disease. But sadly, most of the depressed individuals are consigned to darkness without a clue about how to cope, without any form of support. It doesn't help to dump them into a separate category, as if to know one is to know them all. Each depression afflicts a unique individual. Isolation is one of the worst problems with depression (Smith;1997). Social isolation is detachment from personal relationships— a sense of not having anyone who is someone to you and not being someone to anyone. In all forms of alienation, the individual feels detached from society in some way (Mirowsky and Ross; 1986).Ponzetti Jr. (1990) discussed how loneliness is characterized by an unpleasant, painful, anxious yearning for another person or persons. It reflects an interpersonal deficit that exists as a result of fewer or less satisfying personal relationships than a person desires. Lonely students report feelings of emptiness, hopelessness, restlessness, alienation, anxiety, and being unloved. Preventing loneliness is important because remediation is more difficult when depression and learned helplessness accompany it. Depression can reach fatal stage too where the patient ends his/her life due to intolerable mental suffering. Research on the prevention of suicide has focused, on early recognition and identification of depression in young people and on ways of developing better coping and communication skills.

Gotlib (1992) noted that there are significant differences in the quality of relationships reported by depressed and non depressed persons. For example, depressed individuals report being uncomfortable in interactions with others, often perceiving these interactions as unhelpful or even as unpleasant or negative. Indeed, depressed persons report that they have a greater number of arguments with members of their social networks than do non depressed individuals. Thus, individuals who report having few social contacts and little social support appear to be at increased risk for developing a depressive episode when faced with stressful events.

A study by Fujiwara and Kawachi (2008) suggests that perceptions of higher levels of cognitive social capital (social trust, sense of belonging, mutual aid) are associated with lower risks of developing major depression (MD). People with more social capital may be able to achieve higher socioeconomic status; they may have greater chances to find a desired mate and get married; they may be more attractive to or more likely to be recruited by social organizations, or be more willing to participate in voluntary activities, or be more able to afford the cost of social participation; and people who identify with higher class positions may be more motivated to interact with people with higher social status and accumulate more social capital (Song; 2011).

Study by Driesen et al. (2011) discusses how shift work is associated with disruptions in social and domestic life. Working in shifts implies hampered social life and leisure time activities, because employees working in shifts are working at irregular times of the day when others are taking rest and therefore often have time off when others are working. This results in irregular social interaction. This may lead to a lack of social support, which is an important risk factor for depressive disorder.

Vogli (2010) discussed how the benefits of social relationships are observed in multiple settings, including the work environment, and they extend not only to physical health but also mental health. Both the horizontal and vertical components of social relationships at work exert an independent effect on depression. People deeply care about how they are treated by others in equal or higher positions in the social hierarchy and there is substantial evidence indicating that unfair treatment and lack of social support can generate adverse emotional reactions and depressive symptoms. Lennon and Limonic (2009) analysed consequences of unemployment on one hand and different types of work and the treatment one receives they're on the other influence mental health. Pfeiffer et al. (2011) reviewed the role of peer group as discussed previously by scholars for the treatment of depression. Interacting with peer group members reduce the impact of stressors by providing buffering effect, decrease isolation by bringing together people with similar kind of health complaints, also result in increased sharing of health-related information. Harris (2001) emphasized the positive role of social support, as they can work not only as protection against development of depressive symptom but also for the promotion of recovery.

Another important perspective about social support is given by Ross and Mirowsky (1989). According to the findings of their study the threat of depression can be dealt with alternatively with support and control. Depression can be decreased by either of them, each function successfully if the other is absent. An individual, who has strong social support system, does not depend on the feeling in control of life. On the other hand, the person who feels very much in control of his or her life does not need strong social support group to decrease depression.

Even when the disease is on physiological level, social support can play a very significant role in reducing its negative effect while promoting recovery. Cobb (1976) highlights its role in protecting individuals from a wide range of illness such as tuberculosis, arthritis to depression, alcoholism. In discussing cultural influences on mental illness, Laungani (1989) argued, no culture or no society has all the answers concerning the very serious and debilitating problems of mental illness. He viewed the genesis of the problem as more in religious, social, and cultural terms than in psychiatric or in medical terms.

House, Landis and Umberson (1988) demonstrated how social relationships, or the relative lack thereof, constitute a major risk factor for health rivalling the effects of well-established health risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical activity. This idea of "social support," or something that maintains or sustains the organism by promoting adaptive behavior in the face of stress or other health hazards, provided a general theory of how and why social relationship should causally affect health.

