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The Relationship Between Low Socioeconomic and Depressive Symptoms: A Case Report

Fairuz Ridlo[1], Rezza Dwi Ar Rasyid[2], Rika Nur Karida[3], Ajeng Prisnidiawati[4], Shinta Maulydiyah Basuki[5], Tutik Nur Kasiani[6], Hafid Algristian[7]
Universitas Nahdlatul Ulama Surabaya, Indonesia[123457]
Rumah Sakit Radjiman Wediodiningrat, Indonesia[6]
Correspondent: dr.hafid@unusa.ac.id [7]

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ABSTRACT: Depression is a prevalent mental health disorder that significantly impacts both individual well-being and broader societal functioning. Socioeconomic disadvantage manifested through low income, limited educational attainment, and reduced access to mental health care has consistently emerged as a key risk factor for the development and persistence of depressive symptoms. In Indonesia, the mental health burden among low income populations remains under recognized and under treated. This case report details the clinical presentation of a 35-year-old woman diagnosed with major depressive disorder, originating from a low socioeconomic background. The patient experienced chronic psychological distress linked to financial instability, family rejection, and social stigma related to her informal digital employment. Data were collected through comprehensive psychiatric evaluation, including structured interviews, mental status examination, and physical assessment, in accordance with DSM-5 diagnostic criteria. The patient's symptoms marked by insomnia, anhedonia, anxiety, suicidal ideation, and psychosomatic complaints highlight the complex interplay between environmental hardship and mental health. Her case exemplifies how economic precarity and insufficient social support contribute to both emotional and physical deterioration. This report not only contributes to a deeper understanding of depression among socioeconomically marginalized individuals in Indonesia but also emphasizes the importance of culturally contextualized mental health strategies. It advocates for community based, low barrier interventions that incorporate psychosocial and economic dimensions. Ultimately, addressing mental health within low SES populations requires holistic approaches that extend beyond clinical treatment and include policy reforms focused on employment protection, social welfare, and anti-stigma efforts.

Keywords: Depression, Low Socioeconomic Status, Psychosocial Stress, Single Mother, Case Report.

INTRODUCTION

Depression is a common mental health disorder that affects over 300 million individuals worldwide, with an estimated global prevalence of 3.8% (Vahid-Ansari & Albert, 2021). In Indonesia, the burden of depression has shown a marked increase over the past decade. The National Basic Health Research (Riskesdas) reported a rise in the prevalence of mental health

disorders from 6% in 2013 to 9.8% in 2018. Specifically, depression affected approximately 6.1% of individuals aged 15 years and older, but alarmingly, only 9% of those affected received adequate treatment (Handajani et al., 2022). These figures underscore a significant treatment gap and the need for improved mental health systems.

The COVID-19 pandemic further exacerbated psychological stress among vulnerable populations. Job insecurity, social isolation, and disruption in daily routines contributed to elevated rates of anxiety and depression, particularly among individuals from low socioeconomic backgrounds (Han et al., 2023; Hewitt et al., 1996; Park, 2025). Informal workers and women with caregiving responsibilities faced heightened emotional and financial pressures during prolonged lockdowns, which often lacked accompanying social protections.

Socioeconomic status (SES) has consistently been linked to mental health disparities. Individuals from lower SES backgrounds are more likely to experience cumulative disadvantages, such as chronic illness, lower educational attainment, and limited access to quality healthcare. Beyond material deprivation, SES is also associated with perceived control, exposure to adverse life events, and ability to access support systems. These conditions create a fertile ground for the development of mood disorders, particularly in low- and middle-income countries like Indonesia (Assari & Lankarani, 2017).

According to the Indonesia Family Life Survey (IFLS), which represents approximately 83% of the national population, individuals actively seeking employment have a 16.1% higher probability of experiencing depressive symptoms compared to those with stable jobs. Moreover, individuals with at least a high school education are less likely to report depression, and household wealth remains inversely associated with depressive symptoms (Amer et al., 2024; Dewi et al., 2021; Ibrahim et al., 2019).
These findings align with the theory of *social determinants of health*, which posits that health outcomes are deeply influenced by the social, economic, and political environments in which individuals live (WHO, 2022). Structural inequities—such as limited access to education, employment, and healthcare—can predispose individuals to long-term mental health conditions. Depression, therefore, cannot be examined in isolation from the broader context of socioeconomic stress and marginalization.

