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Original Research Article

The influence of family function and structure on depression in middle aged women

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ABSTRACT

Background: Depression is both a mood disorder and a chronic illness of public health importance that accounts for a great socioeconomic burden worldwide. The family influences the health beliefs and health related behavior and it is supposed to provide emotional, financial, physical and emotional support during this period. Aim of the study was to assess the influence of family function and structure on depression in middle-aged women.
Methods: The study was a descriptive cross-sectional hospital-based study. Three hundred and two (302) middle-aged women were recruited by simple random sampling method. Relevant data were collected using pretested interviewer administered questionnaire that incorporated family structure, family APGAR and major depression inventory (MDI).
Results: More than half (56%) of the participants had a functional family, 66.2% of them were in a monogamous marriage while 64.7% were from a nuclear family. The prevalence of depression was 5.3%; 31.3% of these were from functional family while 68.7% were from dysfunctional family. There was a significant association between family functionality, spousal characteristics such as wife beating and spousal alcohol use with depression.
Conclusions: The prevalence of depression was low amongst married middle-aged women currently living with their spouses while no relationship was noted between family structure and depression. Family assessment especially family functionality is highly recommended in assessing depression.

Keywords: Depression, Family function, Family structure, Middle-aged women

INTRODUCTION

Depression is a major public health problem with a great socioeconomic burden worldwide.[1] It is strongly associated with higher utilization of health resources, poor social functioning and quality of life.[2] Depression is a mood disorder that is associated with different symptoms which tend to last for more than two weeks and can occur with or without a history of manic, hypomania episode or mixed.[3,4] Mood disorders are common and in most recent survey depressive disorder has the highest lifetime prevalence of about 17% of all psychiatric disorder.[4]

According to United Nation world health statistics report depression was responsible for 4.5% of the total burden of disease and the lifetime prevalence of depression is 10%-15%.[3,5] Mood disorders have a 12-month prevalence

which varies from 3% in Japan to over 9% in the US.[5] In Nigeria, the lifetime prevalence of major depression was 3.3%.[2]

A patient suffering from depression will usually experience at least four symptoms from a list that includes changes in appetite, weight gain, changes in sleep activity, lack of energy, feeling of guilt, recurring thoughts of death or suicide and problems with thinking and making decisions.[4] Some of the symptoms also seen in women with depression include failure to maintain good looks and appearance; neglect of spouse, children or even pets; loss of interesting at work or career or in a favorite hobby or television program; irregular menstruation; negative comments and complaining; mood swings; loss of self-esteem; excessive crying and lack of sexual desire.[6]

Depression among the middle age women has become a serious public health issue as it is a significant cause of morbidity and disability. The unique manifestations and multi-factorial etiology of middle age depression makes it difficult to recognize and treat. Furthermore, the symptoms of depression may overlap with those associated with menopause, there by presenting a clinical dilemma for health professionals involved with women's health.[7] The impact of gender roles, family and caring responsibilities can impact on women coping capacities and the development of depression related illness.

Majority of Nigerians believed in the family and they live in the nuclear or extended families and maintain a traditional role where the father is the bread winner and the mother is the home maker.[8] The family as a unit of care has great influence on mode of transmission of communicable diseases, health behaviours, resource utilization as well as health and illness definition.[9] Family members particularly a spouse, appear to be the most important source of social support and account for most of the association between social support and health.[10] Family supports are crucial in the recovery and return to well-being of a depressed individual.[10]

A functional family is characterized by emotional closeness, warmth, support and security. It also includes good and consistent communication, age appropriate expectations as well as stimulating and educational interactions.[11] Standard expectations in a normal functional family include provision of support to each other, establishment of interdependence to enhance personal growth of each member, creation of rules that govern the conduct of each member, adaptation to change and interpersonal communication.[11] A functioning family is therefore a critical consideration in family-based care of depressed patients.

This study therefore, aimed to assess the effect of family function and structure on depression in middle-aged women and to determine the family factors that could influence depression. This information can be used to improve the current approaches to management of this group of patients in family practice and other clinical settings.

METHODS

Study area

The study was conducted at the general outpatient clinic (GOPC) of federal medical centre, (FMC) Owo, Ondo State, Nigeria. The GOPC offers comprehensive health care to adult patients and it is run by Family Physicians and family medicine residents in training. An average of 100 patients receives treatment daily at the clinic.

