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FAMILY DYSFUNCTION AS PREDICTORS OF DEPRESSION AMONG WOMEN

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ABSTRACT

The study investigated family dysfunction as predictors of depression among women. A total of 107 participants comprising 62 female nurses and 45 female administrative staff were selected making use of available sampling techniques from Federal Neuropsychiatric hospital Enugu were used for the study. Hence, two sets of instruments were used namely; FAD - Family Assessment Device (Epstein, Baldwin & Bishop, 1983); and CES-D - Center Epidemiologic Studies Depression scale (Rudloff, 1977). A cross-sectional design was adopted; while hierarchical multiple regression analysis was applied as a statistic to test the hypothesis that the family dysfunction facet would independently/ jointly predict depression among women. The result revealed that family dysfunction facets accounted for an additional 7.8% ($\Delta R2$= 4.7%) variation in depression and this change in *R2* was not significant, $F(9, 97) = .92$, $p>.05$) and the relationship between variables was not strong enough (R =.28). In addition, the hierarchical multiple regression revealed that educational level, marital status, and age had no significant contribution to the regression model, $F(3, 103) = 1.10$, $p>.05$). However, the relationship between variables was not that strong(R =.18) and accounted for 3.1% ($\Delta R2$=3.1%) of the variance in depression scores. The findings were discussed in relation to the literature reviewed and suggestions made.

Keywords: *Family Dysfunction, Nurses, Depression and Women*

INTRODUCTION

Depression is an important contributor to the global burden disease that affects people of communities all over the world. Psycho-biologically depression is a disorder of motivation that is usually associated with the insufficiency of biogenic amines. Depression is also referred to as a common mental disorder worldwide and a leading cause of disability with debilitating symptoms. According to Moussavi, Chatterji, & Verdes,

(2007), as cited in Hamman et al (2004) around 350 million people suffer from depression globally with reports stating that almost 3.2% of individuals express having a depressive episode at least once in their lives (Costa, Santos, & Santos, 2012). Evidence has shown that the prevalence of depression is higher in dysfunctional families than in the general population.

Depression in adolescents is associated with a variety of environmental stressors, including dysfunctional family, but not limited to divorce, marital conflict, poor quality of relationships with parents, personally stressful life events, and negative peer and social relationships (Birmaher et al., 1996; Lewinsohn & Essau, 2002; Rudolph et al., in press). Additionally, the presence of parental depression is known to be one of the strongest predictors of depression and other psychopathology in offspring (Beardslee et al., 1998). However, due to the considerable overlap between parental depression and stressful family factors, it is difficult to evaluate the contributions of the multiple factors and to disentangle those due to parental depression as such. Numerous studies have examined multiple risk factors in families of depressed women, attesting to the importance of adverse family conditions (Davies & Windle, 1997; Fergusson et al., 1995; Goodman & Gotlib, 1999; Lovejoy et al., 2000; Seifer et al., 1996). Fendrich et al. (1990) as cited in Hamman et al (2004) found that family risk factors (marital adjustment, parent-child discord, low family cohesion, affectionless control, and parental divorce) were more prevalent among families with depressed women. Depressed women have been shown to have marital and relationship dysfunction as well as relatively more conflictual interactions with their children, even when not currently depressed (Hammen & Brennan, 2002; Joiner, 2002; Lovejoy et al., 2000).

Nevertheless, depression is a common mental disorder, characterized by persistent sadness and a loss of interest in activities that one usually enjoys, accompanied by an inability to carry out daily activities, for at least two weeks (World Health Organization, 2015). Also, people with depression often have the following manifestations: a loss of energy; a change in appetite; sleeping more or less; anxiety; reduced concentration; indecisiveness; restlessness; feelings of worthlessness; guilt, or hopelessness and thoughts of self-harm or suicide (World Health Organization, 2015). The symptoms of depression start at an early stage. They either remain persistent or increase at the alarming state, depending

on the exposure to the environment and the potential capacity throughout the life of an individual, (Moussavi, Chatterji, & Verdes, 2007). Globally, the total number of people with depression was estimated to exceed 300 million in 2015 (World Health Organization, 2018). Depression occurs in every age and every country (Ibrahim, Kelly, & Adams, 2013). Depression is ranked by the World Health Organization (WHO) as the single most significant contributor to global disability (7.5% of all years lived with disability in 2015). Depression is also the major contributor to suicide deaths, which went up about 800,000 for each year (World Health Organization, 2017).

