INFLUENCE OF DEPRESSION ON ACADEMIC PERFORMANCE AMONG SECONDARY SCHOOL STUDENTS IN KADUNA STATE, NIGERIA

BY

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MED/EDUC/47505/2012-2013

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DECLARATION

I declare that this thesis titled Influence of Depression on Academic Performance among Secondary School Student in Kaduna State Nigeria is written by me under the supervision of Dr. M. I. Abdullahi and Prof. Sani Sambo of the department of educational psychology and counseling. This thesis has not been written or submitted for the award of any degree to the best of my knowledge. All sources of publications and other related literature cited in this research are duly acknowledged.

_____ _____

Jamila Aliyu SULEIMAN **Date**
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CERTIFICATION

This thesis titled "Influence of Depression on the Academic Performance among Secondary School Students in Kaduna State, Nigeria", written by Suleiman Jamila Aliyu meets the regulations governing the award of degree of Masters in education (M.Ed.) in Guidance and Counseling of Ahmadu University, and is approved for its contribution to knowledge and literacy presentation.

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DEDICATION

This work is dedicated to my beloved children Zahra, Iman and Abba who gave me the will, strength and the zeal to carry on with this programme, my husband Dr Aliyu Muhammed and to my parents Late Alh. Suleiman Aboki and Haj. Fatima Aboki.

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In the name of Allah, most beneficent, most benevolent, and most merciful, all adorations, praises, and eulogies belong to Allah, the Omnipotent and the Nourisher of the world. May the peace and blessings of Allah be upon the prophet, his household, his companions, and those who follow his path until the day of resurrection.

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TABLE OF CONTENTS

Title Page ii

Declaration iii

Certification iv

Dedication v

Acknowledgments vi

Table of contents viii

List of Tables xi

Abbreviations xiii

Operational definition of terms xiv

Abstract xv

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study 1

1.2 Statement of the Problem 5

1.3 Objectives of the Study 6

1.4 Research Questions 7

1.5 Hypotheses 8

1.6 Basic Assumptions 8

1.7 Significance of the Study 9

1.8 Scope and Delimitation of the Study 10

CHAPTER TWO: REVIEW OF RELATED LITERATURE

2.1	Introduction	12
2.2	Concept of Depression	12
2.2.1	Prevalence of Depression	28
2.2.2	Symptoms of Depression	28
2.2.3	Forms of Depression	30
2.2.4	Depression and Suicide	31
2.3	Causes of depression	32
2.3.1	Women and Depression	34
2.3.2	Men and Depression	39
2.3.3	Depression and the adolescent girl	41
2.3.4	Depression and Home background	41
2.3.5	Depression and Age	43
2.4	Concept of Academic Performance	44
2.5	Depression and Academic Performance	47
2.6	Theoretical Framework	48
2.6.1	Interpersonal Theory	48
2.6.2	Rational Emotive Behavioral Theory	53
2.6.3	Cognitive Behavioral Theory on Depression	59
2.6.4	Academic Performance Theory	64
2.7	Review of Empirical Studies	71
2.8	Summary	77

CHAPTER THREE: METHODOLOGY

3.1	Introduction	79
3.2	Research Design	79
3.3	Population	79
3.4	Sample and Sampling Technique	80
3.5	Instrumentation	81
3.6	Validity	83
3.6.1	Pilot Testing	83
3.7	Reliability	84
3.8	Procedure for Data Collection	84
3.9	Procedure for Data Analysis	85

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1	Introduction	86
4.2	Distribution of Respondents by their Bio Data Variables	87
4.3	Testing of Hypotheses	88
4.4	Summary of Major Findings	94
4.5	Discussions	95

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1	Introduction	99
5.2	Summary	99
5.3	Conclusion	102
5.4	Contribution to knowledge	103
5.5	Recommendations	104
5.6	Suggestions for Further Studies	104
	References	106
	Appendices	123

LIST OF TABLES

Table 3.4.1	Showing the distribution of respondents by zones, schools, and number	80
Table 4.1:	Distribution of respondents by their bio-data	86
Table 4.2.1:	Showing Pearson Product Moment Correlation between depression and academic performance among secondary school students in Kaduna State	87
Table 4.2.2:	Showing Pearson Product Moment Correlation between depression and academic performance among male secondary school students in Kaduna State.	88
Table 4.2.3	Showing Pearson Product Moment Correlation between depression and academic performance among female secondary school students in Kaduna State.	89
Table 4.3.3	Analysis of Variance statistics showing the difference in the academic performance of depressed secondary school students of different age bracket in Kaduna State.	90
Table 4.3.3	Scheffe Post Hoc statistics showing the difference in the academic performance of secondary school students of different age bracket in Kaduna State.	91
Table 4.3.4	Analysis of Variance statistics showing the difference in the academic performance of secondary school students of different home background in Kaduna State.	92
Table 4.3.4	Scheffe Post hoc statistics showing the difference in the academic performance of secondary school students of different home background in Kaduna State.	92

ABBREVIATIONS

ADHD**:**	Attention Deficit Hyperactivity Disorder
AIDS:	Acquired Immune Deficiency Syndrome
BA:	Behavioral Activation
CBT:	Cognitive Behavioral Therapy
CDC:	Center for Disease Control
DSM-IV TR:	Diagnostics and Statistical Manual of Mental Health Disorder
HIV:	Human Immunodeficiency Virus
IPT-A:	Interpersonal Psychotherapy for Adolescents
OLS:	Ordinary Least Squares
PMDD:	Premenstrual Dysphoric Disorder
PTSD:	Post Traumatic Stress Disorder
REBT:	Rational Emotive Behavioral Therapy
SAD:	Seasonal Affective Disorder
SSS:	Senior Secondary School
SA:	Self Actualization
nACH:	Need for Achievement
nPOW:	Need for Power
nAFF:	Need for Affiliation

OPERATIONAL DEFINITION OF TERMS

The following terms are operationally defined as follows

Depression- is the feeling of sadness, hopelessness, and loss of self-worth, inability to handle everyday decisions, and loss of interest in regular and pleasurable activities among secondary school students in Kaduna State.

Academic performance – is seen as academic scores in mathematics and English test of SSS II Secondary School Students in Kaduna State.

Parental Marital Status – This among the secondary school is seen as the marriage status of the respondent's parents.

ABSTRACT

The purpose of this study was to investigate "Influence of Depression on the Academic Performance among Secondary School Student in Kaduna State Nigeria". Five objectives, research questions, and hypotheses guided the study. Descriptive Survey design was used to study a sample size of 777 secondary school students purposely selected from six educational zones. A close ended questionnaire and a researcher designed academic performance test were used to obtain responses from the subjects. Data collected for this study were analyzed using descriptive statistics of percentages, mean, standard deviation, and inferential statistics of Pearson Product Moment Correlation (r) and Analysis of Variance ANOVA tested at 0.05 alpha level of significance. The findings showed that significant relationship exists between depression and academic performance among secondary school student in Kaduna State, ($r = -0.723$, $p<0.05$), significant relationship exist between depression and academic performance among male secondary school students in Kaduna State,($r = -0.738$ $p < 0.05$) and also significant relationship exist between depression and academic performance among female secondary school students in Kaduna State, ($r = -0.827$ $p < 0.05$) similarly, the result showed that significant difference exist in the academic performance of students with different age bracket ($f = 11.152$ $p < 0.05$) and significant difference exist in the academic performance of secondary school students from different home background in Kaduna State ($f = 4.103$, $p < 0.05$). On the basis of the result, recommendations were made among which are; professional psychologist and counselor should render psychological interventions using cognitive behavioral techniques to counsel secondary school students who are depressed so as to help improve their academic performance. Similarly, Schools psychologist and counselor should target depression by teaching coping strategies and this should be targeted towards those female students who are at risk for depression.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The issue of academic performance among secondary school students has been a matter of great concern to educators, parents and government. Even though measures have been taken to improve the situation, a large proportion of secondary school students perform poorly. Secondary school students in recent times tend to perform below expectation in most of the internal and external examinations; this may be attributed to the influence of so many factors. For most among them is the influences of depression and host of others.

Everyone has most likely experienced a sad mood at one time or another in his or her life. A short period of sadness is not uncommon as humans struggle with the pressures of everyday life, such as financial, marital, and job difficulties. Raising children and taking care of aging parents add to the increase in people's sometimes sad moods. However, it is depression that is of significant concern in the society, today. Many adults experience depression which can result in significant health consequences and even death from suicide.

Furthermore, depression is one of the most common disorders that occur among secondary school adolescents. Depression affects 5 to 8 percent of adolescents (Son, 2000). Depression can have devastating effects on secondary school adolescents. Research indicates that depressed secondary school students are at risk for increased illness, low academic performance, difficult family and peer relations, substance abuse, and delinquent behavior (Allen-Meares, Cola Rossi, Oysterman, & DeRoos, 2003). Depression is often associated with suicide among youths and suicide is the third leading

cause of death for youth ages 15-24 in almost all parts of the world but most especially in America (McCarthy, Downes, & Sherman, 2008). The dangers associated with depression are evidence that recognizing, understanding, and treating depression are extremely important. However, while adolescent depression is common it is difficult to recognize. It is imperative that society, especially parents, educators, and mental health professionals understand what depression is (most especially among secondary school students), recognize its symptoms and its causes, as well as recognize the effects depression has on secondary school students.

Depression is an emotional state that involves feelings of great sadness, worthlessness, and guilt. The Diagnostic and Statistical Manual of Mental Health Disorders (4th ed., text revised) (DSM-IV TR) requires that five out of nine symptoms must be present for at least two weeks for a diagnosis of depression to be given. These nine symptoms include a sad, depressed mood most of the day, for most days, loss of interest and pleasure in regular activities, difficulties sleeping, lethargy or agitation, loss or increase in weight and appetite, loss of energy, negative self-concept and feelings of worthless and guilt, difficulty concentrating, and recurrent thoughts of death or suicide. The symptoms of either depressed mood or loss of interest and pleasure must be one of the five symptoms for a depression diagnosis to be made. Other symptoms include low self-esteem, and somatic complaints. Depression is a recurrent disorder and has increased steadily over the last fifty years, especially among adolescents worldwide (Davison & Neale, 2001).

Secondary school students may experience more symptoms of somatic complaints, social withdrawal, and irritability rather than a sad mood. Symptoms of

depression can also be different for secondary school students of different ages. Younger secondary school students may have symptoms of anxiety manifested in clinging behaviors, fearfulness, and physical complaints. Furthermore, research indicates that 89% of depressed adolescents usually show signs of sleep difficulty while 79.5% show appetite and weight disturbances (McCarthy, Downes, & Sherman, 2008).

Education at secondary school level should supposedly be the bedrock and sure foundation for higher knowledge in tertiary institutions. It is an investment as well as an instrument that can be used to achieve a more rapid economic, social, political, technological, scientific and cultural development in the country. The Federal Ministry of Education (2007) by emphasizing the National Policy stipulated that secondary education is an instrument for national development that fosters the worth and development of the individual for further education, general development of the society and equality of educational opportunities to all Nigerian children, irrespective of any real or marginal disabilities. The role of secondary education is to lay the foundation for further education and if a good foundation is laid at this level, there are likely to be fewer problems at subsequent levels.

Depression is a disorder that may affects secondary school students. It leads to sadness, discouragement, and a loss of self-worth and interest in their usual activities. Depression can be a response to many situations and stresses. In teenagers that are in the secondary school, depressed mood is common because of the normal process of maturing and the stress that occurs with it, which include the influence of sex hormones, Independence conflicts with parents, It may also be a reaction to a disturbing event, such as: The death of a friend or relative, breakup with a boyfriend or girlfriend, Failure at

school. Girls are twice as likely as boys to experience depression. A family history of depression also puts secondary school teenagers at greater risk. Depression in secondary school teenagers is often difficult to diagnose because normal adolescent behavior is marred by both up and down moods, these moods may alternate over a person, time or day.

The following events or situations can cause depression among secondary school students: Bullying or harassment at school or somewhere else, Child abuse - both physical and sexual, Lack of social skills, Learning disabilities, Long-term illness, Poor parenting or caregiving, Stressful life events, such as the loss of a parent to death or divorce .Many secondary school students with depression may also have: Anxiety disorders, Attention deficit hyperactivity disorder (ADHD), Bipolar disorder, Eating disorders. Depression may change the way secondary school students see themselves, their lives, and the people around them. Most secondary school students who are depressed usually see everything more negatively. They can't imagine that any problem or situation can be solved in a positive way. Depressed secondary school students may be at risk for much co-morbidity, including conduct problems, personality disorders, and substance abuse, and obesity, interpersonal conflict, failing social relationships, educational and occupational under achievement (Zalsman Brent &Weensing 2006).

Physical signs of depression in secondary school students include appearance and hygiene neglect, pale and tired appearance, sad or irritable affect, psychomotor retardation or agitation. Impaired concentration, and diminished abstract reasoning ability for their age (Jettery, 2005). According to Chen and Li (2000) depression affects academic performance of adolescents in secondary school, students with depression are

vulnerable to educational under achievement. Also using the information based on a resources allocation model of the effect of a depressed mood on cognition, students with symptoms of depression are predisposed to focus their attention on interfering, irrelevant thoughts, leaving the little sustained attention available for cognitive tasks which may then leads to academic failure (Busari & Uwakwe 2001). Frojd (2008) reported that depression impair cognitive functioning blocks cognitive sources and many of the academic performance and also homework depends on the ability to sustain attention and concentration, thus depression which is known to disrupt concentration and attention in school is likely to undermine academic performance.

Furthermore, cognitive risk factors for depression in secondary school students may include elevated level of anxiety, low self-esteem, high self-criticism, cognitive destructions, poor school performance, and social skills deficient (Bearly & Beardslee, 1998). Depression as a mood disorder may affect a person's ability to perform life activities including academic performance (Hysenbergasi, Hass & Rowland 2005). It is common for people who suffer from depression to engage in self-blame, experience confusion and a feeling of hopelessness.

1.2 Statement of the Problem

Depression and other affective disorders continue to be an area primarily ignored by the public schools. Countless number of secondary school students may be affected by depression which may also affect academic performance. Depressed students often result in having other behavioral problems like skipping school which may result in poor academic performance. Also secondary school students that are depressed are usually

hopeless, have concentration ability difficulty and pay less attention in class and their studies in general and thus may low performance.

