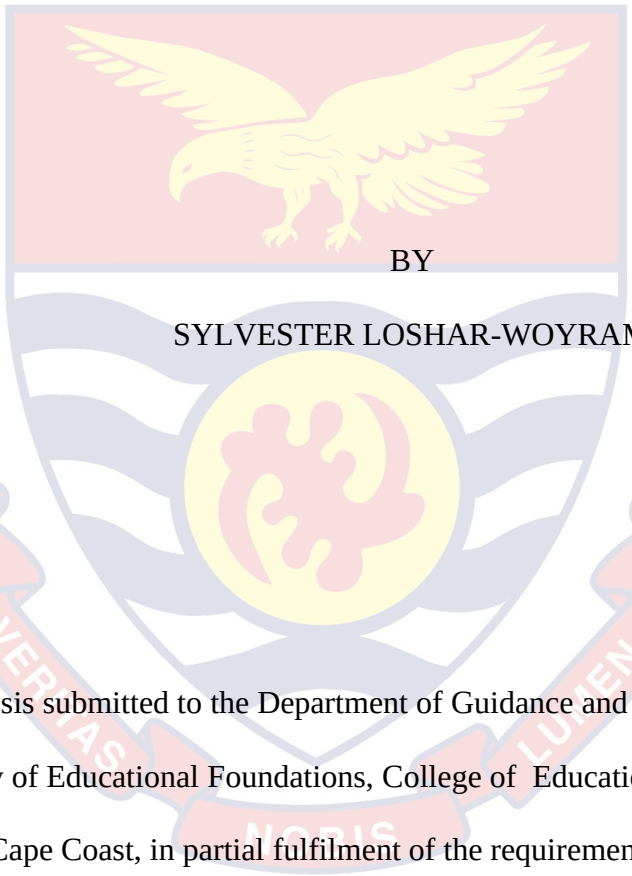
UNIVERSITY OF CAPE COAST

DEPRESSION AMONG WOMEN IN THE KETU-SOUTH MUNICIPALITY: COUNSELLING IMPLICATIONS



BY

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature..... Date.....

Name: ……

Supervisor's Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines of supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: ..... Date.....

Name: ……..…….

Co- supervisor's Signature: ……..... Date……..….

Name: ……...……

ABSTRACT

The purpose of this study was to investigate the influence of family stressors on depression among women in the Ketu-South Municipality. The study used the descriptive sample survey design through the quantitative approach. The census method was used to select a sample of 70 women for the study. The Family Inventory of Life Events and Changes (FILE) and Beck Depression Inventory (BDI II) were used to collect data for the study. The data gathered were analyzed using means, standard deviation, Pearson Product Moment Correlation Co-efficient, and Linear Multiple Regression. The study revealed that the prominent family stressor among the women experiencing depression in the Ketu-South Municipality is losses (overall mean of 4.22). The study further revealed that age significantly contributes to depression among women although its contribution is weak (R=.366, p=.049). However, marital status does not contribute to depression among women. In addition, the study revealed that family stressors significantly contribute to depression among women (R=.749, p=.039) with losses being the best contributor to depression (Beta=2.123, p=.037). The study also revealed that occupational status (R= -.627, p=.020) and monthly income (r= -.501, p=.014) made significant contributions to depression in women. However, educational status does not contribute to depression in women. The study recommended that family stressors should be controlled among women living with depression by the government and non-governmental agencies.

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Finally, lots of gratitude go to my families for their moral and material support. I could not have come this far without their support.

DEDICATION

To God'slove N. Loshar-Woyram and to God'sgift N. Loshar-Woyram for enduring the long periods of my absence.

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CHAPTER ONE

INTRODUCTION

Inability to meet the demands that put strains on the family can lead to social and psychological problems. Such problems raise the stress threshold of the household and bring about subsequent depressive episodes. Globally, more than 264 million people of all ages suffer from depression and more women are affected by depression than men (World Health Organization, 2020). Depression in women has negative consequences for the family especially the children. Besides, depression in women transcends from the family to their work settings and affects economic activities as well. Meanwhile studies conducted in Ghana did not consider specifically how family stressors contribute to depression among women. It is deemed appropriate that interpersonal therapy which focuses on social dysfunctions related to depression could be employed to deal with problem areas such as interpersonal role disputes, interpersonal role transitions, unresolved griefs, and interpersonal deficits.

Background to the Study

Depression has existed since recorded history. Physicians and clinicians have observed how some people behave in obvious and distinctly different ways from what would be considered normal at the time. Kraeplin in 1921, and Freud in 1917 (as cited in Cochran & Rabinowitz, 2000) recognized and attempted to characterize what we today would call depression. Early descriptions of depression, or melancholia, as it was often termed at the time, are remarkably similar to the current diagnostic descriptions.

Hippocrates (as cited in Cochran & Rabinowitz, 2000) clearly recognized the existence, in what he called melancholia, of a condition that would today be considered a major depressive disorder (MMD). To Hippocrates, this mood disturbance was caused by an excess of one of the four body humors- "black bile". The build up to this substance in the body was thought to produce the disturbances of thought and mood that characterize depression. The influence of this perspective has been enormous, and Hippocrates' conceptualization of melancholia represents one of the earliest attempts to formulate a biological or somatic explanation for depression. This early identification and description of what is depression is an important step in understanding mood disorders.

Kraeplin in 1921 (as cited in Cochran & Rabinowitz, 2000) suggested a terminology that separated manic episode from depressive episode. He noted that in depression, the individual manifested a "sad or anxious mood, retardation of thought and behaviour". Manic episode, on the other hand, was characterized as consisting of "flight of ideas, exalted mood, and pressured activity". These observations regarding the distinction between manic episode and depression have stood the test of time. Today, they form the basis of one of the main distinctions between the two classes of mood disorders. These are the depressive disorders and bipolar or manic depressive disorders. According to Cochran and Rabinowitz (2000), depression is called unipolar depression when not accompanied by manic episode. Bipolar or manic-depressive disorders, on the other hand, are characterized by both depressed aspects of mood and a manic component of mood. Manic episode refers to an elated,

expansive or elevated mood that is frequently accompanied by restlessness, increase in motor behaviour, distractibility, racing thoughts and irritability.

According to Cochran and Rabinowitz (2000), depression is considered a disorder of the mood, sometimes called an affective disorder, signifying the disturbance of "affect" in all widely used classification and diagnostic schemes. In general, a mood disorder represents a departure from what we might consider to be a typical mood state experienced by persons most days of their lives.

The World Health Organization (2016) describes depressive episode as characterized by lowering of mood, reduction of energy and decrease in activity. The capacity for enjoyment, interest, and concentration is reduced. Marked tiredness even after minimum effort is common. Sleep is usually disturbed and appetite diminished. Esteem and self-confidence are almost always reduced and even in the mild form. Some ideas of guilt or worthlessness are often present. There is lowered mood which does not only vary from day to day but also unresponsive to circumstances. This may be accompanied by somatic symptoms. These somatic symptoms include loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, weight loss, and loss of libido.

Knauss and Schofield (2009) indicate that depression is a common mental disorder and one of the leading causes of disability worldwide. According to Knaus and Schofield, data from Australian Bureau of statistics have shown that in the prior 12 months, about 6% of the adult Australian population had one or more depressive disorders. Women have higher

prevalence rates (7.4%) than men (4.2%). To Knaus and Schofield, a study of depression in Australian adolescents has found a prevalence rate of 14%, with significantly higher rates of depression in girls than boys (18.8% versus 9.3%). Besides, O'Mara, Lee, and King (2013) indicate that more adolescent girls significantly report depression than adolescent boys. This gender difference first appears between the ages 13 and 15 years and then becomes more pronounced between the ages 15 and 18 years. This suggests women are more likely to develop a major depressive disorder. These gender differences seem to emerge in adolescence and persist throughout adulthood.

Abramson, Alloy, and Metalsky (as cited in O'Mara et al., 2013) indicate the development of depression in a vulnerability-stress model. In this view, an individual has some degree of vulnerability to developing depression. An example is genetic predisposition, or psychological vulnerabilities. This vulnerability is triggered by either an acute stressor or accumulation of stressors. To Abramson et al., each individual's vulnerability varies, such that a person with a high level of vulnerability may need only a relatively minor stressor to trigger a depressive episode whilst a person with a low level of vulnerability may need a high level of stress, or multiple stressors to trigger a depressive episode. The stressors may include trauma and abuse, interpersonal conflicts, and lack of social support. The stressors at one point in time may become diathesis at a later point in time. A woman may initially experience some form of abuse as a stressor, and over time, this experience may increase her vulnerability by lowering the amount of stress needed to aggravate depressive symptoms at a later point in time.

Marshall and Harper-Jaques (2008) posit that the interaction between marital distress and depression is contributed to by one partner's self-absorption, history of childhood sexual abuse, or fear of abandonment or by the other partner's inability to provide support and reassurance. To Marshall and Harper-Jaques (2008), depression in women also arises from feeling isolated from an important relationship.

Coles (as cited in Khairudin, Sulaiman & Amin, 2016) points out that the rapid social, physical, and economic changers can be very demanding and challenging on young people and their families. Failure to meet the demands and challenges may result in all kinds of social and psychological problems. In the views of Coles (as cited in Khairudin et al., 2016) unwed pregnancies were identified as one of the most serious and complex social problems in the United States of America. Thus, unwed pregnancies bring about negative psychological effects on both mothers and their babies. Hudson (as cited in Khairudin et al., 2016) adds that depression, low self-esteem, loneliness and need for social support are quite common among unwed pregnant women.

According to Khairudin et al. (2016), pregnant adolescents are at greater risk for symptoms of depression than pregnant adults. Depression may be related to cognitive distortions, stressful life events, and physiological states. The perception of not being able to control outcomes may cause a person to feel helpless and depressed. To Khairudin et al. (2016), this supports Bandura's (1982) assertion that depression is cognitively caused by dejected ruminative thoughts and also low sense of efficacy to have a control on the thoughts.

The National Mental Health Association (2003) cited in Yusuf and Adeoye (2011) states that the majority of working women with depression admit that depression is the number one barrier to their success in the workplace as well. That is, depression experienced by women in their families spills over to their work settings. The women surveyed in the United States reported having various depression related behaviours which affect their work. These include not returning from lunch, avoiding contact with other workers, and being unable to face the challenges of the job. The National Mental Health Association in the subsequent year further indicates that depression interferes with the ability to work, sleep, eat, study, and enjoy activities.

Marshall (1993) points out that the women who may be chronically depressed have been pin-pointed as being especially vulnerable to the dangers of postpartum depression. Postpartum depression occurs around or following the birth of a child. To Marshall (1993), the problem of postpartum depression was first mentioned by the great Greek doctor Hippocrates in the fourth century BC. The women who have had emotional or mental troubles before, those who have real life stressors such as lack of money, severe pre-menstrual tension, previous abortion or miscarriage, poor housing or being a single parent are all susceptible to developing postpartum depression.

In Ghanaian socio-cultural settings, socioeconomic and demographic characteristics of individuals seem to influence their attitudes towards depression. Individuals from lower socioeconomic backgrounds with lower educational levels exhibit less knowledge and more negative attitudes towards depression. In typical socio-cultural settings, emotional disturbances are not really considered within the realm of health and wellbeing. Depressive

symptoms are viewed as normal emotional responses to particular events. As a result, the depressed individuals are often discouraged to seek help and are left to their fate. It is noteworthy that depression is more common than how people perceive it.

Again, in many Ghanaian neighbourhoods, individuals also adversely engender depression by intensifying the harmful mental health impact of negative events in people's life. For instance, a married woman who experiences childlessness, or has only a disabled child in a more disadvantaged neighbourhood is more likely to become depressed than a woman who experiences similar challenge in a more advanced neighbourhood. The reasons for this heightened vulnerability may include local norms that promote ineffective coping and negative interpretations of events. In the views of Cutrona, Wallace, and Weisher (2006), adverse neighbourhoods precipitate depression as interpersonal relationship is affected, or as social disorder heightened.

Besides adverse neighbourhoods, most factors associated with depression of women in the Ketu-South Municipality and Ghana at large are stressors from the family of these women. Owusu-Adjah and Agbemafle (2016) assert that the prevalence of domestic violence in Ghana remains unacceptably high with numerous consequences ranging from psychological to maternal and neonatal outcomes, and morbidity in pregnant women. Ardayfio-Schandorf (2005) identifies violent acts against women in Ghana such as wife beating, defilement, rape, forced marriages, and widowhood rites. In the views of Ardayfio-Schandorf, many men who admitted beating their wives see it as a way of correcting them, though they accepted it is a wrong practice. To

Owusu-Adjah and Agbemafle (2016), regular alcohol consumption by other partner, exposure to harsh physical discipline during childhood and witnessing the father beating the mother during childhood are all the risk factors of domestic violence which put women at an increased risk of depression, suicide attempts, psychological disorder, and physical injury.

Relationship factors are not left out; they are prominent stressors influencing depression among women in many families in Ghana. Marital conflicts, marital instability, male dominance in the family, poor family functioning, and expressed emotions by other spouse are relationship factors that contribute to marital dissatisfaction, which in many instances results in depression. The other partner's expressed emotions, for instance, criticism, hostility, and emotional over-involvement are all in many instances stressors that characterize depressive family settings. Marano (2002) indicates that the fear centers are activated in the brain when depression-susceptible people are subjected to criticism. To Marano (2002), an atmosphere of highly expressed emotions multiples the chances of depression relapsing two to three times.

Statement of the problem

Depressive disorders rank among the leading causes of disability worldwide (World Health Organization, 2020). According to the World Health Organization, depression is a major contributor to global burden of diseases among men and women, however, more women are affected by depression than men.

There has been a series of consistent reports of depression in the Ketu-South Municipality from 2015 and persisted through to 2018. In 2015, the medical records of the Mental Health Unit of the Municipal Hospital indicate a

total of 54 registered cases of depression. A breakdown of this figure shows 36 reported cases of depression among women including postnatal mothers putting women in the lead. However, 4 of such registered cases happened among adolescent girls and the remaining 14 registered cases also happened among men.

In 2016, the medical records of the Mental Health Unit of the Municipal Hospital show a total of 55 registered cases of depression. Also a breakdown of this figure is made up of 33 women. However, 17 of such registered cases were among men and the remaining 5 registered cases happened among adolescent girls.

In 2017, the total registered cases of depression according to the medical records of the Mental Health Unit in the Municipal Hospital is 70. Again, a breakdown of this figure shows 47 registered cases of depression including postpartum depression among women. The 18 registered cases happened among men and the 5 cases were among adolescent girls.

In addition, data available to the Department of Social Welfare in the Ketu-South Municipality indicates 26 cases where women experienced depression in 2016. Again, the department dealt with 18 cases where women suffered depression in 2017. A breakdown of this figure later shows 14 women and 4 adolescent girls experienced depression. Table 1 shows the statistics of depression cases in the Ketu-South Municipality.

Whiffen (as cited in Marshall & Harper-Jaques, 2008) establishes that in families with a depressed mother, the interactions between the mother and child shows more negativity. Thus, when the mother of a young child is depressed, the effects on the child include impairment on the infant's

physiological development, poorer physical health, and incidence of major depressive disorders. A mother's depression in the early years of an infant's life may affect the child's psychological development causing very significant intellectual deficits. Other effects include insecure attachment, difficulties with developing social skills and academic challenges.

Extreme cases of depression can lead to suicide. The World Health Organization (as cited by Blege, 2017) establishes that at its worst, depression can lead to suicide. According to Blege (2017), in the month of February and March, 2017 suicide made the headlines in Ghana. Again Blege (2017) citing September 15, 2015 edition of the Daily Graphic indicates that Ghana records 1,500 suicide cases annually mainly due to depression. Coincidentally in 2017, the theme for the celebration of World Health Day, which is held April 7 every year, is "Depression: Let's talk".

Various research works have been done on depression in Ghana. Ackom (2006) appraised effectiveness of cognitive behaviour therapy in treating anxiety and depression among the youth and the elderly. Odame (2010) investigated depression and coping strategies among people living with hypertension. Buabeng (2015) examined the risk factors that influence postpartum depression among women. It appears there is less research work on the influence of family stressors on depression among women. The family is the basic social unit of every society.

In sum, depression is a growing mood disorder happening in the Ketu-South Municipality. The question is whether an investigation into the family setting would reveal family stressors influencing depression among women in the Ketu-South Municipality.

Table 1: The Statistics of Depression Cases in the Ketu – South Municipality

Year and Total Cases	Cases in Women	Cases in Men	Cases in Adolescent Girls
2015 – 54 cases	66.7%	25.9%	7.4%
2016 – 81 cases	72.8%	20.9%	6.2%
2017 – 88 cases	73.7%	20.5%	6.2%
2018 – 91 cases	83.5%	16.5%	–

Source: Ketu South Municipality (2015 – 2018)

Purpose of the Study

The purpose of this study was to investigate the influence of family stressors on depression among women in the Ketu-South Municipality. The specific objectives are to:

1. investigate what kind of family stressors influence depression among women in the Ketu-South Municipality;
2. examine the extent to which age and marital status contribute to depression among women in the Ketu-South Municipality;
3. investigate if family stressors will significantly contribute to depression among women in the Ketu-South Municipality.
4. investigate the extent to which socioeconomic status contribute to depression among women in the Ketu-South Municipality;

Research Questions

The following research questions guided the study:

1. What kind of family stressors influence the women experiencing depression in the Ketu-South Municipality?

2. To what extent do age and marital status contribute to depression among women in the Ketu-South Municipality?

Statement of Hypotheses

H_0: Family stressors will not significantly contribute to depression among women in the Ketu-South Municipality.

H_1: Family stressors will significantly contribute to depression among women in the Ketu-South Municipality.

H_0: Socioeconomic status will not significantly contribute to depression among women in the Ketu-South Municipality.

H_1: Socioeconomic status will significantly contribute to depression among women in the Ketu-South Municipality.

Significance of the Study

The incidence of depression especially higher rates among women calls for solution in one way or another. This study seeks to investigate the influence of family stressors on depression among women and the implications for counselling.

The findings of this study will bring to bear some of the marital problems of married couples. It will also suggest some counselling techniques and pragmatic ways such problems could be resolved. The outcomes of the study will be useful to the relevant institutions and organizations like churches, health and social workers, marriage counsellors, counselling centers, and other stakeholders of mental health. These institutions will benefit from the study because these are the places where counselling services are offered.

Finally, the outcomes of this study also add up to enhancement of social policies on the welfare of vulnerable women in the society. Basically,

the research outcomes also point out the relationship of family stressors and mental health issues among women.

Delimitations of the study

This study is delimited to the influence of family stressors on depression among women in the Ketu-South Municipality and counselling implications. The scope of the study also covered educational status, occupational status, monthly income, age, and marital status although there are several socioeconomic and demographic variables.

Limitations of the study

The study faced some limitations. First, family issues being highly sensitive in nature, there was difficulty convincing most of the respondents to honestly answer the questions posed. The researcher anticipated that respondents will be biased in terms of the actual situation at stake which might slightly affect the results of the study. The study was also limited in methodology since there was the need to gather quantitative data which did not allow for in-depth responses of respondents. This might slightly affect subjectivity in the responses. Also, some of the subscales of one of the instruments used in the data collection for this study had low reliability coefficients. Therefore, the possibility of slight inaccuracies wth regard to the results relative to such subscales are expected. This not withstanding, the reliability coeffient of this scale was most solidly demonstrated by the total scale.

Definition of Terms

Depression: This is a state of mood characterized by sadness, loss of interest, feelings of guilt, low self-esteem, tiredness, disturbed sleep or appetite, and poor concentration.

Depression Subtype: This is a type of depression that is subordinate to or included in another type of depression.

Disorder: This is a mental or physical condition which prevents the afflicted person from functioning effectively. It is characterized by abnormal thoughts, feelings, and behaviours.

Episode: This is an occurrence of a recurrent pathological abnormal condition.

Family Stressors: These are direct causes of stress in the family, such as emotional abuse, or losing a vital relationship.

Organization of the Study

The study is structured under five chapters. Chapter one covers the introduction. This is made up of the background to the study, the statement of the problem, the purpose of the study, and the research questions. The rest are the statement of hypotheses, significance of the study, delimitations, limitations, definition of terms, and the organization of the study.

Chapter two presents reviews of related literature. It comprises the theoretical review, conceptual review, and empirical review.

Chapter three is about the research methods of the study. Spcifically, the chapter entails the research design, population, sample and sampling techniques, research instruments, data collection technique, and data processing and analysis procedures.

Chapter four presents the results by research questions, and hypotheses. The researcher also discusses the findings of the study. The chapter ends with the implications of the findings.

Chapter five presents the summary, conclusion, recommendations, and counselling implications of the study. The chapter ends with suggestions for further research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In this chapter, theoretical framework underlying the study as well as literature on studies conducted over the years in Ghana and other countries which are related to the current study are reviewed. The review has been classified into three parts, theoretical review, conceptual review, and empirical review. The theoretical review is on transactional model of stress, and stress process model. The conceptual review deals with family stressors, depression, socio-economic and demographic characteristics, factors such as intra-family strains, marital strains, pregnancy and child-bearing strains, finance and business strains, work-family transitions and strains, illness and family care strains, losses, transition into and out of family, and family legal violations as related to the family stressors and depression among women. The empirical review entails some related studies on depression among women in Ghana and beyond.

Theoretical Review

The study is based on Lazarus and Folkman's Transactional Model of Stress and the Stress Process Model. These theories present appraisal of family stressors, context in which they occur, consequent coping mechanisms, and outcomes of wellbeing.

