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QUALITY OF LIFE AND GENDER-DIFFERENCE AMONG PATIENTS WITH LATE-LIFE DEPRESSION ATTENDING PSYCHOGERIATRIC CLINIC IN TERTIARY NEURO-PSYCHIATRIC HOSPITAL, SOUTHWEST, NIGERIA

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ABSTRACT: *This study investigates quality of life (QoL) and gender differences among patients with late-life depression (LLD) attending the Psychogeriatric clinic in the Neuropsychiatric Hospital, Southwest, Nigeria. Using a descriptive cross-sectional design, 98 participants were selected. Data were collected between June and September 2024, using the World Health Organization quality of life scale (WHOQOLs)-brief and the Satisfaction with Life scale (SWLs). The findings reveal that majority 82 (83.7%) were 70 years and above, 40 (40.8%) were males and 58 (59.2%) were females. 35 (87.5%) males and 38 (65.5%) females had moderate (40.2) satisfaction on Physical health domain, also 33 (82.5%) male and 44 (75.9%) female on psychological health, (59.1), 32 (80.0%) of male and 44 (75.9%) females 'a little' satisfaction (40.0) on socio-economic, 25 (62.5%) male and 35 (60.3%) female 'neutral' (19.8) to environmental health. On satisfaction with life, 19 (47.5%) male and 27 (46.6%) female 'slightly agreed' (scored 23). Gender of patients had a significant impact on their physical health satisfaction levels ($\chi 2 = 8.78$, $p < 0.05$), but no significant effect on other domains. The study concludes that there is need for public health sensitization on gender-ageing and disease conditions especially LLD.*

KEYWORDS: Gender-difference, Late-Life Depression, Neuropsychiatric, Psychogeriatric, Quality of Life, Southwest-Nigeria.

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INTRODUCTION

Late-life depression (LLD) is a major public health concern globally, representing one of the most prevalent mental disorders among older adults. Evidence consistently demonstrates gender variations in the occurrence and outcomes of LLD, with implications for quality of life and overall well-being (Li et al., 2022; Moreno et al., 2022; Ojeahere et al., 2022; Adewale et al., 2023; Cheung & Mui, 2023; WHO, 2023). According, National Bureau of Statistics (2022), about 133 million Nigerians experience low quality of life which encompassing different levels of poverty, poor health conditions and living standard, unemployment, and insecurity issues with reports that indicate a rising prevalence of LLD which is projected to become one of the highest globally by 2030 (Ojagbemi et al., 2024). Despite this growing burden, there remains a paucity of empirical studies examining the interplay between gender, LLD, and quality of life within the Nigerian context, limiting the development of targeted, gender-sensitive interventions.

The global demographic shift toward an ageing population further exacerbates this challenge. The World Health Organization (2022) estimates that by 2030, one in six individuals worldwide will be aged 60 years and above. This demographic transition is particularly concerning in sub-Saharan Africa, where health systems are often under-resourced and ill-prepared to manage age-related comorbidities, including mental health disorders (Gold et al., 2020; Sialino et al., 2022; Triolo et al., 2023). Nigeria, which currently has the largest elderly population in Africa and ranks 19th globally, is projected to rise to third place by 2050, thereby facing an increased risk of age-associated health challenges such as LLD (Adewale et al., 2023; Mbam et al., 2022; Aina et al., 2023).

Depression, particularly major depressive disorder, is classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a leading cause of disability worldwide. It significantly impairs cognitive, emotional, and functional capacities, thereby diminishing quality of life (Bain & Abdijadid, 2023; WHO, 2023). Among older adults, the impact is often compounded by social isolation, chronic illnesses, and reduced functional independence.

Given these dynamics, understanding the gender-specific patterns and their association with quality of life among individuals with LLD is critical. Such insights are essential for informing contextually relevant interventions aimed at improving mental health outcomes and reducing disability among the ageing population in Nigeria. Therefore, this study seeks to investigate the QOL of patients with LLD and determine whether significant gender differences exist in the various domains of QOL and SWL among affected older adults.

LITERATURE REVIEW

Depression is a major mental health disorder characterized by persistent emotional, cognitive, and functional impairment, and it remains one of the leading causes of disability globally (WHO, 2020; WHO, 2023). Among older adults, depression assumes a distinct clinical form known as late-life depression (LLD), defined as major depressive episodes occurring from the age of 60 years and above (Sekhon et al., 2023; Bains &Abdijadid, 2023). LLD is typically associated with symptoms such as persistent low mood, anhedonia, sleep disturbances, fatigue, and suicidal ideation, which significantly impair quality of life (WHO, 2022).

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Conceptualization and Types of Depression

Depression is classified using diagnostic frameworks such as the DSM-5 and ICD-11, encompassing various subtypes including major depressive disorder, persistent depressive disorder, bipolar disorder, and atypical depression (Bains &Abdijadid, 2023). Of particular relevance to this study is major depressive disorder, which becomes LLD when first diagnosed in older adulthood. This form is often complicated by comorbid medical conditions and psychosocial stressors, making its management more complex (Szymkowicz et al., 2023).