Although family discord may come from within the family, such as having a mentally retarded child, lack of funds, inability to have children, lack of satisfying the partner sexually or losing a family member, or from outside the family, such as environmental stressors thereby throwing the family into a state of disorganization when the family is unable to restore their sense of equilibrium or manage their stress, a crisis will emerge resulting to depression (Curran, 1997 & Minnes, 1988).

However, no family is perfect, and you do not get to choose the family you are born into or raised in. There are many reasons, both external and internal, that lead to dysfunctional families. In a normal functional family, there is mutual respect between family members and everyone has each other's back. For dysfunctional families, there is always tension and mistrust amongst the parents and children, and amongst husband and wife, etc. Also, the authority of the parents in the family is often misguided and without accountability. Even amongst adults, there is a certain level of mistrust and resentment. The members do not create a safe surrounding for a child to grow. There is an underlying fear and hurt constantly while growing up. Also, dysfunctional families do not value apology and do not allow for emotions to be expressed reasonably leading to depression. What is more, a family where conflict, neglect, and misbehaviour are constant and everlasting is dysfunctional. According to Nwankwo (2009), modern psychology defines dysfunctional families as those with anxious systems within them. There is a tremendous amount of emotional disturbance within the family members, and it sometimes means that it is coupled with child neglect and abuse. Children from dysfunctional families assume that this situation is normal as they are exposed to that environment regularly and do not know the different aspects of dealing with a dysfunctional family. A family whose

interrelationships serve to detract from, rather than promote, the emotional and physical health and well-being of its members is said to be a dysfunctional family. In a dysfunctional family, children who come from dysfunctional families often have low self-confidence or low self-esteem and grow up thinking that such kind of behaviour is normal. They have some adverse effects of dysfunctional families on child development, Kaslow, (1996).

However, the effects of growing up in a dysfunctional family are enormous. Growing up in a dysfunctional family can largely have negative effects on the children in the family, (Josie et al 2008). The family members of a dysfunctional family tend to accept it to be normal or deny there is a problem in the family, without realizing its damaging effects. Mistrust, anxiety, despises and other negative emotions lead to a very insecure adult. Certain common behaviour patterns can be observed in people who come from a dysfunctional family. They are but not limited to:

1. They have a bad image of self and suffer from a lack of self-confidence and self-esteem.
2. They find it difficult to form healthy adult relationships and are shy or have a personality disorder.
3. They get angry frequently and easily and prefer to be in isolation.
4. In studies, their performance is usually poor as they struggle to concentrate and focus.
5. They exhibit self-harm or self-destructive behaviour.
6. They are prone to addiction to alcohol, drugs, or smoking.
7. They can suffer from serious mental conditions such as depression, suicidal thoughts, anxiety, paranoia, etc.
8. Such people may lack discipline as they do not have a good role model to look up to while growing up and can become irresponsible or destructive.
9. They can also lose their childlike qualities of innocence as they have to take major responsibilities at an early age.

Considering all these factors, it is assumed that women who have dysfunctional families are at a higher risk for added marital stress, for instance, altered relationship with friends and families, major changes in family activities, major changes in physical and psychological wellbeing's, medical concerns, specialized unhealthy happiness, lack of time commitments and intra-family strains.

Behavioural Theory of Depression

This theory emphasizes the organisms' overt behaviours that can be directly observed, recorded, categorized and measured. Thus the theory postulates that both normal and abnormal behaviours can be learnt or unlearned. Specifically, in this study, the focus is on the depressive condition of the participants who are women working in the Federal Neuropsychiatric Hospital Enugu. As the woman struggles to work do they have a dysfunctional family and were they depressed? Studies have been conducted to explore how far a dysfunctional family influences the personality of these women. Watson (1958) asserts that depression results from faulty learning. Considering the fact that women battle with conflicts emanating from the dual responsibilities of a dysfunctional family, could it be inferred that their personality could be affected? This could be how they may have learnt to handle realistically predicting depression. Wetzel (1999) opined that the activity of depressed persons and the feeling of sadness are partly due to the low rate of positive reinforcement and a high rate of unpleasant experiences.

