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Investigating the Relationship between Depression Literacy and Quality of Work Life

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Background and Objectives: Depression literacy is a specific type of mental health literacy that is defined as the ability to recognize depression and make informed decisions about treatment. This study was designed and conducted to determine the relationship between depression literacy and quality of work life of employees of the Faculty of Mashhad University of Medical Sciences.

Materials and Methods: This cross-sectional study was conducted during the first half of 2024. The statistical population of this study was employees working in the faculties of the medical sciences in Mashhad. To collect data, a multistage sampling method was used, depending on the statistical population.

Results: Based on the results, the mean (±SD) D-Lit and quality of work life of employees were 40.19 (±7.06) and 80.72 (±15.42), respectively. Based on the results of Pearson's correlation coefficient, there was a statistically significant but clinically and practically negligible positive correlation between D-Lit and quality of work life ($r = 0.022$, $p < 0.05$). D-Lit was significantly higher in those who reported consulting a psychiatrist compared to those who did not ($p<0.001$). Participants with a family history of mental illness and those whose family members had been referred to a psychologist for psychological issues had significantly higher D-Lit levels than the others ($p<0.001$).

Conclusions: The results showed a statistically significant but clinically and practically negligible positive correlation between depression literacy and quality of work life ($r = 0.022$). Depression literacy alone is not a meaningful predictor of quality of work life. Therefore, improving depression literacy should not be expected to substantially enhance employees' quality of work life, and organizational interventions should also address structural and environmental factors.

Keywords: Depression Literacy, Depression, Quality Of Work Life

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Introduction

Depression is a common and serious mental health concern (1). Depression is a disorder that increasingly affects diverse populations, with an estimated prevalence of 4.4% worldwide (2). Depression is a pervasive problem that can potentially affect employee performance and personal well-being (3). Research has shown that depression negatively impacts educational pathways, work performance, and other areas of life (4).

Quality of work life (QWL) has become an important issue today (5) In fact, improving QWL is a comprehensive process to improve the quality of life of employees in the workplace and is essential in any organization to attract and retain employees (6).

Studies show that employees have poor quality of work life, and the majority of these employees are dissatisfied with most aspects of their quality of work life (6). Depression and anxiety at work can cause dissatisfaction with work and the work environment (7).

Depression literacy is a specific type of mental health literacy that is defined as the ability to recognize depression and make informed decisions about treatment (8). Depression literacy is defined as the number of people in a community who have information about the early signs and symptoms of depression and ways to deal with them (9).

Quality of work life is a source of philosophy and attitudes towards human resources (10). Accordingly, employees are the most important assets in the organization because they are reliable, responsible, and capable of making valuable contributions (10). A low quality of work life increases the level of stress, obsession, distress, and anxiety in individuals (10). In fact, improving employee performance, with a focus on work life, is defined as employees' understanding of how working conditions in the organization can meet their personal and work needs (10). The results of one study showed that D-Lit is a potential factor that can affect people's mental health status and increase their quality of life (11). Another study showed that 60% of nurses reported an average quality of work life, 37.1% reported a poor quality of work life, and 2% reported a good quality of work life (5).

Since diagnosing depression is the first step in seeking help and treatment, it seems to be very important to educate employees to recognize the symptoms of this type of disorder and improve depression literacy and quality of work life. Therefore, this study aimed to determine

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the relationship between depression literacy and quality of work life among employees of Mashhad Medical Sciences Schools.

Materials and Methods

This cross-sectional study was conducted in 2024 among 198 employees working at Mashhad University of Medical Sciences. The statistical population of this study was employees of the Mashhad University of Medical Sciences.

Sample size

To determine the sample size, a preliminary study was first conducted on 30 employees. Then, based on the information from the preliminary study and considering a power of 80 percent and a confidence interval of 95 percent in the following formula, the sample size was estimated to be 198 people:

$$n=[(Z\alpha+Z\beta)/c]\ 2\ +3=198\text{‹}C=0/05\times\ln\ [(1+r)/(1-r)]=0/2$$

Sampling Method

The statistical population of this study was employees working in the faculties of the medical sciences in Mashhad. To collect data, a multi-stage sampling method was used, according to the statistical population. The proportional stratified sampling method was used in the first stage, and a simple random sampling method was used in the second stage. In the proportional stratified sampling method, all faculties of the Mashhad University of Medical Sciences were identified with their populations, and each faculty member was considered as a stratum. In the next stage, the required sample size was selected from each faculty using a simple random sampling method among those who were willing to participate in the study and met the inclusion criteria. To collect data, questionnaires were distributed among employees working at medical universities. After explaining the purpose of the study to the participants, the questionnaire was completed as a self-report. The inclusion criteria included signing informed consent to participate in the study and completing the questionnaire. Exclusion criteria included leaving the study for any reason that prevented participants from participating. Confidentiality and anonymization of data were maintained throughout all stages of the research.