The etiology of LLD is multifactorial, involving biological, psychological, and social determinants. Biologically, chronic illnesses such as hypertension, diabetes, stroke, and cancer significantly increase vulnerability to depression in older adults (Szymkowicz et al., 2023). Age-related cognitive decline and genetic predisposition also contribute, with heritability estimates ranging between 40–50% (Zhao et al., 2020). Psychosocial factors such as bereavement, loneliness, unemployment, and inadequate social support further exacerbate the risk (Tang et al., 2022; NIHR, 2023). Environmental influences, particularly in low-resource settings, have also been linked to higher prevalence rates, with developing countries reporting significantly higher burdens of LLD compared to developed nations (Zhao et al., 2023).

Prevalence and Gender Differences in LLD

Empirical evidence consistently identifies gender as a key determinant in LLD. Globally, depression is approximately 50% more common among women than men (WHO, 2023). Studies across diverse settings report higher prevalence rates among elderly women, attributed to factors such as longer life expectancy, higher morbidity burden, and greater likelihood of reporting symptoms (Cheung & Mui, 2023; Li et al., 2022). Conversely, depression in men is often underreported due to sociocultural norms that discourage emotional expression, leading to delayed diagnosis and higher suicide rates (Moreno et al., 2022; Staiger et al., 2020). However, some studies indicate higher prevalence among men in specific contexts, highlighting the complexity of gender dynamics in LLD (Paul et al., 2023).

Quality of Life and Life Satisfaction in LLD

Quality of life (QOL) is a multidimensional construct encompassing physical, psychological, social, and environmental domains (Teoli & Bhardwaj, 2023). Depression significantly diminishes QOL by impairing daily functioning, increasing comorbidities, and reducing social engagement (Triolo et al., 2023). Similarly, satisfaction with life (SWL), a subjective evaluation of one's overall well-being, has been strongly linked to depressive symptoms (Gigantesco et al., 2019). Factors such as financial instability, poor health, and weak social networks negatively influence both QOL and SWL, thereby increasing susceptibility to LLD (Malvaso & Kang, 2022). Empirical studies in Nigeria and other low-income settings have reported significantly lower QOL scores among individuals with depression, underscoring the burden of the condition (Ojeahere et al., 2022).

Evidence on LLD and Associated Factors

A growing body of research highlights the association between LLD and socio-demographic, health, and environmental factors. In Asia, studies consistently linked higher rates of LLD to social isolation, living arrangements, and poor access to healthcare services (Chen et al., 2021; Qin et al., 2022) and in Africa, studies conducted in Ethiopia and Ghana reveal that predictors

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such as female gender, chronic diseases and poor social relationship, gender, poor access to treatment are associated with LLD with prevalence report rates ranging from 7.2% to over 50%, depending on context and population characteristics (Kasa et al., 2022). In Northern Nigeria, studies conducted in Plateau and Kano have demonstrated significant associations between LLD, loneliness, female gender, OOL, and widowhood while in South-western, Nigeria, studies associate LLD with socio-demographic variables such as marital status poor QOL, and living conditions (Afolabi et al., 2024; Akinsulore et al., 2020; Ojagbemi & Gureje, 2019; Ojeahere et al., 2022). Despite these findings, there remains a notable gap in research exploring the intersection of gender, QOL, and LLD in the Nigerian context.

Theoretical Underpinning: Biopsychosocial Model

This study was anchored on Biopsychosocial (BPS) Model proposed by George L. Engel (1977). BPS provides a suitable theoretical framework for examining how biological, psychological, and social factors influence quality of life among patients with late-life depression and underscores the need for holistic approaches to its assessment and intervention (Adewale et al., 2023; Anum et al., 2024).

Biologically, physical and cognitive changes due to ageing process or chronic illnesses such as endocrine disorders, cardiovascular diseases, and mobility problems leads to psychological disturbance such as persistently low mood, decreased self-esteem and poor sleep (Maschall, 2023). Psychologically, older adults frequently encounter stressful life events such as retirement, bereavement, declining health, and loss of social roles which may impair emotional well-being, cognitive functioning and life satisfaction, thereby affecting the quality of life negatively (Akinsulore, 2020).

Socially, family support, economic resources, and community participation are very vital to healthy ageing, hence, older adults who experience social isolation, loneliness, poverty, inadequate emotional support, poor living arrangement, and constant financial constraints are at greater risk of developing depression (Xie, 2023). The existing literature substantiates the multifaceted nature of LLD and highlights significant gender differerences, strong associations with quality of life, and the influence of biopsychosocial factors. However, limited context-specific evidence in Nigeria necessitates further investigation on quality of life and gender differences among patients with LLD to inform targeted and gender-sensitive interventions.

