PSYCHOSOCIAL STUDY OF DEPRESSION AMONGST WOMEN IN WESTERN REGION OF NEPAL

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ABSTRACT

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"Depression among female patients due to social discrimination and lack of empowerment in Nepal"

Background
In Nepal, 1 - 2 % of the population suffers from severe mental illness, 5 % from moderate mental problems, while 20 - 30 % of all the patients coming to health institutions have some problems related to mental illness.

Aims
The aim of the study was to describe the socio-demographic profile and problems of the female patients with depression attending psychiatry OPD of Western Regional Hospital & Manipal Teaching Hospital, Pokhara

Settings and Design
The study was carried out in the Out Patient Department of Psychiatry at Manipal Teaching Hospital and Western Regional Hospital, Pokhara, from May 2005 to April 2006.

Material and Method
Cohort data of 50 patients from MTH and 50 patients from WRH were collected. The screening criteria for cases for inclusion in the study were as follows: Female patients with headache, mental tension, feeling of hopelessness and persisted sadness in women with abnormal behavior. The diagnosis and management of all the cases were done by the Psychiatrists and doctors of MTH and WRH. The primary source of data was interview of the patients, their relatives and doctors and observation by the study group

Statistical Analysis
Data were analyzed using descriptive statistics with SPSS, version 16, statistical analysis program (SPSS, Inc., Chicago, IL).

Results
71.51% female patients and 48.29% male patients visited psychiatry OPD at MTH during the study period. Likewise, compare to male patients (47.5%), female patients (52.5%) were higher in WRH during the study period. Most of the women in depression were in productive age group in both the hospitals ; 42% between 21-30 yrs followed by 33% in 31-40yrs , 16% in 41-50yrs and 4% in 51-60 yrs . 17% women were service holder in different fields, 39% were housewives, 7% in Business, 33% were working in Agriculture / laborer and 4% were in miscellaneous fields.

Conclusion
Higher caste women suffered more from depression and incidence is more in rural than in urban areas. Due to lack of awareness, most of the mental disorders go unreported. Sociological intervention in needed for the treatment of mental health problems.

Key Words: Depression, Women, Western Region, Nepal

INTRODUCTION

In Nepal, 1 - 2 % of the population suffers from severe mental illness, 5 % from moderate mental problems, while 20 - 30 % of all the patients coming to health institutions have some problems related to mental illness [1]. Some women may develop post-partum depression after delivery some women have episodes of depression which may be related to family problems and other socio-cultural and religious factors. Various authors have shown the association between depression and social factors like age, sex, social class, race, socialization, family and marital problems[2,3,4,5]. Usually prevalence of depression is significantly higher among women than men and more in urban area than in rural setting as evident from case records or community survey[6]. In addition to the other factors women face with significant gender discrimination and associated factors like poverty, hunger, malnutrition, overwork domestic violence and sex related violence. Although the Constitution of the of Nepal Government 1990, guarantees equal rights to both men and women, the status of women is much to be appreciated in every sector. They face discrimination at most of the areas of work or at home. They have less access to healthy nutrition (boys are more valued and therefore receive better nutrition), and to health education. This could be one of the causes of the low life expectancy for women (53.9 years, compared to 56.1 years of Men) earlier; though things are turning better.

The Fourth World Conference on women held at Beijing in 1995 defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female violence, rape, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation. Multi sectorial approach is needed to improve the health status of women in Nepal. There are no reports indicating the prevalence of sex based depression in Nepal especially in women. With the rise of women's activism time has come to explore such social condition and their impact on mental health of women to raise awareness and provide effective services. For that purpose, social context of mental disorders in women needs to be analyzed thoroughly in Nepal. The objective of the study was to describe the socio-demographic profile and problems of the female patients with depression attending psychiatry OPD of Western Regional Hospital & Manipal Teaching Hospital, Pokhara

MATERIALS AND METHODS

Settings and Design

The study was carried out in the Out Patient Department of Psychiatry at Manipal Teaching Hospital and Western Regional Hospital, Pokhara, from May 2005 to April 2006. 50 patients from MTH and 50 patients from WRH were selected. Both the hospitals are catering for the population of western region of Nepal from both the urban and the rural areas.