Lazarus and Folkman's Transactional Model of Stress

The Lazarus and Folkman's Transactional Model of Stress is based on appraisal of environmental stressors and consequent ways of coping. It has also been called cognitive theory of stress. Lazarus and Folkman defined stress

as “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her wellbeing” (Lazarus & Folkman, 1984, p.19). The appraisals are evaluative perceptions, thoughts, and inferences that are utilized to interpret an event and determine the adaptational response. The appraisal process is subjective and personal and depends on an individual’s evaluation of his or her own ability to cope with the stressor. The appraisal process may not necessarily be a conscious process, but rather an automatic process influenced by the person’s previous experiences. The Transactional Model of Stress suggests primary appraisal, secondary appraisal, and reappraisal in the appraisal process (Lazarus & Folkman, 1984).

In the primary appraisal process, the individual assesses the interaction between the self and the environment, based on how the interaction impacts him or her. The primary appraisal process consists of irrelevant, benign-positive, and stressful appraisals. Irrelevant appraisal is made when the situation does not have any implications for the individual’s well-being. Benign-positive appraisal is made when the outcome of an encounter seems positive to the individual. However, stressful appraisal includes harm or loss, threat, and challenge. Harm or loss, is damage that has already occurred to a person, such as loss of a loved one. Threat is anticipation of harm or losses whereas challenge is events from which individuals can improve (Lazarus & Folkman, 1984). In the views of Lazarus and Folkman, threat, loss, and challenge appraisals are separate constructs and not necessarily mutully exclusive ones. This implies threat and loss appraisals can occur simultaneously and this relationship can also change based on the nature of

stress. This suggests that an appraisal of threat about a potential harm may result in a maladaptive stress experience which could probably lead to depressive episodes.

In the secondary appraisal process, individuals evaluate what can be done in response to the stressor, and whether their coping options and resources are sufficient to meet the demands posed by the stressor (Lazarus & Folkman, 1984). The individual adopts two types of coping strategies based on how they manage the stressor. In this view, the problem-focused coping is utilized when the woman manages or alters the stressor with the environment causing the distress. The emotion-focused coping, on the other hand, is employed when the woman regulates her emotional response to the stressor. Both primary appraisals and secondary appraisals interact with each other to create the stress responses and the emotional reaction (Lazarus & Folkman, 1984). Given this, when the woman appraises her situation as a challenge, then she is likely to have a sense of control over the situation. In this instance, she is more likely to engage in problem-focused coping. However, when the woman appraises her situation as a threat, harm or loss, then the stakes might be high and she is not likely to have a sense of control over the situation. Therefore, she is more likely to engage in emotion-focused coping. Coping is determined by cognitive appraisal, which is influenced by coping resources. As indicated by Kim (2017), higher threat appraisals lead to passive emotion-focused coping whereas a higher challenge appraisals lead to active problem-focused coping. This suggests that individuals who engage in passive emotion-focused coping experience greater impairment which in turn results in depressive symptoms.

The coping resources may be tangible, biological, psychological, and social mechanisms and may include financial resources, physical health, self-efficacy, attachment styles, social skills, and social support sources of the woman for managing the demand from the stressor (Lazarus & Folkman, 1984). In the views of Gayman, Kail, Spring, and Greenidge (2017), the negative mental health consequences of stress exposure are weakened at higher levels of coping resources and are magnified at lower levels of coping resources. This implies the lower levels of coping resources in the wake of stress exposure could influence negative mental health consequences such as depression.

Moreover, the psychological and personal resources of the woman, for instance, her self-efficacy may be crucial in evaluating the demands of her situation. A woman with high self-efficacy beliefs is more likely to appraise a stressful situation as a challenge whereas the woman with low self-efficacy beliefs evaluates a stressful situation more as a threat. In this view, the extent to which the woman feels capable to handle the stress situation determines whether the situation is perceived as a challenge or threat. Thus, if the woman feels less confident about her competence to handle the stress situation then she is likely to perceive the situation as a threat, an indication that she might have low self-efficacy beliefs. This supports the views of Zuckerman (1998) that depressed people tend to have feelings of low self-efficacy, perhaps because they lack control over outcomes of events in their lives. Having high self-efficacy beliefs, however, the woman is likely to choose activities, intensify effort, persist in the face of the stressor, and reduce anxiety that comes with the stressor.

Re-appraisal is a changed appraisal. This suggests that appraisal can be changed based on a person's own reactions to the environment, new information from the environment, and as a result of cognitive coping efforts. The cognitive appraisal processes can also mediate reciprocal processes between the personal and environmental factors (Lazarus & Folkman, 1984; Kim, 2017). As such, a challenge appraisal can be reappraised as a harm or threat appraisal, following the feedback from an initial cognitive appraisal. For instance, a woman providing care for her hospitalized child may initially engage in a challenge appraisal if she feels she has the support of significant people. This implies that if she perceives support is available, she is likely to interpret the burden of care as less stressful. This enhances her capacity to cope with the situation and in turn has beneficial effects on both physical and psychological well-being. However, if she discovers support from significant others is not forthcoming, she may begin to engage in a threat appraisal which influence subsequent psychological response which in turn results in depression.

Summarily, the transactional model of stress entails primary appraisal, secondary appraisal, and a reappraisal. The interactions between the family stressors and appraisal processes can change the course of stress. In as much as experiencing family strains has been construed as stressful, how the woman amid of all these stressful circumstances appraises the situation matters. If the woman encounters strains in her family and perceives them as uncontrollable to her, she is likely to experience stress. Further, the personal and psychological resources available to her, for instance, monetary assets, social network, problem solving skills, attachment style, or self-efficacy may not be

adequate to contain the stress generated in her family. If the woman perceives her resources as inadequate, then she is likely to experience more stress which will translate into more emotional problems and depressive episodes.

A limitation associated with the transactional model of stress is that it fails to distinctively differentiate between appraisal and re-appraisal. The re-appraisal is seen essentially as an appraisal.

However, the theory is used in this study because it demonstrates that cognitive appraisal processes provide a common pathway that mediates the associations between the stressors and depressive episodes. Besides, the theory argues comprehensive integration of the stress processes, outcomes, and depression, and is deemed useful in explaining the findings of this study.

Stress Process Model (SPM)

The stress process model was developed by Pearlin in 1989 and in the views of Frishman (2012), was subsequently modified for different purposes and situations. According to Pearlin (1989), stressful experiences don't spring out of a vacuum, but can be typically traced to social structures and people's location within them. The model establishes four core components in the the development of the stress process and its outcomes. The four core components of the stress process model encompass background and context characteristics, objective and subjective primary stressors, moderating resources, and outcomes of well-being (Frishman, 2012; Pearlin, 1989).

The background and context characteristics provide an understanding for the fixed and dynamic characteristics of the individual who is in stressful circumstances. These characteristics are lifelong attributes of the individuals that may impact their well-being and at the same time describe the individuals'

current environment and circumstances. These characteristics comprise socio-demographic characteristics which include age, marital status, educational attainment, occupationl status, and level of income of the individuals. The stress background and context characteristics also include family and network composition, living arrangement, as well as a dependency (Pearlin, 1989). In the views of Gayman, Kail, Spring, and Greenidge (2017), people with higher socioeconomic status in this instance are more likely to engage in lifestyles devoid of health risks and problems through deployment of knowledge, money, support networks, and psychosocial coping resources. Besides, socioeconomic status of individuals influence mental health not only through education and economic resources but also through the ability to avoid and overcome life stressors. According to Gayman et al. (2017), individual's higher socioeconomic status is associated with fewer depressive symptoms. This implies that individuals with lower socioeconomic backgrounds are more likely to experience depressive symptoms.

According to Pearlin (1989), the stressors are experiences and related reactions that threaten individuals, and challenge their ability to adjust to the demands of stressful circumstances. In the views of McCubbin and Patterson (1987), and Walsh (2004), the strains in the family circles that constitute family stressors are intra-family strains, marital strains, pregnancy and child-bearing strains, finance and business strains, work-family transitions and strains, illness and family care strains, losses, transitions strains, and family legal violations. Judge, Menne, and Whitlatch (2009) indicate objective and subjective primary stressors. Objective primary stressors account for the amount and type of impairment experienced and the potential distress that is

subsequently created is the subjective primary stressors. Objective primary stressors are the starting point for the stress process, the point from which the entire process unfolds. Subjective primary stressors are the psychological and emotional consequences experienced by individuals subsequently. According to Judge et al. (2009), the stress process is driven by the primary stressors, which in turn, lead to additional sources of stress in the form of secondary strains. Thus, secondary strains are considered secondary because they occur as a direct result of living with stress outcomes. In the views of Goodyer (2001), exposure to stressful life circumstances is not only associated with intensity of depressive symptoms in individuals but also its severity.

The moderating resources provide buffering effects to stress through direct and indirect pathways (Pearlin,1989). The stress-buffering indicates that the negative mental health consequences of stress exposure are weakened at higher levels of coping resources and are magnified at lower levels of coping resources (Gayman et al., 2017). The moderating resources can cushion or prevent the development of the stress process and its outcomes. Judge et al. (2009) identified internal and external mediators as moderating resources. Internal mediators originate from within an individual, and are enduring individual characteristics, and can help explain coping. The internal mediators include life orientation, personality, and self-efficacy. External mediators are coping resources that stem from a person's environment and do not originate from within the individual. They include financial assets, social support, and family hardiness. Coping implies management of the stress situation, meaning of the situation and stress symptoms that result from the situation. The individuals can be affected negatively or positively based on how coping is

deployed which implies that being affected negatively could result in depressive episodes.

The final component of the stress process, outcome of well-being, is the consequence of stress which in this view is depression. The connection between stress and depression is complex and circular (Shapiro, 2017). Besides the direct impact on the body and mood, excess stress can lead to poor habits like drinking and overeating, which will then exacerbate the feelings of depression.

Although the stress process model shares the premise of social stressors which are recognized as major contributors to depressive episodes in individuals, the independent contribution of various sources of social stressors to depression could be insignificant. The stressful events and depressive symptoms could be as well mediated by biological or genetic factors.

However, the theory is used in this study because it offers unique interpretation of how enduring vulnerabilities and stressful events typical of family settings influence depressive episodes. The theory is also deemed appropriate in explaining the findings of this study.

Conceptual Review

Family Stressors

The conditions that put strains on the individuals are stressors. Basavanthapa (2004) posits that a stressor is an event or a stimulus that causes an individual to experience stress. Likewise, McCubbin and Patterson (as cited in Mondragon, 2017) also indicate that family stressors are life situations or changes that place strain on the family unit and may lead to changes in functioning of the family. Discrete life events as well as ongoing family

pressures contribute to the stressors families struggle with. McCubbin and Patterson (1987) outline life events and strains that constitute family stressors. These stressors include intra-family strains, marital strains, pregnancy and childbearing strains, finance and business strains, work-family transitions, illness and family care strains, losses, transition into and out of the family, and family legal violations.

In the views of Masten and Shaffer (2006), family stressors occur in conjunction with one another and have cumulative consequences on both children and parents. McCubbin and Patterson (as cited in Moes, 1999) strongly indicate that families with a higher accumulation of life events have been found to have lower family functioning and poorer physical and mental health. That is, persistent stressors in the family can influence the development of depression. This lends credence to the views of Goodyer (2001) that being exposed to stressful life events is a precursor for the intensity, frequency, and severity of depression.

Depression

Depression occurs as a result of adverse life events such as loss of a significant person, relationship challenges, or health issues. Depression can also occur due to no apparent cause. Depression can lead to substantial impairments in an individual's social, occupational and other important areas of functioning. As indicated by Cesar and Chavoushi (2013), depression is a mental condition characterized by severe feelings of hopelessness and inadequacy, typically accompanied by a lack of energy and interest in life.

In typical mild, moderate or severe depressive episodes, the depressed person suffers from lowering of mood, reduction of energy and decrease in

activity. The capacity for enjoyment, interest and concentration is reduced, and marked tiredness after even minimum effort is exerted. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced. There is lowered mood which varies from day to day, and is unresponsive to circumstances. This may be accompanied by somatic symptoms such as loss of interest and pleasurable feelings. Other common symptoms include waking in the morning several hours before the usual time, marked psychomotor retardation and agitation, loss of appetite, weight loss, and loss of libido. Depending on the number and severity of symptoms, a depressive episode may be specified as mild, moderate, or severe (World Health Organization, 2016).

Mild depressive episode is experienced when two or three of the above symptoms are usually present. The depressed person is usually distressed by these symptoms but will probably be able to continue with most activities. On the other hand, a person experiences moderate depressive episode when four or more of the above symptoms are usually present and the depressed person is likely to have great difficulty in continuing with ordinary activities.

Severe depressive episode incorporates depressive episode without psychotic symptoms and depressive episode with psychotic symptoms. Severe depressive episode without psychotic symptoms is a condition in which several of the above symptoms are marked and are distressing, typically loss of self-esteem and ideas of worthlessness or guilt are common and a number of somatic symptoms are usually present. It can be a single episode without

psychotic symptoms. Psychosis is loss in touch with reality (World Health Organization, 2016).

Severe depressive episode with psychotic symptoms is an episode of depression as described in the case of the severe depressive episode without psychotic symptoms, but with the presence of hallucinations, delusions, psychomotor retardation so severe that ordinary social activities are impossible. There may be danger to life from suicide, dehydration or starvation. The hallucinations and delusions may or may not be mood-congruent. That is, the content of hallucinations and delusions is either or not consistent with typical depressive theme. An example is major depression with psychotic symptoms (World Health Organization, 2016).

Depressive disorders, according to the American Psychiatric Association (2013), include disruptive mood dysregulation disorder, major depressive disorder, premenstrual dysphoric disorder, persistent depressive disorder (dysthymia), substance or medication–induced depressive disorder, depressive disorder due to another medical condition, and other specified depressive disorder. To the American Psychiatric Association (2013), the common feature of all these disorders is the presence of sad, empty or irritable mood accompanied by somatic and cognitive changes that significantly affects the individual's capacity to function. The differences among these disorders are based on duration, timing, and symptoms severity.

According to American Psychiatric Association (2013), major depressive disorder represents the classic condition in this group of disorders and is characterized by discrete episodes of at least two-week duration although most episodes last considerably longer. There are subtypes of major

depressive disorder which incorporate variations in different forms of major depressive disorder namely: depression with psychotic features, depression with catatonic features, depression with melancholic features, depression with atypical features, depression with seasonal pattern, and depression with postpartum onset (American Psychiatric Association, 2010).

Age, Marital Status, and Depression

Age and Depression

Depression has age correlates. In the views of Bonful and Anum (2019**),** there are lower levels of depressive symptoms among younger women than among older women. Bonful and Anum maintain that the prevalence of depressive symptoms and sociodemographic correlates among 3,183 women in Accra indicate that women 55 years and older are more likely than women between the ages of 18 and 24 to experience depressive symptoms. According to Bonful and Anum, women between the ages of 35 and 54 are also 1.95 times more likely than women between the ages of 18 and 24 to experience depression.

Marital Status and Depression

Marital status could be single, married, separated, divorced, or widowed. The American Psychological Association (as cited in Opoku-Mensah, Asamani, & Asumeng, 2017) indicates that families headed by single-parents have become more common in the past 20 years than the two biological parents upbringing children. Ghana Statistical Service (2012) reports cited in Opoku-Mensah et al. (2017) also pointed out that many men continue to neglect their children in Ghana. According to Ghana Statistical Service, the female-headed households constitute 34.7% and the proportion of

male-headed households has been reducing steadily from 71.4% in 1970 to 65.3% in 2010.

Keski-Rahkonen, and Hudeson (as cited in Opoku-Mensah et al., 2017) indicate that comparing single mothers and married mothers, high level of psychological resources available to married mothers improve their mental health and reduces the likelihood of depression. Opoku-Mensah et al. suggest that for married mothers, levels of self-esteem and social support are maximized and the amount of stress they experience is minimized. To Opoku-Mensah et al., this results in a discrepancy in mental health outcomes that benefits married mothers. In the views of Urban and Olson (2005), married mothers obtain emotional supports from their spouse which often reduce their stress.

Additionally, single mothers do not usually receive financial support from their ex-spouses or the family. However, married mothers often share these economic difficulties with their spouses. Christopher, England, Smeeding, and Ross as well as Mejer and Siemann (as cited in Opoku-Mensah et al., 2017) point out that such foregoing conditions of single mothers make them victims of economic hardship and find it difficult take up multiple roles as breadwinners. Opoku-Mensah et al. (2017) posit that such conditions make single mothers experience more depression and psychological distress compared to married mothers.

Socioeconomic Status And Depression

Socioeconomic status (SES) encompasses not only income but also educational attainment, financial security, and subjective perceptions of social status and social class. Socioeconomic status can mean the quality of life

attributes as well as the opportunities and privileges afforded to people in society. The women with low socioeconomic status have been found to experience significantly more depressive symptoms than women with high socioeconomic status (American Psychological Association, 2018).

Lower socioeconomic status is associated with higher rates of depression, anxiety, attempted suicide, cigarette dependence, illicit drug use, episodic heavy drinking, higher levels of aggression, hostility, perceived threat, and discrimination among the youth. Pregnant women with low socioeconomic status report significantly more depressive symptoms, which suggests that the third trimester may be more stressful for low-income women (American Psychological Association, 2018).

Educational Attainment and Depression

In general, education has a greater protective effect for women than for men, and for people growing in families with limited socioeconomic resources. A major way education is linked to lower levels of depression is through the development of a sense of mastery and self-efficacy, which in turn helps people cope with life's problems and stresses. Adolescence is a critical period for the development of mastery and self-efficacy. Thus, it is possible that higher education is effective at instilling these psychological resources especially for people growing in families with socioeconomic resources (Bauldry, 2015).

Similarly, higher education is associated with lower levels of depression through the attainment of more fulfilling careers and higher wages. Such jobs provide economic resources and a work environment that can mitigate financial stress, support healthy lifestyles, and thereby promote

mental health (Bauldry, 2015). This supports the views of Peyrot, Lee, Milaneschi,…, Pennix (2015) that there is an association of lower educational attainment and major depressive disorder. Gan, Lin, Xie,…,Zhang (2011) also indiacte the impact of educational attainment on chances of curbing depression in the population.

Occupational Status and Depression

Single mothers assume responsibilities of providing for their families without having a partner with whom to share these responsibilities. This means that earnings of the single mothers are substantially insufficient for the entire family needs. As a result, the financial strains accounted for negative mental distress among single mothers (Opoku-Mensah et al., 2017).

Besides, married parents in full-time employment experience high amount of stress from the occupational characteristics of the workplace and the work-family demands. However, the financial benefits associated with such full-time employment reduce the likelihood of experiencing negative mental distress (Opoku-Mensah et al, 2017). Bollovia and Frone (as cited in Opoku-Mensah et al, 2017) compared married and unmarried parents in full time employment and noted that married professional parents experience significantly fewer work-family demands.

Level of Income and Depression

Two to three months after childbirth, women with low income have been found to experience significantly more depressive symptoms than women with high-income. According to American Psychological Association (2018), one out of nine babies has a mother suffering from severe depression, and half have mothers experiencing depression at some level of severity.

Women with low income are more likely to develop problems with drinking and drug addiction, which are significantly influenced by the social stressors linked to poverty. Women with insecure, low-status jobs with little to no decision-making authority experience higher levels of negative life events, insecure housing tenure, more chronic stressors, and reduced social support. The World Health Organization (as cited by American Psychological Association, 2018) indicates that low employment rank is a strong predictor of depression.

Intra-Family Strains

Emotional Problems and Depression

Whereas the couples' perception of positive emotions is likely to be beneficial for their marital satisfaction, their perception of negative emotions is likely to lead to their marital distress (Papp, Kouros, & Cummings 2011). Given this, Cox, Paley, Burchinal, and Payne as well as Davila, Kamey, Hall, and Bradury (as cited in Papp et al., 2011) maintain that depression and marital dysfunction are interconnected over time detailing spouses with elevated depressive symptoms showing relational dissatisfaction. In line with this, Greenberg and Goldman (as cited in Papp et al., 2011) indicate anger as the most powerful emotion expressed in relational conflict, and may escalates fast and manifest itself in cycles. To Pepp et al., anger, and hostility more generally, is related to marital dissatisfaction and impairs couples' effort at resolving conflicts.

In the views of Bawah, Akweongo, Simmons and Philips (1999), family planning and health project in northern Ghana identified fear of violence as the most common expressed emotion among women in Kasena-

Nankana. In this case, violence unleashed on women by their spouses is often in connection with their refusal to engage in sexual relations, resulting in perpetual fear of these women. This suggests that emotional or psychological abuse of women makes them constantly unhappy, miserable, or overwhelmed with anxiety, and makes them experience depressive symptoms.

Additionally, Brown (as cited in Papp et al., 2011) also states that individuals with depression may be more likely to focus on partner emotions such as sadness that is related to their own depressive symptoms. This supports the views of Hatfield, Cacioppo, and Rapson (as cited in Papp et al., 2011) that transmission of negative emotions occurs between close relational partners.

Alcohol or Drugs Dependency and Depression

Center for Substance Abuse Treatment (2004) describes characteristic patterns of interaction which are likely to occur in families where substance use is common. A significant attribute of such families is miscommunication and more frequent arguments due to addiction raising the stress level of the household. Thus, communication that occurs within the household is negative, taking the form of complaints, criticism and other expression of displeasure. According to Rivera, Philips, Warshaw, Lyon, Bland, and Kaewken (2015), relationships of substance use and intimate partner violence has been established through national surveys, studies utilizing community samples, and studies of specific group of people. In the views of Schneider and Burnette (as cited in Rivera et al., 2015) men and women entering into substance abuse treatment showed a lot of women experienced victimization by an intimate partner at some point in their lives. Lander, Howsare, and Byme (2013) also

hold the same view that between one third and two thirds of child maltreatment cases also involve some degree of substance abuse.