Owo is located in the South-Western part of Nigeria, in Owo local government area of Ondo State, with an estimated population of 237,400.[12] Farming constitutes the main occupation of the people.

Study design

The is a descriptive cross-sectional hospital-based study

Target population

The target populations were the middle-aged (45-64 years) women attending general out-patient clinic of FMC, Owo, Ondo-state. The inclusion criteria were middle-aged (45-64 years) women who are currently married and who gave informed consent while the exclusion criteria were middle-aged women with severe psychotic ailment or cognitive problems such as mental retardation.

Sample size determination

The sample size was determined using the formula for estimation of proportion.[13]

$$n = \frac{Z^2Pq}{d^2}$$

Where n=desired sample size. Z=Standard normal deviate corresponding to 5% level of significant=1.96, P=proportion in the target population estimated to have a particular characteristic. The prevalence of 25% for depression from a previous study was used.[14] P=25%, =0.25 was used. q=proportion of middle-aged women without depression (1-0.25=0.75). d=degree of accuracy desired or maximum allowable margin of error. This has been estimated to be 0.05.

Based on the above information the sample size (n) for this study was arrived thus

$$n = \frac{1.96^2 \times 0.25 \times 0.75}{0.05^2}$$

=288

Adding 5% for non-response, a total of three hundred and two (302) was obtained.

Ethical consideration

Ethical clearance registration number FMC/OW/380/VOL.XVII/175 was obtained from the ethics and research committee of the federal medical centre, Owo, Ondo State. Detailed but simple information about the research was provided to each respondent and written consent was obtained before recruitment.

Sampling method

A systematic random sampling method was used in selecting the study samples from amongst those who met the inclusion criteria. The study lasted for a period of three months (September 2021 to November 2021). An average of 70 middle aged women are seen in the clinic weekly, this translates to a sample frame of about eight hundred and forty patients over a three months period. Using systematic random sampling, a sample interval of one in three was obtained (sample frame/sample size 840/302=2.78). Hence every third patient was recruited into the study.

Data collection instrument and procedure

Pretest: Prior to commencement of the study, the questionnaire was administered on 30 patients that met the inclusion criteria attending State specialist hospital, Akure, Ondo-State. This was to help determine the acceptability and clarity (or ambiguity) of the instrument items and identify logistic problems.

Data collection procedure

Patients were directly interviewed on clinic days using a semi-structured interviewer administered questionnaire at the GOPC before consultation at a private room dedicated for this study.

The questionnaire was categorized into four sections: Section A was on socio-demographic data which includes age, sex, marital status, level of education, occupation, ethnicity, and parity. Section B was on personal and family information such as family structure and characteristics. Section C was on family APGAR (an acronym for adaptability, partnership, growth, affection and resolve) scoring tool for assessing family functioning while Section D focused on MDI.

The family APGAR consists of five questions: adaptability, partnership, growth, affection and resolve and has a score ranging from 0-4 for each parameter and a total minimum obtainable score of 0 and maximum obtainable score of 20. The higher the score, the higher the level of perceived family function. A score of $\geq$15 was considered a functional family while <15 was considered a dysfunctional family. Respondents were scored as follows: 15-20 points=highly functional, 9-14 points=mildly functional, and 0-8 points=dysfunctional. The family APGAR has good reliability and validity. The Cronbach's alpha value of the family APGAR was 85% and an item-to-total correlation was 65%.

The MDI is a self-report mood questionnaire developed by the world health organization.[15] The MDI contains 10 items and each of the 10 items is scored from 0 to 5 thereby making the minimum total score 0 and the maximum total score 50.[15] MDI total score of $\geq$20 is depression.

Data analysis

Data was analysed using SPSS for Windows software version 22. Means and standard deviations, proportions and percentages were determined as appropriate. Test of associations between categorical variables was done using the Chi-squared test or Fisher's exact test as applicable and 95% confidence intervals (CI) were documented for those with significant association. Probability (*p*) values were used as measures of significance with values less than 0.05 accepted as statistically significant.