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Data Collection Instruments

The data collection tool consisted of a three-part questionnaire, the first part of which was related to demographic information and the second part was the Depression Literacy Questionnaire (D-Lit**)** (11)**.** The third part was the Walton Quality of Work Life Questionnaire (QWL) (12).

The first part included demographic information, including age, gender, marital status, education level and occupation, duration of employment, age at which employment began, number of children, monthly income, and referral to a psychologist/psychiatrist.

The second part of the Depression Literacy Questionnaire (D-Lit) consisted of 21 questions and 5 subscales: awareness of psychological symptoms (5 items), awareness of the effectiveness of existing treatment methods (4 questions), awareness of cognitive-behavioral symptoms (6 questions), awareness of medication use and their side effects (4 items), and awareness of disease severity (2 items). These items are rated on a three-point scale (true, false, and do not know), with a score range of 21 to 63. For each correct answer, a score was assigned, with higher scores indicating better D-Lit status. This questionnaire has high validity and reliability, and its Cronbach's alpha and McDonald’s omega coefficients were 0.890 and 0.891, respectively (11).

The third part of the Walton Quality of Work Life Questionnaire consists of 32 items, that examine the quality of work life of employees in eight dimensions: fair and adequate pay (questions 1 to 5), safe and healthy work environment (questions 6 to 8), provision of opportunities for continuous growth and security (questions 9 to 11), legality in the organization (questions 12 to 17), social dependence on work life (questions 18–20), general living environment (questions 21–25), social integration and cohesion (questions 26–29), and development of human capabilities (questions 30–32). A five-point Likert scale ranging from very little (1 point) to very much (5 points) was used to answer the questions. A score between 32 and 64 indicates low quality of work life, a score between 64 and 96 indicates average quality of work life, and a score above 96 indicates high quality of work life. The Cronbach's alpha coefficient of the questionnaire is 0.91 (12).

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Statistical analysis

Data were analyzed using SPSS version 24 software using independent t-tests, chi-square tests, one-way analysis of variance, and Pearson's correlation. In all tests, a significance level of 0.05 was considered.

Ethical considerations

This study was approved by the Research Ethics Committee of the Mashhad University of Medical Sciences (ID: IR.MUMS.REC.1403.063). First, the study objectives were explained to the participants, and informed consent was obtained. Confidentiality and anonymity of information were maintained.

Results

In this study, most participants were female (79.1% (N=155) and 31.6% (N=62]) in the 41-45 age group. A total of 76% (N=149) of the participants were married. A total of 63.8% (N=125) had a master's degree, and 80.1% (N=157) reported their financial status as an average.

In this study, only 34.2% (67) of the participants stated that they had consulted a psychologist/psychiatrist for psychological issues. 7.7 percent (15 people) reported a history of mental illness among their family members and 62.8 percent (123 people) stated that they encouraged their family members to see a psychologist/psychiatrist. The majority of the participants (132 people, 67.3%) reported receiving information about mental disorders. Demographic factors are shown in Table 1.

Based on the results in **Table 1**, there was no significant relationship between sex and D-Lit ($p>0.05$). The results showed that there was no significant relationship between age and D-Lit levels ($p>0.05$). The educational level of the study participants was significantly associated with their D-Lit levels, and individuals with higher educational levels had higher D-Lit levels ($p<0.001$).

There was a significant relationship between financial status and D-Lit, with individuals with better financial status having higher D-Lit scores ($p<0.001$). The results showed no significant relationship between marital status and D-Lit levels ($p>0.05$).

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Participants who reported consulting a psychologist their psychological issues had significantly higher D-Lit levels than those who did not ($p<0.001$). Participants with a family history of mental illness and those whose family members had been referred to a psychologist for psychological issues had significantly higher D-Lit levels than the others ($p<0.001$). In addition, participants who obtained information about mental disorders showed significantly higher D-Lit levels than those who did not ($p<0.001$).

Table 1 shows the status of participants' responses to the D-Lit questionnaire. Based on the results, 17.9 percent (n=35) were able to answer one to seven questions correctly, 48.5 percent (n=95) were able to answer eight to 14 questions correctly, and only 4.9 percent (n=9) were able to answer 15 or more questions correctly. 1.5 percent (n=3) did not know the answers to the questions or gave wrong answers. Additional information is presented in Table 1.