Various life-events influence one's mental health status. Among negative ones, effect of terrorism has been discussed by Johnson and Hobfoll (2009). They showed that discourse on such topic has its roots in the traumatic stress perspective. Lewis and Araya (2001) argue about the importance of depression for public health research. They have discussed that the link between various adverse life events and a depressive episode is stronger during the first episode of depression than subsequentdepressive episodes. Barlow (1991) suggests that early experiences with lack of control on emotion provide a psychological vulnerability for anxiety. If this vulnerability is combined with a biological vulnerability and triggered by the stress of negative life-events, leads to clinical anxiety and, sometimes to depression. Thus, developing depressive symptomology is dependent on the individual's history of controllability and coping.

Article by Thoits (1982) highlighted the problem of inadequate conceptualization and operationalization of the term social support. Shumaker and Brownell (1984) highlighted several gaps in the social support literature. They measured the costs and benefits of supportive exchanges for both participants, the recipient of the support and the provider. The authors also identified the factors that influence support effects and suggest a broad range of consequences for both parties.Pearson (1986) examined definitions, constructs, and theories of social support and summarizes various studies about latest scales for

measuring social support and analysing social network morphology. She suggested that the help from counsellors could be sought as they could help the patient to identify and utilize social supports. The study by Zimet et al. (1988) reconfirmed the previously claimed relationship between high levels of perceived social support with low levels of depression and anxiety symptomatology. As important source of social support, three groups have been identified in their study— family, friends and significant other. Bolger, Zuckerman and Kessler (2000) highlighted the role of social support which remains unnoticed by the recipient yet promote coping to major stressors. Study by Branje, van Aken and van Lieshout (2002) examines the degree to which perceived support differs in horizontal relationship (marital and sibling) to vertical (parent child) relationship.

Loneliness is another related indicator which increases risks of getting depressed. Children, teenagers, young adults, middle aged, older adults— loneliness exists within every age group; however, adolescents and young adults appear to be particularly vulnerable. Although loneliness is usually described as a feeling or emotion of individual, its roots are essentially social. Everywhere, isolated individual feels detached from society in some way. This isolation is detachment from personal relationships— a sense of not having anyone who is someone to you and not being someone to anyone (Mirowsky and Ross; 1986). Being happy at home makes these individuals feel good about themselves, enhances their self-esteem and hence less lonely. Even negative experience outside home cannot affect them much if support base in the family domain is strong enough. Reduction in the size of one's social network and resulting loneliness are two important features of modern social environment and depression and several mental disorders are caused by these two interlinked traits of modernity.

Zuckerman (2011) discussed the process of 'othering' in American society that exists for adolescent. 'Othering' involves making someone antagonistic to majority and more powerful 'us'. Adolescents are typically viewed and feared by adults for rejecting established norms, a struggle to define self and forming bond to peer groups. One'sbelief system may play a role in determining his or her mental health status.

Williams, Frech and Carlson (2009) discussed how marital status and related factors such as age, race, gender, cultural standards like values and beliefs and prior mental health condition influence mental well-being. Eaton, Muntaner and Sapag (2009)have made an attempt to review sociological theories and measurements of stratification and social class relating inequality to mental disorder. The authors argue that stratification and one's socioeconomic status have a complex relationship to the occurrence of mental disorder. Researchers in general agree on the point that have found that socioeconomic status (SES) is inversely related to mental disorder; that is, those in the lower classes experience higher rates of disorder and those in higher classes experience lower rates of disorder. Related factors of educational and occupational attainment have been taken into account as people low in these two qualities are likely to drift down the SES ladder.

Williams, Costa and Leavell (2009) present the problem that comes with the analysis of the mental health status of minority groups as social, economic, political and cultural factors affect it in many ways. The authors suggest that crucial issue like racism and migration must be taken into account while dealing with themembers of this group. A paper by Thoits (1985) focuses on judgments made by the individual on himself. In order to do that it has utilized assumptions made by labelling theory, symbolic interactionism, share the assumption that self-conceptions emerge from and are sustained in social relationships.