This case report seeks to contribute to the growing literature on the mental health implications of low socioeconomic status by presenting a clinical case of a woman in Indonesia who developed major depressive disorder in the context of financial instability, family rejection, and occupational stigma. Through this case, we aim to highlight the urgency of context-sensitive mental health care and the need for integrative strategies that incorporate social policy, family education, and accessible treatment options.

METHOD

This case report employs a qualitative descriptive approach to explore the relationship between low socioeconomic status and depressive symptoms. The subject was a 35-year-old female patient

diagnosed with Major Depressive Disorder (MDD) based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Data collection involved comprehensive clinical assessments conducted during the patient's psychiatric consultation, including in-depth history-taking, mental status examination, and physical health evaluation. The interviews explored the patient's personal, occupational, and psychosocial background, with a focus on identifying stressors related to economic hardship, family dynamics, and social stigmatization. Observations were documented through narrative field notes and clinical impressions. The case was analyzed using a biopsychosocial framework, which considers the interplay between biological vulnerabilities, psychological factors, and social contexts. Special attention was given to psychosomatic manifestations and how the patient's socioeconomic environment influenced her emotional and physical symptoms.

Ethical considerations were upheld throughout the report preparation. The patient provided informed consent for the use of anonymized clinical data for academic publication. All identifiable information has been removed or altered to protect patient confidentiality. The report adheres to the ethical principles outlined in the Declaration of Helsinki for human subject research. This method allows for a deeper understanding of how socioeconomic disadvantage manifests in individual psychological experiences and contributes to mental health decline, especially in underrepresented populations such as single mothers and informal workers in Indonesia.

RESULT AND DISCUSSION

Case Presentation

Mrs. N is a 35-year-old woman who presented with symptoms consistent with major depressive disorder. She is widowed and has been experiencing persistent anxiety, reduced motivation, and loss of interest in daily activities for the past three years. These symptoms were gradually worsening and began to interfere with her sleep, leading to insomnia and frequent nightmares. She sought psychiatric evaluation following a period of increased emotional distress and functional impairment.

Previously, the patient worked as a university lecturer with a stable monthly income of approximately IDR 8–10 million. However, two years prior to her current evaluation, she resigned from her position due to psychological pressure and a lack of support from faculty leadership. Since then, she has relied on an irregular income generated from live-streaming content on social media platforms. This income is highly unstable; in the most recent month, she was only able to cover roughly 50% of her essential expenses, including rent, school fees for her children, and utility bills.

Mrs. N has three children and is divorced from her ex-husband, who provided neither financial nor emotional support during their marriage. She currently lives with her mother, who frequently criticizes her for being a single mother without a "real" job. This strained family dynamic has contributed to her feelings of rejection and social inadequacy. The stigma associated with her

current occupation as a content creator further exacerbates her social stress and perceived marginalization.

In addition to her depressive mood, Mrs. N reported ongoing anxiety, poor concentration, and disrupted sleep patterns. She also experienced psychosomatic symptoms, particularly recurrent gastritis, which she associated with emotional tension and interpersonal conflict at home. These complaints indicate a significant overlap between her psychological state and physical health, suggesting that her mental distress manifests through both emotional and somatic channels.

Mrs. N's case illustrates how persistent economic hardship can disrupt psychological equilibrium and trigger clinical depression. Her transition from a stable academic position to a precarious livelihood reflects a dramatic shift in financial security and personal identity. This narrative aligns with literature linking downward socioeconomic mobility with increased depressive symptoms (Kim & Lee, 2023). Unlike population-level studies, this case emphasizes the subjective experience of income instability and its impact on self-worth, particularly when compounded by social stigma.

Financial stress activates chronic physiological stress responses, which have been associated with neurobiological changes in the prefrontal cortex and dopaminergic circuits involved in motivation and emotion regulation. Mrs. N's reduced drive, anhedonia, and disrupted sleep patterns may reflect these alterations. Her gastritis episodes suggest prolonged sympathetic activation and somatic expression of psychological distress phenomena frequently observed in economically stressed individuals (Nasir et al., 2024). Thus, her symptoms resonate with both the psychological and physiological models of stress-related depression(Heim & Binder, 2012a, 2012b).

