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SPATIAL DISTRIBUTION OF DEPRESSION AMONG WOMEN AGED 18 TO 49 IN CAPITAL CITY DISTRICT PESHAWAR (CCDP) PAKISTAN

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ABSTRACT

The purpose of the study was to analyze and find out the spatial distribution of depression amongst women in Capital City District Peshawar (CCDP). The preliminary data was collected from different hospitals KTH, LRH and Mental Hospital located in Peshawar. Discussion made with the officials and experts indicated that Depression is highly prevalent among females in CCDP. The household survey was the main source of primary data. Data was also gathered from the OPD record registered patients from various hospitals. For the statistical analysis SPSS (Statistical Package for Social Sciences) was used. The study revealed that social, economic and cultural factors such as, low level of literacy, poverty, conservativeness of society, violence, noise pollution and use of drugs were the main causes responsible for depression amongst the female of age between 18 to 49 years. Many women unfortunately do not seek help because they are embarrassed or do not recognize or realize their problems and symptoms as a disease called depression. Women being significant members of a family, if they suffer from any type of depression the whole family, especially youngster children are at risk of developing psychiatric and behavioral problems. If depression is left untreated they can seriously impede patient's chances of recovery. In order to deal with the problem it is essential to recognize how the socio- economic, cultural, legal, infrastructural and environmental factors affect women's mental health.

Key words: Depression, spatial distribution, poverty, education, socio-cultural and economic factors.

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Introduction

Life consists of different stages in our lives, we enjoy and cherish happy times as well as face challenges; in fact, many of the things that bring us great joy and fulfillment, such as, close relationships, a promotion, having a baby, buying a car, a home, also can cause stress on our mental health. At some point we also have to cope with traumatic life events such as, dealing with a loved one's serious illness or death, a job loss, domestic violence or sexual assault. Changes in our physical health also affect our mental health. Changes in the body's hormone levels from pregnancy and childbirth, or from menopause, can cause depression, anxiety, irritability, and tearfulness. Depression also comes along with many illnesses such as cancer, heart disease, stroke, HIV, or autoimmune diseases.

We all feel worried, anxious or sad from time to time but many people find that their personal growth and a sense of purpose in life begin to decline in midlife. Such an attitude, as a result, starts affecting various domains of life, such as, social relationships, work and community life. Sometimes it is hard to cope with resulting mental disorders making the person deficient in functioning normally. Women are approximately two times more likely than men to suffer from depression and dysthymia (Li, Zhang, Cai. et al, 2023). Prevalence rates of depression and anxiety disorders as well as psychological distress are higher for women than men. Depression occurs most frequently in women age 25 to 44 (Albert, 2015). A survey carried out in Nepal demonstrated that women had a higher psychiatric morbidity than men, with a sex ratio of 2.8:1 in the Health Post, and 1.1:1 in the District Hospital (Wright et al, 1999). Complex biological, psychological, and social factors that operate in women's life also contribute more depression in women than men (Di Benedetto, Landi, Mencacci & Cattaneo, 2024). In certain countries boys are given priority over girls for better food, care and education. (Niaz, 2004). Some experts have suggested that the traditional upbringing of girls might foster these traits and that may be a factor in the higher rate of depression in women (Di Benedetto, Landi, Mencacci & Cattaneo, 2024).

One of the major causes of high prevalence rate of depression among women is the multiple roles that they fulfill in society which expose them to greater risks of experiencing mental problems than others in the community. Women bear the burden of responsibility associated with being wives, mothers. In addition to the many pressures placed on women, they must contend with significant gender discrimination and the associated factors of hunger, poverty, malnutrition, and overwork (WHO, 2000).

In order to investigate the causal factors of depression among women in society we need to look at the spatial distribution of depression in different areas addressed by Medical Geography which is an important new area of health research, a hybrid between geography and medicine dealing with the geographic aspects of health and healthcare considering the effects of local conditions and environments such as,

climate, socio-economic, cultural and epidemiological conditions upon health (Barrett, 2000; Meade and Earickson, 2000). The present research investigated the spatial distribution of depression among women in CCDP, because women are significant members of a family, if they suffer from any type of depression and left untreated the whole family including children's are at risk of developing psychiatric and behavioral problems. Further it may also adversely affect the household income and expenditure balance and community as well.

Objectives

To find the spatial pattern of depression among women in CCDP.

To suggest measures that minimizes the risk of depression amongst the female living in the CCDP.