Depression has a great effect on students' age and to a large extent students' academic performance, is a well-known fact that there is a certain period in student development that they tend to learn faster and whatever they learnt are permanently stamped in their memories. Similarly, there are certain periods in one's life that the rate of learning tends to decline that is to say the rate of assimilation is slow, and as such students who are young and depressed may tend to have low academic performance and those who are older may even have a worst case scenario. On the influence of depression on gender, it is worth noting that the academic performance of male students may likely be higher than that of their female counterparts in some areas and vice versa. Depressed females may likely perform better than their male counterpart because female have higher impulse control than the males. Similarly, depressed secondary school students from different home background may have different educational outcome that is, student from divorced, separated and single parents are likely to have difficulties with their studies, lower literacy level and display negative attitude to school, in other words, one's educational success may depends largely on the parental marital status of his or her family. Therefore, it is important to understand the extent to which depression influences academic performance among secondary school students in Kaduna State.

1.3 Objectives of the Study

The objectives of the study are:

1. To determine the influence of depression on academic performance among secondary school students in Kaduna State.

2. To find out the influence of depression on academic performance of male secondary school students in Kaduna State.
3. To find out the influence of depression on academic performance of female secondary school students in Kaduna State.
4. To determine the differential influence of depression on the academic performance of secondary school students on the basis of age in Kaduna State.
5. To determine the differential influence of depression on the academic performance of secondary school students on the basis of their home background in Kaduna State.

1.4 Research Questions

The following were the questions this study answered.

1. What is the influence of depression on the academic performance of secondary school students in Kaduna State?
2. What is the influence of depression on the academic performance of male secondary school students in Kaduna State?
3. What is the influence of depression on the academic performance of female secondary school students in Kaduna State?
4. What is the differential influence of depression on the academic performance of secondary school students of different age bracket in Kaduna State?
5. What is the differential influence of depression on the academic performance of secondary school students of different home background in Kaduna state?

1.5 Hypotheses

The following hypotheses guided the study,

1. There is no significant influence of depression on the academic performance among secondary school students in Kaduna State.
2. There is no significant influence of depression on the academic performance of male secondary school students in Kaduna State.
3. There is no significant influence of depression on the academic performance of female secondary school students in Kaduna State.
4. There is no significant differential influence of depression on the academic performance of secondary school students of different age bracket in Kaduna State.
5. There is no significant differential influence of depression on the academic performance of secondary school students of different home background in Kaduna State.

1.6 Basic Assumptions

This study was based on the following assumptions

1. That depression may not influence the academic performance of secondary school students in Kaduna State.
2. That depression may not influence the academic performance of male secondary school students in Kaduna State.
3. That depression may not influence the academic performance of female secondary school students in Kaduna State.

4. That depression may not have differential influence the academic performance of secondary school student of different age bracket in Kaduna State.

5. That depression may not have differential influence the academic performance of secondary school students of different home background in Kaduna State.

1.7 Significance of the Study

The outcome of this study would benefit the government, school administrators, psychologist and counselors, parents, public, and students

Government: The findings of this study would be of significant importance to the government in making educational decisions; the studies would therefore provide government with evidence based data which would help in making appropriate educational decisions and to ensure the reduction of depression among students at all levels of education particularly at secondary school level. The study was also important at state level, because students were evaluated by their performance on standardized tests geared toward specific ages and based on a set of performance students in each age group are expected to meet

School administrators: Similarly, school administrators would find the findings of this study of great importance in planning school activities and curriculum to ensure that all the variable (depression) advantages and disadvantages were incorporated for a smooth school planning and administration.

Teachers: The findings of this study would expose teachers to understand how depression in particular can hamper the effort of students to achieve high academic

performance. Thus exposing them to having the knowledge of who needs more attention and why, how and when

School psychologist and counsellors: would find the findings of this study very important because they could serve as key players in depression management, gender bias issues, mediators in giving family therapy, which would in turn help improve students' academic performance.

Parents: The findings of this study would be very important to the parents who were concerned with their children's education and welfare. It would help parents to understand what they should do to minimize poor academic performance of their children and also know the symptoms and causes of depression so as to take early precaution against repeated episodes or severe depression.

Public: The findings of this study would be of immense importance to the general public who on daily basis face lots of challenges; this could be achieved if the findings and recommendations of this study would be disseminated to the public through media, conferences, workshops, and seminars.

1.8 Scope and Delimitation of the Study

This study was centered on depression and how it could influence the academic performance of secondary school student in Kaduna State. This study was also delimited to SSSII public senior secondary schools in Kaduna state and the research only used senior secondary school students in SSSII both male and female as respondents. The

study was also delimited to depression because other variables like anxiety, self -concept and stress were not included.

CHAPTER TWO:

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter is set to deal with the review of current literature related to the study. Many books, journals and magazines have been written by different authors on depression and academic performance. The review will be presented under the following sub-heading, theoretical framework, Conceptual framework, concept of depression, review of previous studies and summary.

2.2 Concept of Depression

Depression and anxiety disorders are the most common psychiatric disorders (Kessler, 2007). Depression is expected to be one of the top three leading causes of disability by the year 2030 (Mather's & Loncar, 2006). Anxiety and depressive disorders have consistently been found to be highly comorbid (Kessler, 1997, 2007; Essau, 2007) and are linked to the personality trait neuroticism (Essau, 2007; Weinstock & Whisman, 2006). In addition, there is a sequential link between early anxiety and later depression (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). Anxiety disorders include generalized anxiety disorder, social anxiety disorder, obsessive compulsive disorder, post-traumatic stress disorder and separation anxiety disorder (Evans, Foa, Gur, Hendin, O'Brien, Seligman, 2005). Depression is considered a chronic illness that requires long-term management, much like diabetes or high blood pressure. Debilitating symptoms can be relieved quickly with psychological therapies, medications or a combination of both. Adjusting lifestyle can then reduce the quantity and severity of future episodes [Bennett, 2006]. Major depression effects one in fifty school children. Countless others are affected

by milder cases of depression which may also affect school performance (Lamarine, 1995). The peak age of depression correlates with the peak years of low self-esteem. Feldman & Elliot (1990) write that the prime period for low self-esteem is early and middle adolescence with a peak period between the ages of thirteen and fourteen. A high school with a population of 2,000 students can expect 50 attempted suicides per year (Kahn, 1995). And yet depression and other affective disorders continue to be an area primarily ignored by the public schools.

One of the factors that make depression so difficult to diagnose in adolescents is the common behavior changes that are normally associated with the hormonal changes of this period (Lamarine, 1995). It has only been in recent years that the medical community has acknowledged childhood depression and viewed it as a condition which requires intervention. Historically, children were not considered candidates for depression (Whitley, 1996). Mostly because of Freudian notions about the unconscious, depression had been viewed as a condition which only affected adults. Today, childhood depression is widely recognized and health professionals see depression as a serious condition effecting both adolescents and young children (Lamarine, 1995; Whitley, 1996).

Views on adolescent depression have changed significantly even since the 1970's where childhood depression was thought to be masked by other conditions (Kahn, 1995). The debate continues, even today, as to whether other childhood and adolescent behaviors are simply "masks" for childhood depression. Fritz (1995) writes that depression may often be seen in physical ailments such as digestive problem, sleep disorders or persistent boredom. Lamarine (1995) considers that in children, depression may often be mistaken for other conditions such as attention deficit disorder,

aggressiveness, physical illness, sleep and eating disorders and hyperactivity. Although depression in children may be confused with attention deficit hyperactivity disorder (ADHD), ADHD must begin before the age of 7 (Burford, 1995).

Other writers prefer to move past the philosophy of masked depression and view adolescent depressive symptoms as similar to those of adults (Kahn, 1995; Sanford, 1996; Fritz, 1995; Rao, 1994). Students are also more likely to idealize suicide as a solution to feelings of helplessness. Adolescents may also socially isolate themselves when depressed out of feelings of guilt. Dramatic behaviors such as aggression and an obsession or fascination with death often accompany their depression (Lamarine, 1995). Secondary school student's problems that correlate with low self-esteem include depression, unsafe sex, Criminal activities and drug abuse (New model 1995). Educators and schools can be ideal scouts for depression in adolescents. Since depression may often results in lower academic performance, behavior problems, and poor socialization, schools are often the best place to observe all these symptoms (Lamarine, 1995]. Social skills deficits are harder to determine as it is difficult to find whether the inability to form good social skills causes, or results from the depression (Lamarine, 1995). Sexual orientation adjustment problems have also been linked to depression, especially in communities with strong social pressures. One of the factors that correlate with recurring depression is a negative relationship between adolescents and their fathers along with an inability of the mothers to monitor behavior (Sanford, 1996).

Depressed adolescents with a history of sexual abuse have a higher incidence of posttraumatic stress disorder, but no increase in the severity of neither depression symptoms nor tendency for suicide (Brand, King, Olson, Ghaziuddin, and Naylor, 1996).

Another factor associated with adolescent depression and negative behaviors is difficulty in establishing autonomy in the adolescent's relationship with parents. Adolescent depression is seen in higher frequency in families where the children have difficulty establishing their own identity because of negative communication patterns and other dysfunctional family attributes (Allen, Hauser, Eickholt, Bell, & O'Connor 1994).

Transition from elementary to junior high school or from junior high to senior high increases feeling of low self-esteem. Students who do not make such a change in school have a reduced incidence of low self-esteem. Unfortunately, some students, particularly females, do not recover from this low self-image in later adolescence (Feldman & Elliot, 1996). 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. 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 were unclear in their goals. While unpopular 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.

Hindering solution strategies, is the stigma that remains attached to mental health problems, especially for youth. This makes it difficult for educators to consider emotional problems as a cause for poor academic performance (Lamarine, 1995). It is important however, to recognize the signs of adolescent depression early, before the depression interferes with the child's interpersonal relationships which will ultimately affect self-esteem, depression and not willfulness or laziness. Approximately 4% to 12% of school-

aged children (depending upon their age) meet the criteria for being depressed, and since depression isn't just experienced at home, it's likely to affect a teen's performance at school. Teenagers experiencing symptoms of depression usually have difficulty completing schoolwork and are at risk for academic underachievement and failure. Without early diagnosis and treatment, a teen is likely to have a negative cycle of depression > school failure > increased depression because of the failure.

Kessler (2007) reports that the incidence of mental illness among 15 to 24-year-olds is higher than any other age range and that the average age of onset for major depressive disorder is close to 15 years of age. The Center for Disease Control reports that in the United States, approximately 6 to 9 million children and adolescents have serious emotional disturbances (U. S. Public Health Service, 2000). The criteria for a diagnosis of Major Depression are five or more symptoms including depressed mood, diminished interest and pleasure in activities, weight loss/gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, diminished concentration, and recurrent suicidal ideation. One of the symptoms must be either depressed mood or loss of interest/pleasure, and symptoms must represent a change in previous functioning and have been present for a two-week period (American Psychiatric Association, 2000).

Early onset of mental health disorders for adolescents and young adults can have long-lasting serious effects into adulthood. Developmentally, major social, emotional, physical and cognitive changes take place during this period so that even mild mental health problems can have long-term detrimental effects. As adolescents and young adults, students begin to separate from their parents and make decisions regarding peer group

affiliations, intimate relationships, and educational achievement. Depression can alter vocational choices and interrupt educational achievement that can impact individuals for the rest of their life (Kessler, Foster, Saunders, & Stang, 1995).

From cognitive theories on depression, negative belief systems contribute to the onset and exacerbation of depressive symptoms. Depressed individuals tend to make more stable, global, and internal attributions about negative events. Negative cognitive styles tend to cause individuals, when confronted by stressful events, to view the event and its consequences more negatively, increasing their chances of becoming depressed. Several cognition types have been linked to depression, such as low self-esteem, negative automatic thoughts, and cognitive distortions (Beck, 1987) attritional style (Abramson, Seligman, &Teasdale, 1978), and hopelessness (Abramson, Metalsky, & Alloy, 1989).

From the interpersonal perspective on depression, the emphasis is the individual's home environment and the importance of developing secure attachments. Secure attachments are formed when an infant's need for security, comfort and acceptance are met. Bowlby's (1982) attachment theory has become the foremost theory in understanding affect regulation especially when under stress. He believed that infants are born with an attachment behavioral system that emerged through evolution as a means to insure the survival for the infant who is completely helpless and dependent on others for food and protection. Two kinds of cues that activate the attachment system (Bowlby, 1973) are threat-related cues and detecting the unavailability of the attachment figure. Once the attachment system is activated, the distressed infant then engages in behaviors to seek and maintain proximity to its caregiver. If the caregiver is consistently responsive and supportive, the infant develops security-based regulatory strategies. However, when

the attachment figure is not supportive or responsive and the proximity seeking fails to relieve stress, a decision is made on the viableness of proximity seeking as a protective strategy and this results in the development of secondary attachment strategies, i.e., hyper activating or deactivating strategies (Mikulincer, Shaver, &Pereg, 2003).

If the decision is made that the proximity seeking is viable or essential, due to previous experience, hyper activating strategies are then employed. Very intense and repeated attempts are then made to gain the attachment figure's attention, love, and support. Hyper activating strategies increase the vigilance to the threat-related cues and lower the threshold for detecting cues related to the unavailability of the attachment figure. Mikulincer & Shaver, (2005) wrote that these strategies:

> *…also intensify negative emotional responses to threatening events and heightened rumination on threat-related concern, keeping these concerns active in working memory. As a result, minimal threat-related cues are easily detected, the attachment system is chronically activated, and psychological pain related to the unavailability of attachment figures in exacerbated. These concomitants of the attachment-system hyper activation account for many of the psychological correlates of attachment anxiety*. (p. 141).

This type of strategy increases the anxiety level in infants and results in higher level of anxiety/depressive (and neuroticism) symptoms later as children and adults. The other secondary attachment strategy is the deactivating strategy which is employed when the infant believes that proximity will not relieve distress and tries to inhibit his or her attempts for support. According to Mikulincer and Shaver (2005), deactivating strategies' primary goal is to:

> *…keep the attachment system deactivated in order to avoid frustration and further distress caused by attachment-figure unavailability. These strategies involve denial of attachment needs and avoidance of emotional involvement, intimacy, and dependence in close relationships. They also involve the dismissal of threat- and attachment-related cues and the suppression of threat- and attachment-related thoughts. These tendencies are further reinforced by assuming a self-reliant attitude that decrease dependence on others and discourages acknowledgement of personal faults*. (p. 151).