In this study, 45.91 percent (n=90) answered all questions about awareness of the psychological symptoms subscale correctly. A total of 1.53 percent (n=3) correctly answered all questions about the effectiveness of the available treatment methods. A total of 7.14 percent (n=14) correctly answered all questions about cognitive-behavioral symptoms. About 13.26 percent (n=26) answered all questions about knowledge of medication use and their side effects correctly. A total of 26.53 percent (n=52) answered all questions about disease severity correctly **(Table 2).** Based on the results in Table 3, the mean (±SD) D-Lit and quality of work life of employees were 40.19 (±7.06) and 80.72 (±15.42), respectively. The means (±SD) of the D-Lit and quality of work life subscales are presented in **Table 3**. The results of Pearson's correlation coefficient showed a positive and significant correlation between D-Lit and quality of work life ($r=0.022$, ($p<0.05$) **(Table 4).**

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Table 1. Frequency distribution of demographic factors (n=196)

Variables	n (%)		Depression literacy status n(%)				P-value [c]	D- Lit	P-value
			Incorrect / response Don't know	Correct response to 1–7 questions	Correct response to 8–14 questions	Correct response questions 15 to and more		Mean (SD)	
Gender	female	155(79.1)	1 (33.33)	27 (77.1)	73 (77.6)	9 100	0.246[c]	39.77 (7.27)	0.106[a]
	Man	41 (20.9)	2 (66.66)	8 (22.85)	21 (22.34)	0		41.78 (6.01)	
Age group	<25	2 (1.0)	0	0	2 (2.10)	0	0.014[c]	37.0 (0.0)	0.361[b]
	26-30	33 (16.8)	0	10 (28.52)	14 (14.73)	0		40.51 (4.76)	
	31-35	31 (9.7)	1 (33.33)	0	10 (10.52)	3 (33.33)		39 (8.03)	
	36-40	42 (21.4)	1 (33.33)	11 (31.42)	18 (18.94)	3 (33.33)		38.76 (6.99)	
	41-45	62 (31.6)	1 (33.33)	9 (25.7)	35 (36.84)	2 (22.22)		40.03 (7.68)	
	46-50	32 (16.3)	0	3 (8.57)	15 (15.78)	1 (11.11)		42.09 (7.47)	
	51-55	3 (1.5)	0	0	1 (1.05)	0		6.35 (3.66)	
	>55	3 (1.5)	0	2 (5.71)	0	0		44.3 (4.04)	
Marital status	Single	39 (19.9)	0	7 (20.0)	15 (15.78)	4 (44.44)	0.078[c]	39.51 (8.57)	0.102[b]
	Married	149(76.0)	3 (100)	25 (71.42)	78 (82.10)	5 (55.55)		40.21 (6.56)	
	Separated	5 (2.6)	0	3 (8.75)	0	0		47.20 (1.64)	
	Spouse deceased	3 (1.5)	0	0	2 (2.10)	0		36.33(10.96)	
Education level	Diploma	3 (1.5)	0	1 (2.85)	5 (5.26)	0	0.129[c]	45.0 (0.0)	[b]<0.001
	Associate Diploma	9 (4.6)	0	3 (8.57)	3 (3.15)	0		44.55 (2.7)	
	Bachelor's Degree	43 (21.9)	0	7 (20.00)	3 (3.15)			41.06 (7.29)	
	Master's Degree	125(63.8)	3 (100)	21 (60)	20 (21.05)	0		39.64 (7.30)	
	PhD	10 (5.1)	0	3 (8.57)	64 (67.36)	3 (100)		38.90 (6.64)	
	Professional Doctorate	6 (3.1)	0	0	0	0		38.5 (3.83)	
Financial	Good	25 (12.8)	0	2 (5.71)	14 (14.73)	3 (33.33)	0.001[c]	38.60 (6.14)	[b]<0.001