RESULTS

A total of three hundred and two middle aged women were recruited into the study. Table 1 showed the distribution of the socio-demographic characteristics of the respondents. The age ranges between 45 and 64 years with a mean age of 52.08±5.29 years. Majority, 113 (37.4%) of the respondent were in the age groups of 45-49 years. Amongst the respondents, 229 (75.8%) were from Owo and its environs. Majority of the respondents were Christian (89.4%). Most of the respondents were of the Yoruba ethnicity (81.1%). The respondents who were traders was 140 (46.4%) and 32 (30.5%) of respondents were civil servant. More than half of the respondents (60.9%) had been married for more than 25 years.

Table 2 shows the family structure of the respondents. More than half of the respondents (66.2%) were from a monogamous family and about two-third of the respondent (64.9%) have a nuclear family structure. About half, 152 (50.4%) had about 4 household members (HM) while only 27 (8.9%) had more than 8 household members. More than half, 169 (56.0%) of the respondent had a functional family while only 52 (17.2%) of the respondents had dysfunctional family.

The socio-demographic characteristic of the spouses of the respondents is shown in Table 3 Most of their spouses 159 (52.6%) were more than 60years old, less than half 141 (46.7%) of them had tertiary education while only 21 (7%) had no formal education. Less than half of the spouses of the respondents 138 (45.7%) were self-employed. Slightly over a quarter 78 (25.8%) of respondents reported that their spouses drink alcohol but

only 25 (8.3%) of them drink alcohol excessively. A high percentage, 186 (61.6%) of the respondents reported that their husbands were not faithful to them while only 35 (11.6%) of the respondents have been beaten by their spouses before

Figure 1 showed that amongst the respondent, 16 (5.3%) were depressed. Table 4 revealed the association between socio-demographic characteristics and depression. It shows that age, level of the education, current employment status, years of the marriage and monthly income had no statistically significant association with the depression.

Table 5 showed the association between family and spousal characteristics and depression. Family functionality (p=0.047), beaten by spouse (p=0.001), spouse alcohol us (p=0.023), and spouse drink alcohol excessively (p=0.013) had a statistically significant association with depression among the respondents.

Table 1: Socio-demographic characteristics of the respondents.

Variables	Frequency	Percentage (%)
Age group (In years)		
45-49	113	37.4
50-54	90	29.8
55-59	61	20.2
60-64	38	12.6
Place of residence		
Owo	228	75.6
Akure	42	13.9
Akoko	24	7.9
Ekiti	4	1.3
Others*	4	1.3
Religion		
Christianity	270	89.4
Islam	32	10.6
Ethnic group		
Yoruba	245	81.1
Igbo	29	9.6
Others	28	9.3
Educational status		
No formal education	30	9.9
Primary school	78	25.8
Junior secondary	30	9.9
Senior secondary	29	9.7
Tertiary	135	44.7
Occupation		
Trading	140	46.4
Civil servant	92	30.5
Teaching	45	14.9
Farming	12	4.0
Unemployed	13	4.2
Duration of marriage (In years)		
$\leq$ 25	118	39.1
>25	184	60.9

Other* Edo 3.3%, Urhobo 1.7 %, Hausa 2%, Ibira 1%, Igala 0.7%, Efik 0.7%, Ishan 0.7%, Itsekiri 0.3%.

Table 2: Family structure of the respondents.

Variables	Frequency	Percentage (%)
Type of family		
Monogamous	200	66.2
Polygamous	102	33.8
Structure of family type		
Nuclear	196	64.9
Extended	106	35.1

Continued.

Variables	Frequency	Percentage (%)
Household population		
1-4	152	50.4
5-8	123	40.7
> 8	27	8.9
Perceived family function		
Functional	169	56.0
Mildly functional	81	26.8
dysfunctional	52	17.2

Table 3: Socio-demographic characteristics of spouses of respondents.

Variables	Frequency	Percentage (%)
Age of spouse (In years)		
≤60	143	47.4
>60	159	52.6
Educational status		
No formal education	21	7.0
Primary	58	19.2
Secondary	56	18.5
Post-secondary	26	8.6
Tertiary	141	46.7
Employment status		
Self employed	138	45.7
Government employed	102	33.8
Private employed	9	3.0
Retired	35	11.5
Unemployed	18	6.0
Spouse drink alcohol		
Yes	78	25.8
No	224	74.2
Spouse drink excessively		
Yes	25	8.3
No	277	91.7
Spouse smoke cigarette		
Yes	23	7.6
No	279	92.4
Is spouse faithful to you		
Yes	186	61.6
No	116	38.4
Spouse has beaten you		
Yes	35	11.6
No	267	88.4

Table 4: Association between the socio-demographic characteristics of the respondent and depression.

