ACTIVITY SCHEDULE AND ANTICIPATION TRAINING AS COUNSELLING STRATEGIES IN MANAGING MILD-DEPRESSION AMONG NIGERIAN ADOLESCENTS

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A THESIS IN THE DEPARTMENT OF EDUCATIONAL FOUNDATIONS (WITH EDU. PSYCHOLOGY)

SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, UNIVERSITY OF LAGOS

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF DOCTOR OF PHILOSOPHY (Ph.D) IN GUIDANCE AND COUNSELLING

NOVEMBER, 2010.

APPROVAL

THIS RESEARCH REPORT HAS BEEN APPROVED FOR THE DEPARTMENT OF EDUCATIONAL FOUNDATIONS AND THE SCHOOL OF POSTGRADUATE STUDIES, UNIVERSITY OF LAGOS

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CERTIFICATION
This is to certify that the Thesis:

"ACTIVITY SCHEDULE AND ANTICIPATION TRAINING AS COUNSELLING STRATEGIES IN MANAGING MILD DEPRESSION AMONG NIGERIAN ADOLESCENTS"

Submitted to the
School of Postgraduate Studies
University of Lagos

For the award of the degree of
DOCTOR OF PHILOSOPHY (Ph.D)
is a record of original research carried out

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DEDICATION

This study is dedicated to the All sufficient God, my Strength, my Anchor, my Defense. To my late father and my precious mum who struggled to lay the foundation. Also to my wife and loving children Demilade, Oluwadara, Folasade & Olasupo (Jnr.) who all 'sacrificed' to make this dream a reality.

ACKNOWLEDGEMENTS

First and foremost, I thank God the great counsellor for His support, grace and strength in making this work a dream come true. This is surely the confirmation of His promise in Psalms 91:15.

My profound gratitude and appreciation go to my supervisors, Prof. (Mrs.) A. M. Olusakin and Dr. (Mrs.) B. O. Makinde. I appreciate their motherly guidance, encouragement, patience, constructive criticisms and useful suggestions at every stage of this study.

My sincere thanks equally go to all my able lecturers, Prof. G. C. Ilogu, Dr. (Mrs.) I. I. Abe, Prof. (Mrs.) Omoegun, Rev. (Fr.) Dr. F. M. Isichei, Prof. N. Osarenren (Hon. Commissioner for Education, Edo State), Dr. P. I. Nwadinigwe, Dr. M. B. Ubangha, Dr. C. E. Okoli, (Chairman Departmental P. G. Committee), Dr. Sola Aletan, Dr. A. A. Oni, and Dr. (Mrs.) O. M. Alade. They all stood by me through thick and thin in the course of this study. I also express my deep appreciation to the administrative staff of the Department of Educational Foundations for their ever ready assistance throughout my course of study. May the great Lord remember them for good in all their endeavours.

I equally express unreserved appreciation to the Dean of Post-Graduate Studies, Prof. T. O. Ogundipe. May God continue to strengthen him as he strives to empower his students. I am equally indebted to Prof. Felix Famoye (Visiting Professor from Central Michigan University CMU). He patiently taught me how to analyze data with the Statistical Package for Social Sciences (SPSS). I wish him more glorious years ahead in the noble profession.

I am equally indebted to the Principals, Vice Principals, Year Tutors, Class Teachers, School Counsellors and Librarians of the schools where the data for

this study were collected. I will ever be grateful to the wonderful participants in this study for their patience, resilience and cooperation that led to the success of the work. To my Research Assistants, I am very grateful for their relentless service, dedication and competence in data collection, collation and analysis.

I cannot but mention my sisters and brothers who have always stood by me through thick and thin, Sis Remi, Bro Kayode, Kola, Nike and Debola. Thanks for giving me the moral support and endless prayers. Nothing can ever pull us apart! God bless your respective families. I also acknowledge the efforts of Late Prof. Olasupo Esan, Ch. C. A. Agboola, Mr. and Mrs. C. A. Williams. I am very grateful for the support and prayers.

Coming home to my seniors and colleagues, Dr. (Mrs.) Utuama, Dr. Aneke & Dr. Saidu, thanks for their financial support. Dr. Oseni, & Dr. Aremu, mentored and supported me all the way. Mrs. Favour Nwolisa, she is more than a sister to me. (Favour please continue to follow me!). For the great three; Dr. (Mrs.) Iriobe, Dr. (Mrs.) Anya, and Mrs. Nwokedinobi you inspired me greatly at the APC. Through them, I learnt never to walk alone! Mrs. Oluwo, Mrs. Ajaero, Alh. Agunbiade, Mrs. Anyama, Ayo Thomas, Akinteye, Bolaji, Fakorede, Yemoo, Mrs. Weli, Mrs. Adeleye, Mrs. Madueke, and the entire CASSON members in Lagos State. They made various individual and collective contributions towards this study!

My sincere appreciation goes to the entire staff of Surulere LGEA. From Mr. A. I. Ajagunna, Mrs. Y. A. Fatoke, Mr. G. B. Alade, Mr. Kelani (Sir K.), Mr. Awoyo, Mrs. U. O. Ajaero, Mrs. C. O. Obani, Mrs. C. R. Ofoegbu, Mrs. F. I. Fasoyiro, Mrs. R. E. Igbokwe, Mrs. A. N. Nwabudike and Mrs. C. C. Emeh (Plc). My unreserved appreciation also goes to Ch. & Mrs. Okezie (Iya Ibeji), they were more than friends. For my caucus at the Personnel Section of Surulere LGEA: Ayodele,

Baba, Josef, Kosoko (Iya Segun), Yemi (Rodo), Fagbemi (Iya Odogunyan), Gbenga, Bisi and others too numerous to mention, I am grateful.

Finally, I could not have completed this work successfully without the support of Dr. Oye Arif, Dr. Jide Agboola, Mr. & Mrs. Orenisile, Mr. & Mrs. Adisa, Benthel, Yemi and their respective families. God bless them all.

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ABSTRACT

This study investigated the impact of Activity Schedule and Anticipation Training as counselling strategies in managing mild depression among Nigerian adolescents. Six Senior Secondary Schools were randomly selected from three Education Districts in Lagos State. The total population of SS 2 students, available for the study in the six schools, was 2,982. To select the participants for the study, The Self-Rating Depression Scale (SDS) was administered to assess the cognitive, affective, psychomotor, somatic and social interpersonal dimensions of depression in the students. The SDS has a test-retest reliability coefficient of 0.93, showing good stability. After the baseline assessment, the total sample for the study comprised 96 participants. The sample accommodated all the characteristics of participants in terms of age and gender from the senior secondary schools chosen for the study.

The study utilized Quasi-experimental pre-test post-test control group design comprising three groups (1, 2 & 3). Two research instruments, Depression Inventory and Index of Self-Esteem were employed to generate relevant data for the study. Six null hypotheses were postulated and tested using Analysis of Covariance (ANCOVA). Testing of the hypotheses was set at 0. 05 level of significance. Results of the data analyses indicated that:

1. The two counselling techniques Activity Schedule (AS) and Anticipation Training (AT) were effective in managing mild depression (lack of concentration, feelings of guilt and worthlessness, persistent sad and empty moods).

2. There is a significant interaction effect on adolescents' depression scores due to self esteem across the experimental groups.
3. There is no significant difference in depression level of participants due their socio-economic status.
4. There is insignificant effect of participants' family size on their depression level.
5. There is no significant gender difference in the post-test scores of participants across the three experimental conditions.
6. There is insignificant difference in the depression scores of participants based on their birth order.

In the light of these findings, a number of recommendations were made with the hope that if implemented, cases of adolescents' mild depression will be assessed and effectively managed with the use of Activity Schedule and Anticipation Training as counselling Strategy.

CHAPTER ONE

Background to the Study

Adolescence, the transition period from childhood to adulthood, is a stage that is characterized with emotional instability. Adolescents tend to experience stress, as they get conflicting messages; have conflicts within the family and school with difficulties in establishing self-identity and self-esteem. It is a period of increased thinking, emotionality and mood swings ranging from depression to the height of elation (Nair, Paul & John 2004). Adolescents hardly schedule their activities, yet they would like to engage in a thousand and one tasks at the same time. Muddled up activities often produce negative results. Continuous failure may result in pessimistic anticipation of events by the affected teens.

The family and society are supposed to assist adolescents in overcoming some of the crises that are inherent in this stage of development. The Nigerian society can hardly play this stabilizing role because of the deteriorating state of education, alarming rate of unemployment, galloping inflation, near collapse of social amenities among other ills plaguing the nation at this time. These affect the overall well being of Nigerian adolescents negatively by exacerbating feelings of depression, aggression, social maladjustment, low self-esteem and unassertiveness among others (Olusakin, 1990).

One of the most important social contexts for the development and expression of self esteem is the family. The family is the most important context because its major function is the socialization and care of the children (Gorbet & Kruzek, 2008). The size of the family and the ordinal position of the child have effect on the parental attention received by the child. The family is the first primary group where most important identities take shape. Assessments of role performances based on these identities become early sources of self esteem. Depression and

low self esteem may be viewed as a vicious circle. The inability to relate positively in social situations may lead to low self esteem which leads to depression. The depression then leads to further inability to relate with others or be fully accepted in social groups which then adds to the feelings of low self esteem (Davilla, Hammen, Burge, Parley & Daley, 1995).

The most turbulent state of human development is agreeably the adolescent stage. The adolescent is characterized by identity crisis, aggressive, hostile and manifest destructive behaviour (Nwadinigwe, 2004). The problems of Nigerian adolescents cannot be overemphasized. Apart from being the most difficult of the stages of development, the inefficiency in every area of the nation adds more to the burden of this important group of the society. It may lead to a pessimistic anticipation of future events. Some may even think that life is not worth living or worth the effort to even maintain their appearance or hygiene.

Depression is defined as an illness when the feelings of sadness, hopelessness and despair persist and interfere with an individual's ability to function. Though the term "depression" can also be described as a normal human emotion, it also can refer to a mental health illness. Depressive illness in children and teens is defined when the feelings of depression persist and interfere with the child or adolescent's ability to function. Adolescent depression is a mood condition occurring during the teenage years marked by persistent sadness, discouragement, loss of self worth and loss of interest in usual activities.

Depression can be disabling to the point where the depressed adolescent can no longer function in the daily rigors of life. Absence from school is common, for the severely depressed individual does not have enough energy or motivation to participate in or enjoy previously pleasant events (Comer, 1992). Life can be a lonely experience for depressed adolescents. Their sense of humour is lost and

they seldom smile. They are often tired from either too little or too much sleep. They are continually having intense feelings of shame and guilt because they believe that everything that goes wrong is their fault. Feelings of inadequacy may eventually lead to feelings of hopelessness. Due to their negative anticipation of events, they believe nothing can go right and nothing will ever improve. While some depressives may shy away from family and friends, some display an overdependence on others. When they are shunned by those they depend on, they become even more depressed (Schwatz & Schwatz, 1993).

Depression may arise not only when things are at their worst but also when there is a discrepancy between one's aspirations and the likelihood that these wishes and hopes, whether for oneself, ones family or the society would be fulfilled in reality (Olusakin, 1990). The family and social life of a depressed adolescent affect him or her greatly. The interpersonal field and the individual's adjustment to it are of notable importance. Once there is depression, the state of mind exerts powerful influence on the depressed person's capacity to perform his or her social obligations and on the reactive responses of those around the individual to his or her symptoms, complaints, impairments and frustrations (McAllister-Williams, 2006).

Fridolin (1983) stated that it has been well established that, regularly administered, most antidepressant treatment-pharmacotherapy and electroconvulsive therapy (ECT)-reduce the sensitivity of the sensitive adenylate clyclase in the brain linked to the down-regulation of the beta andreceptor subpopulation. The negative side effect of the antidepressant drugs cannot be overemphasized. In his report, Baldessarini (1984) affirms that the therapeutics of major depression has been dominated by agents and theories based on monoamine neurotransmission in the central nervous system (CNS) and that

virtually all effective medical treatment for depression have important monoamine transmission-enhancing effects.

What this implies is that drugs alone cannot totally eliminate depression though many people have depended for too long on antidepressant drugs. If someone is suffering from anxiety or stress, there are no drugs of comparable value to ease or correct the situation. Psychotherapy would by far be the most suitable for people in this category.

Some psychotherapeutic techniques that are commonly used to modify depression in adults include: Psychoanalysis; Cognitive Restructuring; Rational Emotive Therapy; Transactional Analysis among others. This psychotherapy has to be done by trained psychotherapist like the counsellor. It is not just anybody that can perform useful psychotherapy. Amateurs in this field can find themselves in great trouble (Olusakin, 1990).

Adolescents without psychosocial problems are assets to the society given the ravaging menace of anti-social behaviours especially in recent times. Osarenren, Ubangha and Oke (2008) identified the role of the family in the socialization and care of children as pivotal especially in the development and expression of self-esteem. Positive self-esteem is crucial in individuals that must live to comply with societal norms or standards. Low self-esteem has been connected with a wide array of difficulties and failures in life, even with crime (Adejumo, 2008).

In looking for possible solutions to this psychological problem of the Nigerian adolescent, the researcher is interested in the use of counselling strategies as against antidepressant drugs. While depression can be a debilitating condition, successful treatment rate is encouragingly high. As many as 85 percent to 95 percent of depressives who seek treatment get better (Fritz, 1995). Psychotherapy has the therapist acting as a confidant to the depressed. He often

employs counselling techniques from the available views of depression. For example in dealing with a depressed client, there should be assurance of a regular emphatic hearing up to a point in time as this will create the feeling that someone is taking their condition seriously and this will facilitate the feeling that the condition is explicable. The therapist can act as a catalyst to help the client understand their problems clearly and explore possible solutions (Olusakin, 1990).

Statement of the Problem

Depression is a serious mood condition that can take the joy from an adolescent's life. Mild depression usually has symptoms that are detectable and impact upon daily activities. The depressed will show diminished interest in things which he or she usually finds interesting or enjoyable. The severity of depression symptoms vary with individuals over time.

The alarmingly common nature of this mood imbalance makes it to be one of the many problems that confront adolescents. It is estimated, for example, that more than 330 million people worldwide suffer from serious depression, a condition characterized by overwhelming sadness and a loss of pleasure in everyday activities (Schwartz & Schwatz, 1993). Studies done among Nigerian adolescents by (Adewuya, Ola & Aloba, 2007; Ogun, Obagaye, Dada, Okewole & Akinsulore, 2008) have shown a prevalence of 6.9% depression in the general population and 35% in clinic population.

Depression is a worrisome mood condition among adolescents. Studies have shown that as much as one third of adolescents attending psychiatric clinics are depressed. Despite this, depression in this age group is greatly under diagnosed, leading to serious difficulties in school work and personal adjustment which often

continue into adulthood (Ogun, et. al., 2008). The consequence of this are abnormal behaviours like paranoia, schizophrenia etc.

Nigeria's name was introduced to terrorism list on Christmas day 2009 when Farouk Abdul-Mutallab attempted blowing up an America bound plane with explosives in his underwear. The justice Department said 23 year old Umar Farouk Abdulmutallab had a device containing a high explosive attached to his body on Flight 253 from Amsterdam. As the flight neared Deltroit's airport, Abdulmutallab set it off-but it sparked fire instead of an explosion (Gambrell, 2009).

Both the father and the stepmother noticed abnormal withdrawal of Farouk from the rest of the family anytime he is on holiday. The father even warned the American Central Intelligence Agency (CIA) that the boy might be a security risk to the Americans.

Apart from this, there are some strange psychosocial behaviours that were hitherto unheard of in Nigeria that are now predominant. Some of this includes; kidnapping, bombing, organized robbery, internet scam (419), political violence etc.

All this might be the direct result of hardship from unemployment, underemployment, strict admission policies and erratic display of ill-gotten wealth by visionless political leaders among other causes. These might have disillusioned the youth of the country who now have little or no choice than turn to or be overwhelmed by the myriads of problems around them.

Attempts made before now, in addressing depression among Nigerian adolescents, were done in Psychiatric Hospitals for adolescents who have severe

depressive symptoms. This condition often requires admission into the hospitals as the depressed cannot function efficiently in any task.

It is against this background that a need arises to try out intervention measure to manage mild depression-as characterized by increase in feelings of guilt, worthlessness, reduced concentration, indecision, memory loss, apathy, low self-esteem and difficulty in concentration among Nigerian adolescents.

Theoretical Framework

The study is hinged on the following theories:

- The Psychodynamic Theory
- The Cognitive Behavioural Theory
- Rational Emotive Behavioural Theory
- Developmental Theory

The Psychodynamic Theory

The psychodynamic view of depression is adapted from Sigmund Freud (1856-1939) an Austrian physician, neurologist and founder of psychoanalysis. The psychodynamic view of depression is anchored on the principle of loss, which states that depression is a result of internal, unconscious conflicts. Psychodynamic theorists focus on people's past experiences and the resolution of childhood conflicts. They believe that the root of all depression lies in the loss of something loved, whether it is a person or an object. The loss can be real or it can be imagined (Lamarine, 1995).

The philosophy of this theory claims that human emotions are basically ideogenic in their origin and that to control or change one's most intense feelings or perception, it is better to change one's idea. In using this theory, the youth world view was assessed and attempts were made to show how individual philosophies

of life may be the root cause of many of the problems that may be besetting the individual. Once this understanding was achieved, the next thing was to show adolescents how to uproot the negative self-defeating or illogical thoughts and replace them with logical thoughts and reality oriented ideas.

Psychodynamic theorists contend that depression develops as a response to a loss at the unconscious level. Psychodynamic clinicians make extensive use of free association (Comer, 1992). The hope is that by having the depressive talk about whatever is on his or her mind the identity of the lost object will come to the surface. The therapist and client discuss events that might have led to a loss or losses and attempt to interpret the events. The interpretations are intended to provide the client with some insight into his or her self-anger that Freud believed is present with a loss that precipitates a depressive episode.

It is the loss of self esteem, many psychodynamic theorists claim that starts a person down the path of depression (Comer, 1992). Whether an individual loses his or her self esteem depends on the quality of the individual's relationship as an infant with his or her mother during the first year of life. If an individual does not have positive experiences with his or her mother during the first year of life, then a predisposition to depression may be planted (Whitley, 1996).

From the axiom of Psychodynamic Theory, adolescents with mild depression need to associate with significant orders by talking (free association). This will bring the "lost object" to the surface so that the same can be properly addressed.

The Cognitive-Behavioural Theory (CBT)

This is an offshoot of Aaron Beck (1963), an American psychiatrist, who noticed that his depressed patients had pessimistic views of their lives and future and

that these attitudes distorted and changed their everyday experiences into negative events. In this therapy, a person learns to understand and eventually eliminate those habits of negative thinking. Beck believes "depressives suffer from a kind of basic thinking that distorts reality" (Papalia & Olds, 1988). According to Carson & Butcher (1992), people's feelings are influenced by what they think or how they view life events. It is not people's experiences or situations that make them angry, depressed or anxious but the way they process the information and think about those experiences.

The CBT helps individuals to change some of their habitual modes of thinking about themselves, their situation and the future. Change negative styles of thinking and behaving often associated with depression.

As a kind of psycho-therapy used to manage depression, anxiety, phobias and other forms of psychological imbalance, CBT involves:

- ✓ Recognizing distorted thinking
- ✓ Learning to replace it with more realistic substitute ideas
- ✓ Locate the cause of depression i.e. irrational thoughts.

CBT combines two effective methods i.e. Cognitive and Behaviour Therapy. Behavioural Therapy helps to weaken the connections between troublesome situations and the habitual reactions to emotions such as fear, rage, depression and self-defeating/self-damaging behaviour. It also helps individuals to calm the mind and body, so that he can feel better, think clearly and make better decisions. Cognitive Therapy teaches how certain thinking patterns are causing depression by giving a distorted picture of what is going on in the individual's life and making him feel anxious, depressed or angry for no good reason.

The theory is interested in how an individual chooses and decides from many possibilities, clarifies, develops personal worldview on achievement orientation,

acts and behaves in relation to reality, since the same stimulus produces different responses in different people (Szymanska & Palmer 2000). The theory has been applied to a wide range of mild to severe emotional and behavioural disorders. These could be the result and the amount of cognitive "gap" created as a distortion between the "espouse theory" and the "theory-in-use". The issue of cognitive gap in human beings is always creating an internal drive for a need to balance their behaviour with their beliefs so that the two could be in consonance.

The theory is relevant to this study in that positive anticipation of life events will go a long way in ameliorating not only depression in adolescents but also low self-esteem and social maladjustment among others. Since negative thinking towards self, the world and the future is the nucleus of depression, anticipation training will be employed to equip adolescents with certain thinking patterns to avoid the thoughts of distorted picture of what is going on in their lives which make them feel anxious, depressed or angry for no good reason or provoking them to ill-chosen actions.

Rational Emotive Behavioural Theory (REBT) Albert Ellis (1995)

According to Ellis (1995), human beings have strong innate or biological tendencies to think, feel and behave in certain ways. Human beings can largely but not exclusively control their own destinies, particularly emotional destinies. We do so by evaluating the ways we feel about and interpret or choose to look at the events that occur in our lives and by the actions that we choose to take in response to our evaluation of these occurrences. He explained that if there is an Activation experience or Event at Point A and there is an emotion or behaviour consequence at point C, for example one feels quite depressed about what happened and thus avoid seeking for solution. The emotional behavioural

consequence C follows immediately and directly after the occurrence of the Activation Experience A and one assumes that A causes C. REBT maintains that this conclusion is a non-sequitur, for C did not automatically follow A. instead the Consequence (C) followed your beliefs about A. the beliefs are two:

- Irrational Behaviour (iB) and
- Rational Behaviour (rB)

One who holds rB can produce the evidence of what happened being a reality but he can also say, that is not the end of the world. Though there will be regrets, sorrow and disappointments at C. The iB makes one experience despair, depression and complete inadequacy at point C.

Having detected and discriminated the (iBs) from the (rBs), the next step is D. D stands for Disputing. Clients here are encouraged to question and find evidence for irrational ideas which generate and sustain their emotional unsettledness and dysfunctional behaviour. The end result of REBT is to acquire a new philosophy, which enables them to think about themselves, others and the world in a more sensible way in the future. When one acquires this new Effect (E), the person not only acquires a new philosophy if the person truly believes in it and follows his belief, he will acquire a new emotive Effect (eE) and behavioural Effect (bE) as well. Thus there will be no depression again about what happened. He will then be active and assertive. The theory was therefore useful in carrying out counselling sessions with the adolescent.

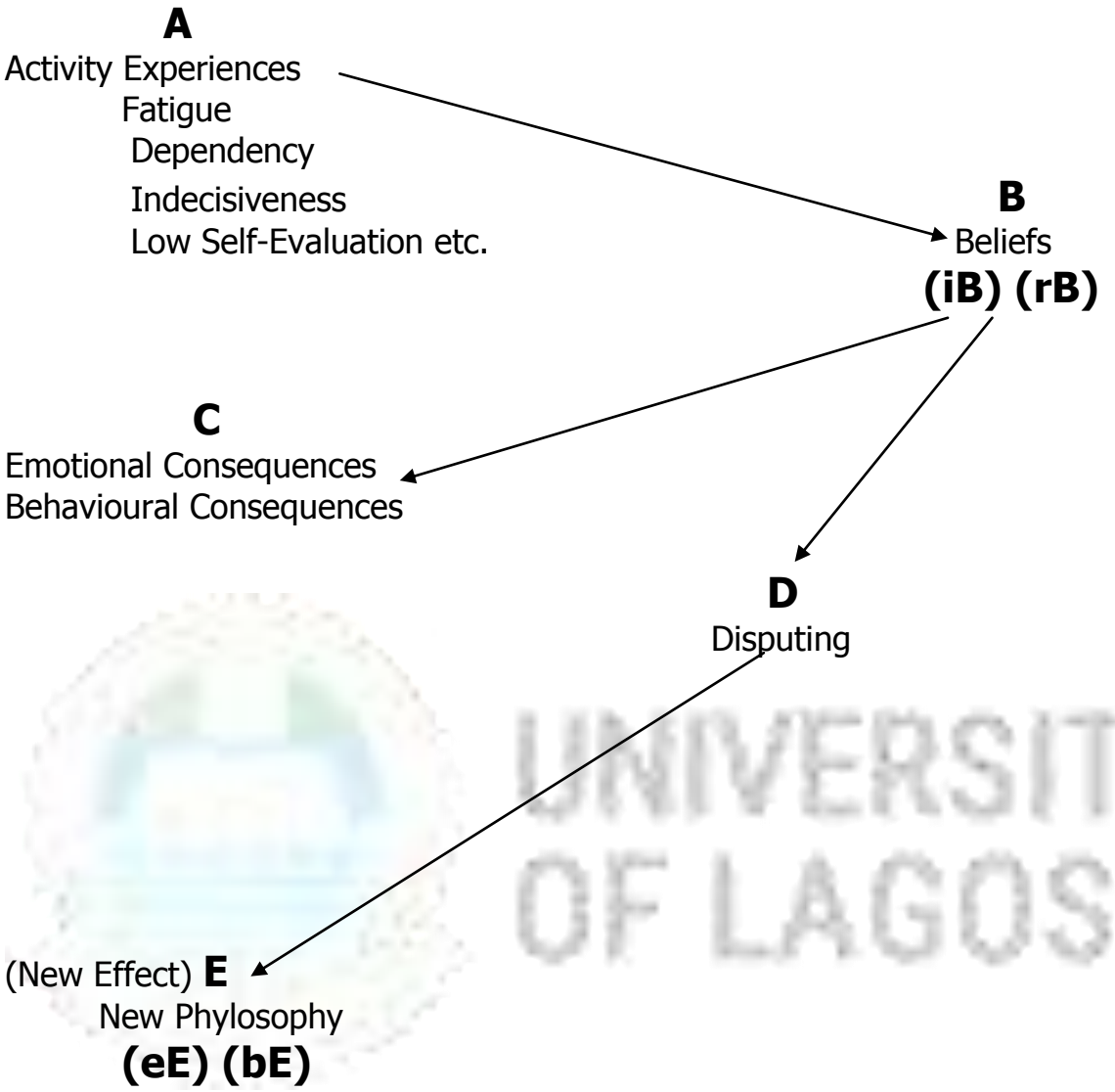

Fig 11: Relationship between the modalities (Adapted from Albert Ellis REBT, 1995).

Developmental Theory of Erik Erikson (1902-1994)

Erik Erikson, an American psychoanalyst proposed a relatively stages of personality growth that strongly emphasize social influence within the family. Erikson's eight stages span the entire life course, and contrary to Freud's stages, each involves a conflict in the social world with the possible outcomes. In

infancy, for example, the conflict is "trust versus mistrust" based on whether the baby is confident that others will provide nurture and care. In adolescent, "identity versus role conflict" defines the teenager's search for self understanding.

Erikson's Psychosocial Theory focuses on how society shapes and influences a person's growing sense of ego and the quest for identity. Society is seen as a positive force that fosters the growth and development of the self. Each stage pointed out by Erikson represents a crisis in form of gradually increasing conflicts; each represents a crucial moment where specific problems need to be solved so that the acting person can gain maturity (Farzaneh, 2008).

If the crisis is resolved in a satisfactory manner, the ego moves on to the next stage, which would foster feelings of competence and self-confidence. On the other hand, failure to resolve the conflict would hinder the ego to develop and grow in a healthy manner and can lead to various mental health problems and maladjustments.

The stages of development according to Erikson are:

Stage 1: Trust versus Mistrust

Stage 2: Autonomy versus Shame and Doubt

Stage 3: Initiative versus Guilt

Stage 4: Industry versus Inferiority

Stage 5: Identity versus Confusion

Stage 6: Intimacy versus Isolation

Stage 7: Generativity versus Stagnation

Stage 8: Integrity versus Despair

(Farzaneh, 2008).

