REALITY ORIENTATION APPROACH IN THE REDUCTION OF SYMPTOMS OF DEPRESSION AMONG WOMEN IN THE COMMUNITY MENTAL HEALTH CENTER, ARO-ABEOKUTA, OGUN STATE, NIGERIA

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Abstract

This study investigated reality orientation in the reduction of symptoms of depression among women in community mental health center, Aro-Abeokuta. Eighty (80) women whom were discharged temporarily from psychiatric hospital Aro-Abeokuta to community mental health center for further observation participated in this study. Depression symptoms questionnaire (DSQ) developed by the investigator was the instrument used to collect data for the study. The posttest outcome confirmed that reality orientation approach could lead to reduction in the symptoms of depression among women and enhanced well being of the subjects.

Keywords: Reality Orientation, Symptoms of Depression, Women, Community Health Centre

1. Introduction

Women are two times more likely than men to suffer from depression and the way women experience depression is often different than it is for men according to mental health association (2003). Approximately 12 million women in the united experienced clinical depression and about one in every eight women can expect to develop clinical depression during their lifetimes.

Report from American physiological association (2005) had it that women are about twice as likely as men to suffer from depression. This two-to-one difference persists across racial, ethnic, economic divides. In fact, the gender difference in rate of depression is found in most countries around the world. There are a number of theories, which attempt to explain the higher incidence of depression in women, many factors have been implicated including, biological, psychological, and social factors (Brener 1998).

2. Review of Literature

2.1 Biological Factors

i. Premenstrual problems: Hormonal fluctuation during the menstrual cycle can cause the familiar symptoms or premenstrual syndrome (PMS) such as bloating, irritability, fatigue, and emotional reactivity. For many women, PMS is mild but for some women, symptoms are severe enough to disrupt their lives and a diagnosis of premenstrual dysphonic disorder (PMDD) is made.

ii. Pregnancy and infertility: The many hormonal changes that occur during pregnancy can contribute to depression, particularly in women already at high risk. Other issues relating to pregnancy such as miscarriage, unwanted pregnancy and infertility can also play a role in depression.

iii. Postpartum depression: Many new mothers experience the 'baby blues'. This is a normal reaction that tend to subside within a few weeks. However, some women experience, severe, lasting depression. The condition is known a postpartum depression. Postpartum depression is believed to be influenced, at least in part by hormonal fluctuations.

iv. Perimenopause and menopause: Women may be at increased risk for depression during perimenopause, the stage leading to menopause when reproductive hormones rapidly fluctuate. Womenwith past histories of depression during menopause as well.

2.1.1. Social and Cultural Factors

i. **Role strain:** Women often suffer form role strain over conflicting and overwhelming responsibilities in their life. The more roles a woman is expected to play (mother, wife, working woman), the more vulnerable she is to role strain and subsequent stress and depression. Depression is more common in women who receive little help with housework and childcare. Single mothers are particularly at risk. Research indicates that single mothers are three times more likely than married mothers to experience an episode of major depression (Wethington and Kessier 1999).

ii. **Unequal power and status:** Women's relative lack of power and status in our society may lead to feeling of hopelessness. This sense of hopelessness puts women at greater risk of depression. These feelings may be provoked by discrimination in the workplace leading to underemployment. Low socio economic status is a risk factor for major depression.

Another contributing factors is society's emphasis on youth, beauty and thinness in women, traits which to a large extent are out of their control (Rosenfield 1990).

iii. **Sexual and physical abuse:** Sexual and physical abuse may play a role in depression in women. Girls are much more likely to be sexually abused than boys, and researchers have found that sexual abuse in childhood puts one at increased risk of depression in adulthood. (Kupler 1991). Higher rates of depression are found in victims of rape, a crime almost exclusively committed against women (Caton, Rutter, Ludman 2001). Other common forms of abuse including physical abuse and sexual harassment which may also contribute to depression.

iv. **Dissatisfaction with marital relationship:** While rates of depression are lower for the married than for the single and divorced, the benefits of marriage and its general contribution to well-being are greater for men than for women. Furthermore, the benefits disappear entirely for women whose marital satisfaction is low. Lack of intimacy and marital strife are linked to depression in women.

v. **Poverty:** Poverty is more common among women than men. Single mothers have the highest rates of poverty across all demographic groups (Lewis 2001) poverty is a severe, chronic stress that can lead to depression.