Inclusion exclusion criteria

The screening criteria for cases for inclusion in the study were as follows: Female patients with headache, mental tension, feeling of hopelessness and persisted sadness in women with abnormal behaviour. The diagnosis and management of all the cases were done by the Psychiatrists and doctors of MTH and WRH. The primary source of data was interview of the patients, their relatives and doctors and observation by the study group.

Outcome variable

The main outcome variable was the problems of

of the female patients with depression attending psychiatry OPD

Explanatory variables

Explanatory variables were age, caste/ ethinicity , Mothly income, educational status, marital status family type.

Ethical committee approval

Prior the study, ethical committee approval was taken from the institutional ethical committee, Manipal Teaching hospital, Pokhara, Nepal and WRH. The Research was conducted in accordance to latest version of the Declaration of Helsinki.

Data management and statistical analysis

The data collected was analyzed using Excel 2003, R 2.8.0 Statistical Package for the Social Sciences (SPSS) for Windows Version 16.0 (SPSS Inc; Chicago, IL, USA) and EPI Info 3.5.1 Windows Version.

RESULTS

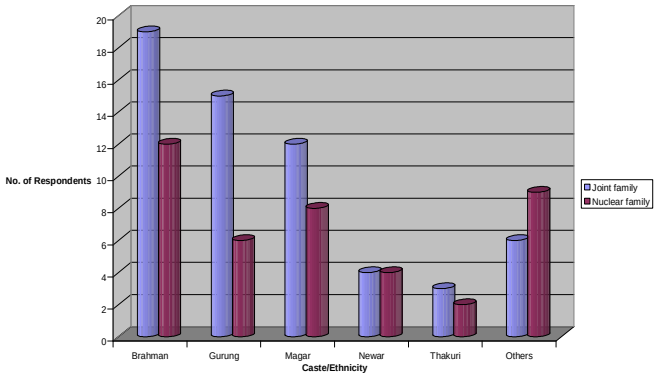
In comparison between women and men with depression, more number of women suffered from depression than the males who attended psychiatry OPD of both hospitals (51.88% female and 48.12% male). 71.51% female patients and 48.29% male patients visited psychiatry OPD at MTH during the study period. Likewise, compare to male patients (47.5%), female patients (52.5%) were higher in WRH during the study period. Most of the women in depression were in productive age group in both the hospitals ; 42% between 21-30 yrs followed by 33% in 31-40yrs , 16% in 41-50yrs and 4% in 51-60 yrs . 17% women were service holder in different fields, 39% were housewives, 7% in Business, 33% were working in Agriculture / labourer and 4% were in miscellaneous fields.

Education wise, 41% were either illiterate or studied up to primary level, 34% up to secondary/SLC level, 16% Intermediate level and9% had Bachelor/ Masters degree.

It was seen that more case of depression were in lower income group than in higher income group of families 31% had monthly income below Rs 5000 (41.94% in MTH and 50.06% in WRH), 26% had Rs 5000-10000 (53.84% in MTH and 46.16% in WRH) and 21% had Rs. 10000-15000(38.09% in MTH and 61.91% in WRH).

Graph 1 shows 31% women in depression were Brahman/Chhetry followed by 21% Gurung , 20% Magar and 5% were Thakalis.The above data also indicates 59% joint family and 41% nuclear family structure. Likewise, 61.3% women with depression of Brahman/Chhetry and 38.7% of Gurung caste were also in the joint family structure.

54% had arranged marriage. 39% Love marriage and 7% were unmarried.