The family also experiences parental inconsistency as a result of drug dependency. Rule setting is erratic and enforcement is inconsistent. Children are confused because they cannot figure out right and wrong. These family conditions create altered and damaged family dynamics (Center for Substance Abuse Treatment, 2004). In the views of O'Mara, Lee, and King (2013), the stressors at one point in time may become vulnerabilities at a later point in time. Thus, the damaged family dynamics may increase the vulnerability by lowering the amount of stress needed to trigger depressive symptoms at a later point in time.

Marital Conflicts and Depression

A significant relationship process variable that contributes to marital conflicts and depression is displeasing spouse behaviour. That is, depression results from high rates of aversive behaviours by spouse. The couples experiencing dissatisfaction are likely to attribute negative actions by spouse to stable traits and characteristics and see little hope of change (Akpadago & Anovunga, 2018). In the views of Whisman and Kaiser (2008), the rates of negative partner behaviours are positively correlated with depressive symptoms in women.

Another relationship process variable associated with marital conflicts and depression is spouse criticism. Coyne, Thompson, and Palmer (2002) contend that spouses of depressed women report frequent arguments, differing social needs, and being blamed for things going wrong. In support of this view, spouses of depressed women rate their wives more negatively, make

more dispositional attributions for negative events involving their wives than the spouses of non-depressed women (Whisman & Kaiser, 2008).

Hooley and Teasdale (as cited in Whisman & Kaiser, 2008) maintain that partner criticism is associated with depressive relapse. In the views of Hooley and Teasdale, 9-month relapse was associated not only with marital distress, but also with spouse criticism. Kwon, Lee, and Bifulco (2006) also indicate a positive association between perceived criticism and depressive relapse in Korean outpatients which suggests that perceived criticism may be an important factor predicting depression across cultures.

Additionally, marital conflict and depression is also closely associated with spouse abuse. According to Akpadago and Anovunga (2018), whereas the men report that their wives verbally abuse them, the depressed women on the other hand report that their husbands physically abuse them.

In-laws Conflict and Depression

In-law relations can contribute to happier marriage if couples get along with them. However, if couples do not get along with in-laws the marriage can go through distress which could probably result in depressive episodes (Akpadago & Anovunga, 2018).

Differences in values have been identified as key sources of in-law conflict. This means that a different lifestyle from parents-in-law may result in a great deal of stress on daughters-in-law. In this view, disagreements about social and daily living arrengements are common occurrences (Soeda & Araki, 1999).

Further, some parents-in-law transfer all their negative emotions from their sons to their daughters-in-law. Thus, daughters-in-law have conflicts

with in-laws as a result of conflicts their husbands have with close relatives. In this instance, they become scapegoats of their husbands (Sev'er, 2002).

According to Hyder, Noor and Tsui (2007), disagreement between parents and the spouses of their sons, daughters-in-law, can arise out of infertility. The authors maintain that many parents-in-law hold the view that the role of the wife is to produce children, and conflict may arise if this expectation is not met. In support of this, Akpadago and Anovunga (2018) indicate the causes of divorce as enumerated by some of these women as mothers-in-law not appreciating what daughters-in-law are putting into the marriage, and interfering into their private issues like sexual intercourse where infertility was a problem.

Parenting Stress and Depression

All parents are subject to varying degrees of relative stress due to the intimate stress involved in parenting (Rodriguez-Jenkins & Marcenko, 2014). The authors further maintain that poverty complicates family structure characteristics and their impacts on parenting stress. In addition, Taylor, Washington, Artinian and Lichtenberg (as cited in Rodriguez-Jenkins & Marcenko, 2014) also assert that single parenting and family size are the family structure factors most often associated with parenting stress. As indicated by Opoku-Mensah et al. (2017), single mothers do not usually receive financial support from their ex-spouses or the family. Christopher et al., and Mejer and Siemann (as cited in Opoku-Mensah et al., 2017) all point out that such conditions of single mothers make them victims of economic hardship and therefore find it difficult to take up multiple roles as

breadwinners. In the views of Opoku-Mensah et al. (2017), such conditions make single mothers experience more depression and psychological distress.

Marital Strains

Negative Marital Events and Depression

According to Whisman and Kaiser (2008), the impact of negative marriage–oriented events devalue the individual in relation to the self and spouse. Cano and O'Leary (2000) identify these negative marriage-oriented events as discovery of extra-marital affairs, spouse initiated separation or divorce, and separation or divorce due to extra-marital affairs or violence. The occurrence of these events is associated with increased risk of major depression (whisman & Kaiser, 2008).

In the views of Kanogo (as cited in Kioko, 2009), many men have extramarital affairs while their wives must remain faithful. According to Akpadago and Anovunga (2018), deep emotions that portray hurt is associated with extramarital affairs. In the views of Rice (1999), extra-marital affairs have varying effects on married people as well as their marriages and some marriages are never the same afterward. According to Rice (1999), guilt, anger, distrust, loss of respect, and destruction of intimacy are associated with extra-marital affairs. Cano and O'Leary (2000) point out that extramarital affairs are associated with increased risk of psychological health problems including depression and anxiety.

Braver, Shapiro, and Goodman (2006) are also of the view that divorce has been rated the most leading life stressor. As a result, divorced parents are more likely to be afflicted with poor psychological health than the married ones. Divorced parents have a higher risk of depression, suicidal ideation,

motor accidents, and alcoholism (Braver et al., 2006). Simon and Marcussen (as cited in Braver et al., 2006) also indicate that divorced parents report higher levels of depression, anxiety, and unhappiness.

Similarly, Christian-Herman, O'Leary and Avery–Leaf (2001) indicate the impact of severe negative marital events on incidence of major depression among women with no history of depression. To Christian–Herman et al., women who experienced severe events most commonly involving separation or divorces, extramarital affairs, and physical aggression also experience major depressive episodes.

Distressed Sexual Relations and Depression

Distressed sex relation is significantly associated with depression. In the views of Yazdanpanahi, Beygi, Akbarzadeh, and Zare (2016), emotions related to depression such as sadness, disillusion, and lack of pleasure, have been shown to be strong correlates of sexual dysfunction.

Pregnancy and Childbearing Strains

Unintended Pregnancy and Depression

According to Boakye-Yiadom, Shittu, Dutt, Dapare and Alhassan (2015), antenatal period is associated with biological, psychological, and social challenges especially due to dealing with new demands. Additionally, unintended pregnancy or birth has an effect on the woman, the couple, the child, and the entire family. The risk factors for the development of depression in pregnancy include insufficient social support, loneliness, marital discord, having an unwanted pregnancy, or having multiple children (Wichman & Stem, 2015). Unwanted pregnancy and birth has proven as one of the main factors associated with the development of depression during pregnancy and

thereafter, and with lower levels of psychological well-being during pregnancy, postpartum, and in the long term (Wichman & Stem, 2015).

Child-bearing Strains and Depression

According to Guo, Bindt, Te Boule, Appiah-Poku, Tomori, Hinz, …, Tamich (2014), psychosocial and medical factors of mothers and children associated with parenting stress include lower education, high work load, unemployment, both younger and older maternal age, poor social or partner support, negative life events, preterm birth, child physical or mental disorder, child temperament, and child caretaking hassles. Moreover, transition to motherhood is associated with increased psychological vulnerability because of major physical, family and social role changes, and requirements to adjust to the multiple needs of the infants. This period may be particularly stressful to many women in Africa settings. In this sense, they are exposed to increased self and offspring related health risks around pregnancy, delivery, and the early years of motherhood, and often tasked with handling the challenging aspects of early childcare without substantial spousal support (Guo et al., 2014). Maternal depression is linked to negative affect and attributions and have been found to influence the degree to which the infant's behavioural characteristics are experienced as demanding and stressful. Further, maternal distress is associated with infant's traits, for instance, the degree of affective reactivity at 4 and 5 months, and other determinants of child behaviour difficulties (Guo et al., 2014).

Postpartum Depression

Mood disturbances following childbirth are not significantly different from affective disorders that occur in women at other times. The postpartum

period can also be a high-risk period for occurrence of depressive episodes. The post-partum depression also presents with depressed mood most of the day. American Psychiatric Association (2013) identifies postpartum depression as a major depressive disorder with postpartum onset and indicates that depressive symptoms begin within 4 weeks following childbirth. According to the World Health Organization (2016), postpartum depression is a mild mental and behavioural disorder beginning within the first 6 weeks of delivery. The postpartum depression can be characterized by disinterest in the new infant, negative feelings toward the new infant, and decreased interest in and pleasure from activities (Howell, Mora, & Di Bonaventra, 2009). The first symptoms usually appear between the 4th and 6th week following childbirth. However, postpartum depression can start from the moment of birth, or may result from depression evolving continuously prior to or during pregnancy.

Naturally, maternity blues may occur for a short period of few hours to days, usually 4 to 7 days after delivery. Postpartum blues, on the other hand, may present symptoms within a few days of delivery, usually on day 3 or 4, and persist for hours up to several days. Both maternity and postpartum blues are time-limited, mild and do not require any treatment. The tendency to develop maternity or postpartum blues is not related to any environmental stressors or previous history of affective disorders. However, these factors may influence whether the postnatal blues lead to postpartum depression. The postpartum depression is more severe than the typical maternity and postpartum blues many women experience for the first week after giving birth but not severe like postpartum psychosis.

Apart from psychological factors, biological, pediatric, sociodemographic, and cultural factors are all closely associated with postpartum depression. Prenatal or antenatal anxiety is one of such significant factors that lead to postpartum depression. According to Hassan, Said, and Hassanine (2017), pregnant women become more anxious when unexpected threat occurs. The authors maintain that the potential risk factors of antenatal anxiety which causes postpartum depression comprise five factors. These are women's life satisfaction, associated medical disorder, complications diagnosed during pregnancy, expected birth mode and birth complications, and expected fetus's birth complications. The women's life satisfaction includes unwanted pregnancy, disharmony in the family, marital dissatisfaction and others. The associated medical disorder consists of anemia before pregnancy, essential hypertension and others. The complications diagnosed during pregnancy entails sleep deprivation, prolonged sick leave during pregnancy and others. The expected birth mode and birth complications consist of expected Cesarean Section, expected vaginal and perineal trauma and others. Finally, the expected fetus's birth complications are made up of known congenital anomalies, possible neonatal development disorders and others.

Finance and Business Strains

Business Strains and Depression

Job instability is one of the factors associated with business and financial strains. Hansen (2009) attributes job instability to worker dislocation and displacement. Dislocated workers are the persons permanently separated from their jobs and connotes disappearance of the job and dislocation of the

individual workers from the enterprise. Geewax (as cited in Nichols & Mitcell, 2013) maintains that self-employed workers who become unemployed due to economic conditions and homemakers who are no longer supported by any family member are all dislocated workers. In the views of Geewax, displaced workers are the persons who lost or left jobs because their enterprise closed or moved, there is insufficient work to do, or their position or shift is abolished. As there are changes in markets, and technologies open new opportunities and shrink others, job losses may outweigh creation of new ones leading to worker displacement (Hansen, 2009).

Nichols and Mitcell (2013) point out relationships of dwindling employment prospects and declining mental health. As economic stress increases, anxiety may also increase, and as individuals fall in their social hierarchy, serotonin pathway disorders, including depression may become more common among these individuals.

Economic Hardship and Depression

Economic hardship leads to economic pressure. Economic hardship also increases the risk for behaviour problems and mental health problems. The markers of hardship may include low income, negative financial events, and high debts relative to assets. These objective economic conditions influence family functioning primarily through the economic pressures they generate. The economic pressure leads to parents' psychological distress which in turn generates inter-parental conflict. The inter-parental conflict also leads to parenting problems which eventually creates child adolescent problems (Conger, Reeb, Little, Crain, Shebloski, & Conger, 2012).

Pressures such as unmet marital need, in this view, inadequate food or clothing, the inability to pay bills or make ends meet, and having to cut back on necessary expenses of health care are the psychological manifestations and responses to economic hardship. These pressures are thought to place parents at increased risk for emotional distress of depression, anxiety and anger. The emotional problem heightens conflict between parents which in turn disrupts supportive parenting. Parents preoccupied by their personal problems and marital distress are likely to demonstrate less affection and more hostility toward their partners. These disruptions in the relationship between couples spill over into interactions with children leading to harsh and inconsistent parenting. All these family contextual circumstances largely influence the social and emotional wellbeing of the entire family (Conger et al., 2012).

According to Ponnet (2014), interpersonal conflict and depressive symptoms are closely associated with financial stress and adolescent problem behaviour in all families. Newlands, Cox, and Mill (as cited in Neppl, Senia, & Donellan, 2016) also indicate that economic pressure is associated with maternal depression and somatization, which in turn significantly decreases sensitive and supportive parenting practices.

Indebtedness and Depression

Financial difficulties such as being unable to pay bills also appear to be related to mental health (Richardson, Elliot & Roberts, 2013). The psychological consequences of high indebtedness have been pointed out as depression, low self-control, insufficiency, alienation and guilt. In the views of Richardson et al., this relationship is moderated by stress about the debt.

Work-Family Transitions And Strains

Work-family Conflict and Depression

Work-family conflict occurs when the domains of work and home spillover into another, resulting in conflict (Kossek, Pichler, Bodner, & Hammer 2011). In the views of Livinston and Judge (2008), as dual-career families increase, greater conflict between family and work roles also increases.

In the views of Frone, Russell and Coope (as cited in Amankwah 2018), work-family conflict is bi-directional in the sense that it could be either work-to-family or family-to-work conflicts. When work interferes with family life, work-to-family conflict occurs whiles family-to-work conflict means family life interfering with work. However, work-to-family conflict is more recurrent than family-to-work conflict for both men and women with either partners and children.

Kalliath, Kalliath, and Chan (2017) indicate that work-family conflicts encompass time-based conflict, strain-based conflict, and behaviour based conflict. Time-based conflict occurs when the time needed for a particular role, either family or work role, prevents a person from devoting adequate time to other duties the person undertakes in the family or work. There are two main aspects of time-based conflict. First, the fulfilment of demand of a role may be prevented by time strain in another role; secondly, the time strain in a particular role may delay a person's fulfilment of the responsibilities of another role.

The tensions of two roles produce the second dimension of work-family conflict, the strained-based conflicts, which are associated with the

depressive symptoms. In the views of Zhang and Liu (2011), anxiety or fatigue are the root causes of the strained-based conflict. That is, carrying out responsibilities in one domain may be inhibited by another role's anxiety. Work-family conflict will therefore be produced by any pressure which result from roles at home or work.

Kalliath et al. (2017) indicate that the difference between role-specific behaviours result in behaviour-based conflict. In this sense, role-specific behaviours of one role impede fulfilling the requirement of another. As a result, conflict emerges in an event of failure to fulfill the expectations of the roles.

Retirement Monetary Stressors and Depression

Cho, Margolis, Newhouse, and Robalino (as cited in Fernadez-Nino, Bonilla-Tinoco & Sosa-Ortiz, 2018) are of the view that increase in job informality is related to poverty and exposes workers to abuse, exploitation and income fluctuations, since they are not protected by work regulations. Also, informal jobs are not covered by social security systems which grants access to pensions.

Further, Fernadez-Nino et al. (2018), posit that in retirement, financial stability and income are closely related to psychological well-being and retirement adjustment. In this sense, people who have economic support and stable incomes have a better psychological well-being during retirement and a better adjustment process. The financial stress from retiring from a job is one of the most common stressful event for older adults, especially when there is no social support to compensate for this financial change.

Illness and Family Care Strains

Family Caregiving Strains and Depression

Having to provide care for an ailing spouse is one of the greatest family stressors. There is also reciprocal relationship between men and their spouses so that as the men's problem increases, spouses' quality of life decreases (Ofori, 2017).

Stress from caregiving is associated with financial burden where the spouse has to give up work, or combine both in order to care for the man. The economic and monetary stressors of caregiving are challenges especially among low income families.

In the views of Chumbler, Rittman, Van Puymbroeck, Vogel, and Qin (2008), a patient related factor that is often associated with depression in caregivers is the severity of the ailments. A caregiver related factor which is also associated with depression is the poorer physical health of the caregiver.

Meltzer and Mindell (as cited in National Research Council and Institute of Medicine, 2009) also indicate that high levels of depressive symptoms have been found to be more common in mothers of children with specific medical conditions. These medical conditions with associated psychosocial issues include chronic epilepsy, conditions with high daily care demands such as medical fragility, severe burn, and major developmental disabilities. Stress from caregiving, anxiety, lack of social supports, and disrupted caregiver sleep have all been shown to play a role in how a chronic condition relates to maternal depression (National Research Council and Institute of Medicine, 2009).

Losses

Dependency, Relationship Depth, Complicated Grief, and Depression

A close relationship influences a wide range of physical, cognitive, and emotional processes in everyday life. Having lost a close relationship through death, psychological responses to the loss may be complex, and vary in intensity and types of symptoms.

According to Mash, Fullerton, Shear, and Ursano (2014), a major factor which may play a role in the development of a complicated grief and depression in bereavement is the relationship of interpersonal and personality characteristics. The personality variable such as dependency, in combination with the quality of the relationship between the bereaved and the deceased may lead to the development of complicated grief or depression, particularly among young adults. In the views of Denckla, Mancini, Bornstein, and Bonanno (as cited in Mash et al., 2014) individuals identified as dependent are likely to be motivated by hopes of obtaining care, nurturance, guidance, and support from the deceased. Bonanno, Wortman, Lehman, Tweed, Haring, Sonnega, Carr, and Neese (as cited in Mash et al., 2014) assert that dependency has been associated with chronic or unresolved grief characterized by symptoms of persistent intense yearning and distress following loss of a loved one. Johnson, Cohen, Gould, Kasen, Brown, and Brook (2002) point out that high levels of dependency together with interpersonal conflicts are also associated with depression.

According to Mash et al. (2014), another factor that may lead to development of complicated grief and depression is the degree of closeness or depth of a relationship. This implies that the extent to which an individual

positively values and is committed to a relationship prior to the loss may contribute to development of complicated grief or depression after loss. Mancini, Robinaugh, Shear, and Bananno (2009) hold the view that feelings of trust, security, intimacy, and mutual support in a relationship are associated with increased grief, particularly in older adults following loss. Stroebe, Abakoumkin, and Stroebe (2010) indicate that positive relationships characterized by high levels of satisfaction have been related to the core grief symptom of yearning.

Circumstances of Loss and Depression

According to Keyes, Pratt, Galea, McLaughlin, Koenen, and Shear (2014), circumstances of loss, or loss of a close relationship in an unexpected death is a stressful life event and may be associated with development of mental health disorders. This supports the views of Bowlby (1980) that sudden unexpected death is felt as a far greater shock than is predictable one. In the views of Bowlby, Harvard study of widows and widowers under age 45 shows that in that age group, after a sudden death not only is there a greater level of emotional disturbance but also anxiety and depression.

Transitions into and Out of the Family

Household Size, Social Network, and Depression

The nature and extent of an individual's social network, such as quantity and quality of social relationships, and frequency of contact can have a significant impact on health (Rich-Uribe, Caballero, Tobias-Adamczyk, Koskinen, Leonardi, & Miret, 2016). According to Anderson and Thayer (2018), an individual's social network and physical isolation are top predictors of loneliness, although depression, and overall health could also be

contributory factors. To Anderson et al. (2018), the social network factor comprises the number of people who have been supportive, people with whom you can discuss matters of importance, and diversity of social relationships including family, spouse, and friends. The physical isolation factor also comprises disability status, number of hours spent alone, and household size.

According to Hole (2011), loneliness is about an individual's perception and interpretation of their social relationships and a discrepancy between what they have and what they desire. As one's social network increases, loneliness decreases. Similarly, as physical isolation decreases, loneliness also decreases (Anderson et al., 2018). This implies that relocation of household members to other places due to work, education, or marriage can limit household size, decreasing social network, and increasing physical isolation. According to Anderson et al. (2018), development of depression and anxiety is associated with increased likelihood of loneliness.

Family Legal Violations

Incarceration of a Family Member and Depression

When a parent is incarcerated, many dimensions of the family undergo significant changes. The emotional support systems, the financial relationships, income levels, and living arrangements may be affected. Travis (as cited in Asomaning, 2013) holds the view that 71% of most parents incarcerated were employed either on full-time or part-time in the month preceding their arrest. Incarceration of parents is termination of sources of income to the family, creating financial strains on the family.

Besides, a significant consequence of incarceration of a family member associated with depression is the collective experience of stigma and

discrimination of the whole family (Hannem, 2008). In the views of Jones, Farina, Hastorf, Markus, Miller, and Scott (as cited in Hannem, 2008) when individuals are stigmatized, the reactions, observations, and evaluations elicited from other people may be disproportionately negative to them. Experiences of stigma often contribute to emotional difficulties including depression, and social withdrawals.

Another effect of incarceration of a family member associated with depression is isolation and loneliness. Many families deal with the stress and trauma of imprisonment in isolation (Hannem, 2008). Many women with an incarcerated spouse experience a reduction in available social support to cope with the stress associated with incarceration, implying that incarceration of a family member does not come with sympathy from the society.

Domestic Violence and Depression

Domestic Violence Act (Act 732) maintain that domestic violence within the context of previous or existing relationship means engaging in acts that constitute a form of harassment, threat, or harm to a person. In other words, behaviours likely to result in physical, sexual, economic, social, and emotional or psychological abuse constitute domestic violence (Owusu-Adjah et al., 2016).

Physical violence is the use of physical force against a person including slapping, pushing, hitting or denying a person access to adequate food, water, clothing, shelter, rest, or subjecting a person to inhumane treatment. Sexual violence is the forceful engagement of a person in a sexual contact, acts of unwanted sexual comments, or sexual act by a person aware of having sexually transmitted diseases with another person without giving the

person prior information of the infection. Economic violence is the denial of financial resources for expenses even if financial means are available or hindering the use of a property in which a person has material interest or is entitled to by law. Psychological violence is any conduct that makes another person feels constantly unhappy, miserable, humiliated, worthless, depressed or intimidations and acts aimed at scaring someone. Social violence comprises acts of controlling behaviour including preventing someone from seeing family of birth or friends, or requiring to know where someone is at all times (Institute of Development Studies & Ghana Statistical Service, 2016).