From the theories and treatment methods proposed for this study, the researcher formulated a theoretical framework of the study as follows:

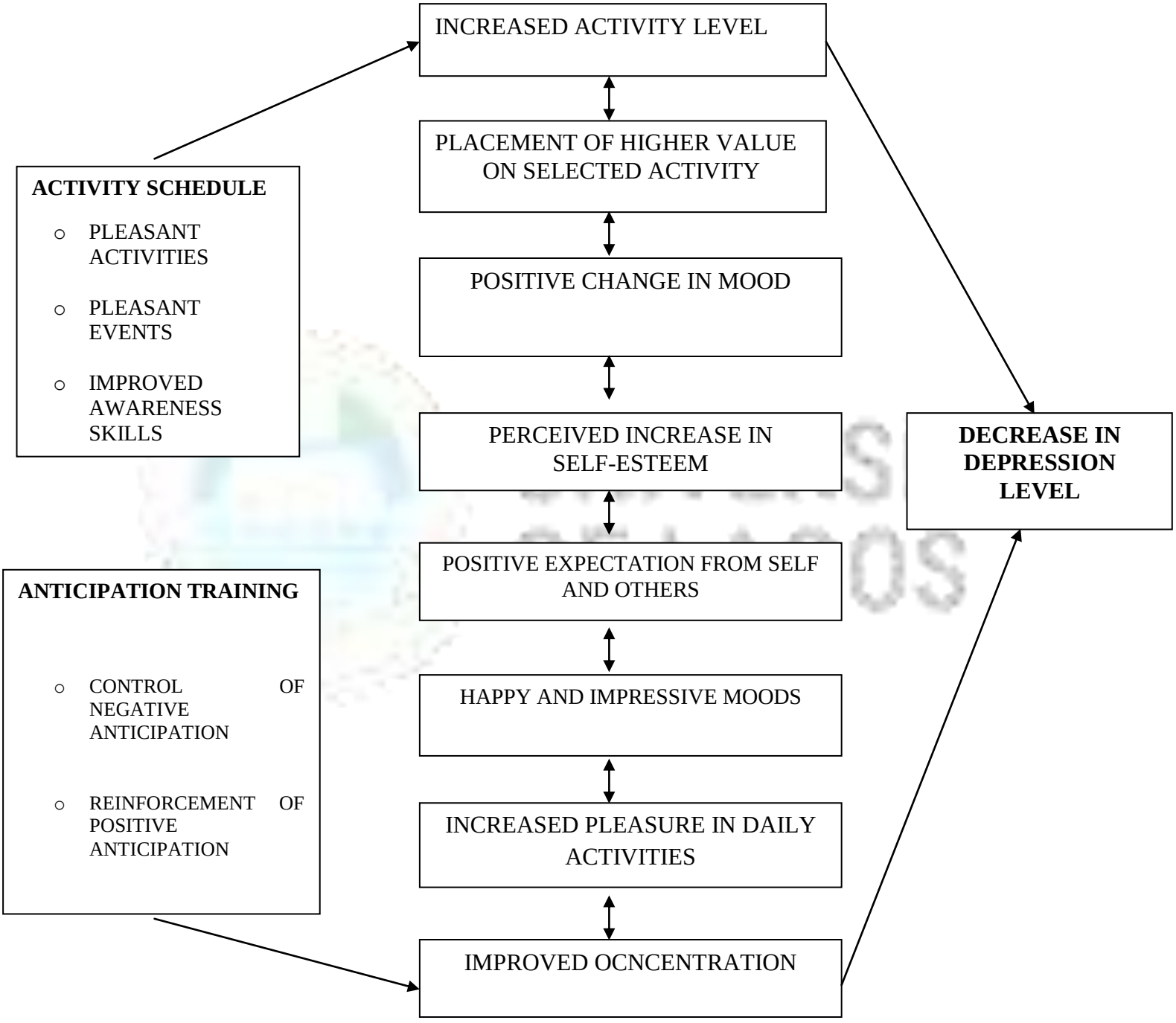

Fig. 111: Researcher's Conceptual Framework

The success of the above theories is not only to make the depressed adolescent realize themselves; but also help them in changing their behaviours towards what they felt were responsible for their irrational behaviours.

Purpose of the Study

The study was designed to evaluate the impact of activity schedule and anticipation training strategies on the management of mild depression among Nigerian adolescents. Specifically, the study sought:

1. To ascertain the effect of Activity Schedule and Anticipation Training strategies on the participants' depression level.
2. To evaluate the effects of Activity Schedule and Anticipation Training Strategies on participants' depression level.
3. To assess the influence of participants' socio-economic-status on participants' level of depression.
4. To evaluate the influence of study groups' family size on participants' depression level.
5. To determine the effect of participants' gender on participants' depression level.
6. To investigate if the birth orders of participants influences their level of depression.

Research Questions

The following research questions guided the study:

1. Will there be any difference in the participant's depression level across Activity Schedule, Anticipation Training and Control groups?

2. Is there any difference in participants' depression level due to self esteem across the treatment groups?
3. To what extent does social economic status influence study groups' depression level?
4. Does the depression level of Nigerian adolescents depend on their family size?
5. Is there any gender difference in the post-test depression scores of participants across the three experimental conditions?
6. To what extent does birth order influence the level of depression of participants?

Research Hypotheses

The following hypotheses directed this study:

1. There is no significant difference in the post-test depression scores of participants across Activity Schedule, Anticipation Training and Control groups.

2. There is no significant difference in the post-test depression scores of participants due to self-esteem and experimental conditions.

3. Social economic status does not significantly influence participants' depression scores.

4. Nigerian adolescents' depression level is independent of their family size.

5. There is no significant gender difference in the post-test depression scores of participants across the three experimental conditions.

6**.** There is no significant difference in the depressive mood of participants based on their birth order.

Significance of Study

The findings of the study will alert and sensitize parents to spot depressive mood in their children. They will not mistake acts like apathy, withdrawal, excessive irresponsible behaviour pattern etc. as normal childhood misdemeanors/activities that will pass with age. Any depressive behaviour pattern that is exhibited for a considerable length of time will be promptly addressed by the parents

This study will help adolescents in self examination. Since no one is closer to an individual as himself/herself, individual adolescent will be able to do self-assessment and promptly check any deviation into depressive mood that can affect their studies or make them unadjusted to their family members and peers at home or in the school. Adolescents will also be able to seek help when they notice any or a combination of the symptoms of depression over a period of time.

The adolescent stands at a prime position in the society. This study will awaken their sense of patriotism in that critical self-examination, that is a preoccupation of this study, will leave adolescents well adjusted to themselves and the Nigerian society generally. This will also lead to economic development of the nation. Adolescents constitute the nucleus of the nation's youth. Their satisfaction and contentment will be invaluable to the overall well being of the country.

The counsellors, psychologists and other health workers, through this study, will be able to diagnose adolescents with depressive mood when they have difficulties at making decisions, preoccupation with self, acting out behaviours, anorexia, insomnia and other depressive behaviours over a considerable period of time. After comprehensive diagnosis, the therapist will be able to apply the right strategy to assist such adolescent to manage and overcome such imbalance or refer recurring depressive mood to a significant order.

This study will also contribute to research on the impact of activity schedule and anticipation training as counselling strategies in managing mild depression among Nigerian adolescents. These strategies can be extended to children and adults who show symptoms of depression over a considerable period of time.

Scope/Limitation of the Study

The study covered SS2 students in three Education Districts in Lagos State. The study is limited to these three Districts because of the nature of the study which required individual participant's supervision. 2,982 SS 2 students in the six schools, randomly selected for this study, were examined with the Self Rating Depression Scale. 96 students with the highest scores in the instrument (Self Depression Scale) were systematically selected as samples for the study. The treatment and data collection were done during the 2007/2008 academic session in the students' respective schools.

There are various levels and factors associated with depression, in this study; the management of mild depression among Nigerian adolescents is the main concern. With the myriads of psychotherapy methods available for treatment of emotional deficits, emphasis was on the use of *Activity Schedule and Anticipation Training* as counselling strategies.

Operational Definition of Terms

Adolescence: This is the period from puberty to adulthood in human beings. It is the stage of maturation between childhood and adulthood. The term denotes the period from the beginning of puberty to maturity. It usually starts at about age 12 in males and age 10 in females. The transition to adulthood varies among cultures, but it is generally defined as the time when individuals begin to function

independently of their parents. In this study, apart from the above, adolescence will refer to youths between 10-19 years of age.

Child: This refers to a young human being preferably between birth and puberty. In this study, apart from the above, child is used for adolescents. It refers to someone between 0 and 19 years.

Depression: This is defined as an illness when feelings of sadness, hopelessness and despair persist and interfere with an individual's ability to function. Depression refers to normal emotions variously called sadness, disappointment or discouragement. Apart from the above, in this study, depression would be taken to be a complex pattern of deviation in feelings, cognition and behaviour that persist for a minimum of two weeks.

Mild Depression: In this study, mild depression was taken to be feelings of sadness, hopelessness and despair that are present in adolescents and interfere with the individual's ability to function effectively. Though the individual with mild depression experiences some psycho-social problems, these disturbances are not strong enough for hospitalization.

Activity Schedule: In this study, Activity Schedule was taken to be a comprehensive ordering of exercises which adolescents engage in daily or weekly for positive and rewarding experiences. The guiding principle for the behavioural treatment of depressed individuals is to restore an adequate schedule of positive reinforcement for the individual by altering the level, the quality and the range of his activity and interactions. Depressed individuals as a group engage in relatively few activities compared to normal individuals and that the depressed engage in fewer activities that they themselves consider as being pleasant or rewarding.

Anticipation Training: To anticipate is indicative of the predictive and motivational features which point to the future. Anticipation is both push and pull of personal constructs. A person anticipates events by construing their replications. This means that events are predicted by placing an interpretation upon or structuring the recurring aspect of events. Anticipation training in this study referred to the expectant waiting for some pleasant events by adolescents

Bipolar Depression: In this study, this refers to a classification of depression where the individual experiences fluctuation in moods. If the individual's depressive mood is significantly lifted he/she slips into manic stage and if the manic stage is- by drug treatment- reduced, the individual slips back to depression.

Delusion: This is gross and false overestimation of personal worth, importance, powerfulness or attractiveness. In depression, different types of delusions occur and these could be grouped into several categories such as somatic delusions, delusions of worthlessness and delusions of poverty.

Endocrine System: This is a group of specialized organs and body tissues that produce, store, and secrete chemical substances known as hormones. As the body's chemical messengers, hormones transfer information and instructions from one set of cells to another.

Loss of Mirth Response: Mirth is laughter, happiness or enjoyment, especially accompanied by laughter. Depression usually leads to a loss of humour. This is not as if the depressed cannot perceive the point of a joke, it rather seems they cannot respond to humour the usual way. With mild depression, somebody who enjoys listening to jokes finds it no longer a ready source of gratification. Here, loss of mirth response will refer to the absence of laughter and happiness when the atmosphere warrants such.

Unipolar Depression: For the purpose of this study, this is a type of depression where the individual mood is limited to depression alone. There are no other significant accompanying mood conditions.

Assumptions

Since the research is not a comparative study and is not designed to treat specific maladjusted participants, samples could be taken from any part of Lagos State and the generated findings could be generalized. Therefore, the six schools for the study-with two schools representing each of the three treatment groups-were chosen randomly. What the study is interested in is the impact of activity schedule and anticipation training on management of mild depression among adolescents, notwithstanding where they come from. This is in line with the findings of Gibson (1991) that adolescents are age-related and remarkably similar regardless of background, socio-economic status or gender except perhaps those from disadvantaged populations.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter focuses on a review of related studies. Specifically adolescent depression and the management of mild depression in adolescents by reviewing the related research to illuminate and summarize already established facts.

Specifically, the review covers the following listed areas:

- Adolescence
- The Nature of Depression
- Symptoms of Depression
- Causes of Depression
- Classification of Depression
- The Prevalence of Depression in Adolescents
- Behaviours That may Indicate Risk of Adolescent Depression
- Relationship between Depression and Self-Esteem
- Socio-Economic Status, Family Size, Birth Order and Depression
- The Concept of Emotion and Social Adjustment
- Adolescents' Home Relationship and Social Adjustment
- Parental Separation and Adolescents' Social Adjustment
- Depression vis-à-vis The Nigerian Culture
- The Management of Depression
- Activity Schedule as a Counselling Strategy in the Management of Depression

- Anticipation Training as a Counselling Strategy in the Management of Depression

Empirical Studies

- Emotional Manifestations
- Studies on Conceptual Performance and Perceptual Threshold of Depressives
- Studies on Distortion of Time Judgment and Spatial Judgment in Depressives
- Some Factor-Analytical Studies on Depression
- Cross-cultural Studies of Depression
- Cultural Theories of Depression

Adolescence

Omoegun (1995) defined adolescence as the transition period from childhood to adulthood when the child attains puberty. Adolescence chronologically refers to a period between puberty and adulthood (Osarenren, 1996). Adolescence is a mid-way between two worlds; adulthood and childhood. The adolescent is no longer a child and is not yet an adult. The child looks up to him for help while the adult looks up to him for greater responsibilities which he has not got the will-power to accomplish satisfactorily. More so, the physiological changes heralding the stage makes the transition period even more challenging.

Walter, Castle & Spinger (1974) as reported in Emeri (2008) perceived adolescence as the period between childhood and adulthood. They maintained that the adolescent lives in two worlds at the same time. He craves for

independence, but often feels dependent. He resents parental correction but needs parental sympathy and help. He thinks he has known much and suddenly finds that he does not know enough to solve his problems. He wishes to control his own life but finds life full of frustrating obstacles. Hence he may be aggressive or rebellious in a day, and cooperative and affectionate the other day.

In the light of this, various researchers have described the period as: a period of storm and stress, most turbulent, most problematic, turbulent teens and identity crisis among others. Freud (1952) viewed it as a period of heterosexual attachments of interest. Rogers (1981) cited in Osarenren (1996) described adolescence as a process of achieving the attitudes needed for effective participation and functioning in the society. The physical changes in the adolescent are accompanied by new and often times, confusing emotional responses, a broadening of social awareness and functioning (Osarenren, 1996). Ausubel & Sullivan (1970) cited in Omoegun (1995) described the period in which new and continuous changes in personality organization are being formulated as transitional phases. During this period, the individual is in the marginal position of having lost an established and accustomed status and of not yet having acquired the new status, towards which the factors impelling developmental changes are driving him.

Havighust (1975) cited in Omoegun (1995) identified the multifarious problems that adolescents face as a result of physical and psychological changes characterizing adolescence as sex problems, developmental problems, problem of somatic variation, problem of egocentrism, problem of aggression and anti-social problems among others.

Olayinka & Omoegun (2001) identifying personality characteristics of the adolescent, predisposing him to abuse, observed that children who have a placid

temperament are less likely to be victims of abuse within a family than are hyperactive children by virtue of their placidity; they may be less affected by emotional turmoil surrounding them.

The Nature of Depression

Depression is defined as an illness when the feelings of sadness, hopelessness and despair persist and interfere with an individual's ability to function. Though the term "depression" can also be described as a normal human emotion, it also can refer to a mental health illness. Depressive illness in children and teens is defined when the feelings of depression persist and interfere with the child or adolescent's ability to function. Adolescent depression is a mood condition occurring during the teenage years marked by persistent sadness, discouragement, loss of self worth and loss of interest in usual activities.

McAllister-Williams (2006) wrote that depression may be defined in terms of the following attributes:

- A specific alteration in mood; sadness, loneliness and apathy
- A negative self concept associated with self reproaches and self blame
- Regressive and self punitive wishes, desire to escape, hide or die
- Vegetative changes; anorexia, insomnia, loss of libido; and
- Change in activity level; retardation or agitation.

Symptoms of Depression

Becks (1967) carried out an intensive study using fifty depressed patients and thirty non-depressed patients in need of psychotherapy. He attempted to tally which symptoms occurred significantly more often in the two groups. On this basis, he constructed an inventory consisting of items relevant to depression and

pre-tested it on one hundred patients. The inventory was finally revised and presented to a nine hundred and sixty-six psychiatric patients. The symptoms were discussed in terms of how they are likely to appear in the mild, moderate and severe states of depression.

Emotional Manifestations

In the area of emotional manifestation, Beck touched the area of dejected mood; negative feeling toward self; reduction in gratification; loss of emotional attachments; crying spells and loss of mirth response. According to him, the term emotional manifestations refer to the changes in the patient's feelings or the changes in his overt behaviour directly attributable to his feeling states. The individual's pre-morbid mood level and behaviour as well as what might be considered as the normal range should be taken into consideration.

Dejected Mood

Various descriptions could be given by depressed patients. Among the adjectives used by the depressed patients in answer to the question "How do you feel?" in Beck's study, are; miserable, hopeless, sad, lonely, unhappy, down-hearted, humiliated, ashamed, worried, useless, guilty (eighty-eight percent of the severely depressed patients reported some degree of sadness or unhappiness, as compared with twenty-three percent of the non-depressed patients).

The patient in the mild stage indicates that he feels sad and unpleasant feeling tends to fluctuate considerably during the day and at times may be absent and even the person may feel cheerful at times. The sad feeling can be partially or completely relieved by outside stimuli such as compliment, a joke or a favourable event. Positive response could be evoked with little effort.

The feeling of sadness tends to be more pronounced and more persistent as depression deepens. The negative feeling is less likely to be influenced by other people's attempts to cheer the patient up. Even if there is a seemingly relief it would be temporary. The mood is often worse in the morning and tends to be alleviated as the day progresses.

A patient with a severe state is likely to state he feels hopeless, miserable or worried. Beck reported that seventy percent of the severely-depressed patients indicated that they were sad all the time and "could not snap out of it", that they were so sad that it was very painful or that they could not stand the sadness.

Negative Feelings toward Self

The frequency of self-dislike ranged from thirty-seven percent in non-depressed group to eighty-six percent among the severely depressed and the patients according to Beck appear to distinguish feelings of dislike for themselves from negative attitudes about themselves.

At the onset of depression, the patient states his feeling is accompanied by ideas such as "I have let everybody down …… if I had tried harder, I could have made the grade". At relatively higher state, the feeling of self-dislike is stronger and may progress to a feeling of disgust with himself and the feeling is accompanied by ideas such as: "I am a weakling….. I don't do anything right….. I am no good" and other related statements. For a severely depressed individual, the negative feeling towards self may progress to the point where the person hates himself. At this stage statement such as "I am a terrible person….. I don't deserve to live….. I am despicable…… I loathe myself" are made.

Reduction in Gratification

According to Beck, the loss of gratification is a pervasive process among depressives that many of them regard themselves as the central feature of their illness and that ninety-two percent of the severely depressed group reported at least partial loss of satisfaction which turns out to be the most common symptom among the depressed group.

This reduction in gratification appears to start with a few activities and spread to other areas as the depression progresses. The spread extends even to activities that are generally associated with biological needs such as eating or sexual experience. Similarly stripped of their pleasurable properties are experiences that are primarily psycho-social such as achieving fame, receiving expressions of love or friendship or even engagement in conversations. When the depression is mild, complaints that the joy has gone out of her that she no longer gets pleasure from her family, friends or job, are frequent. Activities involving responsibility, obligation or effort become less satisfying to her whereas she finds greater satisfaction from passive activities involving recreation, relaxation or rest. Unusual types of activities might be sought in order to get some of her former thrill.

Boredom becomes the order of the day for a depressed individual at the moderate stage. She may try to enjoy some of her former favourite activities which seems flat to her now. The feeling of boredom returns upon resumption of normal activities even after a temporary relief from change such as vacation. At a severe stage, the depressive experiences no enjoyment from activities that were first mostly enjoyable instead she may even feel an aversion for such activities. Expression of love or friendship no longer brings any degree of satisfaction that could be noticed.

Loss of Emotional Attachment to Other People or Activities

A decline in the degree of interest in particular activities or in affection or concern for other people, Beck found out that sixty-four percent of the severely depressed group reported loss of feeling for others or loss of interest in others whereas only sixteen percent of the non-depressed group reported that they experience this loss of affection.

There is some decline in the degree of enthusiasm for the absorption in the activity of the mild cases. The depressed may feel more dependent on family members and may not experience the same intensity of love or affection for other members of the family or friends. When depression increases, indifference may result from a progressive loss of interest which a number of depressives studied by Beck described as a "wall" between themselves and other people. A mother may be concerned that she does not seem to care for her children or what happens to them. A previously devoted employee may report that she is no longer concerned about her job while a student may no longer care about her appearance both at home or in school.

When it is severe, apathy may result from loss of attachment to external objects. Not only may the depressive report a loss of any positive feeling for members of the family but her only reaction towards them may be negative in nature. This may even develop to hatred.

Crying Spells

Among the depressives, increased periods of crying are frequent. Beck found out that this is particularly true of depressed women. Eighty-three percent of the severely depressed group studied by Beck reported that they cried more frequently than they did before becoming depressed or that they felt like crying

even though the tears did not come. Those who rarely cried when depressed were able to diagnose the onset of depression by observing a strong desire to weep. For example, Beck reported one woman as saying "I don't know whether I feel sad or not but I do feel like crying so I guess I am depressed" and that further questioning elicited the rest of the cardinal symptoms of depression.

At a mild stage, tendency to cry increases and stimuli or things that would not affect the person ordinarily speaking, may now elicit tears. As depression progresses, the patient may cry during interview and references to his or her problem may elicit tears, even men who are not used to crying may cry while discussing their problems.

Severe depression may take a patient who was easily moved to tears in the earlier phase of depression, find that he no longer can cry even when he wants to, even when terribly hurt. At times the person may weep without shedding tears. Beck also found out that twenty-nine percent of the severely-depressed patients reported that although they had previously been capable of crying when feeling sad, that they could no longer cry again, even though they wanted to.

Loss of Mirth Response

Loss of sense of humour is considered another symptom and the problem does not seem to be the loss of the ability to perceive the point of jokes, it rather seems to be that the depressive does not respond to humour in the usual way. She may not be amused by things that normally amuse people. Such a person may not get any feeling of satisfaction from a jesting remark or joke and may not feel like laughing.

Nussbaum & Michaux (1963) studied the response to humour in the form of riddles and jokes in eighteen women with severe depression and they found that

improvements in response to humourous stimuli correlated well with clinical ratings of improvement of depression. When the depression is mild, somebody who frequently enjoy listening to jokes and participating, find that this is no longer a ready source of gratification.

At a moderate level, the depressive may see the point in a joke and may even force a smile but usually, she is not amused. At the severe stage however, the depressive does not respond to humourous jokes or statements at all rather, he/she is likely to respond to the aggressive or hostile content and feel hurt.

Cognitive Manifestation

In his expectation of the cognitive manifestations of depression, Beck (1967) viewed it as including a number of diverse phenomena. One group is composed of the depressive's distorted attitudes toward him/her, their experience and future. The phenomena also include low self evaluations, distortion of body image and negative expectations while the symptom of self blame expresses the depressive's notion of the clause. The individual is prone to hold himself/herself responsible for any difficulties or problems. She is also indecisive when it comes to decision making.

Low Self-Evaluation

This is a common characteristic of depression. It is part of the depressed person's pattern of viewing himself/herself as deficient in those attributes that are specifically important to him in the area of ability, performance, intelligence, health, strength, personal attractiveness, financial resources and popularity. This symptom, which according to Beck (1967) was reported by eighty-one percent of the depressed group and by thirty-eight percent of the non-depressed, is often sense of deficiency which is expressed in terms such as " I am inferior". At times,

the sense of deficiency may be reflected in complaints of deprivation of love or material possessions especially with people who have had an unhappy love affairs or financial difficulties.

At a mild stage, the depressive may show an excessive reaction to any of his/her errors or difficulties and may regard them as a reflection of his/her inadequacy or defect in himself/herself. The individual may compare himself/herself with others and counts himself/herself inferior. At this stage, it is still possible to correct his/her inaccurate self-evaluations by revealing appropriate evidence to the individual. As the depression progresses, most of the depressives thought content may just revolve about his/her sense of deficiency and then neutral situations are interpreted by the depressive as being indicative of his/her deficiency.

Exaggeration of the degree and significance of any error is a common characteristic. The individual is likely to see his/her failures as outstanding and his/her successes as faint by comparison, when he/she looks at the present and past life. He/she complains that he/she has lost confidence in himself/herself and the sense of inadequacy may be such that when confronted with the tasks he/she has done perfectly in the past. The initial reaction is to express the inadequacy to perform such tasks. A depressive who places a premium on the personal attractiveness, intelligence or business success and is a religious or moral person tends to believe that he/she has slipped in such areas.

A severely depressed individual's self-evaluation is always at the lowest level. Most often, the individual drastically down-grades himself/herself in terms of the personal attributes he/she might describe himself/herself as worthless and a total failure. Claims of being a burden to the family members are frequent.

Distortion of Body Image

This is also quite marked in depression. The depressive might have a distorted picture of his/her physical appearance and this is common in girls than in boys. At the initial mild stage of depression, the depressive begins to be excessively concerned with his/her physical appearance and at times frowning at his or her reflection whenever he/she passes a mirror. The adolescent might be examining the face frequently for signs of blemishes.

As the depression progresses, the concern about physical appearance becomes greater and when the depressed sees an ugly person, he/she may think that that is the way he/she looks. In the process of being worried about the appearance, the brow may become furrowed and when he/she observes this in the mirror, he/she thinks that it is the whole face is wrinkled and that the wrinkle would never disappear. He/she may believe he/she has grown fatter even though the evidence is to the contrary.

A severely depressed adolescent's idea of personal unattractiveness may become more fixed. He/she may believe that he/she is ugly and repulsive looking and expect others to turn away from him/her.

Negative Expectations or Anticipation

Beck (1967) reported that more than seventy-eight percent of the depressives reported a negative outlook as compared with twenty-two percent of the non-depressed group. The negative outlook may often constitute a source of frustration to the friends and family when they try to help them. The depressive may likely think of a future in which the present deficient condition, whether financial, social or physical will continue or even get worse unlike the anxious

client who tempers the negative anticipations with the realization that the unpleasant events may be avoided or will pass with time.

At the onset of depression, the depressive tends to expect a negative outcome in ambiguous situations. When others around the depressive feel justified in anticipating favourable results, his/her expectations lean towards negative. As the depression deepens, the future looks more and more unpromising as if there is nothing to look forward to. A severely depressed adolescent is likely to think that he/she would never get over his/her troubles and that things cannot get better.

Self-Criticism and Self-Blame

The depressive is prone to ascribe adverse occurrences to some deficiency in him/her and then blame himself/herself for the conjured defect. He/she may blame himself or herself for the occurrences that are in no way connected with him/her and may lead to savage self-abuse**.** At the onset of depression, the depressive is prone to blame and criticize himself/herself whenever he/she falls short of the rigid standards.

When there is a problem and the solution is not forthcoming, the depressive is likely to blame and criticize himself/herself for being dull, slow or stupid. As the depression advances, the depressive is likely to criticize himself or herself harshly for any aspect or of the personality that is judged to be substandard. Mistakes that are obviously not his/her making are likely to attract self-blame. In the severe stage, the depressive becomes extreme in self-blame and self-criticism. She is likely to see himself or herself as a social criminal and interprets extraneous stimuli as signs of public disapproval.

Indecisiveness

This is also one of the characteristics of depressives. Difficulty in making decisions and frequent changing of decisions on the part of the depressive can be quite vexing to the family and friends as well as to such adolescent. In the cognitive sphere, the depressive may anticipate making the wrong decision and as such, each time he/she considers one of the various possibilities he/she tends to regard it as wrong and to think that he/she will regret making the choice and so moves to the next alternative.

Another facet is primarily motivational and is related to avoidance tendencies and increased dependency. Lack of motivation to go through the mental operations that are required to arrive at a conclusion and even the idea of making decisions might represent a burden to the depressive and he/she might therefore, try to evade any situation that he/she perceives as being burdensome. The reality that making a decision may necessarily commit him/her to a course of action, since he/she does not want to act, he/she tends to avoid straight forward decision-making process.

In a mild case, someone who ordinarily could make rapid decision may now find out that solutions do not seem to come readily. Decisions that could have been made before without much thought may take longer period for the individual to mull over, review the possible consequences of the decision and consider a variety of often irrelevant alternatives and a general sense of uncertainty pervade the thoughts as a result of the fear of making wrong decision. As the depression progresses, difficulty in making decisions spreads to almost every activity and includes minor problems as what route to take to school, what clothes to wear, how to spend free time and so on.

Generally, the severely depressed adolescent may believe that he/she is incapable of making a decision and may not even try to choose between alternatives. He/she may have doubts about nearly everything he/she does or say. Uncertainty pervades his/her entire relationship.