Sociocultural and Healthcare Factors Influencing Late-Life Depression

Sociocultural factors play significant roles in determining wellbeing of older individuals.

Socially, older adults often experience social isolation which may result from death of spouses or lifelong companion, and economic dependence, these often lead to persistently low mood and precipitate depression (Donovan & Blazer, 2020). Also, abandonment resulting from urbanization, migration, and changing family structures have weakened support networks, leaving many older adults vulnerable to loneliness and depression (Fiske et al., 2024; United Nations, 2023).

Culturally, LLD is often attributed a normal part of ageing process or supernatural causes such as witchcraft, spiritual attacks, or divine punishment rather than a treatable medical condition, resulting to delayed diagnosis and treatment (World Health Organization [WHO], 2024). Undefined gender roles and seeking behavior are also crucial predictors of depression among

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older adults as unlike women, men are less likely to seek help even though they manifest depressive symptoms because of societal expectations regarding masculinity (WHO, 2025).

Lack of accessibility to mental health services, inadequate healthcare facilities and shortage of mental health professionals also influence prognosis of mental illness among older adults. Older adults living in rural areas often encounter transportation difficulties and financial constraints which may lead to exacerbation of the mental health conditions and delayed treatment (WHO, 2024). Likewise, many mental health care facilities in low-and middle-income countries, including Nigeria, are often underfunded and inadequately covered by health insurance schemes, hence, discouraging help-seeking behaviours (WHO, 2022).

Research gap

In Nigeria, there are few studies on QOL among depressed older adults, scarcity of studies that investigate LLD, QOL, and gender differences simultaneously, and lack of hospital-based studies on gender variations in LLD and QOL. This study addresses the gap by describing the relationship between the quality of life, gender, and LLD among clinical population in Neuropsychiatric hospital, Ogun state.

METHODOLOGY

Study Design and Setting

This study adopted a descriptive cross-sectional research design to assess QOL and SWL among older adults diagnosed with late-life depression (LLD). A descriptive cross-sectional design was considered appropriate because it enabled the researcher to collect data at a single point in time and describe the existing conditions, perceptions, and experiences of the respondents without manipulating any study variables. This design was suitable for examining the physical, psychological, social, and environmental domains of quality of life, as well as the respondents' overall SWL.

The study was conducted at the psychogeriatric clinic of the Federal Neuropsychiatric Hospital (FNPH), Aro, Abeokuta, Ogun State, Nigeria. FNPH is a federal government-owned specialist hospital established to provide mental health services, training, and research in Nigeria. The hospital is one of the foremost neuropsychiatric institutions in the country and serves as a major referral centre for mental and geriatric psychiatric care. Its psychogeriatric clinic provides specialized mental healthcare services to older adults with mental health disorders, making it a suitable setting for this study.

Study Population and Sampling

The target population for this study comprised older adults receiving treatment at the psychogeriatric clinic of FNPH, Aro, Abeokuta. The accessible population consisted of 198 patients diagnosed with mental disorders such as anxiety disorder, schizophrenia, epilepsy, dementia, mania, and late-life depression. However, the study specifically focused on patients aged 60 years and above diagnosed with late-life depression having scored 10-15 points and were receiving treatment at the Psychogeriatric clinic, using a 15-item version of Geriatric Depression Scale (GDS-15) being one of the preferred screening tools in the clinic as it is more focused and specific than the original 30-item version.

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Participants were selected based on clearly defined inclusion and exclusion criteria. Eligible participants were adults aged 60 years and above diagnosed with depression, attending the psychogeriatric clinic, willing to participate, and mentally stable enough to comprehend the research questions and provide coherent responses. Patients with paranoia were excluded from the study due to the possibility of impaired judgment and inability to provide reliable responses.

A purposive sampling technique was employed to recruit respondents for the study. This non-probability sampling method allowed the researcher to deliberately select participants who met the inclusion criteria and have cognitive capability to provide valid information relevant to the study objectives. The researcher adopted total enumeration method due to the limited population hence, involved the entire 98 respondents who were diagnosed with late-life depression for participation to eliminate sampling error.

Data Collection Instrument and Procedure

The researcher adopted the WHOQOL-BREF and the SWLs as the primary instruments for data collection. WHOQOL-BREF is confirmed internationally to have good internal consistency with Cronbach's Alpha ranging between of 0.80 and 0.82 (Gil-Lacruz et al., 2022) and locally to be 0.83 (Nkporbu et al., 2023). It consists of 26 items grouped into four domains comprising physical health, psychological health, social relationships, and environmental health. Responses were measured on a 5-point Likert scale ranging from 1 (“Not at all”) to 5 (“An extreme amount”). Higher scores indicated better quality of life.

Domain scores were calculated by obtaining the mean score of items within each domain according to the WHOQOL-BREF scoring manual (Gil-Lacruz et al., 2022). The resulting scores were interpreted according to WHO standard as 0–20 very poor, 21-40, poor, 41-60, moderate, and 61-100 as good quality of life. The researcher categorized and interpreted 0-60 as poor, and 61-100 as good.

