THE PREVALENCE, CAUSES AND TRADITIONAL MANAGEMENT OF DEPRESSION AMONG FEMALE GENDER IN IJEBU ODE LOCAL GOVERNMENT

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CERTIFICATION

This is to certify that this project was carried out under my supervision by **OGUNLOYE OLUWATOBILOBA SAMUEL** Matric No **17012407005** of the Department of Biology, School of Sciences, Tai Solarin College of Education, Omu Ijebu, Ogun State.

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DEDICATION

This research work is dedicated to the glory of the Almighty God, the maker and giver of knowledge and understanding, whose grace and mercy endures forever.

And it is also dedicated to my parents Mr. and Mrs. Ogunloye and also to all the women all over the world facing challenges in one way or the other.

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ABSTRACT

The study aimed at examining the prevalence, causes and traditional management of depression among female gender in Ijebu Ode Local Government.

Data were collected with the aid of a structured questionnaire administered to one hundred and twenty (120) respondents in Ijebu Ode. Simple percentage statistics method was used to analyzed the data.

Out of the total number sampled, 70% of the respondents (women) were found to be depressed. Of the married women found to be depressed, there were more widow than those who are present with their husband. A feeling of sadness over family, living and working conditions was more consistent among the depressed.

In conclusion, the prevalence of depression in the study population was significantly associated with a lack of formal education among respondents. Improving universal basic education coverage and providing employment opportunities will thus reduce the burden of depression among the women in the upcoming generation.

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CHAPTER ONE

1.1 Background to the Study

Depression is a mental health disorder that is characterized by extreme sadness and or loss of interest in activities that were once pleasurable. Depression is among the health problems which many people experience at least once in their life time (APADS, 2013). It is the leading cause of disability worldwide in terms of total years lost due to disability and it is predicted to be the leading cause of disease burden by 2030. Depressive disorders are common in all parts of the world. There is a bidirectional relationship between depression and chronic morbidities. Depressive disorders tend to be common in old age and can affect the outcome of common chronic conditions such as arthritis, cardiovascular disease, cancer and diabetes (Steel et al., 2014). Despite the fact that it has been predicted to be the second leading cause of global disease burden by 2030, majority of those affected are not aware of their health condition, and only a few are seen in our primary and secondary health facilities where few research has been done (Steel et al., 2014). Low and middle income countries such as Nigeria, experience double epidemic from upsurge of both communicable and non-communicable disease of which depression contributes significantly to paradoxically, disproportionately low percentage of gross domestic product is allocated to the health sector in such nations (Warren and Taylor, 2013).

Women bear the major brunt of the family and suffer in silence. Depression is an inexplicable agony among women, almost unidentified among mental health problems in Nigeria. Global Burden of Disease

study identified major depression as the fourth leading cause of worldwide disease burden in 1990, ranking ahead of ischemic heart disease, cerebrovascular disease, and tuberculosis. Even more striking is the projection that major depression will become the second leading cause of disability worldwide (Gadit and Khalid, 2012).

According to the WHO Global Burden of Disease 1996 statistics, the leading cause of disease burden for women in 1990 was Unipolar depression, amounting to 13% of all causes of disease burden in women of developing countries. Epidemiological studies report that major depression has an annual prevalence varying from about 1% to 6% in community samples worldwide with evidence that it is becoming more prevalent over time in younger cohort (Thacore et al., 1999). The position of women can be easily ascertained from the very fact that the male female ratio population wise is 108 males to 100 females of 140 million. Women constituted 48% of the total population and 22% of women are in reproductive age group and 26% are less than 15 years. Women have low literacy rate i.e. 24% majority of women are housewives and are economically dependent on men and not conscious of their legal rights. The psychosocial stresses of women are present throughout their life cycle from childhood to adolescence adulthood, middle age and old age. Studies carried out in developing countries have shown reasonably consistent high rates for depressive and anxiety disorders particularly high rates among women have been reported (Niaz, 2000). As per local studies, identified predisposing factors for mental illness are: low socioeconomic conditions, illiteracy, unemployment or poor job conditions, denial of justice or lawlessness, social discrimination,

loosening of cohesion in society and violations of human rights (Gadit et al., 2008). There is need to explore social and cultural factors contributing in depression because incidence of mental illness is rising in our country and the general awareness about existence and causation of mental illness is lacking. In Nigeria, people give more importance to evil eye, possession, and magic influence as being the major causes of mental distress and usually approach a traditional healer for seeking treatment.

1.2 Statement of the Problem

Depression is a major cause of psychological illness. Depression affects not only the life of the person who suffers from the disorder, but also the lives of family and friends and depression ultimately affects society as a whole. There are several possible causes of depression. They can range from biological to circumstantial. They are family history, early childhood trauma, brain structure, medical conditions and drug use. It is also characterized by changes in mood status presenting as feelings of sadness which may fluctuate from slight hopelessness to severe feelings of disappointment. Due to the negative impact of depression in families and society at large there is need to reduce the rate at depression that occurs in developing countries especially Nigeria.