Graph 1: Cross tabulation of Caste/ Ethnicity and family status of women in depression

Graph 2 shows the husbands of most of the women in depression (33%) were away doing jobs abroad (54.54% in MTH and 45.46% in WRH), 7% women were unmarried. 24 % women in depression were living with husband and 20% depressed women were married. The highest rank (35%) of physically abused in respondents were 21-30 yrs age group (54.29% in urban and 45.71% in the rural area). The Lowest percentage (7%) was in age group 51-60 yrs (42.85%

in urban and 57.15% in rural area). 14% of the respondents did not answer about physical abuse.

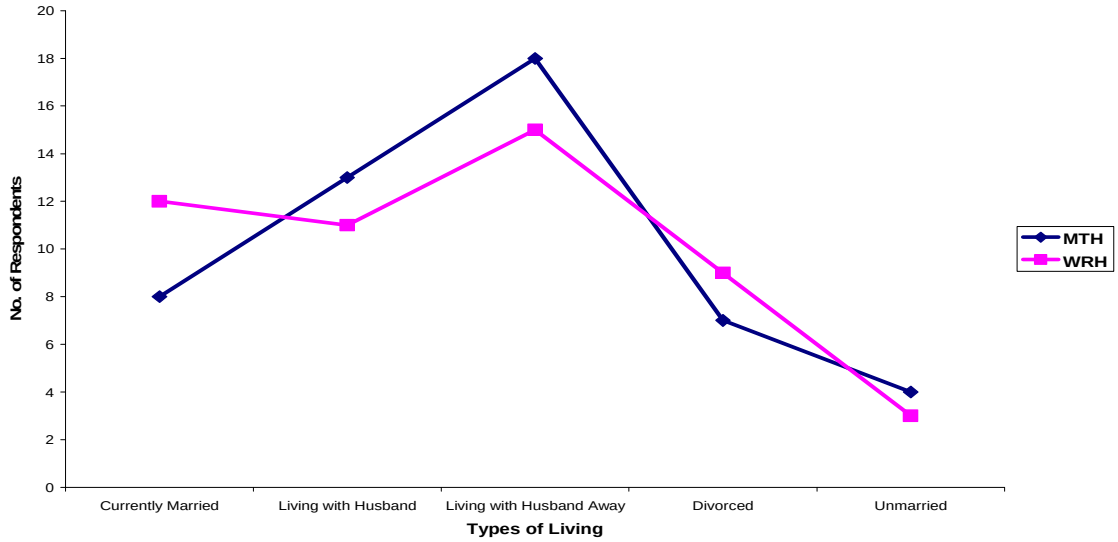
Graph 3 shows the highest percentage of discrimination on depressed women was found at their home and family (35%), followed by 23% at work station, 13% at school/colleges, 8% in public places and 9% were discriminated in other areas. 12% did not answer questions related to discrimination.

Table 1 shows the highest percentage of domestic violence to depressed women were psychological torture (25%), physical violence including slapping (20%), forced sex by their partners, sexual by their partners, sexual harassment in work place (9%)& rape (2%). WHO world report on violence and health summary (2002) indicates that domestic violence is the leading cause of depression in women between ages of fifteen and forty four in the United States.