The SWLs is a 5-item instrument developed Diener et al. (1985) to subjectively assess respondents’ cognitive judgment of life satisfaction on 7-point Likert scale ranging from 1 (“Strongly disagree”) to 7 (“Strongly agree”), with higher scores indicating greater satisfaction with life. The instrument has also demonstrated strong psychometric properties and has been widely used among older adults in African settings as well as in Nigeria with reliability coefficients ranging from 0.79 to 0.89, (Aina et al., 2023; Ogunsemi & Adegbayi, 2024).

Respondents who scored between 31 to 35 points were categorized as “strongly agree”, 26 to 30 as “Agree”, 21 to 25 as “Slightly agree”, 20 as “Neutral”, 15 to 19 as “slightly disagree”, 10-14 as “Disagree”, and 5-9 points as “Strongly disagree” to having life satisfaction. The researcher categorized and interpreted “Strongly agree, Agree and Slightly agree” as good and “Strongly disagree, Disagree and Slightly disagree” as poor. Poor level of SWL is an indicator for depression (Atafuah et al., 2021).

Data collection was conducted over three months from June to September 2024. Following ethical approval, the researcher visited the psychogeriatric clinic on designated clinic days to brief health personnel and eligible participants on the purpose of the study. Respondents who met the inclusion criteria and consented to participate were recruited purposively. The questionnaires were administered through face-to-face interaction. Participants who were able to read and write completed the questionnaires under supervision, while those who required assistance were supported by the researcher after an adequate explanation in a language they

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understood. Each questionnaire took approximately 30-40 minutes immediately after which the researcher did on-the-spot check to ensure completion.

Ethical Considerations

Ethical approval for the study was obtained from the Babcock University Health Research Ethics Committee (BUHREC) and the Federal Neuropsychiatric Hospital Health Research Ethics Committee (NHREC/FNPH-HREC/29/82023) before commencement of the study. Permission was also obtained from the management of the study setting.

The study adhered strictly to ethical principles guiding human subject research. Informed consent was obtained from all participants after a detailed explanation of the study objectives, procedures, risks, and benefits in comprehensible language. Participation was voluntary, and respondents were informed of their right to decline participation or withdraw from the study at any point without penalty. Confidentiality and anonymity were ensured by coding questionnaires and excluding identifying information from the data. All information obtained was used strictly for research purposes. The principles of beneficence, non-maleficence, justice, autonomy, veracity, and respect for persons were upheld throughout the study.

Data Analysis

Data collected were coded, entered, and analyzed using the Statistical Package for the Social Sciences (SPSS) version 26. Both descriptive and inferential statistics were employed for data analysis. Descriptive statistics such as frequencies, percentages, means, standard deviations, and ranges were used to summarize respondents' socio-demographic characteristics and study variables. Findings were presented in tables and charts for clarity.

Inferential statistics were used to test relationships among study variables. Chi-square analysis was used to test associations between categorical variables, while correlation and multiple regression analyses were used to determine the relationships and predictive influence of selected variables on quality of life and life satisfaction. Statistical significance was set at $p < 0.05$.

RESULTS

Table 1: Socio-demographic characteristics of respondents

Variable	Response	Frequency (%)
Age group (Years)	65-69 70-74 75-79 80 and above	16(16.3) 47(48.0) 33(33.7) 2(2.0)
Gender	Female Male	58(59.2) 40(40.8)
Religion	Christianity Islam Traditional	64(65.3) 33(33.7) 1(1.0)

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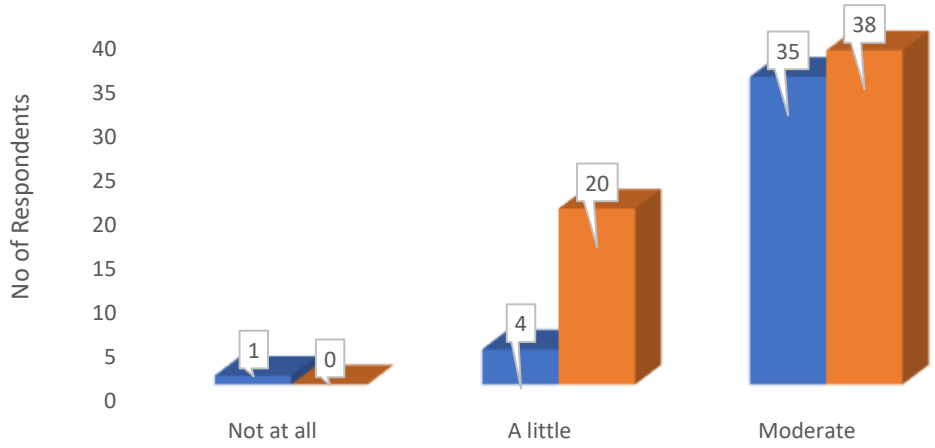
Educational Level	No formal education Primary School Secondary School Tertiary Institution	33(33.7) 28(28.6) 13(13.3) 24(24.5)
Marital Status	Never married/Single Married Separated Divorced Widowed	9(9.2) 7(7.1) 18(18.4) 12(12.2) 52(53.1)
Employment Status	Unemployed Self-employed Retired	18(18.4) 52(53.1) 28(28.6)
Residential Partner	Living alone Living with carer Living with children Living with distant relative Living with spouse	24(24.5) 32(32.7) 9(9.2) 26(26.5) 7(7.1)