In relation to dysfunctional family life experiences, studies have revealed that there is a significant positive relationship between dysfunctional family life experience and depression. Since in the extant literature, these carried out in non-Igbo culture, revealed that dysfunctional family impact negatively in the personality of women, the present study is not in tandem or did not explore this relationship between in Igbo cultural environment. The purpose of this study was to investigate the family dysfunction facet independently/jointly significantly predict depression among women. It was hypothesized as follows:

1. That family dysfunction facet would not independently/ jointly predict depression among women.

METHOD

Participants

A total of 107 participants comprising 62 female nurses and 45 female administrative staff from Federal Neuropsychiatric hospital Enugu were selected making use of available sampling technique. Their ages ranged between 25 and 60 years. They were all Christians. They possessed various educational qualifications, length of service and different job positions.

Instrument

Two sets of instrument were used for the study:
The Family Assessment Device (MFAD) by Epstein, Baldwin and Bishop (1983), adapted by the researcher and Center for Epidemiologic Studies Depression Scale (CES-D) by Radloff (1977) validated by Okafor (1997) and Ugwu (1998).

The Family Assessment Device (MFAD)

The McMaster Family Assessment Device (MFAD; Epstein, Baldwin, & Bishop, 1983) is a 60-item self-report instrument intended to evaluate several aspects of family relationships based on the McMaster model of family functioning (Epstein, Bishop, Ryan, Miller, & Keitner, 1993). Items are phrased to denote both effective (e.g., "We feel accepted for what we are.") and problematic family functioning (e.g., "We don't get along well together."). Respondents rate how well each statement describes their family; response options include *strongly agree*, *agree*, *disagree*, and *strongly disagree*. Items are reverse scored as needed, such that higher scores indicate poorer family functioning. In addition to a General Functioning Index, the MFAD generates scores on six dimensions (problem solving, communication, roles, affective responsiveness, affective involvement, and behavioral control). Epstein and his colleagues (1983) obtained a cronbach alpha for the different scales as follows: Problem solving .74, communication 75, Roles .72, affective responsiveness 3, affective involvement .37, behaviour control .72, and general functioning, .92. Kreutzer et al, (1994) obtained internal consistencies (alpha = 0.89 and alpha 0.80 respectively) for the six dimensions and the General functioning scale of the American FAD.
The FAD has been translated into fourteen languages with empirical evidence of its utility in different cultures (Qingqing, Lili, & Scott, 2019); Kelin, et al, 2001). It has also been used in over forty research studies (Kreutzer et al, (1994).

The researcher carried out a pilot study to re-establish the validity and reliability of the instrument using Nigerian sample. For purpose of this validation study, 72 female staff of the Enugu State University Science and technology (ESUT), who agreed to participate in the pilot study, had the instrument administered to them in group. The data obtained was analyzed using the SSPS-17. The results showed an internal consistency reliability estimate Chronbach alpha of .92 for the entire scale, with alpha ranging from .44 to .82 for the subscales. A maximum likelihood factor

analysis confirmed the original factors for the first six scales as proposed by Epstein, Baldwin and Bishop (1983). It also shows multiple factors on the General functioning scale as indicated by the authors. The confirmation of the factor loading shows factorial validity of the instrument. The researcher obtained a mean of 2.05 from the scores of the participants. This served as the basis for interpreting the scores for the participants. Hence, participants who scored below 2.05 on the FAD were classified as having functional families while those who scored above 2.05 were classified as having had dysfunctional families.

Center for Epidemiological Studies-Depression Scale (CED-D)

This is a standardized psychological assessment instrument developed by Radloff (1977) and validated for use with Nigerian samples by Okafor (1997) with a reliability index of 0.85, Ugwu (1998) with concurrent validity index of 0.41 and Omeje (2000) with reliability and validity index of 0.85 and 0.92 respectively. The instrument contains 20-items designed to measure symptoms of depression in the general population. The Scale was developed at the American Institute of Marital Health. It is scored on a 4-point scale ranging from 1 (rarely) to 4 (always). But, items 4, 8, 12 and 16 reflect positive outcomes and are scored in the reverse order, for instance rarely (4) to always (1). The remaining 16-items reflect the negative outcome. The participants were instructed to report the frequency with which the 20-items were experienced within the previous 6 months. If any participants scored above 20, that indicated the participant had experienced depression.