1.3 Purpose of the Study

The purpose of this study is to measure the prevalence and causes of depression among female gender and to describe the measures to be use for depression management. The chore of medicine is to preserve and restore patient's health and to minimize their suffering. To achieve these

goals, intellection about depression is a must because depression is universally understood as a pointer to disease and it brings the patient to the physician recognition. Depression can originate from any situation such as financial problem being the major cause. The best place for a student to start if they are feeling down or need someone to talk to is to reach out to the on-campus counseling center.

1.4 Significant of the Study

This research project is aimed at detecting the prevalence, causes and traditional management of depression among female gender. At end of this research, it will enable married woman to solve their individual problem at home and society. Furthermore, the findings of the study can be used by policy makers and planners to revamp the causes of depression.

1.5 Research Questions

1. What is the prevalence of depression among female gender?
2. What are the causes of depression among female gender?
3. What is the traditional management of depression among female gender?

1.6 Scope of the Study

This research is focus on the prevalence, causes and traditional management of depression among female gender. Hence, the research will be limited to married women in Ijebu Ode Local Government, Ogun State.

1.7 Definition of Terms

Gender: refers to the characteristics of women, men, girls and boys that are socially constructed.

Prevalence: is the number of disease cases present in a particular population at a given time, whereas incidence is the number of new cases that develop during a specified time period.

Depression: A group of conditions associated with the elevation or lowering of a person's mood, such as depression or bipolar disorder. Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning.

Management: the process of dealing with or controlling things

Female: a person bearing two X chromosomes in the cell nuclei and normally having a vagina, a uterus and ovaries, and developing at puberty a relatively rounded body and enlarged breasts, and retaining a beardless face; a girl or woman.

CHAPTER TWO

LITERATURE REVIEW

2.1 Concept of Depression

Depression is the most common mental illness experienced by women.The lifetime prevalence of depression in women is about 21% compared with 13% in men, and it is the second leading cause of disease burden for women in the United States, women today have a 10 times greater chance of suffering from depression than their grandmothers did Alexander (2007). The risk of depression increases as women age, and anxiety symptoms are present in about 58% of depressed outpatients Alexander (2007). The course of depression across the life span is marked by recurrent episodes of depressive symptoms followed by periods of remission, and the course of depression tends to be more chronic in late life than in younger adults. For some, an initial episode of major depression will evolve over time (with remissions and recurrences) into unipolar major depression, whereby each new episode confers new and more severe risks of chronicity, disability, and suicide Schreiber (2006).

Major depression is associated with considerable impairment in functioning, comparable to and sometimes worse than that experienced by patients suffering from a variety of chronic medical conditions.7 One study reported that depressed outpatients function at lower levels than outpatients with any other illness except cardiac illness Schreiber (2006).

Depression has many forms including major depressive disorder, dysthymic disorder, psychotic depression, postpartum depression, and

seasonal affective disorder, and is characterized by persistent sadness, anxiousness, hopelessness, guilt, worthlessness, irritability, restlessness, loss of interest in activities or hobbies, fatigue, difficulty concentrating, impaired memory and decision making, insomnia or hypersomnia, overeating or appetite loss, suicidal ideation or attempts, or persistent aches or pains, headaches, cramps, or digestive problems that do not ease with treatment National Institute of Mental Health (2009). Symptoms interfere with normal functioning in daily life, and persist for a matter of months to years. Ten to fifteen percent of patients formerly hospitalized with depression commit suicide, with major depressive disorder accounting for 20% to 35% of all deaths by suicide.

The greatest risk factor for a future depressive episode is a past depressive history. Women who have a history of depression are nearly five times more likely to have a future episode of major depressive disorder, with the risk of recurrence increasing with each episode, and an association with a stressful life event becoming progressively weaker with each new depressive episode Alexande (2007).

Treatment of depression most often includes pharmacologic agents in conjunction with cognitive-behavioral therapy or interpersonal therapy, the combination proving important for full recovery and preventing relapses. However, an even more aggressive and comprehensive program that includes dietary and lifestyle changes including regular exercise and sleep, a diet high in w-3 fatty acids, tryptophan, folic acid, vitamin D, and vitamin B complex, exposure to bright light, spiritual ‘‘therapy,’’ and complementary and alternative medicines like acupuncture, may bring about even more thorough and long-lasting recovery Meyer, (2008).

2.2 Prevalence of Depression

Major depressive disorder, which will be subsequently referred to as depression, is one of the most frequently diagnosed psychiatric disorders, with current and lifetime prevalence rates reported to be 15 and 23%, respectively Kessler, Berglund, Demler *et al (*2003*)*. Indirect evidence suggests that the prevalence of depression has increased steadily during the mid- to-late 20th century, while at the same time the age of onset has decreased, with an average age of onset in the mid-twenties. The high prevalence rate of depression is even more concerning given the associated significant occupational and social impairment, and the high rate of associated comorbid medical and psychiatric illnesses (Hasin, 2005). Given these data, it is not surprising that depression has been identified as one of the top five leading causes of disability and disease burden throughout the world.

