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A STUDY ON PREVALENCE AND CAUSES OF DEPRESSION AMONG ADULT POPULATION OF KIRTIPUR MUNICIPALITY, KATHMANDU

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TABLE OF CONTENTS

Table of Contents
List of Figures
Abstract
Preface

Introduction 1
Kirtipur 4
Objectives of Study 5
Literature Review
Methodology 8
Sample site and Population 8
Screening Instrument 8
Training 9
First Stage 9
Data Analysis 10
Results 11
Demography 11
First Stage 11
Second Stage 12
Prevalence 12
BDI scores and Socio-demographic Factors 12
Discussion Groups 18
Summary of FGD Session 19
Discussion 22
Summary of Results 22
Prevalence of Depression 22
Depression and Socio-demographic Factors 23
Depression and Sex 23
Depression and Age 24
Depression and Martial Status 25
Depression and Educational Level 26
Depression and Occupation Level 26
Depression and Socio-economic Status 27
Depression and Race/Ethnicity 28
Implications of the Present Study 29
Methodological Issues 31
Further Research 32
Conclusion 32
Reference 33
Appendix - 1 38
Appendix - 2 41
Appendix - 3 42

Accession No. 132
Call No.

TABLES OF FIGURES

FIGURE 1. BDI MEAN SCORE BY SEX AND WARDS 12
FIGURE 2. BDI MEAN SCORES BY SEX DIFFERENCE 13
FIGURE 3. BDI SCORES BY AGE AND GENDER 14
FIGURE 4. BDI MEAN SCORES BY MARITAL STATUS 15
FIGURE 5. BDI MEAN SCORES BY EDUCATIONAL LEVEL 15
FIGURE 6. BDI MEAN SCORES BY OCCUPATION LEVEL 16
FIGURE 7. BDI MEAN SCORES BY SOCIO-ECONOMIC STATUS 17
FIGURE 8. BDI MEAN SCORES BY ETHNICITY 18

PREFACE

"The world of happy man is a different one
From that of the unhappy man"
Wittgenstein

Depression - feeling of being pressed down by the world - is a commonplace of human experience. It is, and seemingly has always been, a recurrent theme of our conversation and our culture. In our attempt to convey to each other our personal experience of depression we have called upon every kind of metaphor. We have drowned analogies from disease and injuries- to be sick at heart, to suffer a broken heart.

Our everyday "Psychology of depression" recognizes its variations in severity, its signs and effects, its origins and its antidotes.

Our account of depression scales it from a mild but burdensome feeling that life is flat, state, dull and unprofitable to a kind of raging despair.

We sense it as a short lived "mood" or seemingly endless state, what I hope to achieve by this research is to promote our understanding of depression in terms of meaning, experience, and causes rather than in terms of illness. It highlights the prevalence of depression in Kirtipur Municipality in nut-shell.

This research was made possible by a grant from National Health Research Council. I would like to thank the Member Secretary and all officials of the Council.

It is my pleasure to acknowledge the contribution of my students who worked with me in the depression research project as well as community dwellers who were voluntarily involved as a respondent. I have gained so much from them and from all the people who at one time or another have talked with me about their experience. Warm thanks are extended to them. I would like to thank to Ms Rojina Manandhar who carried out the work of statistics.

ABSTRACT

Despite the fact that depression is the major type of mental illness found in Nepal, there are conflicting results in critical factors that affects depression. Conflicting findings in scientific inquiries impends the scholars and professional practitioners more than clears about the phenomenon under study. The present study on prevalence of depression was made to examine the factors and identify the local variables related to depression. Knowledge of, attitude toward and related illness behavior were also examined to explore the views and level of information possessed and social practice of the health seekers. The study was conducted at Kirtipur with a total number of 190 adult samples. Results shows that almost one fourth of total sample were depressed among which educated as compared to illiterate, female as compared to male, and people with insecure jobs, economically with low status were found to suffer more. In context of socio-cultural groups more low caste, ethnic groups were found to suffer from depression than high caste group.

INTRODUCTION

Depressive disorders have been with man since the beginning of recorded history. In the Bible, King David, as well as job, suffered from this affliction. Hippocrates referred to depression as Melancholia, which literally means black bile. Black bile, along with blood, phlegm, and yellow bile were the four humors (fluids) that accounted for the basic medical, physiology of that time. Depression has been portrayed to literature and the arts for hundred of years, but what do we mean today when we refer to a depressive disorder? In the nineteenth century, depression was seen as an inherited weakness of temperament. In the first half of the twentieth century, Freud linked the development (pathogenesis) of depression to guilt and conflict.

According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994) there are several forms of mood disorders. For a diagnosis of Major Depressive Episode, five of the following symptoms must be present during the same two-week period, and one of the symptoms must be either depressed mood or loss of interest or pleasure: (1) depressed mood; (2) markedly diminished pleasure in all, or almost all, activities; (3) significant weight loss or weight gain when not dieting; (4) insomnia or hypersmnia; (5) Psychomotor agitation or retardation; (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, recurrent suicide attempt or a specific plan for committing suicide.

Dysthymic Disorder is a depressed mood for more days than not over a period of two years accompanied by other depressive symptoms. This disorder is not as severe as major depressive episode. If the mood disorder is due to substance abuse or to a general medical condition a diagnosis of dysthymic disorder or major depressive disorder would not be made. For bipolar disorder, major depressive episode alternative with one or more manic episodes that are characterized by elevated mood, or if wishes are thwarted by irritability (DSM-IV, American Psychiatric Association, 1994)

Depression is generally defined as "persistent feeling of sadness which is excessive to situations", commonly depression occurs after difficult or stressful events in the person's life-bereavement, examination failure, loss of job, economic problems or relationship problems, and though sometime it follows physical illness or acute infection (Nepal and Wright 1988).

Depressive disorders come in different forms, just as do other illness, such as heart disease and diabetes. Three of the most common types of depressive disorders are given below. However these types are vary in the number, severity, and persistence of symptoms.

Major Depression is characterized by a combination of symptoms, including sad mood that interfere with the ability to work, sleep, eat, and enjoy once-pleasurable activities. Disabling episodes of depression can occur once, twice, or several times in a lifetime.

Dysthymia is a less severe type of depression. It involves long-term (chronic) symptoms that do not disable, but yet prevent the affect person from functioning at "full steam" or from feeling good. Sometimes, people with dysthymia also experience episodes of major depression. This combination of the two types of depression is referred to as double-depression.

Another type of depression is bipolar disorder, which was formerly called manic-depressive illness or manic depression. This condition shows a particular pattern of inheritance. Not nearly as common as the other types of depressive disorders, bipolar disorder involves cycles of depression and mania, or elation. Bipolar disorder is often a chronic, recurring condition. Sometimes, the mood switches are dramatic and rapid, but most often they are gradual.

Some types of depression run in families, indicating that a biological vulnerability to depression can be inherited. Major depression also seems to occur in generation after generation in some families, although not as strongly as in Bipolar I and II. Indeed, major depression can also occur in people who have no family history of depression.

An external event often seems to initiate an episode of depression. Thus, a serious loss, chronic illness, difficult relationship, financial problem, or any unwelcome change in life patterns can trigger a depressive episode very often, a combination of genetic, psychological, and environmental factor is involved in the onset of a depressive disorder.

Nothing in the universe is as complex and fascinating as the human brain. The over 100 chemicals that circulate in the brain are known as neurochemicals or neurotransmitters. Different neuropsychiatric illness, seem to be associated with an over- abundance or a lack of some of these neurochemicals in certain parts of the brain. A certain medications that alter the levels of neurochemicals system: norepinechrine, serotonin, dopamine, and acetycholine can alleviate the symptoms of depression.

Psychosocial factors also contribute to a person's vulnerability to depression. Thus, persistent deprivation in infancy, physical or sexual abuse, clusters of certain personality traits, and inadequate ways of coping (maladaptive coping mechanism) separation, divorce all can increase the frequency and severity of depressive disorders, with or without inherited vulnerability.

The effect of maternal-fetal stress on depression is currently an exciting area of research. It seems that maternal stress during pregnancy can increase the chance that the child will be prone to depression as an adult, particularly if there is a genetic vulnerability. It is thought that the mother's circulating stress hormones can influences the development of the fetus's brain during pregnancy. This altered fatal brain development occurs in ways that predispose the child to risk of depression as an adult. Further research is still necessary to clarify how this happens. Again, this situation shows the complex interaction between genetic vulnerability and environmental stress, in the case, the stress of the mother on the fetus.

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KIRTIPUR

Kirtipur, meaning the city of glory, is one of the sub-metropolitan cities of Kathmandu district. It is about five kilometers south-east of the Capital, Kathmandu. Kirtipur, also known as Kipu and Kyapu, is one of the oldest settlements in valley, and is recorded as an ancient capital of Nepal. The town, inhabited largely by Newars, the earliest population group of the valley, occupies the top of a steep rocky hill, a location very different from the other main towns of the valley as Kathmandu and Patan. In ancient times, Kirtipur was a stronghold, probably fortified, and the historical records show that up to the 18th century the control of Kirtipur was a key to maintaining power in the valley.

During 1960s, establishment of Tribhuwan University brought a great change in the infra-structure of Kirtipur. New houses were built at the foot of the south-east of Kirtipur, called Naya Bazaar directly linked to the down town. It is also recognized by its historical and cultural importance of the temples particularly the 16th century Bagh Bhairav, and main Buddhist Stupa.

The population of Kirtipur is predominated by Newar community, they are inhabited at numbers of wards respectively 1, 2, 3, 4, 5, 6, 11, and 17, surroundings and the foot of Uma Maheswar, and Bagh Bhairav Temple. Hindu high caste Brahmin and Chhetri groups reside in the plain areas. On the contrary, Magar and Tamang are loved to live at the ridges of Champa Devi Hillock within ward nos. 7 & 8. Most of community dwellers are Hindu and Buddhist, some are adopted Christianity recently. But there religious harmony is well maintained in community. The Newars observe more festivals than any other population group in Nepal, these festivals may be observed nationally or by particular local communities in certain localities. They include Indrayani Jatra, Bagh Bhairav Jatra, Buddha Jayanti, Gaijatra and Krishna Janmastami.

Social life in Kirtipur is organized into a tightly bound and regulated structure which has remained stable for many years, perhaps mainly as a result of the lack of change in the needs of the members of this farming community over the generation. Most people still live in extended families spanning three to four generations. They mostly

depend on agriculture for livelihood, no doubt, some of the family members are engaged in various kind of occupation e.g., government, non-governmental services, skilled work, contract and daily wages work.

They do have the health facilities made available by GOS/ NGOS, as Bikalp Sahakari Sanstha (NGO) situated at 17 ward, phect-NEPAL (NGO) at ward no. 2, and Primary Health Centre (GO) at ward no, 1 respectively. They have made action plan to run out-reach clinic once a week some of wards away from centre even though people have strong belief on traditional healer and folk medicine. Most of city dwellers are illiterate. It is very hard to find literate women above 40 years. They are totally depended in family and agriculture for livelihood. But they do not have access on the family properties.