Sorenson and Golding (as cited by the World Health Organization, 2000) enumerates the psychological effects on women subjected to violence. Women who experienced violence in both childhood and adulthood have worse psychological outcomes than women who never been victimized and those who had been victimized once. Thus, women who suffered double or multiple abuses have significantly higher rates of psychological disorder (World Health Organization, 2000).

Effects of Depression on Women

Depression can be disabling to anyone experiencing it. Its impact goes beyond the affected woman to the broader family context and especially to her children. Under these circumstances, depression becomes a disorder that have serious biological, psychological, behavioural, and social consequences. A major effect of depression on women is helplessness and trauma that come with it. The woman who experiences depression feels helpless and trapped in her own situation. This leads to a severe feeling of low energy which in turn translates into poor performance at work. Subsequently, this situation worsens

depression as the woman continues to feel more worthless and loses all enthusiasm in daily tasks and even in formerly enjoyable activities.

Another significant effect of depression on women is its negative impact on the family. “Like a pebble that creates ripples when dropped into water, depression creates ripples in the interactions with the family” (Marshall & Harper-Jaques, 2008, p.58). When a woman is depressed, there is a greater probability that other family members will experience emotional problems. That is, mother-child interactions may be constrained, and spouses may experience less satisfaction with the marriage. Besides, the afflicted mother’s negative point of view and irritability often puts other family members off.

Additionally, an obvious effect of depression among women is the negative consequences it imposes on the children. According to England and Sim (2001), 15.6 million children below 18 years live with an adult who experiences depression. In families with a depressed mother, interactions between the mother and the children is negative. In the views of Marshall and Harper-Jaques, when the mother of a young child is depressed, the effects on the child can include alterations in the child’s physiological development, poor health in the child, and increased incidence of major depressive disorders. Other effects of maternal depression on the children include insecure attachment, difficulties with developing social skills, and academic challenges.

Finally, the effects of depression on women can also be associated with suicidal tendencies. Battacharjee and Deb (2007) indicate that although people commit suicide for reasons other than depression, depressed people are 20 times more likely to commit suicide than non-depressed people. Depression among women can develop and threaten their entire existence and the very act

of living can become painful to them. In such circumstances, the afflicted person may choose to put an end to her suffering by taking her own life. Even if self-harm or suicide attempts do not materialize, they can do long-term damage to these women.

Effects of Women's Depression on the Economy

Depression among women also impairs their work functionality. This suggests that women's economic quality declines due to depression. Women, according to the United Nations (2018), bear disproportionate responsibility for unpaid care and domestic work. Elson (1999) indicates that the unpaid care work is essential to the functioning of the economy, but often goes uncounted and unrecognized. Meanwhile it is estimated that if women's unpaid work were assigned a monetary value, it would constitute between 10% and 39% of Gross Domestic Product (GDP) (United Nations, 2018). The severe low energy experienced by a depressed woman translates into poor performance of her domestic care work invariably affecting productivity.

Rural women make up a quarter of the world's population (United Nations, 2018). These women grow much of the food stuffs, participate in markets, make economic decisions of their households, and strengthen economies. According to the United Nations (2018), when more women work, economies grow. However, depressed women remain less likely to participate in their economic activities which implies decline in economic growth.

Depressed women employees also exhibit strained working relationships at work. They may feel disadvantaged and insecure and the ultimate reaction is either lashing out at other workers and even clients, or feeling reluctant to do anything. However, success at workplace demands co-

operation with colleague workers. Interpersonal relationships at work improves job satisfaction, and perceived organizational support. Failure to co-operate with other workers leads to a dysfunctional working environment and subsequently decreases productivity.

Finally, another effect of women's depression on the economy is referred to as "presenteeism." According to Singh (2017), presenteeism is productivity loss resulting from health problems. Underlying presenteeism is the assumption that people do not take their jobs lightly, and that they want to continue if they can. More serious illnesses compel people to stay at home from work which does not often happen in the case of depression. In this view, depression among women at the workplace results in presenteeism. Stander, Korb, De Necker, De Beer, Miller-Janson and Moont (2017) indicate behaviours that depressed women exhibit at work which constitute presenteeism. These behaviours include regularly coming in late, making more mistakes than usual, missing deadlines, taking more time to complete simple jobs, withdrawing from colleagues, crying at work, falling asleep at work, and difficulty making decisions.

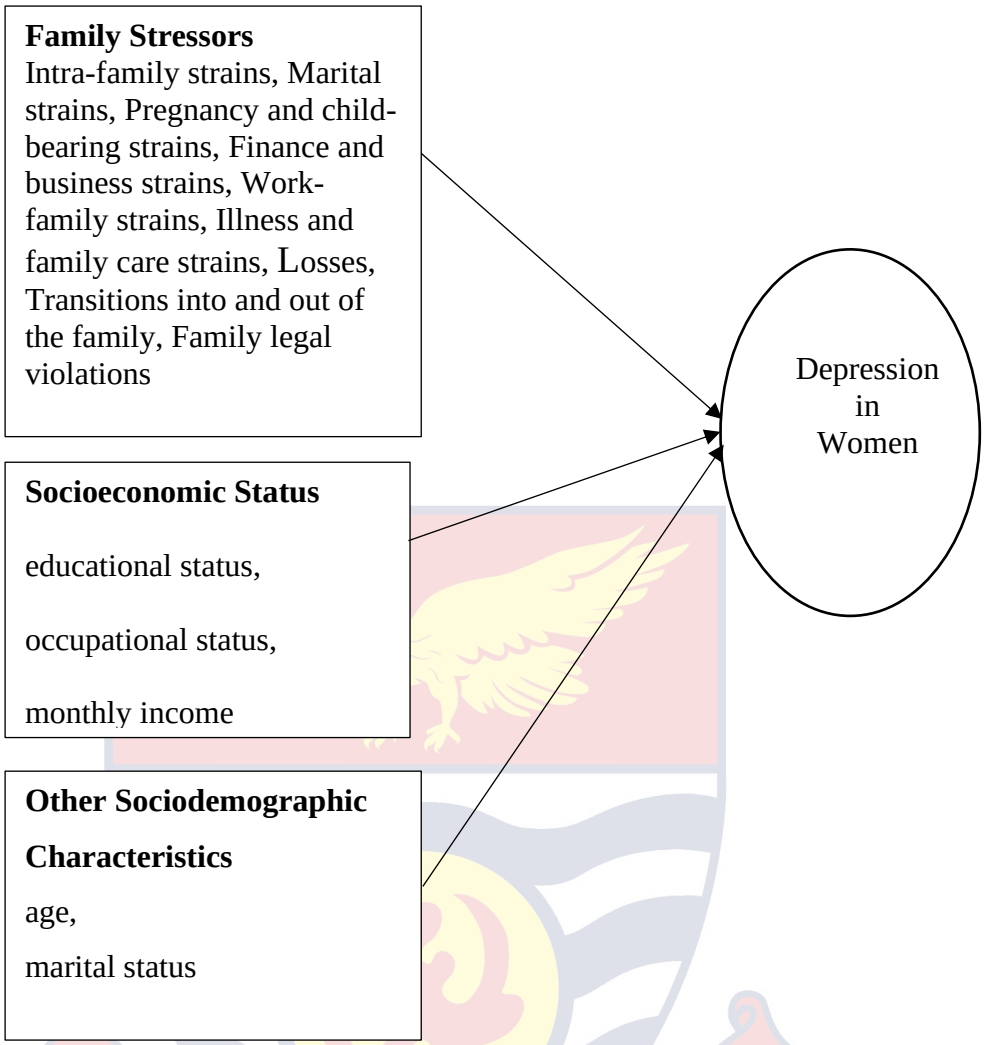

Figure 1: Conceptual framework of depression

Source: Author's Construct (2020)

Figure 1 shows the interactions of family stressors, and socioeconomic and demographic variables which bring about the stress processes and subsequent depressive symptoms. Thus, the interactions of family stressors, and socioeconomic and demographic characteristics in the context of appraisal processes, and the core components in the development of stress processes can change the course of stress and subsequently result in depression.

Empirical Review

This section reviews related empirical studies. This is done under themes or subtopics.

Age, Marital Status, and Depression

Age as well as marital status influence depression. A number of studies also identified age as a predictor of psychological well-being. Singh, Kaur, Singh and Junnarka (as cited in Afun, 2016) studied the relationship between psychological well-being and socio-demographic variables among mothers in rural India. The study involved 221 mothers within the ages of 18 and 56. The authors concluded that age had a significant correlation with well-being, in that, as one ages the person's life satisfaction decreases hence their low psychological well-being. A study by Buabeng (2015) revealed that women who were 35 years and above had increased odds of getting depression as compared to those who were 25 to 34 years. Another study done by Bonful and Anum (2019) also showed lower levels of depressive symptoms among younger women.

According to Booth and Edwards (as cited in Anim, 2013) young people are on average worse at being spouses than older people. Anim (2013) studied the influence of psychosocial factors on marital distress among married men and women in Ghana. The youngest age for the study sample for husbands was 28 years, and 25 years for wives. The oldest age for husbands was 64 and 56 for wives. The results did not show which age group is more distressed. Age and distress of wives were correlated and Pearson's correlation coefficient revealed a negative low correlation which suggests that the lower the age of wives, the higher their distress. This implies that as the wives grow older, their distress level decreases.

A study conducted by Ghaffar, Iqbal, Khalid, Saleem, Hassali, Baloch, Ahmed, Bashir, Haide, and Bashaar (2017) also demonstrated that age of a

pregnant woman predicted depression. A study by Karachi (as cited in Ghaffar et al., 2017) also indicated that increasing age is associated with increasing depression among women of the reproductive age group.

Regarding marital status, a study by Opoku-Mensah et al. (2017) showed a reduced likelihood of depression among married mothers compared to non-married mothers. A study done by Buabeng (2015) also showed that being married or living together decreased the likelihood of getting depression as compared to those who were never in a union. Dziak, Janzeen, and Muhajarine (as cited in Opoku-Mensah et al., 2017) examined the psychological distress, psychological work quality, and work-family conflict of both employed single mothers and employed married mothers. The results revealed that single mothers experienced higher levels of psychological distress due to economic hardship. Further, single mothers have significantly higher rates of depressive episodes, anxiety, stress, unhappiness, and physical health problems than married mothers.

Socioeconomic Status and Depression

A study by Buabeng (2015) indicated that of 450 depressed women, majority of them had basic education (primary or junior secondary). Results also showed that 18.3% had completed senior high or vocational school and 10.2% had no formal education. Peyrot, Lee, Milaneschi,…,Pennix (2015) conducted a study on the association between lower educational attainment and depression owing to generic effects in Netherlands. The study involved 9,662 participants with 59.4% females. The authors confirmed an association of lower educational attainment and major depressive disorder, which suggests

that environmental factors such as socio-economic status could be involved in major depressive disorder.

Gan, Lin, Xie…, Zhang (2011) examined 1,970 females in a study to investigate the impact of educational status on the clinical features of major depressive disorder among Chinese women. The women were aged between 30 and 60 and had two or more episodes of major depressive disorder. The authors, however, concluded that low educational status was not found to be associated with an increase in the number of depressive episodes. Rather, more years of education is a risk factor for recurrent major depressive episodes in Chinese women.

Regarding employment status, Buabeng (2015) reported that of 450 depressed women, 46.2% were self-employed (traders) whereas 11.2% were officially employed (civil servants). The study, however, showed that 17.8% were unemployed whiles 22.5% had other occupations including tailoring, hairdressing, and farming. A study done by Ghaffar et al. (2017) reported that unemployed women were more depressed during pregnancy. According to Ghaffar et al. (2017), unemployed women lack economic support and have a lot of time to think about their pregnancy.

For monthly income, a study by Buabeng (2015) reported that approximately half of 450 depressed women earned GHS 200.00. A study by NajahAliAqe and Thabet (2017) suggested that family stressors in families with low monthly income (less than $350) were more than in families with higher family monthly income. The authors also reported that depression was more in women with low monthly income than in women with higher monthly income. This is supported by another study by Snell-Rod, Haunstein,

Leukefeld, Feltner, and Marcum (2017) which in a study of 28 low-income women living in southeastern Kentucky, used Center for Epidemiological Studies Depression Scale (CES-D) to screen these women. The study showed that the mean CES-D score was 32 among the women they interviewed, suggesting moderate to severe depression. Combs-Orme and Cain (2006) examined the impact of income and social support on parenting stress in a study involving 103 African-American families. Examining four family configuration, (mother and baby; mother, baby, and grandmother; mother, baby, and unmarried partner; and mother, baby, and married partner), the authors reported that as total family income decreased, parental distress increased with no impact from family configuration on parenting stress. Lee, Yip, Leung, and Chung (2000), and Patel, Rodrigues, and DeSouza (2002) all specifically studied the effects of low income in populations in India and China respectively and found that financial strain was an important risk factor in postpartum depression within these populations.

Intra-family Stress and Depression

Scholle, Rost, and Golding (1998) examined 303 depressed women in a study to find out the prevalence of physical abuse by partners. One hundred and sixty-one (161) representing 52% reported ever experiencing physical abuse as adults since age 16. Forty-one (41) women representing 14.5% reported recent abuse, defined as physical abuse occurring during the year-long study, 40.7% reported previous abuse, defined as physical abuse occurring since age 16 but not during the study year. Results also showed that among women with recent abuse experience, 42.1% reported severe abuse. Owusu-Adjah and Agbemafle (2016) studied the determinants of domestic

violence against women in Ghana and reported that of 1,524 ever married women, the proportion of women (19%) who consumed alcohol was less than the number of men who drank alcohol (37%). The authors reported that 33.6% of women had ever experienced domestic violence with women whose husbands drink alcohol 2.5 times more likely to experience domestic violence as compared to women whose husbands do not drink alcohol. In a study by Mondragon (2017), a significant relationship between family stressors and interparental conflict among Latino families was established. McCubbin and Pattererson (as cited in Mondragon, 2017) suggested that overwhelming stressors can be very emotionally taxing, and shifts may occur in family functioning and family interactions. This is supported by a study done by Beck (as cited in Buabeng, 2015) which also found higher levels of perceived life stress to be associated with depression.

In another study, Jeffery (as cited in Oti-Boadi, 2015) examined the mediating role of parenting stress in the relationship between parents' depressive symptoms and behavioural problems of the child. Fifty-eight (58) mothers were involved in the study measuring depression, stress and child's behaviour problems. The results from the multiple regression anlysis showed that parenting stress mediated the relationship between parental depression and child behavioural problems.

Marital Stress and Depression

In a study by Buabeng (2015), a significant association between emotional relationship with the men with whom the women had a baby and depression was found. The study also revealed that father not being part of the life of mother and baby and not providing financial support also increased the

risk of suffering depression. This is consistent with previous studies by O'Hara and Swain (1996) which also found association between poor marital relationship and depression. A study done by Brown and Harris (1978) also reported that life events including relationship breakdowns, divorce or moving home are known to cause stress and can trigger depressive episodes in individuals with no previous history of depression. Also, Sipsma, Ofori-Atta, Canavan, Osei-Akoto, Udry, and Bradly (2013) examined 3,007 women in relationships to investigate associations between empowerment and poor mental health among women in Ghana. The authors concluded that all of the components of women's empowerment, including attitudes about their roles in decision making, attitudes towards intimate partner violence, partner control, and experiences of abuse were strongly associated with worse mental health.

In another study, Anim (2013) examined 80 married men and women consisting of 40 husbands and 40 wives in a study to identify psychosocial factors influencing marital distress in Ghanaian married couples. Results indicated that 55% of husbands and 52.5% of wives experienced distress in sex relations. Amidu, Owiredu, Wood, Addai-Mensah, Quaye, Alhassan, and Tagoe (2010) conducted a study on incidence of sexual dysfunction in Ghana among women. The study comprised 301 females. Results revealed that the overall prevalence of sexual dysfunction was 72.88%. Severe difficulties with sexual function were identified in 3.3% of the studied population. The most prevalent areas of difficulty were anorgasmia (72.4%), sexual infrequency (71.4%), dissatisfaction (77.7%), vaginismus (68.1%), avoidance of sexual intercourse (62.5%). Similarly, Amidu, Owiredu, Wood, Appiah, Quaye, and Gyasi-Sarpong (2010) examined 102 men in a study to investigate sexual

dysfuntion among men in Ghana. Results showed that of 102 men, 88.2% were married, 88.2% were also non-smokers, and 61.8% abused alcohol. The prevalence of sexual dysfunction was 59.8%. The highest prevalence of sexual dysfunction was among ulcer patients (100%), followed by men who have undergone surgery (75%), diabetes (70%), hypertension (50%), STDs (50%), and migraine patients (41.7%). Alhassan, Ziblim, and Muntaka (2014) examined 100 infertile women in a study to investigate the prevalence and severity of depression in Ghanaian infertile women. The results showed a high depression prevalence of 62.0% among infertile women.

Pregnancy and Childbearing Stress and Depression

The relationship between pregnancy and child-bearing stress, and depression has been studied by several authors. In the study done by Ghaffar et al. (2017) those pregnant women whose number of children was between 1 to 5 were depressed. The authors attributed the depressed states of these women to unplanned pregnancy or poverty.

The findings of a study by Lambon (2018) also suggested that due to the various meanings assigned to stillbirth, mothers after stillbirth grieve and equally face challenges such as isolation, or social withdrawal, spouse or partner challenges and stigma. The author reported that mothers after stillbirth are likely to develop psychological problems such as depressive symptoms.

Iranfar, Shkeri, Ranjbar, Nazhad, Jafar and Razaie (2005) carried out a study on 163 pregnant women seeking antenatal care at all clinics over a 1-year period in Kermenshah city in Islamic Republic of Iran. One hundred and five (105) intended and 58 unintended pregnancies were studied. Out of 58 women with unintended pregnancy, 43% reported attempting to abort the

pregnancy. Depression at 37 weeks' gestation was slightly higher in the unintended group (53.4%) than the intended group (41.0%) and depression, 10 days postpartum, was much higher in the unintended group (48.7%) than the intended group (25.6%). Najman, Morrison, Williams and Andersen (1991) studied 6,642 women in Australia starting at prenatal checkups through to 6-months postpartum. The study included only women who carried their pregnancy to term. Two hundred and seventy-seven (277) were reported as those who not only had not planned their pregnancies but also showed emotionally negative reaction to them during their first prenatal checkup. Results also revealed the group of women who in general had initially rejected their pregnancy showed a clear increase in the risk of anxiety and depression both during the pregnancy, as well as at one and six months postpartum.

Further, Guo et al. (2014) explored mental health related determinants of parenting stress among expectant mothers in Ghana and Cote D'ivoire. Women in the last trimester of pregnancy were selected for the study in two major hospitals, one in Ghana and the other in Cote D'ivoire, during their antenatal care visits. A total of 577, 531 women in Ghana, and 264 women in Cote D'ivoire completed the parenting stress assessment at 3 months, 12 months, and 24 months postpartum across the two sites. The prevalence of parenting stress at each point in time was 33.1%, 24.4%, and 14.9% in Ghana and 30.2%, 33.5%, and 22.6% in Cote D'ivoire respectively. At all three time points, the parenting stress scores were significantly higher among depressed mothers than non-depressed mothers.

Finance and Business-Induced Strains and Depression

Financial constraints were found as important risk factors for depression. However, in a study by Abeasi (2014) the relationship between financial constraints and depression was found to be no longer statistically significant after controlling for social support, which shows that the relationship between the two variables was due to social support. The author indicated that when there is available social support, the financial burden reduces and consequently the negative impact of financial constraints on emotional or psychological health reduces. Ghaffar et al. (2017) reported that social support mechanisms serve as assistance in improving adaptation and emotional stability. In the views of these authors, as social support increases psychological stress decreases, hence women having low levels of social support experience higher rates of depression.

On the other hand, Dooley, Pause, and Ham-Rowbottom (as cited in Amissah, 2016) examined the link between change in employment status and depression using data from the National Longitudinal Survey of Youth in the U.S. The study included 5,000 respondents who were adequately employed in 1992 prior to the study, and who were followed up in 1994. Results showed that becoming unemployed, inadequately employed, or inactive were all significantly associated with increased depression compared to those remaining adequately employed.

Vinokur, Price, and Caplan (1996) examined 815 recently unemployed job seekers who reported living with a spouse or a partner in a romantic relationship as a couple, and their 815 spouses or romantically attached partners. The authors explored the relationship between concurrent financial

resources and financial strains at the six-month follow-up, a time by which nearly 50 percent of the job seekers had gained employment. The authors concluded that the higher the job seekers' monthly income, the lower their reported financial strains. Neppl et al. (2016) studied 451 families and reported that economic hardship was significantly associated with higher levels of economic pressure. Economic pressure was significantly associated with higher parental emotional distress. Parental emotional distress was significantly associated with higher levels of couple conflict. Couple conflict was significantly associated with higher levels of harsh parenting, which in turn, was significantly associated with externalizing behaviours in children between the ages of 6 and 10. In a similar study, Brown and Morgan (as cited in Stack & Meredith, 2018) examined marital status, poverty, and depression in female parents over a two-year period. The authors found that single parents were twice as likely as their married counterparts to be in financial hardship. In the views of Richardson et al. (2013), four studies examined relationships between debt and health in adults. All these studies used data from existing wider studies, and therefore had large sample sizes. Results showed that debt increased the risk of depression.