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status	Medium	157(80.1)	3 (100)	32 (91.42)	81 (85.26)	6 (66.66)		39.68 (6.90)	
	Weak	14 (7.1)	0	1 (2.58)	0	0		48.78 (4.40)	
Consulting a psychologist/psychiatrist about mental health issues	yes	67 (34.2)	1 (33.33)	13 (37.14)	34 (35.78)	3 (33.33)	[c]<0.001	38.94 (5.87)	[a]<0.001
	no	129(65.8)	2 (66.66)	22 (62.85)	61 (64.21)	6 (66.66)		40.84 (7.45)	
Family history of mental illness	yes	15 (7.7)	0	5 (14.28)	9 (9.47)	0	[c]<0.001	38.46 (6.13)	[a]<0.001
	no	181(92.3)	3 (100)	30 (85.71)	86 (90.52)	9 (100)		40.33 (7.13)	
Encouraging the family to see a psychologist/psychiatrist	yes	123(62.8)	2 (66.66)	17 (48.57)	62 (65.26)	6 (66.66)	[c]<0.001	40.06 (7.13)	[a]<0.001
	no	73 (37.2)	1 (33.33)	18 (51.42)	33 (34.78)	3 (33.33)		40.41 (6.98)	
Obtain information related to mental illness	yes	132(67.3)	2 (66.66)	24 (68.57)	68 (71.57)	6 (66.66)	[c]<0.001	39.75 (6.51)	
	no	64 (32.7)	1 (33.33)	11 (31.42)	27 (28.42)	3 (33.33)		41.09 (8.06)	[a]<0.001

[a] Independent Samples t Test
b One-way ANOVA
c Chi-square

Table 2. Participants' response to the D- Lit questionnaire

Subscale	Items	n (%)		
		Correct response	Incorrect response	Don't know
F1: Knowledge of the psychological symptoms	1. People with depression may feel guilty when they are innocent. (True)	152 (77.6)	21 (10.7)	23 (11.7)
	2. Loss of confidence and low self-esteem may be a sign of depression. (True)	151 (77.0)	21 (10.7)	24 (12.2)
	3. Too little or too much sleep can be a symptom of depression. (True)	183 (93.4)	-	13 (6.6)
	4. Eating too much or losing interest in food may be a symptom of depression. (True)	155 (79.1)	17 (8.7)	24 (12.2)
	5. People may move more slowly or become agitated due to their depression. (True)	140 (71.4)	10 (5.1)	46 (23.5)
F2: Knowledge about the effectiveness of available treatment methods	6. Clinical psychologists can prescribe antidepressant medications. (False)	37 (18.9)	106 (54.1)	53 (27.0)
	7. Many treatments for depression are more effective than antidepressant medications. (False)	105 (53.6)	14 (7.1)	77 (39.3)
	8. The effects of counseling are similar to those of cognitive- behavioral therapies for depression. (False)	65 (33.2)	31 (15.8)	100 (51.0)
	9. The effect of cognitive-behavioral therapies is the same as that of antidepressant medications for mild to moderate depression. (True)	65 (33.2)	33 (16.8)	98 (50.0)
F3: Knowledge about cognitive-	10. People with depression often speak sporadically and irrelevantly. (False)	58 (29.6)	65 (33.2)	73 (37.2)
	11. Reckless and foolhardy behavior is a common symptom of depression. (False)	40 (20.4)	77 (39.3)	79 (40.3)

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behavioral symptoms	12. Not walking on cracked and broken sidewalks may be a symptom of depression.(False)	14 (7.1)	82 (41.8)	100 (51.0)
	13. People with depression often hear sounds that are not normally heard. (False)	40 (20.4)	62 (31.6)	94 (48.0)
	14. Depression does not affect your memory and concentration. (False)	45 (23.0)	138 (70.4)	13 (6.6)
	15. Having several distinct personalities can be a symptom of depression. (False)	92 (46.9)	51 (26.0)	53 (27.0)
F4: Knowledge about taking medications and their side effects	16. Of all the alternative and lifestyle therapies for depression, vitamins are the most beneficial. (False)	34 (17.3)	55 (28.1)	107 (54.6)
	17. People with depression should stop taking antidepressant medications as soon as they feel better. (False)	13 (6.6)	132 (67.3)	51 (26.0)
	18. Antidepressant medications are addictive. (False)	96 (49.0)	45 (23.0)	55 (28.1)
	19 .Antidepressant medications are usually rapid-acting. (False)	25 (12.8)	101 (51.5)	70 (35.7)
F5: Knowledge of severity of disease	20. Most people with depression need to be hospitalized. (False)	4 (2.0)	176 (89.8)	16 (8.2)
	21. Many celebrities have suffered from depression. (True)	81 (41.3)	43 (21.9)	72 (36.7)

Table 3 Descriptive statistics of D-Lit questionnaire subscale scores among employees of Mashhad University of Medical Sciences