Procedure

The permission and cooperation of the Head of Research and Training FNHE Enugu and the staff were solicited and obtained. After establishing a rapport with the participants, assuring them of the confidentiality of their responses, the researcher distributed 150 copies of the two sets of research materials to the participants. Out of these, only 107 were completed correctly, 33 were poorly completed and 10 copies were not recovered. 4 research assistants helped the researcher to collect the data. Participants were told that participating in the study was voluntary and they received no financial or monetary reward for their participation in the study.

Design/Statistics

A cross-sectional design and hierarchical multiple regression statistics were used for data collection and analysis.

RESULTS

Table 1: Summary table of Hierarchical Multiple Regression Model between the Negative Sexual Experience, Facets of Family Dysfunction and Depression among Women.**(N = 107)**

Variable	B	*SEB*	B	*t*	*R*	R^2	ΔR^2
Step 1					.18	.031	.031
Educational Level	-2.43	1.8	-.13	-1.34			
Marital Status	-.99	2.37	-.04	-.42			
Age	2.85	2.44	.11	1.17			
Step 2					.28	.08	.05
Educational Level	-2.87	1.84.	-.16	.35			
Marital Status	.20	2..49	.01	.08			
Age	2.01	2.53	.08	.79			
Family Dysfunction							
Problem Solving	-1.09	.89	-.12	-1.21			
Communication	-1.14	1.19	-.09	-.95			
Roles	.72	.99	.07	.72			
Affective Responsiveness	.53	1.02	.05	.52			
Affective Involvement	-1.61	1.12	-.15	-1.44			
Behaviour Control	.61	1.12	.06	.55			
					.51	.26	.18***

From the table above, the hierarchical multiple regression revealed that at step one, educational level, marital status and age had no significant contribution to the regression model, $F(3, 103) = 1.10$, *p>.05)*. However, the relationship between variables were not strong(R =.18) and accounted for 3.1% (ΔR^2=3.1%) of the variance in depression scores. Furthermore, adding family dysfunction facets (Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement and Behaviour Control) to the regression model in step 2 accounted for an additional 7.8% (ΔR^2= 4.7%) variation in depression and this change in R^2 was not significant, $F(9, 97) = .92$, *p>.05)* and the relationship between variables were not strong enough (R =.28).

DISCUSSION

The result of this study revealed that dysfunctional family does not necessarily predict depression among women; hence the hypothesis which stated that family dysfunction facet would not independently/

jointly predict depression among women was accepted. The result of the finding was in tandem with Mgbenkemdi, (2016) and Mgbenkemdi, Omeje, & Eze, (2017). However, this is in contrast to Sonnentag, (2001); Major et al (2002). Similarly, this incongruence also found that people who grew up in dysfunctional families manifest symptoms of psychopathology (Epstein, Bishop, Ryan, Miller, & Keitner, 1993; Josie et al, 2008). This finding was not consistent with the findings of Ridenour et al (1996), Ryan et al, (2005) and Ridenour, et al (2005) who found family dysfunction as a risk factor for depression. This incongruence could be explained by cultural variations. In Igbo-African culture, women who succeed in getting into paid employment have a sense of accomplishment. Moreover, the earning capacity empowers the women with the resources they need to obtain health services when necessary to manage/ or control the dysfunctional family together. Thus, even when there is the conflict between family members, the resources accruable from the work domain tend to douse its impact on the family hence they remain peaceful. Besides, financial empowerment from the job enables women to procure the necessary resources and support that will always ameliorate the impact of family dysfunctionality. It could be asserted that women empowerment, therefore, engenders vitality, harmonizes the family, freedom from worry, an opportunity for an increase in financial security, strengthened the parenting competence, personal satisfaction and self-fulfillment.

Although, the finding indicated no significant relationship between dysfunctional family and women as a predictor of depression the study has its weaknesses. The population and the sample size are too small compared with the number of women in Federal Neuropsychiatric hospital Enugu. Again this study was confined to available sample staff of Federal Neuropsychiatric hospital Enugu; therefore, any attempt to generalize this finding to all kinds of staff in the Federal Neuropsychiatric hospital Enugu; or any other organization should be made with caution.

CONCLUSION

Although the finding indicated no significant relationship between dysfunctional families as a predictor of depression among women, in Igbo-African culture, women who succeed in getting into paid employment have a sense of accomplishment. Thus, the earning capacity empowers the women Nurses with the resources they need to manage/ or and control the dysfunctional family. This result also suggests that more

attention should be directed to pay job activities to reduce the prevalence of depression, especially among women. This study has suggested that African women especially women nurses in South-Eastern Nigeria should continue to protect and promote our cultural values such as harmonizing and managing one's family. If not because of these cultural values and the joy of paid employment, the result would have been the contrary.