Family-Work Stress and Depression

In a study to investigate the influence of family stress and conflicts on depressive symptoms among working women, Ju, Park, Ju, Lee, Kim, Chun, and Kim (2017) examined 4,663 women. The authors found out that the combination of family stress and family-work conflicts strongly influenced the depressive symptoms of working married women. This is supported by a study done by Stoeva and Greenhaus (as cited in Ju et al., 2017) in which they

reported that family stress and family-work conflict from multiple roles influence depressive symptoms among women. European Agency for Safety and Health at Work (as cited in Amankwah, 2018) explored the relationship between work-to-family and family-to-work conflicts on health outcomes. The results showed that both work-to-family and family-to-work conflicts are related to heavy alcohol use, depression and poor physical health. From the study it was also revealed that women had a higher chance of experiencing job dissatisfaction and had the strongest relationship between work-to-family conflict and health outcomes.

In another study by Reddy, Vranda, Ahmed, Nirmala, and Siddaramu (2010), rearing children is significantly related to family-work conflicts in working married women. Another study by NajahAliAqe and Thabet (2017), showed that working women with 8 and more children had more family stressors than those women with 7 and less children in the family. A study by Grzywacz and Marks (2002), reported that mother role influences depressive symptoms in working women with regard to child-rearing. The authors further stated that when working women do not fulfil their role as mothers, then the failure to maintain the mother role influences depression. However, in a study done by Ju et al. (2017), rearing children was associated with reduced depressive symptoms among working married women, but not significant.

Fernadez-Nino et al. (2018), explored individual and social variability in the association between work status and depression in older adults, based on information from six countries, including Ghana, having different socioeconomic and cultural conditions. The study composed of 9, 420 men (44.0%) and 11, 990 women (56.0%). Results showed that being retired with a

pension was found to have a protective effect on major depressive episode for men in China and Ghana and for women in India and South Africa. Results also revealed that not working due to disability was a risk factor for both men and women across all the six countries.

Caregiving Stress and Depression

U.S. National Comorbidity Survey (as cited in NajahAliAqe et al., 2017) showed that women contend with increased exposure to the social risk factors associated with depression including chronic stress, experiences of trauma, and family caregiving responsibilities. In a study by Abeasi (2014), the level of depression among caregivers of stroke survivors is low. However, in the same study, non-caregivers reported a significant lower level of depression than caregivers of stroke patients. The author also reported that caregivers of stroke patients who had high social support reported lower level of depression and better quality of life than those who had lower social support. Fatoye, Komolafe, Adewuya, and Fatoye (2006), explored emotional distress and quality of life among family caregivers of stroke survivors in Nigeria using a cross-sectional design. Of 103 caregiver participants assessed, 24% were found to be depressed. Cameron, Cheng, Streiner, Coyte, and Stewart (2006), conducted a study using a cross-sectional design involving 94 informal caregivers who were identified from two health facilities and one health institution. The caregivers provided care at least more than 20 months. Results revealed that 45% of caregivers reported depressive symptoms

However, a study conducted by Khalid and Kausar (2008) reported high prevalence of depression among caregivers of stroke survivors. Thrush and Hyder (2014) reported in their study that what matters most to the caregiver is

not the level of impairment of the patient but the burden of caregiving which is also subjective. The authors suggested that different caregivers giving care to patients with the same level of severity may perceive the burden posed to them differently.

Bereavement and Depression

Bereavement has been identified to be related to development of depression. Fried, Arjadi, Bockting, Borsboom, Amshoff, Cramer, Epskamp, Twelincky, Carr, and Stroebe (2015) conducted a study that evaluated the common cause and the network approach to illuminate the association between spousal loss and depressive symptoms. The authors reported that the association pattern between symptoms is far more complex than the common cause that can be explained, and the network revealed that bereavement mostly triggers loneliness, which activates further depressive symptoms. In a related study by Mojtabai (2011), bereavement-induced depressive episodes were more common in women than men. Keyes et al. (2014), examined associations of a loved one's unexpected death with first onset of common anxiety, mood and substance use disorders. The authors concluded that unexpected death was associated consistently with elevated and new onsets of post-traumatic stress disorder, panic disorder, and depressive episodes at all stages of the life course.

In another study, Mash et al. (2014) investigated the association of dependency and quality of the relationship with the deceased and subsequent complicated grief and depression. Of 157 young adults between ages 17 and 29 who experienced loss of family member within the past three years, study results revealed that 16% of bereaved young adults showed complicated grief,

and 34% had mild to severe depression. The authors concluded that the effect of dependency on complicated grief was moderated by the level of depth of the relationship. The degree of depression as reported by the bereaved participants was influenced only by their level of dependency, independent of depth or conflict within the relationship, suggesting that a depressive response to loss is more related to personality trait of dependency.

Transitions into and out of the Family

A study by Anderson et al. (2018) examined social connections and loneliness in relation to social isolation factors. The sample for the study comprised 6,343 U.S. residents age 45 and older. Of those sampled, 3,020 completed the survey, resulting in a 50.8% completion rate. Results showed that loneliness is highest among those who dealt with a close relative moving away (38%), compared to a good friend (33%), or neither (35%). Santini, Koyanagi, Tyrovolas, Mason, and Haro (2015) investigated the association between social relationships and depression and reported that social networks play a protective role against depression just as social support does.

Family Hostility and Legal Violations

A study by Gafarov, Panov, Gromova, Gagulin, and Gafarova (2016) found that 11% of women with family stress had high rate of major depression. The study also indicated that the prevalence of hostility and vital exhaustion in those with stress are 41% and 27.4% respectively. Given this, a study by Institute of Development Studies (2016) across the erstwhile 10 regions of Ghana to find out the incidence, attitudes, determinants, and consequences of domestic violence showed that, of 2,989 women, experiences with at least one form of physical violence were reported by 46% of divorced,

separated, or widowed women, and by 41.8% of women who were married or living with a partner, as compared to 35.1% of women who were never married. The incidence of sexual violence in 12 months prior to the study was highest among never married women which was 22.6%. The results also showed that 41% of women who were married or living with a partner, and 41.5% of women divorced, separated, or widowed experienced social violence in comparison to 39.9% of women who were never married. Thirty-three percent of divorced, separated, or widowed women experienced economic violence, compared to 18.6% of never married women, and 27.6% of married women or women living with a partner. The results indicated a very strong correlation between exposure to domestic violence and women's mental health status.

In another study, Moris (as cited in Halemani & Venumadhava, 2017) investigated 825 imprisoned men in England and 469 of their spouses to determine socioeconomic impact of imprisonment on the prisoner's family. Results showed that the impact of economic hardship on the family was more than demoralization through stigma. Among the most common problems reported, 63% of wives experienced deterioration in financial situations, 81% some deterioration in their work, 46% deterioration in present attitude to marriage, 63% deterioration in social activity, 60% deterioration with in-laws, and 57% deterioration in relationships with friends and neighbours. Koyanagi et al. (2015) investigated the association between social relationships and depression and reported the essence of social networks as a protective factor against depression just as social support.

Chapter Summary

This chapter reviewed related literature. It had three main parts, the theoretical review, the conceptual review, and the empirical review. The theoretical review considered the Lazarus and Folkman's Transactional Model of Stress, and the Stress Process Model. The conceptual review considered socio-demograpic characteristics as related to depression, concept of family stressors, and concept of depression. The conceptual review also covered McCubbin and Patterson's life events and strains that constitute family stressors. Finally, there was a review of related empirical studies.

For the Lazarus and Folkman's Transactional Model of Stress, Lazarus and Folkman (1984) came up with a strong view in explaining the appraisal processes. It was found that the major premise for the theory is that depressed women engage in primary appraisal, secondary appraisal, and reappraisal in the appraisal processes. The primary and secondary appraisals interact with each other to create the stress responses and emotional reaction which translate into depressive episodes.

In reviewing the Stress Process Model, the basis of the theory was traced to social structures and people's location within them. The theory comprises four components in the development of stress process. These are background and context characteristics, primary stressors, moderating reources, and outcomes of wellbeing which could be depressive episodes.

The conceptual review incorporates variables such as stressful life events as experienced in the family. McCubbin and Patterson (1987) outlined these family stressors as intra-family strains, marital strains, pregnancy and childbearing strains, finance and business strains, work-family transitions and

strains, illness and family care strains, losses, transitions into and out of family, and family legal violations.

In reviewing the related empirical studies, it was found that age as well as marital status influenced depression. Most of the reviewed studies showed that increasing age is associated with increasing depression. The reviewed studies also showed that being married reduced the likelihood of getting depression.

In terms of socioeconomic status, the study found family stressors in families with low monthly income than in families with higher monthly income. Some studies also reported that unemployed women were more depressed during pregnancy.

The review of related empirical studies also showed a significant association between family stressors and depression. Studies reviewed found that poor marital relationship was associated with depression. Life events like relationship breakdowns, divorce, or separation cause stress and trigger depression.

The findings also established that childbearing strains can trigger depression. It was found that depressed states of women could be due to unplanned pregnancy and poverty.

Finance and business constraints were also found as factors for depression. However, it was found that available social support mitigated finance and business strains hence depression.

A combination of family stress and family-work conflicts were also found as factors that triggered depression. However, rearing children was

associated with reduced depressive symptoms among working married women, but not significant.

Further, it was also found that caregiving stress exposed women to depression. However, some authors reported that caregivers who had high social support also had lower level of depression.

Finally, findings reviewed also indicated bereavement as a factor in developing depression. Some studies reviewed also found bereavement-induced depressive episodes were more common in women than in men.

CHAPTER THREE

RESEARCH METHODS

Introduction

This chapter discusses the research design, population, the sample as well as the sampling procedure that was used in the study to investigate the influence of family stressors as well as the socio-economic and demographic characteristics on depression among women. The research design and the research instruments used in the data collection have been discussed. The data collection and data analysis procedures have been discussed as well.

Research Design

The descriptive sample survey design with a quantitative approach was used for this study. The descriptive survey is basically designed to find out the existing situation of a particular phenomenon and the issues revolving around it. It is concerned with the present status of a phenomenon and it deals with what exist such as determining the nature of prevailing conditions, and practices. It is the type of design usually used to estimate the prevalence of the outcome of interest for a given population (Gay, 1992).

The descriptive survey design involves the collection of data in order to answer questions or test hypotheses concerning the current status of the subjects of study. It also results in a description of data, whether in words, pictures, charts, or tables (Gay, 1992).

The researcher deems the descriptive sample survey design the most appropriate for this study because it presents explicit statement about relationships between variables (Amedahe, 2002). Another advantage is that the use of descriptive survey designs allows variables and procedures to be

described as accurately as possible so that other researchers can replicate the study. Again, Hackett (as cited in Awabil, 2002) indicated that the descriptive survey design can be used to gather data on client attitudes and needs, and to aid the provision of counselling services.

These advantages, notwithstanding, the design is associated with some weaknesses. Among them, Hackett (as cited in Awabil, 2002) stated difficulties in obtaining a truly random sample of the population, and the problem of low response rating that plagues all surveys. However, this study adopted a census of the total population. In spite of the shortcomings, the descriptive sample survey design was the most appropriate as it would lead the researcher to draw meaningful conclusions from the data obtained.

Finally, the quantitative approach as used for this study also lent credence to the fact that the philosophical underpinning for the study was positivism or empiricism. Thus, the positivist or empiricist paradigm was in line with the quantitative approach which allowed for collection of data to answer and test research questions and hypotheses respectively to make room for generalisations.

Population of the Study

The study was conducted in the Ketu-South Municipality in the Volta Region of Ghana. This area was selected for the study because it illustrates mental health challenges such as depression among women in typical rural communities in Ghana. A case in point is the ease of access to these women either at the Mental Health Unit of the Municipal Hospital or the Department of Social Welfare. The target population for the study comprised all women experiencing depression in the Ketu-South Municipality. The study, however,

centered on an accessible population of 76 depressed women who were selected from the two sources which are the Mental Health Unit of the Ketu-South Municipal Hospital and the Department of Social Welfare.

Sample and Sampling Procedure

The sample frame of depressed women in the Ketu-South Municipality was not very large (76 depressed women), coupled with the desire to provide all the depressed women a chance to participate in the study, a census of the total population was adopted for the study. To this end, all the 55 depressed women were selected from the Mental Health Unit of the Municipal Hospital together with all the 21 depressed women drawn from the Department of Social Welfare. A total of 70 depressed women, of the 76 depressed women sampled, however, participated in the data collection. In the views of Cothari (2004), when the population is not very large, it is no use resorting to a sample survey. By adopting a census, the researcher is sure of the representative nature of the population and that the objectives of the study would be attained.

Research Instrumentation

The researcher used mainly 2 instruments namely Beck Depression Inventory (BDI II), and Family Inventory of Life Events and Changes (FILE) to collect data for this study. The Beck Depression Inventory (BDI II) was adopted whilst the Family Inventory of Life Events and Changes (FILE) was adapted for this purpose. The researcher used both Beck Depression Inventory (BDI II), and Family Inventory of Life Events and Changes (FILE) to collect data from the women experiencing depression. The researcher assisted the depressed women in the data collection by explaining the items of the instruments to them before asking them to give their responses.

Beck Depression Inventory

The Beck Depression Inventory is a series of questions developed to measure the intensity and severity of depression. The adopted scale comprises 21 items, that are scored on a 4 point Likert Scale with a total score of 63. Each response is allocated a score ranging from zero to three based on intensity of each specific depressive symptom. The 21 items that make up Beck Depression Inventory assess mood, pessimism, sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusation, suicidal ideation, crying, irritability, social withdrawal, indecisiveness, body image, work difficulties, insomnia, fatigue, appetite, weight loss, bodily preoccupation, and loss of libido respectively (Beck, Steer, & Brown, 1996).

Beck Depression Inventory is scored differently for the general population and for those who have been clinically diagnosed with depression. Thus, for the general population, a score of 21 or beyond represents depression. For the individuals who have been clinically diagnosed of depression, scores of 0-9 represents minimal depressive symptoms, whiles scores of 10-16 indicate mild depression, scores of 17-29 indicate moderate depression, with scores of 30-63 representing severe depression (Beck, Steer, & Brown, 1996).

Family Inventory of Life Events and Changes (FILE)

McCubbin, Patterson, and Wilson (1979) developed the initial version of Family Inventory of Life Events and Changes (FILE). The original version of the scale was made up of 171 items. Its formulation was informed by other life change inventories at the time. However, its development was based on an additional interest in the developmental and situational changes that occur in

families during different life cycles. The development of items for the instrument was guided by research by Coddington (1972), and Holmes and Rahe (1967), and modified with data from a sample of 322 families who have a chronically ill child living with cerebral palsy (Moes,1999; McCubbin & Patterson, 1987; Coddington, 1972; Holmes & Rahe, 1967).

The current Family Inventory of Life Events and Changes has 71 items that measure family stressors. The items are organized into nine subscales. These subscales are: Intra-Family Strains Scale, Marital Strains Scale, Pregnancy and Child Bearing Strains Scale, Finance and Business Strains Scale, Work-Family Transitions and Strains Scale, Illness and Family Care Strains Scale, Losses Scale, Transitions into and out of Family Scale, and Family Legal Violations Scale (Walsh, 2004; McCubbin & Patterson, 1987).

The Family Inventory of Life Events and Changes (FILE) is originally made up of items with dichotomous responses and is intended to assess the pile-up of family stressors with higher scores indicating higher family stress. However, for the purposes of this study, the scale was modified to 45 items, rating on a five point Likert scale using a score ranging from (1 – 5) as Very True, True, Somewhat True, Not True, and Not at All True. To this end, some of the items in the original scale were omitted.

Six items originally included in Intra-Family Strains subscale (Increased difficulty in managing teenage children; Increased difficulty in managing school age children (6-12yrs); Increased difficulty in managing preschool age children (2-6yrs); Increased difficulty in managing toddlers (1-2yrs); Increased difficulty in managing infants (0-1yr); Increase in the amount of outside "activities" which children are involved in) were modified to focus

strictly on child-rearing difficulties ("There is increasing child-rearing difficulties in my family. I am fed up.")

The modified version of the scale also incorporated items from Finance and Business Strains subscale of the original scale (Change in Agriculture Market, Stock Market, or land values which hurt family investment or income; Change in conditions (economic, political, weather) which hurts the family business) reframed into one item ("There are changes in economic, political, and weather conditions which hurt the family business or income"). The rest of the items (A member purchased or built a new home; A member purchased a car or other major item; A member went on welfare) were omitted from the modified version of the scale hence they would end up as eustress and not distress in the current population and would more likely result in benign-positive appraisals.

Two items originally included in Work-Family Transitions and Strains subscale (A member lost or quit a job; A member stopped working for extended period) were reframed into a single item ("A family member stopped working for extended period due to lay off, leave of absence et cetera. I am unable to cope with this). The rest of the items (A member started or returned to work; A member changed to a new job or career) were omitted from the modified version of the scale because they would also amount to eustress and would more likely result in benign-positive appraisals.

Three items which were also originally included in Illness and Family Care Strains subscale (Spouse became seriously ill or injured; Child became seriously ill or injured; Close relative or friend of the family became seriously

ill) were also reframed into one item ("There is increasing difficulty in managing seriously ill or injured member").

Two items which were also originally included in Losses subscale (Death of husband's or wife's parent or close relative; Close friend of the family died) were also reframed into one item ("A close relative died. This does not give me optimistic view for the future").

To establish the reliability of the modified scale within the current population, it was piloted using 15 women in depressed states, drawn from women victims who lodged complaints at the Domestic Violence and Victims Support Unit of the Ghana Police Service in the Ketu-South Municipality. The Cronbach alpha for the 45 items for the 15 women was .892 and was significant at .05 alpha level.

Validity of the Instruments

The Beck Depression Inventory has been tested for content, concurrent, and construct validity. High concurrent validity ratings are given between Beck Depression Inventory and other depression instruments including Hamilton Depression Rating Scale, and Minnesota Multiphasic Personality Inventory. The scale is positively correlated with the Hamilton Depression Rating Scale, r=0.71. The Beck Depression Inventory has also showed high construct validity with the symptoms it measures (Beck, Steer, & Brown, 1996).

According to McCubbin and Patterson (1987), construct validity of the Family Inventory of Life Events and Changes (FILE) is supported when correlated with a family functioning scale. Predictive validity has also been demonstrated. Besides, the scale also demonstrates moderately high

concurrent validity with Family Stress and Support Inventory (FSSI) Stress Scale (r=.50, p=.00), indicating that both assess similar, but not identical, family stress dimensions (Walsh, 2004; McCubbin & Patterson, 1987).

Reliability of the Instruments

The Beck Depression Inventory (BDI II) has a coefficient alpha rating of .92 for outpatients and .93 for college student samples. The BDI questionnaire also demonstrates high internal consistency with alpha coefficient of .81 for non-psychiatric population and .86 for psychiatric population (Beck, Steer, & Brown, 1996).

The overall alpha reliability of the Family Inventory of Life Events and Changes, total scale, is .81 (Cronbach's alpha) and subscale reliabilities vary from .73 to .30. The internal consistency is also most solidly demonstrated by the total scale (McCubbin & Patterson, 1987).

Pilot Testing

The pilot testing was done at the Domestic Violence and Victims Support Unit of the Ghana Police Service in the Ketu-South Municipality using non-clinical women who expressed depressive symtoms. The Domestic Violence and Victims Support Unit of the Ghana Police Service was chosen for the pilot testing because all the victims at the unit were women and the complaints they lodged at the unit constitute family stressors (family legal violations) which influence depressive symptoms among these women. Thus, the women at the unit are victims to all forms of domestic violence and have similar characteristics of family stress and depressive symptoms. Since depression is not diagnosed at the Domestic Violence and Victims Support Unit, the non-clinical women who lodged complaints at the unit were selected

to participate in the exercise only after they expressed depressive symptoms when the Beck Depression Inventory (BDI II) was administered to them by the researcher and the assistants. Beck Depression Inventory is scored differently for the general population and for those who have been clinically diagnosed with depression. Thus, for the non-clinical women, a score of 21 or beyond represents depression (Beck, Steer, & Brown, 1996). In all, 15 women who lodged complaints at the unit and also expressed depressive symptoms, were selected for the pilot testing.

The pilot testing allowed for the researcher to decide whether the study was feasible or not and whether its continuation was worthwhile. It again provided an opportunity to assess the practicality and appropriateness of the instruments being used for data collection. The pilot testing indicated a moderate family stress among the majority of women who lodged complaints at the Domestic Violence and Victims Support Unit of the Ghana Police Service in the Ketu-South Municipality. The pilot testing also brought to light a minimal depressive symptoms among most of these women who expressed a moderate family stress at the unit.

The data was collected from the 15 participants using both Family Inventory of Life Events and Changes (FILE), and Beck Depression Inventory. The Family Inventory of Life Events and Changes, which was adapted or modified and measured family stress recorded an alpha of .892. This suggested that the scale was reliable enough to be used for the study. Although the reliability coefficient of 0.509, 0.480, 0.309, and 0.187 were recorded by some subscales of the Family Inventory of Life Events and Changes, the reliability coefficient of this scale as well as its internal

consistency were most solidly demonstrated by the total scale. The reliability analysis as conducted on the FILE questionnaire and its subscales was presented in Table 2 below.

Table 2: Reliability Analysis of the Family Inventory of Life Events and Changes from a Pilot Testing of 15 Depressed Women

Subscales	Number of Items	Reliability Coefficient
Overall reliability	45	0.892
Intra-family strains	7	0.509
Marital strains	4	0.309
Pregnancy and child bearing strains	4	0.094
Finance and business strains	7	0.819
Work-family transitions and strains	7	0.805
Illness and family "care" strains	4	0.702
Losses	4	0.710
Transition into and out of family	4	0.187
Family legal violations	4	0.480

Source: Field survey (2019)

Data processing and analysis procedures

The data were edited, coded and processed using the statistical package for social sciences (SPSS version 20.0) software. The researcher analysed the data according to the formulated research questions and hypotheses.