Delusion

In depression, different types of delusions occur and these could be grouped into several categories such as somatic delusion; delusion of worthlessness and delusion of poverty.

In the area of somatic delusions, the depressive believes that the body is deteriorating and may even state that he/she has some incurable disease. Statements like "I can't think", "My digestive system is not working" might be uttered.

Delusions of worthlessness are also manifested by severely depressed patients who consider themselves of no value and some who think they are sub-human. An outgrowth of the over concern with finances and standard of living are manifested by the depressives as delusions of poverty. A depressive who is very wealthy may complain bitterly that all his/her money is gone.

Sleep Disturbance

This is one of the most frequent symptoms of depression, though it is not limited to this group of people alone. Sleeping difficulty among the depressed may also be accompanied with restlessness and movement at night.

In mild depression, the depressive may report waking up a little earlier than usual. In some cases, someone who is used to sound sleep until awakened by alarm clock may now wake up before the time set for the alarm. In some cases

however, the sleep disorder may be in the reverse direction whereby the depressive sleeps more than usual if he/she is afraid of facing reality.

A severely depressed patient wakes up frequently and may find it difficult or impossible to return to sleep. Some may even claim they are thinking continuously at night.

Fatigue

The depressive is likely to get tired easily, even early in the morning. Most of the normal activities seem to accentuate his/her tiredness. Someone who customarily could walk long distances prior the onset of depression may feel exhausted after short walks when depressed. Mental activities also increase the sense of tiredness. A severely depressed patient may even complain that he/she could not sum up enough energy to lift the hand or that he/she is too tired to do anything. Although when under external pressure, they may sometimes perform tasks requiring even a huge expenditure of energy but without external stimulation, they may not be able to mobilize the energy to perform even the simplest of tasks such as feeding or bathing.

Loss of Appetite

This is also a major characteristic complaint of depressives. For many, loss of appetite may even be their first sign of depression while the return of appetite may be the sign that it is beginning to subside. A mildly depressed individual may find that he/she no longer feels like eating meals and when attempt is made to eat, the customary enjoyment derived from such meal may not be there. A severely depressed individual may not want to eat at all. He/she may have to be forced to eat as an aversion for food may be developed and this may eventually lead to weight loss.

Motivational Manifestation

Consciously experienced desires, impulses and strivings are part of the motivational manifestations which are prominent in depression. They can be inferred from observing the depressive's behaviour. One of the features of the characteristic moderations of depressed individuals is their regressive nature because they may seem drawn to activities that are less demanding for them in terms of the degree of responsibility or initiative required. They may decline tasks that require some amount of energy, turn away from activities that are specifically associated with adult role and seek the ones that are childish in nature. They may be passive in choice than active and be rather dependent instead of being autonomous. They are more likely to avoid responsibility and escape from their problems rather than trying to solve them, seek immediate, but transient gratifications instead of delayed, but prolonged satisfaction. In a bid to avoid even the simplest problems, they may find that the problems accumulate overwhelmingly. They may even miss the chance to obtain personal satisfaction through accomplishment or interpersonal relations.

Avoidance Wishes

There is the urge to break away from the usual pattern of life among the depressives. For example the house wife may yearn and wish to leave her domestic duties as she is likely to regard such duties as dull, meaningless or burdensome and may wish to escape to a more relaxing activity.

At the mild level of depression, the individual may experience strong inclination to avoid certain things that he/she counts as uninteresting or tasking. The depressive is likely to avoid activities that do not promise immediate gratification and tends to shy away from attending the details that he/she considers

important. The individual may prefer more passive and less complex activities and be repelled by activities that involve effort or responsibility.

As depression advances, avoidance wishes become stronger and spread to a much wider areas. The depressive may even withdraw from most social contacts since interpersonal relations may even seem too demanding. A severely depressed individual may engage in marked seclusion, may stay mostly in bed and when people approach him/her, may hide under the covers while some may even feel a strong desire to end their lives as a means of escape in situations which seem intolerable to them.

Dependency

The desire to receive help, guidance and direction is also a common phenomenon among the depressives. The help may at times not be realistic since, if enough effort is made, the person will be able to reach his/her objective without assistance, but emotionally, the depressive find this satisfying, at least temporarily.

In mild depression, someone who is ordinarily self-sufficient and independent may begin to express a desire for help and support. The individual may now find out that he/she prefers people doing things for him/her. He/she may be craving for help even though he/she does not need it when the help comes.

Increase in depression would make the depressive's desire to have things done for him/her and to receive instructions become stronger. The individual now view the wish for help as a need and not an optional luxury but a necessity. At this stage, the depressive readily seeks for help when confronted with a task even before attempting to undertake it personally. He/she may express that he/she wants to be told what to do and may seek around for opinions about certain

course of action. Eventually, the depressed may seem to be more interested in the idea of getting advice than in using it. For example, an adolescent may ask so many questions about trivialities but may not pay much attention to the answers.

In severe cases, the depressive's desire to be helped would increase and the content of the wish may have a predominantly passive outlook. He/she may want someone to do everything for him/her and to take care of every aspect. The individual may not only be concerned about getting direction or advice but may want the other person to do the job or to solve the problem. He/she might become emotionally attached to the psychotherapist and may show the dependency by not willing to end counselling sessions at the end of therapy.

Paralysis of the Will

The will to perform even the most elementary and vital tasks such as going to the toilet, eating or taking medication may be paralyzed in depression. Although the depressive may be able to define what to do in a particular situation, he/she may not experience any internal stimuli to carry it out.

The desire to act urgently may not be present, but an actual or impending shift in a depressive's life situation may serve to mobilize the constructive motivations which previously have been lying fallow.

In a mild case, the depressive may find out that he/she has no spontaneous desire to do certain things that may not bring immediate gratification. Later on, as the depression progresses, the loss of spontaneity may spread to almost all the depressives' usual activities. In severe cases, the depressive may have complete paralysis of the will and have no desire to do anything, even those that

are essential to life. As a result of this, the depressive may be unable to act by himself/herself unless spurred into action by others (Miller, 1975).

Considering all these assertions, it seems clear that the depressed needs help from competent therapist to find his/her bearing again and this is what this study is set up to accomplish.

Causes of Depression

There are three major views as to what causes depression. They are; the psychoanalytic theory, cognitive-behavioural theory and the biological theory.

The psychoanalytic view of depression anchors on the principle of loss of something loved, whether it is a person or an object. It is the loss of self-esteem, many psychodynamic theorists claim that starts a person down the path of depression (Comer, 1992).

The Cognitive-Behavioural view of depression, an offshoot of Aaron Beck's cognitive-behavioural theory, believes that depressives suffer from a kind of basic thinking that distorts reality (Papalia & Olds 1988). Depressives according to Beck, distorts reality by harboring negative feelings about anything and everything. They tend to take things too personally and believe the future is bleak and dim. The behavioural theorists believe depression is learned. Charles Ferster, one of the first researchers to suggest a link between depression and behaviour, hypothesized depression develops as a result of a lack of positive reinforcement for the depressive's actions.

The Biological view on depression anchors on the role of the brain and heredity in the likelihood an individual will develop depression. In twin studies done examining bipolar depression, researchers have found out the likelihood of 80

percent both twins will develop depression if at least one has it (Schwartz & Schwartz, 1993).

Adolescent depression of various types and depths can be triggered by a single major reversal, such as failure to get a coveted job or the end of a romance. It can be the result of lesser setbacks, such as a scolding by the parents, broken date and a quarrel with a friend. It can reflect adolescents' perception of the broader society as inhospitable, even hostile-offering no handholds with which to get a grip on adult life. Even though some cases of depression may be nothing but romantic posturing, most are real and serious. It is out of deep and enduring depression that some adolescents attempt or commit suicide (Whitley, 1996).

Classification of Depression

From the diversity of symptoms and apparent contributing causes, numerous attempts have been made to define subtypes of depression with specific features of the symptoms or causation.

According to McAllister-Williams (2006), the classification of depression (what types of depression exist) is a controversial topic that has caused much debate between psychiatrists that is if there are different causes and outcomes, and response to different treatments. Dispute arises because diagnoses are simply based on the presence of certain, arbitrarily defined, symptoms. There is still no diagnostic test for depression such as blood test or scan, which is able to confirm whether somebody has the illness. This lack of an objective "gold standard" diagnosis means that doctors do not know for certain whether the cluster of symptoms they use for diagnoses are valid or if they are dealing with one or more diseases that have the same central symptom of low mood.

Primary versus Secondary Depression

This distinction is based on the proposed cause of the depressive disorder in an individual.

Primary; the depressions is not as a result of any other medical or psychological cause.

***Secondary*;** the depression has been caused by a medical condition (e g a disorder of the thyroid gland) or psychiatric illness (e g schizophrenia).

Unipolar versus Bipolar Depression

This classification is based on the course of the disorder that the individual experiences; If the individual has only ever had episodes of depression, they are described as having a unipolar affective disorder (recurrent depressive disorder). Nemeroff (1998) listed Major depression as synonymous with unipolar depression describing it as the most common form of mood disorder. He stated further that bipolar depression, formerly called manic depressive illness, includes periods of depression that may suddenly lift and are followed immediately by periods of mania. He described manic depression or bipolar affective disorder as situation where the two extreme states, mania and depression, alternate in the same individual. It is very difficult to treat; if the depressive state is lifted too high for example, by drug treatment, then the person may swing into manic phase; if the manic state is 'damped down' too much, then the person may slip into depression.

The Prevalence of Depression in Adolescents

Osarenren (1996) described adolescence period as the time when a "new birth" occurs in the personality of the individual. It is a period of rapid and marked

changes which transform the child into a totally new personality. These changes result from sexual maturity and are thus biologically generated. These changes are pronounced and rapid, and of "storm and stress", a time when the individual is erratic, emotional, broken and unpredictable.

Olayinka, (1996) noted that early studies of adolescent psychology referred to adolescence as a period of life characterized by abnormalities of behaviour, natural to that period and outgrown as the individual reaches a mature level of development. Akinade & Sulaiman (2000) stated that "scientific studies have revealed that adolescence is not a period of life separated and isolated from the rest. Rather it is one part of a whole growth process which is being influenced by what preceded it and leaving its mark on what is to come.

Hayes (2000) in his study of "Youth and sex" said:

> *"The adolescent is characteristically secretive about himself and his feelings, but bares it in mind. He rejects his parents as if they were Lepers in a community of healthy people".*

Ainsworth (1990) also defined adolescence as a period of transition from childhood to adulthood depending on the culture of the community. Adolescence is an important period in the life of an individual. The adolescent undergoes basic changes during this stage of his growth and development. He is incapable of "going out alone", therefore the adolescent needs help at this stage.

Until comparatively recently, adults do not think that children suffer from depression. Recent studies have shown that this is more common a problem than was thought, especially among adolescents. The prevalence of Major Depressive Disorder (MDD) in Nigerian adolescents is comparable to those found

in western culture (Adewuya, et. al. 2007). Large-scale studies by Rutter & Rutter (1983) found that 10 per cent of pre-adolescents and 40 per cent of adolescents were described by parents or teachers as appearing miserable or depressed. If depressed episodes lasted six months or longer and are accompanied by other symptoms which typify depression, then the individual is regarded as being clinically depressed or suffering from depressive disorder. Studies suggest that these numbers run at between 3 and 8 per cent for child and adolescent populations (Patterson 1993). He found out that 50 per cent of adolescent school refusers were depressed; Kohn (1993) put the figure at 45 per cent. There seems to be an overlap between depressions, anxiety and conduct disorders in a number of clinical samples which have been analyzed.

This is one problem area where boys do not outnumber girls: the ratio is approximately equal, although in teenage years, girls are beginning to predominate. A number of researchers indicate that the children of depressed parents are more likely to become depressed; whether this is genetically or environmentally influenced has not been clearly demonstrated. Early developmental studies have demonstrated that children of depressed mothers are insecurely attached; the depressed mother tends to be non-responsive, which promotes a feeling of helpless resignation, which has been identified in many depressed adults.

Countless adolescents are affected by milder cases of depression which usually affects school performance (Lamarine1995). The peak age of depression correlates with the peak years of low self- esteem. Feldman and Elliot (1990) write that the prime period for low self-esteem is early middle adolescence with a peak period between the ages of thirteen and fourteen.

One of the factors that make depression so difficult to diagnose in adolescence is the common behaviour changes that are normally associated with the hormonal changes of this period (Lamarine, 1995). It is only in recent years that the medical community has acknowledged childhood depression and reviewed it as a condition which requires intervention.

Behaviours that may Indicate Risk of Adolescent Depression

New findings from a study supported by the American National Institute on Drug Abuse (NIDA), National Institute of Health, shows that girls and boys who exhibit high levels of risky behaviours have similar chances of developing symptoms of depression. However, gender differences become apparent with low and moderate levels of risky behaviours with girls being significantly more likely than boys to experience symptoms of depression. The study which incorporates data from almost 19,000 teens is published in the May 15, 2006 issue of the *Archives of Women's Mental Health.*

"The burden of illness associated with depression during adolescence is considerable and psycho-social problems, including substance abuse, are associated with depressive disorders in teens," says NIDA Director Dr. Nora D. Volkow. The findings from this study create a more complete picture of commonalities and differences of the risk of depression among boys and girls who engage in risky behaviours and provide information for healthcare providers to consider as they screen, evaluate and treat their young patients".

Dr Martha Waller of The Pacific Institute for Research and Evaluation and her colleagues provided new findings from teen interviews conducted as part of the National Longitudinal study of the Adolescent Health in 1995. The researchers clustered the teens into 16 groups according to their behaviours with symptoms of depression. Groups included abstainers, who refrained from engaging in

sexual activity and from using alcohol, tobacco and other drugs; teens who engage in low and moderate risk behaviour such as experimenting with substance abuse and sex; and teens who engage in high risk behaviours, such as exchanging sex for drugs or money or abuse of intravenous drugs (Conger, 1977).

"Difference in symptoms of depression between boys and girls were guided by risk behaviours," says Walker, & Satterwhite, (2002). "Among abstainers, there were no differences between boys and girls in their likelihood of having symptoms of depression." When abstaining girls were compared with risk-taking girls, the researchers observed that any risk activity, no matter how modest in degree, was associated with an increased risk of symptoms of depression. For example, girls who experimented with drugs, tobacco and alcohol were more than twice more likely to have symptoms of depression than girls who abstained completely. Girls who experimented with sex were almost four times as likely to have such symptoms, while girls who used intravenous drugs were 18 times as likely to have symptoms of depression as girls who abstained completely (Conger & Miller 1966). Among boys, most but not all, risk profiles were associated with greater likelihood of such symptoms, compared to abstainers. Boys who drank alcohol and those who were binge drinkers were about two-and-one-half times as likely to experience symptoms of depression as boys who abstained completely.

For most of the high-risk behaviours profiled, there were also no significant gender differences in symptoms of depression. However, for one exchanging sex for money or drugs, girls were seven times more likely than boys to report such symptoms. Among teens who engage in low and moderate risk behaviours, girls were significantly more likely than boys to report symptoms of depression (Conger, 1977).

"Although it has not been shown that these behaviours trigger depression, it may be that screening for substance abuse and other behaviours in teens may provide enough information to the health care provider to also warrant screening for depression, particularly for girls," says Dr. Waller. "Both substance abuse and sexual activity may alter a girl's social context, which could induce stress and or change self-perceptions both of which could contribute to depression. In addition, there may be differences in how boys and girls physically respond to substance abuse that help explain the gender differences" (Coleman & Hendry, 1990).

Self-Esteem

This can be referred to as the personal theory of self and has been defined variously, with somewhat broad key aspects:

- Appreciating one's worth and importance
- Being accountable to oneself and acting responsibly towards others

(Burns, 2000)

Self-esteem may be understood as including the feelings and thoughts that individuals have about their competence and worth, about their ability to make a difference, to confront rather than to retreat from challenges, to learn from both success and failure and to treat oneself and others with respect. Self-esteem guides and motivates actions and the outcome of actions in turn affects self-belief so that a dynamic, reciprocal process is continuously in force. Children with high self-esteem display adaptive strategies that promote growth e.g. spending more time learning difficult skills. On the contrary, children with low self-esteem frequently rely on coping behaviour that is counter productive and actually intensifies difficulties e.g. bullying, cheating, denial or making excuses. Such

coping behaviour often signals that a person is feeling vulnerable and is attempting to escape from challenging situations he believed will lead to failure (Longe, 2008).

Though every individual, while young, sometimes show self-defeating behaviour but its regular appearances strongly suggest low self-esteem (Bong & Clark, 1999; Skaalvik & Rankin, 1996). Self-esteem is thus the valuing, the feeling, the belief or affective part of one's self-picture. It is also the person's judgment of the self-concept formed, whether it reaches personal standards and values. However, Bandura, (2001) & Kohn, (1993) posit that self-esteem is not synonymous with self-concept, while both include one's idea of self; esteem has an evaluative component which is not included in self-concept measures. The "who am I" type of question does allows the person to describe self but does not require the evaluation of the impact of specific personal attributes on self-esteem. Self-esteem or belief includes two basic processes; the process of self-evaluation and the process of self-worth. These influences attitude and behaviour in that if someone does not like an idea, the tendency to become negative or depressed is very apparent. Thus, the kind of thought a person has about himself is the cognitive part of the self-picture (Bandura, 2001). Self-esteem is therefore the personal theory of self and it is important in learning and achievement or in success attainment. It is the overall self-evaluation, the summation of all self schemas and 'possible selfs' i.e. visions of the self, one's dreams of becoming. Globally, self-belief according to Giddens (2000) colours one's feelings about personal traits, abilities, memories and thoughts.

Relationship between Depression and Self-Esteem

There is a strong correlation between a person's emotional reaction and his environment in social relationship. Therefore, to increase one's self-esteem, one

need to improve one's standing in interpersonal relationships rather than trying to fix some perception about oneself. Research has shown that it doesn't have to be the actual rejection of a person by a social situation; it may be the imagined or anticipated rejection. (Davilla, et. Al., 1995).

Osarenren, Ubangha & Oke (2008) stated that the most important years in the development of an individual's self-esteem occur during childhood and adolescence. New research indicates that behaviour is not the result of low self-esteem, but rather the result of social rejection which leads to low self-esteem. In other words, self-esteem does not cause a person to behave in a particular way; it is the result of poor social relationships.

Depression and self-esteem may be viewed as a vicious cycle. The inability to relate positively in social situations may lead to low self-esteem which leads to depression. The depression then leads to further inability to relate with others or be fully accepted in social groups which then adds to the feelings of low self-esteem (Davila, et. al, 1995). This research opens a new area of study into the relationship between depressed people and their environment. Following Bronfenbrenner's (1986) notion of the mesosystem model of interactions, the relationship between an individual and the various environments of influence, must be considered just as important as the individual's self.

Since poor interpersonal problem solving skills lead to higher levels of depression, which in turn leads to more interpersonal difficulties, one may argue that teaching problem solving skills is the intervention solution. However, there does not appear to be a relationship between adolescent cognitive problem solving abilities and interpersonal skills. Therefore, one could conclude that it is not that adolescents do not know how to solve problems but they lack the desire or willingness to use those interpersonal skills (Davila, et. al, 1995).

Other factors affect depression and other affective adolescent problems. Parental influences on self-esteem are reported by Feldman & Elliot (1990) who discovered that parents who model openness and acceptance of new ideas can have a positive effect on their child's self-esteem. Other parental factors include encouragement for children to form their own viewpoint, as well as a secure family relationship to form a basis for exploration.

Competition is a popular blame agent for low self-esteem. It is easy for an adolescent to interpret a competitive loss with failure, thereby damaging self-esteem. Not only does competition damage self-esteem, it hinders interpersonal relationships. Instead of being a demonstration of strength and confidence, competition is a show of insecurity (Kohn, 1993). Competition may be viewed as a disservice by educators who should be improving the adolescent's ability to relate well with others. Instead, this spirit of competition held in many school activities serves to block healthy communication. Regarding competition in schools, Kohn writes "kids face it all the time in an award assembly, an event usually held in school auditorium that instantly transforms most people present into losers.

Goals set by socially unpopular adolescents tend to focus on non-social goals involving peer relations. As might be expected, aggressive adolescents value dominance and revenge over affiliation (Kohn, 1993). These adolescents had a higher incidence of depression, which points to lack of self-esteem. Interestingly, while popular students were very clear in their goals of affiliation, non-popular students ranked dominance and revenge higher, they also indicated a significant value for affiliation. This leads researchers to conclude that aggressive or unpopular children have greater internal conflict than popular children (Kohn, 1993).

It is important to consider the possible factors affecting self-esteem as it has been supported that one's self-esteem affects several aspects of one's life. Psychologists have posed several hypotheses about what may affect self-esteem, but no definite conclusions have been drawn (Osarenren et. al., 2008). Some studies have contradictory results of the above. There are two connotations of self-esteem (Rosenberg, 1965). One way of looking at it is to say that a person with high self-esteem considers himself to be "very good". Another view of self-esteem is to say that a person with high self-esteem believes he is "good enough" (Rosenberg, 1965), a person with high self esteem "simply feels that he is a person of worth; he respects himself for what he is….. He does not necessarily consider himself superior to others. He defines a person with low self-esteem as someone who 'lacks respect for the self (Rosenberg, 1965).

It is important to study self-esteem because of the implications of high and low self-esteem on an individual. Rosenberg, (1965) claims that a major determinant of human thought, behaviour and prime motive in human striving ….. is the drive to protect and enhance one's self-esteem. This suggests that the thoughts and actions of an individual are greatly influenced by his/her self-esteem. Thus, studying self-esteem and its factors is important to psychologists in helping to explain a person's thoughts and behaviours (Osarenren et. al., 2008). Studies have supported the idea that there is some relation, under certain conditions, between self-regard and socio-metric status, i. e. that high self-regard will lead to better ability to get along with others, and that acceptance by others will maintain or enhance self-regard (Wylie 1961 as reported in Osarenren et. al. 2008). This indicates that a person's self-esteem is related to how that person relates with others. Studies have also shown that high self-esteem is significantly associated with lower incidence of ……. depression sign (Wylie 1961 as reported in Osarenren et. al. 2008).

Since self-esteem is considered important to the well-being of an individual, it is of interest to determine possible factors affecting self-esteem. One theory is the self-attribution theory. "The self-attribution theory suggests that people evaluate themselves largely in terms of their own behaviour or its outcomes" (Rosenberg, 1979). According to the self-attribution theory, achievement is an important factor in determining self-esteem in both children and adults.

Another view takes the position that what influences self-esteem is different for each individual. One important thing to notice, however, is that "we are not completely free to choose our self-values" (Rosenberg, 1979). Many of our self-values are learnt from our families at a very young age, and sometimes these values are not in our best interest. This becomes significant when such self-values are difficult to change, because it may affect how a person feels about himself. He may excel in one area, but if he fails to excel in the area which he values most, it may have a detrimental effect on his self-esteem. Also, some self-values stem from the social role definitions and social group norms. At an early age, the child learns what is right or wrong, important or unimportant, for him, and these ideas are internalized in his value system" (Rosenberg, 1979). A person will constantly be judged by his significant others, and so "he must seek to excel in terms of their values not his own" (Rosenberg, 1979). Conflicts may arise between self-values and the values of others, which may affect self-esteem.

How a person feels about himself is also affected by how he thinks others view him. It is the perceived self-what we think others think about us-that affects our self-attitude (Rosenberg, 1979). The views of significant others, those people important to the individual, whose opinions he values, are the most important to the individual. Symbolic interaction theory states that children's feelings about themselves depend on their perception of how their parents view them. Similarly,

phenomenological theory posits that children's self-perceptions are affected by the way significant others treat them (Zervas & Sherman, 1994). Significant others vary among individuals, as it is a personal opinion who one considers to be significant in one's life. However, it is reasonable to assume that one's parents fall into the category of significant others. A child's thoughts of how his parents view him can be a great influence on how he feels about himself. If he feels his parents are disappointed in him or are not concerned about him, then he may feel that he is a failure or not worthy of their attention. This could have a negative effect on his self esteem.

Other factors affect depression and other affective adolescent problems. Parental influences on self- esteem are reported by Feldman and Elliot (1990) who find that parents who model openness and acceptance of new ideas can have a positive effect on their child's self-esteem. Other parental factors include encouragement for children to form their own view points, as well as a secure family relationship to form a basis for exploration.

According to Omoegun (1995), assertiveness means standing up for our rights and expressing our thoughts as well as our feelings in a direct, honest and appropriate manner. A lot of people have difficulty speaking up in conflict situations or in public. Others may feel intimidated by bullies or extroverts and regularly put aside their own desires in favour of what others want. This can result in a variety of psychosocial problems like depression, low self-esteem, aggression, unassertiveness and social maladjustment (Feldman & Elliot, 1990).

Socio-Economic Status, Family Size, Birth Order and Depression

There is a high positive correlation between the financial situation in the home and the kind of opportunities provided for the child, regardless of the methods used in raising them (Odunukwe, 2008). She established further that the value

and practices of child rearing vary substantially with the family's class. Olayinka, (1995) cited low self concept and low self-esteem as some of the major characteristics among youths of lower socio-economic status.

Bronfenbrenner (1986), as reported in Odunukwe (2008), establishes that value and practices of child rearing vary substantially with the family's class. He stressed that middle and high class parents are more permissive to the child's desires, express affection more freely, appeal to their children rather than physical punishment, scolding or threats more than parents of lower class. Consequently, children from higher socio-economic status are more responsible and show high level of aspiration than those from the lower class.

Parents in the lower class show less warmth to their children because of the stress of living in a non-conducive environment (Odunukwe, 2008). She stated further that lower class parents tend to see themselves more as autocrats than as participator the "family's democratic process". Olayinka (1995) stated that the socio-economic status of the family into which a child is born affects it. He cites low-concept and low self-esteem as some of the major characteristics among youths of lower socio-economic status. The type of foods the mother eats at prenatal stage and antenatal care she received affect the overall health of the child. He stated further that weight is an index of nutrition. Infants from poor homes usually weigh less and are shorter than those from rich homes. He is of the opinion that speech may be delayed if the child lives in a home where there are few play things.

Contrary to the above, Anadi (1993)-as reported in Odunukwe (2008), in his contribution to the problems of indiscipline in Nigeria, finds drug offence acts: like smoking of different types and drunkenness are exhibited mostly by students

from high socio-economic status families. The explanation he gave was that children from high socio-economic status families can afford to smoke and drink.

According to Okon & Anderson (1982), the background of a child affects his/her success in school. The word 'background' here may refer to two things. It may refer to natural or hereditary factors-the genetic characteristics within an individual which either inhibit or facilitate his/her ability to learn-factors which limit the potential of an individual. The second meaning refers to the social background of an individual-the people around him and his general environment.

The factors of social environment that may affect a child include; the house the child lives in, the occupational status of the parents, the educational background of the parents, the parents' attitude towards their children's schooling and the expectations they have towards their children.

A child from a higher socio-economic background has advantages over the child from lower socio-economic class. In a higher class, there may be television set, satellite dish, internet facilities, radio, telephones, pictures, reading and writing materials, all of which help to prepare a child for learning in school.

It is hypothesized that parents of upper socio-economic class have more positive attitudes towards their children' schooling and therefore have more expectations and standards for the children (Okon & Anderson 1982). Such children are given high motivation for success in the school. the parents' ability to provide, say, books and equipments for the school, combined with a positive attitude stimulates the children to learn. Furthermore, the upper class child eats a balanced diet and thus has good health. Again the values he is exposed to at home are similar to what he finds in the school, and therefore is able to adjust to school life. A feeling of belonging to a comfortable social school environment further helps him to show his best (DuBey, 1973).

A child from a lower class is handicapped in that there are few facilities and amenities to prepare him for school. He may suffer ill-heath, and even find it difficult to make satisfactory adjustment at school (Oseni, 2008).

Besides the disparities in home background, there are also the disparities when two children of different classes start schooling. A child from the upper class starts with the nursery, kindergarten or reception education. This is in contrast to the overwhelming number of children who start primary school without having gone through any form of infant schools. Often they cannot even write their names. Worst of all, they start with poorly qualified teachers in the primary schools (Okon & Anderson 1982).