Objectives of the Study

Despite the high incidence of depression among the Nepalese population no systematic comprehensive empirical research has been conducted to understand depression and its impact on individual's total health. Mental health in Nepal is a largely neglected area and faces numerous barriers to improvement, including social stigma, inadequate resources, personnel and health facilities. The target of research is to observe the prevalence of depression in terms of sex and other major demographic variables in understanding its nature and causes in Kirtipur adults population. The objectives of this study are threshold:

1. To find out the gender differences in depression
2. To find out the relationship between age, marital status, caste and ethnicity, socioeconomic condition, occupation and education level, and depression
3. To find out the knowledge, attitude and illness behavior in relation to depression.

LITERATURE REVIEW

As in other countries, about 12% of Nepal population suffers from some of degree of mental illness at any given time. Of this, at least 2% suffer from severe but treatable mental illness. The burden of mental illness greatly affects contribute from to family, community and workplace.

Rapid and largely unplanned modernization has had a tremendous impact on Nepalese society, undermining traditional family and community support systems that have long stabilized the mental health of its people. Sudden changes in social and economic norms have contributed to virtual epidemic of psychosocial problems-drug and alcohol abuse, family and marital conflicts, young people with lost identities, victims of torture are all increasing. Male and female, young and old are forced to seek help outside the family to mange their new complex problems.

The world health organization estimates that by the year 2020, depression will become the social leading causes of the global disease burden. Women in developing and developed countries experience depression at a rate almost double that of men; currently, depression constitutes women's leading cause of disability in the world. In Nepal, almost no attention has been focused on women's depression, even though the World Health Organization ranks depression as the most important women's health problem in the world overall (Cabral, Meena & Asbury, 2000).

Depression was and is one of the most serious mental problems of this era. Major depressive disorder is a relatively common psychological disorder. Out of every 100 people, approximately 13 men and 21 women develop the disorder at some point in life (Kessler et al, 1994). Reflected in these statistics is the fact that women are much more likely than men to experience this disorder (Spancer, Bland & Newman, 1994).

Depression can cause severe impairment in social land physical functioning and is often a major precipitating factor in suicide. It has been associated with higher medical cost, greater disability, poor self-care and adherence in medical regimens, and increased mortality from medical illness (Katon & Sullivan, 1990)

Women are approximately two times more likely than men suffer from depression and dysthamia (Research Agenda for psychosocial and behavioral factors in women's health, 1996). According to Terrence Real (2000) depression is considered a "female disease", since affect women reportedly outnumber me by four to one. Yet male depression may be more rampant than we realize. The causes of depression differ in men and women as well. While depressed women often feel disempowered, depressed men feel disconnected, from their needs and from others. This begins in childhood, as society teaches boys early on to pull away from their mothers, their emotions and their vulnerabilities.

Although men and women exhibit similar symptoms of depression, women report more atypical symptoms including anxiety, somatization (the physical expression of mental processes such as aches and pains with no physiological causes), increases in weight and appetite, oversleeping and expressed anger and hostility (Nami, 1996 – 2002).

In relation to socioeconomic status it was found that higher levels of depression symptoms are particularly common among individuals with economic problems and these of lower socioeconomic status. Individuals who are less educated and unemployed are at higher risk for depression. These risk factors are overrepresented among women (McGrath et al 1990).

METHODOLOGY

Sample site and Population

Due to its several suitable characteristics Kirtipur municipality was chosen for the present research site. The physical features of Kirtipur's situation and time restrictions of data collection meant that small sample population was selected from each wards representing the municipality as whole. The study population was defined as these adults aged 20-45 living in the 19 wards. Local census data from 2001 listed the total numbers of house and population. Then sample size was fixed 190, in each and every wards, 10 (male and female) people were interviewed along with standardized Beck Depression Inventory (II).

Before administered the questionnaire in the community of Kirtipur, pretest was done in ten uneducated city dwellers of down town especially Newar community to acknowledge the adequate understanding of the questionnaires. Secondly, the proportional representation of ethnic group approximates that of the wards as a whole.

Permission was obtained from the municipality office and introductions were made to the wards officials. A map was drawn of the wards and the number of houses in each ward noted from the local census data (2001).

First sample was drowned by lottery method from the number of house. Then, the house number is selected by dividing sample number (10) systematically from each ward. If sample is not found within the age range (20-45) in the selected house number, the alternative method is applied.

Screening Instrument

A standardized Beck Depression Inventory (BDI-II) was chosen as screening instrument. As it has been used in previous research done in Nepal, and therefore allows some consistency. The original version of BDI was introduced by Beck, Ward, Mendelson, and Mock & Erbangh in 1961. The BDI was revised in 1971 and made copy right in 1978 (Groth in Marnat, 1990). Both the original and revised

versions have been found to be highly correlated (.94 Lightfoot & Oliver, 1985 cited in groth-Marnat, 1990).

The BDI is a 21 – item self-rating scale of measuring supposed manifestations-depression. Each item comprises 4 statements (rated 0-4) describing increasing severity of the abnormality concerned. Person completing the scale is required to read each group of statements and identity the one that best describes the way they have felt over the preceding week.

The BDI takes approximately 10 minutes to complete, although clients require a fifth-sixth grade reading age to adequately understand the questions (Groth-Marnat, 1990). The Nepali version of BDI was chosen for the present study. A Nepali translations and back translations were made by research group.

Attached with the questionnaires of socio-demographic information, these included educational status, occupation, socio-economic status, age, sex, marital status, and ethnicity. A copy of the BDI and additional questions used is presented in appendix.

Training

Two male and two female research assistants were chosen from undergraduates, department of Psychology, of Tri-Chandra Multiple Campus, Kathmandu. They were trained in the administration of BDI in one day training, during which practice interviews were observed by the PI. Satisfactory interrater reliability standards were achieved. A pilot study was then completed over one day in down town especially uneducated Newar community dwellers. From this study, points of difficulty in administration and community response were then discussed with the PI before departure for the study site.

First Stage

A two stage screening procedure was used as in Harding et al. (1980). During the first stage, all female participants were interviewed by the female research assistants and male participants were interviewed by the male research assistants.

At each house occupants were given a brief explanation, and their consent was obtained. As many of the participants were illiterate, the BDI was administers orally in Nepali and sometimes in Newari as their demands. The Participants aged 20-45. Interviews were conducted in as much privacy as possible.

Second Stage

Selection for the second stage was based on BDI scores. The cut-off was chosen at 6/7 to reveal depression, and all participants scoring above this threshold, were chosen for second stage diagnostic interview. Interviews were conducted by PI, made without knowledge of BDI scores, and diagnosis was made often discussion between the interviewers. It was decided to reveal the causes of depression. If the interviewee was rated by depression, she/he were referred to the phect- Nepal (community based health care centre and counseling centre) for counseling services. In case the severe depressive case were found in the community, referred to Mental Hospital or rehabilitation centre.

Data Analysis

Non- Parametric statistics tests were administered. SPSS program is drawn and used to analyze the data and data treatment. Co-relation is computed where it was possible, many cases it was not possible to derive the correlation because of uneven mean scores. BDI mean scores between different groups were compared to see the reliability.

RESULTS

The data collection was carried out during first two weeks in November 2003. One hundred and ninety peoples (males & females) were interviewed from nineteen wards of Kirtipur municipality. Both male and female are equally represented from each ward. The selection is based on recent national census data 2001.

Demography

The selected adults aged 20-45 ranges were living in nineteen wards of Kirtipur municipality. The proportion of the population of men was 20,928 whereas women were 18,843 according to National Census data in 2001. However, there is diversity of ethnicity, socioeconomic status, educational and occupational level found in Kirtipu, which is predominated by Newar community.

First Stage

The BDI was administered to 190 adults in nineteen wards, representing of total adult population in the study frame (n=190). Nobody refused to participate in the survey. The BDI includes altogether 21 questions regarding Depression symptoms as Sadness, Pessimism, Past failure, Loss of pleasure, Guilt feelings, Punishment feelings, Self-dislike, Self-criticalness, Suicidal thoughts or wishes, Crying, Agitation, Loss of interest, Indecisiveness, Worthlessness, Loss of energy, Changes in sleep pattern, Irritability, Changes in appetite, Concentration difficulty, Tiredness of fatigue & Loss of interest in sex.

To screen for depression, a cut-off score of 6/7 on the range of mild, moderate, and severe, BDI II (BDI-21) was used; 11.0% of male and 13.1% of female scored above this threshold. Of those scoring below this threshold, men are responded "yes" in loss of pleasure, pessimism, past failure, sadness, agitation whereas women responded loss of energy, changing in sleeping pattern, crying, pessimism, sadness, guilty feelings, irritability, self criticalness and tiredness of fatigue.

Second Stage

It was decided that those scoring over 6/7 on the BDI, might have depression, therefore, all those who scored, were selected for diagnostic interview. There were 21 male and 25 female were attended interview.

Despite the numbers of participants scoring positively on depression, there were 12 clients who really needed counseling, so they were referred to phect-NEPAL (community based reproductive health care and counseling centre) for counseling and relaxation services

Most of them had physical problems, they were advised to see the medical doctors, and two women were referred to mental hospital for medication. A special request was made to phect-NEPAL field worker and social worker for follow visit to them.

Focus group discussion session was run to reveal the causes of depression, to acknowledge the awareness, attitude, and illness behavior of community. All of those respondents rated depression as well as FCHV, male volunteer, ward member, and city dwellers were requested to participate in the session. FGD session was held in wards number as 2, and 11, respectively.

