SOCIO-CULTURAL FACTORS INFLUENCING LATE LIFE DEPRESSION AMONG ELDERLY WOMEN IN SAMARU COMMUNITY, ZARIA, NIGERIA

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ABSTRACT

Depression is a common mental health problem facing the elderly that is often overlooked and subsequently untreated by health care professionals. Recognition of the problem can be aided by knowledge of the causes or at least the factors associated with it. Identification of specific socio cultural factors has important implications for psychiatric nursing practice, education, and research. This research was carried out to determine the socio-cultural factors influencing late-life depression among elderly women in Samaru community, Zaria. A structured questionnaire was used as instrument for data collection which was distributed to a sample of 393 respondents out of the 58272 total populations in the community using multistage cluster sampling technique. Validity of instrument was tested and ethical considerations given as consent were obtained from the district head before administration of questionnaires. A return of 376 questionnaires was achieved. The data collected were coded, analyzed and presented using frequency distribution table and percentages. The findings indicated that more than half of the respondents are within the age of 60-69 years, very few are within the age of 80-89 years. More than half of the respondents had ever been depressed. The explored socio cultural factors influencing their depression include; lack of social support, marital distress, financial crises, loss of loved ones, stressful life events among others. Result shows that 78.5% of the elderly do not seek for depression care indicating their negative attitude regarding therapeutic depression care. Almost all of the respondents (93.1%) have heard about late life depression but have no adequate knowledge about it. This study has shown that absent support and financial crisis mainly influenced late-life depression among elderly women in Samaru community.

Keywords: Attitude, depression, elderly, late life, socio-cultural.
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INTRODUCTION

Depression enduring geriatrics is associated with increased medical morbidity, impaired body working, disturbed social functioning, and dementia [1]. Depression is illustrated by insufficient sleeping hours, mood swings, glumness or isolation, and suicide ideation [2]. In 2006, more than 400 million sufferers of depression were recorded in the world [3]. Frequency in cases of depression horribly amplified and stood on fourth position according to global burden of diseases. Depression was announced an alarming mental health disorder. In developing countries such as Nigeria, it is expected to be on second rank by the year 2020 [3]. Late Life Depression refers to a major depressive episode occurring for the first time in an older person usually over 50 or 60 years of age. Depression is not a normal part of aging. However, "more than 2 million of the 34 million Americans age 65 and older suffer from some form of depression" [4]. Concurrent medical problems and lower functional expectations of elderly patients often obscure the degree of impairment. Typically, elderly patients with depression do not report depressed mood, but instead present with less specific symptoms such as insomnia, anorexia, and fatigue [4]. Approximately 3 percent of healthy elderly persons living in the community have major depression [5]. Recurrence may be as high as 40 percent. Suicide rates are nearly twice as high in depressed patients as in the general population. Major depression is more common in medically ill patients who are older than 70 years and hospitalized or institutionalized. Severe or chronic diseases associated with high rates of depression include stroke (30 to 60 percent), coronary heart disease (8 to 44 percent), cancer (1 to 40 percent), Parkinson's disease (40 percent), Alzheimer's disease (20 to 40 percent), and dementia (17 to 31 percent) [5]. The exact changes in brain chemistry and function that cause either late life or earlier-onset are unknown. It is known, however, that brain changes can be triggered by the stresses of certain life events such as illness, childbirth, death of a loved one, life transitions (such as retirement), interpersonal conflicts, or social isolation. Risk factors for depression in elderly persons include a history of depression, chronic medical illness, female sex, being single or divorced, brain disease, alcohol abuse, use of certain medications, and stressful life events [6]. The

prevalence and predictors of depression in population of elderly demonstrated that female older adults are more vulnerable to later life depression as compared to male older adults. In 2003, a published research study reported the incidence of depression in women is thrice higher than in men [7].