The medium of expression-English Language-is something totally strange to the child with a disadvantaged background. Pictures and illustration are things that are abstract and far removed from his world, and even when they are available, he cannot readily appreciate and use them for his advancement. A few very intelligent ones from these poor primary schools manage to succeed in spite of the odds but they are then admitted into the relatively poor secondary schools, where the struggle against the odds begins again.

Upper class children who have had all the advantages have better chances of being admitted into good post-primary institutions. Among these schools are the Federal Government-controlled Colleges. Admission into these colleges is based on the performance in the National Common Entrance Examination. Good performance in this examination can be expected from among the upper class children who have had more advantaged homes, social environment and primary school education. Thus these children who attend the best colleges have more chance of attending post-secondary institutions, including universities.

It follows logically that when one has a poor educational background; one has limited chances of adjusting well in class and may most likely end up in the lower socio-economic class (Oseni, 2008). She stated further that educational opportunities are not fully dependent on the basis of intelligence. It is useful to remember that, those children, who attended poor primary and secondary schools do not do so necessarily because they are intellectually inferior. It is rather that they were not given the same social and educational advantages because of the social position of their families.

Socio-economic status is associated with a very complex number of variables Okon & Anderson (1982). Environment is not a simple or one-dimensional thing, and SES is associated with other family characteristics, such as family size. Increasingly in Nigeria, among the most highly educated, families are becoming smaller. Research in other countries shows, for example, that children from lower SES homes, where the family is large, start school with a verbal disadvantage. This is assumed to be because such children have less frequent interaction with adults since mothers and older siblings are working (Okon & Anderson 1982). This finding is related to SES as well since different forms of communication opportunities are available to children of different status. Okon & Anderson (1982) has shown family size to be negatively associated with achievement in Nigeria school children.

Other aspects of family structure besides size are associated with adjustment in school. In the United States of America, academic achievement is positively related to a relatively egalitarian or democratic family structure (Okon & Anderson 1982). It was also found out that children of authoritarian parents associated with particular religious and ethnic background were related to a negative achievement orientation (Boocock, 1972). Parental dominance when it is extreme tends to discourage children in school.

The father's occupation or SES tends to be strongly associated with the style of interaction between members of the family. Middle and upper-class families tend to give more freedom to their children participating in decision-making as part of independence training; they expect their children to take greater initiative in matters affecting them; there is greater freedom to experiment by trying to work things out. At the same time, parents of middle-class children are more available for guidance and consultation. This kind of learning technique on the part of the parents approximates the learning conditions in school and, just as importantly; it is this combination of initiative, independence, experimentation and risk-taking which characterizes the managerial and professional class which their parents belong. These are behavioural requisites for persons who wish to occupy the most prestigious and rewarding jobs in the society (Okon & Anderson 1982).

Children from the lower class are raised in conditions of great restrictiveness. Control is more directly exercised. Both parents probably work and everyone must contribute to keep the family functioning. Resources are scarce; nothing must be wasted. There can be little room for innovation or risk-taking, following set patterns is safer. Also in large lower-class families, there is less time available for adults who put in long, hard hours of manual labour to be guides to their children or to allow them to experiment. A tight command seems to be the best way to manage such household. The father is used to taking orders from his superior; this is the model he uses at home to run his family, and this is the relationship that will characterize his son's activities if he follows his father's footsteps. This authoritarian style may be counterproductive for adolescent's adjustment in school. Adolescents are expected to be responsible, independent and to take initiative. He is expected to take some risks in order to learn. He sometimes needs to question authorities and challenge some written statements.

Thus, the kinds of relationships and communication patterns that middle-class children in developed societies have with their parents help them to participate in the expected direction in school, while parents from the lower classes do not provide the same opportunities for their children. Reasons for these are differences in experience, knowledge, economic security and the requirements of their work situations (Kohn, 1968). Recent research in Nigeria does seem to support these conceptualizations. Bolarin (1977) illustrates how patterns of child behaviour established in the home have a direct carry-over to the school. Holding ethnic groups constant, children from similar social background tend to have learning problems in common (Bolarin, 1977; Mu'azu & Misau, 1977).

National child development study has highlighted the handicap effects of large families on the child. This handicap starts from birth and affects not only the physical, but also the psychological and educational development of adolescents. Adolescents in small sized families have an averagely high self concept while those in large sized families have low self concept (Okoli, 1993). He went further that stress and hardship are magnified in families with large number of children. Cramped condition which denies privacy, space for play and other activities readily leads to irritability, restlessness and temper tantrum.

No other agent of socialization is as important to the total make-up of the child as his family: his primary socialization begins here Okon & Anderson (1982). The important identifications with ethnic group, culture religion, social class and even how he views himself as a male or female have their origins in the family. When he answers the question 'who am I?', the child will be doing so largely as a member of his particular family. It is the nexus of the biological association perhaps which results from the interaction of love and need or dependence and the power relationships between members of the family.

The family is the first training school in behaviour and it is the channel through which the child becomes familiar with culture and becomes competent to live in. Once a home is unstable, it would be difficult for the child to acquire desirable qualities. The dominant role of the family culture as in the shaping of character and personality cannot be over-emphasized. The beliefs, the values, the thinking and perceptions of every adolescent are embedded in the past experiences encountered while growing up and are stored in the mental repertoire as espoused theories to fall back on. This explains why every nation pays attention to the development of her youth, which according to Nwadinigwe, (2000); Omoegun (2000) & Umaru (1998) is assurance for the corporate existence of the society.

Family is defined by Walker & Satterwhite, (2002) as a group of people with a past history, a present reality and a future expectation of interconnected transactional relationships. Families develop certain operating principles or rules that allow for constancy and predictability. These rules have frequently been passed along generation to generation from the spouses own primary families. They can be conditioned by growth experiences by family members but they operate largely outside conscious awareness. These experiences that are out of conscious awareness are the "espoused theories" of the individuals or the myths of the family (Longe, 2008). The myths predicts the outcome as well as prescribes behaviour, which means there are pre-conditioned behaviour expected from individuals in the family.

At adolescence, individuals would have achieved a fairly responsible "mores" towards personal and social obligations. Meanwhile, adolescent's verbal concepts of moral values are not always reflected in the behaviour. They are engaged in curiousity to understand the relationship between adult admonition concerning conduct and adult behaviour as observed. This type of understanding held by

adolescents influences the emotions and behaviours (Oman et.al., 2002; Lavallee & Campbell, 1995).

Umaru (1998) in his findings alluded that Nigeria, like any other countries of the world has great concern for family structure and proper child adjustment process. The psycho-social process which includes emotional, personal and social development of the individual is of obvious concern in the upbringing of the adolescent. They suggested that those processes in every individual are being influenced by the efforts of the family culture, community and the larger society. Their finding have also shown that the total psyche development of an individual depends so much on the foundation laid by the parents in the type of upbringing of their children. In the same vein, Reid et.al. (2002) & Larson (2000) in their findings stated that the family impacts most of the societal values, beliefs, customs and codes of behaviour in the child. They further said respectively that family plays very important role in molding the individual personality and behaviour especially during childhood and which continues till adolescence.

It has been demonstrated through many studies that there is a strong relationship between family factors and mental development of the family members. This relationship is one of the major influences on individual's personality. Freud, in his psycho-sexual theory of development in Longe, (2008) stated that a person's personality is determined by the experiences of the first five years of life, especially the quality of parent-child interactions during that period. Subsequent development is more or less an elaboration on the foundation already laid by early childhood experiences. The psychosocial theory of development by Erikson also emphasizes the important role of the family in determining a healthy personality.

Efforts have been elucidated on some specific ways in which different family experiences affect a child's development, behaviour and overall performance. Longe, (2008) summed up the results of a number of observations on this issue mostly on performance as follows: Children from deprived backgrounds;

- Score well below middle class children on standard individual and group measure of intelligence,
- They come to school without the skills necessary for coping with school curricula,
- Their language development, both written and spoken is relatively poor,
- Auditory and visual discrimination skills are not well developed,
- In scholarship achievement, they are retarded on average of two years by first year and almost three years by third year in school.
- They are more likely to drop out of school before completing secondary education,
- Even when they have adequate ability, they are less likely to go to school due to low success aspiration.

The likely explanation of these differences is that different families create environment that influence children's intellectual, values and success motivation in different ways. For example, in a situation where a parent ignores the child's questions most of the time and another parent create relationship by reading to the child everyday. The first has created an environment that mitigates against

learning and excellence, while the second one promotes further learning unto excellence.

Why the family setting exerts a powerful influence on the child's values and behaviours is said to be due to several reasons. First, the intensity and scope of a child's relationships and interactions in the family generally surpass those experienced in any other setting. Secondly, the child's family experiences largely precede and to some extent determine the relationship which the individual has with people, groups and institutions outside the family. Family contextual factors determined by the neighbourhood inhabited, the type of aspiration and orientation possessed and the nature of formal education received dictate the child's realm of socialization experiences. It follows therefore that in order to understand an adolescent's perception of values and orientation towards success one must endeavour to identify factors in the familial context which act to shape adolescents' beliefs, thinking and experiences (Reid et. al., 2002).

While few researchers deny the importance of family setting as a determinant of a person's success/achievement orientation, considerable debates exist over which family variables are most important in this respect. The disagreement among researchers over the nature of family impact on achievement generally centers on the kind of parental behaviours and parent-child relationships believed to affect level of success (Ryan & Deci, 2000).

Omoegun (2001) opines that parents are largely responsible for the lapses in the child's behaviour. Many fail to serve as role models in giving needed attention to the child's development through inculcation of right sense of discipline and orientation via the employment of logical rational thoughts. This refers to the success of future social adjustment of youth both in value clarification and success orientation cannot be dissociated from the family. If the adolescent is to

achieve any consistency in social behaviour, he must first arrive at standards of conduct known as ideals or values. The adolescents must decide the kind of person to be and ascertain for himself/herself what things are worthwhile. Secondly, when the individual becomes independent of home, will the parents approve the standards that subsist? Lastly, they should be able to close up the mental gap between ideal self and the real self.

Nwadinigwe (2000) averred that the way in which a family is organized and the way in which it socializes its members clearly affect the motivational patterns of the children, with regard to their future achievement. It also provides them with the skills and fundamental knowledge that substantially determine their eventual success attainment. In his assertion, when the parents explicitly and consistently lay down for their children the kind of behaviour they wished them to adopt, these children will not only be void of distortions in thought, but also show good level of self-efficacy and self-concept in all their endeavours. He stated in his findings that confidence and independence in adolescents have been shown to be related to the democratic parenting style. Adolescents who grew up in a home with warm and supportive parents are most likely to be active, social, outgoing, creative, self-assertive, warm, loving, consistent and curious with positive life orientations. Parenting style range from over indulgence (permissive) to cooperative (authoritative/democratic) through controlling and dictatorial (autocratic) to indifference and detached (neglecting) or laisser-faire (Gottman & Declaire, 1997; Adams et.al. 1994).

The four types of parental behaviour result in specific types of discipline. A warm but controlling parent who restricts the behaviour of the child will be either over-protective or indulgent in parenting and this may inhibit creativeness in the child. A cold or unemotional parent who controls the child through restrictive parenting will be dictatorial and antagonistic. While a parent that is undemanding,

permissive but highly nurturing will be democratic and cooperative. However, a parent that is cold or hostile and also permissive will be one of indifference and detachment from the child (Longe, 2008).

The autocratic style gives all the power and authority to the parents while the adolescent is not expected to express his/her opinion on any subject nor given any opportunity to exert leadership or initiative in decision making. A style Fafunwa (1967) as reported in Longe, (2008) referred to as being practiced by an average African parent who believed that the child "is to be seen and not heard". An approach, which he asserted, stifles the child's curiousity and at the same time impedes the development of the child's reasoning and motivation.

It is stressed further that adverse family and social environment can retard physical, emotional and intellectual growth and adversely affect the moral values. Such situation can engender delinquency, underachieving, engaging in substance abuse and indiscipline. Home & Orpines (2003); Oman et.al. (2002); Shaffi & Shaffi (2001); Idowu (1999); Poise (1996) & Schwatz & Reisberg (1995) are of the opinion that a lot of backwardness in school work or poor success orientation of children have been traced to poor emotional environment most of the time is responsible for the onset of abnormal patterns of behaviour which later in life could develop into conduct disorder. They highlighted that the home is the best insurance against juvenile delinquency or a major factor in the causation of delinquency.

It must be noted, too, that the family has the potential of continuing to exercise a strong influence over the life of an adolescent even when he is an actor in other important fields of socialization, such as the school or his place of work Okon & Anderson (1982). In Nigeria, the family remains the most significant group to which one is attached throughout the life of the vast majority of

Nigerians, including those who have worked or studied abroad for long periods of time.

However, families differ vastly in terms of their significance in the social order Okon & Anderson (1982). Some families have more prestige, money and power than other families. Some have wider experience and knowledge of how to operate within the context of their social environments. Some have more knowledge of the workings of education, industry, urbanity and politics of the developed or more modern sectors which control the operation of the society. Some families are therefore in a better position to help members of the family, whether this is in the experience of schooling or any other important social institution.

Osarenren (1994) sees adolescents as a unique group of individuals whose experiences, however they acquire them, have remarkable influence on their thoughts, attitudes, behaviour, feelings of self and perception. Adolescents, in her view, face problems of their lives at this stage. Some of these are emancipation from parental control and formulating a satisfactory philosophy of life.

The personalities of the oldest, middle and youngest child in the family are likely to be different because of the distinctive experiences that each child has as a member of a social group (Odunukwe, 2008). According to her, the first child feels dethroned with the arrival of the second child. He may start hating people, protecting himself against sudden reversal and may also develop feelings of insecurity. She concludes that while the youngest child is spoilt because of over pampering, neurotics, criminals, drunkards and introverts are often first born children.

There has been a long-standing fascination with exploring associations between variables, such as the numbers of children in the family and a child's ordinal position in the family vis-à-vis the children's academic achievement. Birth order refers to the order in which siblings may be ranked numerically according to their order of appearance, four positions are typically recognized. First, middle, youngest and only child.

Parish (2000) also explored the relationship between birth order and academic achievement and found out that there is a significant correlation between birth order and academic performance. Sewell & Farty (2003) quoting Szymanska & Palmer (2000) proposed a provocative theory of intellectual development that viewed a family unit as being the key ingredient in the formation of intelligence. In the data, they categorized birth order in the following ways:

A. First-born children tend to have higher IQs than their young siblings.
B. The more children in the family, the lower the IQ of all the children
C. Twins have lower IQ than single born
D. Children from one-parent homes have lower IQs than children from homes where both parents are present. (The younger the child at the time of parental loss, the more severe the resulting IQ deficit).
E. The only child has a lower IQ than those of the first born in a two or three child family.

In his interpretation of these facts, Sewell & Farty (2003) believed that the more children there are, the lower their academic achievement. In addition, they assert that the more spacing between children, the less the damage to the family's intellectual environment. They claim that only child has less opportunity to be a "teacher", to show a younger brother or sister how to hold a pencil, grip a baseball bat or tie shoe laces. In conclusion, Sewell & Farty (2003) believe that

the family size has a lot to do with the child's emotional state and academic performance.

Since parents are such significant figure in an individual's life, the parent-child relationship is of great importance when considering the effects significant others have on self-esteem. Several studies have been done on the parent-child relationship and how it affects the psychological well-being of a child. McHale, Crounter, McGuire & Updegraff (1995) conducted research on the differential treatment of siblings and its effects on children's well-being. They measured the differential treatment of siblings using a rating scale procedure adapted from the Siblings Inventory of Differential Experiences which asked parents to evaluate their "affection and discipline towards the first versus the second born child". It was found that "differential treatment almost always took the form of favouritism toward the younger siblings" (McHale et. al., 1995). Their finding indicated that "there may be some positive concomitants, particularly for younger children's well-being and ratings of their parent-child relationships, of being the favoured child".

Not only is it important for a child to feel that he is important in the eyes of his parents, it is also important that the child does not feel that his parents favour other siblings over him. Zervas and Sherman (1994) found that "total self-esteem and two facets of self-esteem were related to parental favouritism". Zervas and Sherman (1994) administered Coopersmith Self-Esteem Inventory and a favouritism questionnaire to 91 college students. They found that "both the no-favouritism and the favoured groups had significantly higher self-esteem than the non-favoured group" (Zervas & Sherman, 1994). When asked for a reason why a certain child was favoured by their parents, 52% of the participants selected birth order as one of the factors (26% said oldest and 26% said youngest).

There is no disputing the fact that the family is the most useful organ that promotes emotional care and physical security for all its members (Makinde, 2004). The size of the family and the ordinal position of the child seem to have an effect on the parental attention received by the child. Falbo & Polit (1986) reviewed the research on only children, finding that their development is similar to that of first born and children from small families. They reviewed 115 studies concerning the development of only children. These studies included research on sibling relationship, birth order and family size. They studied only children as compared to non-only children, only children compared to groups defined by family size. Falbo & Polit (1986) found that first-born and children from small families….. have warmer relationships with their parents than later-born and children from larger families. First-born children and children from small families tend to receive more individual attention from their parents than later-borns and those from large families.

Mellor's (1990) research concluded that the developmental paths of children are similar to the paths of first-born and children from two-children families but dissimilar to paths of children from large families. He administered the Ericson Psychological Stage Inventory, as well as questionnaires used to determine birth order and family size to 434 students of 11-19 years of age (Mellor, 1990). He found that "on the basis of developmental outcomes related to resolution of developmental crises in childhood, adolescence and early adulthood, the crucial outcome differences appear precisely between the only child, whether defined as only-born or first-born, and the later-born child on the birth-order variable and precisely between children from two-children families and three-children families on the family size variable" (Mellor, 1990). This supports the contention that family size as well as birth order may be of importance when considering child development. It has also been suggested that "in large families, the youngest

children receive less parental attention than the older children because parents transfer responsibility for catering to the older siblings (Mellor, 1990).

Self-esteem has also been studied directly as a function of birth order. Gates et. al. (1988) administered the Piers-Harris Children Concept Scale, the State-Trait Anxiety Inventory to 404 children aged 7-12. They found that "first-born children showed significantly higher levels of self-esteem than second-born and youngest children". They also found that "first-born (in some comparisons) showed less depression, less anxiety and higher self-esteem than later-born and only children".

Greenberg et. al. (1993) administered the California F Scale, the Allport Study of Values and the Gordon Personal Profile to 264 students ranging from 18-24 years. They found that the first-born children had the lowest self-esteem, which is consistent with Adler's theory. However, the critical ratios between the oldest and middle children are not significant in most cases (Greenberg et. al. (1993).

According to Lessing & Oberlander (1997) in Osarenren et. al. (2007) first-born children reveal a healthier level of adjustment than later-born on a Self-Report Personality Inventory. They administered the California Test of personality to 272 fifth graders, 242 eight graders and 341 eleventh graders. The study was designed as a systematic, controlled exploration of the relationship between the ordinal position and personality adjustment. They found that although "some significant sex differences emerged… no significant interactions between sex and ordinal position were obtained". They also found that "in comparison with the later-born children, the first-born children presented a healthier picture of themselves". They also found that the importance of ordinal position was found to decline over grades, with an independent birth-order effect remaining after

two covariance adjustments in grade five, after one in grade eight, but none in grade eleven.

Rosenberg (1965) conducted extensive self-esteem research using the Rosenberg Self-Esteem Scale. He found that only-children had higher self-esteem than children with siblings, although he found that male only-children were more likely than female only-children to have high self-esteem. He found that "the only girl has no general self-esteem advantage over girls with siblings". Furthermore, regarding the gender distribution of siblings, it was found that boys in a family of mostly older sisters usually have high self-esteem. While for girls, the sex distribution of siblings had very little importance. He concluded that if a family consists mostly of boys, then, as far as self-esteem is concerned, it makes no difference whether the boy is among the earlier or the later-born. Rosenberg (1965) did not look at self-esteem taking into account only gender differences, but in most of his analysis, boys tended to have a higher self-esteem than girls.

Nystul (1995) also conducted research on the effects of birth order and sex on self-esteem. He administered the Tennessee Self-concept Scale to 168 college students. He found out that birth order did not have a significant effect on self-esteem. He did find, however, that girls have higher self-concept than males and have less basic personality defects and weaknesses with less of a tendency to void reality than males.

Parents' emotional influence and behaviour can be models to the children so also can be detrimental. Mallum & Mallum (1991) holds the view that middle class parents as compared with parents of low socio-economic status are more likely to use power assertive techniques such as deprivations of needs than physical punishment. Nystul (1995) points out that recent studies have shown that middle-class mothers tend to verbalize their children when they are young than

mothers from low socio-economic status. This is understandable since parents of low socio-economic status perhaps have worries about money, poor housing and the like and as a result are more preemptive in dealing with children.

Consequently upon home and parental relationship, Nystul (1995) opined that some parents pass their maladjustments to their children unknowingly. He admits that the parents who will not tolerate smoking, use of cosmetics or social dancing are almost sure to have socially maladjusted children.

Moreover, most adolescents are found to be irrational in their behaviour as is manifested in aggression, rudeness and the like. The reason can be deduced from the fact that such adolescents inherit such behaviours from their parents. The other cause of this is frustration. As Demo (1997) pinpoints, frustration is a negative emotional state that occurs when one is prevented from reaching a goal. Supporting this view, Nystul (1995) added that frustration arises as a result of environmental needs which a person desires. Adolescents who constantly repeat a class or lack certain guide as to their future or school adjustment may often react negatively to school rules and regulations. In the words of Nystul (1995) the diffused effect of frustration may often be destructive. A frustrated adolescent is not likely to approach other problems coolly, calmly or effectively.

The Concept of Emotion and Social Adjustment

According to Okoli (2002), it is useful to study the association between adolescent's emotional and psychological adjustment in the context of the broader relationships with parents. He is of the opinion that adolescent emotional autonomy may differ depending on the quality of the parent-adolescent relationship.

More specifically, Makinde (1997) demonstrated that emotionally autonomous adolescents who also perceive their parents as being unsupportive show a negative pattern of adjustment and competitiveness. However, emotionally autonomous adolescents, who perceived high level of parental support, show a positive pattern of adjustment and competence, maintaining relationships and confidence. Okoli (2002) is also of the opinion that individual adolescents in his study were also less anxious; less depressed and had higher self-esteem than did adolescents who had detached relationship with their parents.

A broad picture of the quality of parenting as perceived by the adolescent is related to the emotional and social behaviour of the adolescent Makinde (1997). Okoli (2002) asserted that social adjustment is the success with which people adjust to other people in general and to the group with which they are identified in particular. The home and family are the most effective agencies of social control and the child is at the mercy of the parents for emotional and intellectual development. Therefore for a child to function effectively, he/she must be emotionally intact. According to Bolarin (2003) home worries include lack of understanding between children and their parents, illness of parents, difficulties in marriage, friend's health, problem of money and personality weakness. Emotional problems have profound effects on the life of the adolescent as they have damaging effects on such adolescent's life. Constant emotional tension may cause lack of sleep, restlessness, headache, depression, chronic fatigue and lack of appetite.

Bolarin (2003) conducted a research on the effects of continuous emotional tension on people. She reported that emotional tension affects the efficiency of the individual, inconsistency in behaviour also affects memory and that forgetting increases in such emotional state. Such individual cannot reason, think and

concentrate with the problem. Constant emotional pressure disturbs learning ability; fear, anger and the like bring about change in attitude towards life.

Yoloye (1990) is of the opinion that a lot of backwardness in school subjects has been traced to poor emotional environment; insecurity and anxiety are factors which certainly affect the adolescent's school work; they drain his energy, reduce concentration and prevent him from attaining his intellectual potential. Yoloye (1990) also pointed out that broken homes place children at a disadvantage socially, emotionally and economically. All these may lead them to drop out of school with less social support. We may therefore infer that a well-socialized adolescent is a well-adjusted adolescent.

Adolescents' Home Relationship and Social Adjustment

A popular cliché states that "charity begins at home". A child is first of all the product of his/her immediate environment which is the home (Omoegun, 1995). The effect of the home factor on the overall development of the child cannot be over emphasized. Right from conception, when life begins, the embryo develops in the mother's womb till birth. A child is affected positively or negatively by the hereditary qualities which are passed to the child from the parents at conception as well as the environmental factors to which he is exposed before and after delivery (Oseni, 2008). While such physical characteristics as the height, facial appearance, nose skin colour etc. are conspicuous hereditary traits in children (Omoegun, 1995). She stated further that other factors like intelligence and temperamental qualities are regarded as being influenced by both heredity and environmental factors.

A child who is born into warm environment as well as peaceful and loving home is more likely to grow up happily, showing love to others. An unwanted child, who starts to experience frustration and rejection at an early age, is more likely

to grow up as an unhappy child (Omoegun, 1995). By the time such child matures into adolescence, the character is made up from his childhood experiences. However, it is mainly at the adolescent stage that parents begin to notice the deviant behaviours in their child when he fails to meet up with their expectations, without thinking of the foundation they have provided for the child's development (Omoegun, 1995).

Osarenren (1996) in her analysis of adolescent adjustment classified the problems into four categories. According to her, adolescents face four of the most serious, difficult and far reaching problems of life at this stage. These are:

- Adjustment to the opposite sex
- Finding his/her place in the world of work
- Emancipation from parental control and
- Formulating a satisfying philosophy of life.

Each of these calls for a series of decisions and hundreds of adjustment techniques. This partly explains the temporary insecurity in adolescents.

Osarenren (1996) further asserted that the adolescent is socially awkward, sometimes loud and noisy; he tends to show off, swings quickly from one mood to another, occasionally reverts to childish behaviour and has periods of rebellion to authority. All these and other similar patterns of behaviour may be exhibited to friends, family and school authority when the adolescent relates with others.

She stated that constant criticism of the adolescent, nagging at him or inflicting punishments on him are more likely to make him worse. Hence, there is the need for patience, support and understanding based on the fact that if the

adolescent feels the encouragement of an adult, he will come through this phase of growth fairly.

Parental Separation and Adolescents' Social Adjustment

Most adolescents from separated homes do not adjust very well in schools (Oseni, 2008). Most of such adolescents, according to her, show some sense of insecurity. They lack internal control, they are involved in breaking school rules and regulations, they appear untidy, they lack textbooks and notebooks for their studies and also show signs of psychological problems. According to Omoegun (1993), a child's anxiety on aggression by the parents over the anticipated loss of the parents' love leads him/her to hostility, incorporation of parents' prohibitions and generally model behaviour after that of the parents. Adolescents who misbehave have unsatisfied emotional needs. Such adolescents, according to Omoegun (1993) may express feelings of inadequacy or frustration in a variety of negative ways. They may break rules, take to vandalizing school properties, bully junior students or mates disturb classes or divert attention to scenes outside the classroom during lessons or look dejected, sad or life may be meaningless to them.

A child who, due to parental separation, is made to suffer and is deprived of an inspector to oversee him in order to direct him to proper path to make something positive in life may result to delinquent act. Fagbamiye & Durosaro (2004) stated that adolescent without a propeller to incite him to action and that often goes without a maintenance officer to sustain him in dependent years of his life may result to maladaptive behaviour.

Akinade & Sulaimon (2000) in their work have shown that children from separated families flourish according to the quality of care they are given following the separation. In such a situation, they may be deprived of adequate

care, for example in an institute, while in another situation, a foster home, the care may be adequate. The heart of the matter is not the mere fact of a child being separated from his parents but whether or not the child is deprived of the right care. This also goes to explain that not all children from separated homes have sad experience; some may have pleasant experiences if they are given the care and affection by the parent substitute (Omoegun, 2001). The conditions applying before, during and after the separation are more important in determining whether or not there will be harmful effects than the fact of separation itself.

The most complete separation is the assumption of parental rights by another family or the use of hostels for maladjusted children or placement of a child in special boarding schools. Makinde (2001) stated that partial separation allows the child to live at home but they arrange his life in such a way that there is a minimum contact between the disturbed parents and the child. This can be organized within home with the utilization of a house-help to look after the children while both parents are out at work. It can also be done with the use of nannies or by putting the child in foster-schools' care, nursery schools for maladjusted children, day schools for maladjusted children where they can be supplied with the positive emotional care. This is done during those hours they are in schools and after school hours when the child would otherwise be in a hostile and negative emotional climate. Alutu (2005) stated that helping parents to carry out his responsibilities for his child without usurping any of that responsibility often becomes a delicate problem which requires the teacher to exercise both sensitivity and forthrightness. To take over the parental role beyond the real need of the parents could lead to decreasing the strength in the family rather than strengthening them.