REFERENCES

Beardslee WR, Versage EM, Gladstone TR (1998), Children of Affectively ill Parents: A Review of the Past 10 years. *J Am Acad Child Adolesc Psychiatry* 37:1134–1141

Birmaher B, Ryan ND, Williamson DE et al. (1996), Childhood and Adolescent Depression: A Review of the Past 10 years. Part I. *J Am Acad Child Psychiatry* 35:1427–1439

Costa EF , Santos SA , Santos AT , (2012). *Burnout Syndrome and Associated Factors among Medical Students: A cross-Sectional Study. Clinics 2012;67:573–9.doi:10.6061/clinics/2012(06)05* CrossRefPubMedWeb of Science Google Scholar

Curran, D. (1997). Stress and the Healthy Family. San Francisco: Harper & Row, Publishers.

Davies PT, Windle M (1997), Gender-specific Pathways between Maternal Depressive Symptoms, Family Discord, and Adolescent Adjustment. *Dev Psychol* 33:657–668

doi:10.1037/h0024490

Edger, A.D (2012). Counseling the Mentally Retarded and their Parents. Journal of Clinical Psychology, 9, 114-117.

Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster Family Assessment Device. *Journal of Marital and Family Therapy, 9*, 171–180.

Epstein, N. B., Bishop, D., Ryan, C., Miller, I. W., & Keitner, G. I. (1993). The McMaster Model View of Healthy Family Functioning. In F. Walsh (Ed.), *Normal Family Processes* (pp. 138–160). New York: Guilford.

Fendrich M, Warner V, Weissman MM (1990), Family Risk Factors, Parental Depression, and Psychopathology in Offspring. *Dev Psychol* 26:40–50

Fergusson D, Horwood LJ, Lynskey M (1995), Maternal depressive symptoms and depressive symptoms in adolescents. *J Child Psychol Psychiatry* 36:1161–1178

Goodman S, Gotlib I (1999), Risk for Psychopathology in the Children of Depressed Mothers: a Developmental Model for Understanding Mechanisms of Transmission. *Psychol Rev* 106:458–490

Hammen C, Brennan P (2002), Interpersonal Dysfunction in Depressed Women: Impairments Independent of Depressive Symptoms. *J Affect Disord* 72:145–156

Hammen,C, Brennan, P A & Shih, J H (2004). Family Discord and Stress Predictors of Depression and Other Disorders in Adolescent Children of Depressed and Nondepressed Women. *the Department of Psychology, UCLA (C.H., J.H.S.), Los Angeles; Departments of Psychiatry and Biobehavioral Sciences (C.H.) and Psychology (P.A.B.), Emory University, Atlanta.* DOI: 10.1097/01.chi.0000127588.57468.f6

Ibrahim AK, Kelly SJ, Adams CE, et al. (2013) A Systematic Review of Studies of Depression Prevalence in University Students. J Psychiatr Res47: 391–400.

Joiner TE Jr (2002), Depression in its Interpersonal Context. In: *Handbook of Depression,* Gotlib IH, Hammen CL, eds. New York: Guilford, pp 295–313

Josie, K. L., Peterson, C. C., Burant, C., Drotar, D., Stancin, T., Wade, S. L., et al. (2008). Predicting family burden following childhood traumatic brain injury: A cumulative risk approach. *The Journal of Head Trauma Rehabilitation, 23*(6), 357–368.

Kaslow, F. W. (1996). ed. *Handbook of Relational Diagnosis and Dysfunctional Family Patterns.* New York: John Wiley.

Kelin D.N., Lewinshohon, P.M., Seeley, J.R., & Rohede, P, (2001). A family study of major depressive disorder in a community sample of adolescents. Archives of General psychiatry, 58, 13-20.

Kreutzer, J. S., Gervasio, A. H., & Camplair, P. S. (1994). Patient Correlates of Caregivers' Distress and family functioning after Traumatic Brain Injury. *Brain Injury, 8*(3), 211–230.