As shown in Table 1, the socio-demographic characteristics of 98 participants (n=98) that took part in the study, 58 (59.2%) were females, 40 (40.8%) males. Majority 47(48%) were within 70-74years, 33 (33.7%) were Christians, 33(33.7%) had no formal education, 52 (53.1%) widowed, 52 (53.1%), self-employed and 32 (32.7%) were living with carers.

Figure 1: Physical health domain chart of the male and female genders

Physical Health Domain of the male and female genders



There were *4* males *(10.0%)* and *20* females *(34.5%)* participants with a "little" satisfaction level. Participants with a "Moderate" level of satisfaction with their physical health domain were *35* males *(87.5%)* and *38* females *(65.5%) (Figure 1).*

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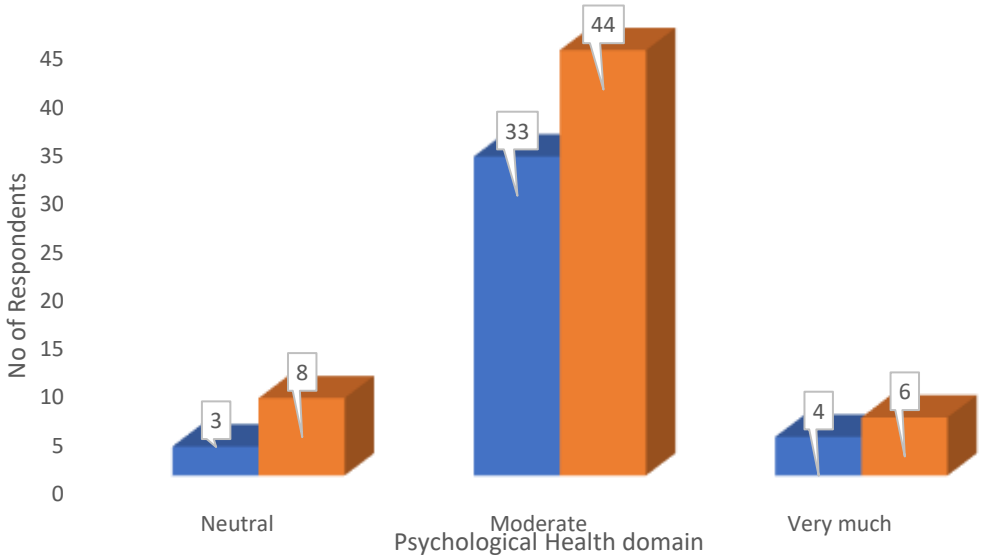
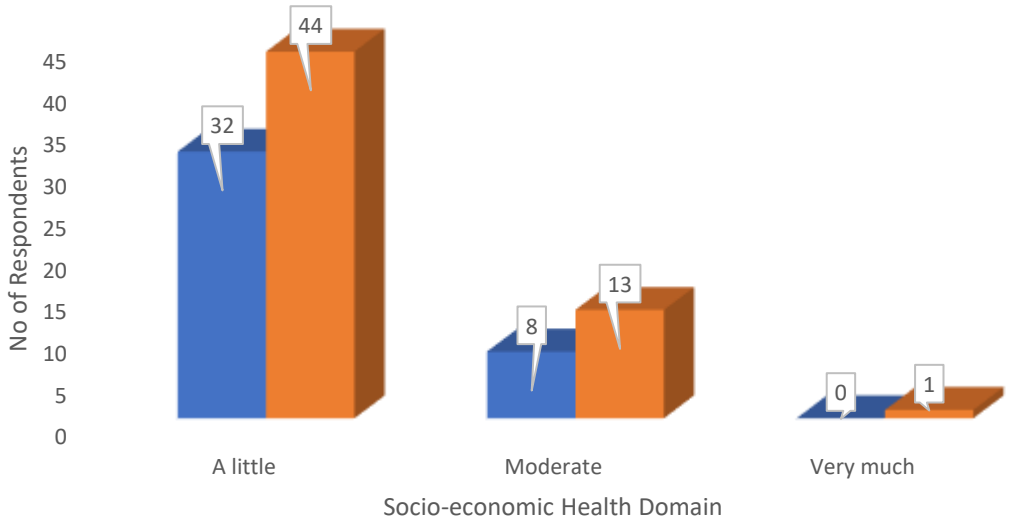
Figure 2: Psychological health domain chart of the male and female genders



It shows that 3 males (7.5%) and 8 females (13.8%) had a "Neutral" opinion about their psychological health. Also, 33 males (82.5%) and 44 females (75.9%) were of a "Moderate" satisfaction level with their psychological health domain (Figure 2).