Policies and procedures that lead to helping parents carry out rather than relinquish responsibilities and roles as parents are the best form of education. The family is the main influence in the psychogenesis and cacogenic development of the individual (Nwabani, 2000). She stated further that the family is the creator of most psychogenesis personality and also one of the most important sources of social influences. Attitude towards the personal properties of others, towards the law enforcement agencies, towards other coercive institutions such as the schools, church/mosque and the society generally receive their development in the family.

Separation in the family raises some problems for the child. According to Clayton (1999) there is the difficulty for the child to understand that the two people they love do not love each other any more. Most children, even adolescents, are unable to fully comprehend the complexities of strains that lead to a rupture in the marital bond again there will still be problems of explaining to their friends what has happened. Looking at all these, we can say that separation is not healthy for children emotionally and physically. Children from separated families are forced into life of tension and difficulties. Rice (1999) opined that children from disrupted marriages are more likely than others to be delinquents, psychologically disturbed, unhappy and educationally low achievers. Campbell (1993) stated that delinquency among youths today is associated with the products of broken or separated marriages. According to him, most of the inmates of approved schools are products of broken homes. The view tallied with the findings of Demo & Small (1997) when they stated that 41.4% of delinquents were from broken home or from separated marriages. The assertion was supported by Gallancheer & Harris (1998). They discovered that 60.4% of delinquents are from broken homes and 34.2% from non-broken homes. Gardner & Tessman (1998) criticized these findings in their study. They reported

that delinquent group from broken or separated marriage was 42% which was very close to 36% for intact homes. They concluded that broken home night not necessarily lead to delinquent acts.

Children are very emotional and there is nothing as traumatic for children as the de-stabilization of the family (Oseni, 2008). A child who experience parental separation may undergo a great deal of personal pain, confusion and anger with the whole world. Responsible authorities still support the adage that 'a bad natural home is better than any other home'. A child who has been used to depending on both parents may now find himself/herself with only one or non at all which will make the child to assume the position of authority because the family structure has been weakened and the collective power of both parents has been fragmented and neutralized. According to Yoloye (1990) a lot of backwardness in school subjects has been traced to the poor emotional environment in homes. He stated further that emotional development of the child very often influence the performance in the school. He found out that high anxiety in the child is detrimental to his functioning in intellectual tasks. This is true because a child that is emotionally insecure or feels unwanted may devote a lot of his energy to getting through eccentric behaviour instead of intellectual pursuit, such a child will not have interest in school work.

Rutter (1998) agreed that emotional stress, insecurity and anxiety are factors which certainly affect children's school work, reduce concentration and prevent him from attaining the peak of his intellectual powers. Such children carry the problem at home to the school and in most cases such a child acts abnormally. Fraser (2000) stated that at every point of the intelligent quotient scale, the performance of the children from abnormal home is below that of children from intact homes.

Parish (2000) in an article titled 'What makes a good father?' discusses the fact that the father has a very important role to play in meeting the emotional needs of his children. For the newborn, it does not matter whether the father loves him/her or not provided someone is playing that role; but where the father does not realize the enormity of his responsibilities, things would naturally go wrong. Separation is not healthy for children both emotionally and physically. Ponzetti (1990) stated that early fathers' absence disrupts cognitive development more than latter absence. Also a child with an absent father performs poorly than a child from an intact home (Brown, 2004).

Popenoe (2000) stated that the home with two married parents provide the best environment for children to learn and grow well while Olayinka (1993) and Obe (1990) stated that the type of encouragement or motivation given to the child by parents facilitate or inhibit the academic performance and social adjustment of such child. Teagarden (1992) and Ruffer (2001) opined that when family relationship is seriously disturbed, children are likely to become neurotic, maladjusted and may find it difficult to react successfully and satisfactorily to the demands of his environment.

Olusakin (1996) stressed that quarrels at home hinder the educational attainment of a child. This is due to the fact that children learn by imitation and whenever the parents have misunderstanding resulting in fighting or quarreling, the child will be affected. Mutual love and understanding in a home is very important. Problems at home do not only affect the spouses but also the children as well. Studies have shown that children from a home where there is love and affection stand better chances of being socially stable and performing well academically as against children from homes that are devoid of love and affection.

Durojaiye (1995) in his research found out that adverse emotional factors in the home negatively affect the educational attainment or achievement of a child. He believes that if a child is sad and miserable, in his personal life, it will reflect in his academic performance. Adeleye (2000) pointed out that parents play a big and important role in the life of their children and that adolescents' performance is either facilitated by the environment he grew up in, the opportunities available to him or the type of encouragement or motivation given him. Cohen & Becker (1992) reported that an adolescent's background proved to be a more significant predicator of his achievement than the inputs from the school system.

Depression vis-à-vis The Nigerian Culture

According to Lambo (1960), the psychology of Nigerians in relation to that of other Africans shows certain features such as mystic contemplation, comforting dependency, effortless satisfaction, freedom of unpremeditated spontaneity and a more fundamental psychology of interpersonal relation in its pure form. Traditionally the Nigerian family system upholds polygamy which is patriarchal and authoritarian in nature. This stimulates the empathic response and directs his focus of attention. Right from infancy, the dynamic growth and normal interaction with the social environment are particularly stimulated and given the appropriate chance.

In Nigeria, the newborn's every need is anticipated and fulfilled by a confident mother and extended family members. He is born into a warm, affectionate and enthusiastic culture where he is seen as a force to bring the parents into a kind of interaction that will itself develop emotionally-charged and effective living. In the early months of the child's development, he is inseparable from the mother and enjoys the emotional security of the extended family. Breastfeeding is for a lengthy period of time and the child enjoys psychological warmth. Traditionally,

childhood in Africa is a happy period with memories of love and consideration. At times however, anxiety, fear of the unknown and superstitious beliefs might affect the adult behaviour and interpersonal relations.

In spite of its seemingly simplicity in function, culture is highly differentiated into sub-parts, requiring more guided observation at all levels before one can make an overall statement but there are certain characteristics that cut across Nigerian cultural heritage such as the lack of apparent clear-cut well-defined ego boundary among Nigerians. There is also an amorphous ego structure, flexibility in behaviour and strong identification with the group. The super-ego is usually externalized and there is constant projection of wishes among Nigerians (Lambo, 1960).

Jegede (1977) reported that somatization of psychological disorders, especially depressive illness and anxiety syndrome, is common in Nigerian population. Though this phenomenon was said to be common mostly among the less educated and those of low socio-economic class in America, it is however common among Nigerians, irrespective of their level of education. The practical significance of the phenomenon of somatization is the fact that affected patients may be subjected to endless investigations for an organic illness that is non existent. A psychologically sophisticated clinician would be able to detect emotionally oriented illness and apply appropriate technique or make a referral. It is however important to be aware of the fact that physical illness may precipitate a reaction of depression in a patient to the extent that the two may co-exist. In such cases appropriate medical referral should be quickly made in addition to the psychotherapeutic interference.

For effective management of patients, there is need for awareness of the relationship between psychological and physical factors because according to

Jegede (1978), both psychological factors and physical symptoms often combine to produce the clinical picture presented by patients whether physical illness is primary or physical symptoms complicate a primarily psychological illness.

There is a group of disorders in which emotional factors play an important etiological role. These conditions were originally termed psychosomatic disorders but that term has now been largely discarded because of the implied notion of mind-body dualism. Some psycho-physiologic disorders are accompanied by structural change in the organs involved while others show no such changes (Jegede, 1977).

Even though depression is considered to be one of mankind's oldest known disorders, it is still a source of great confusion and debate to both professionals and the ordinary man on the street. According to Marsella (1976), cross-cultural studies of depression hold much promise for increasing people's knowledge of depression because they can offer opportunity to validate the notions about the conceptions, distribution, manifestation, measurement, personality correlates and socio-cultural causes of depressive experience and disorder. The following conclusions were reported by Marsella (1976) based on extensive review of the cross-cultural literature:

- Depressive experience and disorder vary considerably as a function of socio-cultural factors.
- The epidemiology of depression is not known because of limitations in research methods, but there is reason to believe that the frequency of depression is higher in western societies.
- The experience and manifestation of depression differ as a function of westernization and those cultures with evidence of subjective epistemological orientations tend to avoid the psychological interpretation

of their experience and thus do not manifest psychological and existential symptoms in depression.

- ❖ Depression assessment methods are highly ethnocentric and need to emphasize greater attention to somatic and interpersonal processes in the diagnosis of depression in non-western cultural settings.
- ❖ Personality correlates of depression vary across culture with respect to the presence or absence of guilt, self-concept discrepancy and body image dissatisfaction.
- ❖ Existing socio-cultural theories of depression are lacking in explanatory and predictive power and require more comprehensive views of the mechanisms by which socio-cultural factors influence the various aspects of depression.

Durojaiye (1995) agrees that a polygamous home, which is common in Nigerian homes, is often characterized by strains such as jealousy and rivalry among co-wives and among siblings. The child's need for security may be frustrated by the siblings' rivalry and stepmother[s] impression. The hospitality of the stepmothers is the commonest fear of delinquents. If such a family is devoid of love and trust, the individual child's mother will be expected to care for the child. There is also the neglect of the children by the father except those of his favourite wife or wives. It is also impossible, according to Durojaiye (1995) for a man who earns an average income to cope with demands of all the members of his family. This situation, he claims, has adverse effect on children because of the inability of parents to perform their parental roles adequately. Parental unconcerned attitude for the well-being of the child and the failure of parents to make the home pleasant for the child might result to undesirable behaviour or personality maladjustment.

Concluding, Durojaiye (1995) claimed that poor family relationships and inconsistent requirement from different adults can affect the emotional security of any child, whether in monogamous or polygamous families. Aggression is a means of satisfying the need for social recognition, delinquency as a means of belonging and the continuous search for affection may be the pattern of behaviour in children from these homes. However, not all polygamous homes breed children with undesirable behavioural disposition. In such exceptional homes, rejection, tension, rivalry, aggression and the likes are replaced by acceptance, love, trust, interest a sense of security warmth and support.

The Management of Depression

Many people are used to medical treatment and eventually, their first point of call, even when they are depressed, is the hospital to seek for medication. Oftentimes, antidepressants are prescribed for them. Some others combine some form of psychological interventions with the antidepressants.

There are wide range of psychological treatments which may differ in intensity and duration, depending on the individuals involved and the professional training of the therapist. The treatment may be individual or group therapy, family or marital therapy, behaviour therapy, social casework and so on. Generally, psychological treatment can be said to have two aims. The first is to hasten the client's recovery from the depressive episode by providing emotional support and assurance, opportunity for ventilation and by dealing with the consequences of the illness and preventing further impairment.

There is the need to focus on the maladaptive behavioural patterns that predisposed the client to difficulties and bring out a more basic restructuring to avoid further intensification of the problem.

Many people may see medication as a quick and simple way of reducing the symptoms of depression, thinking that the reduction of the symptoms will automatically improve most of the social impairments. This is however questionable because the depressive's impairment in the area of social interpersonal functioning may not be modified by medication.

Looking at it critically, it is evident that medication alone cannot solve the problem of depression which can be considered to be basically linked with behavioural and social problems. Thus, the relevance of this present study which employs two psychological methods in managing depression cannot be overemphasized.

Activity Schedule as a Counselling Strategy in the Management of Depression

Lewinsohn & Libet (1974) reported that it was a well established clinical and empirical fact that depressed individuals as a group engage in relatively few activities compared to the normal and that depressives engage in fewer activities that they themselves considered as being pleasant or rewarding. The guiding principle for behavioural treatment of depressives is to restore an adequate schedule of positive reinforcement for the individual by altering the level, the quality and the range of his activities and interactions.

In making use of activity schedule, the number of activities per day should be noted at the baseline level and also the length of time used in engaging in such activities. Contingencies have to be provided to produce an increase in pleasant activity level. Reinforcement could be said to have taken place when the occurrence of some observable event changes the potentiality of occurrence of a behaviour that has preceded that event with regularity and consistency. There is internal reinforcement when someone experiences an event that has value for

him or her. External reinforcement may be described as the occurrence of an event known to be reinforcing for a group to which someone belongs while the internal and external reinforcements are not necessarily related in a one-to-one manner, an occurrence that results in internal reinforcement for a particular person, may also be considered as an external reinforcement for that individual.

Positive reinforcement can also be described as a reward and a habit can be established and maintained by arranging for a reward or positive reinforcement to follow each or many of its performance. This has got therapeutic potentials if properly handled.

Kahn (1995) explained reinforcement operations basically involving an environmental event or stimulus consequence that is contingent upon a particular response and whose occurrence increases the probability that the response will occur again. He went on to conclude that in any experimental design or clinical application, the effectiveness of a particular stimulus must first be demonstrated for the given situation and for a given subject and that in the clinical situation in which conditioning may proceed over a long period of time, it is even necessary to re-evaluate the effectiveness of a reinforcing stimulus sometime after its general introduction. Thus the effectiveness of a stimulus varies with the reinforcement schedules.

Schedule of activities could be in form of reinforcement given not only continuously after each response but intermittently on various schedules in terms of time intervals that must elapse before reinforcement or in terms of the number of responses per reinforcer or ratio schedules. Time intervals or ratio schedules could be fixed or varied but behaviour established by intermittent schedule could be more stable and resistant to extinction. The activity schedule program has to begin with continuous reinforcement that would gradually be

reduced on a schedule as too rapid reduction and change in schedules may disrupt behaviour.

Olusakin (1996) agrees that positive reinforcement is very useful in treating behavioural deficits, that is, in dealing with responses that fail to occur in sufficient frequency or intensity, in appropriate form or under appropriate conditions. Thus, it is going to be employed in this work to increase the activity level of depressed adolescents.

Anticipation Training as a Counselling Strategy in the Management of Depression

To anticipate is to think or be fairly sure that something will happen. According to Encarta (2008), anticipation is expectant waiting: the feeling of looking forward usually excitedly or eagerly to something that is going to happen. Beck et. al. (1988) reported that more than seventy-eight percent of depressives reported a negative outlook as compared to twenty-two percent of non-depressives. This negative outlook may often constitute a source of frustration to their friends and family when they try to help. Depressives are more likely to think of a future in which their present deficient condition, whether financial, social or physical will continue or even get worse unlike the anxious client who tempers her negative anticipation with the realization that the unpleasant events may be avoided or will pass with time.

At the onset of depression, the depressive tends to expect a negative outcome in ambiguous situations. When others around feel justified in anticipating favourable results, a depressive's expectations lean towards the negative. As the depression deepens, the future looks worse as if there is nothing to look forward to. A severely depressed person is likely to think that he/she would never get over the troubles and that things cannot get better (Beck et. al. 1988).

Indecisiveness: Depressives have difficulty in making decisions and frequent changing of decisions can be irritating to other family members and friends as well as to the depressive. Cognitively**,** the depressive may anticipate making the wrong decision and as such, each time she considers one of the various possibilities, he/she tends to regard it as wrong and to think that he/she will regret making that choice and so moves to the next alternative. Another facet is primarily motivational and is related to avoidance tendencies, and increased dependency. Lack of motivation to go through the mental operations that are required to arrive at a conclusion and even the idea of making a decision might represent a burden to the depressive thus he/she might try to evade, any situation that he/she perceives as burdensome. The reality of making a decision may necessarily commit him/her to a course of action and since he/she does not want to act tends to avoid straight forward decision-making process. In a mild case, someone who ordinarily could make rapid decision may now find that solutions do not seem to come to him/her readily. Decisions which he/she could have made before without much thought may take longer period to mull over.

*Negative Feelings towards Self***:** According to Beck et. al. (1988), the frequency of self-dislike ranged from thirty-seven percent in the non-depressed group to eighty-six percent among the severely depressed. Depressives appear to distinguish feelings of dislike for themselves from negative attitudes about themselves. At the onset of depression, the depressive states that his feeling is accompanied by ideas such as: "I have let everybody down… if I had tried harder, I could have made the grade." At a relatively higher state, the feeling of self-dislike is stronger and may progress to a feeling of disgust with him/her which is accompanied by ideas such as: "I am a weakling… I don't do anything right… I am no good" and other related statements (Olusakin, 1990).

Kelly (1969) affirmed that a person's processes are psychologically channeled by the ways in which the person anticipates events. The word *anticipates* is an indication of the predictive and motivational features which points to the future. Anticipation according to Kelly is both push and pull of personal constructs. A person anticipates events by construing their replications. This is to say that events are predicted by placing an interpretation upon or structuring the recurring aspect of events. Individuals differ from one another in their construction of events since no two individuals participate in the same event in the same way at a specific point in time.

Training involving deliberate anticipation of positive consequences by a depressed individual would alleviate the gloomy attitude and lighten the sad mood of the depressed. The forward looking attribute involved in anticipation is important and if properly channeled could be quite useful in alleviating depressive moods (Olusakin 1990).

Empirical Studies

Several studies have been carried out on depression. One of the earliest studies to employ control groups was that of Bowman (1984) who presented case comparisons of depressives, schizophrenics, general paretic, and normal to determine personality differences. In comparing depressives with non-depressed, he drew a number of scattered conclusions which did not easily suggest any recognizable specific personality style.

Granick (1963) made a comparative analysis of the performances on the Wechsler Adult Intelligence Scale Information and Similarities Tests and on the Thorndike Gallup Vocabulary test of fifty psychotic depressives and fifty non-depressed matched for age, sex, race, education, religion and nativity. Granick

(1963) did not record any significant difference in performance between the two groups.

In his own study, Friedman (1964) administered thirty-three cognitive, perceptual and psychomotor tests to fifty-five depressives and sixty-five non-depressed matched for age, sex, education, vocabulary score and nativity. Eighty-two test scores were derived from the various test administered and the depressed ranked lower than the non-depressed in only four percent of the test scores and this can be due to chance. The author concluded that actual ability and performance severe depression is not consistent with the depressives' unrealistically low image of himself or herself. This view was upheld by Bebbington (1985).

In one of their studies Loeb, Beck, Diggory & Tuthill (1966) matched twenty depressed with twenty non-depressed male clients and gave them two card sorting tasks. They found out that although the depressed clients tended to underestimate their performance, their actual performance was as good as that of the non-depressed group.

Shapiro, Campbell, Harris & Dewberry (1958) also found out that depressed clients do not have significant impairment of psychomotor ability as they found that depressed clients following recovery did not show any significant change in their performance on a battery of psychomotor tests when compared to a control group.

Studies on Conceptual Performance and Perceptual Threshold of Depressives

In their investigation on the conceptual thinking in depressed patients, Payne & Hirst (1987) administered the Epstein Over-Inclusion Test to eleven depressed

and fourteen non-depressed matched for age, sex, and vocabulary level. Their findings indicated that depressives show significantly greater tendency towards over-inclusion than the non-depressed and that the depressed seem to be more extreme with respect to over-inclusion of thinking than the schizophrenics.

In the area of perception, Hemphill, Hall & Grookes (1952) attempted to measure the pain and fatigue tolerance of depressed patients as compared with other psychiatric clients. It was found that depressed patients showed significantly higher threshold for both pain and fatigue than the other groups, which could account for the differences in thresholds for perception of fatigue and pain. It was also found out that the depressed were more persevering in a fatiguing task than the non-depressed patients. Wadsworth, Wells & Scott (1962) found no difference in fatigability or work performances between a group of depressed and a group of schizophrenics.

Studies on Distortion of Time Judgment and Spatial Judgment in Depressives

Mezey & Cohen (1961) in their investigation of the subjective experience of time and the judgment of time of twenty-one depressives included in their study the introspective statements about time experience as well as objective tests involving projection and verbal estimation of time intervals ranging from one second to thirty minutes. They fond out that about three quarter of the depressed felt that time was passing slowly than normal and that this feeling tended to disappear on discovery. The objective tests indicated that the verbal estimation of time under experimental conditions was accurate during the depressed phase as during the recovery.

According to Fisher (1964) a number of studies have suggested that depressives experience some changes in spatial perception and the assignment of sad terms used in describing a series of facts. Estimation of the upward versus downward directionality of personality was made by means of auto kinetic phenomenon and by judgments requiring the adjustment of a luminous rod to the horizontal. The findings supported the proposition that participants with sad affect showed a downward bias in perception while participants with neutral affect showed an upward bias in perception.

Lack of interest in positive activities would have contributed to the seemingly low passage of time, so if activities could be increased, then the problem of distortion of time judgment would likely be solved.

Some Factor-Analytical Studies on Depression

A seventeen-item rating scale was administered to forty-nine depressives by Hamilton (1960). He computed the Product Moment Correlation for the seventeen variables and the correlation matrix was factored and then transformed to exact four factors. The first factor was defined by suicidal thoughts, loss of libido, retardation, depressed mood and loss of insight. The second factor consisted of gastro-intestinal complaints, sleep difficulty, loss of interest, body preoccupation and loss of weight. The third factor consisted of anxiety items while the fourth factor was equivocal in nature.

In an intensive study to determine the prominent trait-dimensions, Grinker, Miller, Sabshin, Nunn & Nunnall (1961) carried out a pilot study of twenty-one patients diagnosed as depressives by experienced psychiatrists and studied them intensively to define the major trait

factors. The raw data got from the study were translated into a list of "feelings and concerns" and a list of "current behaviours". The feelings and concerns list dealt with the verbalized experiences of the depressives such as envy of others, sense of failure and fear of death or dying; while the current behaviour list dealt with the visible actions of the depressives with traits that require only a low level of inference on the part of the later. The reliability of the feelings and concern list was found to be high while that of the current behaviour list was too low.

After the pilot study, the large scale study was conducted by Grinker, et.al. (1961) using ninety-six depressives while ten non-depressed patients were used as control group. Analysis of the data from the study showed five factors in the feeling and concerned list and these factors made sense psychologically and were described as:

- Depression;
- Projective defense;
- Restitution;
- Free anxiety and
- Attempt to manipulate the environment.

The ten factors revealed through the analysis of the current behaviour, according to Grinker et.al. (1961) were characterized as follows:

- Isolation, withdrawal and apathy;
- Retardation of thought processes and speech;
- General retardation in behaviour and gait;

- Angry provocative behaviour;
- Somatic complaints;
- Organic syndrome;
- Agitation, tremulousness and restlessness;
- Rigidity;
- Somatic symptoms such as dry skin/hair and
- Ingratiating behaviour.

Some traits which were expected to be manifested in depression did not appear in any of these factors. Traits like loss of interest in oral satisfaction, suicidal ideas, fatigue, wishes to cry, loss of esteem by others, relief after hospitalization ambivalence towards important personal issues.

In the pilot study, Grinker et.al. (1961) showed that an investigation of precipitating factors suggested that there was rarely a single clear-cut precipitating event or experience that is, a series of events led up to depression. They went further to say that the factors derived from the feelings and concern list did not correlate with the factors for current behaviour and that the subjective symptom-anxiety-for example did not correlate with the behavioural factor-agitation. A lack of correspondence between the self-report of the patients and the clinicians' inferences based on their overt behaviour, was suggested by this finding.

Factors similar to those above were again reported by Grinker et.al. (1961) when they carried out a study of one hundred and seventy psychotic depressed patients who were rated independently on a rating scale of symptoms, tracts and themes. The five factors extracted were **Factor A** which contained items

relevant to the affective component of depression, these included loss of self-esteem, feeling of guilt, degree of depression and loss of satisfaction. **Factor B;** which was defined by retardation and apathy, loss of energy, withdrawal and isolation. **Factor C** ; which was characterized by the vegetative signs of depression such as loss of appetite, sleep disturbance, constipation and work inhibition. **Factor D;** which was defined by items relevant to irritability, preoccupation, complaining and agitation. **Factor E;** which was equivocal.

Attempt was made by McNair & Lorr (1964) to determine the basic mood factors in a neurotic population. A mood scale was administered to a series of psychiatric samples and five moods were identified. These include: tension; anger; depression; vigor and fatigue. The depression was defined by a series of adjectives such as worthless, helpless, unhappy, discouraged and blue.

Loeb, Beck, Diggory & Tuthill (1966) exposed depressives to varying experimental conditions. They randomly assigned a group of twenty-two non-depressed patients to an experimentally induced superior and inferior performance condition. Before and immediately following the experimental task, they were all asked to rate their own mood and indices of self-confidence were also obtained.

It was found out that the depressives tended to be more affected by task performance than the non-depressed when they were estimated on how they would do in a future task. However, the group did not differ in performance effect or self ratings.

Another study by Loeb et.al. (1966) measured into the effects of success and failure on mood motivation and performances. In the study, twenty depressed and twenty non-depressed patients were selected on the basis of their having high and low scores respectively in their depression inventory and high or low

ratings of depression made independently during a psychiatric interview. It was submitted that the depressed patients were significantly more pessimistic about their likelihood of succeeding and tended to doubt the quality of their performances, although their actual output was the same as that of non-depressed patients. The previous experience of success and failure had contrasting effects on the actual performances of the two groups on a second task. Success was found to improve the performance of the depressed patients while failure improved the performance of the non-depressed patients used in the study.

In another experimental study by Harsch and Zimmer (1965), sixty-two male and thirty-four female college students were selected on the basis of their performance on the Zimmer sentence completion test. Forty-eight students were considered to exhibit a predominantly extra punitive behaviour pattern while the remaining forty-eight were considered to exhibit a predominantly intropunitive behavior pattern. The intropunitive behaviour pattern was considered as being characteristic of depression. The experiment tried to produce abandonment of the characteristic behaviour pattern and adoption of a different behaviour pattern which could be considered as being better. This was carried out by rewarding participants for statements contrary to the basic behavior pattern or punishing the participants for statements conforming to the negative behaviour pattern. As a result of the experimental manipulation, both groups showed significant shifts in behaviour patterns as measured again by Zimmer test. Over an eight day follow-up period, it was recorded that the experimentally induced changes in the direction opposite from the starting points persisted.

Kiloh & Garside (1963) carried out a study designed to differentiate between endogenous and exogenous depression. The records of one hundred and forty-three depressives were studied and relevant data to their investigation extracted.

Out of the sample, thirty-one had been diagnosed as having endogenous depression, sixty-one as having exogenous depression and fifty-one as being doubtful.

Thirty-five features of the disorder were selected for additional study and a factor analysis was carried out and two factors extracted. The first factor was a general factor; the bipolar second factor considered by the authors to differentiate between exogenous and endogenous depression. The second factor accounted for a greater part of the total variance than the general factor and was therefore more important in producing the correlations among the thirty features analyzed in the study.

They also found significant correlation between certain clinical features and each of the diagnostic categories ad the clinical features that correlated significantly at 0.05 level of significance with the diagnosis of exogenous depression were, in decreasing order of magnitude of their correlations: reactivity of depression; precipitation; self-pity; variability of illness; hysterical features; inadequacy; initial insomnia; reactive depression; depression worse in evening; sudden on set; irritability; hypochondriasis; obsessionality. The features that correlated significantly with endogenous depression were: early awakening; depression worse in the morning; quality of depression; retardation; duration one year or less; age forty or older; depth of depression; failure of concentration; weight loss of seven or more pounds and previous attacks.

Another study was later carried out by Carney, Roth and Garside (1965) and extended to in-patients to overall approach used by Kiloh & Garside in their study of outpatients. Carney and his co-workers studied one hundred and twenty-nine in-patient depressives. All the patients were followed up for three months and one hundred and eight were followed up for six months. All of them were initially

scored for the presence or absence of thirty-five features considered to discriminate between endogenous and exogenous depressions.

A factor analysis of the clinical features was found to produce three significant factors: a bipolar factor "corresponding to the distinction between endogenous and exogenous depression;" a general factor with high loadings for many features common to all the depressive cases studied; and a "paranoid psychotic factor". The bipolar factor closely resembled that which was extracted in the study by Kiloh and Garside (1963). Among the features with high positive loadings on the first factor and thus corresponding to a diagnosis of endogenous depression were: adequate premorbid personality; absence of adequate psychogenic factors in relation to illness; a distinct quality to the depression; weight loss; occurrence of previous depressive episode; early morning awakening; depressive psychomotor activity; somatic and paranoid delusions and ideas of guilt features with negative leading corresponding to exogenous depression were anxiety; aggravation of symptoms in the evening; self-pity; a tendency to blame others and hysterical features.