Subscales		Item	Range	Mean	Standard deviation
D- Lit	Knowledge of the psychological symptoms	5	5-15	6.67	2.10
	Knowledge about the available effectiveness of treatment methods	4	4-12	8.28	2.35
	Knowledge about cognitive-behavioral symptoms	6	6-18	12.62	2.57
	Knowledge about taking medications and their side effects	4	4-12	8.58	1.85
	Knowledge of severity of disease	2	2-6	4.01	0.93
	Total Score of D- Lit	21	21-63	40.19	7.06
Quality of work life	Total Score of QWL	32	32-160	82.70	15.42

Table 4. Pearson correlation between attributes of D- Lit and quality of work life

Variables	1	2	3	4	5	6	7
1. Knowledge of the psychological symptoms	1						
2. Knowledge about the available effectiveness of treatment methods	**0.287	1					
3. Knowledge about cognitive-behavioral symptoms	**0.407	**0.418	1				

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4. Knowledge about taking medications and their side effects	**0.280	**0.463	**0.427	1			
5. Knowledge of severity of disease	**0.337	**0.398	**0.342	**0.454	1		
6. Total Depression literacy	**0.660	**0.764	**0.783	**0.717	0.609	1	
7. quality of work life	-0.022	-0.070	**0.147	0.060	-0.131	*0.022	1

* $P < 0.05$ ** $P < 0.01$

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Discussion

This study was designed and conducted to determine the relationship between depression literacy and quality of work life of employees at the Faculty of Mashhad University of Medical Sciences. The results of this study showed that most participants had moderate D-Lit levels (13, 14).

The results of the study showed that participants answered 67 percent of the questions correctly (15). Another study showed that participants answered 57 percent of the questions (16). The results of this study revealed that while there was a statistically significant positive correlation between D-Lit and quality of work life among employees of Mashhad University of Medical Sciences ($r=0.022$, $p<0.05$), the magnitude of this relationship was extremely small. The correlation coefficient of 0.022 indicates a practically negligible effect size. According to Cohen's guidelines, values around 0.1 are considered small, 0.3 medium, and 0.5 large(17); a value of 0.022 is therefore almost indistinguishable from zero. Moreover, the coefficient of determination ($r^2=0.000484$) shows that only approximately 0.05% of the variance in quality of work life can be explained by depression literacy. In other words, more than 99.9% of the factors influencing quality of work life in this population are unrelated to depression literacy. Therefore, although this relationship is statistically significant (i.e., unlikely to be due to chance), it is clinically and practically unimportant. This finding suggests that although depression literacy may have some statistical association with quality of work life, it is not a meaningful or practical predictor in this context. Several explanations can be proposed for this finding. First, the study population consisted of university employees, the majority of whom held a master's degree (63.8%) and reported average financial status (80.1%). This group likely possesses a relatively high level of general health literacy and stable employment conditions, which may create a ceiling effect and reduce the observable impact of depression literacy on quality of work life. Second, for such employees, organizational factors such as salary, job security, workload, and organizational culture may play a far more dominant role in shaping their quality of work life than their level of depression literacy. Third, it is possible that depression literacy alone is not sufficient to improve quality of work life unless it is accompanied by supportive organizational policies and accessible mental health services. Furthermore, even when individuals possess adequate depression literacy, the absence of adequate environmental or organizational support may prevent this knowledge from

translating into improved quality of work life. This is consistent with previous research suggesting that a gap may exist between knowledge and actual behavior, especially in the absence of access to adequate information or environmental support(18, 19). Future research should investigate the moderating or mediating role of these organizational variables and explore employees' own perceptions of what most strongly affects their quality of work life.

Studies have shown that people with depression or severe anxiety have lower work ability and quality of life (20). In addition to poor work performance, low literacy levels are also associated with poor health outcomes, including anxiety and depression (21). Organizational interventions, such as improving mental health literacy and focusing on work-life balance, may help prevent depression in the workplace (22).

Based on the results of this study, there was no significant relationship between sex and D-Lit. However, other studies have shown that women have greater knowledge about depression than men (8, 23). The lack of a significant gender difference in our study may be attributed to the relatively high educational level of the study population, as the majority of participants held a master's degree, which may have equalized access to mental health information across genders.

In this study, no significant relationship was observed between age and D-Lit levels. Other studies have highlighted differences in depression literacy across different age groups (24, 25). This lack of difference in depression literacy among university-employed age groups may be due to the ability of employed individuals to use media, such as the Internet. Additionally, the relatively narrow age range of the participants (mostly between 26 and 50 years) may have limited the ability to detect age-related differences.