Security-based attachment strategies help to alleviate distress through constructive actions and builds resources for maintaining psychological health in times of stress. Security-based affect regulation consists of three main coping strategies: acknowledgment, display of distress support seeking, and engagement in instrumental problem solving. Mikulincer et al. (2003) wrote:

> *…acknowledging and expressing of feelings and seeking emotional support – work in the service of down-regulating distress so that 'problem-focused coping' components - seeking instrumental support and solving problems – can proceed successfully….The building of these constructive capacities can also inhibit the activation of other maladaptive means of coping, including ruminative and passive emotion-focused strategies, withdrawal and escapist strategies, and primitive defense mechanisms that distort perceptions and generate interpersonal conflicts.* (p. 83).

In studies of adolescents and adults, attachment styles have been conceptualized in two dimensions, avoidance and anxiety (Brennan, Clark, and Shaver, 1998). Individuals with secure attachments are low in the avoidance and anxiety dimensions and are characterized as being at ease with emotional intimacy, interdependency, and having a

reliance on support seeking and the use of constructive emotion-based and problem-focused coping behaviors when under stress.

Those who are high in either anxiety or avoidance or both are considered to have insecure attachments. In individual with an attachment avoidance style will try to stay emotionally distance and independent from partners and mistrusts relationships in general. Those high in the avoidance dimension have compulsive self-reliance tendencies and employ deactivating strategies (avoidance) to reduce stress and frustration. Individuals with insecure attachment styles who are high in the anxiety dimension have a continuous fear that an attachment figure will not be available in times of need.

Individuals in the high anxiety dimension have a fear of being rejected; they worry about relationships and have a strong need for closeness (Mikulincer et al., 2003). They will use hyper activating strategies to get support from their attachment figures (such as a partner). These strategies would include clinging and controlling behaviors to gain the attachment figure's attention, love, and support and will have overdependence on relationship partners as a source of security (Shaver & Hazen, 1993).

As a result of the attachment process, infants develop an internal model of close relationships that consist of two interrelated emotional and cognitive schemas, one about themselves and one about others. The self-model consists of one's view of one's self-worth, one's value and competence and the model of the "other" provides information regarding the trustworthiness, and responsiveness of important people in one's life. These models, once formed, remain fairly stable throughout one's life. If caretakers were unresponsive or inconsistent, insecure attachments are formed and negative working models of others and one (i.e., low self-esteem) can result.

Adolescents and young adults who have insecure attachments with their parents are more likely to be depressed (Kenny, Moilanen, Lomax, & Brabeck, 1993) and develop anxiety disorders. Secure attachments to parents are predictive of successful social, academic, personal, and psychological functioning (Bradford & Lyddon, 1993; Hinderlie & Kenny, 2002, Kenny & Gallagher, 2002; Kenny & Rice, 1995; Lapsley & Edgerton, 2002).

According to attachment theory, "one's early experiences with environments that promote feelings of security or threat result in internalized dispositions that largely determines a person's resilience and vulnerability to stressful life events" (Lopez and Brennan, 2000). Individuals with secure attachments are able to take positive steps to reduce their distress much more effectively than their more insecurely attached counterparts. Hence, securely attached individuals are better able to manage anxiety and depression, during periods of stress (Lopez & Brennan 2000).

Those with insecure attachment systems use maladaptive ways to cope when under stress resulting in a reduction in the effectiveness of dissipating their distress. The development of insecure attachment systems increases the reactivity of individuals to stress both physical and psychologically, which in turn, increases their risk for anxiety and depressive disorders and raises their level of neuroticism. Extensive research has documented the strong association of anxiety and depression with those who score high on neuroticism (Weinstock & Whisman, 2006). Individuals with high levels of neuroticism also tend to have more somatic symptoms. Somatic symptoms refer to all classes of physical complaints, including headaches, muscle tension, nausea, and respiratory difficulties (Pennebaker, 2000).

The relationship between stressful life events and depression in children and adolescents has shown a strong empirical association (Compas, Grant, & Ey, 1994). Stress is a response (subjective feeling) to the perceived demands in some situation that may be considered threatening or uncontrollable. How well one can cope with stress determines the degree, duration and frequency of a stressful event (Larsen & Buss, 2008). In addition, personality influences how one may cope with a stressful event. The transactional model shows how personality can interact with one's coping strategies in three possibly ways. Larsen and Buss writes: …(1), it can influence coping…; (2), it can influence how the person appraises or interprets the events; and (3) it can influence the events themselves….In the transactional model, it is not the event itself that causes the stress, but rather, how the event is appraised or interpreted….The third point.…is, people don't just respond to situations they also create situations through their choices and actions….the model adds two additional roles for personality in influencing whether a stress response is evoked: first, personality influences the kind of situations one encounters in life and second, personality influences how one interprets the situations one encounters…personality is thought to directly influence the relationship between stressful events and illness (Larsen & Buss; 2000).

In order for stress to occur, two cognitive events must take place: primary appraisal and secondary appraisal (Lazarus, 1991). In the primary appraisal, individuals perceive there is a threat to themselves or to their goals such as getting an A on an upcoming exam. In the secondary appraisal Larsen and Buss (2008) writes:

> *The person decides that they do not have the resources to cope with the demands of the threatening event. If either of these appraisals are absent - if the person does not perceive the event as threatening or if the person feel they*

> *have plenty of resources for coping with the threat then stress is not evoked. For example, if…an upcoming exam is perceived as threatening to someone's goals, yet they feel that…they have been studying and preparing for the exam, then the person might experience the event more as a challenge than a stress*. (p. 598)

Coping is referred to as efforts to deal with the threatening or harmful situations (Carver, 2007). Being able to cope effectively is important to mental health and well-being. Emotional-based coping and problem-based coping are two distinctions that have been made within the definition of coping (Folk man & Lazarus, 1984). Both emotional- and problem-based coping can be interrelated, such as when individuals engages in emotional-focused coping so that they can calm down and then employ problem-based coping strategies. Numbing one from a loss or a failure by using alcohol or drugs would be emotion-focused coping that would not be very effective; however, ineffective problem-focused coping can also occur. Insecurely attached individuals tend to use more maladaptive coping strategies such as those that are oriented toward avoidance of the feelings (e.g., mental disengagement, thoughts of suicide) or diverting attention (e.g., self-criticism/self-blame, blaming others). These coping styles tend to relieve stress in the short term, but increase it in the long term (Bolger, 1990).

In terms of the personality traits, neuroticism predicted problematic coping strategies like wishful thinking, withdrawal, and emotion-focused but, like extraversion, also predicted support seeking while extraversion predicted more problem-solving and cognitive restructuring. Coping responses have also been identified as either approach coping or avoidant coping. Approach coping, where the individual engages with the stress directly or indirectly and uses problem-focused or emotion-focused coping

strategies, has been linked with the trait extroversion. In avoidant coping (linked with neuroticism), the individual attempts to escape the feelings of distress, and acts as if the stressor does not exist, by using wishful thinking or even denial.

Definitions of stress include conditions where the individual feels their well-being is threatened either physically or psychologically. This can occur as an accumulation of minor negative events, or as a major event (Grant, Compas, Stuhlmacher, Thurm, McMahon & Halpert 2003). Stress can be a normal part of one's life such as transitioning to college or a relationship breakup, or it can be pathological (i.e., abuse). Evans et al. (2005) writes, "Stressful events…. may be independent of or directly related to and thus dependent on an individual's action. Objective environmental consequences of a stressor (i.e., can be reliably rated by objective observers) are hypothesized to have a direct effect on the development of depression."

Environmental stressors such as maternal or paternal deprivation, emotional, physical and sexual abuse, and the experience of loss early in life are major risk factors when controlled for heritable risk factors (Evans et al., 2005). Neurobiological processes that underlie the pathophysiology of depression can be altered as a result of early, chronic and the cumulative effects of psychological trauma. Stress has been shown to permanently change the developing brain resulting in increasing the individual's responsiveness to stress as adolescents and adults and altering the processing of emotions leading to the development of psychiatric disorders such as depression and anxiety disorders (Brenner, 2003; Sullivan, Wilson, Feldon, Yee, Meyer, Richter-Levin, 2006).

Researchers use tests of cortisol levels to determine the level of stress an individual is experiencing. Higher levels are associated with behavioral inhibition or

withdrawal (Davis, Donzella, Krueger, & Gunnar, 1999; Gunnar & Donzella, 2002). Stress during pregnancy is related to higher cortisol levels and greater cortisol reactivity among adults (Reynolds, Walker, Syddall, Wood, Phillips, & Whorwood 2001). Insecure attachments formed with caregivers results in elevated cortisol levels in children (Sullivan et al., 2006). Essex, Klein, Cho, & Kalin (2002) found that maternal stress while the child was in infancy highly correlated with elevated levels of cortisol at age four. Higher cortisol levels were also reported in children whose mothers were depressed as infants (Lupien, King, Meaney, & McEwen, 2000).

Other research showed that for children and adolescents whose mothers were depressed there were higher levels of withdrawal emotions such as sadness, anxiety and fear (Halligan, Herbert, Goodyer, & Murray, 2004) and increased risk of depression in adolescents (Goodyer, Herbert, &Tamplin, 2003). It is theorized that the depressed mother of an infant is less able to provide sensitive, supportive and responsive care (secure attachment) to the infant, thus adversely altering the development of the neurobiological system that then increases the risk for depression for adolescents and adults. Studies have shown that prolonged activation of neural and hormonal responses to stressors elevates the anxiety set point and makes individuals more reactive to stress (Bremner, 2003; Sullivan et al., 2006). In addition, animal studies have shown that the expression of genes in brain regions that regulate stress reactivity can be turned on or off as a result of the maternal care in the first week of life (Caldji, Diorio, &Meaney, 2003; Francis, Diorio, Liu, &Meaney, 1999). Thus, the way infants respond to stress is in a large way influenced by their caretaker (Rapee, 1997). Therefore, early child

environmental events influence and increase the risks for higher levels of anxiety and depressive disorders (Evans, 2005).

The effects of stress cause physiological changes in the body by affecting the sympathetic nervous system and the hypothalamic-pituitary-adrenal cortical axis (Allen, 1995). Even adults who have repeated or prolonged activation of these systems are at risk for developing psychiatric disorders. An individual instinctively has two choices when faced with a threat – commonly referred to as fight or flight (actually, there is a third option that is referred to as freezing). As the body readies itself for fight or flight (rage or fear), it sets off hormones from the adrenal glands into the blood stream. This physiological activation helps to create and perpetuate the feelings of anxiety even though the neocortex (thinking part of the brain) knows the danger has passed. Anxiety is a state of high arousal, a state of readiness to cope (take flight), of feeling agitated, distressed, and upset and is an example of high negative emotion. Depression is a state of low positive emotion; of giving up the attempt to cope. This has the absence of excitement or pleasure, a general disengagement from the world, low arousal, and can be experienced as lethargy or lack of energy, lack of interest in doing anything or lack of drive. Anxiety is often followed by depression as chronic anxiety wears down an individual's system (Allen). Allen notes:

> *Anxiety has been associated with feeling helpless – not knowing what to do or which way to turn. Depression can be characterized as a state of hopelessness – a sense that nothing can be done, that no effective action can be taken... Depression has been described as an inborn 'conservation-withdrawal reaction' that serves to shut down arousal to avert the excessive stress to the organism associated with prolonged agitation.* (p. 62-63).

Students also come to college with other experiences that have caused severe anxiety or depression in their lives. It's estimated that 50 - 60% of the population has experienced a potentially traumatic event such as a serious accident, natural disaster or a trauma (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

Depression in the Classroom:

Depression is a term we are hearing more often regarding children and adolescents. For many years, it was believed that young people could not experience depression, but we now know that they can and do become depressed, sometimes to a serious level. With sufficient information, teachers can detect depression and are in a good position to identify it and seek help for the student. In the classroom, depressed students may appear unmotivated and uncaring about their work when, in fact, they are unable to function to their level of ability. Often, they have difficulty with sustaining attention, effort, performance, and social relationships. Coaxing, cajoling, punishment, and reinforcement typically have little effect on behavior and achievement, (Huberty,2004).

Depression Left Untreated:

Depression can lead to continued academic and social problems, substance abuse, social alienation, risk-taking behavior, and suicidal thinking and behavior, perhaps into adulthood. Although students with depression may need counseling and therapy, teachers, school psychologists, counselors, and administrators in collaboration with parents can do much to help them in the classroom by knowing what to look for and learning how to be helpful. (Koplewicz, 2002).

2.2.1 Prevalence of Depression

Depression is one of the most common, but unrecognized, conditions of childhood and adolescence, and often is mistaken as a motivation or behavior problem. It is estimated that 8–10% of student's experience depression serious enough to require intervention, and up to 20% of all adults may have a depressive disorder at some time in their lives. Adolescent girls and women are twice as likely to develop depression as are adolescent boys and men. However, there is no difference in frequency of depression between pre-adolescent girls and boys. A teacher in a middle school or high school may have as many as 3 students in a class of 30 who have mild to serious depression, with most of them likely to be girls. (Merrell, 2001).