With the use of multiple regression analysis, three series of eighteen weighted coefficients for the differential diagnosis between the two varieties of depression and for the prediction of response at three and six months were calculated. The multiple correlations between the summed features on the one hand and diagnosis and outcome at three and six months, on the other were found to be 0.91, 0.72 and 0.74 respectively. The weights based on the eighteen clinical features were complex. Therefore a table was constructed giving simplified weights based on ten features of diagnosis. The weighted features scores for each patient were computed and it was found out that of the patients with a score of six or higher, fifty-two had been diagnosed clinically as endogenous and three as exogenous while those patients scoring below six included one

endogenous and sixty exogenous depressives. Consequently, the amount of overlap was small and the findings supported the two type hypotheses.

In the prevalence of major depressive disorder and validation of the Beck's Depression Inventory among Nigerian Adolescents, Adewuya et. al. (2006) discovered the presence of major depressive disorder (MDD) in 6.9% male and 8.9% female in the 1095 adolescents used in the study. While the MDD in males and females was statistically significant in their study, no age-gender-interaction difference was found.

While investigating the Factors Associated with Depressive Symptoms in Nigeria, Omigbodun (2004) observed 127 referred adolescents and discovered that 62.2% of them had significant psycho-social stressors in the year preceding presentation. Problems with primary support, such as separation from parents to live with relatives, disruption of the family, abandonment by mother, psychiatric illness in a parent and sexual/physical abuse occurred in 50 (39.4%) of the adolescents. Problems with social environment occurred in 11 (8.7%), 39 (30.7% had educational problems, 5 (3.9%) had economic problems and 15 (11.8%) of the children had had other psycho-social stressors.

In Depression amongst Nigerian University Students' Prevalence and Socio-Demographic Correlates, using The Mini International Neuro-psychiatric Interview (MINI), Adewuya, et.al. (2007) discovered that out of a sample of 1206 students living in halls of residence of a federal university, 101 (8.3%) of the students met the criteria for depressive disorder with 68 (5.6%) having minor depressive disorder and 33 (2.7%) having major depressive disorder. They found out that the factors that were significantly associated with depressive disorder in students include problems with accommodation (95%), very large

family size (95%), female gender (95%), high level of alcohol consumption (95%).

In Family Characteristics as Correlate of Self-Esteem, Osarenren, Ubangha & Oke (2008) investigated 200 students with Rosenberg's Self-Esteem Scale and Personal Data Card. The resultant data was analyzed with one-way analysis of variance and independent t-test. The result showed a significant difference in self-esteem of young adults with respect to their ordinal position in the family. Young adults' self-esteem had no link with their family size and a significant gender difference in the adolescents' self-esteem.

Olusakin & Aremu (2009) investigated the relative effectiveness of Transaction Analysis and Life Skills Therapy in promoting social competence among 150 secondary school adolescents. Using the factorial analysis of covariance, they discovered significant improvement in social competence of experimental groups over control and a significant gender difference in control and treatment groups.

Cross-cultural Studies of Depression

There have been a lot of books and journal articles aimed at summarizing the existing state of affairs in the field of depression among different ethno-cultural groups. One of the earliest reviews was published by Benedict and Jacks (1954). Based on the little information available at that time, they concluded that "depressive states, in any form are relatively new in the native population studied". Most of the studies cited by Benedict and Jacks in their comments on depression were conducted in Africa during the colonial period. In his review on literature on "culture and symptoms", Al-Issa (1970) included a brief section on cross-cultural studies of depression where he commented on both the expression and the prevalence of depression in different culture and it also offered some interpretations of reported differences.

Kiev (1963) also presented a small section on cross-cultural depressive studies in his book on trans-cultural psychiatry, but the section is more noteworthy of the author's observation and interpretation regarding the "rarity of depressive disorders" in certain cultures than it is for literature review purpose for which it was designed, through some coverage of cross-cultural studies, depression was made available in the literature. German (1972) who focused his discussion on psychiatry in sub-Saharan Africa published one of the best reports. He offered a detailed analysis of the classic psychiatric investigations conducted in Africa. His paper stands out among others because of its perceptive analysis of the African depression studies and their implication for understanding the phenomenon of depression.

Based on his experience as the coordinator for international collaborative research projects conducted through the World Health Organization (WHO) Sartorius (1973) reviewed some studies in hi report on the epidemiology of depression. His report represents one of the earliest efforts to systemize depression literature. Fabrega's (1974, 1975) papers are more of an analysis of the potential influence of culture and social factors on depression and he thus concluded that cultural factors are quite important in depression.

A comprehensive coverage of cross-cultural studies on depression is provided by Singers (1975) and a valuable aspect of his paper is his coverage of the different socio-cultural theories of depression. Despite the fact that Singer is critical of the methodological limitations of some of the research works, he concludes that the concept of depression is "universally valid". This conclusion is strongly criticized by Kleinman (1977) who accused Singers (1975) of a number of conceptual and methodological errors including what he termed "category fallacies" and a disease "preoccupation". The former denoting-imposing culturally biased

categories on deviant behaviours in non-western cultures, while the later refers to the concept of disease as an entity that is independent of a cultural context.

Prince (1968) paper is considered very important because it summarizes the research literature on depression in African both colonial and post-colonial periods. In his paper, many psychiatric studies conducted among black Africans are compared and he observed that out of the fourteen reports published prior to 1957, only one, that of Field (1960) reported instances of depression among black Africans. The others concluded that psychotic depression is extremely rare and does not assume forms similar to western depression that is, there is absence of self-blame and suicidal considerations. Prince (1968) however observed that in most of the reports published after 1957, the rate of depression is claimed to be frequent even though the forms it assumed still varied from western patterns.

Pfeiffer (1968) also summarized forty reports of depression from twenty-two non-European countries and according to him, "there is a core of depressive symptomatology that does exist across cultures. These symptoms include sleep, libido, appetite dysfunctions and abnormal body sensations, mood changes are not always found because of cultural variations in self-description. Motor agitation or retardation and apathy are also found in some instances. Pfeiffer (1968) feels that guilt, as is conceptualized in western culture is not found but that variant is present in form of loss of relationship to a social group and that persecutory feelings may also arise if the environment assumes a threatening role. His conclusion, that the somatic dysfunctioning in the absence of any psychological report of depression or mood variation is sufficient to warrant a diagnosis of depression, is questionable.

Tonks, Paykel & Klurman (1970) make used of the matched diagnosis strategy for studying the manifestation of depression across culture and this provides a good opportunity to compare the symptoms manifested by different ethno-cultural groups sharing similar diagnoses. The same method was employed by Hanson, Klerman & Tarner (1973) and both groups concluded that the differences between black and white depressed patients were minimal and that the similarities between the two groups were far more prominent than differences. Simon, Fliess, Gurland, Stiller & Skarpe (1973) found several important differences leading to their conclusion that "blacks have qualities to their depression that are different from whites."

Helzer (1975) in his study of bipolar depression among male American blacks and whites hospitalized in Saint Louis area reports that the group differed only with respect to a higher incidence of initial insomnia among the blacks and that there were no differences in their levels of euphoria, irritability, flight of ideas, grandiosity and hyperactivity.

Gudill & Schooler (1969) factor-analyzed a group of twenty-four symptoms for a sample of male and female Japanese patients and they found that depression among the males were characterized by sadness, irritation, loss of appetite, suicidal attempts and sleep disturbances, While depression among the females was characterized by sadness, self-depreciation, suicidal attempts, loss of appetite, withdrawal and apathy. This factor analysis revealed some notable differences in the manifestation of depression for the two sexes.

Binitie (1975) compared the factorial structure of the Hamilton Rating Scale for a group of westernized Nigerian and a group of English patients. Even though there is no information in the article regarding the demographic characteristics of the samples such as age, social class and education levels, nonetheless Binitie

(1975) reported that the Nigerian sample showed no evidence of guilt, but depressed mood, motor retardation and somatic symptoms were present. The Nigerian sample, it was reported, did not show evidence of suicidal rumination whereas the British sample showed all the signs of classic depression. This report cannot be generalized beyond those Nigerians who are westernized unless there are more information regarding the characteristics of the Nigerian sample because German (1972) and Diop (1967) reported that acculturated African depressed patients present similar symptoms to western depressed patients while acculturated Africans did not present similar pictures.

Cultural Theories of Depression

There have been numerous cultural theories of depression that account for the variations in the rates and expression of depression across cultures. Psychodynamic and social psychological conceptual frameworks have been assumed by these theories.

The family structure as one of the earliest cultural theories of depression to be set forth emphasized the role of the family structure in the mediation of depression. Stainbrook (1954) speculated that depression may occur less often in non-western cultures because extended family structures serve to minimize early frustrations of life through what he called multiple mothering and generalization of object interest to several family members. Collomb (1967) reported that depression may be lower in the non-western cultures because of close mother-child relationship and long period of permissiveness which reduce psychological insecurities in childhood and thus act against the development of personality types sensitive to endogenous depression. Also, Tseng & Hsu (1969) found that the extended family system in Taiwan promotes a feeling of belonging to a group and lessens the risk of early loss which predisposes to depression.

Arieti (1959) noted that depression may be due to child-rearing patterns and family structures that encourage the development of a conforming personality, since they would willingly accept parental expectations that subsequently lead to "pathological introjections". The pathological introjections may in turn lead to feelings of resentment towards the parental figures and society for impositions. The hostility produces the guilt feelings and withdrawal tendencies associated with depression and this according to Arieti, is more likely to occur among the highly socialized individuals who tend to conform with societal and parental pressures. The cross-cultural evidence tends to conflict with the "conformity" hypothesis, since depression rate is said to be much lower in those cultural settings that stress conformity to the group rather than individuality.

Chance (1964) and his colleagues also attempt to test a cultural theory of depression by examining the hypothesis that depression may be related to the level of social cohesion in the society. Social cohesion is the extent to which members of a society share value orientations and the extent to which they are highly socialized and under such conditions, it has been speculated that depression rates would be higher among women, members of highly traditionalized and tightly knit social groupings (Chance, 1964). Internalization of hostile feelings and impulses would be a likely mechanism.

Savage and Prince (1967) observed that the use of projective mechanism make the risk of depression among the Yoruba tribe in Nigeria quite low. They found that there is heavy reliance on denial, which is bolstered by magical practices. Vitols (1962) and Vitols & Prange (1962) argued that American blacks living in the south are relatively immune against depression because of their tendency to limit their self-expectations and demands. Failures do not occur very often and self-esteem is maintained by relatively simple acts among these blacks.

It has also been suggested by a number of writers that the mourning rituals in many non-western cultures reduce the risks of depression (Olusakin, 1990). Tseng & Hsil (1969) reported that the low depression rates in Taiwan may partly be due to the overt expression of grief that accompanies Chinese funeral rites. They also observed that the practices of ancestral worship in Japan act against the occurrence of depression because love objects are not considered to be totally lost through death. Also the conclusion that the mourning practices among black Americans also mitigate against depression by the rich opportunity for "adequate grieving" and the fact that death is often perceived as a relief from life's burdens an a chance to enter heaven, was reached by Vitols & Prange (1962) and Vitols (1967).

Kendell (1970) in postulating another popular cultural theory of depression argues that cultures providing outlets for aggression will experience low levels of depression. Lyous (1972) compared the rates of depression in Belfast, Northern Ireland and a relatively peaceful community and found out that the suicide rate dropped by more than 50 percent in Belfast and that depression rates decreased during the period of civil hostility in Belfast while the peaceful neighbouring community showed a sharp increase in its rate of depression.

Marsella, Kinzie & Gordon (1978) speculated that the expression and experience of depression across culture may vary as a function of culture's position on a continuum of subjective versus objective epistemological orientations. He also found out that there is close relationship among the self-structure, language and mode of experiencing reality. In certain cultures, an individual self-structure, a metaphorical language structure and an imaginable mode of experiencing reality are present in all intimate reciprocal relationship. Cultures at the end of the continuum tend to develop subjective epistemic orientations that make it difficult to capture or portray internal effective states like depression in objective terms

and experiences. So the result of subjective mood distress is absent and the experience itself is altered considerably. Whereas, some cultures are characterized by individuals who have individuated self structures, abstract languages and a lexical mode of experiencing reality, such cultures tend to develop objective epistemological orientations in which internal affective state is experienced in a more detached manner. Depressive disorders, in these instances, are expressed and experienced in ways that are similar to traditional psychiatric representations of depression (Marsella et.al. 1978).

Generally speaking, depression appears to be related to both the quantity and quality of stresses present in a culture, especially during critical periods of childhood when object attachments are being formed (Olusakin, 1990).

CHAPTER THREE

RESEARCH METHODOLOGY

The following will be discussed under this section: Research Design; Study area; Population for the Study; Sampling; Instrumentation; Procedures for Data Collection; Pilot Study; Treatment Procedure and Data Analysis.

Research Design

The research design used for this study was a 3 X 2 factorial design. The two treatment strategies, Activity Schedule and Anticipation Training, as well as the control group made up the 3 rows. The two columns are made up of two levels of male and female students. There were consequently six groups consisting of four treatment and two control groups

Table 1: Distribution of Participants by Experimental Condition and Gender

EXPERIMENTAL GROUP	GENDER		TOTAL
	MALE	FEMALE	
ANTICIPATION TRAINING	16	16	32
ACTIVITY SCHEDULE	16	16	32
CONTROL	16	16	32
TOTAL	48	48	96

The Study Area

The study was carried out in Lagos State. Adolescents from secondary schools in Education Districts 11, 111 & 1V constitute the sample. Lagos State is in the

South-Western part of Nigeria. She is bounded by Ogun State in east and north while in the south she adjoins the Atlantic Ocean. She is the boarder city of the country with Benin Republic in the west. Lagos was the capital city of Nigeria and still serves as the commercial nerve centre of the country. The State is highly-heterogeneously-populated. The 2006 census (as released by the National Population Commission, N.P.C.) puts the State's population at 9.7 million.

As the economic capital of Nigeria, there are some unique features that easily predispose adolescents to depression in Lagos State. Some of these are:

- High cost of living
- Absence or fluctuating social services like water, electricity,
- Unemployment
- Absence of good roads
- Reckless display of affluence by the rich

Population

The target population comprised all adolescent students at the Senior Secondary Schools in Lagos State. SS 2 students were used for the study because they were more available than SS 1 and SS 3 students who are busy preparing for the Senior School Examination.

Sample and Sampling Technique

Participants for the study were drawn from three randomly selected Education Districts, out of the six, in Lagos State. The hat and draw method was used to select the three districts. Two senior secondary schools were thereafter randomly selected from each Education District. The schools were selected through the table of random sampling method.

The Self-Rating Depression Scale was administered on all available 2,982 (SS II) students in the selected schools to identify mildly depressed teens (These were participants with a score of 40 and above in the Self-Rating Depression Scale). Secondly, the students were stratified into male and female before the random sampling method was employed to select the 96 students (48 males and 48 females) for the study.

Instrumentation

Three major instruments were used to obtain relevant data for this study.

1. Self-Rating Depression Scale (SDS)
2. Depression Inventory (DI)
3. Index of Self-Esteem (ISE)

Self-rating Depression Scale (SDS)

This is a 20 item instrument developed by Zung (1982) for participants to score themselves on a four point scale. It was specifically designed to assess the cognitive, affective, psychomotor, somatic and social interpersonal dimensions of depression. Zung (1982) provided the original psychometric properties for American samples while Obiora (1995) provided the properties for Nigerian samples. SDS has a fair internal consistency of 0.86 and 0.73 in the two studies; and a test-retest reliability coefficient of 0.93, showing good stability (Obiora, 1995). A coefficient of concurrent validity of .79 was obtained by Zung (1982). For Nigerian samples, the mean scores obtained by Obiora (1995) are 48.77 and 47.87 for male and female respectively.

Administration: In administering the SDS, respondents were given the following instructions.

Please shade the right number to the correct statement, which has described how you feel now. The scale stands for:

1 = A little or none of the time *3 = Good part of the time*

2 = Some of the time *4 = Most or all the time*

A sample of some of the items in SDS

	1	**2**	**3**	**4**
I feel down-hearted, blue and sad				
Morning is when I feel the best				

Scoring of SDS

Add together the values of the numbers ticked in all the 20 items. For example, if in items 7, 8, 9, 10 & 11 the numbers shaded are 4, 1, 3, 2 & 4 respectively, the score for the five items is 4 + 1 + 3 + 2 + 4 = 14. The participant's SDS score is the sum of scores obtained in the 20 items.

Depression Inventory (DI)

This 22 item questionnaire was adapted from Weissman & Paykel's (1974) The instrument has a test-retest reliability of 0.89. This inventory, administered on the participants on pre-test post-test levels was useful in evaluating the outcome of the treatments on the participants.

Administration of Depression Inventory

In order to standardize the administration of the Depression Inventory, there was the need for adherence to the following instructions. This was also important in order to enhance uniformity and to minimize interviewer effects.

Administrative Procedure

The client was told: "This is a questionnaire, on the questionnaire are groups of statements. I will read a group of statements, and then I want you to pick out the statement that best describes the way you feel today, that is right now".

At this point, a copy of the questionnaire was handed to the participants with the instruction "there is a copy for you to follow as I read". Then the entire group of statements in the first category was read to the participants who were then asked "now which one of the statement best describes the way you feel right now?"

When a participant indicated his/her choice by responding with a number, there was the need to read back the statement corresponding to the number chosen by the participants in order to avoid confusion as to which statement was selected. They were made to understand the numbering system after which the numerical answer was a sufficient indication of his/her choice.

- It was necessary to make sure that each choice was indeed the participant's choice and not words put in his/her mouth. Each participant was encouraged to express which statement was his/her choice.
- Where the client indicated that there were two or more statements that fit the way he/she felt, the higher of the values was recorded.

- When the participant indicated that the way he/she felt was between 2 and 3 being more than 2 but not quite 3, then the value which he/she was closer to was recorded.
- Generally, the researcher read aloud the statements comprising each category. However, at times, the participants took the initiative to read the statements in a category silently ahead and picked his/her preference. If the participant made an effective effort like this, he/she was encouraged to continue.
- Explanation was made to the participants on why the statements were read aloud. It was to make sure that he/she had read all the statements in the category before making his/her choice. They were encouraged to read all the statements to avoid making hasty choices. They were also encouraged to reflect sufficiently before making a choice.
- The depression scores of each participant were entered in a record sheet. This was the sum of the weighted responses of items in A through U. The weight of each statement was the numeral adjacent to the statement and the higher the score, the more intense the depression.

Index of Self-Esteem (ISE)

The index of self-esteem (ISE) is a 25-item inventory designed by Hudson (1982) to measure the degree, severity or magnitude of a problem the individual has with self-esteem. Self-esteem is the self-perceived and self evaluative component of self-concept.

Hudson (1986) provided the original psychometric properties for American samples, while Onighaiye (1996) provided the properties for Nigerian samples. Among Nigerian respondents, Onighaiye (1996) obtained mean score of 30.89

for males (n=80) and 32.04 for females (n=80), while Hudson (1982) reported mean score of 30.0 for a mixed sample of male and female Americans (n=1,745).

Administration of ISE: To administer the ISE, the participants were instructed to read each item carefully and tick the appropriate number to the right of each item to indicate how the respondent felt about himself/herself at that time. The alternatives include:

Rarely or none of the time	*= 1*	*A little of the time*	*= 2*
Some of the time	*= 3*	*A good part of the time*	*= 4*
Most or all of the time	*= 5*		

A sample of the items in ISE is as follows:

	1	**2**	**3**	**4**	**5**
I feel that people would not like me if they really knew me well					
I feel that others get along much better than I do					

Scoring of the ISE

There is direct and reverse scoring of items in the ISE.

Direct Scoring: Add together the values of the numbers ticked in items 1, 2, 8, 9, 10, 11, 12, 13, 16, 17, 19 20 & 24 directly. For example, if the options ticked in items 8, 9, 10, 11 &12 are 3, 2, 5, 4 & 2 respectively, the score for the five items is 3 + 2 + 5 + 4 + 2 = 16.

Reverse Scoring: Change the values of the numbers from 1, 2, 3, 4, 5 to 5, 4, 3, 2, 1 respectfully and add together the reversed values of the options ticked in items 3, 4, 5, 6, 7, 14, 15, 18, 21, 22, 23 & 25. For example, if in items 18, 21, 22, 23 & 25 the following options were shaded; 3, 1, 4, 2, & 5 were ticked respectively; the score for the five items is 3+5+2+4+1 = 15.

Add together the result of the direct and reverse scores to obtain the overall score.

Subtract 25 from the overall score to obtain each participant's ISE score.

Scores higher than the norm are indicative of low self esteem.

Pilot Study

A pilot study was carried out to determine the validity and reliability of the research instruments. The pilot study was conducted under conditions as similar as possible to those anticipated in the main study so as to correct any shortcoming that could hamper its success. Forty-eight participants (24 male and 24 female) were drawn from Diary Farm and Sango Senior Secondary Schools in District 1 for the exercise. A test/re-test was carried out within two weeks. The following results were obtained:

Instrument	N	Mean Score	Test/Re-test Score
Self-Rating Depression Scale	48	54.07	0.88
Depression Inventory	48	39.1	0.89
Index of Self-Esteem	48	47.6	0.78

The researcher gave the instruments to his supervisors in order to establish their face and content validity. He incorporated comments and corrections from them in this present state.

Procedure for Data Collection

The research instruments were administered on the students in their schools. These were done by the researcher and four research assistants. The research assistants were Masters Degree students in Educational Foundations Department of University of Lagos. They were appointed and trained for three hours within a week. They were subsequently rewarded by the researcher. Their training was to get them used to the instruments in the administration and scoring.

Procedure for Treatment

This study was carried out in three phases

Phase 1: Pre-Treatment Assessment

Phase 2: Treatments

Phase 3: Post-Treatment Assessment

Phase 1: Pre-Treatment Assessment

The researcher investigated the depression level of participants by administering the Self Depression Inventory (SDI) to all available 2,982 (SS 2) students in the study area. The baseline for treatment was adolescents with a score of 40 and above in the SDI.

Treatments

There were three experimental groups (two treatment and one control groups). The Experimental Group 1, Experimental Group 2 and Control Group were randomly assigned to the three Education Districts consisting of two schools per District. The Biology laboratories of the schools were used for the treatments. The biology laboratories were used because of the convenience of the seats and

their location in the schools Treatment lasted for seven weeks of one session of one and a half hour per week.

Group 1: **Activity Schedule Strategy (ASS)**

The rationale for activity schedule strategy is to enable participants comprehensively order the exercises which adolescents engage in daily or weekly for positive and rewarding experiences. The guiding principle for the behavioural treatment of depressed individuals is to restore an adequate schedule of positive reinforcement for the individual by altering the level, the quality and the range of his activity and interactions.

1st Session

This was used for introduction, orientation and familiarization. The researcher demonstrated warmth and empathic understanding of the participants' plight. The Depression Inventory and Index of Self-Esteem (pre-test) were administered on the participants. Every participant was given a Weekly Activity Log Sheet to fill in the activities he or she would be engaged in during the coming week. This was to be produced at the next session.

2nd Session

The researcher checked the activities listed by each participant and asked them to list the activities they enjoyed doing but which they had not been doing, from their lists, an activity schedule was formed. Activities that are negatively framed were not listed in the schedule of activities for each participant. They were asked to schedule the activities into seven days of the week and make sure they

attempted as many as possible daily. This was an attempt to increase the rate of behaviour which is likely to be reinforced by others and at times intrinsically reinforcing for each of the participants.

3rd Session

After a warm reception, the researcher checked through participants' lists for the past week asking each of them to tick those activities that had been incorporated into their former daily schedule. They were encouraged to make another list of new activities which they loved to participate in the following week and schedule them on a daily basis. They were encouraged to be faithful to themselves by trying to engage in these activities during the following week.

4th Session

The weekly activity log sheet was collected after welcoming participants to see how each of them had increased their involvement in positive activities. Researcher thereafter reinforced their efforts verbally and declared the session and the fifth session as activity sessions. Volunteers were thereby invited to share with the group five nice activities to improve their studies. These were incorporated into the programme to increase the number of activities of the whole group. The group made the schedule of activities for the coming week with promises of sincerity in carrying them out.

5th Session

This was commenced with smiles and rapport. As a scheduled activity session, the activity log sheet was inspected and appropriate commendation made on participants' success. A surprise package was announced; which was that participants engage in chosen activities in the environment for 20 minutes. After this period, participants reported back and indicated what they had done in their log sheet. After commendations, they were asked to list their loved scheduled activities for the next week and schedule these on a daily basis. They were advised to keep up their activity schedule instead of reducing them but this should not affect them negatively.

6th Session

This was used to put finishing touches to the effective use of activity schedule and their construction. The researcher went over past week's log sheet noting those ticked by the participants as been performed and those left out. Participants were encouraged to increase their positive activities instead of brooding over negative ones. Participants were told to prepare another list of activities for the next week, which they were reminded, will be the last one for the group.

7th Session

The last session was commenced with praises and commendations for all the participants. Questions were invited from them with the researcher responding appropriately. The Depression Inventory and the Index of Self-Esteem were administered on the participants to get their post-treatment scores. The Weekly Activity Log Sheet of each of them was inspected with praises and

commendations for a job well done. They were advised to continue to improve upon their positive activities as they consciously engage in them. Participants responded to the Evaluation Questionnaire. Light refreshment was served before asking participants to call back in three week's time for follow up meeting at the same venue and time.

GROUP 2: Anticipation Training Strategy (ATS)

To anticipate is to think or be fairly sure that something will happen. This strategy aimed at positive anticipation of life events by construing their replications on the adolescents' parts. This means that our feeling is dependent on how we think and act. What goes on in our body when we are sick or in pain is the direct result of the actions and thoughts we chose (Glasser, 1999).

1st Session

This was used for general orientation and introduction of participants and group members. The overall goal of therapy was stressed and punctuality emphasized. The Depression Inventory and Index of Self-Esteem were administered at this point to get participants' entry behaviour. The researcher discussed depression, its symptoms and the need for therapy. He also explained Anticipation Training Strategy and the need for the students to avoid negative anticipation of events while upholding the positive during their expectation periods.

The researcher tried, as much as possible, to gain the confidence of the participants through warmth and empathic rapport with them. He was supportive but firm when absolutely necessary. Questions and clarifications were taken with

corresponding response from the researcher. A sheet of paper was provided for participants to write a list of pleasant events they will like to witness or participate in the coming week.

2nd Session

Here, participants were asked to list 4 events they consider pleasant that have taken place during the last week while they also listed 4 pleasant events they were looking forward to during the following week. The researcher asked students to relax, close their eyes and imagine the 1st event on him/her through to the 4th event. They were thereafter asked to voice out anticipatory statements about the pleasant events and how they will enjoy such events with the aid of guided imagery. "Thought Stopping" technique was used to stop any of them that drift off to negative thought and such were redirected back to the positive trend. As assignment, participants were to anticipate the four listed events for five minutes each at least 2 times a day-preferably morning and night as practised in session.

3rd Session

Participants were asked to describe their feelings as to how they coped with their practices during the past week. They thereafter acted out some of these. They also listed another 4 events and anticipated their occurrence and practiced same during the coming week.

4th Session

Participants were relaxed with jokes and discussions on pressing national issues during the week. Those who had taken the assignment seriously were positively reinforced. Four new pleasant events were written by each participant and they were to imagine the joyful reaction as they experience each event.

5th Session

Anticipated pleasant events that would have taken place out of those anticipated and listed by the participants were reviewed with each participants writing praises; "good" "very good" in front of such events. More practices were stressed with encouragement in the morning and evening.

6th Session

Participants were reminded that this would be the last but one session with commendation and praises for each of them. The researcher explained the need for participants to generalize their training after a review of their past week's activities. Participants were to write and imagine 4 events they would like to happen in the coming week. The researcher took participants' questions and observations.