Method

Sample

The study area for this research was the Capital City District Peshawar, consisting of four towns. Ten Union Councils out of 92 of the CCDP were randomly selected for this research and from each Union Council one community was randomly selected to administer the questionnaire. Altogether about 370 households were consulted for this research, females were interviewed. The name of Union Councils along with the communities and no. of households where survey was conducted are as follows:

Union councils (Town)		***Community name***	***No. of house holds conducted***
Gul Bahar	I	Gul Bahar No. 1	37
Sheikh Junaid Abad	I	Gul Bahar No. 4	37
Chamkani	II	Chamkani	37
Ghari Sherdad	II	Mian Khel	37
Chaghar Matti	II	Chaghar Matti	37
Nuthia	III	Nuthia Qadeem	37
Shaheen Town	III	Ward-I	37
Hayatabad-I	IV	Phase-I	37
Hazarkhawani-I	IV	Hazarkhwani-I	37
Surizai Payan	IV	Surizai Payan	37

Hypothesis

The higher the incidence of poverty, unemployment, violence, congestion, overcrowding, noise pollution, and use of drugs, the greater is the risk of depression among women.

Instruments

Two types of data were collected for this research i.e. primary and secondary

Primary Data

Primary data was collected through self-constructed questionnaire survey, interviews, field observation and from records of hospital

Secondary Data

Secondary data was collected from books, journals, reports and Internet etc.

Procedure

Following methodology was adopted to carry out this research.

- Primary data collection and preliminary analysis of the data from the following hospitals namely Khyber Teaching Hospital, Lady Reading Hospital and Mental Hospital (Peshawar).
- Framing of research hypothesis and identification of sampling frame
- Designing of household questionnaire for data collection from the field. Analysis of primary data with SPSS.

Results

Data necessary for this study was collected both from primary and secondary sources.

Table-1 Capital City District Peshawar: Family types by Towns

Family Type						
Town	**Joint Family**		**Single family**		**Both**	
	Frequency	**%**	**Frequency**	**%**	**Frequency**	**%**
Town I	60	56	38	44	98	100
Town II	40	49	48	51	88	100
Town III	55	55	39	45	94	100
Town IV	35	45	55	55	90	100
Capital City District Peshawar	190	51.5	180	48.5	370	100

The town wise distribution of family system also shows this difference. The Table No.1 clearly shows that in Town I, 56% households were living in joint family systems while 44% households live in single family system, In Town II, 49% joint family system while 51% in single family system, in Town III, 55% in joint family system while 45% in single family

system and in Town IV. 45% household preferred to live in joint family system while 55% household preferred to live in single family system. The highest ratios for joint family system were in Towns I and III.

Table-2: Capital City District Peshawar: Monthly Income Level by Towns

Towns	Income Level							
	Rs. 2000-8000		Rs.9000-15000		Rs.16000-22000		Rs.23000-and above	
	F	%	*F*	%	*F*	%	*F*	%
Town I	10	15	43	32.5	32	30	12	22.5
Town II	53	65	45	33	6	2.3	0	0
Town III	32	40	13	18	14	11	16	28
Town IV	56	66	20	21.5	11	10	4	2.5
Capital City District Peshawar	151	46.5	26.5	26.5	63	13.5	32	11.5

Denotation: *F* = Frequency

Table No. 2 shows distribution of income level by town. In Town I, 15% household had total monthly income of Rupees 2,000-8,000,32.5% households had total monthly income of Rupees 9,000-15,000, 30% households had total monthly income of Rupees 16,000-22,000 and 22.5% households had total monthly income of Rupees 23,000 and above, in Town II, 65% household had total monthly income of Rupees 2,000-8,000,33% households had total monthly income of Rupees 9,000-15,000, 2.3% households had total monthly income of Rupees 16,000-22,000 and 0% households had total monthly income of Rupees 23,000 and above, in Town III, 40 %household had total monthly income of Rupees 2,000-8,000,18% households total monthly income of Rupees 9,000-15,000, 11% households had total monthly income of Rupees 16,,000-22,000 and 28% households had total monthly income of Rupees 23,000 and above and in Town IV, 66 %household had total monthly income of Rupees 2,000-8,000,21.5% households had total monthly income of Rupees 9,000-15,000, 10% households had total monthly income of Rupees 16,000-22,000 and 2.5% households had total monthly income of Rupees 23,000 and above.