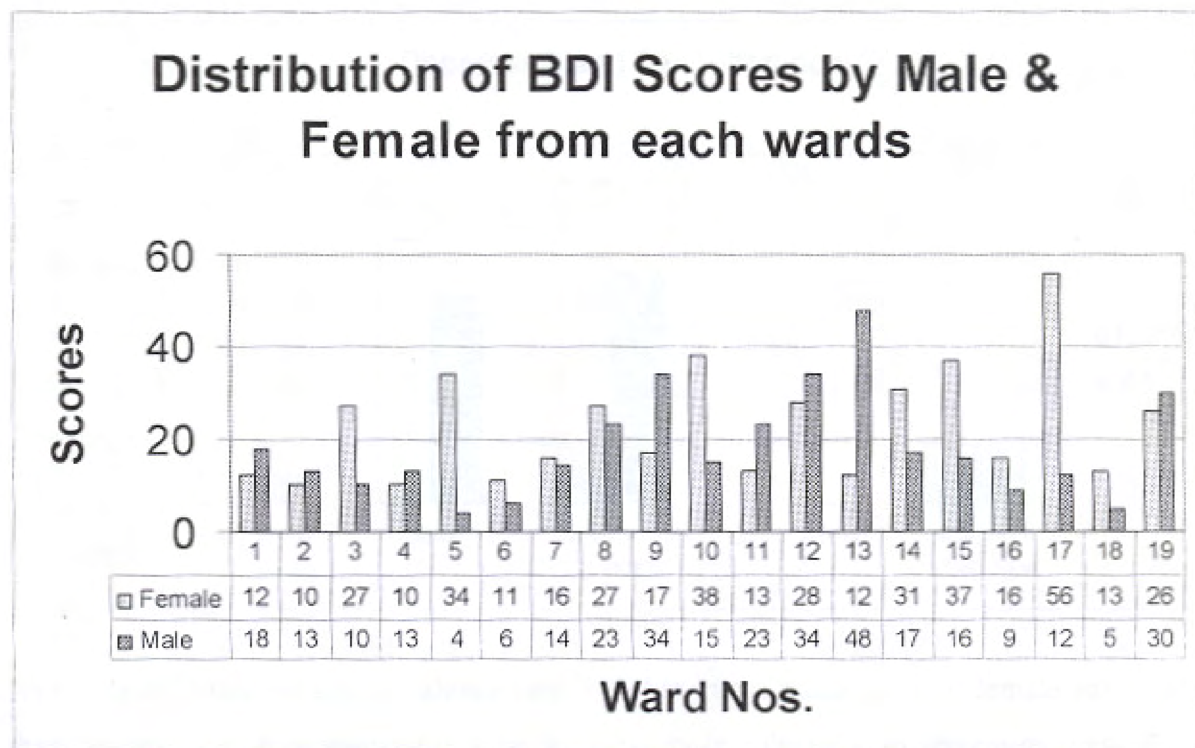
Prevalence

It was decided that the individual who come across the threshold 6/7 scores or more on the questionnaires of BDI was evidence of possible depression. These criteria yield a point prevalence of depression in women and men.

BDI scores and Socio-demographic factors

The mean scores on the BDI-21 was an indication of depression level of 19 wards people of Kirtipur Municipality. Women reported more depression than male in the survey. Highest prevalence found in 17 wards which are closed to Tribhuwan University and the metropolitan city area.

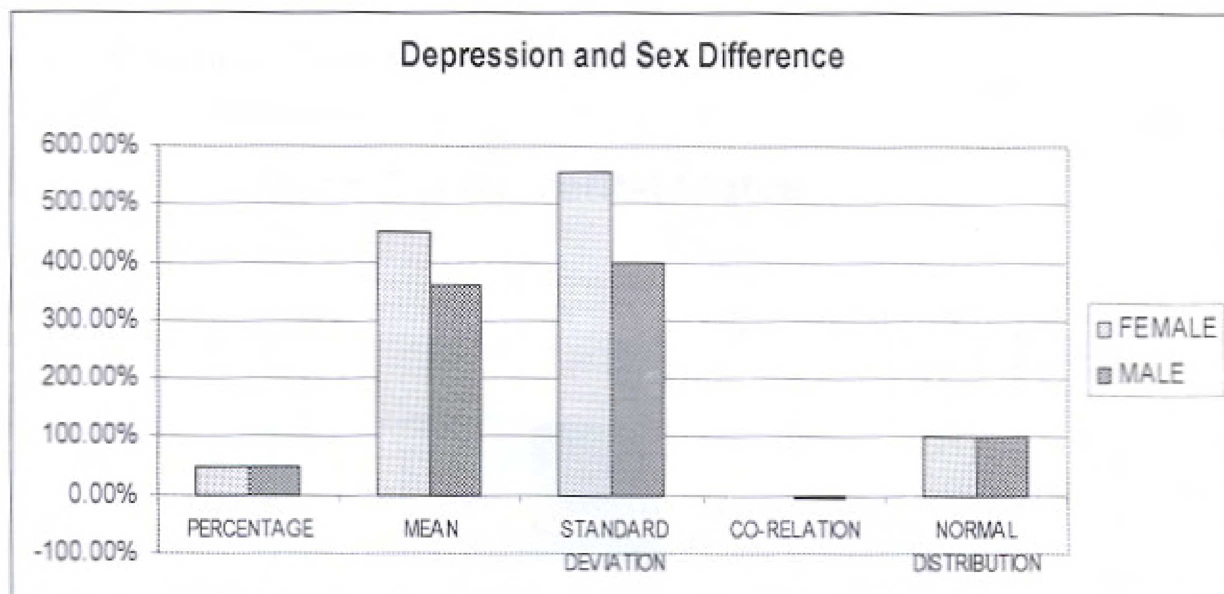
Figure 1. BDI mean score by sex and wards



Though the prevalence of depression found in female higher than male group, this figure seems to contradict the data for prevalence rates. This is accounted for by the higher number of men scoring zero the BDI-21. Thus, although there are more women than men above the cut-off for depression, those higher numbers of zero scores reduce the overall mean scores for women to below those of men.

Which groups of men scored zero? There was a greater proportion of those aged (20-25) 2 male, (26- 30) 5 male, (31-35) 3 male, (36-40)2male, and (41-45) 4 male, who scored zero on BDI, whereas there were just a half of proportion of these aged (20-25) 3 female, (26-30) 1 female, (31-35) I female, (36-40) 2 female, and (41-45) I female, altogether eight female had scored zero. Therefore, those aged were extracted for further analysis.

Figure 2. BDI mean scores by sex difference



As the table indication the prevalence rate is higher in the mean score of female sex than the male one. It is assumed that the female is more vulnerable to depression than men with many psychosocial and cultural reasons. Correlation between male and female is negligible negative.

Figure 3. BDI scores by age and gender

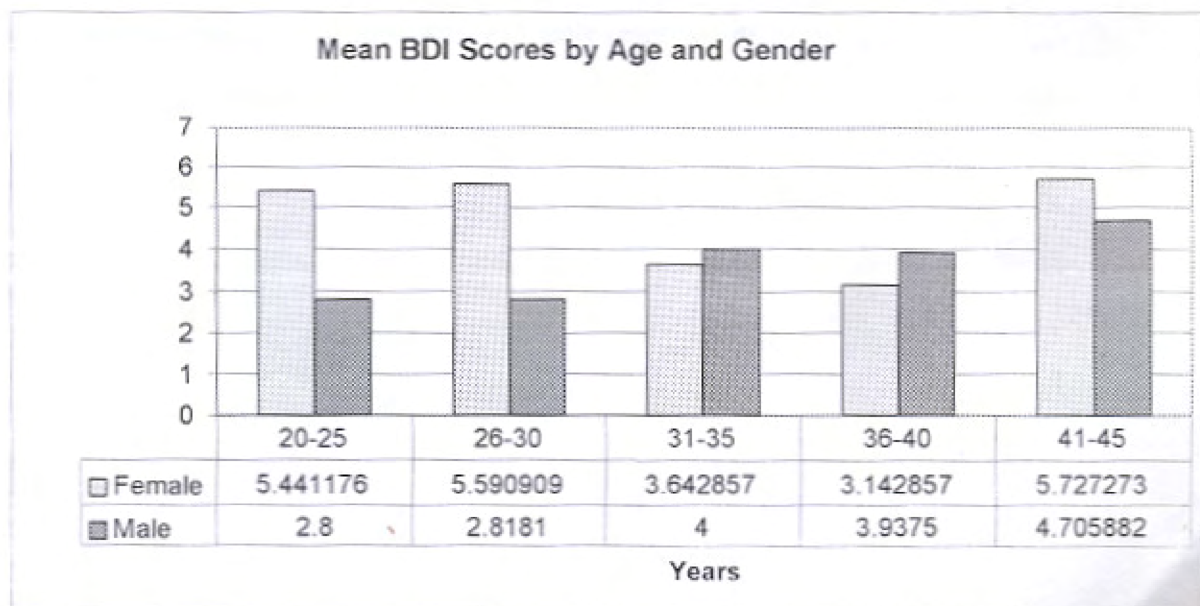
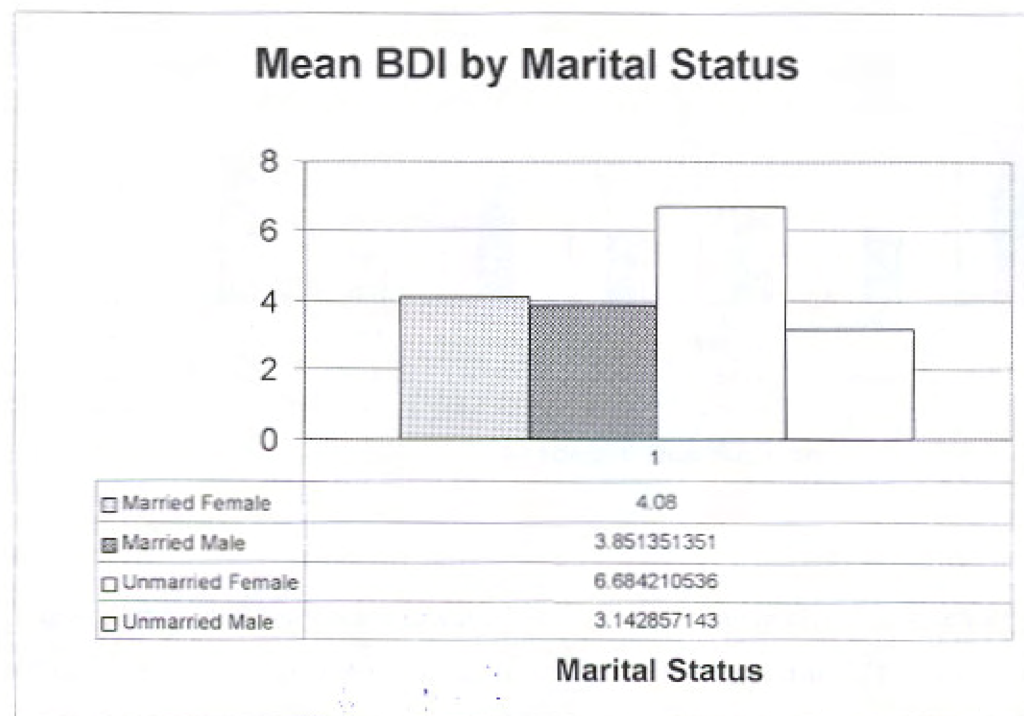