7th Session

Participants were commended for active participation in this training after a review of the assignment given last week. The researcher administered the post

test to ascertain the effect of training on the participants. They were told to report in 3 week's time for follow up at the same time/venue.

Placebo Treatment (Control Group)

The researcher, after introduction and familiarization with participants in this group, made up excuses for not having treatment sessions with them as appointed. The Depression Inventory and Index of Self Esteem were administered to this group on pre-test post-test basis also. Though the researcher was regular and punctual at the scheduled day/time, Anticipation Training strategy was later used for the control group as it was slightly more effective than Activity Schedule strategy. This was held at the Biology laboratory of Ebute-Elefun High School in District 11. Time was 2 - 3. 30pm on Wednesdays for seven weeks.

Method of Data Analysis

The data generated from this study was subjected to both descriptive and inferential statistics appropriate for each hypothesis. All the hypotheses were tested with the Analysis of Covariance (ANCOVA) to adequately reveal the interaction effects of the covariate that is the pretest. The LSD pair-wise comparison was used to determine which pairs of the groups evidenced significant difference in the post-test means.

The level of significance for testing of all the hypotheses was set at 0.05. In addition to the statistical tests, tables were judiciously used to present summaries. The results of the data analysis are presented in chapter four.

CHAPTER FOUR

DATA ANALYSIS

The results obtained from the various statistical analyses carried out in the study are thus presented.

Hypothesis 1: **There is no significant difference in the depression scores of participants in the three experimental conditions.**

Analysis of Covariance was utilized. In the ANCOVA analysis, the independent factor was experimental condition; the dependent variable was post-test depression scores, while the pre-test depression scores were entered as covariate. The results of the analysis relating to this hypothesis are presented in Tables 2 and 3.

Table 2: **Descriptive Statistics of Pre and Post-test Depression Scores across the Experimental conditions with ANCOVA Test of between Subjects Effect.**

Group	N	Pre-test Scores Mean	SD	Post-test Scores Mean	SD	Mean Difference
Activity Schedule	32	39.46	9.61	26.25	3.59	13.21
Anticipation Training	32	41.06	7.22	26.03	2.85	15.03
Control Group	32	41.19	5.83	38.84	7.20	2.35
Total	96	40.57	7.55	30.38	7.75	10.19

Source	SS	df	MS	F
Corrected Model	3465.01(a)	3	1155.00	47.53*
Covariate	21.69	1	21.69	0.89
Exptal Condition	3357.95	2	1678.98	69.10*
Error	2235.50	92	24.99	
Total	94274.00	96		

a R Squared = .608 (Adjusted R Squared = .595)

*The mean difference is significant at the .05 level.

Table 2 shows a pre-test grand mean of 40.57 (SD=7.55) as against 30.38 (SD=7.75) obtained at post-test thus yielding a pre-test post-test mean difference of 10.19. a disaggregation according to experimental conditions shows a pre-test post-test mean difference of 13.21 for the Activity Schedule Group, 15.03 for the Anticipation Training Group and 2.35 for the Control Group. The computed F (2, 92) =69.10, P < 0.05 for experimental condition was statistically significant at the 5% level, thus suggesting that the treatment conditions were effective in reducing mild depression among adolescents. To determine where

the significant differences lie, pair wise comparisons were performed with the following results;

Table 3: Least Significant Difference (LSD) Pair wise Comparisons of Difference in Depression Level of Participants across Groups

Dependent Variable: Depression Inventory Post-Test

(1)Treatment Groups	(J) Treatment Groups	Mean Difference (I-J)	Std. Error	Sig.[a]
Activity Schedule	Anticipation Training	.39	1.25	.76
Activity Schedule	Control	12.41*	1.25	.00
Anticipation Training	Control	12.80*	1.23	.00

Based on estimated marginal means
*The mean difference is significant at the .05 level.
[a] Adjustment for multiple comparisons

An inspection of the p-values shows that both activity schedule and anticipation training strategies differ significantly ($p<0.05$) from the control group. The two treatment groups were however undifferentiated. It means that the two treatment groups are homogeneous. This result means that the two treatment conditions were effective in the reduction of mild depression among Nigerian adolescents.

Hypothesis 2: Hypothesis two states that there is no significant interaction effect on participants' depression scores due to self-esteem and experimental conditions.

Self-esteem refers to self-respect. In other words, it is confidence in ones own merit as an individual person. How a person feels about himself is also affected by how he thinks others view him. It is the perceived self-what we think others think about us-that affects our self-attitude (Rosenberg, 1979).The assumption underlying this scale is that one's self-esteem is closely related to the level of

depression the individual experiences. Results pertaining to the above are presented in Tables 4 and 5.

Table 4: Descriptive Data of participants' post-test depression scores across the three experimental conditions due to self-esteem.

Groups	Self-Esteem Level		Pre-Test		Post-Test		Mean Diff.
		N	Mean	SD	Mean	SD	
Activity Schedule	**Low Self- Esteem.**	24	40.50	8.51	26.83	3.62	13.67
	High Self- Esteem.	8	38.18	10.71	24.50	3.07	13.68
	Total	32	39.45	9.61	26.25	3.59	13.20
Anticipation Training	**Low Self- Esteem.**	28	42.06	7.76	26.04	3.01	16.02
	High Self- Esteem.	4	39.62	6.68	26.00	1.41	13.62
	Total	32	41.06	7.22	26.03	2.85	15.03
Control	**Low Self- Esteem.**	27	42.79	6.43	41.52	3.62	1.27
	High Self- Esteem.	5	38.73	5.23	32.40	3.12	6.33
	Total	32	40.96	5.83	36.84	7.20	4.12
TOTAL	**Low Self- Esteem.**	79	42.92	7.57	31.57	7.97	11.35
	High Self- Esteem	17	37.51	8.20	24.82	2.60	12.69
	Total	96	40.02	7.55	30.38	7.75	9.94

The descriptive data in table 4 indicates that the three groups share some similarities in their mean scores before the treatment. It also revealed that at post test, the two treatment groups (Activity Schedule 26.25 and Anticipation Training 26.03) recorded significant improvement (over Control Group 38.84). To determine if these differences are statistically significant, the ANCOVA results in Table 5 is displayed.

Table 5: 2X3 ANCOVA Test of Participants' Post-test Depression Scores due to Self esteem across Experimental Groups

Source	Sum of Squares	df	Mean Square	F
Model	4713.52a	6	785.59	70.59*
Covariate	1.25	1	1.25	.11
Exptal Condition	594.55	2	297.27	26.81*
Self-Esteem	534.95	1	543.95	48.24*
Exptal Cond. vs Self-Esteem	722.68	2	36.34	32.58*
Error	986.99	89	11.09	
Total	5700.50	95		

a R^2 = .83 (Adjusted R^2 = .82).

*The mean difference is significant at the .05 level.

Evidence from Table 5 shows that the F-value for the main effects was significant beyond the 0.05 level: F-cal (2, 89) $p<0.05$. Thus, we reject the null hypothesis and conclude that treatment was effective in improving the self-esteem of participants. To determine where significance between groups lie, post-hoc multiple comparisons were performed using the LSD procedure and the results shown in Table 6

Table 6: LSD Pair-wise Comparisons of Participants' Post-test Depression Scores due to Self esteem across Experimental Groups

Dependent Variable: Depression Inventory Post-Test

(1)Treatment Groups	(J) Treatment Groups	Mean Difference(I-J)	Std. Error	Sig. [a]
Activity Schedule	Anticipation Training	.33	1.12	.77
Anticipation Training	Control	6.93*	1.20	.00
Control	Activity Schedule	7.27*	1.06	.00
Low Self-Esteem	High Self-Esteem	6.23*	1.18	.00

*Significant at P >0.05

Table 6 shows that only one out of the multiple comparisons done was not significant at the .05 level of significance. The pair of activity schedule and anticipation training groups with a mean difference of -.33 was not significant as against the other pairs.

To buttress the self-esteem by treatment groups' interaction effect on depression level, sequel to the observed significant value of 48.24, the interaction effect among the variables concerned were plotted graphically in Figure III

Fig.III

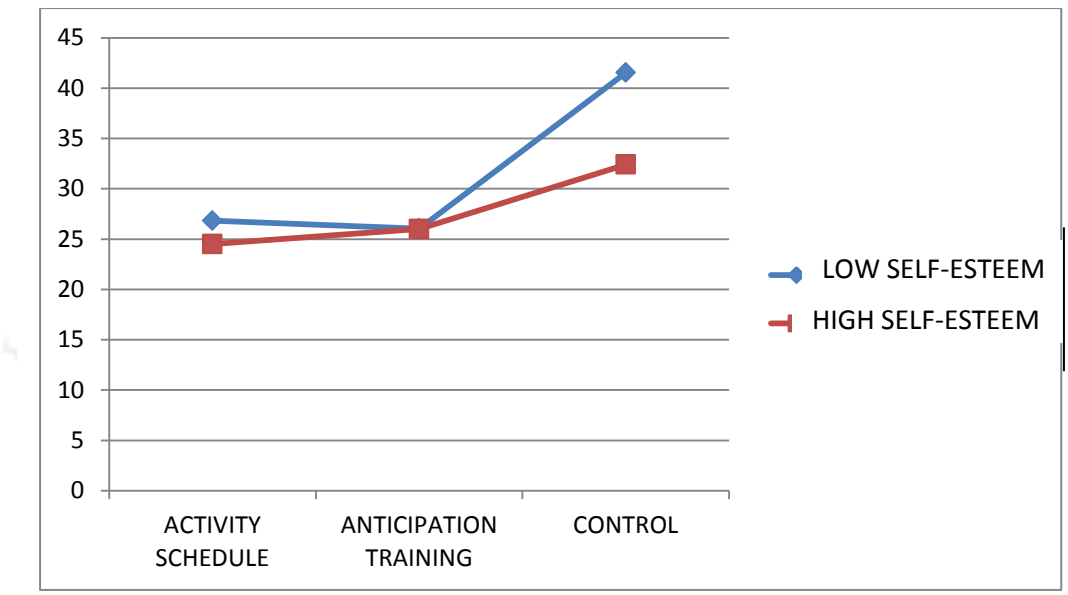

FIG. III: Self-Esteem by Treatment Groups' Interaction Effect on Depression Level of Participants

From the graph in Figure lll, the control group has the highest depression levels of High and Low Self-Esteem. There is ordinal interaction between Activity Schedule and Anticipation Training. This was due to the observed interceptions of high/low self-esteem axis at a point of the graph. This implies that given some

treatment groups, there was significant difference across self-esteem characteristics exhibition while for some other groups such significance was absent.

In summary, the results have shown that the treatment groups have significant influence on the self-esteem of participants. This finding was supported by the significant self-esteem by group interaction effect which was plotted to decipher the direction and nature of interaction.

Consequently, the null hypothesis that there is no significant difference in depression level of participants due to self-esteem across the groups was rejected and the research hypothesis was retained.

Hypothesis 3: There is no significant difference in participants' depression scores due to their social-economic status.

For this hypothesis, participants were classified into three distinct socio-ecomic status groups.

Table 7: Descriptive Statistics of Participants' Depression Scores by Socio-Economic Status Across the three Experimental Conditions.

GROUP	FAMILY S E S	N	PRE-TEST		POST-TEST		MEAN DIFF.
			MEAN	SD	MEAN	SD	
ACTIVITY SCHEDULE	LOW	16	44.34	9.42	26.62	4.65	7.72
	MODERATE	12	38.12	8.73	25.75	2.30	12.37
	HIGH	4	37.06	8.34	26.25	2.06	10.81
	TOTAL	32	39.84	8.61	26.25	3.59	13.59
ANTICIPATION TRAINING	LOW	18	46.21	5.24	26.22	2.02	19.99
	MODERATE	8	36.67	6.43	25.75	1.58	10.92
	HIGH	6	38.14	7.45	25.83	5.71	12.31
	TOTAL	32	40.94	7.22	26.03	2.85	14.91
CONTROL	LOW	16	47.14	9.34	41.06	5.90	6.08
	MODERATE	11	37.45	6.77	35.27	9.05	2.18
	HIGH	5	41.69	7.48	39.60	3.29	2.09

	TOTAL	32	41.76	5.83	38.84	7.20	2.92
TOTAL	LOW	50	46.29	9.56	31.10	8.15	15.19
	MODERATE	31	34.08	6.71	29.13	7.16	4.95
	HIGH	15	36.49	7.59	30.53	7.73	5.96
	TOTAL	96	35.23	7.65	30.38	7.75	4.85

Table 7 indicates that more than half of the participants (50) were from low socio-economic status. The moderate SES group consists of 31 adolescents while the remaining 15 belonged to the high SES. There was not much difference in the mean score of all the groups in the pre-test but there was a noticeable difference in the post-test mean scores of the different groups. The Low SES group has a post-test mean of 31.10 (SD=8.15), the moderate SES group has a grand mean of 29.13 (SD=7.16) and the high SES group has a grand mean score of 30.53 (SD=7.73).

Comparing the mean differences of the three groups, the Low SES group recorded the highest mean difference of 15.19 as compared to 4.95 for moderate SES and 5.96 for the High SES group. To determine the significance of these differences, the ANCOVA test was carried with the result displayed in Table 8.

Table 8: ANCOVA test on Participants' Depression Scores based on their SES across the Groups.

Source	Sum of Squares	df	Mean Square	F
Model	3700.92[a]	8	411.21	17.87*
Covariate	28.94	1	28.94	1.25
Exptal Condition	2600.89	2	1300.44	55.93*
SES	112.69	1	56.35	3.42
Exptal Cond. vs SES	115.28	4	28.82	1.24
Error	1999.58	86	203.25	
Total	29274.00	95		

a R Squared= .65 (Adjusted R Squared = .61)
*The mean difference is significant at the .05 level.

The analyses in Table 8 show that the experimental condition on post-test depression scores of participants, due to socio-economic status, was statistically significant. The calculated F-value of 55.93 was greater than the critical F-value of 3.11 given 2, 86 degree of freedom. However, the F-value of 3.42 for the effect of SES alone was found to be insignificant calculated F= 3.42, given the critical value of 3.11 (p=0.05, df = 2 and 86). The null hypothesis three which stated that there is no significant difference in participants' depression scores due to their social-economic status was thereby accepted.

Hypothesis 4: **Hypothesis four states that there is no significant difference in the participants' depression level due to family size across the experimental groups.**

For this hypothesis, participants were categorized into Large Family Size, Moderate Family Size and Small Family Size. Large family size is made up of participants from families with above six children. Moderate family size consists of adolescents from families having between four and six siblings while small family size contains participants from families with three children and below

Table 9: Descriptive Data of Participants' Pre-test and Post-test Depression Scores due to Family Size.

GROUP	FAMILY SIZE	N	MEAN	SD
ACTIVITY SCHEDULE	SMALL	20	26.65	4.16
	MODERATE	8	25.13	2.10
	LARGE	4	26.50	3.00
	TOTAL	32	26.25	3.59
ANTICIPATION TRAINING	SMALL	15	25.87	2.00
	MODERATE	12	25.67	2.27
	LARGE	5	27.40	5.64
	TOTAL	32	26.03	2.85
CONTROL	SMALL	18	37.56	8.03
	MODERATE	8	42.00	4.24
	LARGE	6	38.50	7.40
	TOTAL	32	38.84	7.20
TOTAL	SMALL	53	30.13	7.58
	MODERATE	28	30.18	8.12
	LARGE	15	31.60	8.04
	TOTAL	96	30.38	7.75

Data in table 10 show pre-test mean scores of all the groups in the same range but the post-test mean scores of the groups varied. The Activity Schedule Group recorded a mean difference of 6.53, while the Anticipation Training Group recorded 6.85 difference. The Control Group also recorded 4.54 mean difference. The small family size group is made up of 53 participants-which is more than half of the total participants. The moderate and large family groups consist of 28 and 15 participants respectfully. There was however a slight variation in the mean differences of the three family sizes. To confirm whether these differences were statistically significant, the ANCOVA test in Table 10.

Table 10: 3x3 ANCOVA test on Participants' Depression Scores based on their Family Size across the Groups

Source	Sum of Squares	df	Mean Square	F-cal
Model	3606.43[a]	8	400.72	16.47*
Covariate	27.90	1	27.90	1.15
Exptal Condition	2760.22	2	1380.11	56.68*
Family Size	20.99	2	10.50	0.43
Exptal Cond. vs Family Size	124.97	4	31.24	1.28
Error	2094.07	87	24.35	
Total	94274.00	95		

a R Squared = .63 (Adjusted R Squared =.59)
*The mean difference is significant at the .05 level.

Table 11 shows that the effect of family size of participants significantly differ, when compared with their post-test depression scores, across the experimental groups. The effect of family size alone was found to be insignificant (calculated F= .65) given the critical F-value of 3.11). Thus the null hypothesis was accepted.

Hypothesis Five: There is no significant gender difference in the post-test depression scores of participants across the three experimental conditions.

For this hypothesis, participants were categorized into Male and Female. The two genders contain equal number of participants, that is 16 Male and 16 Female for each of the treatment groups.

Table 11: Descriptive Statistics of Participants' Pre and Post-test Depression Scores by Gender Across the Experimental Conditions.

GROUP	GENDER	N	PRE-TEST		POST-TEST		MEAN DIFF.
			MEAN	SD	MEAN	SD	
ACTIVITY SCHEDULE	MALE	16	40.19	4.51	25.75	3.02	14.94
	FEMALE	16	39.81	3.59	26.75	4.12	13.06
	TOTAL	32	39.48	3.94	26.25	3.59	13.23
ANTICIPATION TRAINING	MALE	16	41.13	3.58	26.12	3.46	15.01
	FEMALE	16	40.75	3.97	25.94	2.18	14.81
	TOTAL	32	40.94	2.10	26.03	2.85	14.91
CONTROL	MALE	16	39.06	7.66	39.31	7.11	-0.25
	FEMALE	16	43.56	6.73	38.38	7.49	5.18
	TOTAL	32	41.76	7.08	38.84	7.20	2.92
TOTAL	MALE	48	34.79	6.54	30.40	7.97	4.39
	FEMALE	48	35.38	5.77	30.35	7.60	5.03
	TOTAL	96	40.72	6.09	30.38	7.75	10.34

The descriptive data presented above indicates that the three groups were similar before the treatment, with respective mean scores ranging between 39.48 and 40.19. At post test however, male participants in anticipation training group, with 15.01, recorded the most reduction in means followed by male participants in Activity Schedule group with mean difference of 14.94. The control group recorded insignificant reduction in the mean scores with a mean

difference of 2.92. To show whether these differences were significant, the ANCOVA results in table 12 is displayed.

Table 12: ANCOVA Results of Gender Difference in the Post-test Scores of Participants Across the Experimental Conditions.

Source	Sum of Squares	df	Mean Square	F
Model	3482.29[a]	5	580.38	23.27*
Covariate	23.67	1	23.67	.95
Exptal Condition	3353.40	2	1676.70	67.27*
Gender	.00	1	.00	.00
Exptal Cond. vs Gender	17.28	2	8.64	.35
Error	2218.21	89	24.92	
Total	94274.00	96		

[a] R^2 = .61 (Adjusted R^2 = .59)
*The mean difference is significant at the .05 level.

The results displayed above showed F to be significant at 0.05 level for the experimental conditions. F-cal 67.27 is greater than F-critical (2/89) at P < 0.05. The gender effect alone is insignificant with calculated F-value of .000 given the critical F-value of 3.94 at 1 and 89 degrees of freedom. The null hypothesis is thereby accepted and concluded that there was no significant gender effect in the post test scores of participants across the experimental conditions.

Hypothesis 6: The sixth hypothesis states that there is no significant difference in the depression scores of participants based on their birth order.

For this hypothesis, participants were categorized into five groups in the order of their birth in the family. First Born, Second Born, Middle Born, Last Born and Only Born. Middle Born consists of adolescents from third to second o the last in the family.

Table 13: Descriptive Data of Depression Scores of Participants According to their Birth Order.

GROUP	BIRTH ORDER	N	MEAN	SD
ACTIVITY SCHEDULE	FIRST BORN	4	28.75	7.81
	SECOND BORN	7	24.86	2.41
	MIDDLE BORN	12	25.42	2.78
	LAST BORN	8	27.25	2.38
	ONLY BORN	1	28.00	2.35
	TOTAL	32	26.25	3.59
ANTICIPATION TRAINING	FIRST BORN	6	27.25	4.53
	SECOND BORN	4	25.00	1.41
	MIDDLE BORN	12	26.50	1.17
	LAST BORN	8	24.88	2.30
	ONLY BORN	2	24.00	4.24
	TOTAL	32	26.03	2.85
CONTROL	FIRST BORN	3	40.67	1.16
	SECOND BORN	5	35.40	7.37
	MIDDLE BORN	18	38.11	8.16
	LAST BORN	4	43.50	4.12
	ONLY BORN	2	42.00	4.24
	TOTAL	32	38.84	7.20
TOTAL	FIRST BORN	14	30.33	7.25
	SECOND BORN	15	28.64	6.85
	MIDDLE BORN	42	31.17	8.20
	LAST BORN	20	29.55	7.69
	ONLY BORN	5	32.00	9.75
	TOTAL	96	30.38	7.75

Table 16 indicates that the mean score of the first born 30.33 (SD = 7.25), second born 28.64 (SD=6.85), middle born 31.17 (SD=8.20), last born 29.55 (SD=7.67) and only child 32.00 (SD=9.75) are close but different. To investigate

whether the differences are statistically significant, the ANCOVA test in Table 15 is computed.

Table 14: 5x3 ANCOVA Results of Birth-Order Difference in the Post-test Scores of Participants Across the Experimental Conditions.

Source	Sum of Squares	df	Mean Square	F
Model	3769.22[a]	14	251.28	10.41*
Covariate	46.77	1	46.77	1.94
Exptal Condition	2267.11	2	1133.56	46.96*
Birth Order	173.07	4	32.36	1.34
Exptal Cond. vs Birth Order	173.07	8	21.63	.90
Error	1931.28	80	24.14	
Total	94274.00	96		

[a] R^2 = .66 (Adjusted R^2 = 60)
*The mean difference is significant at the .05 level.

The computed F-value of 46.96 for experimental condition is significant. However, the effect of birth order alone was not significant (calculated F=1.34) given the critical F= 2.48 (p=0.05, df=4 and 80) which resulted in accepting the null hypothesis. It means that birth order does not affect the mild depression level of participants.

Summary of Findings

The results of this study indicate that the treatment programme was effective in managing mild depression among Nigerian adolescents. They are summarized as follows:

1. The first hypothesis tested the difference between the treatment groups and the control group. It was discovered that there is a significant difference between the post test scores of participants in the activity schedule, anticipation training and the control group. This confirmed the potency of Activity Schedule and Anticipation Training as counselling strategies in managing mild depression among Nigerian adolescents.
2. Hypothesis two investigated the difference between self-esteem and experimental conditions of participants. Findings revealed interactive effect between self-esteem and participants' experimental conditions. This supports the notion that depression and low self-esteem are two faces of the same coin. The inability to relate positively in social situations may lead to low self-esteem which leads to depression. The depression then leads to further inability to relate with others or be fully accepted in social groups which then adds to the feeling of low self-esteem.
3. Hypothesis three tested the influence of participants' socio economic status on their depression scores. The outcome revealed no significant effect. This shows that the low self-concept of participants does not

influence their "social class". It is a surprising result because adolescents from poor large families where cramped condition denies privacy, space for play and other activities have low self concept accompanied with irritability, restlessness and temper tantrum among others.

4. The fourth hypothesis tested the difference in the participants' family size and their level of depression. Findings revealed no significant difference. This finding is also unexpected because children from small family size do exhibit higher self esteem than those from large family size. This may also be attributed to the fact that children from small families must have developed their self-worth and believe in themselves that they will succeed in life irrespective of their condition of birth and the size of their family.
5. Hypothesis five investigated gender effect on the mean performance of participants across the three experimental conditions. Findings revealed no significant difference in participants' gender across the experimental conditions.
6. The last hypothesis tested the effect of participants' birth order on their depression scores. The outcome showed that birth order does not influence the depression level of participants. This is another unexpected result as the family, especially the parents, consciously or unconsciously treats their children differently in terms of love, care, affection, encouragement, communication and discipline. Not only is it important for a child to feel that he/she is important in the eyes of his parents, it is also important that the child does not feel that his parents favour other siblings over him. Preferential or unequal treatment of children by parents can result in adjustment problems for the child.

CHAPTER FIVE

DISCUSSION; CONCLUSION AND RECOMMENDATIONS

Discussion of Findings

Assessing the difference in the post-test depression scores of participants across Activity Schedule, Anticipation Training and Control groups.

The finding of the hypothesis is that there is a significant difference in the post-test depression scores of participants across Activity Schedule, Anticipation Training and Control groups. This is expected because of the efficacy of activity schedule and anticipation training strategies. This outcome agrees with Kahn (1995) who stated that reinforcement operations basically involving an environmental event or stimulus consequence that is contingent upon a particular response and whose occurrence increases the probability that the response will occur again.

The result is also in line with the one reported by Lewinson and Graf (1973) that both Activity Schedule and Anticipation Training strategies have been found to have significant effect on the treatment of depression generally. The outcome is also in agreement with Fritz (1995) when he stated that while depression can be a debilitating condition, successful treatment rate is encouragingly high. This is

because as many as eighty five and ninety five percent of depressives who seek treatment get better.

Assessing the influence of self-esteem on the depression scores of adolescents across the experimental conditions.

The findings of the second hypothesis that there is a significant interaction effect on depression score of adolescents due to self esteem and Activity Schedule, Anticipation Training and Control groups confirms the fact that the way a person feels about himself is also affected by how he thinks others view him. This view agrees with Zervas & Sherman, (1994) when they stated that phenomenological theory posits that children's self-perceptions are affected by the way significant others treat them. The result is also in line with the fact that low self-esteem and depression maintain a symbiotic relationship. An improvement in one will result in the improvement in the other.

This result also confirms the views of Becks (1967) when he was discussing the loss of self-evaluation as a common characteristic of depression. He viewed it as part of the depressed person's pattern of viewing himself/herself as deficient in those attributes that are specifically important to him in the area of ability, performance, intelligence, health, strength, personal attractiveness, financial resources and popularity. This symptom, which according to Beck (1967) was reported by eighty-one percent of the depressed group and by thirty-eight percent of the non-depressed, is often a sense of deficiency which is expressed in terms such as " I am inferior". At times, the sense of deficiency may be reflected in complaints of deprivation of love or material possessions especially with people who have had an unhappy love affairs or financial difficulties.

The outcome also agrees with Osarenren et.al. (2008) when they claimed that one's self-esteem affects several aspects of one's life. Depression and low self-

esteem may be viewed as a vicious cycle. The inability to relate positively in social situations may lead to low self-esteem which leads to depression. The depression then leads to further inability to relate with others or be fully accepted in social groups which then adds to the feelings of low self-esteem (Davila, et. al, 1995).

This result also supports Wylie (1961) and Osarenren et. al. (2008) when they claimed that the idea that there is some relation, under certain conditions, between self-regard and socio-metric status, i. e. that high self-regard will lead to better ability to get along with others, and that acceptance by others will maintain or enhance self-regard. This indicates that a person's self-esteem is related to how that person relates with others. Studies have also shown that high self-esteem is significantly associated with lower incidence of depression sign (Wylie 1961 as reported in Osarenren et. al. 2008).

Assessing the difference in participants' depression scores due to their social-economic status.

The third hypothesis confirms an insignificant difference in depression level of participants due their socio-economic status. This is surprising in that the disadvantages in low socio-economic status class are fertile ground for low self-esteem and depression. The finding disagrees with the view of Olayinka, (1995) who cited low self-concept and low self-esteem as some of the major characteristics among youths of lower socio-economic status. The result agrees with Odunukwe (2008) when she asserted that there is a high positive correlation between the financial situation in the home and the kind of opportunities provided for the child, regardless of the methods used in raising them. According to her, the values and practices of child rearing vary substantially with the family's class.

The result here is against the views of Oseni, (2008). She stated that "it follows logically that when one has a poor educational background; one has limited chances of adjusting well in class and may most likely end up in the lower socio-economic class". She stated further that educational opportunities are not fully dependent on the basis of intelligence. It is useful to remember that, those children, who attended poor primary and secondary schools do not do so necessarily because they are intellectually inferior. It is rather that they were not given the same social and educational advantages because of the social position of their families.