Perhaps the most striking feature of this debilitating disorder is that the prevalence estimate of depression is approximately twice as high for women than it is for men. Furthermore, this increased prevalence rate of depression is observed across different ethnic groups and countries (Kessler, 2003). The lifetime prevalence rate of depression for women is approximately 21%, whereas it is approximately 12% for men. The rate of depression begins to increase for females around the age of 13 years and this higher prevalence rate for females continues throughout the lifespan. The purpose of this article is to review current knowledge of factors that contribute to the marked increase of depression among women and to describe gender differences in symptom presentation,

course of illness and treatment outcome.

2.3 Depression in Female Gender

Depression is nearly twice as common among women as men, according to the Centers for Disease Control and Prevention (CDC).

Also, some types of depression are unique to females, such as:

- postpartum depression
- premenstrual dysphoric disorder

Postpartum depression occurs after giving birth, and it involves a persistent low mood. It is different from the "baby blues" that many new parents experience.

Having postpartum depression does not mean that a person does not love their baby. It is a mental health condition, and treatment can resolve it. Anyone with symptoms should see a doctor immediately.

Menstruation-, Pregnancy-, And menopause-Related Depression

Premenstrual syndrome (PMS) is a medically unexplained disorder that presents with physical, psychological, and behavioral symptoms during the luteal phase of the menstrual cycle and typically resolves after the onset of menstruation Busse et al, (2009). Mild symptoms are common, occurring in approximately 75% of women of reproductive age, with clinical prevalence of PMS between 19% and 30%, and up to 8% of women experiencing a form of PMS extreme enough to severely disrupt normal functioning, possibly resulting in suicidal ideation or attempt

Busse et. al; 2009. This most severe variant of PMS is termed premenstrual dysphoric disorder, which presents with at least one mood symptom (typically low mood, tension, anger, irritability, or mood swings) and suffering physical or psychological symptoms in most menstrual cycles in the past year. The most frequently reported symptoms of PMS are irritability, depression, fatigue, water retention, weight gain, breast tenderness, headaches, abdominal cramps, and mood swings (Gold, 2007).

Severe PMS symptoms most commonly appear in the late second decade of life, and may be associated with a history of major depressive disorder and anxiety disorders. In a 2007 study, symptom reporting for PMS was related to depression among women exposed to cigarette smoke, reflecting the strong correlation between cigarette smoking and lifetime prevalence of depression. In a perimenopausal cohort, PMS symptoms were reported by 26% of depressed women compared with only 9% of non depressed women. Increasing age has been associated with a decreased reporting of premenstrual anxiety, whereas caffeine intake shows a positive association with premenstrual anxiety Gold et al, (2007).

Current treatment relies primarily on self-management, dietary modifications including vitamin supplementation, exercise, stress management, and cognitive behavioral therapies. Women who are unable to adequately control symptoms through lifestyle changes may benefit from prescription medications. Ante-, peri-, and postpartum depression occur in 10% to 20% of women, with rates of depression increasing in the last 2 trimesters of pregnancy up to 51% in the general population of pregnant women. Women are at greater risk of developing depression in

the postpartum period than at any other time in the life cycle, and postpartum depression is considered the most common postdelivery complication of childbirth (McDowell, 2008). Women with postpartum depression may be greater than four times as likely to screen positive for depression 4 years later than controls who were not depressed postpartum. Postpartum depression may affect the mother's physical health,18–20 the physical and emotional health of the offspring,18–21 and that of family members. Antenatal predictors of postpartum depression include antenatal depression (a 6.5-fold increase in risk), previous infertility, past history of psychiatric illness, lack of social support, and stressful life events.

Depression occurs in about 20% and up to 50% of pregnant women,with women particularly vulnerable to depression and anxiety if they have high-risk pregnancies or are put on bed rest. Women with antenatal depression are less likely to attend regular prenatal visits, follow prenatal advice, including taking supplements, and are more likely to engage in fetal abuse (such as physical assault by punching the pregnant abdomen, or engaging in risk behaviors like tobacco, alcohol, or drug use). Depression increase maternal serum corticosteroid and catecholamine levels, which are suspected of decreasing placental blood flow, which may in turn induce fetal stress and cause fetal brain and heart rate changes. Depression has been positively associated with increased uterine irritability, pregnancy-induced hypertension, preeclampsia, antepartum bleeding, decreased uterine artery blood flow, preterm delivery, increased planned cesarean section, and epidural anesthesia. Babies of depressed mothers are at higher risk of lower Apgar scores, less

breastfeeding, failure to thrive, and increased admissions to neonatal intensive care.

Although it is important to screen high-risk women for depression before, during, and after pregnancy, the high prevalence and deleterious effects of depression provide strong evidence for universal screening. In screening for postpartum depression, when contact with the health care system might afford the best results in terms of identifying and responding to health needs, ‘‘crucial’’ moments have been proposed as at 6 hours, 6 days, 6 weeks, and 6 months postdelivery, loosely interpreted. Nursing care, including home visits, enjoys a strong position in the assessment and detection of depression, education of coping skills, and referrals to appropriate adjunct health care workers to remediate depressive symptoms and their consequences (Tezel, 2012).