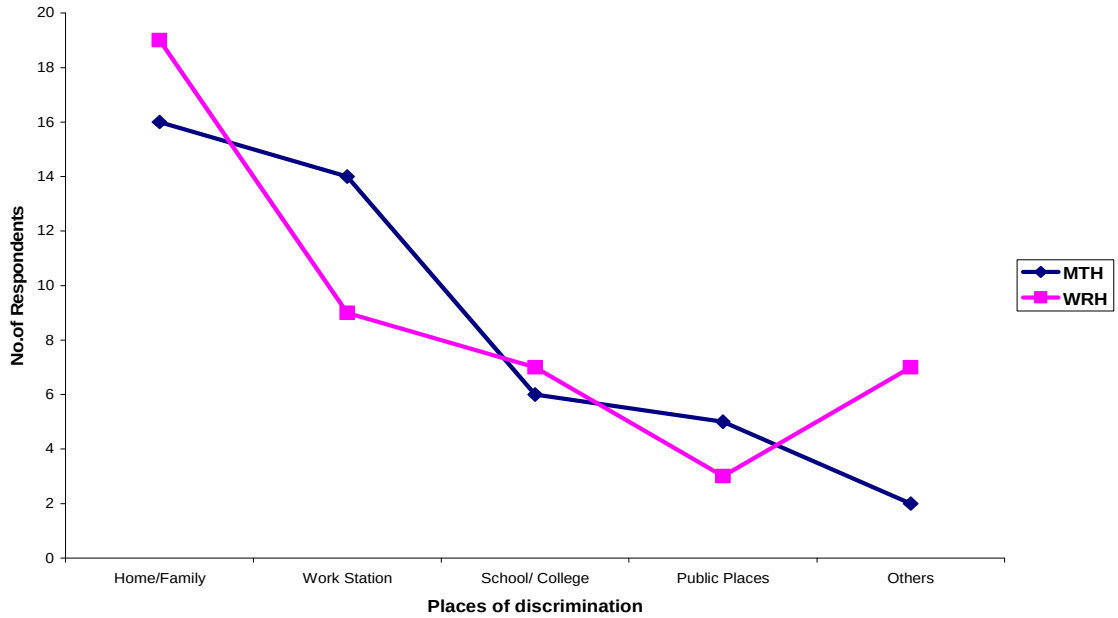
DISCUSSIONS

From the perspective of women and mental health, the key epidemiological finding is the much-replicated association of female gender and Common Mental Disorders (CMD) such as depression and anxiety. Both community-based studies and studies of treatment seekers indicate that women are, on average, two to three times, at greater risk to be affected by CMD. There are a number of potential factors, which may make women more vulnerable to depression. Mental health is the balanced development of the individual's personality and emotional attitudes which enable her/his to live harmoniously with her/his fellow-men. Mental health is not exclusively a matter of relation between person; it is also a matter of relation of the individual towards the community and towards the social institutions. In Nepal, 1 - 2 % of the population is suffering from severe mental illness and 5 % the population suffers suffers from moderate mental problems, while 20 - 30 % of all the patients coming to health institutions have problems, which are related to mental illness[1]. The social and environmental factors associated with mental ill health comprise: worries, anxieties, emotional stress, tension, poverty, frustration, unhappy marriages, broken homes, industrialization, urbanization, changing family structure, population migration, economic insecurity, cruelty, rejection, neglect and so on. When people are sad they sometimes say that they are 'depressed', but the clinical depression that are seen by doctors differ from the low mood brought on by everyday setbacks. Clinically important disturbances of mood are known as depression (affective disorders). Affective disorders or Depressions are more severe and more persistent that simple sadness. Depression occurs after difficult or stressful events in the person's life.

The 'Diagnostic and Statistical Manual of Mental Disorders' (DSM-IV, 1994)[7], reveals the lifetime depression prevalence of 10-20 % for women and 5-12 % for men. Due to lack of research, sex based prevalence of depression in Nepal is not known. However studies carried out in India show greater rates of prevalence of depression among women, in urban as well as rural communities. Similarly number of studies reviewed, showed a greater prevalence of depression in women, especially in the lower socio-economic groups. This sex-based prevalence of depression definitely makes it women's issues, with various social factors exerting their influences. As mentioned above, depression mostly occurs after difficult social situations. Various social factors such as age, sex, class, martial status, childhood experience, socialization, and so on, need to be considered in order to describe how they affect depression in women and thereby the underlying feminine issues could be identified and analyzed. WRHP (1988)[8] research



Graph 2: Hospital wise comparison of marital status of women in depression



Graph 3: Hospital wise comparison of places of discrimination of women in depression