The patient's resignation from her university position was not merely a financial event but also a loss of status and perceived competence. This loss of agency aligns with findings that economic instability undermines self-efficacy and increases vulnerability to mood disorders (Benitez et al., 2022). Unlike those with supportive social environments, Mrs. N faced criticism and lack of validation from her family, intensifying her sense of helplessness. This suggests that beyond income, the perceived inability to regain control over one's life plays a pivotal role in the onset of depressive symptoms.

Coping Mechanisms and Social Isolation

Despite the profound stressors experienced, Mrs. N exhibited limited adaptive coping mechanisms. Her engagement with digital platforms while offering financial possibilities did not provide psychological comfort or community belonging. This lack of meaningful social interaction often exacerbates feelings of isolation, which have been shown to be strong predictors of depressive severity (Acoba, 2024).

Studies emphasize the importance of perceived social support as a buffering factor against emotional deterioration. However, Mrs. N's strained familial relationship, particularly the absence of emotional validation from her mother, created a vacuum in her psychosocial environment. Social disconnection especially in cultures where communal support is valued can amplify perceived helplessness and worthlessness, hallmarks of major depression (Sadock et al., 2025).

Numerous studies confirm that adequate social support serves as a buffer against psychological distress. In contrast, Mrs. N's strained relationship with her mother, coupled with societal judgment against her occupation, amplified her isolation. Her case is emblematic of how reduced social connectedness especially among women with unconventional career paths may worsen mental health outcomes. The lack of empathic support restricted her capacity to process distress, a factor that, according to Sadock et al. (2015), strongly predicts poor prognosis in depression. Recent evidence suggests that single parents experiencing economic hardship are particularly vulnerable to psychological distress, with women being disproportionately affected due to combined caregiving and financial responsibilities (Sage et al., 2025).

Digital Labor and Occupational Stigma

Mrs. N's attempt to secure income through livestreaming on social media reflects a broader trend among marginalized individuals navigating the digital gig economy. While such platforms offer flexibility and access to new forms of employment, they also expose individuals particularly women to novel forms of occupational stigma, online harassment, and unstable income (Nguyen et al., 2024). Dependency on digital gig work has been empirically linked to economic hardship and psychological distress, particularly when earnings are unpredictable and benefits are absent (Glavin & Schieman, 2022). Furthermore, during the COVID-19 pandemic, gig workers exhibited poorer mental health and life satisfaction compared to full-time or part-time employees, largely mediated by loneliness and financial precarity (Wang et al., 2022).

In the Indonesian context, online work is often not recognized as legitimate labor, especially for women in caregiving roles. This leads to internalized shame, role conflict, and diminished self-worth factors highly associated with depressive symptoms (Guan et al., 2022). A study by Kabara et al., (2025) found that minority women engaged in informal online work report higher rates of mental health complaints compared to those in traditional jobs.

As a woman and single mother, Mrs. N's experience reflects gendered dimensions of socioeconomic adversity. Evidence suggests that women with lower educational or occupational status are disproportionately affected by depressive disorders due to dual burdens of caregiving and financial insecurity. Her status as both a caregiver and economic provider, without adequate social safety nets, magnifies this pressure. This aligns with findings that low-SES women are at higher risk not only because of external conditions, but also due to internalized societal expectations and chronic role overload.

Comparative Analysis with Other LMIC Contexts

Similar patterns have been observed in other low- and middle-income countries (LMICs). In a study conducted in South Korea, Han et al. (2023) reported that individuals who experienced COVID-19-related job loss were significantly more likely to develop depressive symptoms, particularly when financial loss coincided with a lack of familial support. In India, informal women

workers reported elevated distress linked to caregiving burden and lack of community safety nets (Jespersen et al., 2023).

Compared to these populations, Mrs. N's experience adds a nuanced understanding of how occupational identity and public perception in the digital age can intersect with traditional stigma, resulting in dual layers of discrimination.

While Mrs. N's condition confirms multiple established risk factors, her case also offers unique deviations. Unlike some low-SES individuals who cope through community integration or extended kinship networks, she faced rejection from her closest family. Additionally, her engagement with digital platforms for income, while innovative, failed to generate emotional validation. These contrasts invite further examination of how modern livelihood strategies such as digital labor interact with mental health, especially among marginalized women. Childhood exposure to socioeconomic hardship has long-term effects on emotional development and mental health, with cumulative disadvantage associated with greater psychological vulnerability in adolescence (Reiss, 2013). A study of China's labor force found that 17.3% experienced depressive symptoms, with lower SES significantly associated with higher depression risk, highlighting both structural and intermediate determinants of mental distress (Zhang et al., 2022).