Depression in women around the time of menopause is seen most often, and with greater severity, in the 2 or 3 years before menstruation stops. The latest research indicates that developing depression during the menopausal transition contains pieces of a continuum of risk (history of postpartum depression, previous stressful events) and evidence of a critical window of vulnerability during this time of life (menopause-related sleep problems, vasomotor symptoms, and health indicators).

2.4 Factors that Contribute to Gender Differences in Depression

Reproductive factors

Reproductive factors such as menstrual cycle, pregnancy and menopause have been speculated to contribute to the high rate of depression among

women, with some evidence that estrogen impacts the neurotransmitter system. In fact, the WHO has identified peripartum and postpartum disorders as a significant global bur-den, which affects approximately 6% of the total world population. Furthermore, researchers have confirmed that sex hormones affect the neurochemistry that influences emotions and mood states, although a specific biological mechanism explaining hormonal involvement has not been identified. Although sex hormone changes have been suggested to contribute to the increased rate of depression among women there has been little research supporting this contention. Although some women do become depressed during periods of hormonal change (e.g., puberty, premenstrual period of menstrual cycle, menopause and postpartum period), it appears that these depressive episodes are not the result of the direct effects of hormonal changes on mood. Moreover, depression during these periods of women's lives cannot account for the disparity of lifetime prevalence rates of depression among women (Nolen-Hoeksema, 2001).

Stressful life events

A plethora of research in depression has consistently found that the rate of depression rises dramatically in adolescence and, starting early in adolescence (after the age of 13 years), more girls than boys become depressed (Hammen, 2005). Notably, the chronological age at which the rate of depression doubles for girls compared with boys also marks the time of puberty development. In fact, pubertal development predicts the emergence of the gender difference in depression better than age alone, and girls who pass through puberty early are at the greatest risk of

developing depression Hankin et al; 2001.

What happens around puberty that may account for the general rise in depression in girls? Prior research has found differences in the kinds of stressful life events that typically occur in different age groups, and such stressful life events have been linked to the onset of depression. Specifically, preadolescents most frequently report family events, adolescents report interpersonal, peer-related events, and young adults report academic/achievement events. Studies that have examined gender differences in stressful life events in adolescence have found that girls report more interpersonal (especially peer-related) stressors than boys, whereas boys report more negative academic and school-related events (Angold, 1998). Other research has shown that early maturing girls choose more antisocial, deviant peers for friends compared with on-time or later-maturing girls, and associating with these more deviant peers may lead to the occurrence of a greater frequency of life stressors (Cyranowsk, 2000). In addition, starting around the age of 8 years and persisting into young adulthood, Caucasian girls show less satisfaction with their physical appearance than do boys. Moreover, adolescent girls express dissatisfaction with their body shape and weight even when they are within the normal weight range for their height. Finally, early maturing girls are at higher risk for negative perceptions of their body image and weight compared with peers who mature on time.

Another stressful life event that has been directly implicated in the development of depression is childhood maltreatment and abuse. Childhood trauma is particularly relevant as girls are substantially more likely to be exposed to childhood sexual abuse and assault than are boys

(Rhodes, 2006).

Unfortunately, the increased rate of stressful life events for females continues into adulthood, with a number of specific stressful life events being noted to occur in greater frequency for adult women. For instance, women are substantially more likely to be victims of traumatic stress such as sexual abuse and assault than are men. Although chronic stressors have received less empirical attention than acute stressors, women also appear to be more affected by chronic stress than men. These chronic stress conditions include single parenting, chronic health conditions, and caring for elderly and ill relatives. Importantly, all of these chronic stressors have also been linked to depression. Poverty is another significant chronic stressor experienced more frequently by women than men. Low socioeconomic status is also associated with a number of other related stressors such as poor access to healthcare, social isolation, poor nutrition and increased risk of victimization (Spiege, 2003). Not surprisingly, poverty has also been found to be predictive of depression.

Women's greater exposure to both acute and chronic stressful life experiences has biological consequences that further increase a woman's risk for depression. That is, research indicates that highly stressful conditions produce abnormalities in hypothalamatic–pituitary–adrenal (HPA) activity, such as changes in cortisol levels. Moreover, chronic stress may result in a hypersecretion of cortisol, possibly leading to hippocampal atrophy due to neural death. Abnormalities in HPA axis functioning have been speculated to play a critical role in the development of an initial depressive episode, as well as relapse of the disorder. Thus, women's repeated exposure to stress throughout their lifespan may have

direct biological consequences that contribute to the increased rate of depression among women.

Behavioral genetics

Although women experience stressful life events more frequently than men, it is unlikely that stressful life events alone lead to depression. In fact, a large number of people are resilient in the face of highly stressful life experiences. Therefore, there must be other factors that are at least partially responsible for the increased risk of depression among women. Indeed, in recent years there has been emerging evidence that the development of depression is best accounted for by a transactional model of biological vulnerability and stressful life events (Marcus, 2005). That is, behavioral genetics research has documented that the risk of depression after a stressful life event is elevated among people who are at high genetic risk, whereas the risk is diminished among people who are at low genetic risk. A recent prospective, longitudinal study by Caspi and colleagues examined whether specific genes exacerbate or buffer the effects of stressful life events on depression. These investigators found that individuals with one or two copies of the short allele of the 5-hydroxytryptamine (5-HT) gene-linked polymorphic region (*5-HTTLPR*) were significantly more likely to exhibit clinical depression in relation to stressful life events compared with individuals homozygous for the long allele. In addition, Caspi and colleagues found that as the number of stressful life events increased (especially beyond four events), the risk for depression also increased, although this was only the case among those

individuals with the short allele of the *5-HTTLPR*. Importantly, these findings were subsequently replicated by Kendler and colleague.