2.2.2 Symptoms of Depression

Depression is not the same as the occasional adolescent mood swings or feelings of frustration and anger that accompany daily hassles, such as arguments with friends or complaints about school. Those events usually do not last long and do not affect social and school performance. Depression, on the other hand, is a constant mood of feeling down, blue, sad, or down in the dumps that impairs the ability to function. Moreover, the student does not seem to be able to do much to change the mood and does not respond to suggestions to snap out of it. No two people with depression show it in the same way. Different circumstances and problems cause or contribute to it. However, there are some behaviors that may be signs of depression:

- Depressed mood for more than 2 weeks
- Loss of interest or pleasure in almost all activities
- Irritability or anger

- Changes in appetite or weight (weight loss not due to dieting or exercise)
- Sleeping too much or too little (sometimes, people seek help for sleeping problems that turn out to be signs of depression)
- Decreased energy or physical activity; even small tasks seem overwhelming and require too much effort (e.g., students may complete homework at a level less than they can do and/or may not turn in completed work)
- Feelings of worthlessness, guilt, and low self-esteem
- Difficulty thinking, concentrating, or remembering
- Difficulty getting necessary things done, such as homework
- Difficulty making decisions, often unable to make relatively minor decisions
- Negative thoughts about self, the world, or the future
- Repeated thoughts of suicide, including planning or attempting
- Tired and listless
- Would be better off if he or she were dead
- Believes that he or she is ugly and unattractive
- Decreased personal hygiene and self-care efforts
- Excessive crying or weepiness Feeling blah and seeming to have no feelings at all (i.e., feeling empty)
- Reports "Not caring about anything"
- Increased or decreased appetite
- Interpret minor day-to-day events as personal failures or defects
- Blaming self for things that are not his or her fault
- Statements that others over relatively small things

Not all depressed people will show all of these signs or to the same degree. If you see several of them in a student, however, they may indicate depression, (Koplewicz, 2002).

2.2.3 Forms of Depression

There are several forms of depressive disorders that occur in both women and men. The most common are major depressive disorder and dysthymic disorder. Minor depression is also common.

- **Major depressive disorder**, also called major depression, is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life.
- **Dysthymic disorder**, also called dysthymia, is characterized by depressive symptoms that are long-term (e.g., two years or longer) but less severe than those of major depression. Dysthymia may not disable a person, but it prevents one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.
- Minor depression may also occur. Symptoms of minor depression are similar to major depression and dysthymia, but they are less severe and/or are usually shorter term.

Some forms of depressive disorder have slightly different characteristics than those described above, or they may develop under unique circumstances. However, not

all scientists agree on how to characterize and define these forms of depression. They include the following:

- **Psychotic depression** occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality; seeing, hearing, smelling or feeling things that others can't detect (hallucinations); and having strong beliefs that are false, such as believing you are the president (delusions).
- **Seasonal affective disorder** (SAD) is characterized by a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy also can reduce SAD symptoms, either alone or in combination with light therapy (Rohan, Lindsey, Roecklein, & Lacy 2004).
- Bipolar disorder, also called manic-depressive illness, is not as common as major depression or dysthymia. Bipolar disorder is characterized by cycling mood changes – from extreme highs (e.g., mania) to extreme lows (e.g., depression). (Koplewicz, 2002)

2.2.4 Depression and Suicide

A frequent concern about depression is the increased risk of suicide. A small proportion of depressed students show serious thoughts of planning or attempting it. Although depressed youth are at higher risk for thinking about suicide, the vast majority do not attempt it. Most people considering suicide give several indications of their plans, but others may not pick up on them. Some attempters do not show obvious signs of depression, making detection difficult. Predicting suicide is challenging because of its

relatively low frequency and the lack of an accurate profile of potential attempters. Thoughts of suicide occur more often when the person begins to feel that nothing will help to improve the situation. Feelings of hopelessness that things will never change and the pain will not end may lead to an increased risk of suicide. Behavioral signs of suicidal planning may include giving away personal or prized possessions, making statements like, "I won't be around," visiting friends and family not seen in a while, taking care of personal matters (e.g., repaying debts, completing unfinished tasks), and talking about how he or she will like to be remembered. (Koplewicz, 2002)

2.3 Causes of Depression

The causes of depression are complex. Some people have a greater likelihood of developing depression, such as those who have first-degree relatives with depression (e.g., parent), living in highly stressful and demanding environments, or suffer traumatic events (e.g., loss of a loved one). Depression may be a long-term condition that has persisted over several weeks, months, or years or it may be of recent onset, such as in trauma. Long-term depression is more difficult to treat and most often requires professional help. Recent or sudden onset depression may subside more quickly, but may require professional help to show the best improvement. Most experts agree that depression is associated with changes in the chemistry of some neurotransmitters in the brain, and this can be chronic.

Some evidence indicates that children who believe that others do not view them as competent are more likely to develop depression. This view has particular salience in schools. That is, if teachers and peers view a student as not being academically or socially capable, there may be a greater risk of development of depression. Similarly,

because schools can be stressful places for children who are not successful, they can be at increased risk for depression. Many children who have not been successful at school relate feelings of sadness and depression because they do not do well or fit in.

Depression is associated with other conditions seen in children and youth. For example, approximately 50% of children with depression also have problems with anxiety. Some of the same symptoms are shown in anxiety and depression, which makes it difficult to identify the Primary problem. Perhaps surprisingly, depression co-occurs with Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, and substance abuse problems at levels ranging from 17 to 79% of cases. Therefore, many students who have acting out problems also may be depressed, requiring intervention for both affective and behavior problems. As depression worsens in children and youth, there is an increased likelihood of developing some of these behaviors. Causes of depression number almost as high as symptoms of depression. There appears to be a genetic factor to depression. Families with a history of depression often exhibit the symptoms during adolescence (Fritz, 1995). And depressed children frequently come from parents who have been depressed. Besides genetic predispositions to depression, social skills deficits may also contribute. These social skills deficits are harder to determine as it is difficult to find whether the inability to form good social skills causes, or results from the depression (Lamarine, 1995). Sexual orientation adjustment problems have also been linked to depression, especially in communities with strong social pressures.

2.3.1 Women and Depression

Everyone occasionally feels blue or sad, but these feelings are usually fleeting and pass within a couple of days. When a woman has a depressive disorder, it interferes with daily life and normal functioning, and causes pain for both the woman with the disorder and those who care about her. Depression is a common but serious illness, and most that have it need treatment to get better. Depression affects both men and women, but more women than men are likely to be diagnosed with depression in any given year (Kessler, Berglund, Demler, Jin, Koretz, Merikangas, Rush, Walters, & Wang 2003) Efforts to explain this difference are ongoing, as researchers explore certain factors (biological, social, etc.) that are unique to women.

Many women with a depressive illness never seek treatment. But the vast majority, even those with the most severe depression, can get better with treatment. Scientists are examining many potential causes for and contributing factors to women's increased risk for depression. It is likely that genetic, biological, chemical, hormonal, environmental, psychological, and social factors all intersect to contribute to depression.

Genetics

If a woman has a family history of depression, she may be more at risk of developing the illness. However, this is not a hard and fast rule. Depression can occur in women without family histories of depression, and women from families with a history of depression may not develop depression themselves. Genetics research indicates that the risk for developing depression likely involves the combination of multiple genes with environmental or other factors (Tsuang, Bar, Stone, & Faraone 2004).

Chemicals and hormones

Brain chemistry appears to be a significant factor in depressive disorders. Modern brain-imaging technologies, such as magnetic resonance imaging (MRI), have shown that the brains of people suffering from depression look different than those of people without depression. The parts of the brain responsible for regulating mood, thinking, sleep, appetite and behavior don't appear to be functioning normally. In addition, important neurotransmitters-chemicals that brain cells use to communicate-appear to be out of balance. But these images do not reveal WHY the depression has occurred.

Scientists are also studying the influence of female hormones, which change throughout life. Researchers have shown that hormones directly affect the brain chemistry that controls emotions and mood. Specific times during a woman's life are of particular interest, including puberty; the times before menstrual periods; before, during, and just after pregnancy (postpartum); and just prior to and during menopause (perimenopause).

Premenstrual Dysphoric Disorder

Some women may be susceptible to a severe form of premenstrual syndrome called premenstrual dysphoric disorder (PMDD). Women affected by PMDD typically experience depression, anxiety, irritability and mood swings the week before menstruation, in such a way that interferes with their normal functioning. Women with debilitating PMDD do not necessarily have unusual hormone changes, but they do have different responses to these changes (Schmidt, Nieman, Danaceau, Adams, & Rubinow 1998). They may also have a history of other mood disorders and differences in brain chemistry that cause them to be more sensitive to menstruation-related hormone changes.

Scientists are exploring how the cyclical rise and fall of estrogen and other hormones may affect the brain chemistry that is associated with depressive illness (Rubinow, Schmidt, & Roca, 1998, Ross & Steiner 2003, Dreher, Schmidt, Kohn, Furman, Rubinow, & Berman 2007).

Postpartum Depression

Women are particularly vulnerable to depression after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming. Many new mothers experience a brief episode of mild mood changes known as the "baby blues," but some will suffer from postpartum depression, a much more serious condition that requires active treatment and emotional support for the new mother. One study found that postpartum women are at an increased risk for several mental disorders, including depression, for several months after childbirth (Munk-Olsen, Laursen, Pederson, Mores, & Mortensen 2006).

Some studies suggest that women who experience postpartum depression often have had prior depressive episodes. Some experience it during their pregnancies, but it often goes undetected. Research suggests that visits to the doctor may be good opportunities for screening for depression both during pregnancy and in the postpartum period (Chaudron, Szilagyi, Kitzman, & Conwell 2004, Freeman, Wright, Watchman, Wahl, Sisk, Fraleigh, & Weibrecht 2005).

Menopause

Hormonal changes increase during the transition between premenopausal to menopause. While some women may transition into menopause without any problems with mood, others experience an increased risk for depression. This seems to occur even

among women without a history of depression (Freeman, Sammel, Lin, & Nelson 2006, Cohen, Altshuler, Harlow, Nonacs, Newport, Viguera, Suri, Burt, Hendrick, Loughead, & Vitonis, Stowe, 2006). However, depression becomes less common for women during the post-menopause period (Bebbington, Dunn, Jenkins, Lewis, Brugha, Farrell, & Meltze, 2003).

Stress

Stressful life events such as trauma, loss of a loved one, a difficult relationship or any stressful situation-whether welcome or unwelcome-often occur before a depressive episode. Additional work and home responsibilities, caring for children and aging parents, abuse, and poverty also may trigger a depressive episode. Evidence suggests that women respond differently than men to these events, making them more prone to depression. In fact, research indicates that women respond in such a way that prolongs their feelings of stress more so than men, increasing the risk for depression (Nolen-Hoeksema, Larson, & Grayson 1999). However, it is unclear why some women faced with enormous challenges develop depression, and some with similar challenges do not.

Depression often coexists with other illnesses that may precede the depression, follow it, cause it, be a consequence of it, or a combination of these. It is likely that the interplay between depression and other illnesses differs for every person and situation. Regardless, these other coexisting illnesses need to be diagnosed and treated.

Depression often coexists with eating disorders such as anorexia nervosa, bulimia nervosa and others, especially among women. Anxiety disorders, such as post-traumatic stress disorder (PTSD), obsessive-compulsive disorder, panic disorder, social phobia and generalized anxiety disorder, also sometimes accompany depression, (Regier, Rae,

Narrow, Kaebler, & Schatzberg 1998, Devane, Chiao, Franklin, Kruep 2005). Women are more prone than men to having a coexisting anxiety disorder, (Kessler, Barker, Colpe, Epstein, Gfroerer, Hiripi, Howes, Normand, Manderscheid, Walters, & Zaslavsky 2003). Women suffering from PTSD, which can result after a person endures a terrifying ordeal or event, are especially prone to having depression.

Although more common among men than women, alcohol and substance abuse or dependence may occur at the same time as depression, (Kessler, Barker, Colpe, Epstein, Gfroere, Hiripi, Howes, Normand, Manderscheid, Walters, & Zaslavsky 2003, Regier, Rae, Narrow, Kaebler, & Schatzberg 1998). Research has indicated that among both sexes, the coexistence of mood disorders and substance abuse is common among the U.S. population (Conway, Compton, Stinson, & Grant 2006).

Depression also often coexists with other serious medical illnesses such as heart disease, stroke, cancer, HIV/AIDS, diabetes, Parkinson's disease, thyroid problems and multiple sclerosis, and may even make symptoms of the illness worse, (Cassano, & Fava 2002). Studies have shown that both women and men who have depression in addition to a serious medical illness tend to have more severe symptoms of both illnesses. They also have more difficulty adapting to their medical condition, and more medical costs than those who do not have coexisting depression. Research has shown that treating the depression along with the coexisting illness will help ease both conditions (Katon, & Ciechanowski 2002).

2.3.2 Men and Depression

Depression is a costly and debilitating illness; approximately 16% of the US population (>32 million people) will meet the criteria for major depressive disorder in a

given year (Kessler, Berglund, & Dembler et al 2003). Typically, women are diagnosed with depression twice as often as men. This sex ratio appears in almost every setting, including Western and most non-Western community studies (Wolk &Weissman 1995, Bebbington 1998). Most research exploring this difference focuses on explanations for why women are at greater risk for developing depression.

More than 10 years ago, an alternative approach to explaining this disparity was proposed. This literature critiques the validity of the current diagnostic criteria, arguing that men may experience alternative depression symptoms (APA 2000). In part because traditional depressive symptoms (sadness, crying) are at odds with societal ideals of masculinity, men may be reluctant to report experiencing these symptoms. Second, men's experiences of depression may manifest with symptoms that are not currently included in traditional diagnostic criteria. Addis (2008) proposes 4 conceptual frameworks within the existing literature that address how gender shapes men's experiences, expressions, and reactions to depression: (1) the sex difference framework, (2) the masked depression framework, (3) the masculine depression framework, and (4) the gendered response framework.

The sex differences framework is rooted in the idea that the construct of depression is the same in men and women and seeks to investigate sex differences in a range of related variables, including symptoms (Addis 2008). Although this has been a popular approach to date, it is often critiqued for relying on oppositional binaries that understand "male depression" only as it is contrasted with "female depression," which fails to acknowledge the heterogeneity that exists within these groups.

The masked depression framework proposes that men are more likely to express their emotional and psychological distress in the form of "depressive equivalents" because direct admission of sadness and emotional weakness or vulnerability in men is seen as socially unacceptable (Lynch and kilmartin 1999). The biggest critique of this framework is that it remains difficult to identify the depressive equivalents.