The finding of this hypothesis disagrees with the views of Odunukwe (2008) who stated that parents in the lower class show less warmth to their children because of the stress of living in a non-conducive environment. She stated further that lower class parents tend to see themselves more as autocrats than as participants in the "family's democratic process". Olayinka (1995) stated that the socio-economic status of the family into which a child is born affects it. He cites low-concept and low self-esteem as some of the major characteristics among youths of lower socio-economic status. The type of foods the mother eats at prenatal stage and antenatal care she received affect the overall health of the child. He stated further that weight is an index of nutrition. Infants from poor homes usually weigh less and are shorter than those from rich homes. He is of the opinion that speech may be delayed if the child lives in a home where there are few play things. What these assertions mean is that the environment a child finds himself determines the adjustment pattern of the child, especially during adolescence.

Assessing the difference in participants' family size and their depression level Across the Experimental Groups.

Findings of the fourth hypothesis, which shows an insignificant effect of participants' family size on their depression level, is surprising because one expects adolescents from small families to exhibit higher level of self-esteem than those from large family size. The result disagrees partly with the findings of Falbo & Polit (2006) in Osarenren et.al. (2007) where they stated that children from small families have warmer relationship with their parents than children from larger families but found no significant difference in the level of self-esteem of children from both small and large families.

This view is against the views of Okoli, (1993) when he, in National Child Development Study, highlighted the handicap effects of large families on the child. This handicap according to him starts from birth and affects not only the physical, but also the psychological and educational development of adolescents. Adolescents in small sized families have an averagely high self concept while those in large sized families have low self concept. He went further that stress and hardship are magnified in families with large number of children. Cramped condition which denies privacy, space for play and other activities readily leads to irritability, restlessness and temper tantrum.

The result also disputes the views of Oseni (2008) when she stated that Children from the lower class are raised in conditions of great restrictiveness. Control is more directly exercised. Both parents probably work and everyone must contribute to keep the family functioning. Resources are scarce; nothing must be wasted. There can be little room for innovation or risk-taking, following set patterns is safer. Also in large lower-class families, there is less time available for adults who put in long, hard hours of manual labour to be guides to their children or to allow them to experiment. A tight command seems to be the best way to manage such household. The father is used to taking orders from his

superior; this is the model he uses at home to run his family, and this is the relationship that will characterize his son's activities if he follows his father's footsteps. This authoritarian style may be counterproductive for adolescent's adjustment in school. Adolescents are expected to be responsible, independent and to take initiative.

Assessing significant gender difference in the post-test depression scores of participants across the three experimental conditions.

Hypothesis five which stated that there is no significant gender difference in the post-test scores of participants across the three experimental conditions was accepted. The hypothesis was tested using analysis of covariance.

As shown in the analysis, male participants in the anticipation training group with 15.69 recorded the most reduction in mean followed by male participants in activity schedule group with a mean difference of 14.94. However, when the main post-test scores of both gender were compared, female participants had a lower mean post-test score than the males. The calculated F value of .000 as shown in table 12 was found to be insignificant.

The result disagrees with Nystul (1995) who found out that girls have higher self-concept than males; have a more positive feeling about their identity than males and have less basic personality defects and weaknesses with less tendency to avoid reality than males.

The result is against the views of Coleman & Hendry (1990) when they concluded that. "…. Although it has not been shown that these behaviours trigger depression, it may be that screening for substance abuse and other behaviours in teens may provide enough information to the health care provider to also warrant screening for depression, particularly for girls," "Both substance

abuse and sexual activity may alter a girl's social context, which could induce stress and or change self-perceptions which could contribute to depression. In addition, there may be differences in how boys and girls physically respond to substance abuse that help explain the gender differences".

Assessing the significant difference in the depression scores of participants based on their birth order.

The sixth hypothesis, which states that there is no significant difference in the depression scores of participants based on their birth order, was tested with analysis of co-variance. The calculated F value of 1.340 is insignificant leading to accepting the hypothesis and the conclusion that there is no effect of birth order on the level of depression of the participants.

The result is against the views of Odunukwe (2008) who stated that the personalities of the oldest, middle and youngest children in the family are likely to be different because of the distinctive experiences that each child has as a member of a social group. The first child always feels dethroned with the arrival of the second child. He may start hating people, protecting himself against sudden reversal and may also develop feelings of insecurity. She concludes that while the youngest child is spoilt because of over pampering, neurotics, criminals, drunkards and introverts are often first born children.

The finding is also contrary to the views of Falbo & Polit (1986) when they claimed that first-borns and children from small families …… have warmer relationship with their parents than later-borns and children from large families. According to them, first-born children and children from small families tend to receive more individual attention from their parents than later-born children and children from large families.

The finding agrees with the views of Uruk & Demir (2003) which claims that from infancy through the pre-school years, most studies find few differences between boys and girls in overall mental and motor development, or in specific abilities.

Conclusion

In summary, the findings of this research work confirm the effectiveness of Activity Schedule and Anticipation Training as counselling strategies in managing mild depression among Nigerian adolescents.

Activity Schedule used in this study entails restoring an adequate schedule of positive reinforcement for the depressive by altering the level, the quality and the range of his/her activities and interactions. This could be in form of reinforcement given not only continuously after each response but intermittently on various schedules in terms of time intervals that must elapse before reinforcement or in terms of the number of responses per reinforce or ratio schedules.

In Anticipation Training, the researcher emphasized the deliberate anticipation of positive consequences by a depressive to alleviate the gloomy attitude and lighten the sad mood.

Most researches had focused mainly on the causes of poor academic performances and maladaptive behaviours but there have been very few studies reporting the effect of treatment techniques on the adjustment of adolescents in schools. This study attempts to fill this gap.

Through the findings, it can be concluded that Activity Schedule and Anticipation Training strategies employed in this study are psycho-therapeutic techniques that

are potent in addressing mild depression among adolescents complementing or serving as alternative to antidepressants.

On the basis of the findings of this study it is concluded that Activity Schedule and Anticipation Training strategies are effective in the management of mild depression among adolescents. Depression level of adolescents can be attributed to their socio-economic status, gender family size and birth order. Therefore, it is hereby recommended that:

Parents should be observant of depression symptoms in their children and seek treatment if the symptoms persist. This is because depression is often mistaken in the Nigerian adolescents' population with low academic performance, hallucinations, somatic symptoms and lately, kidnapping/terrorism being common features. Adolescents should be self-conscious. They should note and act on any change in their mood that persists and become uncontrollable.

Responsibility lies on all agencies responsible and concerned with adolescents' personality development and behavioural maladjustment to initiate programmes that will change distorted thoughts and irrational beliefs in adolescents.

Activity Schedule and Anticipation Training strategies should be used as a preliminary step in the treatment of depression, to be followed by specific interventions geared towards the particular needs of each client.

Implications for Counselling

This study clearly points out the impact of Activity Schedule and Anticipation Training as counselling strategies in managing mild depression among Nigerian adolescents. The strategies exposed the roles of psycho-therapy on emotion and essentially in behaviour. This indicates clearly the importance of assisting adolescents to recognize and change irrational beliefs, negative attitudes through

reflection and thinking. It was obvious that all the participants in the treatment groups improved more than the control group.

The research work has implications for both the parents, teachers and guidance counsellors. The fact that many depressives do not do well in their studies shows that they must be assisted to get out of their "confinement". This can be done through academic or behavioural counselling. Guidance counsellors have major roles to play in dealing with depressed adolescents in order to stimulate their intrapersonal/interpersonal development and academic achievement.

Counsellors can also help to sensitize teachers on the change an adolescent is going through and the implications of such. Teachers may need to be mindful of or change their choice of words, or to adapt the curriculum and classroom resources to include various family types; group counselling could be organized to benefit depressed children. Counsellors need to train the adolescents in their schools' assertive training, self-confidence, self-concept, effective social and interpersonal skills to be able to help them when faced with difficult situations.

Counsellors will serve as medium of enlightenment and orientation to people on the importance of home stability and socialization as a prerequisite for proper adjustment in school.

Counsellors are interested in prevention rather than finding solutions. They must therefore be conversant with the techniques used in this study, Activity Schedule and Anticipation Training to assist adolescents in their personal and academic pursuit.

Furthermore, counsellors should be aware of the nature of adolescents and their characteristics to be able to effectively counsel them on the need to behave

within the acceptable norms of the society. When the need arises, counsellors should be able to handle problems which are associated with adolescents.

There is the need to introduce various counselling techniques, like the ones used in this study, into the curriculum of counsellors in training. Many practicing counselors have little knowledge of current behaviour modification techniques such as Activity Schedule and Anticipation Training. If they are ignorant of these techniques, how can they apply these to improve on the adjustment of people with psycho-social problems in schools? It is therefore suggested that counsellors should be exposed to in-service-training or workshops periodically in order to update their knowledge in various counselling techniques.

The above is in line with one of the requirements of a counsellor given by Olayinka (1987) that "The tenth requirement is that it should be developed in the counsellor, a specific knowledge concerning various types of treatment facilities, methods of proper referral and a sense of obligations to work in the community to meet the needs for such facilities".

It is thus critical that counsellors redefine their roles as systematic change agents whose responsibilities go beyond traditional tasks related to educational assessment and career development but also in emotional and academic therapeutic interventions.

Counsellors should be able to help participants to take a honest look at themselves, become aware of personal potentials and weaknesses, consider alternatives in the light of existing facts and information to make decisions. Counselling should aid growth, independent thinking and self-reliance. It should allow clients to explore personal feelings, motivations, experiences and relate them to personal behaviour.

This study has demonstrated that counsellors could help in the process of guiding and counselling adolescents to select right and appropriate social values, operate right type of perceptions for success and successful living.

The study focused on adolescents because of the vital position they occupy in the society as the prominent future leaders. They therefore have right to accurate information, counselling, helps, education, health services and supportive environment for proper development. Adolescents left without adequate support may turn to risky behaviours like drug addiction, cultism, aggression, armed robbery, kidnapping and other vices. Omoegun (2001) posits that 70% of convicted and incarcerated prisoners in Nigeria prisons for social vices are adolescents.

Provision of adequate counselling services in the society today will enhance the upright turning and restoration of pro-social values. Counsellors should thus, be flexible as much as possible in fostering adolescent's adjustment to specific situations as needed and necessary.

Conclusively, Counselling Association of Nigeria (CASSON) in conjunction with the government both at the Federal and State levels with all Non-Governmental Organizations (NGOs) working on children and adolescents' development should intensify their efforts on improving the affective and cognitive needs of adolescents for better and goal oriented behaviour. Only this will bring about sustainable individual, national stability, productivity and rebranding.

Recommendations

On the basis of the findings of this research work, the following recommendations are made:

1. Counsellors in training should be introduced to the practice of Activity Schedule and Anticipation Training strategies which should be introduced into the curriculum of the trainers. It is very crucial as on completion of their courses some of them will in most cases be placed in charge of people with psycho-social problems and will benefit from having access to the operation of the two treatment strategies.
2. State governments, in particular Lagos State Government, should endeavour to include at least a trained counsellor in each of her secondary schools and other educational institutions. If this is effected, adolescents with psycho-social problems in these institutions will have specialists who will assist them to adjust their anti-social behaviours.
3. State Governments, in particular Lagos State Government should make provision for counsellors and social workers to attend refresher courses or workshops where they can update their knowledge on current effective treatment techniques.
4. All schools should be encouraged to launch guidance and counseling units which should be manned by qualified Guidance Counsellors. The presence of counsellors in schools will go a long way in reducing the rate of maladaptive behaviour in schools.
5. Parents/teachers should adequately reward their wards and students' success and see that their failures are effectively corrected. From the psychological point of view, motivation is vital in anything one does including academics. Therefore students should be well motivated to learn and be reinforced when the performance is satisfactory. Their activities should be appropriately scheduled for optimal performance. This is because the future of the country depends on the wellbeing of these

adolescents and therefore in the ability and willingness of parents and non-parents to provide for them.

6. The school authority should make sure that the emotional tone of the school is cordial and conducive for learning. This could be attained if the authority could make sure that there is peaceful and harmonious co-existence between teachers and the school heads and among the teachers and the students
7. Students should develop positive attitude to learning and should also develop positive attitude towards life as to make life meaningful; they should think logically and be rational in behaviour with full concentration on their studies.
8. Early counselling intervention is recommended for secondary school students. Possibly, necessary data could be collected during the school's orientation programme, thus, orientation becomes a mandatory exercise in schools.
9. There may be the need for counsellors to initiate family and parents based interventions. The approach should focus on educating and helping parents to understand child development and other factors that contribute to maladjusted or disordered behaviour. The programme can be initiated at all levels of schooling and can fit-in into the PTA programme. The earlier these family-based interventions begin, the more effective they will be in reducing irrational values and also help in attending to the issue of generational gap syndrome that is increasingly rubbing on parents' sense of control and feelings of parental efficacy. It will go a long way in producing well cultured, success oriented adolescents within amiable environment.

10. Finally, it is essential to strengthen adolescents' competencies, foster their thinking abilities and guide them by directing them toward the implementation of realistic achievements and achievable behavioural objectives. There should be general understanding that young people struggling to become social beings and unique individuals at the same time are in particular need of the various form of social support

Suggestions for Further Study

In view of the experience gained by the researcher in this study, the following suggestions are recommended for further study:

1. There is the need for replication by other interested researchers. As earlier stated not many studies have been carried out in the area of managing depression using psychological methods aside antidepressants.
2. Studies could also be carried out to compare the response of men and women to the psychological treatment of depression.
3. Apart from the above, a research could be carried out using more than two experimental groups to see which would be most effective with Nigerian adolescents.
4. There is the need for further research that would cover a larger area of the country and if possible, draw samples from each geo-political zone in the country.
5. On the basis of the scope and limitations of this study, future researches should endeavour to replicate the study in other states or geo-political zone of the federation, and if possible use a larger sample to have a wider scope and more reliable generalization.

6. There may also be the need to use 'out-of-school' adolescents for similar study or use the 'in-school' adolescents as control group to the 'out-of-school' adolescents or vice versal.
7. There may be the need to use more than one psycho-social problem at a time for such study. This may provide more extensive therapy for wider understanding and specific data results for ease of generalization.
8. More work is needed to determine the long-term effects of Activity Schedule and Anticipation Training strategies used in this study, their applicability to adolescents from varying background and ethnic groups.
9. Depression could be caused by so many factors; research works are needed in this area to address the causes as much as possible.

Contributions to Knowledge

1. Activity Schedule and Anticipation Training Strategies could be used as preliminary steps in the management of mild depression among adolescents.
2. The study demonstrated that depressive symptoms in adolescents can be identified through the use of assessment instruments.
3. This study is peculiar in that few studies had hitherto been carried out in the area of adolescent depression in the school context. Findings from the study will assist in reducing the incidence of low academic performance of the students.
4. The study highlighted the importance of scheduling of activities and position anticipation of life events in fostering overall development of adolescents.
5. The study has corroborated the importance of scheduling of activities and positive anticipation of life events. These two constructs are important to the overall development of the adolescent. Teachers, counsellors and

parents can fashion out academic tasks in such a way that adolescents would not be confused and frustrated.

6. Cognitive restructuring and anticipation training can be employed to alleviate adolescents' negative thoughts, self verbalization and self-defeating beliefs.

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APPENDIX 1

Self-rating Depression Scale (S D S)

Name…….. Sex…….. Age …….. Date……

Instruction:

Below are twenty statements. Please rate each using the following scale

1. = A little of the time
2. = Some of the time
3. = Good part of the time
4. = Most or all of the time

Please record your rating by **SHADING** the appropriate number to the right of each statement has described how you feel now.

1. I feel down-hearted, blue and sad …… 1 2 3 4
2. Morning is when I feel the best …….. 1 2 3 4
3. I have crying spells or feel like it …….. …… 1 2 3 4
4. I have trouble sleeping through the night …….. 1 2 3 4
5. I eat as much as I used to ……1 2 3 4
6. I enjoy looking at, talking to, and being with attractive girls/boys …… 1 2 3 4
7. I notice that I am loosing weight …… 1 2 3 4
8. I have trouble with constipation …… 1 2 3 4
9. My heart beats faster than usual …… 1 2 3 4
10. I get tired for no reason …… 1 2 3 4
11. My mind is as clear as it used to be …… 1 2 3 4
12. I find it easy to do the things I used to …… 1 2 3 4
13. I am restless and can't keep still …… 1 2 3 4
14. I feel hopeful about the future …….. 1 2 3 4
15. I am more irritable than usual …… 1 2 3 4

16. I find it easy to make decisions 1 2 3 4
17. I feel that I am useful and needed 1 2 3 4
18. My life is pretty full 1 2 3 4
19. I feel that others would be better off if I were dead 1 2 3 4
20. I still enjoy the things I used to do 1 2 3 4

APPENDIX II

DEPRESSION INVENTORY (DI)

NAME ..... AGE ..... SEX .....
FAMILY SOCIO-ECONOMIC STATUS ..... (HIGH, MEDIUM, LOW)
NO OF CHILDREN IN MY FAMILY ..... MY BIRTH ORDER.....BORN (1ST, 2ND, MIDDLE, LAST, ONLY)

INSTRUCTION: This questionnaire is designed to know how you feel in order to be able to help you overcome your feelings. Tick (√) the statement in each group which you think best describes the way you feel today.

A

0. I do not feel sad.
1. I feel sad.
2. I am sad all the time and I can't get out of it.
3. I am so sad that I cannot stand it.

B

0. I am not particularly pessimistic or discouraged about the future.
1. I feel discouraged about the future.

2a. I feel I have nothing to look forward to.

2b I feel that I won't ever get over my troubles.

3 I feel that the future is hopeless and that things cannot improve.

C

0 I do not feel like a failure.

1 I feel I have failed more than the average person.

2a I feel that I have accomplished very little that is worthwhile or that means anything.

2b As I look back on my life all I can see is a lot of failures.

3 I feel that I am a complete failure as a student.

D

0 I am not particularly dissatisfied.

1a I feel bored most of the time.

1b I do not enjoy things the way I used to.

2 I do not get satisfaction out of anything anymore.

3 I am dissatisfied with everything.

E

0 I do not feel particularly guilty.

1 I feel bad most of the time.

2a I feel quite guilty.

2b I feel unworthy particularly all the time now.

3 I feel as though I am worthless.

F

0 I do not feel I am being punished.

1a I have a feeling that something bad may happen to me.

1b I feel I am being punished or will be punished.

3a I feel I deserve to be punished

3b I want to be punished.

G

0 I do not feel disappointed in myself.

1a I am disappointed in myself.

1b I do not like myself.

2 I am disgusted with myself.

3 I hate myself.

H

0 I do not think I am any worse than anyone else.

1 I am critical of myself for my weaknesses or mistakes.

2 I blame myself for my fault.

3 I blame myself for any thing bad that happens.

I

0 I do not have any thoughts of harming myself.

1 I have thoughts of harming myself

2a I feel I will be better off dead.

2b I feel my family will be better off if I died.

3a I have definite plans about committing suicide.

3b I would kill myself if I could.

J

0 I do not cry anymore than usual.

1 I cry more now than I used to.

2 I cry all the time now that I cannot stop.

3 I used to be able to cry but now I can't cry at all even though I want to.

K

0 I am no more irritated now than I ever am.

1 I get annoyed or irritated more easily than I used to.

2 I feel irritated all the time.

3 I do not get irritated at all the things that used to irritate me.

L

0 I have no interest in other people.

1 I am less interested in other people now than I used to be.

2 I have lost my interest in other people and have little feeling for them

3 I have lost all my interest in other people and I don't care about them at all.

M

0 I make decisions about matters as well as ever.

1 I try to put off making decisions.

2 I have great difficulty in making decisions.

3 I can't make any decisions at all any more.

N

0 I don't feel I look any worse than I do.

1 I am worried I am looking old or unattractive.

2 I feel that there are permanent changes in my appearance and they make me look unattractive.

3 I feel that I am ugly looking.

O

0 I can work as well as before.

1a It takes extra effort to get started at doing something.

1b I don't work as well as I used to.

2 I have to push myself very hard to do anything.

3 I can't do any work at all.

P

0 I can sleep as well as usual.

1 I wake up more tired in the morning than I used to.

2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.

3 I wake up early everyday and can't get more than five hours sleep.

Q

0 I don't get any more tired than usual.

1 I get tired more easily than I used to.

2 I get tired from doing anything.

3 I get tired to do anything.

R

0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.

2 My appetite is much worse now.

3 I have no appetite at all any more.

S

0 I haven't lost much weight, if any lately.

1 I have lost a little weight.

2 I have lost much weight.

3 I have really lost much weight.

T

0 I am no more concerned about my health than usual.

1 I am concerned about aches and pains, stomach upset or constipation.

2 I am so concerned with how I feel or what I feel that it's hard to think of much else.

3 I am completely absolved in what I feel.

U

0 I have not noticed any recent change in my studies.

1 I am less interested in my studies than I used to be.

2 I am much less interested in my studies now.

3 I have lost interest in my studies completely.

THANK YOU

APPENDIX 111

KEY TO THE ALPHABETICAL LABELS A-U

A - Sadness

B - Pessimism

C - Sense of Failure

D - Dissatisfaction

E - Guilt

F - Expectation of Punishment

G - Self Dislike

H - Self Accusation

I - Suicidal Ideas

J - Crying

K - Irritability

L - Social Withdrawal

M - Indecision

N - Body Image Change

O - Work Retardation

P - Insomnia

Q - Fatigability

R - Anorexia

S - Weight Loss

T - Apathy

U - Paralysis of Will

APPENDIX IV

Index of Self-Esteem (ISE)

Name…….. Sex……. Age ……. Date……

This questionnaire is designed to measure how you see yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can by placing a number by each one as follows:

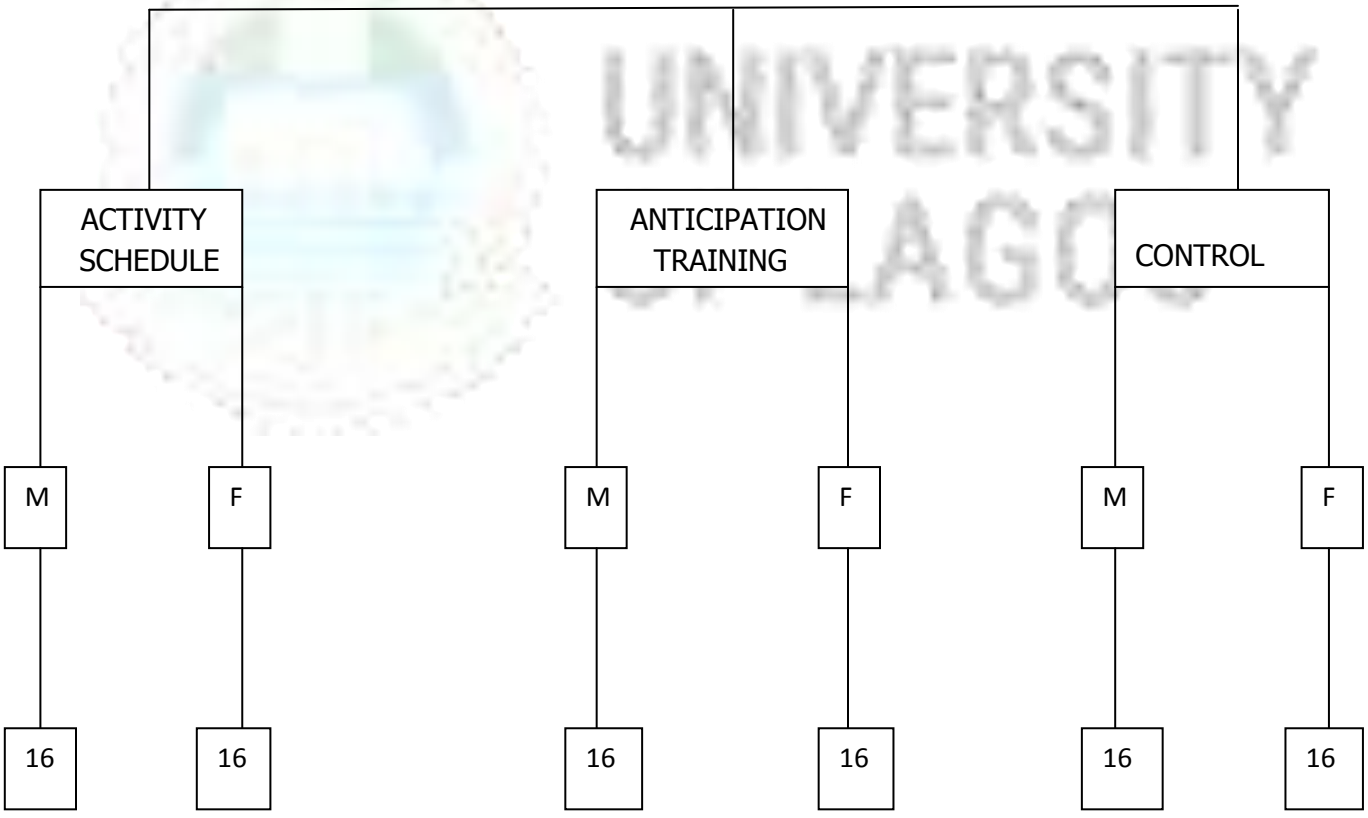
1= Rarely or some of the time
2= A little of the time
3= Some of the time
4= A good part of the time
5= Most or all of the time

…… 1. I feel that people would not like me if they really knew me well.
…… 2. I feel that others get along much better than I do.
…… 3. I feel that I am a beautiful person.
…… 4. When I am with other people I feel they are glad I am with them.
…… 5. I feel that people really like to talk with me.
…… 6. I feel that I am a very competent person.
…… 7. I think I make a good impression on others.
…… 8. I feel that I need more self-confidence.
…… 9. When I am with strangers I am very nervous.
…… 10. I think that I am a dull person.
…… 11. I feel ugly.
…… 12. I feel that others have more fun than I do.
…… 13. I feel that I bore people.
…… 14. I think my friends find me interesting.
…… 15. I think I have a good sense of humour.
…… 16. I feel very self-conscious when I am with strangers.

…… 17. I feel that if I could be more like other people I would have it made.
…… 18. I feel that people have a good time when they are with me.
…… 19. I feel like a wall flower when I go out.
…… 20. I feel I get pushed around more than others.
…… 21. I think I am a rather nice person.
…… 22. I feel that people really like me very much.
…… 23. I feel that I am a likeable person.
…… 24. I am afraid I will appear foolish to others.
…… 25. My friends think very highly of me.

APPENDIX V

GRAPHIC REPRESENTATION OF PARTICIPANTS' DISTRIBUTION



KEY

M = MALE

F = FEMALE

N = 96

DEPARTMENT OF EDUCATIONAL FOUNDATIONS

(WITH EDUCATIONAL PSYCHOLOGY)

FACULTY OF EDUCATION

UNIVERSITY OF LAGOS, NIGERIA

Acting Head of Department
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16th September, 2008

TO WHOM IT MAY CONCERN

This is to confirm that **BAMIDELE, Emmanuel Olasupo** with Matriculation **No. 2090034017** is a Ph. D student of Guidance & Counselling, he is conducting a research on his project **"THE IMPACT OF ACTIVITY SCHEDULE AND ANTICIPATION TRAINING AS COUNSELLING STRATEGIES IN THE MANAGEMENT OF DEPRESSION AMONG SELECTED NIGERIAN ADOLESCENTS"**

It shall be greatly appreciated if you could give him the necessary assistance based on the information above.

Thank you.

HEAD
DEPARTMENT OF EDUCATIONAL FOUNDATIONS
UNIVERSITY OF LAGOS.

Rev. Fr. F.M. Isichei, OP Ph.D

STUDY SAMPLE DISTRIBUTION

Education Districts in Lagos State and the two schools were the study was done are;

DISTRICT 11

- Maryland Senior Grammar School, Maryland.
- Immaculate Heart Senior Secondary School, Maryland.

DISTRICT III

- Ebute Elefun Senior High School, Lagos.
- Hope High School, Lagos.

DISTRICT IV

- Eric Moore Senior High School, Surulere.
- State Senior Grammar School, Surulere.