Taken together, these findings underscore the importance of considering both genetic and environmental factors when attempting to account for the development of depression. It is important to note that the study by Caspi and colleagues did not find any gender differences in genotype frequency, and this finding is consistent with other studies. Unfortunately, Caspi and colleagues did not examine whether men and women differed in the frequency of stressful life events. However, as noted previously, other studies have reported gender differences in frequency (and severity) of stressful life events, with women experiencing a significantly greater number and more severe stressful life events compared with men (Hotopf, 2002).

In summary, the development of depression appears to be best accounted for by a transactional model of a genetic vulnerability in combination with the occurrence of environmental factors, such as stressful life events. Environmental factors such as stressful life events may increase the occurrence of depression in women. Of course, there are many other possible environmental factors that probably contribute to the development and maintenance of depression in women that have not yet been identified.

2.5 Gender Differences in the Symptom Presentation of Depression

Women are more likely to report their depressive symptoms to others and to seek help from healthcare providers compared with men. In contrast, men are more likely to cope with the symptoms of depression by engaging in alcohol and substance abuse. However, epidemiological studies conducted with community samples indicate that women's greater frequency in reporting depression symptoms does not account for their increased prevalence rate of depression.

It is important to note that when both men and women do present for treatment of their depression, they most often present to medical healthcare providers rather than presenting to mental healthcare providers, and this is also the case for patients who present with depression without medical comorbidity. As the prevalence rate for depression in medical patients is higher than the general population, and depression comorbidity is associated with increased mortality among the medically ill, it has been recommended that healthcare providers routinely screen for depression. However, it should be noted that there is disagreement regarding whether practitioners should routinely screen for depression. Distinguishing the symptoms of depression from symptoms associated with a medical condition can often be a difficult task due to symptom overlap (e.g., sleep disturbances or weight loss/gain). However, depression is most readily detected in medically ill patients by the presence of cognitive symptoms (e.g., feelings of worthless, suicidal ideation, feelings of guilt and/or depressed mood) that cause the patient undue distress. Although there has been a suggestion that patients should

be routinely screened for depression in primary care, such screening only improves patient outcome when it is accompanied by notifying the patient of this screening and when the screening changes the provider's behavior (treatment approach). Moreover, there is some evidence that routine screening for depression is only cost effective for specific groups, such as older adults with diabetes Katon et al; 2005.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Study Area

The study will take place in Ijebu Ode Local Government. Ijebu-Ode is a town in Ogun State, South-West Nigeria, close to the A121 highway. The city is located 110 km by road north-east of Lagos; it is within 100 km of the Atlantic Ocean in the eastern part of Ogun State and possesses a warm tropical climate.

3.2 Research Design

A descriptive correlation cross sectional research design will be use in this study, to detect the prevalence, causes and traditional management of depression and incidence of situations, complete descriptions of phenomena, and to identify relationships between variables. Correlation design would be use for the evaluation of relationships and associations among the variables within the study (Polit and Beck, 2014).

3.3 Population of the Study

A population can be defined as any group or objects which are similar in one or more ways and which forms the subject of study in a particular survey (Hassan 2009).

The target population for this study will be base on married women in Ijebu Ode Local Government Area.

3.4 Sample and Sampling Techniques

The Sample for this study will be selected through Simple random sampling techniques. The sample for this study will consist of six (6) selected parts of Ijebu-Ode which include Imepe, Folagbade, Olisa, Ondo-Road, Emuren, and Mobalufon. A total of one hundred and twenty (120) married women in Ijebu-Ode Local Government Area of Ogun State will participate in this study. It would be difficult to cover the entire local government.

3.5 Research Instrument

The instrument that will be used in the collection and gathering of data include questionnaire.

The research instrument to be used is titled “prevalence, causes and traditional management of depression among female gender”.

The questionnaire will be in two parts A and B. Part A will elicit information of demographic and socioeconomic features of respondents. Part B will comprise of items base on the topic.

3.6 Validity of the Instrument

The instrument will be given to the project supervisor to evaluate the strength of the instrument in measuring adequately the area specify. The supervisor will check the entire questionnaire items and make adjustments where necessary.

3.7 Procedure for Data Collection

The questionnaire will be administered to the respondents personally by the researcher.

3.8 Method of Data Analysis

The data collected from this study will properly be analyze, interpreted and discussed through the uses of simple percentage method.