Lewinsohn PM, Essau CA (2002), Depression in Adolescents. In: *Handbook of Depression,* Gotlib IH, Hammen CL, eds. New York: Guilford, pp 541–559

Lovejoy CM, Graczyk PA, O'Hare E, Neuman G (2000), Maternal Depression and Parenting Behavior: a Meta-Analytic Review. *Clin Psychol Rev* 20:561–592

Major, V.S,, Klein, K J & Ehrhart, M G, (2002). Work Time, work Interference with Family and Psychological distress. Journal of Applied Psychology. 87 (3) 427-436

Mgbenkemdi, E.H (2016). Family-Interference with Work as a Predictor of Marital Conflict and Depression among Women in Enugu South-Eastern Nigeria. Journal of Humanities and Social Sciences (IOSR-JHSS). Vol. 21,Issue 10,ver.6 (Oct, 2016) PP.43-49. E-ISSN-2279-0837, P-ISSN:2279-0845. INDIA. http//www.iosrjournals.org/iosr-jhss/pages/21 (10) Version-6.httml.

Mgbenkemdi, E.H, Omeje Obiageli & Eze S.G.N (2017). Influence of Coping Strategies on Depression among Parents Living with Mentally Retarded Children (Down Syndrome). International Journal of Humanities and Social Science Invention (IJHSSI). http://ijhssi.org/papers/v6(3)/version-III/G0603033450.pdf.www.ijhssi.org//Vol.6 issue3//March.2017//pp.34-50.e- ISSN (Online) 2319-7722 & p-2319-7714.

Minnes, P.M. (1988). Family Resources and Stress Associated with Having a Mentally Retarded Child. American Journal on Mental Retardation. 93 (2) 184-192.

Moussavi S, Chatterji S, & Verdes E, (2007) Depression, Chronic Diseases, and Decrements in Health: Results from the World Health surveys. Lancet 370: 851– 858.

Nwankwo, B.E (2009). Psycho-familia Factors Influencing Resiliency in Adolescents from Dysfunctional families. Unpublished Ph.D. Dissertation. Enugu University of Science and Technology.

Okafor, J.O. (1997). Comparative Assessment of Symptoms of Depression among Secondary School Teachers. Health and Movement Education Journal 1. (1), 37-43.

Omeje, O. (2000). Marital Conflict, Coping Strategies, Age and Psychopathology among Battered Women in Three Eastern Nigeria State. Ph.D Thesis, U.N.N.

Qingqing Nie, Lili Tian, E. Scott Huebner, (2019). Relations among Family Dysfunction, Loneliness and Life Satisfaction in Chinese Children: a Longitudinal Mediation Model, Child Indicators Research, 10.1007/s12187-019-09650-6.

Radloff, L (1977). The CES-D Scale: A Self-Support Depression Scale for Research in a Retarded Child. American Journal on Mental Retardation. 93 (2) 184-192.

Ridenour, T. A., Daley, J. G., Reich, W. (1999). Factor Analyses of the Family Assessment Device. *Family Process, 38*(4), 497–510.

Rudolph K, Hammen C, Daley S (in press), Adolescent mood Disorders. In: *Behavioral and Emotional Disorders in Adolescence,* Mash EJ, Wolfe AD, eds. New York: Guilford

Ryan, C. E., Epstein, N. B., Keitner, G. I., Miller, I. W., & Bishop, D. S. (2005). *Evaluating and Treating Families: The McMaster approach*. New York: Taylor & Francis.

Seifer R, Sameroff A, Dickstein S. (1996), Parental Psychopathology, Multiple Contextual risks, and One-year Outcomes in Children. *J Clin Child Psychol* 25:423–435

Sonnentag, C. (2001).Work Recovery Activities and Individual Wellbeing, Journal of Occupational Health Psychology. 6 (3) 196-263

Ugwu, E .C, (1998). Personality types and Social Support on Life Stress Adjustment among UNN Students. Unpublished B.SC. Thesis, UNN.

Watson, D. (1967). Relationship between Locus of Control and anxiety. Journal of Personality and Social Psychology, 6(1), 91-92. doi:10.1037/h0024490

Wetzel, J W (1999). Clinical Handbook of Depression. New York: Gardner Press.

World Health Organization (2015) Mental Health. Available from: https://www.who.int/mental_health/management/depression/en/.

World Health Organization (2017) Depression and Other Common Mental Disorders: Global Health Estimates. Geneva: World Health Organization; License: CC BY-NC-SA.

World Health Organization (2018) Depression. Available from: https://www.who.int/news-room/fact-sheets/detail/depression.