Table-3: Capital City District Peshawar: Education detail of respondents by Towns

Towns	Education Detail					
	Educated		Uneducated		Total	
	F	%	*F*	%	*F*	%
Town I	38	60	35	40	73	100
Town II	20	22	98	78	118	100
Town III	30	50	55	50	85	100
Town IV	22	35	72	65	94	100
Capital City District Peshawar	110	41.7	260	58.3	370	100

Table No. 3 shows that in Town I, 60% females were educated while 40% females were uneducated, in Town II, 22% females were educated while 78% females were uneducated, in Town III, 50% females were educated while 50% females were uneducated and in Town IV, 35% females were educated while 65% females were uneducated.

Table-4: Capital City District Peshawar: No. of persons per room by Town.

Congestion/Town	*No of persons per room*
Town I	3.1
Town II	3.2
Town III	3.4
Town IV	3.1
Capital City District Peshawar	3.2

Table No. 4. shows congestion in Town I, 3.5 persons per room, in Town II, 3.2 persons per room, in Town III, 3.4 persons per room and in Town IV, 3.1 persons per room shows high congestion, in rural towns the congestion is due to high household size and rapid population growth while in city town high room density is due to overcrowding and shortage of affordable dwellings because the land value as well as the rents of houses are very high which strongly effects the mental health.

Table-5: Capital City District Peshawar: Causes of Noise in Town

Towns	***Causes of Noise***							
	Traffic		**Industry**		**Air port**		**NA**	
	F	**%**	***F***	**%**	***F***	**%**	***F***	**%**
Town I	60	77.5	0	0	0	0	22	20
Town II	0	0	0	0	0	0	100	102
Town III	45	60	5	0.2	0	0	40	38
Town IV	33	25	0	0	0	0	65	75
Capital City District Peshawar	138	40.6	5	0.2	0	0	227	58.8

Table No.5 clearly reveals that the cause of noise in majority of sample area was traffic. In Town I, 77.5% households were affected with the noise of traffic, in Town II, 0%

households, in Town III, 60% households and in Town IV, 25% households were affected with the noise of traffic respectively.

Table-6: Capital City District Peshawar: Drug Type used by (Male) Town.

Drug Type						
Towns	***Heroin***		***Opium***		***Chars***	
	F	***%***	***F***	***%***	***F***	***%***
Town I	7	17.5	0	0	22	37.5
Town II	2	2.3	0	0	14	33.3
Town III	2	2.3	2	0.9	11	26
Town IV	3	4	2	0.9	9	25.5
Capital City District Peshawar	14	6.5	4	1.3	56	30.5

Denotation: *F* = Frequency

Table No. 6 shows that in Town I, 17.5% household confirmed that their family members were taking heroin, 0.5% were taking opium and 37.5% were taking chars. In Town II, 2.3% households confirmed that their family members take heroin, 0.3% and 33.3% were taking opium and chars respectively. In Town III, 2.3% households confirmed that their family members were taking heroin, 1.3% and 26% were taking opium and chars respectively. In Town IV, 4% household confirmed that their family members were taking heroin, 3% and 25.5% were taking opium and chars respectively.

Table-7: Capital District Peshawar: Reason for Showing Violent Behaviour (Males to Female) by Town.

Town	Unemployment		Poverty		Drug		Others	
	F	%	*F*	%	*F*	%	*F*	%
Town I	2	7.5	1	0.5	18	32.5	30	59.5
Town II	10	30	25	36.6	2	1.3	9	32
Town III	4	9	8	16.6	11	15	30	59
Town IV	5	22.5	10	27.5	7	12.5	12	37.5
Capital City District Peshawar	21	17.3	44	20.3	37	15.4	81	47

Table No. 7 shows these facts, In Town I 30% respondent told their male family members are showing violent behavior due to unemployment. In Town II 36.6%, In Town III 32.5% and In Town IV 59.5% their male family members are showing violent behavior due to poverty, drugs and others factor respectively.

Table-8: Capital City District Peshawar: Acceptance of Customs and Traditions by Town.

Towns	***Acceptance towards Customs and Traditions***			
	Yes		No	
	Frequency	%	Frequency	%
Town I	40	36	45	64
Town II	23	24.4	90	75.4
Town III	40	36	45	64
Town IV	38	35	49	65
Capital City District Peshawar	141	32.8	229	67.2

Table No. 8 shows the female attitude to accept customs and traditions. In Town I, 36% respondents liked their customs and traditions while 64% respondents did not like them, In Town II, 24.4% respondents liked their customs and traditions while 75.4% respondents did not, In Town III, 36% respondents liked their customs and traditions while 64% respondents did not and In Town IV, 35% respondents liked their customs and traditions while 65% respondents did not.