CHAPTER FOUR
DATA PRESENTATION AND ANALYSIS

4.1 Introduction

In this chapter, effort was made to present and analyze the facts gathered from the respondents. The data presentation and description were guided by the research questions, which were first stated, after which the data collected with regard to each of the questions were descriptively analyzed in tabular form. One hundred and twenty (120) questionnaires were distributed to the respondents and were filled and returned. The researcher used the one hundred and twenty questionnaires for the analysis. The researcher also used simple percentage in analyzing the data.

Section A: Demographic Presentation

Table 1: Respondents Distribution by Age

Age	No of Respondent	Percentage
10-14	0	0
15-19	6	05
20-24	10	8.33
25-29	20	16.7
30-34	36	30
35-39	28	23.3
40-44	10	8.3
45-49	5	4.2

50 and above	5	4.2
Total	**120**	**100%**

The table 1 above revealed that 30-34years of the age group had higher frequency with the population of the respondents observed.

Table 2: Respondents Distribution by Religion

Religion	**No of Respondents**	**Percentage**
Christian	52	43.3
Muslim	48	40
Tradition	20	16.7
None	-	-
Total	**120**	**100%**

From the table above, Christian were the majority of the respondents that participated in the research.

Table 3: Respondents Distribution by Marital Status

Marital Status	**No of Respondents**	**Percentage**
Married	39	32.5
Single	16	13.3
Divorce	22	18.3
Widow	43	35.8
Total	**120**	**100%**

The table above revealed that the majority of the respondents with higher frequency were widow.

Table 4: Respondents Distribution by Type of Marriage

Types of marriage	**No of Respondents**	**Percentage**
Monogamy	38	31.7
Polygamy	77	64.2
Other/not married	5	4.1
Total	**120**	**100%**

Table 4 above shows that 64.2% of the respondents which have higher frequency are from polygamy family.

Table 5: Respondents Distribution by Level of Education

Level of education	**No of Respondents**	**Percentage**
O'level	5	4.2
NCE/OND	55	45.8
HND/BSC	41	34.2
PHD	19	15.8
Total	**120**	**100%**

The above table establishes that the respondents who have high frequency are NCE/OND holder follow by HND/Bsc.

Table 6: Distribution by Occupation

Occupation	No of Respondents	Percentage
Lecturing	5	4.2
Teaching	28	23.3
Medical practicing	19	15.8
Civil service	12	10
Trading	17	14.2
Retired	0	0
Housewife	39	32.5
Total	**120**	**100%**

The analysis from the table above revealed that majority of the respondents was full housewife.

SECTION B

Table 7: Are you living together with your spouse?

Option	No of respondent	Percentage
Yes	73	60.8
No	47	39.2
Total	**120**	**100%**

Table 7 above indicates that 60.8% of the respondents said they are living together with their spouse.

Table 8: How many children do you have?

Option	No of Respondent	Percentage
0	18	15
1-2	30	25
3-4	59	49.2
5-6	10	8.2
7 and Above	3	2.5
Total	**120**	**100%**

The table above establish that 49.2% of the respondents said they have 3-4 children, with this depression are likely to occur.

Table 9: Do you have male children

Option	No of Respondent	Percentage
Yes	61	50.8
No	59	49.2
Total	**120**	**100%**

Analysis from the table above revealed that respondents with higher percentage said they have male children.

Table 10: How well are you treated by your husband?

Option	**No of Respondent**	**Percentage**
Very well	62	51.7
Averagely well	37	30.8
Poorly	21	17.5
Total	**120**	**100%**

The table above revealed that most of the respondents with 51.7% said they are treated very well by their husband.

Table 11: Is your husband not enough to provide for your needs?

Option	**No of Respondent**	**Percentage**
Yes	65	54.2
No	55	45.8
Total	**120**	**100%**

Table 11 above shows that 54.2% of the respondents said they their husband provided their needs.

Table 12: How intimate are you to your husband?

Option	**No of Respondent**	**Percentage**
Intimate	49	40.8
Very Intimate	46	38.30
Not Intimate	25	20.8
Total	**120**	**100%**

The table above revealed that 40.8% of the respondents said they are intimate to their husband.

Table 13: How many intimate friends do you have?

Option	**No of Respondent**	**Percentage**
1	10	8.3
2	57	47.5
3	43	35.8
None	11	8.4
Total	**120**	**100%**

Table 13 above shows that 47.5% of the respondents which have high frequency have 2 intimate friends.

Table 14: Are you satisfied with your present life style

Option	**No of Respondent**	**Percentage**
Yes	65	54.2
No	55	45.8
Total	**120**	**100%**

The table above revealed that 54.2% of the respondents said they are satisfied with their present life style while 45.8% of the respondents said they are not satisfied.

Table 15: Are you having loss of appetite?

Option	**No of Respondent**	**Percentage**
Yes	84	70
No	36	30
Total	**120**	**100%**

The table above revealed that most of the respondents which have higher percentage said they loss appetite due to depression they have.

Table 16: Are you having Suicidal thought?

Option	**No of Respondent**	**Percentage**
Yes	63	52.5
No	57	47.5
Total	**120**	**100%**

The table above revealed that majority of the respondents 52.5% said they have suicidal thought when they have deep thought.

Table 17: Do you think you are experiencing depression?