Research question one intended to find out what kind of family stressors influence the women experiencing depression in the study area. Data for research question one were analysed using means and standard deviation.

Research question two sought the views of respondents on the extent to which age and marital status contribute to depression among women in the study area. Linear multiple regression was used to analyse the responses.

Hypothesis one sought to find out whether family stressors will significantly contribute to depression among women in the study area. Linear multiple regression analysis was used to check the contribution of family stressors to depression.

Finally, hypothesis two was formulated to find out whether socio-economic status will significantly contribute to depression among women in the study area. Linear multiple regression was conducted to ascertain the contribution of the socioeconomic variables to depression. In the analysis, a multiple regression was conducted for educational status and depression, and occupational status and depression whereas Pearson Product moment correlation was conducted for monthly income and depression.

Ethical considerations

A letter of introduction was taken from the Department of Education, College of Distance Education, University of Cape Coast to the administrator of the Ketu-South Municipal Hospital, as well as the Ketu-South Municipal Director of the Department of Social Welfare. After these institutional heads granted the request to conduct the study, a date was fixed for the commencement of the data collection.

The researcher ensured that participation in the study was strictly based on informed consent and willingness to take part in the study. Again, the researcher did not only assure the participants of confidentiality but also adhered to it throughout the process of conducting the study. Two research assistants who also double as mental health nurses were recruited to assist in the data collection.

Chapter Summary

This chapter presented the research methodology. The descriptive sample survey design with quantitative approach was used for the study. The design is usually used to estimate the prevalence of the outcome of interest for a given population. This design also involves collection of data in order to answer questions or test hypotheses concerning the current status of the subjects of study. A major advantage is that the design presents explicit statement about relationships between variables.

The chapter also included sample and sampling procedure. The sample frame of depressed women in the study area was not large (76 depressed women). A census of the total population was therefore adopted for the study.

Beck Depression Inventory (BDI II), and Family Inventory of Life Events and Changes (FILE) were used to collect data for the study. The Beck Depression Inventory (BDI II) was adopted whilst the Family Inventory of Life Events and Changes (FILE) was adapted for this purpose.

Finally, family issues being highly sensitive in nature, there was difficulty convincing some of the respondents to honestly answer questions posed. Also, some of the subscales of the Family Inventory of Life Events and Changes used in the data collection for this study had low reliability coefficients although the reliability coeffient of the scale was most solidly demonstrated by the total scale.

CHAPTER FOUR

RESULTS AND DISCUSSION

Overview

The purpose of this study was to investigate the influence of family stressors on depression among women in the Ketu-South Municipality. For the purpose of the study, the descriptive research design with quantitative approach was used. Beck Depression Inventory and Family Inventory of Life Events and Changes were used to collect data for the study. Descriptive statistics such as means and standard deviations as well as inferential statistics such as linear multiple regression were used to analyse the gathered data. The final sample size for the study was 70 depressed women in the Ketu-South Municipality and they were selected through the census method. This means that, after the data collection, 92.12% response rate was attained.

Results

Demographic characteristics of respondents

This section surveyed respondents' responses on their demographic characteristics including age, marital status, educational status, occupational status, and monthly income. A summary of the responses on the demographic characteristics is presented in Tables 3 to 7.

Age of respondents

The age of respondents is presented in Table 3.

Table 3: Age of Respondents

Age	Frequency	Percentage
20-29	10	14.3
30-39	15	21.4
40-49	18	25.7
50-59	13	18.6
60-69	14	20.0
70 and above	0	0.00
Total	70	100.0

Source: Field survey (2019)

Table 3 shows that 10(14.3%) of the respondents were aged between the range 20-29 years, 15(21.4%) of the respondents were aged within the range 30-39 years, 18(25.7%) indicated that they were aged within the range 40-49 years, 13(18.6%) of the respondents noted that they were aged within the range 50-59 years and 14(20.0%) indicated that they were aged within the range 60-69 years. The results indicate that majority of the respondents were 40 to 49 years of age.

Marital status of respondents

The marital status of respondents is presented in Table 4.

Table 4-Marital Status of Respondents

Marital Status	Frequency	Percentage
Married	21	30.0
Single	6	8.6
Separated	13	18.6
Divorced	15	21.4
Widowed	15	21.4
Total	70	100.0

Source: Field survey (2019)

It can be inferred from Table 4 that out of the 70 respondents that were surveyed, 30.0% were married, 8.6% were single, 18.6% were separated, 21.4% were divorced and 21.4% indicated that they have been widowed. The results show that a greater percentage of the respondents surveyed were married.

Educational status of respondents

The educational status of respondents is presented in Table 5.

Table 5-Educational Status of Respondents

Educational Status	Frequency	Percentage
No formal education	33	47.1
Basic	35	50.0
Diploma	2	2.9
Total	70	100.0

Source: Field survey (2019)

It can be inferred from Table 5 that out of the 70 respondents that were surveyed, 47.1% indicated that they had no formal education, 50.0% indicated that they had basic education while 2.9% indicated that they had diploma. The

results show that a greater percentage of the respondents had basic education as their highest level of education.

Occupation of respondents

The occupation of respondents is presented in Table 6.

Table 6-Occupation of Respondents

Occupation	Frequency	Percentage
Not employed	20	28.6
Officially employed	4	5.7
Self-employed	46	65.3
Total	70	100.0

Source: Field survey (2019)

Results from Table 6 indicate that out of the 70 respondents that were surveyed, 28.6% were not employed, 5.7% were officially employed, and 65.3% indicated that they were self-employed. The results show that a greater percentage of the respondents were self-employed.

Monthly income of respondents

The monthly income of respondents is presented in Table 7.

Table 7: Monthly Income of Respondents

Monthly Income (Gh¢)	Frequency	Percentage
Below 500	20	28.6
500 but less than 1000	30	42.9
1000 -1500	15	21.4
Above 1500	5	7.1
Total	70	100.0

Source: Field survey (2019)

Results from Table 7 indicate that out of the 70 respondents that were surveyed, 28.6% had a monthly income below GH¢500, 42.9% had a monthly income between GH¢500 and GH¢1000, 21.4% had a monthly income of GH¢1000 to 1500 while 7.1% had a monthly income above GH¢, 1500. The results show that majority of the respondents had a monthly income of GH¢, 300 to 500.

Analysis of Main Data

Research Question One

What kind of family stressors influence the women experiencing depression in the Ketu-South Municipality?

The goal of this research question was to find out the prevalence of family stressors among the women experiencing depression in the study area. In order to achieve the purpose of this research question, the Family Inventory of Life Events and Changes which included the nine dimensions of family stressors with sub-questions was used to collect data from 70 depressed women for the study. The instrument was measured on a five point Likert scale namely 5= very true, 4= true, 3= somewhat true, 2= not true and 1= not at all true. In achieving the goal of the questions, a standard mean of 3.0 (5+4+3+2+1 = 15/3) was calculated which was then compared with the means of all the questions under each of the family stressors. In addition, statements with means greater than 3.0 means that majority of the respondents agreed to those statements, and statements with means below 3.0 means that majority of the respondents disagreed with those statement (Appendix D).

The overall means of all the nine dimensions of family stressors are presented in a table (Appendix D). It can be inferred from the table that intra-

family strains obtained a mean of 2.64, marital strains obtained a mean of 3.36, pregnancy and child-bearing strains recorded a mean of 4.17, financial and business strains obtained a mean of 3.21, work-family transitions and strains has a mean of 3.69, illness and family care strains obtained a mean of 3.21, losses obtained a mean of 4.22, transition into and out of family recorded a mean of 4.02 and family legal violations recorded a mean of 3.93. It is evident in the table (Appendix D) that losses recorded the highest mean (4.22) followed by pregnancy and child-bearing strains (mean = 4.17), transition into and out of family (mean = 4.02), family legal violations (mean =3.93), work-family transitions and strains (mean = 3.69), marital strains (mean = 3.36), financial and business strains, and illness and family care strains (mean = 3.21) and intra-family strains being the last (mean = 2.64). The results show that the most prevalent family stressors among women experiencing depression in the study area is losses. This is followed by pregnancy and child-bearing strains, transition into and out of the family, family legal violations, work-family transitions and strains, marital strains, financial and business strains, and illness and family care strains with intra-family strains being the least prevalent.

Research Question Two

To what extent do age and marital status contribute to depression among women in the Ketu-South Municipality?

The ultimate goal of this research question was to ascertain how age and marital status contribute to depression in the women that were sampled. In order to achieve the purpose of this question, the demographic information including age and marital status of respondents as well as the Beck Depression

Inventory were used. Linear multiple regression was used to ascertain the contribution of age (which involved; 1 = 20-29, 2=30-39, 3=40-49, 4=50-59, 5=60-69, and 6= 70 and above) and marital status (which involved 1= married, 2= single, 3= separated, 4=divorced and 5= windowed) to depression. These assumptions included, the criterion variable (scores obtained from age and marital status) being continuous and measured on the interval scale which was fulfilled, having more than two or more predictor variables which was also fulfilled, linearity, multicollinearity, homoscedasticity and residual being normally distributed. In the analysis, the age and marital status were dummy coded to transform them from being nominal scales to interval scales as 0 and 1.

In particular, multicollinearity assumption was tested using the variance inflation factor (VIF) and it was revealed that the VIF value stood at 1.333, 1.440, 1.402, and 1.422 for the predictor variables in age which were all less than 10 (Table 9). In addition the VIF for marital status stood at 1.176, 1.318, 1.347, and 1.347 which were less than 10 and this shows that multicollinearity assumption was fulfilled in both cases (Table 11). The homoscedasticity assumption was also checked and it discovered that there was no clear pattern in scatter plots of residuals in the predicted values or the distribution for age and marital status (Appendix E). Furthermore, the linearity assumption was checked and fulfilled as it was discovered that, apart from (married, age 3 and age 6), there was a linear relationship between the predictors and the criterion variable. In addition, before the conduct of the multiple regression, correlations among all the variables (for age and marital status) were also conducted and it was noticed there was some relationships

(positive and negative) among the variables. For a meaningful analysis, the extent of a summary of the analysis is presented in Table 8.

Table 8: The extent to which age contribute to depression among women

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.366[a]	.134	.080	2.87697	.134	2.506	4	65	.049	1.138

a. Predictors: (Constant), age5, age1, age4, age2)

b. Dependent Variable: BECK

It is evident in Table 8 that there is a significant positive relationship between the predictor variable, ages and the criterion variable (depression) but the relationship is weak with R = .366, p = .049. The result means that as women grow or increase in their age, the level or the extent of depression among them also increases but such relationship is weak. It can also be inferred from Table 8 that the predictor variables (the age categories) explain only 13.4% of the variations in the dependent variable (depression in women) with an R-square of .080. In order to determine the contribution of each of the predictor variables to the dependent variable, the standardised coefficient table was used and the summary of the analysis is presented in Table 9.

Table 9: Contribution of the predictor variables

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	22.722	.678		33.508	.000					
	age1	.778	1.135	.091	.685	.495	.204	.085	.079	.750	1.333
	age2	-.094	.503	-.026	-.188	.852	.091	-.023	-.022	.694	1.440
	age4	-.565	.262	-.295	-2.159	.035	-.249	-.259	-.249	.713	1.402
	age5	-.359	.205	-.241	-1.750	.085	-.182	-.212	-.202	.703	1.422

a. Dependent Variable: BECK

From the results depicted in Table 9, looking at the Beta Coefficients which shows the individual contribution of each of the predictor variables, it can be observed that age4 (50-59) is significantly the best predictor of depression in women with Beta= -.295, p = 0.350. The rest of age categories are not significant. The analysis on the extent to which marital status contribute to depression among women is shown in Table 10.

Table 10: The extent to which marital status contribute to depression among women

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.297a	.088	.032	2.95141	.088	1.572	4	65	.192	1.294

a. Predictors: (Constant), wid , sin , sep, div)

b. Dependent Variable: BECK

It is evident in Table 10 that there is a weak positive relationship between the predictor variable, marital status and the criterion variable (depression) but the relationship is not significant with R = .297, p = .192, and thus, the null hypothesis is retained. The result means although a weak positive relationship between marital status and depression might exist, such relationship can be little or might not exist at all. It can also be inferred from Table 10 that the predictor variables (the marital status of respondents) explain only 8.8% of the variations in the dependent variable (depression in women) with an R-square of .032. This explains that marital status insignificantly (or least) contributes to depression in the women that were sampled. However, in order to determine the contribution of each of the predictor variables (as determined by marital status) to the dependent variable (depression), the standardised coefficient table was used and the summary of the analysis is presented in Table 11.

Table 11: Contribution of Predictor Variables

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	22.095	.644		34.307	.000					
	Sin	.869	.683	.163	1.272	.208	.187	.156	.151	.851	1.176
	Sep	.250	.347	.098	.721	.474	.133	.089	.085	.759	1.318
	Div	-.090	.249	-.050	-.363	.718	-.049	-.045	-.043	.742	1.347
	Wid	-.272	.200	-.188	-1.365	.177	-.225	-.167	-.162	.742	1.347

a. Dependent Variable: BECK

Judging from the standardised Beta Coefficient, it can be inferred from Table 11 that although those women who were widowed best contribute to depression, the contribution was not significant (Beta = -.188, p = .177). The rest of the variables are also not significant as shown in Table 11.

It can be inferred from the results that age significantly contributes to depression in women although its contribution is weak (as justified by the weak relationship) with women who are between 50-59 years being depressed. The results also show that marital status does not significantly contribute to depression in women, although further analysis show that women who are widowed are prone to depression, the results on the individual variable contributor regarding marital status to depression are not statistically significant.

Hypothesis One

H_0: Family stressors will not significantly contribute to depression among women in the Ketu-South Municipality.

H_1: Family stressors will significantly contribute to depression among women in the Ketu-South Municipality.

The aim of this hypothesis was to ascertain if family stressors significantly contribute to depression among the women in the study area. The family stressors which is the predictor variable included intra family strains, marital strains, pregnancy strains, business strains, work strains, illness, losses, transitions, and legal-violations strains. These strains were measured on a five point Likert scale namely 1= not true at all, 2= not true, 3= somwhat true, 4= true and 5= very true. In order to conduct the multiple regression analysis, the composite score of each of the predictors were computed which transformed

the data gathered for each of the predictor variables to interval scale. The criterion variable was the scores obtained from the Beck Depression Inventory. In the conduct of the analysis, assumptions such as the criterion variable (depression) being continuous and measured on the interval scale, the availability of two or more predictor variables, linearity, multicollinearity, homoscedasticity and residual being normally distributed were all checked and fulfilled. The hypothesis was tested at 0.05 alpha and the summary of the regression analysis is presented in Table 12.

Table 12: Regression analysis on family stressors and depression

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.749	.730	.052	1.05866	.730	.709	9	60	.039	1.282

a. Predictors: (Constant), leg, ill, loss, preg, Intra, wor, trans, mari, bus

a. Dependent Variable: BECK

Results in Table 12 shows a strong significant positive relationship between the predictor variable (family stressors) and the criterion variable (depression) R = .749, p = .0.39, and thus, the null hypothesis is rejected and the alternate hypothesis is upheld. The results mean that, as women experience high level of family stressors it will lead to a corresponding level of depression among them. It can also be inferred from Table 12 that the predictor variable (as determined by family stressors) explain only 73% of the variations in the dependent variable (depression in women) with an R-square of .730. This explains that family stressors significantly contribute to depression among the women that were sampled. In order to determine the contribution of each of the predictor variables to the dependent variable, the standardised coefficient table was used and the summary of the analysis is presented in Table 13.

Table 13: Relative Contribution of the predictor Variables

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.	95.0% Confidence Interval for B	
		B	Std. Error	Beta			Lower Bound	Upper Bound
1	(Constant)	17.458	6.605		2.643	.010	4.245	30.670
	Intra	.029	.107	.040	-.268	.790	-.242	.185
	Mari	.067	.108	1.095	1.217	.048	-.283	.149
	Preg	.104	.177	2.087	2.585	.040	-.250	.457
	Busi	.053	.129	1.068	-1.416	.019	-.311	.204
	Workable	.019	.143	.019	.136	.893	-.266	.305
	Ill	.087	.248	.054	-.350	.727	-.584	.410
	Loss	.123	.168	2.123	2.732	.037	-.213	.460
	Tran	.193	.180	1.150	1.555	.026	-.173	.559
	Leg	.040	.130	.044	.310	.758	-.219	.300

a. Dependent Variable: BECK

Judging from the standardised Beta Coefficient, it can be inferred from Table 13 that losses as part of family stressors was significantly the best contributor to depression (Beta = 2.123, p = .037). This was followed by pregnancy strains (Beta = 2.087, p= 040), transitions (Beta = 1.150, p = 0.26) and marital strains (Beta = 1.095, p = .048) and financial and business strains (Beta = 1.068, p = .040). The other variables were not significant as shown in Table 13. The results show that losses was significantly the best contributor of depression among women in the study area.

Hypothesis Two

H_0: Socioeconomic status will not significantly contribute to depression among women in the Ketu-South Municipality.

H_1: Socioeconomic status will significantly contribute to depression among women in the Ketu-South Municipality.

The goal of this hypothesis was to uncover if socioeconomic status of respondents will contribute to depression among the sampled women in the study area. In order to achieve this aim, a linear multiple regression was conducted to check the contribution of the socioeconomic variables to depression in women. The socioeconomic variables as used in the study were monthly income, educational status, and occupation. In the analysis, a multiple regression was conducted for educational status and depression, and occupational status and depression whereas Pearson Product moment correlation was conducted for monthly income and depression. Before the conduct of multiple regression analysis for educational status and occupational status and depression, educational and occupational status were dummy coded in each case. Assumptions such as the criterion variable (depression) being

continuous and measured on the interval scale, the availability of two or more predictor variables, linearity, multicollinearity, homoscedasticity and residual being normally distributed were all checked and fulfilled.

For conducting a multiple regression for 0.05 alpha level for the predictor educational status which was made up of 1= no formal education, 2= basic education and 3= secondary education. These variables were dummy coded into 0 and 1. Multicollinearity assumption was tested using the variance inflation factor (VIF) and it was revealed that the VIF value stood at 9.250 in each case for basic education and diploma (Table 15). The analysis rejected 3 = secondary education and thus, it was not included in multiple regression analysis. The homoscedasticity assumption was also checked and it discovered that there was no clear pattern in scatter plots of residuals in the predicted values or the distribution for age and marital status (Appendix E). Furthermore, the linearity assumption was checked and fulfilled as it was discovered that, apart from (secondary education), there was a linear relationship between the predictors and the criterion variable. In addition, before the conduct of the multiple regression, correlations among all the variables were also conducted and it was noticed there was some relationships (positive and negative) among the variables. A summary of the regression analysis or educational status and depression is presented in Table 14.

Table 14: Regression analysis of educational status and depression

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.226[a]	.051	.023	2.96552	.051	1.806	2	67	.172	1.449

a. Predictors: (Constant), educa2, educa1

b. Dependent Variable: BECK

It is evident in Table 14 that there is a weak positive relationship between the predictor variable, educational status and the criterion variable (depression) but the relationship is not significant with R = .226, p = .172, and thus, the null hypothesis is retained. The result means that, although a weak positive relationship between educational status and depression might exist, such relationship can be little or might not exist at all. It can also be inferred from Table 14 that the predictor variables (as determined by educational status) explain only 5.1% of the variations in the dependent variable (depression in women) with an R-square of .023. This explains that educational status insignificantly (or least) contributes to depression in the women who were sampled. In order to determine the contribution of each of the predictor variables (as determined by educational status) to the dependent variable (depression), the standardised coefficient table was used and the summary of the analysis is presented in Table 15.

Table 15: Individual Variable Contributor

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
	(Constant)	21.500	2.097		10.253	.000					
1	educa1	-.129	2.156	-.022	-.060	.953	-.216	-.007	-.007	.108	9.250
	educa2	.614	1.080	.206	.568	.572	.226	.069	.068	.108	9.250

a. Dependent Variable: BECK

Judging from the standardised Beta Coefficient, it can be inferred from Table 15 that although basic education is seen as the best contributor to depression, the contribution is not significant (Beta = .206, p = .572). The other variable is also not significant as shown in Table 15.

Apart from educational status, a linear multiple regression was conducted on occupational status and depression in order to assess the contribution of occupational status towards depression. The analysis was conducted at 0.05 alpha level for the predictor occupational status which was made up of 1= not employed 2= officially employed and 3= self-employed. These variables were dummy coded into 0 and 1. Multicollinearity assumption was tested using the variance inflation factor (VIF) and it was revealed that the VIF value stood at 5.000, 4.714, and 6.429 for not employed, officially employed, and self-employed respectively (Table 17). The homoscedasticity assumption was also checked and it discovered that there was no clear pattern in scatter plots of residuals in the predicted values or the distribution for age and marital status (Appendix E). Furthermore, the linearity assumption was checked and fulfilled as it was discovered that there was a linear relationship between the predictors and the criterion variable. A summary of the regression analysis on occupational status and depression is presented in Table 16.

Table 16: Regression analysis on occupational status and depression

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	-.627[a]	.591	.088	2.98750	.051	1.192	3	66	.020	1.541

a. Predictors: (Constant), occ3, occ2, occ1

b. Dependent Variable: BECK

Results in Table 16 show a moderate significant negative relationship between the predictor variable, occupational status and the criterion variable (depression) ($\underline{R}$ = -.627, $\underline{p}$ = .020, and thus, the null hypothesis is rejected. The result means that, when women acquire relatively high occupational levels, their level of depression will be relatively low and vice versa. It can also be inferred from Table 16 that the predictor variables (as determined by occupational status) explain only 59.1% of the variations in the dependent variable (depression in women) with an R-square of .088. This explains that occupational status significantly contributes to depression among women who were sampled. In order to determine the contribution of each of the predictor variables to the dependent variable, the standardised coefficient table was used and the summary of the analysis is presented in Table 17.