The masculine depression framework hypothesizes that the struggle to adhere to hegemonic masculine norms places men at risk for experiencing an alternative depression variant often characterized by externalizing symptoms (Addis 2008). Rather than appearing sad, men experiencing emotional pain are more likely to react with anger, self-destructive behavior, self-distraction, or numbing of pain with substance use, gambling, womanizing, and work holism (Diamond 2005). Others have proposed that irritability could be the key symptom linking men and depression (lynch and kilmartin 1999). Winkler et al 2005 found that male patients with depression scored significantly higher on irritability, were more prone to overreact to minor annoyances, experienced anger attacks (sudden spells of anger and aggression with physical features similar to panic attacks), had lower impulse control, exhibited greater substance use, and experienced more hyperactive behavior compared with depressed female patients (Diamond 2005, Newman, Fuqua, & Gray; 2006).

2.3.3 Depression and the Adolescent Girls

Before adolescence, girls and boys experience depression at about the same frequency and by adolescence; however, girls become more likely to experience depression than boys (Bebbington, Dunn, Jenkins, Lewis, Brugha, Farrell, & Meltzer, 2003). Research points to several possible reasons for this imbalance. The biological and

hormonal changes that occur during puberty likely contribute to the sharp increase in rates of depression among adolescent girls. In addition, research has suggested that girls are more likely than boys to continue feeling bad after experiencing difficult situations or events, suggesting they are more prone to depression (Hankin, & Abramson, 2001). Another study found that girls tended to doubt themselves, doubt their problem-solving abilities and view their problems as unsolvable more so than boys. The girls with these views were more likely to have depressive symptoms as well. Girls also tended to need a higher degree of approval and success to feel secure than boys (Calvete & Cardenoso, 2005).

Finally, girls may undergo more hardships, such as poverty, poor education, childhood sexual abuse, and other traumas than boys. One study found that more than 70 percent of depressed girls experienced a difficult or stressful life event prior to a depressive episode, as compared with only 14 percent of boys (Cyranowski, Frank, Young, & Shear 2000).

2.3.4 Depression and Home Background

Not every depressed teenager comes from a troubled home, but many of them do. Instability at home, combined with the pressures of school, romantic relationships, and even the nuances found in different friendships, can make life difficult to navigate for a teen. A lack of support at home can make a young person's mood spiral downward. Regardless of what a child is going through at school, in his circle of friends, or hormonally, parents are the biggest influence in his life. The environment at home can set the tone for every other aspect of daily living. According to MayoClinic.com, a teen’s

risk of depression increases if someone in their family has bipolar disorder, depression, alcoholism, or has committed suicide. The risk also increases if instability and conflict exists in the home. Divorce, the death of a loved one and the prolonged absence of a loved one can also be underlying factors in a child's depressed mood. A 2011 National Institute of Health study found that children who experienced their parents' relationship instability before the age of 5 were more likely to experience a major episode of depression in adolescence. According to that same study, these children were also more likely to experience instability in their own relationships with their parents. Depressive symptoms in youths who experienced their parents' separation might worsen throughout later adolescence and into early adulthood. According to the National Alliance on Mental Illness, one in four teenagers from military families will experience symptoms of depression.

Depression is caused by a chemical imbalance in the brain, which is often genetic. However, it can be triggered in teens by major life events or something as "small" as a breakup with a girlfriend or boyfriend. Family addiction, any type of abuse -- physical, sexual, psychological -- and realistic expectations -- or no expectations at all -- can set off a chemical imbalance and result in the despairing and sometimes hopeless signs of depression, according to the Journal of Adolescent Health. The instability of a teen's residence might also plunge him into sadness. A 2009 study by the University of Aarhus in Denmark revealed that the more frequently an adolescent moved from home to home, the more likely he was to attempt suicide. About 55 percent of the youth's researchers studied who had attempted suicide had moved over three times compared to 32 percent of

non-suicidal children. Additionally, 7.4 percent of suicidal children had moved more than 10 times, compared to 1.9 percent of non- suicidal children.

2.3.5 Depression and Age

Depressive disorders can start at any age. The patterns of prevalence for each age group are different for men and women. In women, the highest prevalence occurs between 35 and 45 years. In men, the prevalence rises with increasing age. Recent trends suggest that depression is becoming more common (or at least being diagnosed more commonly) in younger age groups.

In Ireland 68% of those reporting emotional, psychological and mental health disabilities are of working age (18-64years age group) (CSO Ireland, 2008) Previous research has found that age is one of the demographic characteristics that accounts for much of the variance in the prevalence of depression. A Canadian National Population Health Survey found that the prevalence of 12-month depression varied in men from "too low to report" for men over 65 to a high of 5.2% for the 12 to 24 age group (Patten S, B 2000). Women's prevalence also varied by age, ranging from a low of 3.1% for women over 65 to a high of 9.6% for the 12 to 24 age group (Patten S, B 2000). The Ontario Health Survey found comparable variation based on age (Offord D, R 1996). This pattern is consistent with findings from Australia (Australian Bureau of Statistics 2006). In a study of 6–23-year-old offspring of depressed and of normal parents, an inverse relationship between the rates of major depression among the children and the age of onset of major depression in their proband parents was found. The children of parents who had an onset of major depression that was younger than age 20 years overall had the

highest risk of major depression. There was specificity in the findings in that these higher rates were nearly all accounted for by pre-pubertal onsets of major depression in their children. There was a 14-fold increased risk of onset of depression before age 13 in the children of probands who had onset less than age 20. These results were not confounded by the current age of the proband or the children, by interview status (children were interviewed), by comorbidity in the parents or by assortative mating. Future family genetic studies should examine the rates and patterns of illness of the biological relatives of probands with pre-pubertal-onset major depression.

2.4 Concept of Academic Performance

In Nigeria, academic excellence, qualifications and high performance attainment have been regarded very seriously as the parameters for recruitment, placement and advancement in both public and private sector organizations. More importantly, these parameters are also highly adopted in selection of candidates for admission into tertiary institutions and colleges. Due to this high premium placed on academic performance, individuals do everything possible to obtain excellent results. This no doubt places those concerned, particularly students at varying levels of anxiety and tension in the process, since success in examinations may implicitly be synonymous in work and life. Fianu (1981) asserted, "The structure of the educational system tends to give legitimacy to the inordinate premium put on academic performance as the criteria for recruitment and success in life. Because of the importance attached to tests and their grades as predictive factors, anxiety has been raised in the minds of those concerned. Davidson and Sarason (1960) rightly pointed out in their study that test anxiety is caused by parents who

criticize and expect perfection from their children. Based on this expectation and the society's demand for excellence, the children on their part strive to compete and excel. There is no question that much is expected from our education system in terms of preparing future citizens, workers, and leaders. To that end, schools are expected to influence students' learning, socialization, and even vocational preparedness. Despite the attention paid to a broad definition of outcomes, however, academic performance remains central. Academic instruction is arguably the primary business of education, and it was poor performance that spawned the recent era of reform after the publication of A Nation at Risk two decades ago (U.S. Department of Education, 1983). Further, it is academic performance that is central to the efforts of the No Child Left Behind Act of 2001 to make schools and school districts accountable for assessing and improving student performance annually (Linn, Baker, & Betebenner, 2002). Measuring academic performance can occur at multiple levels and serves multiple purposes. For example, classroom teachers often conduct formative and summative tests to evaluate student mastery of course content and provide grades for students and parents. State tests are designed primarily to measure progress at the school or school district level. In particular, graduation tests are used to determine whether a student has mastered the minimum content and competencies required to receive a high school diploma. Each of these kinds of assessments engenders significant questions related to test design, types of decisions supported by the results, alternative assessments, and accommodations (Heubert & Hauser, 1999; Minnema, Thurlow, Bielinski, & Scott, 2001). Although this is a time of change in the educational arena, within this evolving accountability

environment, it is crucial to understand the progress of all students, and the factors that contribute to their positive academic performance.

Indicators of Students' Academic Performance

Teachers' Perceptions of Students' Academic Performance Although performance on standardized tests receives the greatest attention in discussions of students' academic performance, teachers' evaluations of performance as indicated in course grades represent a common metric of student performance that often is more directly tied to the day-to-day business of teaching and learning than are annual standardized test scores. Grades serve a number of important functions. They communicate to students and parent's information about students' mastery of course content. In high school, a passing grade also is the criterion for a course's contributing to accumulated credit for graduation. Finally, grades provide information for consideration in college admissions (Polloway et al., 1994). However, as a measure of academic performance, teacher-given grades have well-known limitations. Grades are composite measures that account not only for students' content mastery but often for other factors, such as their class participation, attitudes, progress over time, and attendance. Both general and special educators are known to consider these various factors when grading, but to emphasize different factors. For example, special education teachers are less likely than general educators to consider homework or attendance to be important in grading student performance, but are more likely to consider in-class participation to be important (Blackorby, Wagner, Levine, Cameto, & Guzman, 2003). Moreover, substantial variations in grading practices occur across teachers and schools.

2.5 Depression and Academic Performance

Depression as a mood disorder: affects a person's ability to perform life activities including academic performance (Hysenbegasi, Hass, & Rowland, 2005). It is common for people who suffer from depression to engage in self-blame, experience confusion and a feeling of hopelessness. The major components of depression are loss of interest in activities that were once found pleasurable and a depressed mood (Schwartz & Schwartz, 1993). It has been found that loss of interest aspect of depression is associated with lower grade point averages and students who suffer from both anxiety and depression had poor academic performance (Eisenberg, 2009). Quality of performance has become the key factor for personal progress. Parents desire that their children climb the ladder of performance to as high a level as possible. This desire for a high level of achievement puts a lot of pressure on students, teachers, and schools and in general the education system itself. In fact, it appears as if the whole system of education revolves round the academic achievement of students, though various other outcomes are also expected from the system. Thus a lot of time and effort of the schools are used for helping students to achieve better in their scholastic endeavors. The importance of scholastic and academic performance has raised important questions for educational researchers. What factors promote performance in students? How far do the different factors contribute towards academic performance? School performance may be affected by various factors like intelligence, study habits, and attitudes of pupil towards school, different aspects of their personality, their psychological state, age, gender, parental educational and marital status, socio economic status, etc. The desire of success is derived from individual's concept of himself and in terms of the meaning of various incentives as they spell success and

failure in the eye of others, thus a child who sees himself as top ranking, as scholars, may set as his goal the attainment of the highest grade in the class and those who are hopeless and helpless may not desire success and may see themselves as failure and thus may perform poorly in school.

2.6 Theoretical Framework

Interpersonal psychotherapy for adolescents (IPT-A)

One approach to the treatment of adolescent depression that looks promising based on outcome studies is the use of interpersonal psychotherapy. Interpersonal psychotherapy for adolescents (IPT-A) was developed to fill gaps in theoretical and empirical information available for the treatment of adolescent depression. Modifications to interpersonal psychotherapy (IPT) were made to meet the specific developmental and interpersonal needs of adolescents who are depressed (Moreau, Mufson, Weissman & Klerman, 1991).

IPT is a brief, time-limited treatment originally developed and tested for use with adults diagnosed with a depressive disorder (Moreau et al., 1991). The goals of IPT treatment include reducing symptoms related to depression and identifying interpersonal problem areas connected with the start of depression (Moreau et al., 1991). No assumptions about the underlying origins of depression are made; rather the onset of depression is linked to one of four interpersonal problem areas. These areas are frequently associated with the beginning of depression in the adult population (Weissman & Markowitz, 1994). According to Weissman and Markowitz (1994), these problem areas are interpersonal deficits, role transitions, interpersonal role disputes, and grief. IPT theorists believe that discerning the interpersonal problems that contribute to depression

and working to alleviate those problems is sufficient for the treatment of depression regardless of other biological or personality factors (Moreau et al., 1991). IPT therapy emphasizes the current interpersonal relationships and social contexts of the individual (Weissman & Markowitz, 1994). In the past decade, IPT has been modified for use with a host of different populations including adolescents who are depressed (Weissman & Markowitz, 1994).

A number of empirical investigations into the efficacy of IPT-A with depressed adolescents have been undertaken (Mufson & Fairbanks, 1996; Mufson, Moreau, Weissman, Wickkramaratne, Martin, &Samoilov., 1994; Mufson, Weissmam, Moreau., & Garfinkel 1999; Rossello & Bernal, 1999; Santor & Kusumakar, 2001). Moreau et al. (1991) asserted that the goals of IPT-A closely mirror those of IPT for depressed adults. Like IPT, IPT-A seeks to identify and change interpersonal problem areas associated with the onset of the adolescent's depression as well as alleviate depressive symptomology (Mufson et al., 1996).

The four interpersonal areas (interpersonal deficits, role transition, interpersonal role disputes, and grief) used by IPT in the treatment of adult depression are also addressed in IPT-A (Mufson & Moreau, 1998) A fifth problem area, single-parent families, has been added to IPT-A by Mufson, Moreau, and Weissman (1996) because of the frequency of single-parent families among depressed adolescents and the necessity to address the conflicts resulting from a parent's absence in the family. Moreau et al. (1991) also emphasized that IPT-A has been designed to meet the unique developmental needs of adolescents. Issues addressed in IPT-A are specific to concerns and issues adolescents face (Mufson et al., 1996). Some issues identified in IPT-A

include individuating from parents, peer pressures, romantic relationships, experiences with death, and issues of control and authority with parents (Moreau et al., 1991).

The main goal of the IPT-A therapy is to associate these interpersonal problem areas to the depressive symptomology currently being experienced by the adolescent (Moreau et al., 1991). Five interpersonal problem areas are examined during this time: grief, interpersonal role disputes, role transitions, interpersonal deficits, and single-parent families (Mufson & Moreau, 1999). The focus of these interpersonal problem areas has been modified from IPT to meet the developmental needs and issues of depressed adolescents (Mufson & Moreau, 1998).

Grief: Adolescents who have lost a parent due to death may experience depression. Depression can often be the result of three types of abnormal grief--distorted, delayed, and chronic (Mufson & Moreau, 1998) Adolescents who are experiencing problems coping with grief may exhibit such symptoms as withdrawal, feelings of abandonment, substance abuse, sexual promiscuity, and reverting to earlier developmental stages (Mufson and Moreau, 1998). According to IPT-A, failure to successfully navigate through the stages of grief can lead to depression (Mufson and Moreau, 1999). Mufson and Moreau (1999) noted that IPT-A treatment method seeks to help adolescents discuss and accept loss in their lives and identify feelings that coincide with that loss. There are several key factors that therapists are advised to attend to when dealing with the interpersonal problem area of grief. These factors include the social support system of the adolescents, their place in the family structure, psychosocial development, and the quality of the relationship lost.