Socio cultural factors consistently have been recognized as major factor in signifying the unpredictability in the prevalence of depression in the elderly. With the advancement in modernization, cases of physical and mental health issues are increasing day by day and society become mechanical [8]. The lust of fame and money makes an individual deprived of socio cultural values. Because of this novel behavior, the elderly are significantly affected by health issues including depression. Additionally, life events, ignorance from family members, loss of loved ones, financial crises, phase of retirement, and inter- or intrapersonal conflicts accompanied with other health issues lead to late life depression [9].

The researchers observed that women in Samaru Community especially the elderly frequently complain of signs and symptoms of depression especially sadness, mood swings, insomnia, loss of appetite, and social withdrawal which they consider as normal process of ageing. This prompted the current study to assess the socio-cultural factors influencing late-life depression among elderly women in Samaru community, Zaria**.**

MATERIALS AND METHODS

The study employed cross-section descriptive survey designed to explore the socio -cultural factor influencing late-life depression among elderly women in Samaru Community Zaria. The area of the study is Samaru community which is a district situated in Zaria, Sabon – Gari Local Government Area of Kaduna state. Geographically, it is located at latitude 11.0° N and longitude 7.37° E with an altitude of 2,398 feet (730 meters). It is also located opposite the famous Ahmadu Bello University (ABU) main campus Samaru, Zaria. The Samaru community is a heterogeneous society of diverse ethnic groups, cultural beliefs and religious beliefs.

A structured questionnaire was used as instrument for data collection. It consisted of four sections: Section A: Socio demographic data of the respondents (e.g. age, tribe, occupation, etc), Section B: Socio cultural factors influencing late life depression, Section C: Attitude towards therapeutic depression care, Section D: Knowledge on late life depression.

The population of the study includes all women who are 60 yr and above living in Samaru Community, Zaria. According to National Population Commission, it was estimated that there are about 58,272 numbers of older women who are 60 yr and above.

The sample size used for the study was determined using a formular postulated by Yamane in 1967 [10]. Thus, $n=N/1+N\ (e)^2$

Where n- sample size

N- population size

e- level of precision i.e 5%=0.05

$n=58272/1+58272\ (0.05)^2$

n=397.3

Therefore, the sample size for this study was approximately 397 people.

Multistage Cluster Sampling Technique was employed based on residential area.

STAGE 1: Using cluster sampling technique, Samaru Community was divided into 8 clusters i.e Samaru metropolis, Ganga Uku, Hayin Dogo, Hayin Dan Yaro, Anguwan Dakarkari, Pensioners Quarters, New Extension and Danraka.

STAGE 2: Using simple random sampling method, four clusters were selected. They are; Samaru metropolis, Danraka, Pensioners quarters and Hayin Dogo

The researchers went from house to house in the selected cluster to administer the questionnaire to elderly women residing in those areas. However, houses without elderly women were skipped. Some of the questionnaires were collected immediately, while some were collected some days later. For respondents that cannot read, the questions were interpreted to them in their local dialect before they respond. Permission to conduct the study was obtained from the district head of Samaru. The consent of the respondents was sought and obtained before administering the questionnaires to them. The respondents were not compelled to participate in the study. Descriptive statistical analysis was used to analyze the data using frequency tables and percentage. The statistical software used was statistical package of social sciences (SPSS).

RESULTS

Findings of the study are presented in the Tables 1- 4:

Table 1: Socio-demographic data

1	**Age (Year)**	**Frequency**	**Percentage**
A	60 – 69	234	62.2%
B	70 – 79	82	21.8%
C	80 – 89	60	16.0%
D	90 – above	0	0%
	Total	376	100%
2	**Religion**		
A	Islam	280	74.5%
B	Christianity	96	25.5%
C	Others	0	0%