Biopsychosocial Impact of Prolonged Financial Stress

Financial hardship has been associated with dysregulation in the hypothalamic-pituitary-adrenal (HPA) axis, a key pathway in the neurobiology of stress. Chronic activation of this axis can impair prefrontal cortex function and alter serotonin pathways, which are directly implicated in the development of depression (Peacock et al., 2022).

Mrs. N's constellation of symptoms including insomnia, somatic complaints, and anhedonia mirror this dysregulation. Her recurring gastritis further supports the notion that somatic symptoms often co-occur with mood disorders, especially in women with high stress burden and limited emotional outlets (Laila et al., 2023; Michalak & Sterna, 2023). Subjective social status has also been shown to predict depressive symptoms and suicidality independently of objective socioeconomic indicators (Hoebel et al., 2023).

Mrs. N's narrative highlights not only the well-documented association between poverty and depression but also lesser explored domains such as family-based microaggressions, modern occupational stigma, and unmet emotional needs. These factors emphasize the need for integrated mental health services that go beyond pharmacologic treatment and include counseling, digital literacy training, and stigma reduction programs tailored to informal workers. The Family Stress Model illustrates how financial strain within households initiates a chain of coercive family dynamics and emotional dysregulation, often culminating in mental health problems such as depression (Conger et al., 1994).

This case underscores the importance of context-sensitive approaches to mental health care, particularly for patients navigating economic transitions and social stigma. Psychosocial

interventions should not only address symptom relief but also empower individuals in low-SES settings to reclaim agency and rebuild meaningful social connections. Future research should explore how tailored interventions such as peer support, financial counseling, or occupational reintegration may mitigate the psychological toll of economic disenfranchisement.

Patient Narrative Reflection

"I used to be someone with a clear path. I had a job, a title, a stable income. But everything changed when the pressure became too much. Leaving the university was not only about quitting a job it was about losing my identity."

"Since then, every day feels uncertain. I wake up not knowing whether I'll be able to pay for rent, or school fees, or food. I livestream to survive, but people don't understand that. Even my own mother calls it shameful. Sometimes I feel like I've failed everyone, including my children."

"What hurts most is not the money, but how people treat me like I'm not trying hard enough, like I've chosen this life. The loneliness is suffocating. When I try to talk about it, they say I'm too emotional, too dramatic. But they don't know that I cry at night, every night."

"When the doctor asked me how long I've felt this way, I couldn't answer. Because the truth is, I stopped feeling years ago. I stopped hoping. I just survive. But part of me still wants to believe that things can get better that I'm not broken beyond repair.

CONCLUSION

This case report illustrates the multifaceted impact of socioeconomic adversity on mental health, particularly in the context of a single mother navigating financial instability, occupational stigma, and strained familial relationships. Mrs. N's experience reflects how the erosion of economic security, compounded by social rejection and the burden of caregiving, can culminate in clinically significant depressive symptoms. These included insomnia, anxiety, anhedonia, suicidal ideation, and somatic complaints such as recurrent gastritis—symptoms consistent with both the psychological and physiological effects of chronic stress.

Beyond validating previously known risk factors, this case brings attention to lesser-recognized dynamics in modern societies, such as the psychosocial burden of informal digital work, internalized stigma, and the absence of supportive social networks. Mrs. N's lack of emotional reinforcement from close family members, coupled with societal judgments surrounding her livelihood, intensified her psychological vulnerability.

These findings underscore the necessity for mental health services that are not only accessible and affordable but also sensitive to cultural and socioeconomic realities. Public policies must evolve to include protections and support mechanisms for individuals engaged in informal labor sectors,

particularly women with caregiving responsibilities. Interventions should include community-based psychosocial support programs, financial literacy and empowerment initiatives, and education to combat stigma against mental illness and nontraditional employment.

From a clinical perspective, mental health practitioners must consider socioeconomic context and family dynamics as integral components of assessment and treatment planning, particularly in culturally diverse and economically stratified populations.