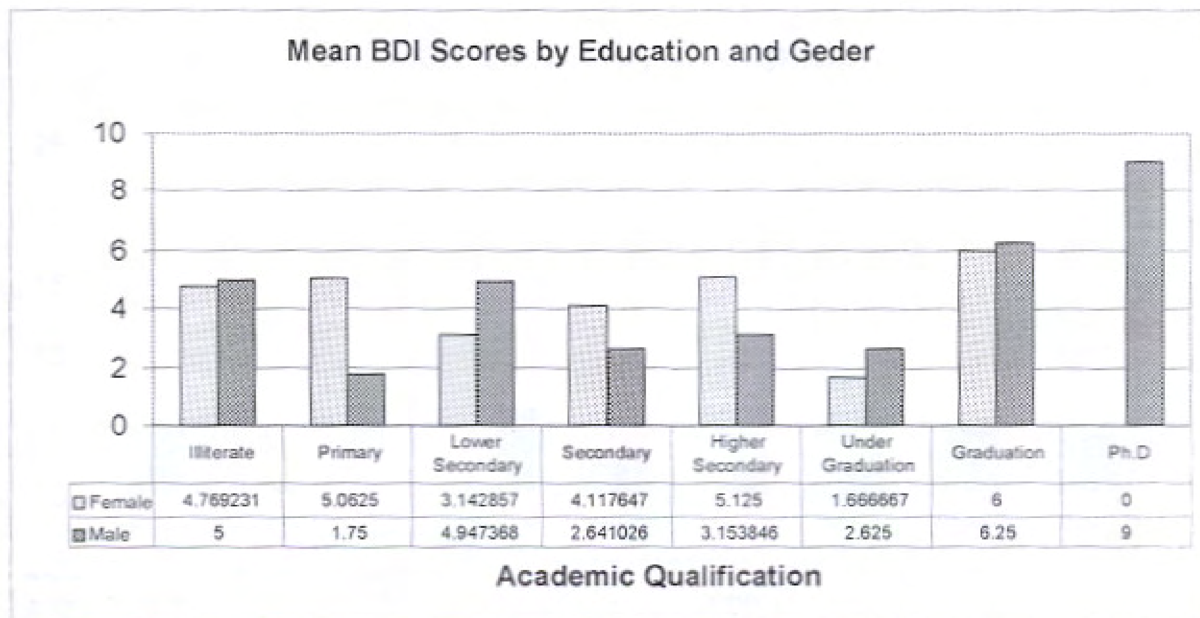
Figure shows that there is increase in mean BDI scores among women,(41-45) age range, dipping in the 36-40, and rising steeply in the over 28-30 age group.

Figure 4. BDI mean scores by marital status



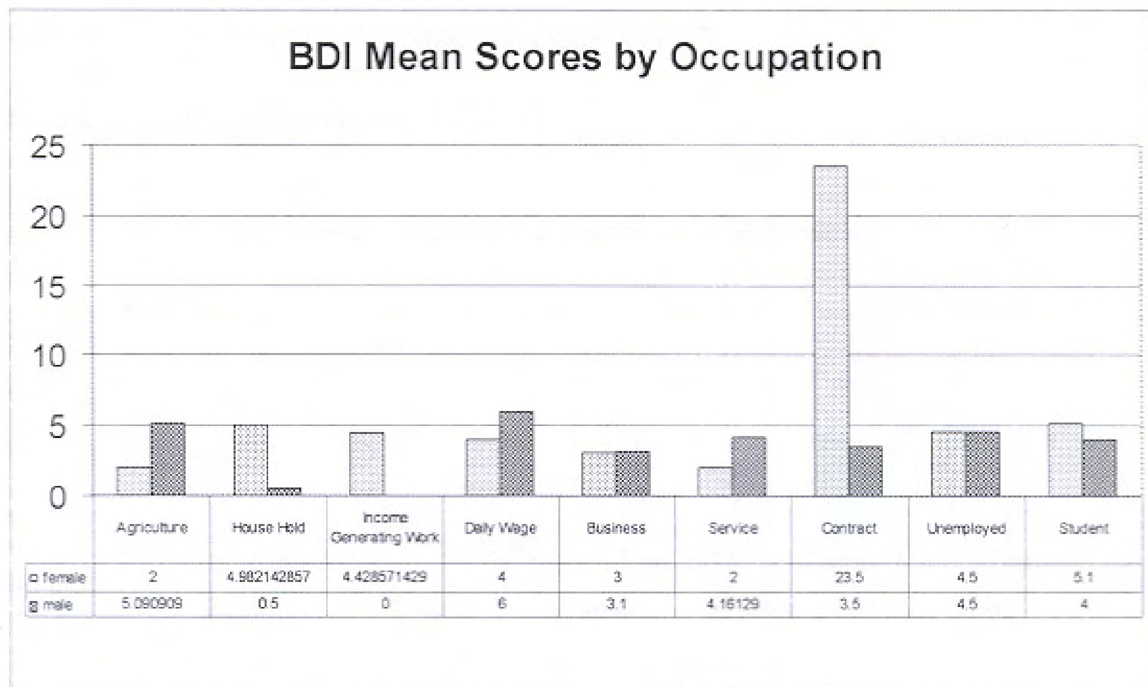
As the majority of the populations over the age of 25 were married, analyses were carried out with these aged 20-45. Young unmarried female had higher BDI scores than married women in comparison with male respondents.

Figure 5. BDI mean scores by educational level



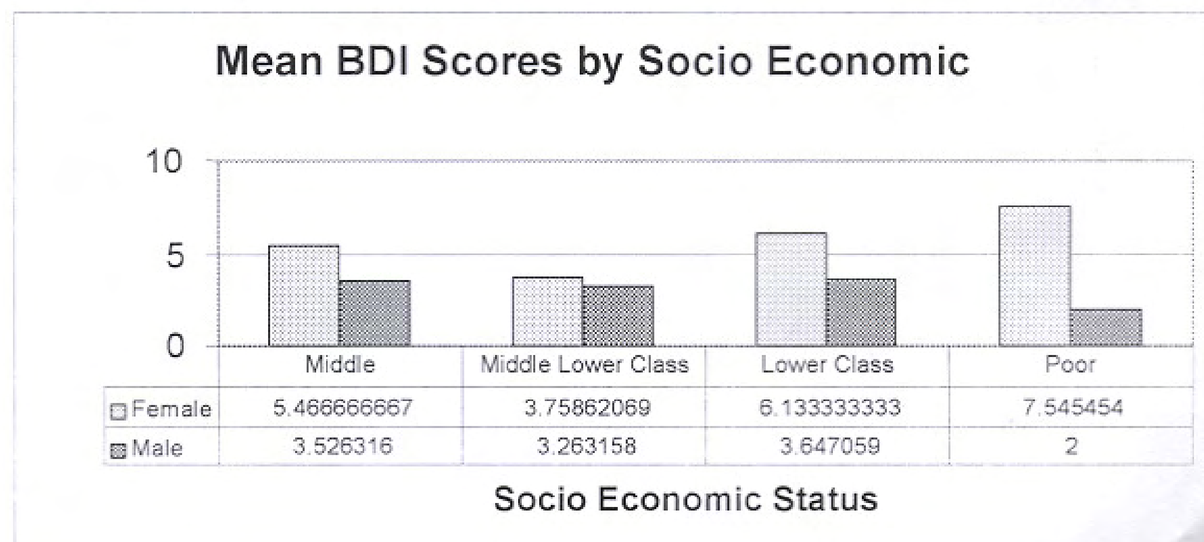
A few women and men were educated in Kirtipur municipality. Numbers of literate women were very low above 40 years of age. However the BDI mean scores of illiterate people were low in comparison of graduate respondents or high education level. In study site, there found 89% women were illiterate out of the total sample number.

Figure 6. BDI mean scores by occupation level



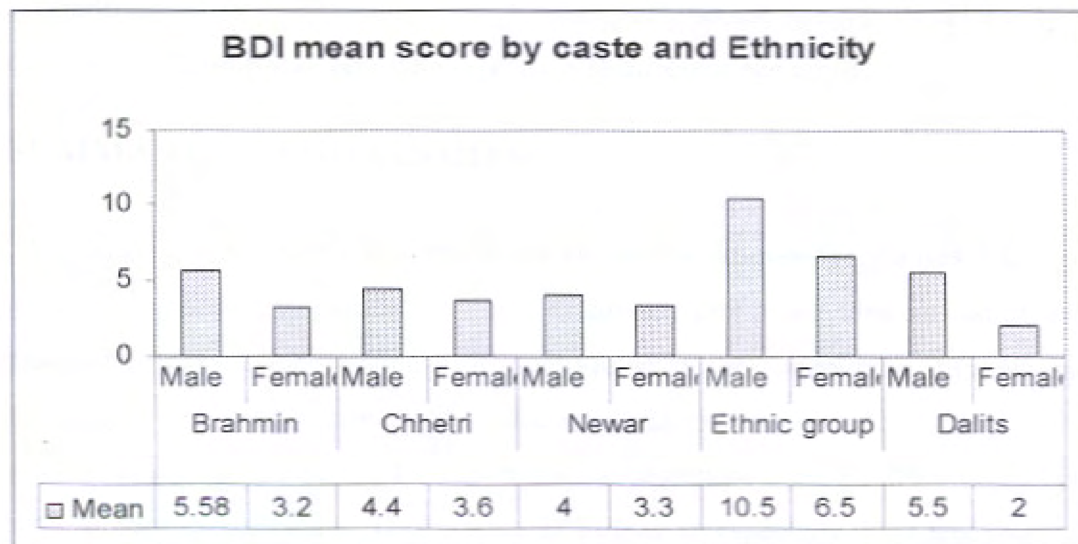
The rate of depression means scores higher in female respondents work in contract, in comparison with other occupation group. Lowest scores found in the agriculture occupation as well as government service holder. In total research sample, there is only one Ph.D holder respondent came in across with researcher: he is rated by mild depression.

Figure 7. BDI mean scores by socio-economic status



Statistics & graphic representation indicated high level of depression in poor women (7.54). Relatively the depression level is increasing in lower economic class scoring BDI mean 6.13 in women in comparison to male scores.

Figure 8. BDI mean scores by ethnicity



	Brahmin Male	Brahmin Femal	Chhetri Male	Chhetri Femal	Newar Male	Newar Femal	Ethnic group Male	Ethnic group Femal	Dalits Male	Dalits Femal
Mean	5.58	3.2	4.4	3.6	4	3.3	10.5	6.5	5.5	2

This table indicates the prevalence of depression in ethnic (marginalized) and Dalit (unprivileged) group in comparison with predominant ethnic group (Newar) of Kirtipur municipality.

DISCUSSION GROUPS

Focus group discussion was organized twice in different wards respectively two and ten wards. The participants representing different groups of people were brought together by PI in ward office. The participants were ward members, FCHV (female community health volunteer), male volunteer, social worker and people of community. Group was very heterogeneous of different age group.