Interpersonal Role Disputes. When there are different expectations between two individuals about their relationship, interpersonal role disputes are evident (Mufson & Moreau, 1999). Interpersonal role disputes are identified by Moreau et al. (1991) as common to the developmental issues of adolescents and may occur with parents over issues of sexuality, power, finances, and morals. Specific issues may include different expectations about premarital sex, curfews, allowances, and values about homosexuality.

Treatment of role disputes with adolescents often involves bringing in parents to discuss the disputes and to navigate the relationship (Mufson & Moreau, 1998). In addressing interpersonal role disputes, IPT-A counselors seek to help adolescents explain their expectations for the relationship, consider which expectations may be impractical, and help adolescents cope with non-negotiable expectations (Mufson et al., 1996). Several techniques are employed to meet these objectives including helping adolescents identify the dispute, negotiate options with parents, examine and change relationship expectations, and clarify and alter communication styles (Mufson & Moreau, 1998).

Role Transitions: Role transitions are another frequent problem area for adolescents with depression (Moreau et al., 1991). Some role transitions are common to the developmental levels of adolescents. Transitions that can prove problematic for adolescents include initiation of romantic relationships, puberty, parting from parents and family, and transition into work or higher education (Mufson & Moreau, 1999). Problems arise in this area when the adolescent is unable to cope with the role transition or when the parents are unable to handle the new role of their child (Mufson et al., 1996). If parents are involved in the adolescent's struggles with role transitions, then they may also be included in some of the counseling sessions (Moreau et al., 1991). The mental

health counselor's function in these sessions is to help the family adjust to the adolescent's new role and to elicit support and encouragement from the parents in the adolescent's attempts to adjust to the new role (Mufson & Moreau, 1999). Mental health counselors working with adolescents who are experiencing problems with role transitions might also help adolescents to process their old roles and associated feelings and identify why the transition is necessary (Moreau et al., 1991).

Interpersonal deficits: Interpersonal deficits are particularly important to address during the adolescent years, because these deficits can have a great impact on adolescents' achievement of developmental tasks (Moreau et al., 1991). Developmental tasks that can be impacted by adolescents' interpersonal deficits include making friends, beginning romantic relationships, forming social ties, and making choices about romantic commitment, vocation, and sexuality (Mufson & Moreau, 1999). Lack of interpersonal skills may lead to adolescents becoming socially isolated from their peers (Mufson et al., 1996). As a result of being ostracized from peers, adolescents may withdraw, leading to a further delay in the acquisition of appropriate social skills (Mufson & Moreau, 1999). Deficits identified in the IPT-A approach are those that result from depression rather than from inherent personality traits (Mufson et al., 1996). There are several techniques used to address interpersonal deficits (Mufson & Moreau, 1999). Some approaches include helping adolescents identify what specific role deficits have played in current and past interpersonal relationships, consideration of what deficits need to be changed, and encouragement of those changes in significant relationships (Mufson & Moreau, 1999). Role-plays are often used to help adolescents identify their interpersonal deficits and to help them practice new skills (Mufson et al., 1996). Asking adolescents to practice new

behaviors outside of counseling sessions may also help them generalize new skills to other situations (Moreau et al., 1991).

Single-parent families: Single-parent homes are identified as another common problem area for many depressed adolescents. Mufson and Moreau (1999) suggest that the conflicts a single-parent home can engender can lead to depression among adolescents. Typically, factors such as the finality of the parting of the parent, its abruptness in happening, and whether a parent has parted before can impact the severity of the adolescent's depression. When considering the nature of the adolescent's depression, the mental health counselor also needs to be cognizant of the adolescent's relationship with both the custodial and absent parent. IPT-A is a time-limited therapy that calls for a once weekly, 12-week treatment schedule (Mufson & Moreau, 1998). The goals of IPT-A are met by identifying interpersonal problem areas with which the adolescent is struggling and by focusing on how those problems are currently impacting their relationships (Mufson & Moreau, 1998). There are three treatment phases identified as part of the IPT-A model--initial, middle, and termination (Mufson et al., 1996).

Rational Emotive Behavior Therapy

Rational Emotive Behavior Therapy (REBT) is both a psychotherapeutic system of theory and practices and a school of thought established by Albert Ellis. Originally called rational therapy, its appellation was revised to rational emotive therapy in 1959, then to its current appellation in 1992. REBT was one of the first of the cognitive behavior therapies, as it was predicated in articles Ellis first published in 1956, (Ellis, 1957), nearly a decade before Aaron Beck first set forth his cognitive therapy. (Beck, 1970).

Precursors of certain fundamental aspects of REBT have been identified in various ancient philosophical traditions, particularly Stoicism, (Robertson, 2010). For example, Ellis' first major publication on rational therapy describes the philosophical basis of REBT as the principle that a person is rarely affected emotionally by outside things but rather by 'his perceptions, attitudes, or internalized sentences about outside things and events.' He adds,

> *This principle, which I have inducted from many psychotherapeutic sessions with scores of patients during the last several years, was originally discovered and stated by the ancient Stoic philosophers, especially Zeno of Citium (the founder of the school), Chrysippus [his most influential disciple], Panaetius of Rhodes (who introduced Stoicism into Rome), Cicero, Seneca, Epictetus, and Marcus Aurelius. The truths of Stoicism were perhaps best set forth by Epictetus, who in the first century A.D. wrote in the Enchiridion: "Men are disturbed not by things, but by the views which they take of them." Shakespeare, many centuries later, rephrased this thought in Hamlet: "There's nothing good or bad but thinking makes it so (Ellis, 1962).*

Theoretical Assumptions

One of the fundamental premises of REBT is that humans, in most cases, do not merely get upset by unfortunate adversities, but also by how they construct their views of reality through their language, evaluative beliefs, meanings and philosophies about the world, themselves and others (Ellis, 2001). This concept has been attributed as far back as the Greek Philosopher Epictetus, who is often cited as utilizing similar ideas in antiquity (Ellis, 2001). In REBT, clients usually learn and begin to apply this premise by learning the *A-B-C*-model of psychological disturbance and change. The A-B-C model states that it normally is not merely an *A, a*dversity (or *a*ctivating event) that contributes

to disturbed and dysfunctional emotional and behavioral *C*s, consequences, but also what people *B, b*elieve about the *A, a*dversity. *A, a*dversity can be either an external situation or a thought or other kind of internal event, and it can refer to an event in the past, present, or future (Dryden & Neenan, 2003).

The *B*s, beliefs that are most important in the *A*-*B*-*C* model are explicit and implicit philosophical meanings and assumptions about events, personal desires, and preferences. The *B*s, *b*eliefs that are most significant are highly evaluative and consist of interrelated and integrated cognitive, emotional and behavioral aspects and dimensions. According to REBT, if a person's evaluative *B, b*elief about the *A, a*ctivating event is rigid, absolutistic and dysfunctional, the *C*, the emotional and behavioral *c*onsequence, is likely to be self-defeating and destructive. Alternatively, if a person's evaluative *B, b*elief is preferential, flexible and constructive, the *C*, the emotional and behavioral *c*onsequence is likely to be self-helping and constructive.

Through REBT, by understanding the role of their mediating, evaluative and philosophically based illogical, unrealistic and self-defeating meanings, interpretations and assumptions in upset, people often can learn to identify them, begin to *D, d*ispute, refute, challenge and question them, distinguish them from healthy constructs, and subscribe to more constructive and self-helping constructs (Ellis, 1994).

The REBT framework assumes that humans have both innate rational (meaning self- and social-helping and constructive) and irrational (meaning self- and social-defeating and un-helpful) tendencies and leanings. REBT claims that people to a large degree consciously and unconsciously construct emotional difficulties such as self-blame, self-pity, clinical anger, hurt, guilt, shame, depression and anxiety, and behaviors and

behavior tendencies like procrastination, over-compulsiveness, avoidance, addiction and withdrawal by the means of their irrational and self-defeating thinking, emoting and behaving (Ellis, 2001).

REBT is then applied as an educational process in which the therapist often active-directively teaches the client how to identify irrational and self-defeating beliefs and philosophies which in nature are rigid, extreme, unrealistic, illogical and absolutist, and then to forcefully and actively question and dispute them and replace them with more rational and self-helping ones by using different cognitive, emotive and behavioral methods and activities, the client, together with help from the therapist and in more life-serving and adaptive ways (Colin, 1997).

Regarding cognitive-affective-behavioral processes in mental functioning and dysfunctioning, originator Ellis (2003) explains:

> *"REBT assumes that human thinking, emotion, and action are not really separate or disparate processes, but that they all significantly overlap and are rarely experienced in a pure state. Much of what we call emotion is nothing neither more nor less than a certain kind of biased, prejudiced, or strongly evaluative kind of thought. But emotions and behaviors significantly influence and affect thinking, just as thinking influences emotions and behaviors. Evaluating is a fundamental characteristic of human organisms and seems to work in a kind of closed circuit with a feedback mechanism: Because perception response and then response tends to bias subsequent perception. Also, prior perceptions appear to bias subsequent perceptions, and prior responses appear to bias subsequent responses. What we call feelings almost always have a pronounced evaluating or appraisal element.*" (Ellis, 1957).

REBT then generally proposes that many of these self-defeating cognitive, emotive and behavioral tendencies are both innately biological and indoctrinated early in and during

life, and further grow stronger as a person continually revisits, clings and acts on them. Ellis alluded to similarities between REBT and General Semantics in explaining the role of irrational beliefs in self-defeating tendencies, citing Alfred Korzybski as a significant modern influence on this thinking (Ellis, 2010). REBT differs from other clinical approaches like psychoanalysis in that it places little emphasis on exploring the past, but instead focuses on changing the current evaluations and philosophical thinking-emoting and behaving in relation to themselves, others and the conditions under which people live.

As would be expected, REBT argues that mental wellness and mental health to a large degree results from a surfeit of self-helping, flexible, logical-empirical ways of thinking, emoting and behaving, when a perceived undesired and stressful activating event occurs, and the individual is interpreting, evaluating and reacting to the situation rationally and self-helpingly, then the resulting consequence is, according to REBT, likely to be more healthy, constructive and functional. This does not by any means mean that a relatively un-disturbed person never experiences negative feelings, but REBT does hope to keep debilitating and un-healthy emotions and subsequent self-defeating behavior to a minimum. To do this REBT generally promotes a flexible, un-dogmatic, self-helping and efficient belief system and constructive life philosophy about adversities and human desires and preferences (Ellis, 2001).

REBT clearly acknowledges that people, in addition to disturbing themselves, also are innately constructivists. Because they largely upset themselves with their beliefs, emotions and behaviors, they can be helped to, in a multimodal manner, dispute and question these and develop a more workable, more self-helping set of constructs.

REBT generally teaches and promotes:

The concepts and philosophies of life of unconditional self-acceptance, other-acceptance, and life-acceptance are effective philosophies of life in achieving mental wellness and mental health. That human beings are inherently fallible and imperfect and that they had better accept their and other human being's totality and humanity, while at the same time not like some of their behaviors and characteristics. That we are better off not measuring our entire self or our "being" and give up the narrow, grandiose and ultimately destructive notion to give ourselves any global rating or report card this is partly because all humans are continually evolving and are far too complex to accurately rate; all humans do both self- and social-defeating and self- and social-helping deeds, and have both beneficial and un-beneficial attributes and traits at certain times and in certain conditions. REBT holds that ideas and feelings about self-worth are largely definitional and are not empirically confirmable or falsifiable.

That people had better accept life with its hassles and difficulties not always in accordance with their wants, while trying to change what they can change and live as elegantly as possible with what they cannot change.

Cognitive Behavioral Therapy on Depression

Cognitive-behavioral therapy (CBT) is a term that encompasses numerous specific treatment approaches for various psychiatric disorders. As the name suggests, cognitive-behavioral treatments incorporate both cognitive and behavioral strategies. With regard to depression, CBT refers to the use of both cognitive restructuring and the behavioral strategy of activity scheduling or behavioral activation.

Cognitive-behavioral approaches to the treatment of depression stem from early behavioral treatments that emerged in the 1960s and 1970s. Among the most prominent was Lewinsohn, Biglan, and Zeiss behavioral treatment for depression. Lewinsohn proposed that depression resulted from deficient response contingent positive reinforcement, which he reported was a function of the following 3 factors:

- Individual differences in what is experienced as reinforcing
- The availability in the individual's environment of potentially reinforcing events
- The skill level needed to obtain reinforcement (Lewinsonh, 1974).

For example, if someone found conversing with others to be reinforcing, had other individuals available with whom to converse, and possessed the social skills needed to engage one of those individuals in conversation, then he or she could experience positive reinforcement. Lewinsohn's treatment, therefore, aimed to increase depressed individuals' ability to obtain response-contingent positive reinforcement and therefore improve their mood; he did this by having them identify and engage in events they described as having been, or potentially being, pleasurable and addressing skills deficits that may preclude them from obtaining the desired reinforcement from identified pleasant events. Numerous depression treatments that included activity scheduling emerged during the 1970s and 1980s.(Halverson, 2014)

Although early versions of activity scheduling primarily focused on increasing mood-related pleasant events, Beck incorporated a form of activity scheduling into his cognitive therapy for depression, aimed at increasing both pleasant events and providing a sense of accomplishment or mastery (e.g., working on a resume, completing a school assignment).Following a component analysis of cognitive therapy that found this activity

scheduling component to be as effective as the full treatment package, interest in behavioral treatments for depression increased, leading to modern approaches called behavioral activation (BA) treatments.

Modern BA approaches are based on the same principles as early versions of activity scheduling but incorporate more sophisticated strategies for identifying activity assignments and addressing barriers to their completion. Several meta-analyses have examined studies of activity scheduling and BA approaches over the past several decades and has provided substantial empirical support for these approaches. (Halverson, 2014)

During the 1970s, cognitive treatments for depression began to gain in popularity and empirical support, with the most well-known being Beck et al's cognitive therapy for depression. Cognitive therapy is based on the fundamental assumptions that cognitive activity affects behavior, cognitive activity can be monitored and changed, and cognitive changes can lead to desired behavioral changes. Cognitive therapy emphasizes the need to change cognitions in order to achieve improvements in mood and behavior. As mentioned above, Beck's cognitive therapy for depression includes activity scheduling treatment strategies adapted from earlier behavioral interventions but also includes cognitive strategies such as cognitive restructuring that were designed to directly challenge and change maladaptive thoughts. (Halverson ,2014).