Future research should explore the intersection between digital gig economies, gendered labor expectations, and mental health, particularly within low- and middle-income countries, where informal labor remains prevalent yet underexamined.

Implication For Practice And Policy

The case of Mrs. N reveals urgent gaps in both mental health service delivery and broader social support systems for individuals experiencing socioeconomic adversity. Several key implications can be drawn for clinical practice, community interventions, and public policy.

Clinical Practice and Mental Health Services

From a clinical standpoint, this case reinforces the necessity of holistic mental health assessments that account not only for symptomatology but also for socioeconomic context. Mental health professionals should be trained to recognize signs of financial distress, role overload, and social rejection as contributors to emotional dysregulation. Integrating economic and familial screening tools into psychiatric intake procedures could allow for more accurate diagnoses and targeted intervention plans.

Psychiatric care should also be accompanied by supportive services, such as social work consultation, family counseling, and community mental health referrals. For patients like Mrs. N, who navigate economic insecurity and nontraditional occupations, validating their lived experience can be a therapeutic step in restoring self-efficacy and hope. Building collaborative care models that include psychologists, social workers, peer mentors, and community leaders may improve both engagement and treatment outcomes.

Community-Based Support Structures

In low and middle-income countries like Indonesia, health systems often struggle to address mental health in community settings. Community health centers (Puskesmas) can be empowered to provide first-line mental health interventions, such as group counseling, psychoeducation

workshops, and culturally adapted cognitive-behavioral therapy. Importantly, these services must be financially and geographically accessible.

For women in informal employment, peer-led support groups whether virtual or in person can offer emotional validation and shared problem-solving. Empowering single mothers to organize through digital communities may also provide protection against stigma and help build social capital.

Educational initiatives that destigmatize digital labor, single parenthood, and mental illness can help reduce community-based discrimination. Health promotion campaigns should highlight that mental health challenges are not a moral failing but a public health issue influenced by social and economic conditions.

Policy-Level Interventions

Policy changes are essential to address the upstream causes of psychological distress in vulnerable populations. These may include:

- Expanding social protection schemes, such as cash transfers or unemployment insurance for informal workers
- Recognizing digital labor as legitimate employment in legal frameworks, allowing workers to access health benefits and protections
- Incorporating mental health into primary care via task-shifting approaches and mobile services in under-resourced areas
- Funding inclusive public campaigns that challenge gender-based stigma and normalize help-seeking behaviors. A global systematic review found a consistent link between income inequality and depression, especially in low- and middle-income countries, where relative deprivation intensifies psychosocial stressors (Patel et al., 2018).

The Indonesian Ministry of Health, in collaboration with local governments and civil society organizations, has an opportunity to pilot integrated mental health programs that focus not only on illness but also on resilience and social justice. In the long term, investing in mental health equity may improve national productivity, family cohesion, and societal well-being.

Future Directions And Global Recommendations

Understanding the intersection of socioeconomic adversity and mental illness in low and middle income countries (LMICs) requires both continued research and international collaboration. While individual case reports offer critical insight into the lived experiences of marginalized individuals, future studies should aim to generate broader data through longitudinal and community based research.

One important direction is the exploration of how informal employment especially in digital or gig-based economies impacts mental health outcomes, particularly among women. As work

structures evolve in the post-pandemic era, psychological risk profiles may shift accordingly. Cross-country comparative studies could examine how different cultural and policy frameworks shape these experiences and either mitigate or intensify distress.

Moreover, integrating mental health data into national economic surveys can provide stronger evidence for structural interventions. By quantifying the emotional cost of job insecurity and caregiving burden, policymakers can be better equipped to allocate funding toward preventive and rehabilitative services.

At the global level, organizations such as the World Health Organization (WHO), the United Nations Development Programme (UNDP), and international NGOs can support scalable interventions that combine economic empowerment with mental health support. For example, programs that pair microfinance with group therapy or digital literacy with emotional resilience training have shown promise in similar contexts.

Finally, it is essential to advocate for mental health as a human right particularly for those in socially invisible roles, such as single mothers and digital laborers. Mrs. N's story is not an isolated case, but rather a reflection of structural neglect. A shift toward inclusive, compassionate, and economically informed mental health systems will not only alleviate individual suffering but also contribute to broader social stability, national productivity, and sustainable development goals.

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