SUMMARY OF FGD SESSION

FGD session was related to community awareness, knowledge, causes and illness behavior in relation to depression. The discussion group provided an indication of mental health awareness amongst different groups in the community. In majority of the population, health care is still characterized by pluralism including western medical science, Ayurvedic, Tibetan medicine, traditional healers (Dhami-jhankris), and folk remedies at home. Dhamis-Jhankries play an especially dominant role in the arena of mental health. Not withstanding multiple alternatives in recent day's western medical practices is perceived to be the only major remedy because it has established a tradition of scientific methods. Therefore, the health sector in Nepal pays more attention to medical science and most of the effort is directed towards curative treatment while little is done for preventive measures. Though, the overall response from each group indicated fair level of knowledge about mental health most participants attributed causes of mental illness to physical and psychological factors, recommended an allopathic health centre for treatment and suggested sound advice for counseling and psychosocial rehabilitation. On the other hand, health care centre/health post of Government service, primary health providing clinic or health centre as *Bikalp* health centre runs clinic at public level and pays more attention to medical science perceiving health as a mere absence of disease. Very few have understood that medical science is the very significant aspect of health. Moreover, there are experts engaged in providing health to the community as medical doctor, child specialist, gynecologist, Master of public health etc. They never attempted to understand the mental symptoms as the cause of physical ailment, considered and recorded other aspects of health. In fact, health is embedded with social,

psychological, cultural, and legal, religion, and economic as well as political context of people. Without taking these contexts into consideration it is not possible for medical science to provide effective treatment.

The world health organization has defined health as a "complete physical, mental, and social well being". However, in practice mental and social component of health has been neglected. During interviews, they revealed that they never got opportunities to participate in the workshop, seminar and training program organized to provide knowledge and skill in mental health. On the other hand, phect-NEPAL established jointly with IDOS in 1999, providing social, psychological and legal counseling to alleviate the health status of community people. Unfortunately, in absence of psychologist, there is no recorded case of depression since 2003, recently they appointed psychologist. This NGO used to train FCHV and male volunteers in mental health area. They advised the people of their wards to seek health in concerned care centre. Thus, Kirtipur's community people are aware of mental illness and health seeking behavior found adequate. However, all the participants stated that their treatment of physical as well as mental illness involved a ritual offering (*puja*) or to ward-off (manchhaune /panchhaune) before seeking health care centre. Shresth et al. (1983) suggested that societies generally make health care decisions based on their attribution of the disorders causes.

During interviews with depression rated male and female in second stage level, the causes were revealed based on their personal experience. Male experienced mostly sadness, pessimism, past failure, guilt feeling, loss of pleasure and agitation. Sadness was revealed caused by insecurity feeling of present political and other situations like Maoist insurgency. They felt pessimism, lack of job security, failure in past life, and discouragement of future. They felt future is hopeless. They are not prepared to adult life adequately due to lack of education and skilled training. They felt guilt of spending their youth without any aim of life, lavishly merry making, and not interested in study. Most of them were deprived of opportunities in young age due to poverty and guardianship. They report male are socialized to be the breadwinner in a family. When a boy grows up to be a man, he is supposed to earn and take care of his family. Males, thus, felt compelled to seek employment and failure to do so result in

frustration, which could lead them to depression. Man felt loss of pleasure to burden the responsibility of whole family. They were always busy to earn money to uplift the economic condition of home without time for personal pleasure.

Whereas women reported highly loss of energy, change in sleeping pattern, crying, tiredness of fatigue, irritability, sadness, pessimism, past failure, and self criticalness. They felt loss of energy because of heavy work load, female duties and responsibilities maintained at home and outside equally. It is even considered unproductive job. Heavy work load invited many to physical and mental tiredness, multiple aches in the body which deprived them for sound sleep. The reason behind loss of energy is child birth as well as aging (psychological perception of growing old). Small children make them upset of their mischievous behavior and their high demands. In the same time, they felt very sad when they could not fulfill their children demands. They could not run and manage family properly with low income. Mostly there is out-crying about the physical ailment though it is result of depression. They couldn't express their sorrows to their in-laws. Suppression of sorrowful events makes them crying or moaning alone. The responsibilities of rearing and caring children as well as aged in-laws make them irritate and cry. They felt guilty that they have not got chance to study in young age. The early marriage is also one of the causal factors of depression. They blame the early marriage as hindrance of their success of life.

They accused themselves as being women, the second sex in the society, having less access to properties rights as well as ritual rites. They felt very sad and pessimist because their future is hopeless and very dark because of lack of education and skillful training.

To sum up, the causes of depression found in Kirtipur were genetic, biochemical and hormonal factors and psychosocial factors as burden of responsibilities, job insecurity, unemployment, uneducated and unskilled, inadequate preparation for adult life and political fluctuation, poverty etc. The causes of female depression, somehow, are different from male. It is associated with poverty, physical illness, family relationship, home and work circumstances.

DISCUSSION

Summary of Results

Prevalence of Depression

A high cut-off score of 6/7 was chosen on the depression to increase the specificity of the questionnaire. Using this threshold, the point prevalence of depression was 24.2%; 13.1% in women and 11.0% in men.

The ICD-10 (International Classification of Disease 1992) of mental and behavioral disorders has classified depression as mood affective disorders and mentioned its three categories – mild, moderate and severe. In the absence of relevant research, the prevalence of depressive disorder cannot be estimated in Nepal. However, some practicing psychiatrists have attempted to analyze the occurrence of mental disorders including depression based on the clinical as well as community sample. But while doing so they have not focused particularly on depression. In the west, adequate attention has been paid to depression. A thirty days prevalence of major depressive disorder in U.S.A was estimated at 49%, and the life-time prevalence was estimated at 17.1% (Blazer ii, 1995).

Likewise, a meta-analysis on prevalence of mental and behavioral disorders in India, estimates the prevalence of depression at 8.9% though the prevalence rates are not frequently calculated. Recently depression is found to be quite common in the Asian countries as well. "Depressive disorder hitherto held uncommon in Afro-Asian countries is now known to be quite prevalent. In some of those, its occurrences has not only reached but has exceeded the western figures (Venkobo Rao 1998: Pp 133).

Various authors (blazer II, 1995; Brown & Harris, 1978; Busfield, 1996; Cooper & Paykel 1993: Cockerham, 1996; Daver 1999), have shown the association between depression and social factors like age, sex, social class, race, marital problems and so on.

DEPRESSION AND SEX

Gender shapes how people experience themselves and others and influences their psychological health and well-being. However, the relation between gender, family process, and the presence of psychological symptoms is not clear. Men and women tend the approach relationship differently. Female depression and anxiety have related to internalized anger, inhibited assertiveness, and loss of emotional connection in key relationships as well as feeling responsible for relationship failures and a sense of in-authenticity associated with doubting the appropriateness of one's actions (Anderson & Holder, 1989, Kapline, 1991).

Community surveys of symptoms of anxiety and depression have generally indicated a female: male ratio of 2:1 (Weissman & Klerman, 1977) a finding supported by the large-scale epidemiological Catchment Area (ECA) survey carried on in the US. The present study found gender differences in line with this pattern, though not of the same magnitude.

Sex based association is distinct with prevalence of depression being significantly higher among females, women's higher risk for depression holds whether one looks at case records or community survey (Russo and Green 1993).

The Gender difference in mean BDI score reached significance amongst aged 20-25. There have been similar findings elsewhere in Nepal, India and The U.S.A Simpson et al (1996) noted that amongst Nepalese students at the Tribhuwan University in Kathmandu (mean age of 25.3), man had significantly higher level of depression than women. On the contrary, the present study states the prevalence of depression is higher in unmarried female group aged (20-25). Because it is the transition of age between youth and adulthood, women's responsibility increase immensely in home and outside, social expectation of marriage, competition for the subsequent 'duties remain in place'.

Diagnostic and statistical manual of mental disorder (DSM-IV), reveal the life time prevalence of 10-25% for women and 5-12% for men. Due to lack of research, sex based prevalence of depression in Nepal is not known.

To understand women's higher rates of depression, it is not enough to detail the social stressors that affect women more after than men. Individuals moderate stress differently. Not all women become depressed in a given environment, yet little is known about how social factors translate into the meaning women make of themselves in their world or about how these factors work interpersonally and psycho-dynamically to affect women's vulnerability to depression are two times higher than those of men in most western industrialized countries (Nolen-Hoeksema, 1990).

Some researchers have suggested that higher rates of depression found for women in community studies may be the result of women in community studies may be the result of women being more likely to admit to symptoms of depression than men. Based on their community surveys, Weissman & Klerman (1977) say they have found evidence that women report symptoms of affective disorder more frequently than men because they feel fewer stigmas or are seeking approval. Another argument is that since more males than females have alcohol problems, depressed men are identified as being alcoholics rather than as depressed. Studies of alcohol and depression transmission in families show that they are independent disorders. The hypothesis has also been put forward that antisocial behavior in men, which lands them in the criminal justice system rather than the mental health system, is an expression of depression in men.

DEPRESSION AND AGE

Age is very subjective feeling of a person. Estimates of depression in older adults range from 10% to 65%. Estimates of depression in older women age ranges from less 2% to more than 50% (Formanek & Gurian, 1987). Several studies indicate that the rates of depression for older men and women are approximately the same (Hale & Cochran, 1983). But the present study is done on the adult of reproductive age (20-45), Women's mean BDI scores increased in (41-45) and (26-30) young adults, whilst the corresponding increase in man's scores occurred after the age of 40. In between

(41-45) years, depression rated BDI mean scores 4.70. A similar trend was reported in Pakistan by Mumford et al (1997), and in western studies of major depressive disorder (weissman & Klerman 1977).

Furthermore, whilst women many household duties from young age, it is often only at an older age that men make the transition to head of household, and take up a more prominent role. On other hand, there is some evidence that depressive symptoms are at their highest in a woman's 20s and in her 40s and 50s (Neugarten & Kraines, 1965). This can be related to hormonal changes. References were made during the discussion groups to the benefit of the work role on mental health. Community work was seen as rehabilitative in its ability to focus the mind away from excessive thinking. Perhaps young men's lesser work role in the family has a debilitative effect. However, these are merely hypothesis, and further investigation is necessary before conclusions can be drawn.

Physical changes in aging such as sleep difficulty, lowered interest in sex, loss of appetite, and constipation are mere likely to be reported by older women than older men, increasing the chance of misdiagnosis of depression (Berry, Storandt, & Coyne, 1984), Himmalfarb (1984) suggested that health status and health locus of control are critical mediators in the relation between aging and depression for women. The prevalence of depression has increased in younger adults with the onset of depression occurring at younger ages (klerman & Weissman, 1985a). This change appears to be due to an increase in the percentage of men experiencing depression rather than a decrease in the percentage of women becoming depressed. This change in the ratio of men to women has also been reported by Murphy, Simons, Vetzel, and Lustman (1984) and Hagnell, Lanke, Rorsman, and Ojesja (1982).

DEPRESSION AND MARITAL STATUS

Marriage confers a greater protective advantage on men than on women. In unhappy marriage, women are three times as likely as men to be depressed than married men and single women. Mothers of young children are highly vulnerable to depression; the more children in the house, the more depression are reported. But the present

study reported high level of depression in unmarried women in comparison with married women and men.