	Total	376	100%
3	**Tribe**		
A	Hausa	115	30.6%
B	Fulani	20	5.3%
C	Yoruba	78	20.7%
D	Igbo	73	19.5%
E	Others	90	23.9%
	Total	376	100%
4	**Marital status**		
A	Single	0	0%
B	Married	270	72.6%
C	Divorced	40	10.6%
D	Widowed	63	16.8%
	Total	376	100%
5	**Level of education**		
A	Primary	120	32.0%
B	Secondary	80	21.2%
C	Non formal	25	6.6%
D	Tertiary	51	13.6%
E	Do not go to school	100	26.6%
	Total	376	100%
6	**Employment**		
A	Employed	60	16.0%
B	Unemployed	116	30.9%
C	Retired	200	53.1%
	Total	376	100%
7	**Occupation**		
A	Teacher	100	28.2%
B	Business woman	90	23.9%
C	House wife	26	6.9%
D	Others	154	41.0%
	Total	376	100%
8	**Geographical location**		
A	Urban	176	47.0%
B	Rural	200	53.0%
	Total	373	100%
9	**Family system**		
A	Extended	210	55.9%
B	Nuclear	166	44.1%
	Total	376	100%

Table 1 above showed that majority of the elderly women in Samaru are within the age group of 60-69 (62.2%), 21.8% are within the range of 70 – 79, only 16.0% of the women are within the range of 80 - 89 and 0% are 90 and above. Majority of the respondents are Muslims (74.5%) while about (25.5%) are Christians. The dominant tribe from the respondents is Hausa (30.6%), followed by Yoruba (20.7%), Igbo (19.5%), Fulani (5.3%), and others (23.9%). Most of the respondents are married (72.6%) while single was (0%), the divorced were (10.6%) and only the widowed (16.8%). About 32.0% attended at least primary school, 21.2% attended secondary school only (6.6%) attended tertiary institutions. (13.6%) had non - formal education while (26.6%) do not go to school. There are about 16.0 % of the respondents that are employed; about (30%) are unemployed with about (53.1%) of the respondents are teachers (28.2%), (23.9%) are business women, 6.9% are house wives and about 41.0% engage in other occupation such as nursing, extension workers, cleaners etc. most of the respondents are from rural geographical location only about 47.0% are from urban location. The dominant family system from the respondents is the extended family with about 44.17% nuclear family.

Table 2: Associated Socio-cultural factors influencing late-life depression

10	**Have you ever been depressed?**	**Frequency**	**Percentage (%)**
A	Yes	326	86.7%
B	No	50	13.3%
	Total	376	100%
11	**How many times?**		
A	Once	10	2.7%
B	Twice	13	3.5%
C	Thrice	60	16.0%
D	Many times	243	77.8%
	Total	376	100%
12	**Associated factors**		
A	Lack of social support	50	13.3%
B	Marital distress/conflict	50	13.3%
C	Family system	46	12.2%
D	Financial crisis	51	13.6%
E	Loss of loved one/objects	50	13.3%
F	Stressful life events	48	12.8%
G	Unemployment	20	5.3%
H	Ignorance	46	12.2%
I	Interpersonal conflict	09	2.4%
J	Phase of retirement	06	2.6%
	Total	376	100%
13	**Cultural view regarding late-life depression**		
A	Normal process of aging	200	53.4%
B	It is spiritual	95	25.3%
C	Psychological	69	18.4%
D	Poor coping method	10	2.9%
	Total	376	100%

From Table 2 above, it was observed that about (86.7%) of the respondents had ever been depressed; only about (13.3%) of the respondents have not been depressed. Majority of the respondents of about (77.8%) have many times recurrence while about (16.0%) had 3 times recurrence, (3.5%) had 2 times recurrence, and only about (2.7%) had no recurrence. It was estimated that about (13.6%) of the respondents believed that financial crisis is the factor influencing late life depression 51 respondents (13.6%) believed that it is influenced by lack of social support, 50 respondents (13.3%) also believed that it is influenced by marital distress/conflict, followed by 46 respondents (12.2%) going for family system, 48 respondents (12.8%) believed that it results from stressful life events, 46 respondents also believed that it results from ignorance, 20 of the respondents (5.3%) relates it to

unemployment, only 9 respondents (2.4%) and 6 respondents (1.6%) relate it to interpersonal conflict and phase of retirement respectively. Most of the cultural belief of the respondents regarding late-life depression is that it is normal process of ageing (53.4%), about (25.3%) of the respondents believe that it is spiritual, (18.4%) view it as psychological and only about (2.9%) believed it to be as a result of poor coping mechanism.