Table 17: Contribution of Predictors

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	18.000	2.988		6.025	.000					
	NE	3.750	1.061	.569	-1.225	.225	-.056	.149	.147	.067	5.000
	OE	1.250	0.670	-1.195	-1.448	.037	-.125	.092	.090	.212	4.714
	SE	1.452	0.007	-1.701	-1.742	.044	.154	.175	.173	.061	6.429

b. Dependent Variable: BECK

Judging from the standardised Beta Coefficient, it can be inferred from Table 17 that self-employed was seen as the best contributor to depression (Beta = -1.701, p = .044). This means women who were self-employed were likely to experience lower level of depression as compared to those who are officially employed (Beta = -1.195, p = .037). The other variable is not significant as shown in Table 17.

In addition to educational status, occupational status, Pearson Product moment correlation was also conducted (at 0.05 alpha level) on monthly income and depression among the women who were sampled. The summary of the analysis is presented in Table 18.

Table 18: Pearson Product Moment Correlations between monthly income and Depression

		monthly income	BECK
monthly income	Pearson Correlation	1	-.501
	Sig. (2-tailed)		.014*
	N	61	61
BECK	Pearson Correlation	-.501	1
	Sig. (2-tailed)	.014*	
	N	70	70

Source: Field Survey (2019)

The results in Table 18 show that there is a significant moderate negative correlation between monthly income and depression (r = .501, p = .014). The results show that at a relatively high monthly income of women, their level of

depression relatively decreases and at a relatively low monthly income of women, their level of depression relatively increases. This shows that monthly income is a significant contributor to depression among women in the study area. Judging from the analysis so far, it can be noticed that educational status as part of socio-economic status did not contribute to depression. However, occupational status and monthly income had significant contribution to depression judging from the case of the women who were sampled.

Discussion of results

The discussion of the results were done based on the specific objectives of the study. The first specific objective of the study was to investigate what kind of family stressors influenced the women experiencing depression in the Ketu-South Municipality. Although all the family stressors were common in the women who were sampled, the results showed that the most prevalent family stressor among women experiencing depression in the study area was losses. This finding is consistent with conceptual and empirical literature. For example McCubbin and Patterson (as cited in Mondragon, 2017) contend that family stressors are life situations or changes that place strain on the family unit and may lead to changes in functioning of the family system requiring a need for adjustment. McCubbin and Patterson continue to indicate that families with a higher accumulation of life events have been found to have lower family functioning and poorer physical and mental health. That is, persistent stressors in the family can influence the development of depression.

According to Mash et al. (2014), a major factor which plays a role in development of a complicated grief and depression in bereavement as in

losses is the relationship of interpersonal and personality characteristics. Denckla et al. (as cited in Mash et al., 2014) noted that individuals identified as dependent are likely to be motivated by hopes of obtaining care, nurturance, guidance, and support from the deceased and when such supports are not available can lead to depression. This implies that the extent to which an individual positively values and is committed to a relationship prior to the loss may contribute to development of complicated grief or depression after loss. It is in this regard that Mancini et al. (2009), hold the view that feelings of trust, security, intimacy, and mutual support in a relationship are associated with increased grief, particularly in older adults following loss. This finding of the study confirms that position of Mash et al. (2014), who found from 157 young adults between ages 17 and 29 who experienced loss of family member within the past three years that 16% of bereaved young adults showed complicated grief, and 34% had mild to severe depression. The study also agrees with Fried et al. (2015), who reported that bereavement mostly triggers loneliness, which activates further depressive symptoms. The finding of the study further confirmed the position of Mojtabai (2011), who found that bereavement-induced depressive episodes were more common in women than men.

It can be inferred from the discussion that losses significantly increase the chances of women in getting depressed and that might have happened in the case of the women that were sampled. Judging from the theoretical framework, the findings confirm Lazarus and Folkman's transactional model of stress which explains that the stress is due to life changing experiences such as losses and for that matter family stressors. For example if a woman

experiences loss of loved ones, she is likely to experience stress and will lead to depression.

The second objective sought to examine the extent to which age and marital status contribute to depression among women in the Ketu-South Municipality. The results of the study indicate that age significantly contributed to depression in women although its contribution was weak with women who were between 50-59 years being depressed. However, the results show that marital status did not significantly contribute to depression among women in the study area. In confirming empirical literature, Bonful and Anum (2019), found from 3,183 women in Accra that women 55 years and older were more likely than women between the ages of 18 and 24 to experience depressive symptoms. The women between the ages of 35 and 54 were also reported to be 1.95 times more likely than women between the ages of 18 and 24 to experience depression.

This indicates that there are lower levels of depressive symptoms among younger women than among older women and thus, depression is associated with age. The finding that age is a predictor of depression is in line with Singh et al. (as cited in Afun, 2016), who found from 221 mothers within the ages of 18 and 56 that age had a significant correlation with depression, in that, as one ages the person's life satisfaction decreases hence their low psychological well-being and depression. The findings also confirm the position of Anim (2013), who found a negative low correlation between age and depression such that the lower the age of wives, the higher their distress implying that as wives grow older, their distress level decreases. What might

have accounted for this finding is that majority of the women who were sampled had increased ages outnumbered their younger counterparts.

On the contrary, the findings refute the position of Wade, Keski-Rahkonen, and Hudeson (as cited in Opoku-Mensah et al., 2017) who indicated that, comparing single mothers and married mothers, there is a high level of psychological resources available to married mothers which improve their mental health and reduces the likelihood of depression as compared to unmarried women. The results further contradicts Dziak et al. (as cited in Opoku-Mensah et al., 2017) that single mothers experienced higher levels of psychological distress due to economic hardship. Further, single mothers have significantly higher rates of depressive episodes, anxiety, stress, unhappiness, and physical health problems than married mothers. However, in the study among women in the Ketu-South Municipality, whether married or not did not contribute to depression. In confirming Lazarus and Folkman's transactional model of stress, and the stress process model, it is obvious that as women age and grow to become old, they are more likely to face the changing phases of life events and they are more likely to be depressed; this might have contributed to the findings of the study.

The third objective sought to investigate if family stressors will significantly contribute to depression among women in the Ketu-South Municipality. The results show that family stressors significantly contribute to depression in the women who were sampled, with losses as part of family stressors which is significantly the best contributor to depression. It must be pointed out the current finding is consistent with literature. For example, Mondragon (2017) found a significant relationship between family stressors

and inter-parental conflict among Latino families. This is supported by a study done by Beck (as cited in Buabeng, 2015) which also found higher levels of perceived life stress to be associated with depression. In a study by Buabeng (2015), a significant association between emotional relationship with the men with whom the women had a baby and depression was found. The study also revealed that father not being part of the life of the mother and baby, and not providing financial support also increased the risk of suffering depression. Lambon (2018) also suggested that due to the various meanings assigned to stillbirth, mothers after stillbirth grieve and equally face challenges such as isolation, or social withdrawal, spouse or partner challenges and stigma. The author reported that mothers after stillbirth are likely to develop psychological problems including depression. Abeasi (2014) found that as there is available social support, the financial burden reduces, and consequently the negative impact of financial constraints on emotional or psychological health reduces. A study by Mash et al. (2014) reported that high levels of dependency were related to more depressive symptoms. In a study done by the Institute of Development Studies (2016) across the then 10 regions of Ghana to find out the incidence, attitudes, determinants, and consequences of domestic violence, of the 2,989 women, the results indicated a very strong correlation between exposure to domestic violence and women's mental health status including depression. A study by Ju et al. (2017) found out from 4,663 women that the combination of family stress and family-work conflicts strongly influenced the depressive symptoms of working married women. This is supported by a study done by Stoeva and Greenhaus (as cited in Ju et al, 2017) in which they

reported that family stress and family-work conflict from multiple roles influence depressive symptoms among women.

The fourth objective sought to investigate the extent to which socioeconomic status contribute to depression among women in the Ketu-South Municipality. The findings of the study show that educational status, as part of socioeconomic status, does not contribute to depression. However, occupational status (with women who are self-employed being less depressed) and monthly income have significant contributions to depression, judging from the case of the women who were sampled. According to Opoku-Mensah et al. (2017), the lack of occupation leading to financial strains accounted for negative mental distress such as depression among single mothers. In other studies, Lee et al. (2000) and Patel et al. (2002) all specifically studied the effects of low income in populations in India and China respectively and found that financial strains, as resulting from lack of occupation, was an important risk factor in postpartum depression within these populations.

The above studies specifically confirm the position of Ghaffar et al. (2017) who reported that unemployed women were more depressed during pregnancy. This will be the fact that unemployed women lack economic support and have a lot of time to think about their pregnancy as compared to employed women. Concerning income, the findings agree with Buabeng (2015), who reported that approximately half of the depressed women earned GHS 200.00 per month and thus, low income is associated with depression. A study by NajahAliAqe and Thabet (2017) suggested that family stressors in families with low monthly income (less than $350) were more than in families with higher family monthly income. The findings also support Snell-Rod et

al. (2017) who found that low-income women living in southeastern Kentucky, demonstrate moderate to severe depression. However, the findings disagree with Peyrot et al. (2015) and Gan et al. (2011) who reported that there is an association of lower educational attainment and major depressive disorder.

These findings are evident, in that, the inability of women to have occupation will result in lack of income leading to excessive stress and depressive symptoms. In the real world, the lack of education or minimum of it may not cause unemployment or lack of income. Significantly, where there is no occupation, there may be the absence of income which might lead to depression (and the inability to face the problems in the society, which confirms Lazarus and Folkman's transactional model of stress as well as the stress process model) and this might have been the case of the women who were sampled in the Ketu-South Municipality.

It can be inferred from the foregoing that family stressors contribute to depression among women and this has been evident in this current study. Naturally, when women are exposed to stressful life events (such as intra-family strains, marital strains, pregnancy and childbearing strains, finance and business strains, work-family transitions and strains, illness and family care strains, losses, transition into and out of the family, and family legal violations), the end result is depression which has been proven in the study.

Chapter Summary

The chapter 4 has presented the results and discussion of the study. The results of the study show that, although the women who were sampled demonstrated several family stressors, the most prevalent family stressors

among women experiencing depression in the study area is losses. The results of the study also indicate that age significantly contributes to depression in women although its contribution is weak, with women who are between 50-59 years being depressed in the study area. However, the results show that marital status does not significantly contribute to depression among women. The findings of the current study also show that educational status, as part of socio-economic status, does not contribute to depression. However, occupational status (with women who are self-employed being less depressed) and monthly income have significant contributions to depression judging from the case of the women who were sampled. The results of the study further show that family stressors significantly contribute to depression among the women who were sampled, with losses as part of family stressors being significantly the best contributor to depression.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter presents a summary of the key findings, the conclusions drawn as well as recommendations made in the study. The chapter also presents the contribution to knowledge as well as the suggestions for further research.

Overview of the Study

This study sought to investigate the influence of family stressors on depression among women in the Ketu-South Municipality. In pursuance of the purpose of the study, the following research questions and hypotheses were formulated:

Research Questions

1. What kind of family stressors influence the women experiencing depression in the Ketu-South Municipality?
2. To what extent do age and marital status contribute to depression among women in the Ketu-South Municipality?

Hypotheses

H_0: Family stressors will not significantly contribute to depression among women in the Ketu-South Municipality.

H_1: Family stressors will significantly contribute to depression among women in the Ketu-South Municipality.

H_0: Socioeconomic status will not significantly contribute to depression among women in the Ketu-South Municipality.

H_1: Socioeconomic status will significantly contribute to depression among women in the Ketu-South Municipality.

The descriptive survey design with quantitative approach was used. Family Inventory of Life Events and Changes (FILE) questionnaire and Beck Depression Inventory (BDI II) were used to collect data from a sample of 70 women living with depression and who were selected through census sampling. Statistical tools used in the analysis included frequencies, percentages, means and standard deviations as well as linear multiple regression.

Summary of key Findings

The key findings are presented in accordance with the objectives of the study as follows:

The first specific objective of the study was to investigate what kind of family stressors influence the women experiencing depression in the Ketu-South Municipality. The results of the study showed that the prominent family stressors among women experiencing depression in the study area were losses. This was followed by pregnancy and child bearing strains, transition into and out of family, family legal violations, work-family transitions and strains, marital strains, financial and business strains, and illness and family care strains, with intra-family strains being the least prevalent.

The second objective of the study sought to examine the extent to which age and marital status contribute to depression among women in the Ketu-South Municipality. The results of the study indicated that age significantly contributed to depression in women although its contribution was weak with women who were between 50-59 years being more depressed.

However, the results showed that marital status did not significantly contribute to depression among women in the study area.

The third objective sought to ascertain if family stressors will significantly contribute to depression among women in the Ketu-South Municipality. The results showed that family stressors significantly contributed to depression among the women who were sampled with losses as part of family stressors being the significantly best contributor to depression.

The fourth objective sought to investigate the extent to which socioeconomic status contribute to depression among women in the Ketu-South Municipality. The results of the study showed that educational status as part of socioeconomic status did not contribute to depression. However, occupational status (with women who were self-employed being less depressed) and monthly income had significant contributions to depression judging from the case of the women who were sampled.

Conclusions

From the findings of the study, the following conclusions are drawn: Making critical reference to the findings suggests that losses are the most prevalent family stressors in the study area. This result might have been evident in that respondents might have experienced family losses as compared to the other family stressors as at the time the study was conducted. The obvious point to note is that, when an individual loses a cherished person, especially if the lost person plays a significant role in the life of the individual, the end result is for the person to be depressed due to numerous contributed factors. Based on this, the study concludes that losses take precedence among other family stressors in the study area.

Secondly, majority of the respondents who were surveyed were between the ages of 40 and above. Naturally, as one ages, the more likely he or she thinks and faces numerous life changes events which according to literature is tantamount to depression and not necessarily the marital status of the individual; and this has been validated in the study area. It is therefore concluded that in the study area, age best contributes to depression among women as compared to marital status.

Thirdly, it can be concluded from the study that family stressors are strongly associated with depression among women. This means that the more a woman is exposed to or experiences family stressors, the more likely she experiences depression. The study also concludes that when a woman loses an important individual, she stands in the position to become more depressed and thus, losses contribute to depression among women in the study area as compared to other family stressors.

Finally, this study also makes a conclusion that while some socioeconomic variables contribute to depression in women, others do not. This has been demonstrated in this current study where educational status as part of socioeconomic status does not contribute to depression, but occupational status and monthly income have significant contributions to depression. Naturally, the better occupation one gets, the better the level of income he or she gets. This means that when a woman has better occupation and income, she is more likely to face life challenges better as compared to the others who have less occupation and income. In addition, it is obvious in today's world that education is not the only way of getting income or

occupation. Such situations might have happened in the case of the women in the study area, hence, the results.

Recommendations

On the basis of the findings of this study and the conclusions drawn, the following recommendations were made:

1. The study recommends that the Ministry of Health, Ministry of Gender, Children, and Social Protection, and other non-governmental agencies put up measures to control the family stressors as experienced by women especially those who are living with depression. Prominent among these measures are instituting counselling centers to provide counselling services specially to depressed women and those who face series of family stressors of any form. This will guide such women to develop better coping strategies where necessary.
2. It is also recommended that counsellors, psychologists, and other stakeholders of mental health should provide better coping strategies to depressed women and explain to the depressed women the contributions of variables such age towards depression. Counsellors and the aforementioned stakeholders should educate (psychoeducation) women especially those living with depression on some issues on depression especially in women when they age. This will help them to develop strategies to cope with depression as they grow.
3. Women should also be educated or encouraged to withstand difficult situations such as losses, pregnancy and child bearing issues, financial issues, marital issues, among others. They should be encouraged by experts such as counsellors, psychologists, among others, that such

situations are part of life and as to how to withstand such events when they occur. Members of the families and loved ones should also develop the habit of being empathetic and showing the needed social support in case of such losses or family stressors.

4. This study also makes a recommendation that the Ministry of Gender, Children and Social Protection, and other non-governmental agencies in mental health institute measures that enhance the vulnerable women's capacity of entering into occupations. Besides, women should be encouraged by the counsellors and industrial psychologists to develop and pursue occupations of their choice in order to make an income. This is important in that the study has demonstrated that occupation and income are linked with depression especially in women. When women enter into an occupation they are likely to get a means of living which might lower the rate at which they will be depressed.

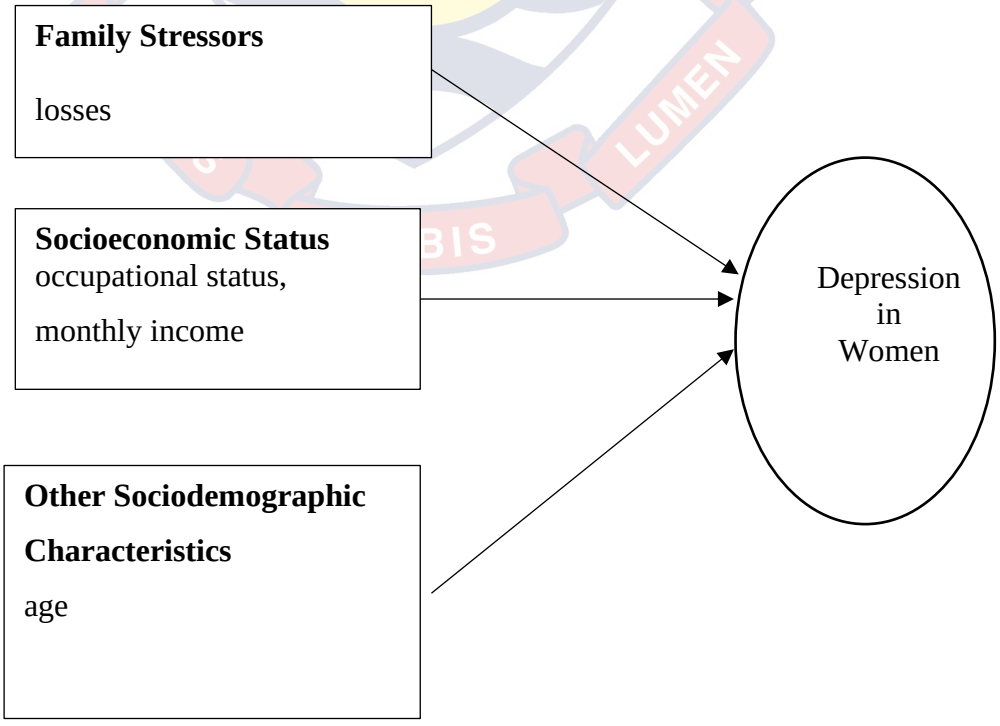

Figure 2: Final observed model of depression

Contribution to Knowledge

It is very important that any research contributes or adds to existing knowledge. It should be noted that the findings of the study has extended the discussion in literature. The findings of the study has refuted and also confirmed some literature on marital status and educational status regarding depression as the study makes a revelation that marital status and educational status do not significantly contribute to depression in women. However, the study has supported and confirmed several empirical literatures that occupation and income levels significantly contribute to depression in women. The modest contribution of the study is that, losses as part of family stressors is the prominent and best predictor of depression, and this is a relatively new finding in family stressors and depression literature, at least in Ghana.

Counselling Implications

Having known what family stressors mean, and how they can contribute to depression, the next area of interest should be the types of treatment that can be given to the women experiencing depression. There should be initial assessment that should include assessment of symptoms and comorbid conditions of depressive symptoms, history of symptoms, severity of depressive symptoms, psychosocial stressors, and social support systems of the individual experiencing depression. Assessing the symptoms and comorbid conditions enable psychologists or counsellors to identify psychosocial stressors including family stressors underlying depression.

Stress management strategies such solution-focused coping and emotion-focused coping strategies should be employed in assisting the women battling with stressors in their families so that these stressors do not degenerate into

depression. Besides, emotion-focused coping strategies should be employed to assist the women where they are threatened by irreparable losses.

Interpersonal therapy which focuses on current interpersonal relationship by analyzing social dysfunctions related to depression should be employed. Four different interpersonal problem areas are interpersonal role disputes, interpersonal role transitions, unresolved grief, and interpersonal deficits or severity (Knauss, 2009).

Suggestions for Future Research

With reference to the present scope of the study, it is suggested that future research works cover the investigation of the problem (influence of family stressors on depression) but using other municipalities, metropolis and districts in other regions in Ghana besides the current study area used. It is also suggested in this study that future researchers should consider the influence of family stressors on depression in males in Ghana. It is also suggested that future research works consider other socioeconomic variables other than the ones that have been used in the current study to assess their contributions to depression in women in Ghana. Lastly, the study also recommends that future research should consider the use of qualitative methodologies to further investigate the current study variables in Ghana.