Variables	Depressed, N (%)		χ^2	P value
	Yes	No		
Age of respondent (In years)				
45-54	12 (5.9)	191 (94.1)	0.464	0.496
55-64	4 (4.0)	95 (96)		
Level of education				
Secondary and below	12 (7.2)	155 (92.8)	2.692	0.081
Tertiary	4 (3)	131 (97)		
Current employment status				
Unemployed	1 (7.7)	12 (92.30)	0.694	0.514
Employed	15 (5.2)	274 (94.8)		

Continued.

Variables	Depressed, N (%)		χ^2	P value
	Yes	No		
Years of marriage (In years)				
≤25	7 (7.4)	87 (92.6)	0.262	0.275
>25	9 (4.3)	199 (95.7)		
Monthly income (In Naira)				
≤18,000	13 (5.2)	239 (94.8)	0.004	0.950
>18,000	2 (5.4)	35 (94.6)		

Table 5: Association of family and spouse characteristics and depression.

Variables	Depressed, N (%)		χ^2	P value
	Yes	No		
Family functionality				
Dysfunctional	11 (8.1)	124 (91.9)	3.953	0.047
Functional	5 (3)	162 (97)		
Family structure				
Monogamous	10 (5)	190 (95)	0.105	0.746
Polygamous	6 (5.9)	96 (94.1)		
Sexually active				
Yes	10 (5)	190 (95)	0.105	0.746
No	6 (5.9)	96 (94.1)		
Have a child				
No	1 (9.1)	10 (90.9)	0.327	0.597
Yes	15 (5.2)	276 (94.7)		
Menopause				
Menopausal	4 (3)	130 (97)	2.568	0.109
Not menopausal	12 (7.1)	156 (92.9)		
Spouse faithful				
Yes	9 (4.8)	177 (95.2)	0.204	0.652
No	7 (6)	109 (94)		
Beaten by spouse				
Yes	6 (17.1)	29 (82.9)	11.070	0.001
No	10 (3.7)	257 (96.3)		
Spouse alcohol use				
Yes	8 (10.3)	70 (89.7)	5.153	0.023
No	8 (3.6)	216 (96.4)		
Spouse drink alcohol excessively				
Yes	4 (16)	21 (84)	6.222	0.013
No	12 (4.3)	265 (95.7)		

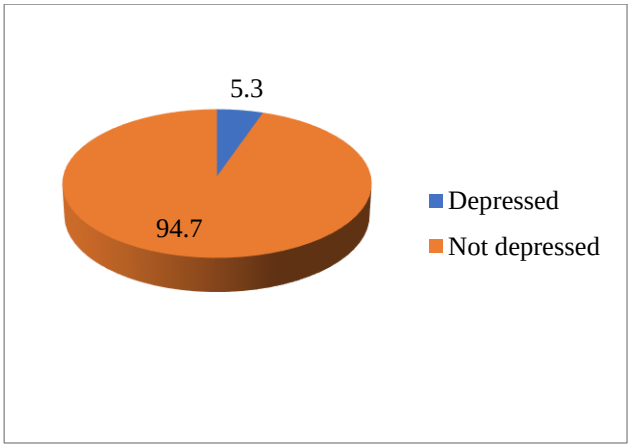

Figure 1: The prevalence of depression among the respondents.