Table-9: Capital City District Peshawar: Family Members Suffering from Psychological Disease by Town

Towns	Name of Disease			
	Depression		Anxiety	
	Frequency	%	Frequency	%
Town I	20	8%	1	.32
Town II	6	4.6%	1	0.32
Town III	9	5.6%	1	0.32
Town IV	5	3.5%	0	0%
Capital City District Peshawar	40	5.5%	3	0.96

Table No. 9 shows that in Town I, 8% females have knowledge about depression while 0.25% females have knowledge about anxiety, in Town II, 4.6% females while 0.03% females have knowledge about depression and anxiety, in Town III, 5.6% females while 0.3% females have knowledge about depression and anxiety and in Town IV, 3.5% females while 0% female have knowledge about depression and anxiety respectively.

DISCUSSION

Stress of any type can make us more vulnerable to developing negative moods. Over time, if the stress becomes too great or stays with us for long periods, we may become depressed. It does not matter what the stressor is. The stress could be due to financial problems, lack of social support or living in poverty or in a noisy or crime-ridden area.

The prevalence of mental illness is affected by certain so-called "social structures" which in turn defines our culture. Culture refers to patterns of thought, behavior, values and feelings. Attitudes, beliefs, values and standards for normal behavior (called "norms") within a society are aspects of culture. All of these cultural aspects play a role in an individual's self identity, which in turn, can either be a determinant of psychological well-being or distress. The supremacy of the male and subordination of the female assumed to be part of the culture and even to have sanction of the religion made violence by one against the other in a variety of its forms an accepted and pervasive feature of domestic life." (Human Rights Commission of Pakistan, 1997). Women's increased risks of adverse mental health outcomes are attributed to a wide range of significant adverse consequences disproportionately experienced by women: poverty, discrimination, violence, socio-economic disadvantage, low social status, and traditional female gender roles (Astbury, 2001; Patel et al, 1999).

A study carried out by Department of Psychiatry, Mayo Hospital, Lahore and the results showed that the female had a higher prevalence rate (56%) of neurotic disorders on the basis of family problem and literacy rate as compared to the males (43%) (Khan, Farid Rabia, et al, 1999). Another study supports the previous studies of stress in remote areas and also contradicts the belief that people who live in the remote rural areas lead stress-free lives or have low rates of psychiatric morbidity (Dodani and Zuberi, 2000). A study carried out in Pakistan showed that factors associated with depressive disorders in upper and middle class women were marital conflicts (25.5%), conflict with in-laws (13%), financial dependency (10%), lack of meaningful job (14%), and stress of responsibilities at home and at work (9%) (Niaz, 1995 pp 76). Education is another important factor related to the overall health of individual. Education, especially girls' education, is key to addressing health disparities in any region. Girls having improved access to education are associated with better health for both women and their children (UNESCO, 2004). Poverty, domestic isolation, powerlessness (resulting, for example, from low levels of education and economic dependence), and patriarchal oppression are all associated with higher prevalence of psychiatric morbidity in women (McGrath et al, 1990). The WHO says women are more vulnerable to such global scourges as poverty, overcrowding, unemployment, wars, and various forms of violence. Such pressures can bring on or exacerbate mental illness (WHO, 1995).

Present research shows that social and cultural factors are strongly responsible for depression amongst women in CCDP. The above depression determinants clearly support our hypothesis that the higher the incidence of poverty, unemployment, violence, congestion, overcrowding, noise pollution and use of drugs the greater are the risk of depression amongst women. In sample areas the women are greatly affected by all these factors as a result of which they are suffering from depression. Depression is not just another problem but a central link between many kinds of problems which lead to depression.

CONCLUSION

In the light of the above evidences this research supports the hypothesis that: Poverty is one of the main independent variable causing depression among women. Poverty is termed as

mother of all diseases. Overall low literacy ratio is another variable which causes depression amongst women. Many women do not seek help from the male members of their family because they do not realize their problems and symptoms as a disease called depression. Socially this is a male dominated society in which men rule over society in general and in households in particular. Many factors associated with mental distress are marital disputes such as, verbal abuse by husband, by in-laws, lack of autonomy and arguments with husband and in-laws.

Violence against women is also one of the reasons of depression among women although during the survey women were reluctant to reveals about violence meted at to them. Women also possessed the right to be looked after because women are the home builders and the whole family depends on their health. Women's health should not be ignored for the sake of the family's happiness and comfort. The present study has contributed to the existing body of knowledge in the field of Medical Geography.

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