Figure 3: Socio-economic health domain chart for male and female genders



Majorly 32 (80.0%) of male and 44 (75.9%) of female participants had a "little" satisfaction with their socio-economic level. Again, 8 (20.0%) and 13 (22.4%) out of male and female participants respectively had a "Moderate" satisfaction (Figure 3).

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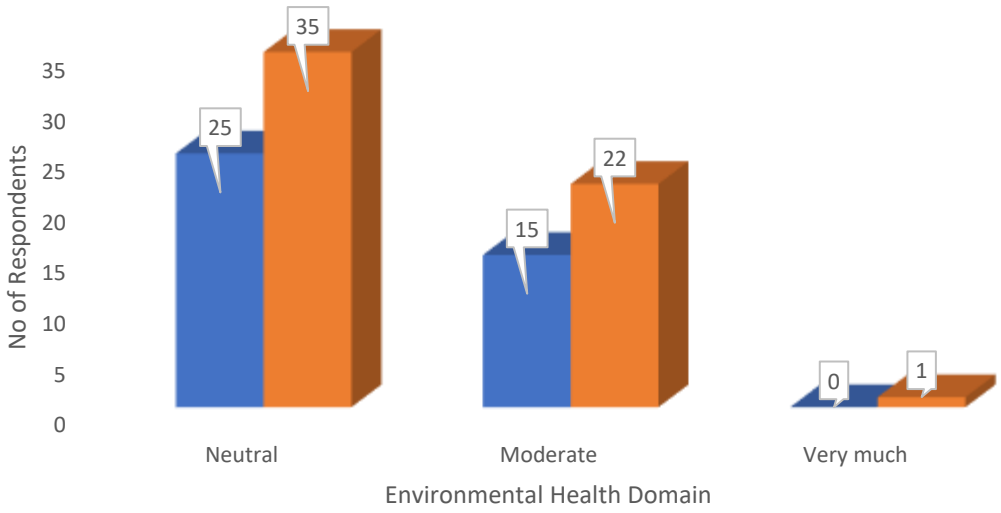
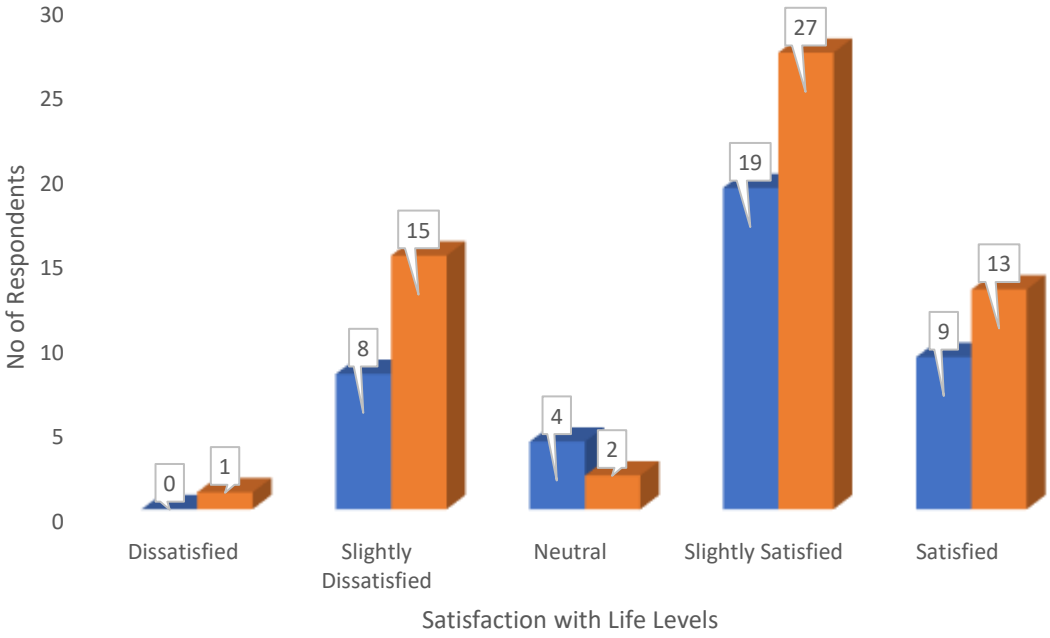
Figure 4: Environmental health domain chart of the male and female gender



Majorly, 25 (62.5%) of male and 35 (60.3%) of female participants had "Neutral" opinion to Environmental health domain, and 15 (37.5%) and 22 (37.9%) out of male and female participants respectively were of "Moderate" satisfaction level.