Although behavioral approaches typically do not include any direct attempts to change cognitions (but attempt to indirectly do so through changes in behavior), cognitive therapy does directly attempt to change behavior but does so for the ultimate goal of changing cognitions in order to reduce depressive symptoms. Therefore, at times,

such approaches may be called either cognitive therapy or CBT, with both incorporating behavioral and cognitive interventions (Halverson, 2014).

Within the CBT model, individuals with depression are viewed as exhibiting the "cognitive triad" of depression, which includes a negative view of themselves, a negative view of their environment, and a negative view of their future. Related to the cognitive triad, depressed patients are believed to exhibit numerous cognitive distortions that maintain these negative beliefs. Examples of these distortions include all-or-nothing thinking (i.e., viewing things in black and white categories), overgeneralization (i.e., assuming one negative event constitutes a pattern of never-ending negative events), and fortune telling (i.e., making negative predictions about the future that are often inaccurate or negatively biased).Within Beck's model, negative automatic thoughts and distortions in thinking are hypothesized as stemming from problematic schemas, which are cognitive structures that influence how information is interpreted and recalled. Schemas are often targeted in the later phases of treatment, whereas behavioral strategies and efforts to elicit and test automatic thoughts are implemented earlier in treatment (Halverson, 2014). Because CBT for depression is a broad category that includes numerous treatment strategies, different aspects of treatment may be emphasized to a greater or lesser extent in practice. In general, however, CBT for depression includes specific behavioral strategies (i.e., activity scheduling) as well as cognitive restructuring aimed at changing negative automatic thoughts. CBT for depression has been examined in numerous clinical trials and has received empirical support across various settings and populations.(Halverson, 2014)

Beck's cognitive therapy for depression has been listed as a well-established treatment by the American Psychological Association's Task Force on Promotion and Dissemination of Psychological Procedures since its inception in 1993. Several meta-analyses have demonstrated the effectiveness of CBT for depression.

Beck's Cognitive Behavioral Theory of Depression (1976)

Beck proposed that negative automatic thoughts generated by dysfunctional beliefs were the cause of depressive symptoms. He hypothesized that depressed patients have a negative view of themselves, their environment and their future. Depressives distort reality by harboring negative feelings about anything and everything and they develop thoughts of worthlessness and inferiority (Papalia & Olds, 1988; Schwartz &Schwartz, 1993). Beck maintained that depression-prone individuals are more likely to notice and remember situations in which they have failed or did not live up to some personal standard while ignoring successful situations. As such they maintain their negative sense of self leading to depression (McGinn, 2000). Some groups of people have been identified as having higher chances of developing depression. Such people include the poor, the unemployed, women and students (Wetzel, 1984).

Beck's Cognitive Behavior Therapy- Cognitive Restructuring

In treating depression Beck emphasized understanding and changing the patient's core beliefs. By restructuring destructive thinking he believed that positive changes could be brought in the patient (Loveleena, 2013). The therapist is expected to involve the patient in setting realistic goals and taking responsibilities for action and thought. By

changing thought and perception a change in behavior and emotional responses can result. The patient is educated on the concept of faulty thinking and new ways and ideas are generated to develop a positive outlook of self- experiences and environment (Loveleena, 2013). In therapy the patient learns to apply cognitive restructuring techniques so that negatively distorted thoughts underlying depression can be corrected and replaced with more logical and adaptive thinking. Many studies have been conducted to ascertain the efficacy of cognitive therapy for depression. In one of such studies, Rush, Beck, Kovacs, and Hollon (1977) compared the use of therapy with the use of tricyclic antidepressant therapy (pharmacotherapy) using patients suffering from clinical depression. They found that cognitive therapy was more effective than tricyclic anti-depressant therapy and relapse rates were lower among patients who received cognitive therapy.

In another study, Blackburn, Bishop, Glen, Whalley, and Christie (1981) investigated the efficacy of cognitive therapy and pharmacotherapy each alone and in combination in the treatment of depression. They found that cognitive therapy was superior to drug treatment in general practice, the antidepressant drug group did less well in both hospital and general practice, and the combination treatment was superior to drug treatment. Some other researches that involve meta-analyses of the effects of cognitive therapy in treating depression (e.g. Dobson, 1989; Wampold, Mnami, Baskin, &CallenTiemey, 2002; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998) found that cognitive therapy was superior to no treatment or placebo; cognitive therapy is as effective as interpersonal or brief psycho- dynamic therapy in managing depression. They also found that cognitive therapy is as effective as and even more effective than

pharmacotherapy in managing mild to moderate unipolar depression. In a review of studies on cognitive therapy and depression, Stuart, Rupke, David Blecke, & Marjorie (2006) confirmed that cognitive therapy is an effective treatment for depression and is as effective as antidepressants or interpersonal or psychodynamic therapy. Their review also confirmed the effectiveness of the combination of cognitive therapy with other forms of therapy. They also affirmed that some studies have shown that cognitive therapy is effective for managing adolescents with depression. Some studies have also shown that relaxation techniques can be used to manage some mental health conditions including anxiety and depression.

2.6.4 Academic Performance Theory

Needs-based motivation theories stem from the understanding that all motivation comes from an individual's desire to fulfill or achieve a need. This also states that human beings are motivated by unsatisfied needs, and typically certain lower needs must be satisfied before higher needs can be satisfied. In general terms, motivation can be defined as the desire to achieve a goal, combined with the energy, determination and opportunity to achieve it. In specific terms to Industrial/Organizational Psychologists, motivation is defined as "Those psychological processes involved with the arousal, direction, intensity, and persistence of voluntary actions that are goal directed" (Mitchell, 1997).

In 1943, Abraham Maslow developed one of the earliest theories of human motivation, commonly referred to as Maslow's Hierarchy of Needs. In his classic article "A Theory of Human Motivation." Maslow utilized the term "prepotent" to express the theory that "in the human being who is missing everything in life in an extreme fashion,

it is most likely that the major motivation would be the physiological needs rather than any others" (Maslow, 1943). Whittington and Evans (2005), referring to that same article, stated that Maslow presented a "prepotent hierarchy in which at least five sets of needs compose the framework". The five sets of needs were divided into two categories: basic needs and higher-order needs. The most basic human needs, represented by food, water, shelter, and safety, are considered essential for human existence. Higher-order needs are those associated with social activities, esteem building, and self-actualization or constant self-improvement.

Elaborating further on this theory, Whittington and Evans (2005) stated that "each of these needs operates at all times, although one deficient set dominates the individual at any one time and circumstance". The motivation experienced by humans to fulfill these needs is either derived from internal or external factors. Intrinsic motivation is found in people who are influenced by factors that cause a sense of accomplishment and pleasure, while extrinsically motivated people are commonly influenced by factors controlled by others, such as money and praise (Deci & Ryan, 1985). Maslow's hierarchy is commonly displayed in a pyramid fashion, with the basic needs at the bottom and the higher needs at the top. The needs were depicted in this way to show the significance of each need on the others, with the most important and broadest category being the physiological needs at the base (Redmond, 2010).

Basic-Order Needs:

1. **Physiological Needs** are basic needs that are *physiologically necessary* for one's survival, such as oxygen, food, and sleep. These needs must be met before moving to satisfy needs higher in the order.

2. **Safety Needs** include the desire to feel safe and secure and to ensure that basic physiological needs will remain met. Examples of this need include shelter or housing, physical ability to defend one's self, the need to have limits or law (or a conscience), and a regular routine that an individual is comfortable with. Once one's physiological needs have been met, she/he will move on to the safety needs.

Higher-Order Needs:

3. **Social Needs** include friendship and companionship. One must know that he/she is not alone in the world and be able to communicate feelings and needs with other individuals. One of the most basic human desires is companionship and a sense of belonging.
4. **Esteem Needs** - An individual eventually needs to feel that he/she has a social status. This goes beyond just having social relationships; the individual must feel that in work or at home he/she is making a contribution. This also includes recognition of achievement from others.
5. **Self-actualization Needs** - This is the final and highest level of needs. Meeting this need is characterized by continuously focusing on personal growth, problem solving, life appreciation, and peak experiences for oneself (Huitt, 2004).

Maslow's concept of self-actualization (SA) represents "everything that one is capable of becoming" (Value Based Management.net, 2009). And he felt that the capacity for this concept was innate to all human beings. It was not learned through conditioning or earned through rewards (Hall, 2007). When observing SA, it is important to note that the category does not complete Maslow's Hierarchy of Needs. Many researchers thought that Maslow believed achieving the SA category would result in the

completion of the progression. Researchers found this unattainable because SA is elastic; as one nears their SA, their abilities develop and grow which makes their true potential even greater. However, O'Connor and Yballe (2007) indicate that Maslow intended his theory to be "an ongoing process that involves dozens of little growth choices that entail risk and require courage".

Maslow believed that in order for the higher-order needs to be successfully met and not affect basic needs, an individual must first acquire the basic-order needs, referred to as **fulfillment progression** (Redmond, 2010). Maslow added cognitive needs as stage five. These include the need for knowledge and meaning. Stage six is known as aesthetic needs. People on this stage appreciate beauty, form, and balance while actively seeking it. Self-actualization needs are stage seven of this theory. The eighth and final stage on the revised hierarchy is transcendence needs. People who have reached this highest stage need to help others become self-actualized (McLeod, 2014).

Some of the value of Maslow's Needs hierarchy lies in its intuitive appeal. Regardless of the lack of support, practitioners continue to use the concept of needs satisfaction to motivate and improve individual performance. This is a theory that is able to seen in younger generations also. When applied to a school environment we can see the application of this theory to children. Maslow's theory has made a major contribution in realm. Before a school can meet a student's cognitive needs, the physiological needs must be met. (McLeod, 2014).

McClelland's Need Theory

In his 1961 book, *The Achieving Society*, David McClelland identified three types of motivational needs, on which he based a model to describe one's style with regard to

being motivated and motivating others, depending on the different level of needs within the individual. There are a few distinct characteristics possessed by individuals with each need. Henry and Murray (1983-1988), a psychologist, whom McClelland was a student of, identified about 20 human needs, and believed a close relationship existed between motivation and personality. Although only three of Murray's original identified human needs continue to be studied, McClelland derived his theory from the three remaining needs; for achievement, for power, and for affiliation.

McClelland's Needs:

Achievement Motivation (nACH) **Needs** - Those with a high need for achievement are attracted to situations offering personal accountability; set challenging, yet attainable, goals for themselves; and desire performance feedback. (Stuart-Kotze, 2009)

Authority/Power Motivation (nPOW) - Individuals with a need for authority and power desire to influence others, but do not demonstrate a need to simply have control. These individuals possess motivation and the need to increase personal status and prestige.

Affiliation Motivation (nAFF) - Finally, those with a need for affiliation value building strong relationships, admire belonging to groups or organizations, and are sensitive to the needs of others. (Stuart-Kotze, 2009) This type of person is a team player and wants to be respected and liked. McClelland's Need Theory suggests that understanding these needs and accurately placing the right people in the right positions should yield greater levels of motivation which, in turn, should increase productivity and reduce turnover.

McClelland has a high interest in those with the nACH. He finds that people with this high need for achievement fascinating. McClelland had experimented with people to see who belonged to which group and to what degree they may possess more than one.

The experiment involved throwing little rings and trying to wrap the little ring around a peg. These games are typically seen in festivals or carnivals. He noticed that those that had the nACH were very much different from the others. McClelland says that those with the nACH were less worried about making it easy like the others. They didn't try to find the easiest way by standing closer or leaning forward as far as they could just so there be an advantage. He explains that the nACH would try to make the game even more challenging by standing further away or coming at it at more difficult angles. McClelland believes there is something else going on other than just setting goals and completing them. Some high nACH individuals need to apply more challenge to their lives and every time a challenge is met successfully they need a stronger more challenging task. He calls this the "balanced challenge" and it is use to keep the person in good shape mentally. (Chapman, 2009) This shows why it is a good idea to know what needs a person has to properly motivate them in the right manner and to expect that not all employees are motivated by challenge.

For those where nACH is high, needs are met when these individuals meet their own goal, regardless of other's performance or situation. For these individuals, well-being (happiness, joy, contentment) is tied directly to the meeting of those goals. The desire to perform at a high level (higher than peers) is present in in individuals who rate high in nACH. This may lead these individuals to seek vocations that require high levels of skill and difficult challenges, this includes vocations that have responsibility and problem solving as core tasks. (Royle & Hall, 2012).

Achievement Goal Theory

Achievement goals have been defined as competence-related objectives that individuals aspire to in an achievement setting and that different competency objectives result in different performance outcomes. Achievement goal research initially used a dichotomous framework distinguishing between performance and mastery goal orientations. Individuals with mastery goals were concerned about developing competency and those with performance goals were more interested in showing competency. From the perspective of achievement goal theory, help seeking had been categorized within the framework of two types of goal orientations – mastery goals (focus on learning) and performance goals (concerns about ability, social comparisons, and maintaining self-esteem). Students with mastery goals were more likely to use instrumental help seeking behaviors and those with performance goals were more likely to avoid help seeking, use expedient help seeking behaviors and feel that there is a cost (threat) in help seeking (Karabenick, 2004).

From the development of approach and avoidance dimensions in the motivation literature, goal orientations have been re-conceptualized similarly so that within each of the categories of mastery and performance goals there would be dimensions of approach and avoidance. Approach is defined as trying to achieve a positive outcome and avoidance as trying to prevent a negative outcome. Achievement goal orientations are then theorized as; mastery-approach, mastery-avoid, performance-approach and performance-avoid (Elliot & McGregor, 2001; Pintrich, 1999). The goals associated with the mastery-approach orientation are to increase levels of competence, and with mastery-avoidance, the goal orientation is to avoid a lack of mastery. The student is concerned

about not being able to understand the material but as with mastery-approach, the focus is on the self and not social comparisons.