During second stage screening, it is understood they are depressed because of identity crisis, less education, lack of opportunities for career development, and unskilled. A higher levels of depression were documented in unmarried Hispanics, especially women, than among married Hispanics, the average unmarried Puerto Rican women in close to "Potential clinical depression" (Gaurnaccia & et al, 1991).

DEPRESSION AND EDUCATIONAL LEVEL

It is believed education enlightened the human race enriching knowledge, diminishing depression. Education level affects likelihood of depression, documented in Mental Health Weekly, June, 26, 2000. Results of new study suggest that as individual's age, the level of their education can provide increased protection against depression, when researcher from the John Hopkins school of Public Health and Pennsylvania state university analyzed survey data from nearly 2,000 adults age 18 to 90, they found that as time went on, less-educated adults were increasingly more likely to suffer from depression than were adults with more education. The people with less education tend to have more health problems, which could make them more prone to depression.

On the contrary, this study finds out depression level high in graduates. As they expressed in the interview, they are likely to depress, lack of opportunities to career development, burden of responsibility, and increase as they grew up as man.

Higher educational attainment is not uniform among all Asian groups; One third of population will not succeed primary level of education. In this research site, most people are found illiterate. A study has done in Undergraduate and graduate students of Tribhuwan University, found difference in educational attainment. Depression is rated to graduate students higher than undergraduates (Jack, D.C., 2001).

DEPRESSION & OCCUPATION LEVEL

Occupational status plays an important role in human lives. Occupational status and prestige are important predictors of mental health for both men and women, and

reports of a gender difference in depression are more likely to be found in studies with samples that have larger differences in male and female employment rates (Golding, 1988).

In present study revealed the fact people is liable to depressed due to job insecurity, lack of job satisfaction and unemployment. Unemployment is also a causal factor of depression. BDI mean scores found, somehow, same to both sex. BDI mean scores reflect the level of depression high in male contract job holder, whereas the high scores in female households' comparison with other occupations comprise a very large proportion in the sample. In fact, all women of different occupations could be called housewives become all of them had to perform the role of housewives, because all of them had to perform the role of housewives even if they were involved in some other activities. Women in occupation have a double workload but still since they could come out of home and get exposed the out side world they found some solace. On other hand, the study found, Professional women have higher incidence of depression and suicide than do women in the general population (McGrath at al., 1990). However, housewives who had no other occupation were quite unsatisfactory and most of such respondents complained of sadness and pessimism.

DEPRESSION AND SOCIO-ECONOMIC STATUS

High levels of depressive symptoms are particularly common among individuals with economic problems (Belle, 1982; brown et al., 1975; Maskesky, 1982) and those of lower socioeconomic status (Hirschfeld & Cross 1982). Although women, particularly low-income, are subject to stressful life events (Makosky, 1982), people of low socioeconomic status exhibit an elevation in symptom scores not explained by differences in life events scores (e.g., Dohrenwend, 1973; Radleff, 1975).

A study done, using the BDI, reported lo income as a risk factor for depression in Mormon women (spendlove, West, & Stanish, 1984). A number of studies reviewed, should a greater prevalence of depression in women, especially those in the lower socioeconomic groups (Raju et al., 1980).

As the study presents the prevalence of depression found in poor female group in comparison with other socioeconomic status groups. Second highest scores found in lower class of women. Hirschfeld et al. reported that the formerly depressed women

were significantly lower in social class and education level and were less likely than control women to be employed full time. Research needed further clarity the relation between poverty and different types of depression.

DEPRESSION AND RACE/ETHNICITY

Kirtipur is enriched of ethnic diversity from its origin before descendents of, the Great conqueror, King Prithivi Bir Bikram Shah. Many ethnic groups differ in the social position. Nepal is a multiethnic and multilingual country. The exact number of ethnic groups and various languages of Nepal cannot be stated precisely. The census of 1991 records 60 such groups without indication as to their ethnic or caste category and 20 major languages. However various ethnic literatures contest the census data to be in accurate and misrepresentative of ethnic/indigenous groups. There are 61 ethnic/indigenous groups and 125 different languages (Bhattachan: 1994). Approximately two third of the total population of the country are Hindu caste groups while the remaining one third is comprised of various non-caste ethnic groups.

In the present study, the predominant group is Newar. Although many differences are observable in the lives of ethnic groups including a significant difference in occupation, there was no difference in levels of distress amongst those screened. As Russo (1987) has pointed out, gender must be conceptualized as a dynamic concept that itself varies across social classes and ethnic groups. Some ethnic minorities have cultural norms of passivity, deference, and courtesy for both sexes that reinforce gender stereotypes for ethnic minority groups in those cultures. Bluestone and Purdy (1977) associated that among Puerto Rican women in the United States, suicide attempts provide an outlet for culturally and environmentally generated anger and frustration. In present study, it is obvious, the proportion Newar group as respondents was higher in comparison with other ethnic groups because the frequency of participation of Newar in large numbers. But the depression mean scores is high in ethnic groups Magar and Tamang (marginalized group) and Dalit (unprivileged group) in the municipality. The causes of more depression among the ethnic and dalit groups can be result of various socio-cultural factors as well as the prejudice and discrimination along with expulsion from mainstream of social world. However, further researches are necessary to locate and examine the various social and cultural factors as the causes of depression among these ethnic and low caste groups.

IMPLICATIONS OF THE PRESENT STUDY

The study was based on the adult population of reproductive age in Kirtipur Municipality, Kathmandu. The sample size was very small other studies are required to determine whether the results found here extend beyond the sample and how they might vary among different populations. Despite these limitations, the findings suggest some useful clinical implication and direction for further research.

Mental illness like depression is one of the main causes of disability (morbidity). It may be associated with smoking, alcoholism and other type of substance abuses. In its severe form depression may cause suicide. Therefore, depression not only has association with the various psychobiological factors, but also at the same time has many social implications.

Depression is a relatively common psychological disorder. Out of every 100 people, approximately 13 men and 21 women develop this disorder at some point in life (Kessler et al., 1994). Reflected in these statistics is the fact that women are much more likely than men to experience this disorder (Spancer, Bland, & Newman, 1994).

However, in practice mental and social component of health has been neglected. Efforts have been made to prioritize mental health for example the Alma Ata Conference in 1978 has assigned mental health the status of one of the eight essential component of Primary health (Nepal & Wright 1988). Unfortunately mental health still continues to be the Cinderella of the medical world. That is why there is so little out cry about the fact that there are 330 million people around the world suffering from depression, 90% of which will not get adequate treatment (The Economist September 1998). In terms of Disability Adjusted Life Years Survey (DALYS), depression is considers as the number one cause of disability (the World Bank, 1998). Despite that depression is not taken seriously and the people suffering mostly do not seek help, as they do not realize that they have a problem. In some cases even if people are aware, they do not wish to acknowledge their problem because mental illness are considered as deviance in most societies and hence subjected to stigmatization (Cockerham 1996).

This study stated that prevalence of depression is about 24.2 % (190 samples). This disorder can be shared by the family member and community, which can result in secondary gain. The collective weight of the cost-physical, psychosocial and economic- need to be understood by health planners. Mental illness is expensive for the community, and present economizing on mental health care is indeed false economy.

The socio-demographic factors identified as having a relationship with depression are possible points of entry for psychosocial intervention. These may be of use to health and education planners in implementing changes in illness behavior and attitudes raising awareness, providing knowledge about the disorder to the common people. Thus, the educational attainment helps to alleviate the levels of depression in the community.

However, so far in Nepal, depression has not been studied from a biopsychosocial perspective. In fact such studies are imperative so as to understand in psychosocial contexts of depression. With adequate reliable information, policies can be formulated to create awareness about the illness so that preventive as well as curative measures can be taken. Since family and community can provide immense support to ill person they must be mobilized in a proper way. Furthermore, most of health post/sub health post staffs are not trained to identify and treat mental illness. Thus, the magnitude of suffering from mental illness in the community is ignored. It is, therefore, an important task of the government runs the orientation and training program to the professional's worker in health area.

METHODOLOGICAL ISSUES

It was thought that participants might give responses based on the perceived expectations of the research workers. Thus, efforts were made to limit this expectation bias; the short explanation given to the participants prior to the presentation of the questionnaire, excluded health related words where possible.

Time and practical constraints necessitated a systematic random selection of the sample population. The sample was chosen from the overall nineteen wards, all of which have better access to the municipality facilities. The community groups attending the focus group discussion were mostly representative from the different wards. The picture may well be different in those areas of Kirtipur, both in terms of illness behavior and the attitude of the treatment or management of depression.

The second stage interviews presented two methodological issues. Firstly, the questionnaire is filled up to reveal the level of depression. Secondly the participants were interviewed by PI who scored above the cut-off point, rated depression- mild, moderate and severe level, to reveal the causes of depression. Then they were referred to the phect-Nepal (community based health care center) for psychosocial counseling. Severe depressive (clinical) were referred to mental hospital for medication. A special request is made to the field worker and social worker for the follow up visit to them. Most of them need to see medical doctor advised to do needful. But the prevalence figures were calculated using only the data from the first stage screening. A small group of people were interviewed. But the prevalence figures are applicable, though the sample is small.

FURTHER RESEARCH

It would be informative to repeat this study in different areas of Nepal. This would enable comparison to be made of areas living under different physical and social conditions, and would help build a more complete picture of the country in terms of epidemiological data. With the ensuing implementation of the National Mental health Policy, it would be beneficial for the government to have this data from which to make plans for action.

To investigate further the effects of some of the socio-demographic factors implicated in this stage, a full anthropological study can be relevant. This would allow for a more through analysis of the effect that these factors have on the mental health of the community.

CONCLUSION

Depression is common experience of human beings in runs of life. The prevalence of depression in Kirtipur Municipality is 24.2% (45 persons out of 190 sample within 19 wards), 13.1% women (25) and 11.0% men (21), within 19 wards.

Women's rates of depression are higher than those of men. For the women, there were several factors in their lives that were related to levels of depression. Women are liable to depressed due to a number of social, economic, biological and emotional factors. Consequently, we need to study women's depression from a biopsychosocial perspective.

The study acknowledges the awareness of mental health in the community but not functioning properly in practice (results in behavior). Health providers are not trained to perceive and treat the mental illness. Public policies must be formulated to help people either avoid depression or overcome it.

REFERENCE

1. Anderson, C., & Holder, D. (1989). Women and serious mental disorders. In M. Mc-Goldrick, C. Anderson, & F. Walsh (Eds.), Women in Families: A framework for family therapy (Pp.381-405), New York: Norton.