Figure 5: Satisfaction with life chart of the male and female genders



The numbers of male and female participants who "Slightly dissatisfied with life were 8 (20.0%) and 15 (25.9%) respectively. Also, 4 (10.0%) out of male and 2 (3.4%) out of female participants were of "Neutral", 19 (47.5%) and 27 (46.6%) out of male and female participants respectively "Slightly agree" with Satisfaction with life. Ultimately, 9 (22.5%) and 13 (22.4%) out of male and female participants respectively agreed with Satisfaction with life.

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Table 2: Association of Physical Health domain of quality of life and Gender of Patients

Variables	Physical Health domain			χ^2	df	p-value
	Not at all	A little	Moderate			
Gender				8.780	2	0.012
Male	1(2.5%)	4 (10%)	35 (87.5%)			
Female	0 (0%)	20 (34.5%)	38 (65.5%)			

The table reveals that the gender of patients had a significant impact on their physical health satisfaction levels ($\chi^2 = 8.78$, $p = 0.012$).

Table 3: Association of Psychological Health domain of quality of life and Gender of Patients

Variables	Psychological Health domain			χ^2	df	p-value
	Neutral	Moderate	Very much			
Gender				0.971	2	0.615
Male	3 (7.5%)	33 (82.5%)	4 (10.0%)			
Female	8 (13.8%)	44 (75.9%)	6 (10.3%)			

The table shows that gender of patients had no significant effect on their psychological health domain of quality of life ($\chi^2 = 0.97$, $p = 0.615$).

Table 4: Association of Socio-Economic domain of quality of life and Gender of Patients

Variables	Socio-economic Health domain			χ^2	df	p-value
	A little	Moderate	Very much			
Gender				0.806	2	0.668
Male	32 (80.0%)	8 (20.0%)	0 (0%)			
Female	44 (75.9%)	13 (22.4%)	1(1.7%)			

The table shows that the gender of patients had no significant effect on their socio-economic satisfaction levels of quality of life ($\chi^2 = 0.81$, $p = 0.67$).

Table 5: Association of Environmental Health Satisfaction domain of quality of life and Gender of Patients

Variables	Environmental Health domain			χ^2	Df	p-value
	Neutral	Moderate	Very much			
Gender				0.709	2	0.702
Male	25 (62.5%)	15 (37.5%)	0 (0%)			
Female	35 (60.3%)	22 (37.9%)	1(1.8%)			

The table shows that the gender of patients had no significant effect on their environmental health satisfaction with the quality of life ($\chi^2 = 0.71$, $p = 0.70$).

Table 6: Association of Satisfaction levels with Life and Gender of Patients

Variables	Satisfaction with Life domain					χ^2	df	p-value
	Dissatisfied	Slightly Dissatisfied	Neutral	Slightly Satisfied	Satisfied			
Gender						2.701	4	0.609
Male	0(0%)	8(20.0%)	4(10.0%)	19(47.5%)	9(22.5%)			
Female	1(1.7%)	15(25.9%)	2(3.4%)	27(46.6%)	13(22.4%)			

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The table shows that gender of patients had no significant effect on satisfaction with life (χ^2 =2.70, p = 0.61).

DISCUSSION

Physical health domain

The physical health domain of quality of life of patients attending psychogeriatric clinic of FNPH showed that lower percentage (10%) of male participants indicated dissatisfaction with their physical health condition when compared with women (34.5%) which may be due the fact that women report higher rates of chronic illness while older men are less likely to seek help because of societal expectations regarding masculinity even though they manifest depressive symptoms (WHO, 2025).

Also, this result closely aligns with existing evidence in Ethiopia by Kasa et al. (2022), as well as Paul et al., (2023) which revealed that there was association between chronic physical conditions and LLD. Similarly, a study that was conducted in China during Covid-19 pandemic revealed that there was increase in the prevalence of LLD after Covid-19 pandemic, especially among LLD patients with other chronic diseases such as diabetes (Zhao et al., 2023).

Psychological health domain

Psychological health domain of patients attending psychogeriatric clinic of FNPHA revealed that vast majority of male participants (82.5%) claimed to be moderately satisfied with their psychological health condition compared with three-quarter of female participants (75.9%), however, this is contrary to the findings of study carried out in Korea which revealed association between unpleasant life events such as adverse childhood experiences to development of depression in late life (Lee et al., 2023) although in another study outcome, a significant association was found between stressful life events such as serious illness, injury, financial problems, divorce and gender difference in LLD (Bjordal et al., 2024).

Findings revealed that there was no relationship between impact of life experiences, acceptance of body appearance, perception and satisfaction about self (psychological factor) and gender difference in LLD among patients. This opposed findings, of a recent study carried out in Korean among adult population, that unpleasant life events such as adverse childhood experiences and bereavement were associated with development of depression in late life (Lee et al., 2023).