DISCUSSION

This study was designed to determine the influence of family function and structure on depression in middle aged women. The mean age of the respondents for this study was 52.08±5.29 years this was similar other study[16] where the mean age was 55.9±8.0 years. The middle age is the bridge between adulthood and old age, during this period there are some physical, social changes and some psychological changes like fear of losing control, dependence on others, cessations of menopause, and lack of sexual desire.[17]

This present study showed that majority (95.7%) of the respondents were gainfully employed and about half (50.4%) were self-employed. Studies have shown that African women make about 70% contribution to the

economy.[16] According to the United Nations food and agricultural organization, women in Africa are responsible for 70% of crop production, 50% of animal husbandry and 60% of marketing; and also undertake nearly 100% of food processing activities in addition to child care and other responsibilities in the households.[18]

About two thirds (66.2%) of the respondents from this study were in monogamous marriages with 64.9% from the nuclear family type. This differs from findings in a community-based study which revealed over half (56.2%) of the subjects were in a monogamous relationship.[19] The difference was because the present study was a hospital-based study which has the tendency to attract the more educated segment of the society while the other study was community-based study. Similarly, these present-day African families are imbibing the western culture where an individual is committed to those of his immediate family only and this is clearly seen in this present study.

In this study, 5.3% of the respondents had depression and this was different from a longitudinal, multiethnic, multisite community-based study which revealed the prevalence of depression across different ethnic group-Hispanic (43.0%), African America (27.4%), white (22.2%), Chinese (14.3%), and Japanese (14.1%) middle aged women.[20] Similarly, a study in Australia revealed the prevalence of depression for middle aged women to vary from 9.2% to 24%.[21] The difference in the prevalence of depression could be that the women in western countries had good health-seeking behaviour so this could have accounted for higher prevalence rate. The difference could also be due to cultural differences. Also, this present study was a hospital-based study while the multisite study was a community-based study which could actually be encompassing, meaning that so many unreported cases of depression could exist in the community.

The prevalence of depression of 5.3% in this study is lower than what was reported in Bayelsa, Nigeria where the prevalence of depression was 22.0%.[22] The difference in the reported prevalence could be because this present study was a prospective study while the study in Bayelsa was a retrospective one and therefore, there could be some incomplete information from the case files and not be a good reflection of the actual prevalence. Also, the present study included middle age women with a mean age of 52.08 years whereas the study in Bayelsa included women of reproductive age with a mean age of 35.5 years and women in the reproductive age group have other factors like post-natal depression that could have accounted for the increased prevalence.

This study revealed significant association between depression and spouse's excessive alcohol use. Alcohol is believed to impair judgment and inability to address conflicts constructively because of the effects of alcohol on cognitive functioning and problem-solving. The alcoholic partner may also engage in highly provocative or aggressive behaviour without thinking of the consequences of his action. This was similar to the findings by Patel et al where he showed notable association between husband's habits and common mental disorders in the women.[23] This was contrary to what was reported by Gupta et al who found no significant association between spousal alcohol consumption and depression at the household level but found woman's own alcohol use as a great influence.[24]

From this study, 56.0% had a functional family which was lower than 64.0% reported in another study by Odue et al.[25] The difference in the prevalence could be because this present study included only middle-aged women while the study by Odue et al included both male and female adult. This present study also found an association between family functionality and depression. The support outside the home cannot compensate for what is missing in the family.[8] Family members especially the spouse has been found to be the most important source of social support and accounts for most of the association between social support and health.[9]

A case control study conducted in Uganda by Muhwez et al showed that there was no significant difference between depressed and non-depressed patients on family dynamics which included family size, family structure, presence or number of children.[26] This was similar to findings from this present study. However, it was also noted that a greater proportion of depressed subjects were from a nuclear monogamous setting than the polygamous setting which was also similar to findings from this study.[26] Other observations from this study included no significant difference between depression and social parameters such as level of education, current employment status, years of marriage, sexual activity and presence or sex of a child. This agrees with findings from a study by Obadeji et al who did not observe any statistically significant association between depression and employment status, educational attainments and average monthly income.[27]

The limitation of this study was recurring bias as women don't like to talk about their sexuality and bias might have been introduced by conducting the survey at the clinic where the participants receive their medical care also this study is a hospital-based study therefore the inference drawn from the result may not be generalized to the target population.

In conclusion, there is a low prevalence of depression amongst married middle-aged women who are currently living with their spouses and the family functionality, spouses' habit and been beaten are risk factors for depression. However, family structure does not influence depression among middle-aged women. This therefore, calls for more attention on the functionality of the family so as to have mentally stable women in the society. The health care providers should consider assessing family function when signs of depression are present and refer

for family counseling. Doctors should be trained on skills to carry out appropriate family assessment which could be a pointer to depression in middle-aged women.

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