2. Beck, Adron T., Depression: Clinical Experimental and Theoretical Aspects, New York. Harper and Raw (c1967)

3. Belle, D. (1982b). Social ties and social support. In D. Belle(ed), Lives in Stress: Women and

4. Berry, J. Storandt, M., & Loyne, A. (1984), Age and sex differences in somatic complaints associated with depression. Journal of Gerontology, 39, 465-467.

5. Bhattachan Krishna and Kailash N. Pyakuryal 1996 "the issue of national Integration in Nepal: An Enthnoregional Approach". In Emerging Ethnicity and Aspects of Community Adaptation Occasional Papers No. 5. Kathmandu: Central Department of Sociology/Anthropology. Tribhuwan University.

6. Blazer ii, Dan, G. 1995, "Mood Disorders: Epidemiology" Pp, 1079-1089 in H. Kaplan and B. Sadock (eds), Comprehensive Text Books of Psychiatry. Vol. 1, 6th ed. Baltimore; Williams & Wilkins.

7. Bluestone, H., & Purdy, B. (1977). Psychiatry services: Two Puerto Rican patients in the Bronx. In Padilla & Padilla (Eds). Transcultural Psychiatry: An Hispanic Perspective, Los Angeles: Spanish Speaking Research Center.

8. Brown, C., N. Bhrolchain, M.N., & Harris, T.O. (1975), Social Class and psychiatric disturbance among women in an urban population. Sociology, 9, 225-254.

9. Cabral, Meena and Astbury, jill: The World Health Organization. (2000). Women's Mental health: An Evidence based Review. http://www.who.int/mental health.org.

10. Cockerham, William C. 1996. Sociology of mental Disorder. New jersey: Prentice-Hall.

11. Depression. Beverly Hills, CA: Sage.

12. Dohrenwend, B.S. (1973). Social status and stressful life events. Journal of Personality and Social Psychology, 28,225-235.

13. DSM-IV (1994) Diagnostic and Statistical Manual of Mental Disorders. 4th revision. Washington D.C., American Psychiatry Association.

14. Formanek, R. & Gurian, A., (Eds.). 1987. Women and depression: A lifespan perspective, New York: Springer.

15. Glied, S., & Kotman, S. (1995, March). Women and Mental Health: Issues for health reform background paper. New York: The Common Wealth Fund, Commission on Woman's Health.

16. Golding, J.M.(1988). Gender differences in depressive symptoms: Statistical Considerations. Psychology of women quaterly, 12, 61-74.

17. Groth-Marnat, G., (1990). The handbook of psychological assessment (2nd Ed.) John Wiley & Sons, New York.

18. Hagnell, O., Lanke, J., Rorsman, B.., & Ojesjol, L., (1982). Are we entering an age of melancholy? Depressive illness in perspective epidemiological study over 25 years: The Lund by Study, Sweden. Psychological medicine, 12, 279-289.

19. Hale, W.D., & Cochram, C.D., (1983), Sex difference in pattern of self-reported psychopathology in the married elderly. Journal of Clinical Psychology, 39, 647-650.

20. Hilde Mausmer – Dorsch "Psychosocial work Environment and Depression: Epidomiologic Assessment of the Demand Control Model" American Journal of Public Health vol, 90, Number., 2000, Page (S) 1765-1770.

21. Himmelfarbo, S.,(1984). Age and Sex Differences in the Mental Health of Older Persons. Journal of Consulting and clinical psychology, 52, 844-856.

22. Hirschfeld, R.M.A., & Cross, C.K.(1982). Epidemiology of affective disorders: Psychosocial risk factors. Archives of General Psychiatry, 39, 35-46.

23. Jack, D.C., 2001,"Depression in Nepalese Women: Tradition, Changing Roles, and Public Health Policy" Western Washington University, USA.

24. Kaplin, A. (1991), the self in-relation: Implications for depression in women. In J. Jorden, A. Kaplan, J. Miller, I. Stiver & J. Surrey (Eds), Women's growth in connection (Pp. 206-222). New York: Guilford.

25. Katon, w., & Sullivan, M.D., (1990). Depression and Chronic Mental Illness, Journal of Clinical Psychiatry, 51, 3-14.

26. Kessler, R.C., McGonagle, K.A., Zhaq, S., Nelson, C.B., Hughes, M., Eshleman, S., Wittchen, H., & Kendler, K.S. (1994). Lifetime and 12-month prevalence of DSM-III-R-Psychiatric Disorder in the United Dtates:Results from the National Comordity Survey. Archives of General Psychiatry, 51,8-19.

27. Klerman, G.L., & Weissman, M.M. (1985a). Depressions among woman. In J.H. Williams (Eds), Psychology of Women: Selected readings. New York: W.W. Norton.

28. Makosky, U.P.(1982), Sources of stress: Events or conditions? In D. Belle(Ed), lives in stress: women and depression (Pp, 35-53). Beverly Hills: Sage

29. McGrath E., Keita, G.P., Stickland, B.R., Russo, N.F. 91990). Women and Depression: Risk factors and Treatment Issues. Washington DC, American Psychological Association.

30. Mumford, D.B., Saeed, K., Ahmad, I., Latif, S. & Mubbasher, M.H. (1997), 'Stress and Psychiatric Disorder in Rural Punjab. A community Survey'. British Journal of Psychiatry, 170, 473-476.

31. Murphy, G.E., Simons, A.D., Wetzel, R.D., & Lustman, P.J. (1984). Cognitive Therapy and Phermacotherapy. Archives of general psychiatry, 41, 33-41.

32. NAMI: the national voice on mental illness, copyright: 1996-2002.

33. Nepal, Mahendra K., and Christina S. Wright, 1988. Manual of Mental Health for community Health Workers. Kathmandu: Jeewan Support Printing Press.

34. Neugarten, B.L., & Kraines, R.J. (1985). Menopausal symptoms in women of various ages. Psychosomatic Medicine, 27, 266-273.

35. Nolen-Hoeksema, S. (1990), Sex difference in depression, Stanford., CA: Stanford University Press.

36. Peter J. Guarneccia, Ronald Angel, and Jacqueline Lowe Worobey "The impact of marital status and employment status on depressive affect for Hispanic Americans", Journal of Community Psychology. Vol, 19 Number. 1991. Page (S) 136-149.

37. Radloff, L.S. (1975). Sex differences in depression: the effects of occupation and marital status, Sex Roles, 1, 249-265.

38. Raju, S.S., N. Kumaraswamy and A.J. Mani, (1980), Socio-demographic Factors of Depressive Disorders in India – A Comprehensive Appraisal". In India Journal of Psychiatry, 22(a, 356-361).

39. Rollins Joan H. 1996. Women's minds/Women's bodies: the Psychology of Women in a Biosocial Context.

40. Russo, N.F. (1987). Position Paper. In A.E. Eichler & D.L.Parron (Eds). Women's mental health: Agenda for research. Rockville, MD: National Institute of mental Health.

41. Russo, N.F., and B.L. Green, 1993. "Women and Mental health", F.L. Denmark and M.A. Paludi (eds), Psychology of Women: A Handbook of issues and theories, Westport, CN: Green-Wood Press.

42. Simpson, P.L., Schumaker, J.K., Dorahy M.J., & Shrestha, S.N., (1996) 'Depression and Life Satisfaction in Nepal and Australia' Journal & Social Psychology, 136, 783, 790.

43. Spancer, D., Bland, R.C., & Newman, S.C. (1994). Major depressive disorder. ACTA Psychiatrica Scandinavica. 89, 7-15.

44. Spendlove, D.C., West, D.W., & Stanish, W.M. (1984). Risk factors and the prevalence of depression in Mormon women. Social science and medicine, 18, 491-495.

45. Venkoba Rao, A., 1998 "Depression Research Some Transcultural Considerations." Pp. 133-137 in Varma et al (eds) Social Psychiatry – A Global Perspective – New Delhi; Macmillan India Ltd.

46. Weissman, M.M. & Klerman, G.L. (1977). "Sex difference in the epidemiology of depression", Archives of General Psychiatry, 34, 98-111.

47. Wittgenstein, L. (1961b) notes books. Black Well, Oxford, p.94

Appendix I

Depression and Sex Difference

	Female	Male
Percentage	50.00%	50.00%
Mean	4.526316	3.610526
Standard Deviation	5.534884	3.968747
Co-Relation		-0.0419
Normal Distribution	1	0.999964

Depression and Age

	BDI Score by age group									
	20 - 25		26 -30		31 - 35		36 - 40		41 - 45	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Femal
Total	185	56	123	62	51	76	44	63	63	80
Mean	5	2.8	5.590909	2.828283	3.642857	4	3.142857	3.9395	5.727273	4.7058
SD	7.977967	2.783409	5.039997	2.889	4.049827	4.049827	4.01625	2.88603	7.643179	5.9662
Corelation				0.102776						

Depression and Marital Status

	Married Female	Married Male	Unmarried Female	Unmarried Male
Percentage	50.33%	49.66%	36.53%	40.34%
Mean	4.08	3.851351	6.684211	3.142857
Standard Deviation	4.519507	4.189623	8.932168	2.885926
NORMAL DISTRIBUTION	0.999997	0.999986	1	0.998049

Depression and Education Level

	Illiterate		Primary		Lower Secondary		Seco	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	Male
total	124	15	81	7	44	94	70	103
percentage	89.65%	10.34%	80.00%	20.00%	42.44%	57.57%	30.35%	69.64%
standard deviation	**4.580897**	**4.582575695**	**5.246824**	**0.5**	**3.416186422**	**4.660397**	**3.551098**	**3.296627**
normal distribution	0.999998	0.999997701	1	0.691462	0.999682426	0.999998	0.999808	0

Cont.. **Depression and Educational Level**

	Higher Secondary		Under Graduate		Graduate		Phd	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
Total	82	41	5	21	18	50		9
Percentage	55.75%	44.82%	27.27%	72.72%	27.27%	72.72%		
Standard Deviation	**8.8005682**	**2.544476**	**2.081665999**	**3.20435**	**8.660254**	**6.670832032**		**#DIV/0!**
Normal Distribution	1	0.994528	0.981313571	0.999323	1	1		#DIV/0!