Option	**No of Respondent**	**Percentage**
Yes	73	60.8
No	28	23.3
I don't know	19	15.8
Total	**120**	**100%**

Tables 17 above establish that 60.8% of the respondents said they observed that they are experiencing depression.

Table 18: How do you experience depression?

Option	**No of Respondent**	**Percentage**
Always	22	18.33
Sometimes	88	73.33
Not at all	10	8.33
Total	**120**	**100%**

The table above revealed that 73.3% of the respondents said they are experiencing depression sometimes when they are experiencing difficulty.

Table 19: What are the likely risk factor for your depression?

Option	**No of Respondent**	**Percentage**
Loneliness	51	42.5
Poverty	20	16.7
Failure	7	5.80
Disappointment	6	5
Marital challenge	32	26.7
Other (Bareness)	4	3.30
Total	**120**	**100%**

Table 19 above shows that the respondents with highest frequency said loneliness, poverty and marital challenges are the major causes of depression.

Table 20: Are you feeling helpless or helplessness

Option	**No of Respondent**	**Percentage**
Yes	78	63.3
No	44	36.7
Total	**120**	**100%**

The table above revealed that they are helpless which cause depression.

Table 21: Are you feeling fatigued, sluggish and physically drained

Option	**No of Respondent**	**Percentage**
Yes	72	60
No	48	40
Total	**120**	**100%**

Table 21 above revealed that 60% of the respondents said they usually feel fatigued, sluggish and physically drained when they are depressed.

Table 22: Are you having concentration problem?

Option	**No of Respondent**	**Percentage**
Yes	48	40
No	72	60
Total	**120**	**100%**

From the table above, out of the total number of the respondents 60% affirm that they have concentration problem when they are depressed. Consequently, there is high prevalence of depression leading to high burdens in the minds of families' friends and society at large.

Table 23: Are you facing problem with making decisions

Option	**No of Respondent**	**Percentage**
Yes	55	45.8
No	65	54.2
Total	**120**	**100%**

From the table 23 above, 54.2% of the respondents said they are facing problem when making decision.

Table 24: Have you been diagnosed by medical doctor for depression?

Option	No of Respondent	Percentage
Yes	77	64.2
No	43	35.8
Total	**120**	**100%**

The table above revealed that respondents with highest percentage 64.2% said they have been diagnosed with depression.

Table 25: What do you do when you feel depressed?

Option	No of Respondent	Percentage
Watch TV	54	45
Listen to music	29	24.2
Take a walk	18	15
Talk to someone	15	12.5
Others (play with friend)	4	3.3
Total	**120**	**100%**

Results from the table above indicates that majority of the respondents said they watch TV and listen to music when they are depressed.

Table 26: What method do you use in treating your depression?

Option	**No of Respondent**	**Percentage**
Traditional	46	38.3
Medical/orthodox	64	53.3
Combine	10	8.3
Total	**120**	**100%**

Table 26 above revealed that 53.3% of the respondents said they used medical/orthodox for the treatment of depression.

Table 27 How often do you take your medication?

Option	**No of Respondent**	**Percentage**
Daily	69	57.5
Twice in a day	31	25.8
Weekly	20	16.7
Total	**120**	**100%**

From the table above, it shows that 57.5% of the respondents said they make use of their medication everyday to solve the problem of their depression.

4.3 Discussion of Findings

The finding of this research revealed that depression is more common among the female gender, which was significant, agrees with other studies that have shown depression and depressive symptoms to be more prevalent in the female gender (Adler, McLaughlin, Rogers, Chang, and Lapitsky, 2006). Some other studies find that mental disorders in general, depression included, occur more in women, while some others show men with a greater prevalence (Yusuf and Adeoye 2012).

The findings also revealed that 30-34years of the age group had higher frequency which is 30% responded to the questions. Higher prevalence of depression has also been reported among women who have lost husbands by being widowed, divorced or separated. Absence of someone to confide in is a vulnerability factor to depression while marriage has been reported to have a protective effect on depression. In this study, the observations were not significant.

CHAPTER FIVE

5.1 Summary

This research focused on the prevalence, causes and traditional management of depression among female gender in Ijebu Ode, Local Government Area, Ogun State. Research questions relating to the study were formulated and the questionnaire leading to data collection was administered.

Also, previous literature on related concepts were reviewed the third chapter of the study dealt with the research design and methodology used for the collection of data and opinion from respondents and the system of analyzing the data for the research work. The fourth chapter consists of the presentation of the data collected, the analysis of data, the data was also interpreted in this same chapter.

5.2 Conclusion

Depression is a common mental disorder that causes human distress and large costs to society. Depression tends to adversely impact individual's quality of life. Female gender are likely to suffer from depression than their males counterpart. Psychosocial factors were reviewed to have a significant role in perpetuating and precipitating depressive illness; traumatic/stressful life events being the most prevalent factor followed by low socioeconomic status, financial issues, social failure, and serious or chronic illness.