Joiner Jr. et al. (1999) discussed how initially non depressed but mildly dysphoric individuals may seek reassurance from others to alleviate their doubts as to whether others truly care about them. Others often respond with reassurance, but the potentially depressed person doubts it. Thus s/he requests others' feedback; once received, however, the reassurance is again doubted, and the pattern is repeated. Because the pattern is repetitive and resistant to attempts to change it, the increasingly depressed person's significant others become frustrated and irritated. Thus, they become increasingly likely to reject the depressed individual who is increasingly likely to become more depressed. In another article Joiner Jr. and Metalsky (2001) argued that dysphoric individual who seeks excessive reassurance in response to perceived threat in one domain may, by excessive reassurance seeking, generate stress in another domain. This new stressor may fuel still more reassurance seeking, leading to further interpersonal disruption, and thus to relationship conflict, loneliness, or both and, in turn, depression. A decade later, Rose et al. (2011) discussed how many Interpersonal theories of depression suggest that depressive symptoms are linked with behaviors that disrupt relationships. For example, youth with depressive symptoms engage in aversive behaviors, such as excessive reassurance seeking and negative-feedback seeking. Individuals can self-label because they are able to observe and classify their behaviors, thoughts, and feelings from the perspective of the wider community. The individual who self-labels is a well-socialized actor who, by sharing the cultural perspective of the larger society, can recognize rule breaking or the violation of normative expectations. There are known categories of norms, whose violations carry cultural labels (e.g., ill-mannered, sinful, criminal) that can be applied to persons who perform such behaviors. Our idea about ourselves is largely constructed by other people's reactions about us and our perception of that reaction. In this context issue of mattering must be discussed. We feel we matter to others if others are interested in us, view our experience and opinion as important. The realization that we do not matter leads many people to be engaged in many risky behaviors (Elliott, Kao and Grant; 2004). Emphasis on appearance and concern for others' opinions are considered to lead to increased self-consciousness and thus increased vulnerability to others' opinions.

Rosow (1965) discussed various forms of socialization and their functions. He showed

that not all socialization is successful as the process does not work like a machine which produces similar type of social products. Socialization results do vary and many causes result deviance. In order to show this variation, he developed a typology consisting of Socialized, Dilettante, Chameleon and Unsocialized. The first group has both the values and behavior, conforming to both sets of expectations. The second group is committed to the values, but does not perform adequately for viable group membership or acceptable role fulfillment. The third group is competent, skilled and actively meets behavioral expectations. But his conformity is essentially adaptive, without the corresponding value basis on which the behavior presumably rests. The last group may reject or be indifferent to the values and be unmotivated or unable to perform the minimally acceptable behavior as it neither has the beliefs nor displays adequate performance. Thoits (1985) demonstrated how the label "crazy" or "mentally ill" is applied to the self by oneself (or by others), there must be some degree of cultural agreement regarding the rule-breaking behaviors involved. Kahneman and Deaton (2010) review the relationship between higher economic status and happiness.

v) Gender Matters

Since our society socializes male and female differently, it is often noticed that the same life-event is viewed by a man in one way, and by a woman, in another. In other words, one particular incident produces effect, which is qualitatively and quantitatively different, for members of different gender. Therefore, a journey through studies focusing on gender differences of a psychological disorder is more than necessary.

Shields et al. (2006) examined the relation between gender and emotion in connection to power relations, and sexuality. Two theoretical approaches— expectation states theory and doing emotion as doing gender— have been used for investigation. The authors marked adolescence as a period in which issues of emotion and gender converge in the process of identity development. Mendle, Turkheimer and Emery (2007) discussed the greater vulnerability of adolescent girls than their male counterpart to develop depressive symptoms. In a later research Mendle et al. (2012) revisit the condition of boys in early adolescence involving depressive symptoms. In order to do that the role of peer relationship quality is examined.Keith and Brown (2009) demonstrate how the connection among various socio-cultural factors such as gender, race and socioeconomic status (SES) affect mental health of African American women as this group faces the double- edged sword of both racism and sexism. It reduces their educational attainment, and chances of socioeconomic improvement. Thus, compared to their White counterparts, they are more prone to stress.

Study by McFarland, Murray and Phillipson (2016) analysed the influence of teacher-student relationships on children's self-concept. It has found different equation for different gender. For boys, closeness with their teachers did not predict their self-

concept much. But if there is conflict in this teacher-student relationship, self-concept is negatively affected. For girls, both conflict and intimacy predicted self-concept. Here also, negative interaction, that is, conflict is found to produce greater effect on self-concept than closeness. Closeness to father prevented girls of divorced families from developing a depressed mood (Palosaari, Aro and Laippala; 1996).

Study by Coster (2005) suggests that male and female experience stress in different ways. First, males and females in this study report exposure to different types of stresses. Whereas males are more vulnerable to the stress of criminal victimization, females are more prone to communal stresses within the family. Females report to be more vulnerable than males to peer stresses, and males appear more vulnerable than females to criminal victimization and achievement failures. These gender differences in exposure and vulnerability reinstate the assumption that females are socialized to be more concerned than males with forming bonding with others and thereby are more affected by communal or relational stresses. Alternatively, males are socialized to be more concerned than females with individual achievements and individual rights and are thereby more affected by failures and stresses that threaten their rights.