According to the results of this study, the education level of the study participants was significantly related to their D-Lit level, and people with higher education levels had higher D-Lit levels. Other studies have shown that higher socioeconomic status and education levels lead to greater access to information about depression (8) Depression is significantly more commonly diagnosed in individuals with less education (26). According to previous research, both depression literacy and quality of work life tend to improve with higher levels of education(5).

In this study, there was a significant relationship between financial status and D-Lit, with people with better financial status having higher D-Lit scores. Previous studies have linked depressive symptoms to socioeconomic status (27, 28). Financial status and debt are associated with an increased prevalence of mental illnesses (29). A possible explanation is that individuals with better financial status have greater access to educational resources, mental health information, and healthcare services, which may enhance their depression literacy.

In this study, those who reported seeing a psychologist for mental health issues had significantly higher D-Lit levels than those who did not. In addition, participants who mentioned a family history of mental illness and those whose family members had been referred to a psychologist for psychological issues showed significantly higher D-Lit levels than the others. According to the results of this study, people who received information about mental disorders from various sources showed significantly higher D-Lit levels than did others.

Using the Internet for health information has recently become a popular choice among the general population (30). Studies have reported an increase in the number of people searching for mental health information online(31). People prefer the Internet to visit their family doctors for advice about depression, although using the Internet to obtain mental health information is not conclusive (30).

Additionally, some people prefer to rely on their family and friends even when they suffer from severe disorders (32). Studies show that Psychiatrists and psychologists can assess and treat people with a wide range of mental health needs (33). Studies have shown that poor knowledge and negative attitudes toward depression negatively influence treatment choices and help-seeking behavior (34).

Less help from a psychiatrist or psychologist may indicate poor knowledge of psychiatric services or lack of understanding of the effective treatments provided by such professionals (35). Some studies have also linked access to information on the Internet to increased use of mental health services and mental health professionals (36).

Studies have shown that people tend to think of depression more as a physical problem and less as a cognitive problem (8). Evidence shows that young people are less likely to seek help from others in mental health, especially professional help from general practitioners (37).

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Some of the barriers to seeking help from psychologists and psychiatrists include difficulties accessing support, concerns about confidentiality and trust, preference for informal sources of help, and feelings of stigma (37).

In some healthcare systems, access to mental health providers is conditional on referral to general practitioners. Financial aspects can also play a role. If free or low-cost care is available, this can lead people to turn to a more reputable source (32).

Given the increasing use of the internet to obtain information in the field of mental health, emphasis should be placed on designing mental health information websites under the supervision of psychologists and psychiatrists. The content of topics that are most frequently searched for on the Internet in the field of mental health should be organized in a coherent manner, reviewed, and supervised by psychologists and psychiatrists, and made available to individuals.

Study Limitations and Strengths: The strengths of this study are the use of standard and valid depression literacy and quality of work life instruments, which reduced the measurement bias. Our study has some limitations. One of the most important limitations of this study was its cross-sectional design. Depression literacy and quality of work life were only studied cross-sectionally; therefore, we were unable to obtain information about the causal relationships that existed. Another limitation of this study is the specific characteristics of the study population. The participants were employees of Mashhad University of Medical Sciences, with the majority holding a master's degree (63.8%) and reporting average financial status (80.1%). This relatively high level of education and stable employment may limit the generalizability of our findings to other working populations, such as manual workers or employees in the private sector, who may have different levels of depression literacy and different determinants of quality of work life.

Conclusion

The results of this study showed a statistically significant but practically negligible positive correlation between depression literacy and quality of work life among employees of Mashhad University of Medical Sciences ($r = 0.022$). The extremely small effect size indicates that depression literacy alone is not a meaningful predictor of quality of work life in this population. Therefore, while improving depression literacy remains a valuable goal for mental

health promotion, it should not be expected to substantially enhance employees' quality of work life. Future organizational interventions may benefit from considering a broader range of factors, including structural and environmental aspects such as fair pay, job security, workload management, and a supportive organizational culture, alongside mental health literacy programs. Future studies with longitudinal designs and more diverse populations are needed to further explore the complex determinants of quality of work life.

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Ethics approval and consent to participate: The study received ethical approval from the Research Ethics Committee of the Mashhad University of Medical Sciences (ID: IR.MUMS.REC.1403.063) in compliance with the Helsinki Declaration. First, the study objectives were explained to the participants, and informed consent was obtained. Confidentiality and anonymity of information were maintained.

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