The causes of depression can vary greatly from person to person. It is a great challenge for clinical practice in the recognition and treatment of depression, particularly when there are barriers in getting the appropriate support, e.g., time constraints in primary care, a strong social stigma attached to mental illness and discrimination. The foundation for policymakers, clinicians, and researchers to develop effective strategies for managing depression. Clinical interventions that target disordered eating, ways to cope in a more social setting, interpersonal effectiveness, body image dissatisfaction, and experience of stigma, may be useful in treating and preventing depression, given that they appear to be consistent risk factors.

Women living with depression have a multitude of medical, psychological and social problems. They do not live in isolation but as integral members of their communities. Although in the current study defaulting with psychotherapy appointments was common, this must not be interpreted as patients not requiring or wanting help. Perhaps this suggests that a different kind of help is needed and not what has been traditionally provided or structured along the expectation and perceptions of present mental health providers.

Many African women are single, heads of households, with young dependent children and who lack actual and perceived support. It should also be remembered that they return to a social context within which depression is increasingly prevalent. Community based organisations such as churches should increasingly provide support to these women. Depression in women begins from an early age and it is essential that

preventative strategies should begin at school, among children and adolescents.

Even though it might be difficult to improve their social circumstances, it might be helpful to provide them with appropriate interventions to improve self-confidence and enhance self-esteem at the early stages of development that are crucial to later healthy functioning. Skill building, stress reduction, problem solving techniques, and psycho-education may be a more appropriate approaches or alternatives to consider.

5.3 Recommendations

There is a need for more community based studies in order to assess the magnitude of depression which is one of the major public health problems.

There is need to improve depression counselling skills in the training of counsellors as well as develop culturally relevant psychometric scale that would reveal other hidden symptoms of depression in clients.

Successful treatment of major depressive disorder should starts with a thorough assessment of the patient.

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DEPARTMENT OF BIOLOGY

Dear Respondents,

The purpose of this questionnaire is to find out the prevalence, causes and traditional management of depression among female gender in Ijebu Ode Local Government. I therefore, solicit for your honest response. I promise that your responses will be treated with utmost confidentiality.

Thank you.

Section A (Socio-Demographic Data of the Respondent)

Instruction: Please mark appropriate option (✓) as applicable to your views.

Age Group: 10– 14 ( ) 15 -19 ( ) 20-24 ( ) 25-29 ( ) 30-34 ( ) 35-39 ( ) 40-44( ) 45-49( ) 50 and above ( )

Religion: Christian ( ) Muslim ( ) Traditional worshiper ( ) none ( )

Marital Status: Married ( ) Single ( ) Divorce ( ) Widow ( )

Type of Marriage: Monogamy ( ) Polygamy ( ) Other Specify…….

Level of Education: O'level ( ) NCE/OND ( ) HND/Bsc ( ) Phd ( )

Occupation: Lecturing ( ) Teaching ( ) Medical Practitioning ( ) Civil service ( ) Trading ( ) Retired ( ) House wife ( )

Geographical Area:…….

Section B

1. Are you living together with your spouse? Yes ( ) No ( )
2. How many children do you have? 0 ( ) 1-2 ( ) 3-4 ( ) 5-6 ( ) 7above ( )
3. Do you have male child? Yes ( ) No ( )
4. How well are you treated by your husband? Very well ( ) averagely well ( ) poorly ( )
5. Is your husband rich enough to provide for your needs? Yes ( ) No ( )
6. How intimate are you to your husband? Intimate ( ) Very intimate ( ) Not intimate ( )
7. How many intimate friends do you have? 1( ) 2 ( ) 3 ( ) none ( )
8. Are you satisfied with your present life style? Yes ( ) No ( )
9. Are you afraid of anything? Yes ( ) No ( )
10. Are you are having a loss of appetite? Yes ( ) No
11. Are you are having suicidal thoughts? Yes ( ) No
12. Are you feeling that everything you have done has been a failure? Yes ( ) No ( )
13. Do you think you are experiencing depression? Yes ( ) No ( ) I don't know ( )
14. How long do you experience depression? Always ( ) Sometimes ( ) Not at all ( )

15. What are the likely risk factor of your depression? Loneliness ( ) Poverty ( ) Failure ( ) Disappointment ( ) Marital challenge ( ) Other (specify) _____
16. Are you feeling helpless and hopelessness? Yes ( ) No ( )
17. Have you lost your ability to feel joy and pleasure? Yes ( ) No ( )
18. Are you feeling agaited, restless, or even violent? Yes ( ) No ( )
19. Are you having strong feelings or worthlessness or guilt? Yes ( ) No ( )
20. Are you feeling fatigued, sluggish and physically drained? Yes ( ) No ( )
21. Are you having concentration problem? Yes ( ) No ( )
22. Are you facing problem with making decisions? Yes ( ) No ( )
23. Have you been diagnosed by a medical doctor for depression? Yes ( ) No ( )
24. What do you do when you feel depressed? Watch films/TV ( ) listen to music ( ) Take a walk ( ) Talk to someone ( ) Others (specify)_____
25. What methods do you use in treating your depression? Traditional ( ) Medical/orthodox ( ) Combined ( )
26. If medical, can you specify the drugs?_____
27. If traditional, can you specify the plant(s) preparation and usage _____
28. How often do you take your medication? Daily ( ) Twice in a day ( ) Weekly ( )