Result of many studies demonstrates that social location and the views of significant others affect how adolescents see themselves. Adolescents are at the point in the life cycle in which status may be heavily contingent on physical appearance because other channels of success, such as careers, are not yet open to them. Moreover, they have arrived at an age in which deviation from weight standards can translate into serious social penalties with respect to dating and popularity. Findings of the study by Levinson, Powell and Steelman (1986) suggest that adolescents tend to denigrate rather than enhance their body image. This derogation is more pronounced for females than for males. The direction by which the derogation occurs varies by sex, with males viewing themselves as too thin and females rating themselves as overweight. Similar view is found in Hoelter's (1984) work, that one's sex appears to play a major role in determining which others are "most significant" with respect to self-evaluation. Emphasis on appearance, interpersonal skills and pleasing others replace competitively based achievement during adolescence for girls, while boys continue to give priority to such achievement throughout life. Tantillo and Kreipe (2006) shows how in a weight-obsessed culture that simultaneously values control, independence, performance, appearance, and youthfulness, while presenting females and males with contradictory role expectations, some individuals with genetic and relational vulnerabilities develop eating disorders. Both women and men can feel tremendous amount of shame and stigma when their body sizes and shapes do not conform to prescribed cultural standards. Eating disorders both emerge from and maintain disconnection from self and others. Starvation maintains disconnections from self and others through biologically based preoccupation with food and its numbing effects, while binge eating and purging lead to fatigue and distraction.

Peer teasing and interest in dieting and internalization of the thin-ideal can amplify body image dissatisfaction, disordered eating, and eating disorders.

Ross (1994) argues if being overweight is stigmatizing, negative evaluations by others may be internalized as high levels of depression. This perspective predicts that being overweight has a direct effect on depression, and that the effect is greater in social groups where being overweight is less common, especially among women. Strickland (1992) discusses how different socialization patterns for males and females reinforce certain stereotypes of appropriate sex role behaviour. Males are encouraged toward independence and mastery behaviour; females are expected to present themselves as attractive, sensitive to other people, and passive in relationships. Because depression is identified as lack of activity and energy, it is not surprising to find that women may be more depressed than men. Men are over represented in those psychiatric disorders that involve active, and sometimes impulsive, behaviour, namely, conduct disorders and substance abuse.

On the other hand, in the study by Newman (1986), adverse effects of four sources of life strain on the well- being of men and women have been examined. Despite greater exposure to these hardships, the researcher has found no evidence to support the widely held view that women are more prone to a depressive syndrome than are their male counterparts. The possible reason may be sex role socialization— that is expressions of sadness in general, and crying in particular, are more widely tolerated in women than in men. That is, contrary to the view that feminine socialization may induce a greater vulnerability to depression, certain features of early sex-role socialization may foster life-strain coping patterns that protect women against the development of depression in the face of adversity. Females are socialized to be more concerned than males with forming connections with others and thereby are more affected by communal or relational stresses. Alternatively, males are socialized to be more concerned than females with individual rights and achievements and are thereby likely to be more affected by achievement failures and stresses that threaten their individual rights (De Coster; 2005).

Simon and Lively (2010) argued that the higher rate of emotional disturbance among women is due to their roles in society, which are more stressful than men's, as women are associated with a host of personal, social and economic problems for themselves as well as their families. On the other hand, men's higher rate of substance problems reflects their tendency to manage (i.e., suppress) inappropriate feelings of depression with mood-altering substances. Rosenfield and Smith (2009) presented a discussion about the different types of mental health problems experienced by men and women, the former more prone to substance abuse and the latter, depression and anxiety. The authors considered various explanations for these differences such as different in the nature, component and size of social ties, difference in their mental make-up and their different occupational position.

Conclusion

This study has discussed finding of various research works related to mental health and illness especially with regard to depression in order to bring into fore the factors which do not necessarily restrict themselves to the realm of psychology. Our life-style or culture, nature of social group of which we become member voluntarily or involuntarily, different societal treatments received by members of different gender— every factor plays a crucial role in shaping the illness experience of individual. Human mind is also essentially related to social nature of human beings. Its nourishment or the lack of it is largely dependent on its surrounding, the very environment which makes a human baby a member of society through the process of socialization. What we do, eat, wear, see— everything contributes to the development of health and disorder we experience throughout our life and depression is no exception. Therefore, limiting it within the boundary of psychology and viewing the disorder as an entity independent of the larger social process would be an erroneous way of dealing with the disease. What we need is a holistic approach so that we can ensure better mind and health for the members of present and future generation.

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