Table 3: Attitude of elderly towards therapeutic depression care

14	Do you seek mental health treatment?	Frequency	Percentage (%)
A	Yes	81	21.5%
B	No	295	78.5%
	Total	376	100%
15	**If yes, where**		
A	Psychiatric clinic	5	6.2%
B	Spiritual healers	28	34.6%
C	Traditional healers	48	59.3%
D	Others	0	0%
	Total	81	100%
16	**Is your Culture against therapeutic care of depression**		
A	Yes	265	70.5
B	No	111	29.5
	Total	376	100%
17	**If yes, why**		
A	Is a mental health problem	102	38.5
B	Stigma attached to it	100	38.0
C	Ignorance	58	21.9
D	Others	05	1.6
	Total	265	100%

From Table 3 above, It was estimated that about (78.5%) of the respondents do not seek for mental health treatment. Only about (21.5%) do seek for mental health treatment (81 respondents), only (6.2%) go to the psychiatric clinic, about (59.3%) go for traditional healers while (34.6%) go for spiritual healers. 0% go to other places for treatment. About (70.5%) of the respondents are against therapeutic depression care culturally. Only (29.5%) of them are not against it. For those that are against therapeutic care of depression, (38.5%) suggest that this is because it is a mental health problem, (38.0%) said it is because of the stigma attached to psychiatric disorder, about (21.9%) said it is due to ignorance, only about (1.6%) have other reasons for that.

Table 4, above shows about(93.1%) of the respondents have ever heard about late-life depression. Only about (6.9%) have never heard about it. For those that heard about it, (28.5%) of them suggest the school as their source of information,
(17.0%) said hospital is the source of their information, (28.5%) with media as the source of the information while about (26.0%) said other sources such as relatives, friends, colleagues are the source of their information. About (23.9%) of the respondents said depression is all about persistent feeling of sadness, (53.2%) said it is insufficient sleeping hours while about (22.9%) said it is all about mood swings. From the analysis, (23.9%) guilt is one of the sign and symptom of depression, (26.6%) go for suicide ideation, (5.3%) go for loss of sexual function, (17.6%) go for loss of appetite and about (26.6%) go for sadness. Analysis show that the chief cause of late life depression is loss of loved ones/objects (50.4% of the respondents) followed by financial crisis (32.0% respondents) while stressful life events had only (17.6%) respondents.

Table 4: Knowledge of elderly regarding late life depression

18	Have you ever heard about late life depression	Frequency	Percentage (%)
A	Yes	350	93.1%
B	No	26	6.9%
	Total	376	100%
19	**If yes, what is the source**		
A	School	100	28.5%
B	Hospital	60	17.0%
C	Media	100	28.5%
D	Others	90	26.0%
	Total	350	100%
20	**What is it all about**		
A	Persistent feeling of sadness	90	23.9%
B	Insufficient sleeping hours	200	53.2%
C	Mood swing	86	22.9%
	Total	376	100%
21	**What are the signs/symptoms**		
A	Guilt	90	23.9%
B	Suicide ideation	100	26.6%
C	Loss of sexual function	20	5.3%
D	Loss of appetite	66	17.6%
E	Sadness	100	26.6%
	Total	376	100%
22	**What are the causes**		
A	Stressful life events	66	17.6%
B	Loss of loved ones/objects	190	50.4%
C	Financial crisis	120	32.0%
	Total	376	100%

DISCUSSION AND CONCLUSION

This survey was conducted to investigate the role of socio-cultural factors on depression among elderly women in Samaru community. Unlike elder women of western world, most women in Samaru are not working so they get isolated that within a short period of time become converted in to depression.