Depression and Socio-economic Status

	Middleclass Female	Middleclass Male	Lower Middleclass Female	Lower Middleclass Male	Lower class Female	Lower class male	Poor Female	Poor Male
Percentage	44.11%	55.88%	50.34%	49.56%	46.87%	53.12%	91.66%	8.33%
Mean	5.466667	3.526316	3.758621	3.263158	6.133333	3.647059	7.545455	2
Standard Deviation	9.67963	4.260522	3.091076	3.583326	7.633261	2.289683	7.878625	#DIV/0!
Normal Distribution	1	0.99999	0.999003	0.99983	1	0.98898	1	

Depression and Occupation

	Agriculture		Household		Income generation		Daily wages		Business		Service
	M	F	M	F	M	F	M	F	M	F	M
Total	**4**	**56**	279	1		31	44	24	12	62	14
Mean	**2**	**5.090909**	4.902143	0.5		4.4.28571	4	6	3	3.1	2
SD	**0**	**4.592484**	5.934464	0.707107		2.149197	4.898979	10.67708	1.414214	4.561162	1.414214

Cont… Depression and Occupation

Contract		Unemployed		Student	
M	F	M	F	M	F
47	56	9	27	51	28
23.5	3.5	4.5	4.5	5.1	4
19.09188	2.529822	3.535534..	2.949576	5.724218	5.446712

Ethnicity and depression

	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Total	67	51	62	54	251	209	21	13	39	16
Percentage	60%	40%	48.27%	51.72%	50%	50%			47.05%	52.94%
Mean	5.583333	3.28125	4.428571	3.6	4.048387	3.370968	10.5	6.5	5.571429	2
St Deviation	4.420167	4.138236	4.013713	2.613154	5.599846	4.293471	14.84924	0.707107	9.571784	2.329929
Nor. Distribution	0.999995	0.999982	0.99997	0.995514	1	0.999991	1	0.76025	1	0.990095

APPENDIX 2

FOCUSED GROUP DISCUSSION
Guidelines

1. Knowledge about physical and mental heath
2. Experience of being ill and subsequent behavior
3. Knowledge about depression
4. Experience self and other about depression
5. Probable cause of depression
6. Local management of depression
7. Availability of the treatment

बी: डी: आई: प्रश्नावली

मिति:____________

नाम:__________________ विवाहित अवस्था:____________ उमेर:______ लिङ्ग:________

पेशा: शिक्षा: आर्थिक सामाजिक स्थीति जात

निर्देशन: यस प्रश्नावलीमा २१ वटा वाक्यहरु समुहगत रुपमा प्रस्तुत गरीएका छन् । कृपया प्रत्येक समुहका वाक्यलाई ध्यानपुर्वक अध्ययन गरी एउटा मात्र वाक्य छान्नु होस्, जुन तपाईले आजको दिनबाट दुई हप्ता अगाडीदेखि अनुभव गरिराख्नु भएको छ । तपाईलाई उपयुक्त लाग्ने वाक्य अगाडीको अंकमा गोलो चिन्ह (O) लगाउनु होस् । यदि कुनै समुहमा एक भन्दा बढि वाक्यहरु उपयुक्त भए त्यस समुहमा भएको सवैभन्दा ठूलो अंकमा गोलो चिन्ह लगाउनु होस् । याद राख्नुस् कि तपाईले एउटा समुहमा एउटै मात्र वाक्यमा चिन्ह लगाउन सक्नु हुन्छ ।

१) दु:खीपन\दिकदारी\ उदासिनता

० मलाई लाग्दैन

१ मलाई प्राय जसो लागिरहन्छ

२ मलाई सधैं लाग्छ

३ मलाई यति लाग्छ कि म सहनै सक्दिन

२) निराशापन

० म मेरो भविष्यप्रति निराश छुइन

१ म पहिलेभन्दा आजकाल अलि वेसि आफ्नो भविष्यप्रति निराश छु

२ मेरो लागि केही कुरा पनि सजिलो होला भन्ने आश गर्दिन

३ मेरो भविष्य अन्धकार छ

३) अतितका\ बितेका असफलता

० म असफल छु जस्तो लाग्दैन

१ म हुनु पर्नेभन्दा वेसी असफल छु

२ आफ्नो अतितलाई सम्झँदा धैरै असफलताहरु महशुस गर्छु

३ मलाई लाग्छ, म पूर्णरुपमा असफल व्यक्ति हुँ

४) आनन्दतामा कमी

० म अहिले पनि पहिले जतिकै आनन्दित हुन्छु

१ म अहिले, पहिला जतिको कुराहरुवाट आनन्दित हुँदिन

२ म अहिले, पहिला आनन्दित हुने कुराहरुवाट पनि आनन्दित हुँदिन

३ म अहिले, पहिला आनन्दित हुने कुराहरुवाट अलिकति पनि आनन्दित हुँदिन

५) दोषी भावनाहरु

० मलाई खास्सै कुनै कुरामा पश्चाताप छैन

१ मलाई मैले गर्नु पर्ने वा गरेका कुराहरुमा पश्चाताप छ

२ मलाई प्राय:जसो समयमा अलिक पश्चाताप लागिरहन्छ

३ मलाई सधैं जसो नै पश्चाताप लागिरहन्छ

६) दण्डीत भावनाहरु

० मलाई लाग्दैन कि म सजाय पाइरहेछु

१ मलाई लाग्छ कि मैले सजाय पाउनेछु

२ म सजायको अपेक्षा गर्छु

३ मलाई लाग्छ कि म सजाय भोगिरहेछु

७) आत्मअरुचि

० मलाई आफ्नो वारेमा सधैं उस्तै लाग्छ

१ मैले आफ्नो आत्मविश्वास गुमाएको छु

२ म आफैमा निराश छु

३ म आफैलाई रुचाउदिन

८) आत्मदोष\ आत्मालोचना

० म आफूले आफैलाई त्यति दोष दिन्न

१ म पहिले भन्दा अहिले आफूलाई अलि दोषी ठान्छु

२ म आफूलाई आफ्नो हरेक गल्तीको लागि दोषी ठान्छु

३ म आफैलाई हरेक नराम्रो कामको लागि दोषी ठान्छु

९) आत्महत्या गर्ने विचारहरु वा चाहनाहरु

० ममा कुनै आत्महत्या गर्ने विचार छैन

१ मलाई आत्महत्याका विचारहरु आए पनि म आत्महत्या गर्दिन

२ मलाई आत्महत्या गरुँ जस्तो लाग्छ

३ मौका पाएंभने म आत्महत्या गर्नेछु

१०) रुनु

० म पहिले जस्तो अहिले रुँदिन

१ म पहिलेभन्दा अहिले वेसी रुन्छु

२ म प्रत्येक सानो-सानो कुरामा रुन्छु

३ मलाई रुऊँ जस्तो लाग्छ, तर म सक्दिन

११) मानसिक अस्थिरता

० म साधारणतया हुनेभन्दा वेसि अस्थिर छुइन

१ म साधारणतया हुनेभन्दा वेसि अस्थिर छु जस्तो लाग्छ

२ म यति अस्थिर छु कि चुपचाप लागेर वस्न सक्दिन

३ म यति अस्थिर छु कि केहि न केहि गरेर वा चलेर वस्नु पर्छ

१२) रुचिमा कमी

० मैले अरु मानिसहरु अथवा क्रियाकलापहरु प्रतिको रुचि गुमाएको छैन

१ म अरु मानिसहरु अथवा क्रियाकलापहरु प्रतिको पहिलेको भन्दा अहिले कमै रुचि राख्छु

२ मैले अरु मानिसहरु अथवा क्रियाकलापहरु प्रतिको प्राय: रुचि गुमाइसकेको छु

३ मलाई कुनै पनि कुरामा रुचि राख्न गाह्रो छ

१३) निर्णय लिन नसक्नु

० म सधैं झैं निर्णयहरु लिन्छु

१ मलाई प्राय निर्णय लिन गाह्रो लाग्छ

२ मलाई पहिलेको भन्दा अहिले निर्णय लिन झनै गाह्रो छ

३ मलाई कुनै पनि निर्णय लिन एकदमै कठिन पर्छ

१४) अयोग्यता\ हिनतावोध

० मलाई म अयोग्य, काम नलाग्ने, अनुपयोगी छु जस्तो लाग्दैन

१ म आफुलाई पहिले जतिको उपयोगी वा महत्वपूर्ण सोच्दिन

२ म आफू अरु मानिसहरुभन्दा अयोग्य छु जस्तो लाग्छ

३ म पूर्ण रुपमा अयोग्य छु जस्तो लाग्छ

१५) शक्ति\ बलमा कमि

० म पहिलेजतिकै वलियो छु

१ म पहिलेभन्दा कमजोर छु

२ मसँग धेरै काम गर्न चाहिने जति शक्ति छैन

३ मसँग कुनै पनि काम गर्न चाहिले शक्ति छैन

१६) सुत्ने बानीमा परिवर्तन

० मैले मेरो सुत्ने बानीमा कुनै परविर्तन अनुभव गरेको छैन

१क म अजकल पहिलेभन्दा अलिक बेसी सुत्छु

१ख म अजकल पहिलेभन्दा अलिक कम सुत्छु

२क म पहिलेभन्दा वेसी नै सुत्छु

२ख म पहिलेभन्दा कमै सुत्छु

३क म दिनभरी जसो नै सुत्छु

३ख म १-२ घण्टा चाँडै नै विउझन्छु र फेरि निदाउन सक्दिन

१७) झर्कोपन\ रिसाहपन

० मलाई पहिले झैं वेसी रिस उठ्दैन

१ मलाई पहिलेको भन्दा वेसी रिस उठ्छ

२ म पहिला भन्दा वेसी रिसाह छु

३ मलाई जहिले पनि रिस उठिराख्छ

१८) आहार प्रतिको रुचिमा परविर्तन

० मैले मेरो आहार प्रतिको रुचिमा कुनै परिवर्तन महशुस गरेको छैन

१क मेरो आहार प्रतिको रुचिमा पहिलेको भन्दा कमि आएको छ

१ख मेरो आहार प्रतिको रुचि पहिलेको भन्दा वढेको छ

२क मेरो आहार प्रतिको रुचि पहिलेको भन्दा निकै घटेको छ

२ख मेरो आहार प्रतिको रुचि पहिलेको भन्दा निकै वढेको छ

३क मलाई भोकै लाग्दैन

३ख म सधै खाने कुराको पछि लाग्छु

१९) एकाग्रतामा कठिनाइ

० म सधैं झैं मन लगाउन सक्छु

१ म सधैं झैं मन लगाउन सक्दिन

२ मलाई कुनै पनि कुरामा धेरै बेरसम्म मन लागिरँहदैन

३ मलाई लाग्छ कि म कुनै पनि कुरामा मन लगाउन सक्दिन

२०) थकान

० म सधैंको भन्दा बेसी थकित हुँदिन

१ म सजिलैसँग पहिलेको भन्दा बेसी थकित हुन्छु

२ म आफूले गर्ने प्राय कामवाट गकित छु

३ म पहिले गर्ने प्राय जस्ता कामहरुवाट एकदमै थकित छु

२१) योनप्रतिको रुचिमा कमि

० मेरो योन प्रतिको आफ्नो रुचिमा कुनै कमि पाएको छुइन

१ म योन प्रति पहिलेको भन्दा कम रुचि राख्दछु

२ म अहिले योन प्रति कमै रुचि राख्छु

३ मैले योन प्रतिको रुचि पूर्ण रुपमा गुमाइसकेको छु

पृष्ठ १ को अंक:-

पृष्ठ २ को अंक:-

पूर्णांक-