Table 1: Cross tabulation of Types of Domestic Violence and residential status

Types of Domestic Violence	Urban	Rural	Total
Injured by weapon	5 (55.6)	4 (44.4)	9
Slapping (Physical Violence)	9 (45)	11(55)	20
Love Tragedy by Boy friend	4 (80)	1 (20)	5
Rape	1 (100)	0(0)	1
Forced sex by partner	7 (53.8)	6 (46.1)	13
Sexual abuse in Childhood	2 (66.7)	1 (33.3)	3
Psychological Torture	12 (48%)	13 (52%)	25
Sexual harassment in work place	7 (77.8)	2 (22.2)	9
Others including non response	2 (13.3)	13 (86.7)	15
Total	**49**	**51**	**100**

Note: Figure in parenthesis indicates per cent of rows

was conducted to collect and analyze information from rural women about their perceptions, socio-cultural and religious traditions, problems and practices in relation to various health issues and environments responsible for women's health and subordinate status in society[9]. Mental disorders are generally viewed as a curse, an infliction, a result of bad deeds either in this life or past, or a result of wrong food, or an un-understandable predicament which has to be endured by the patient and the family. Mental Patients elicit feelings of fear, disgust, pity or hostility among the public. As there was no effective treatment, people believed that these patients had to be managed somehow for life. The families took care of them as much as they could. The socio-cultural organizations, like temples and other religious institutions, offered help and support to keep these patients in their premises. The self-sufficient village community gave shelter to the patients who wandered off from their families[8].

The incidence of depression seems to be higher in women then men and in urban rather than rural settings. Women's higher risk for depression holds whether one looks at case records or community survey[10]. In this study higher caste women suffered more from depression and incidence of depression is more in rural than in urban areas. Depression is more who had arranged marriage than love marriage because the understanding of each other in love marriage was more between partners.

The patriarchy system also plays a vital role in depression in women. The chance of depression in women is high in younger age group than in higher age group because the level of maturity is high in elderly. It was found that lack of sexual satisfaction was a cause of depression in women. Gender discrimination, domestic violence, sexual and physical abuse were major causes for depression. Many customs and rituals can be identified as practices from which violence against women originates i.e. *deuki* (the system of offering a girl to a God), child marriages, *jari pratha* (paying a fine to the husband of a woman with whom one marries), *badi pratha* (the traditional practice of prostitution in Badi community. the *daijo* (dowry system), *tilak pratha* (the fulfillment of the demands of a groom during the marriage ceremony) *chaupadi pratha* (the practice of isolation during the menstruation and post-delivery period) these are the traditional and cultural practices which also are responsible for depression in women. Socio-economic status has been defined as the position

that an individual or family occupies with reference to the prevailing average standards of cultural and material possessions, income and participation in group activities of the community. Hollingshed in USA[8] employed three variables, viz education, occupation and residential address for measuring socio-economic status. Kuppuswamy in India[9] prepared a scale based on education, occupation and income which are the three major variables contributing to socio- economic status in urban areas. Similar scales have also been prepared by Pareek and Kulshrestha[10] for use in rural and urban areas. Armstrong (1998)[11] mentioned that physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs. Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection[12]. An estimated 80% of 50 million people affected by violent conflicts, civil wars, disasters, and displacement are women and children [5]. There are several types of violence against women, all of which need not take the form of brutal assaults. Demands by society on widows, however young they are, to lead a rigidly austere life, social isolation and abstinence from men were considered through ages as necessary measures to keep them from temptation and sin. The practice of '*sati*' in certain parts of India and Nepal in the past where the wife was put supposedly by herself in the funeral pyre of her husband. Such behavior of self-denial, torture and even death were indeed sanctified and glori-fied and there are even temples erected for the goddess of *sati*. Historically, culture, customs, traditions and beliefs have fostered in their own ways, various forms of violence against women.

CONCLUSION

Higher caste women suffered more from depression and incidence is more in rural than in urban areas. Due to lack of awareness, most of the mental disorders go unreported. Sociological intervention in needed for the treatment of mental health problems. In Nepal all should try to maintain social solidarity and fight against gender discrimination & domestic violence against women and promote uplift of women's status in the society and empowerment.

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