Findings showed that marital conflicts are also very prominent in later life. Though, it is really hard for single, widowed, and divorced women to survive solely in this world. Everyone needs somebody to share last stage of

lives, to discuss daily life issues, to spend time with someone as a partner [11]. It has been observed that the married elderly spend healthy life as compared to the unmarried. Absence of a partner at the last stage of life pushes an individual into depression. Single or unmarried older adults are more vulnerable to depression as compared to married older adults.

Similar to South Asian countries [11], extensive family system has being practiced in Samaru community by many families. It is assumed that extended family system is a healthy family system. Larger numbers of people are available in extended family system, to play care-taker role for their older adults. Love and respect are the main source of happiness for elderly in extended family system. They are being surrounded by their second or third generation and elderly people smoothly passed their last stage of life. However several families in Samaru community have started adopting nuclear family system because of inflation and growing trend of modernization. A study conducted on prevalence and predictors of depression among elderly population of Pakistani elaborated that nuclear family system is significantly strong predictor of depression for older adults [12].

Similarly the present study revealed that stress full life events, ignorance from family members, loss of loved ones, financial crises, phase of retirement, and inter- or intrapersonal conflicts accompanied with other health issues lead to late life depression [13].

Findings of the study show little or no problem to phase of retirement, that phase of retirement is not at all depressive stage. Instead they called it honeymoon period[10]. Findings show that 78.5% of the respondents do not seek for mental health treatment. Only about 21.5% do seek for mental health treatment, either in the psychiatric clinic, from traditional healers or from spiritual healers. Findings also showed that elderly are against therapeutic depression care culturally. For those that are against therapeutic care of depression, 38.5% suggest that this is because it is a mental health problem, 38.0% said it is because of the stigma attached to psychiatric disorder, about 21.9% said it is due to ignorance, only about 1.6% have other reasons for that. Stigma is an identified mark or characteristic, which disqualifies those possessing the mark from full social acceptance in society. This includes the negative perceptions, attitudes, and beliefs held about individuals who bear such a mark [11]. Stigma of mental illness is the most fundamental reason why older adults chose not to seek mental health services and the Surgeon General's report on mental health. Furthermore, it is a powerful obstacle to seeking care among the elderly. Older African Americans with depression often experience multiple, concurrent stigmas and may be less likely to seek help due to bearing more than one stigmatizing characteristic (e.g. mental illness, aging, and racial minority status) [13].

Findings showed about 93.1% of the respondents have ever heard about late-life depression. Only about 6.9% have never heard about it. For those that heard about it, 28.5% of them said that the school is their source of information, 17.0% said hospital is the source of their information, 28.5% with media as the source of the information while about 26.0% said other sources such as relatives, friends, colleagues are the source of their information [14].

Despite its prevalence and seriousness, depression in late life remains underappreciated as a source of disability and suffering for older people and their families. Despite a solid and substantial body of research, recognition of depression remains problematic and is often attributed to normal developmental changes in aging. Treatment efficacy data notwithstanding, the adequacy and appropriateness of treatment is highly variable.

It is concluded that elderly women undergo late life depression. Widowhood, family conflicts, unsatisfactory family attitude, financial instability, communication gap, death of loved one(s), unfulfilled early life desires, feeling of guilt, and later life general medical condition collectively act as strong predictors of depression among older adults.

Also, older adults do not have adequate knowledge about late life depression. This make elderly people unaware of their problem and as such worsen morbidity and ageing process.

Negative attitude towards therapeutic depression care was one of the findings which were largely due to the fact that depression is a mental disorder and secondly due to stigma attached to it. This will hinder treatment seeking behavior and largely worsen prognosis.

RECOMMENDATIONS

1. In the beam of the findings of present study, it is highly recommended to design community support programs, welfare centers, policies for older adults' rights, grants or pensions from government sectors, and medical expense arrangements for older adults in Samaru community.
2. Health education programs regarding late life depression should be put in place to update elderly on this issue.
3. Public enlightenment programs on the effect of stigmatization especially on mental health problems should be put in place and if possible home based treatment should be encouraged.

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