2.1.2. Psychological Factors

i. **Coping Mechanism:** Women are more likely to ruminate when they are depressed. This includes crying to relieve emotional tension, trying to figure out why individual is depressed, and talking to friends about it. However, rumination has been found to maintain depression and even make it worse (Beck and Beck 1997) men, on the other hand, tend to distract themselves when they are depressed. Unlike rumination, distraction can reduce depression.

ii. **Stress Response:** According to psychology today, women are more likely than men to develop depression under lower levels of stress. Furthermore, the female physiological response to stress is different. Women produce more stress hormones than men do, and the female sex hormone progesterone prevents the stress hormone system form turning itself off as it does in men.

iii. **Puberty and Body Image:** The gender difference in depression begins in adolescence. The emergence of sex differences during puberty is likely to play a role. Some researchers point to body dissatisfaction which increase in girls during the sexual

development of puberty (Katon, Von Korflin 1995). Body image is closely lined to self esteem in women, and low self-esteem is a risk factor for depression.

2.1.3. Symptoms of depression in women

The symptoms of depression in women are the same as those for major depression. Common complaint includes:

- Depressed mood
- Loss of interest or pleasure in activities used to enjoy
- Feelings of guilt, hopelessness and worthlessness
- Suicidal thoughts or recurrent thoughts of death
- Appetite and weight changes
- Difficulty concentrating
- Lack of energy and fatigue

Although the signs and symptoms of depression are the same for both men and women, women tend to experience certain symptoms more often than men. For example, women are more likely to experience the symptoms of a typical depression. In a typical depression, rather than sleeping less, eating less, and loosing weight, the opposite is observed sleeping excessively, eating more (especially carbohydrates), and gaining weight. Feeling of guilt associate with depression are also more prevalent and pronounced in women. Women also have a higher incidence of thyroid problems.

2.1.4. Objectives

- This paper intends to utilize reality orientation approach to reduce the symptoms of depression among women in community mental health centre, Aro Abeokuta.
- The purpose of this research is to engage the depressed women in structural programme to revitalize and reactivate them in their various daily activities.
- To modify their behaviour by assisting them to increase desirable behaviours and decrease undesirable behaviours.

3. Research hypothesis

The following null hypothesis were formulated and tested and 0.05

level of significant.

Ho1: Women exposed to reality orientation will not differ significantly from their counterparts in the control group' in the reduction of symptoms of depression.

Ho2: Women from high socio-economic background will not differ significantly from their counterparts from low socio-economic background in their level of reduction of symptoms of depression.

Ho3: Married and single women will not be significantly different in their reduction of symptoms of depression.

4. Methodology

4.1. Design

The research design employed in the study is experimental. A 2x2 factorial design was adopted. It consists of one treatment technique reality orientation and the control in the row. The columns are represented by depressed women, temporarily discharged from psychiatric hospital to community mental health center Aro Abeokuta for further observation.

4.1.1. Sample

The sample for the study consisted of 80 depressed women. Their age range was between 32 and 64 years with mean age of 48 years. Out of the 80 participants 56 (70%) were from high socio-economic background 24(30%) were from low 60(75%) were married and 20(25%) were single.

4.1.2. Instrument

Depression symptoms questionnaire (DSQ) developed by the author was the only instrument used for the collection of data for the study. The scale contains 25 items based on a four-point rating scale. It has two sections, Section A consist of the demographic information such as age, socio-economic status, marital status, town of origin, occupation, educational background and so on.

Section B consists of items in the questionnaire eliciting on formation of symptoms of depression. The questions in the section aimed at finding out what are those things that institute depression in women. Questions were also asked on the symptoms of depression as experienced by the participants. A test retest reliability of the instrument was established

within two week interval using 15 depressed women at University College Hospital (UCH) Ibadan to test run the measuring instrument. The test-retest yielded a correlation coefficient of 0.68 and adequate content validity.

4.1.3. Procedure

The treatment group was exposed to reality orientation approach.The focus of reality orientation sessions were on concepts of reality orientation approach, remotivation, habit training techniques, problem solving skills, reduction of negative thinking and training in stress reduction techniques. The session ran for eight weeks. Participants met once a week spending one hour per session. The participants were given a pre-treatment questionnaire. The sessions were as follows:

Session One: General briefing on the purpose of the programme

Session Two: Explanation of meaning of reality orientation

Session Three: Discussion of remotivation i.e. structural programmes to revitalize and reactivate the depressed women to daily activities

Session Four: Training in habit modification to increase appropriate behavior or decrease poor behaviours

Session Five: Discussion of problem solving skills such as assertiveness, patience etc

Session Six: Training in reduction of negative thinking by re directing thinking process to positive and pleasurable things

Session Seven: Training in stress reduction techniques such as regular aerobic exercise, relaxation techniques and other strategies to reduce stress symptoms.