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APPENDICES

APPENDIX A

QUESTIONNAIRE

SECTION A

DEMOGRAPHIC INFORMATION

	Questions	Response
I	Age	20-24 years 25-29 years 30-34 years 35-39 years 40-44 years 45- 49 years 50 – 54 years 55 – 59 years 60 – 64 years 65 – 69 years 70 years and over
II	Marital Status	Married Single Separated Divorced Widowed
III	Educational Status	No formal education Basic education Secondary Diploma Graduate
IV	Occupational Status	Not employed Officially employed Self-employed Student
V	Monthly Income	

SECTION B
FAMILY INVENTORY OF LIFE EVENTS AND CHANGES

NO.	INTRA-FAMILY STRAINS	VERY TRUE	TRUE	SOME WHAT TRUE	NOT TRUE	NOTAT ALL TRUE
1.	My husband spends much more time away from the family. I have needs that are not being met due to this.					
2.	A family member has emotional problem. I am often anxious over this.					
3.	A family member depends on alcohol much to my discomfort.					
4.	In my family, we have conflicts which keep increasing no matter what I do.					
5.	There is increasing child-rearing difficulties in my family. I am fed up.					
6.	There is increase in the number of problems or issues which don't get resolved in my family.					
7.	I experience increasing conflicts with my in-laws or relatives.					
	MARITAL STRAINS	**VERY TRUE**	**TRUE**	**SOME WHAT TRUE**	**NOT TRUE**	**NOT AT ALL TRUE**
8.	My husband separated or divorced. This is disappointing to me.					
9.	A spouse has an "affair". This					

	makes me uncomfortable.					
10	There is increasing difficulty in resolving issues with my previous or separated husband.					
11	I have increasing difficulty in sexual relationship with my husband.					
	PREGNANCY AND CHILDBEARING STRAINS	**VERY TRUE**	**TRUE**	**SOME WHAT TRUE**	**NOT TRUE**	**NOT AT ALL TRUE**
12	I feel overwhelmed by unwanted or difficult pregnancy.					
13	An unmarried member became pregnant. This is embarrassing to me.					
14	A family member had an abortion. I feel tensed over this.					
15	I have difficulty conceiving. I am dissatisfied with myself.					

NO	FINANCE AND BUSINESS STRAINS	VERY TRUE	TRUE	SOME WHAT TRUE	NOT TRUE	NOT AT ALL TRUE
16.	I take loans to cover increasing expenses.					
17.	There are changes in economic, political and whether conditions which hurt the family business or income.					
18.	In my family, I experience increasing financial debts.					
19.	There is increasing financial strain on family "money" for medical expenses.					
20.	There is increasing financial strain on family "money" for food, clothing, energy, and home care.					
21.	There is increasing strain on family "money" for children's education.					
22.	I am delayed in receiving child support or alimony payments.					

	WORK-FAMILY TRANSITIONS AND STRAINS	VERY TRUE	TRUE	SOME WHAT TRUE	NOT TRUE	NOT AT ALL TRUE
23.	A family member stopped working for extended period due to lay off, leave of absence et cetera. I am unable to cope with this.					
24.	A family member retired from work. This is affecting upkeep of home and family.					
25.	I experience decrease in satisfaction with my job.					
26.	I often feel stressed from a family member's increasing difficulty with people at work.					
27.	A family member has more responsibilities at work. This interferes with family responsibilities.					
28.	My family moved to a new home. I tend to experience unpleasant changes.					

29.	A child or adolescent member changed to a new school. I am unable to face up to the challenges.					
	ILLNESS AND FAMILY "CARE" STRAINS	**VERY TRUE**	**TRUE**	**SOME WHAT TRUE**	**NOT TRUE**	**NOT AT ALL TRUE**
30.	There is increasing difficulty in managing seriously ill or injured member.					
31.	There is increasing difficulty in managing chronically ill or disabled member.					
32.	I have increasing responsibility in providing direct care or financial support to my husband's parent.					
33.	I experience difficulty in arranging for satisfactory child care.					
	LOSSES	**VERY TRUE**	**TRUE**	**SOME WHAT TRUE**	**NOT TRUE**	**NOT AT ALL TRUE**
34.	My parent or husband died. This is often hurting me.					
35.	A child member died. I often feel					

	helpless over this.					
36.	A close relative died. This does not give me optimistic view for the future.					
37.	A married son or daughter separated or divorced. I am often getting upset by this.					
	TRANSITION INTO AND OUT OF FAMILY					
38.	A young adult member left home. This makes me highly displeased.					
39.	A young adult member began post high school training. I have difficulty adjusting to this.					
40.	A family member or a new person moved into the household. I am unhappy changing my familiar way of doing things.					
41.	My husband started school or training programme after being away from school for a long time. I experience pressure from his attempting this.					

	FAMILY LEGAL VIOLATIONS	VERY TRUE	TRUE	SOME WHAT TRUE	NOT TRUE	NOT AT ALL TRUE
42.	A family member is sent to jail or juvenile detention. I cannot be myself around my family.					
43.	A family member is arrested by police. I go through stressful legal problems.					
44.	There is physical or sexual abuse or violence in my family. This makes me feel unsafe.					
45.	Someone in my family is on the run. I tend to worry over this.					

SECTION C

BECK DEPRESSION INVENTORY

1.Sadness	0 I do not feel sad. 1 I feel sad much of the time. 2 I am sad all the time. 3 I am so sad or unhappy that I can't stand it.
2.Pessimism	0 I am not discouraged about my future. 1 I feel more discouraged about my future than I used to be. 2 I do not expect things to work out for me. 3 I feel my future is hopeless and will only get worse.
3.Past Failure	0 I do not feel like a failure. 1 I have failed more than I should have. 2 As I look back, I see a lot of failure. 3 I feel I am a total failure as a person.
4. Loss of Satisfaction	0 I am particularly dissatisfied. 1 I am often dissatisfied. 2 I am usually dissatisfied with most aspects of my life. 3 I am dissatisfied with every single aspect of my life.
5.Guilty Feelings	0 I don't feel particularly guilty. 1 I feel guilty over many things I have done or should have done. 2 I feel quite guilty most of the time. 3 I feel guilty all of the time.
6.Punishment Feelings	0 I don't feel I am being punished. 1 I feel I may be punished. 2 I expect to be punished. 3 I feel I am being punished.
7.Self-Dislike	0 I feel the same about myself as ever. 1 I have lost confidence in myself. 2 I am disappointed in myself. 3 I dislike myself.
8.Self-	0 I don't criticize or blame myself more than usual. 1 I am more critical of myself than I used to be.

Criticalness	2 I criticize myself for all my faults. 3 I blame myself for everything bad that happens.
9.Suicidal Thoughts	0 I don't have any thoughts of killing myself. 1 I have thoughts of killing myself, but I would not carry them out. 2 I would like to kill myself. 3 I would kill myself if I had the chance.
10.Crying	0 I don't cry any more than I used to. 1 I cry more than I used to. 2 I cry over every little thing. 3 I feel like crying, but I can't.
11.Irritability	0 I am no more irritable than usual. 1 I am more irritable than usual. 2 I am much more irritable than usual. 3 I am irritable all the time.
12.Loss of Interest	0 I have not lost interest in other people or activities. 1 I am less interested in other people or things than before. 2 I have lost most of my interest in other people or things. 3 It's hard to get interested in anything.
13.Indicisiveness	0 I make decisions as well as ever. 1 I find it more difficult to make decisions than usual. 2 I have much greater difficulty in making decisions than I used to. 3 I have trouble making any decision.
14.Body Image	0 I do not feel I look any worse than I used to. 1 I am worried that I am looking worse than I used to. 2 I feel that I usually look unattractive. 3 I feel that I am or repulsive-looking.
15.Work Inhibition	0 I work as well as usual. 1 I feel that I do not work as used to. 2 Working for me is very difficult. 3 I cannot do any work at all.
	0 I have not experienced any change in my sleeping pattern.

16.Change in Sleeping Pattern	1	I can't sleep as well I used to.
	2	I wake earlier than I used to.
	3	I wake very early and it's impossible to fall back to sleep.
17.Weigt Loss	0	I haven't lost much weight, if any, lately.
	1	I have lost about 5 kilos.
	2	I have lost about 10 kilos.
	3	I have lost more than 15 kilos.
18.Change in Appetite	0	I have not experienced any change in my appetite.
	1	My appetite is somewhat less than usual.
	2	My appetite is much less than before.
	3	I have no appetite at all.
19.Somatic Preoccupation	0	I am no more worried about my health than usual.
	1	I am more concerned about my health than I used to be.
	2	I am so concerned about my health that it is hard to think about anything else.
	3	The only thing I can think about is my health and nothing else.
20.Tiredness or Fatigue	0	I am no more tired or fatigued than usual.
	1	I get more tired or fatigued more easily than usual.
	2	I am too tired or fatigued to do a lot of the things I used to do.
	3	I am too tired or fatigued to do most of the things I used to do.
21.Loss of Interest in Sex	0	I have not noticed any recent change in my interest in sex.
	1	I am less interested in sex than I used to be.
	2	I am much less interested in sex now.
	3	I have lost interest in sex completely.

APPENDIX B

INTRODUCTORY LETTER

UNIVERSITY OF CAPE COAST
COLLEGE OF DISTANCE EDUCATION
DEPARTMENT OF EDUCATION

Tel No: 03321-36947
Fax: 03321 – 36946
Email: cceucc@yahoo.com

University Post Office
Cape Coast

Our Ref. No: CODE/DE/OOM//Vol.1/0004

28th May 2018.

TO WHOM IT MAY CONCERN

Dear Sir/ Madam,

LETTER OF INTRODUCTION

Please, I have the pleasure to introduce Mr/Ms/Mrs Sylvester Loshar-Kloyram to you. He/She is an MPhil student with the Department of Education, College of Distance Education, University of Cape Coast and is undertaking a study titled:

Family Setting Factors Influencing Depression in Women in the Ketu- South Municipality: Counselling Implications.

The study is supposed to be a partial requirement to enable him/her obtain a master's degree.

We would be very grateful to you if he/she is given the assistance to collect research data for the study.

Thanks very much for your co-operation.

Yours faithfully,

Professor Emmanuel Kofi Gyimah

Head

APPENDIX C

A REPLY TO INTRODUCTORY LETTER

In case of reply the number and the date of this letter should be quoted

My Ref No. KDH/J-282

Your Ref. No.....

Our GHS core Values
- PEOPLE-CENTRED
- PROFESSIONALISM
- TEAM WORK
- INNOVATION/EXCELLENCE
- DISCIPLINE
- INTEGRITY

KETU SOUTH DISTRICT HOSPITAL
GHANA HEALTH SERVICE
P. O. BOX AF 274
AFLAO. V/R.

Tel. (0501335482)

E-mail:ketudistricthospital@yahoo.com

4th September 2018

RE: LETTER OF INTRODUCTION
MR. SYLVESTER LOSHAR-WOYRAM-MPHIL STUDENT, UNINIVERSITY OF CAPE COAST

I acknowledge receipt of your letter with ref. no. CODE/DE/OOM/VOL.1/0004 dated 28th May, 2018 in connection with the request to permit above-mentioned student to collect data on the topic **'Family Setting Factors Influencing Depression in Women in the Ketu South Municipality, Counselling Implications'** in this Hospital.

I have the pleasure to inform you that your request has been granted.

As I wish him well during his stay with us, I want to remind him to conduct his study within the rules and regulations governing this facility as set out by Ghana Health Service.

Please, feel free to contact us if there is anything unclear about this letter.

Thank you.

DR. Kuklui GAVUA
MEDICAL SUPERINTENDENT

Head of Department
College of Distance Education
University of Cape Coast
Cc
Mr. Sylvester Loshar-Woyram

APPENDIX D

PREVALENCE OF FAMILY STRESSORS AMONG WOMEN WITH DEPRESSION

Statements	Mean	Std. Dev
Intra-family strains		
My husband spends much more time away from the family. I have needs that are not being met due to this.	2.89	1.33
A family member has emotional problem. I am often anxious over this.	2.87	1.14
A family member depends on alcohol much to my discomfort.	2.93	1.23
In my family, we have conflicts which keep increasing no matter what I do.	2.23	1.04
There is increasing child-rearing difficulties in my family. I am fed up.	2.77	.84
There is increase in the number of problems or issues which do not get resolved in my family.	1.79	.66
I experience increasing conflicts with my in laws or parents	2.97	1.59
Overall mean	2.64*	
Marital strains		
My husband separated or divorced. This is disappointing to me.	3.20	1.66
A spouse has an affair. This makes me uncomfortable.	3.51	1.31
There is increasing difficulty in resolving issues with my previous or separated husband.	3.31	1.59
I have increasing difficulty in sexual relationship with my husband.	3.40	1.10
Overall mean	3.36*	
Pregnancy and child bearing strains		
I feel overwhelmed by unwanted or difficult pregnancy.	4.19	1.16
An unmarried member became pregnant. This is embarrassing to me.	3.36	1.58
A family member had an abortion. I feel tensed over this.	4.27	1.14
I have difficulty conceiving. I am dissatisfied with myself.	4.87	.61
Overall mean	4.17*	
Finance and business strains		
I take loans to cover increasing expenses.	3.55	.68

There are changes in economic, political, and weather conditions which hurt the family business or income.	2.57	.88
In my family, I experience increasing financial debts.	2.79	.70
There is increasing financial strain on family money for medical expenses.	2.53	.68
There is increasing financial strain on family money for food, clothing, and homecare.	2.56	.85
There is increasing financial strain on family money for children's education.	2.59	.71
I am delayed in receiving child support or alimony payments.	2.57	1.0
Overall means	3.21*	
Work-family transitions and strains		
A family member stopped working for extended period due to lay off, leave of absence etc. I am unable to cope with this.	3.31	1.06
A family member retired from work. This is affecting upkeep of home and family.	4.23	1.04
I experience decrease in satisfaction on my job.	2.46	1.00
I often feel stressed from a family member's increasing difficulty with people at work.	4.03	.99
A family member has more responsibilities at work. This interferes with family responsibilities.	3.50	.56
My family moved to a new home. I tend to experience unpleasant changes.	4.09	.83
A child or adolescent member changed to a new school. I am unable to face up to the challenges.	4.19	1.23
Overall mean	3.69*	
Illness and family care strains		
There is increasing difficulty in managing seriously ill or injured member.	2.44	1.21
There is increasing difficulty in managing chronically ill or disabled member.	3.96	.79
I have increasing responsibility in providing direct care or financial support to my husband's parent.	4.00	1.2

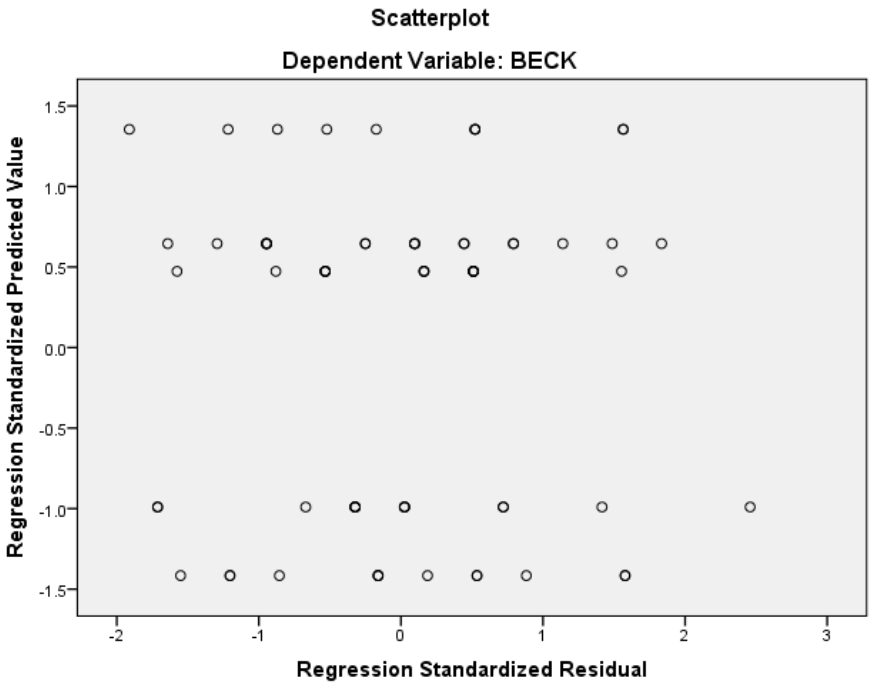
I experience difficulty in arranging for satisfactory child care.	2.44	1.10
Overall mean	3.21*	
Losses		
My parent or husband died. This is often hurting me.	3.85	1.25
A child member died. I often fell helpless over this.	4.43	1.35
A close relative died. This does not give me optimistic view for the future.	4.37	1.11
A married son or daughter separated or divorced. I am often getting upset by this.	4.24	.765
Overall mean	4.22*	
Transition into and out of family		
A young adult member left home. This makes me highly disappointed.	3.63	1.16
A young member began post high school training. I have difficulty adjusting to this.	4.44	1.30
A family member or a new person moved into the household. I am unhappy changing my familiar way of doing things.	3.84	1.10
My husband started school or training programme after being way from school for a long time. I experience pressure from his attempting this.	4.20	1.13
Overall mean	4.02*	
Family legal violations		
A family member is sent to jail or juvenile detention. I cannot be myself around my family.	4.77	.84
A family member is arrested by police. I go through stressful legal problems.	4.06	1.34
There is physical or sexual abuse or violence in my family. This makes me feel unsafe.	3.09	1.43
Someone in my family is on the run. I tend to worry over this.	3.79	1.38
Overall mean	3.93*	

Source: Field Survey (2019), N=70

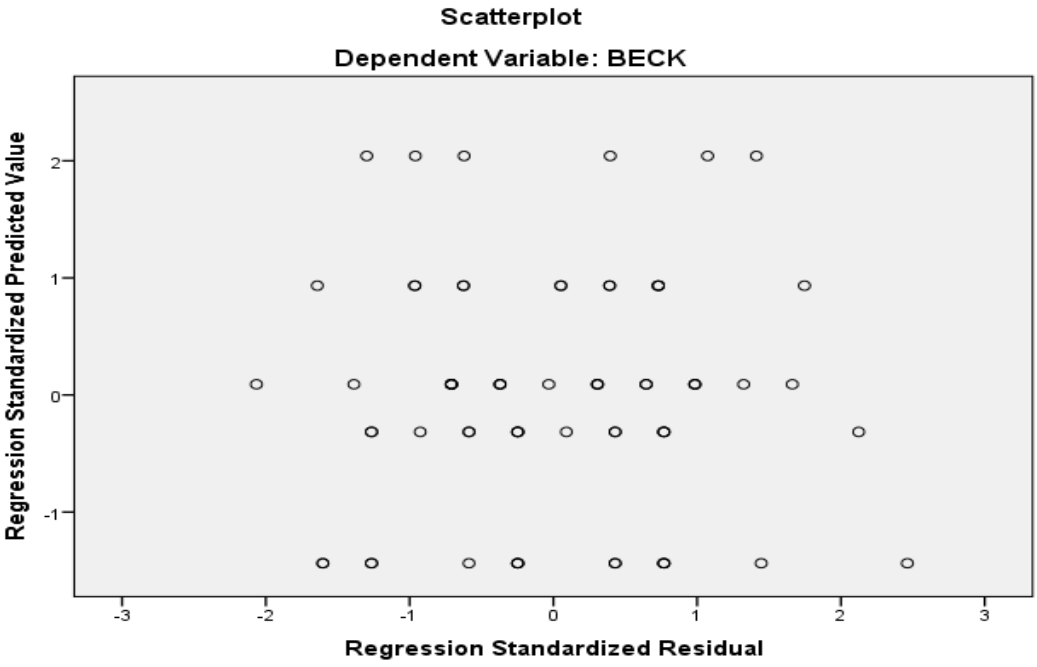
APPENDIX E

SCATTER PLOTS

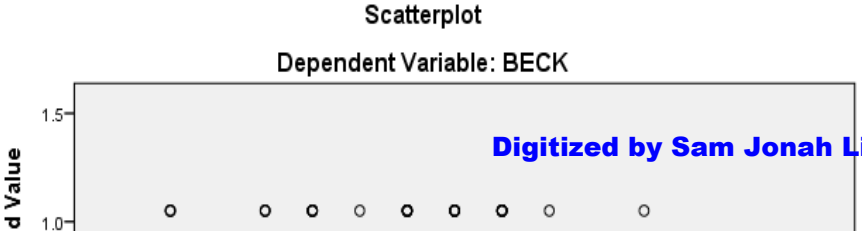
Age and Depression



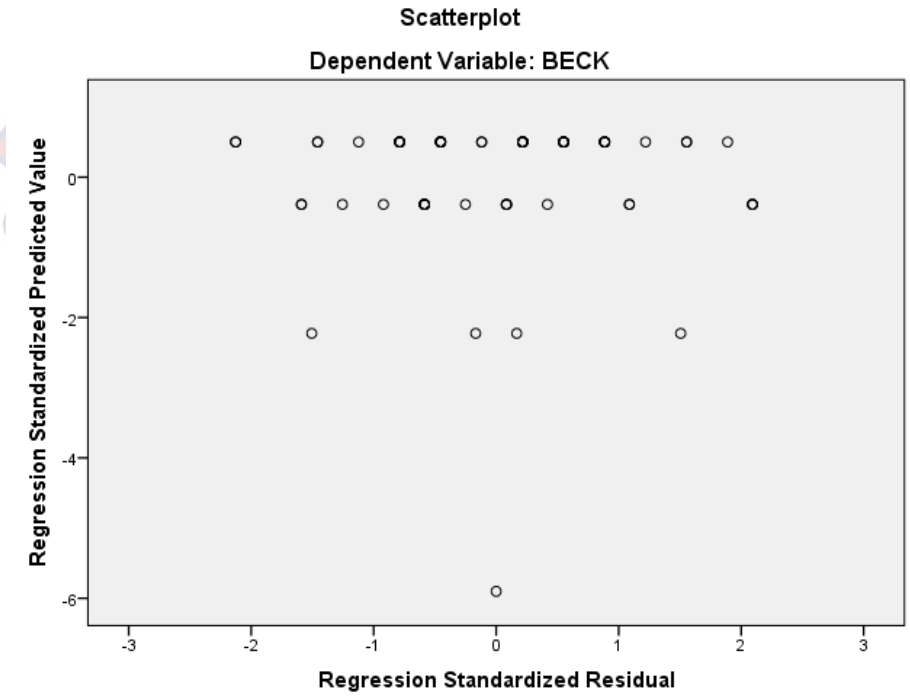
Age and Marital Status



Education and Depression



Occupation and Depression



Family Stressors and Depression