Socio-economic health domain

Findings from socio-economic health domain of quality of life among patients attending psychogeriatric clinic of FNPH indicated that apparently higher percentage of male participants (80%) had little satisfaction with their socio-economic conditions compared with women (75.9%) while the resonates with a cross-sectional study conducted among Community-dwelling adults in Brazil and Portugal (Torres et al., 2023) it negates the outcome of a study conducted in England which associated low socio-economic position of the elderly and inability to maintain frequent contact with families and friends with LLD (Qin et al., 2022).

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Environmental health domain

Result of environmental health domain of quality of life showed that approximately one-third of men and women (37.5 & 37.9%) claimed to be moderately satisfied with the condition of their environment. Also, there was no relationship between level of satisfaction with environmental condition; perceived safety of physical environment, condition of living, opportunity for leisure activities, availability of healthcare information needed in day-to-day life, access to healthcare facility (environmental health satisfaction) and gender difference in LLD patients. This finding contradicted outcome of Xie et al., (2023) and Chen et al., (2021) studies conducted among elderly people in China which showed that housing environment and living arrangement were significantly associated with depressive symptoms in late life.

Level of satisfaction with life

About one-third of the participants (37.8%) slightly agreed to achieving important things in life. This opposes the outcome of a study conducted among elderly populations in Italy, which showed significant association between life satisfaction and depressive symptoms in both male and female participants (Gigantesco et al., 2019). Likewise, a longitudinal study that was carried out in Korea among elderly people on association between Life Satisfaction and Depression indicated that there was significant relationship (Lee et al., 2023). Also, there was no significant association between satisfaction with; level of achievements in life, sense of fulfillment (satisfaction with life) and gender difference in LLD among patients. This is not in line with the outcome of a study conducted among elderly population out in China which discovered significant association between life satisfaction and depressive symptoms (Chen et al., 2021).

IMPLICATIONS FOR NURSING RESEARCH AND PRACTICE

Implications for Nursing Practice

Holistic Patient Care: Nurses should adopt a comprehensive care approach that addresses the physical, psychological, and social needs of older adults with LLD, rather than focusing solely on symptom management.

Gender-Sensitive Interventions: Given the significant gender difference in physical health, nursing care plans should incorporate gender-specific strategies to improve physical well-being, particularly among female patients.

Routine Screening and Assessment: Regular screening for depression and quality of life indicators using standardized tools such as WHOQOL-BREF and SWLS should be integrated into geriatric care.

Health Education and Counseling: Nurses should provide targeted psychoeducation to patients and caregivers on coping strategies, lifestyle modification, and treatment adherence.

Strengthening Social Support Systems: Considering the high proportion of participants living alone or with non-spousal caregivers, nurses should facilitate community support systems and family involvement in care.

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Implications for Nursing Research

Context-Specific Evidence: The study highlights the need for more Nigerian-based empirical research on LLD, particularly focusing on gender dynamics and quality of life.

Intervention Studies: Future nursing research should explore the effectiveness of tailored psychosocial and behavioral interventions in improving QOL among older adults with LLD.

Longitudinal Studies: There is a need for longitudinal designs to better understand causal relationships and the progression of LLD over time.

Multidisciplinary Research: Collaboration with psychologists, social workers, and public health experts is essential to develop integrated care models.

CONCLUSION

This study examined gender differences in quality of life (QOL) and satisfaction with life among older adults diagnosed with late-life depression (LLD) attending the psychogeriatric clinic at the Federal Neuropsychiatric Hospital, Aro, Abeokuta. The findings revealed that while gender had a statistically significant influence on the physical health domain of quality of life, no significant differences were observed across the psychological, socio-economic, environmental domains, and overall satisfaction with life.

Explicitly, male participants reported relatively higher levels of moderate satisfaction in physical health compared to females, indicating potential gender-related disparities in physical wellbeing among older adults with LLD. Still, the absence of significant gender differences in other domains suggests that LLD exerts a broadly similar impact on psychological wellbeing, social conditions, environmental perceptions, and life satisfaction regardless of gender.

In all, the study showcased the pervasive burden of LLD on multiple dimensions of quality of life among older adults. It also emphasizes the importance of adopting a holistic approach, as proposed by the biopsychosocial model, in understanding and managing LLD. Consequently, failure to adopt a holistic approach in the management of late-life depression can have serious negative impact on older adults' mental health, quality of life, treatment adherence, treatment effectiveness, and prognoses.

FUTURE RESEARCH

Based on the findings and limitations, future studies should adopt longitudinal designs to track changes in quality of life and depression outcomes over time, establishing causality. Expanding sample size and including multiple healthcare settings across Nigeria will improve generalizability.

Also, research should focus on testing gender-sensitive and culturally appropriate interventions aimed at improving physical health and overall well-being. Factors such as income level, cultural beliefs, access to healthcare, and caregiver burden should be examined in relation to LLD.

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Moreso, comparative studies between rural and urban populations or between institutionalized and community-dwelling older adults could provide deeper insights. Incorporating qualitative methods will help capture lived experiences and provide a richer understanding of how LLD affects quality of life.

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