Session Eight: General review, rehearsal, and role play of the reality orientation approach activities. Post test measures were also administered on the experimental group.

4.1.4. Follow-Up

Six weeks after completion of treatment programmes, the participants were given the depression symptoms questionnaire (DSQ) the result of which indicated that treatment was effective.

4.1.5 Control Group

The participants in this group took part in the pretest assessment and meetings. They also participated in the post treatment assessment even though they were not exposed to any treatment.

4.1.6. Data Analysis

The data collected on this study were statistically analysed todetermine the effects of the independent variable (realityorientation approach) on the dependent variable (depression). Theanalysis of covariance (ANCOVA) was used to analyze the data.This statistical method was used because it is capable ofcomparing the pre-test and post-test measures.

5. The Results of Hypotheses Testing

The results from the data analysis are presented hypothesis by hypothesis. The first question investigates the level of reduction of symptoms of depression between the subjects exposed to treatment and the control group.

Table 1: Post-treatment Comparison of Subjects Exposed to Reality Orientation Approach and the Control Group using ANCOVA

Source of variation	df	SS	MS	r-ratio Obs	F-ratio crit	Test decision
Between group	3	78036.73	26012.5			
Within group	76	15931.14	204.2	125.7	2.72	Reject Ho
Total	79	93967.87				

Critical value F(3,76) = 125.7, P>0.05

The finding as presented in table 1 reflected the computed outcome pre and post treatment details of the subjects so investigated. According to the results the critical value of F(3,76) = 125.7 with P>0.05 indicated that there was statistical significant difference in the treatment outcome of subjects exposed to reality orientation approach and the control group.

Table 2: Post-treatment Comparison of Subjects from high and low socio-economic background Exposed to treatment using ANCOVA

Source of variation	df	SS	MS	r-ratio Obs	F-ratio crit	Test decision
Between group	3	39968.11	13322.7			
Within group	76	5922.76	70.3	193.68	2.72	Reject Ho

Total	79	45990.87				

Critical value F(3,76) = 193.68, P>0.05

In table 2, the compared computed pre-post treatment out come of subjects form high and low socio-economic background exposed to treatment showed that there was statistical significant difference following the alpha level of 0.05.

The findings revealed that the critical value of F(3,760 = 193.68 with P>0.05 evidently failed to support the predicted null hypothesis.

Table 3: Pre Post-treatment Comparison of Subjects of married and single subjects exposed to reality orientation approach using ANCOVA

Source of variation	**df**	**SS**	**MS**	**r-ratio Obs**	**F-ratio crit**	**Test decision**
Between group	3	67319.3	22439.7			
Within group	76	22892.7	301.3	73.17	2.72	Reject Ho
Total	79	90211.10				

Critical value F(3,76) = 73.17, P>0.05

Table 3 represents the outcome of the computed pre and post treatment details among the married and the single subjects exposed to reality orientation approach. The findings as could be inferred indicated that there was statistical significant difference in the results obtained contrary to the predicted null hypothesis. Consequently, therefore, the null hypothesis was rejected.

6.Discussion

The major finding of the study is that reality orientation approach is effective in reducing the symptoms of depression among the women in the community mental health center. The result of hypothesis one showed the superiority of reality orientation approach over the control group. Subjects form high socio- economic background also demonstrated superior depression symptoms reduction than their counterparts form low socio-economic home. Again, the results of the study indicated that married subjects had their depression symptoms reducing than their single subjects counterpart.

The result agrees with the work of Wethington&Kessier (1999) who found that single mothers are particularly at risk perhaps three times more likely than their married mothers to experience an episode of major depression.

This study also lends support to the findings of Beck and Beck (1997) that women are more likely to ruminate when they are depressed. This includes crying to relieve emotional tension, trying to figure out why individual is depressed and talking to friends about it.

The result from the study is therefore very useful in accounting for the potential in the use of reality orientation approach by the women and others to reduce their symptoms of depression as well as improving on their emotional states. An important point to be noted here is that reality orientation approach is dynamic in nature whatever form it takes it involves self-observation, and monitoring of emotional state of mind. It also involves gathering and making use of basic information geared to orient resident to individual's current life. The use of both self observation and frequency chart makes this approach helpful to the subjects. Infact it allows the subjects to pay attention to their daily manifestation of signs and symptoms of depression and how this could affect their well being.

6.1. Conclusion

We have frequently observed depressive states in women which are atimes misdiagnosed by therapists. The capacity in which individual experience sadness and depression is common to all people. Although there is no question that depression can be provoked by adverse circumstances, women are more liable to experience depression than men who are subjected to similar degree of adversity.

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