With performance-approach, students want to demonstrate publicly their ability to others and with a performance-avoid goal orientation students want to avoid looking less able than their peers. Instrumental help seeking has been shown to be related to mastery-approach goal orientation. Expedient help seeking has been linked to performance-approach goal orientation (Karabenick, 2004).

2.7 Review of Empirical Studies

Sakho (2003) carried out a study of the determinants of academic performance of HEC-Lausanne graduates using a two-bit model. He analyses econometrically the relationship between different variables and the average grade obtained during the license studies by 156 students. The findings suggest that a large number of different factors related with the personal and family background, with the work and study discipline and with the type of degree interact together in order to explain the variation of HEC students' performance

In addition, with respect to the determinants of academic performance, there are several studies based on the ordinary least squares (OLS) estimation. Spector and Mazzeo (1980) produced the first study that applied a qualitative model to determine academic performance. However, their ordered profit analysis concentrated on the probability of getting a letter grade of A versus the probability of not getting an A. Because there are more than two categories in a grading system, the study fails to give enough evidence.

Research has also found a correlation between major depression in adolescence and the likelihood of depression in young adulthood (Rao, 1994). Not only were most depressed adolescents depressed adults, but serious social adjustment problems plagued these individuals as they moved into adulthood. And there is evidence that depression in adolescents is likely to repeat itself within a year or two. In fact, two-thirds of depressed teens will be depressed again during their teenage years (Sanford, 1996; Fritz, 1995). Some studies have focused on adolescent's depression while some focused on the relationship between depression and academic performance. In one of such studies on adolescent's depression, Moilanen (1995) found that the student's depression was often associated with dysfunctional beliefs and negative future attitudes. She suggested that the cognitive theory has reasonable validity for describing the systems of depression for non-referred adolescents. In an earlier study (Moilanen, 1993) evaluated depression in college students and found that students' current depressive states were consistently related to their negative processing of personal information (Moilanen, 1993: 345). She found that the students' cognitive thoughts were affecting them and making them develop symptoms of depression and thereby suggested a cognitive treatment for students' depression. Studies that focused on the relationship between depression and academic performance include those carried out by Hysenbegasi, Hass, and Rowland, (2005), DeRoma, Leach, & Leverett (2009), Busari (2012), and Owens, Stevenson, Hadwin, & Morgate (2012).

Hysenbegasi et al. (2005), studied the impact of depression on the academic productivity of university students and found that depressed students reported a pattern of increasing interference of depression symptoms with academic performance peaking in the month of diagnosis and decreasing thereafter with the lowest levels reported in 4 to 6

months' post diagnosis. DeRoma et al. (2009) in their own study examined the association between self-reported depressive symptomology and college academic performance. They found a significant and negative relationship between depression and academic performance.

In addition, they found that students who reported moderate levels of depressive symptoms demonstrated lower performance within academic environments when compared to those with normal and minimal levels of depression. In another study, Busari (2012) evaluated the relationship between gender, age depression and academic performance among adolescents. She found that depression and academic performance were significantly and negatively correlated, age and academic performance were significantly and positively correlated and females performed significantly better than males. Owens, Stevenson, Hadwin, and Morgate (2012) in their own study investigated the relationship between negative affect, worry, working memory and academic performance, they found that higher levels of anxiety and depression were associated with lower academic performance and concluded that academic performance is reduced in young people with high levels of anxiety or depression as a function of increased test-specific worry that impinges on working memory central executive processes. If worry and negative thoughts are the cognitive component of anxiety (Zeidner, 1998; Speilberger&Vagg, 1995), and negative automatic thoughts generated by dysfunctional beliefs (cognitive components) are the cause of depressive symptoms (Beck, 1976, 1983) then an appropriate treatment for anxiety and depression must involve cognitive therapy.

In one study, Bernat, Ronfeldt, Alhoun, and Arias, (1998) found that 18% of college students have experienced a traumatic loss such as the unexpected death of a

loved one. Trauma can be defined as an emotional experience that has a lasting psychological impact. For psychiatric diagnosis, the person experiences, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and the person's response involved intense fear, helplessness, or horror (American Psychiatric Association1994a). Symptoms associated with trauma can include anxiety and depression.

In addition, research has shown that up to 30% of adolescents report clinically significant levels of depressive symptoms even though the prevalence rate of depressive disorders is 15% for adolescents (Kessler, Avenevoli, &Merikangas, 2001). The American College Health Association (ACHA-NCHA, 2005) reports that the rate of students reporting ever being diagnosed with depression has increased 56% from 10% in spring 2000 to 16% in spring 2005 and it lists depression as one of the top five impediments to academic performance.

Another study, which was performed on Beck's Theory, was Sato & McCann's (2000) study on the Beck sociotropy-autonomy scale. The scale had originally meant to identify self-feelings that would lead to depression, mainly solitude/interpersonal insensitivity, independence, and individualistic achievement. However, the results of the study showed that the independence did not correlate with depression, and the sociotropy, not autonomy was a precursor of depression. As they described, "sociotropy can be characterized by an individual's emphasis on interpersonal interactions involving intimacy, sharing, empathy, understanding, approval, affection, protection, guidance, and help tend to place importance on seeking approval from others and on trying to avoid disapproval from others as much as possible" (Sato, & McCann, 2000, p.66).So it is seen

that a strong correlation with sociotropy and depression was found, which is a trait that is strong when relating to underlying thoughts and emotions. This support for cognitively caused depression is an interesting use of Beck's Theory.

Moilanen's (1995) study of adolescent depression also attempts to validate Beck's theory in a new way, as Beck worked mostly with adults. Indeed, she found that the student's depression was often associated with dysfunctional beliefs and negative future attitudes. She suggests that the cognitive theory has reasonable validity for describing the symptoms of depression for non-referred adolescents, and that the subject's depression is closely correlated with his or her ability to deal with dysfunctional attitudes and beliefs, as well as doubt towards the future. Her findings may not sound truly convincing, because she did find some discrepancies: "However, the results of this study were not entirely consistent with Beck's theory, particularly the proposition that a predominantly negative self-schema underlies the information processing of depressed individuals." (Moilanen, 1995, p.440) We see how perhaps, at least in adolescents, the idea of the negative self-schema is not a clear as Beck wishes it to be.

In a study done by Brown et al (1995) they centered their focus on college students receiving poor exam scores. Brown reported, "The results suggested that a specific construct measured by the DAS interacted with a congruent stressor (poorer than expected performance on a college exam) to predict increases in depressive symptoms." (Brown et al., 1995, p.434) In this study we would say that the students are having negative thoughts about their future, because they may not pass the class. Negative thoughts about the world, meaning they may come to believe they do not enjoy the class.

And finally negative thoughts about themselves, as in they do not deserve to be in college.

Another study done by Saisto, Salmela-Aro, Nurmi, and Halmesmaki (2001), attempted to show how different approaches to becoming a mother could stave off depression common with such a major life event. They hypothesized that if the individual set self-focused goals they would be able to think rationally about their situation. "As expected, the results showed that women who adjusted their personal goals to match the particular stage-specific demands of the transition to motherhood showed a decrease in depressive symptoms, whereas those who disengaged from the goals that focused on dealing with such demands showed an increase in depressive symptoms" (Saisto et al., 2001,p.1154).

2.8 Summary

In this chapter, the research is designed to find out the influence of depression on the academic performance among secondary school students. It opened with the discussion of the conceptual framework of the study in which concept of depression, depression in the class room, depression left untreated, prevalence of depression, symptoms, causes and forms of depression, depression and suicide, concept of academic performance, depression and academic performance, and also theories like interpersonal theory, rational emotive behavioral theory, and becks cognitive behavioral theory of depression and academic performance theory. Furthermore, empirical studies were also reviewed.

It also observed that there are evidences that secondary school students experiencing high levels of psychopathology (psychological distress) are less able to complete complex academic tasks. Specifically, depression has been associated with deficits in short-term memory functioning in tasks requiring information processing. Depression has been found to slow down academic performance. In Nigeria, poor academic performance of secondary school students with its negative consequences has been of concern to many parents, teachers, counselors and educational administrators. The poor academic performance has been attributed to so many factors which include students' poor study habits, psychological adjustment problems such as anxiety, stress, and depression. High incidence of psychopathology has been found among secondary school students in Nigeria. Of much concern in this study is the influence of depression (psychopathology) and academic performance among secondary school students which had not been established nor systematically investigated in Nigeria. Understanding the

influence of depression on academic performance is not only of theoretical importance but may also have implications for devising counseling interventions directed at the negative effects of psychological distress on students' learning outcomes.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter focused on the procedural steps and method used by the researcher. The methods adopted were described under the following headings: Research design, Population, Sample and sampling technique, instrumentation, Validity, pilot testing and reliability of instrument, Procedure for Data collection, and Procedure for Data analysis.

3.2 Research Design

The research design adopted in this study is a survey research design. According to Adewumi (1988) and Bello and Ajayi (2001), descriptive survey involves collecting data in order to test hypotheses or answer research questions concerning the current status of the study and report the way things are. Descriptive surveys are useful for gathering factual information, data on attitudes and preferences, beliefs and prediction, behaviors and experiences, both past and present (Weisberg, 1996). This design was chosen for the study because according to Best (1986), it helps to describe, record, analyze, and interprets the conditions that exist in a study and thus this study assessed the influence of depression on academic performance which involves behavior that already exist between and among respondents which they already have the information needed.

3.3 Population

The population of this study comprised of 109,385 senior secondary school students in Kaduna State. There were 285 public senior secondary schools in the 12 Educational zones in Kaduna State viz: -Anchau, Birnin Gwari, Giwa, Godogodo, Kachia, Kaduna, Kafanchan, Lere, Rigachikun, Sabon Tasha, Zaria, Zonkwa. The total

number of students in the public senior secondary schools in SSS II both males and females were 14,982. They were mainly male and female between the ages of 13-29 from different ethnic, religious and home background (Kaduna State School Census Report 2013/14).

3.4 Sample and Sampling Technique

The sample size used in this study was 777 senior secondary school students and the sample was drawn from the 12 Educational Zones, Kaduna state ministry of education. According to Morgan and Krejcie (1970) a population of more than 1,000,000 has a sample size of 384 and thus the researcher decided to add to this sample size so as to increase the degree of precision. The researcher made use of purposive sampling technique to select 6 educational zones from the 12 educational zones. The educational zones purposively selected were: Giwa, Kaduna, Lere. Rigacikun, Sabon-Tasha,and Zaria. Purposive sampling was also used to make selection from the 6 educational zones in order to select the schools within Kaduna State thus the same procedure was followed and two schools were selected from each Educational Zone making a total of twelve 12 schools that were used for this study. In each school selected, there are six arms ranging from SSII A-F and in each arm there is a minimum of 40-60 students making a total of 300 students in SSII per school, thus the researcher purposively selected 64- 69 students depending on the number of students available per class.

Table 3.4.1 Showing the number of respondents by zones, schools and gender.

Educational Zones	Schools	Respondents male	Respondents female	Total
Giwa	Demonstration school	44	25	69
	G.G.S.S Samaru	-	66	66
Kaduna	Kaduna Capital School	43	22	65
	Government Day Secondary School Badarawa	43	22	65
Lere	Government Secondary School Lere	43	21	64
	G.G.S.S Lere	-	64	64
Rigachikun	Government Secondary School Rigachikun	43	21	64
	Government Secondary School Nasarawa	43	21	64
Sabon Tasha	Command Secondary School	43	21	64
	Government secondary School Sabo	43	21	64
Zaria	Alhudahuda College, Zaria	64	-	64
	Barewa College	64	-	64
Total		518	259	777

3.5 Instrumentation

Two instruments were used to generate the relevant data in this study which were Performance Test and a depression inventory. The researcher–designed instrument titled

Academic Performance Test contains test on English and Mathematics, where each test contains 25 questions each. These questions were carefully formed from the selected school's curriculum and particularly for SSS II students. Each question carries 2mrks making a total of 100 marks for the academic performance test. The depression inventory was a questionnaire that was adapted and modified from Becks Depression Inventory II (BDI II) and the original author Beck (1972). The B.D.I II consists of 21 symptom items described in simple sentences which were modified to 20 symptom items. Each item has 4 different questions (0-3) to which the respondent ticks or circles the one that best describes his or her feelings. The scoring can be done manually and also it is done by adding up the score for each of the twenty questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three (63). This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero (0), the lowest possible score for the test would be zero. This would mean you circles zero on each question. Depression level is considered as; 1-10 these ups and downs are considered normal, 11-16 mild mood disturbance, 17-20 borderline depression, 21-30 moderate depression, 31-40 Severe depression, and over 40 is considered extreme depression (Beck 1972). The questionnaire had three sections which were the bio-data, depression inventory, and Academic Performance Test. A questionnaire was much more efficient in that it elicits good data and requires less time or saves time, it is inexpensive, and permits collection of data from a much larger sample as it has the ability to reach a number of respondents.

3.6 Validity of Instrument

To ascertain the validity of the Beck Depression Inventory and the Performance Test on Mathematics and English Language, the draft questionnaire was first vetted by the supervisors of the researcher while the final draft was vetted by seven lecturers in the department of Educational Psychology and Counseling and their observations were that the issue of sexual feeling among secondary school students as an item should be removed and also some words like feeling blue which is an American way of feeling sad should be replaced with a more simple and familiar words and additional 20 questions should be added to both mathematics and English language and other subjects like biology should be, thus the observations and suggestions were used to rewrite and modify the items of the questions and the questionnaires collated and analyzed.

3.6.1 Pilot Testing

To ascertain the reliability of the instrument, to familiarize the researcher with the sample technique procedure, instrument for data collection and data analysis, the researcher pilot tested the instrument on SSII secondary school students both male and female in kachia educational zone and this zone was not part of the selected zones to be used in the study. A total of 70 questionnaires were used for the pilot testing.

Split half reliability test was used for data collection and the data were statistically analyzed using Spearman Brown Reliability Coefficient to test the internal consistencies and reliability of the instrument used. The result indicated a reliability coefficient of 0.89 which makes it reliable. Sprega and Stevens (1986) stated that an instrument is reliable if the reliability coefficient falls between, 5 and +1. They further stated that the closer it is to 1 the more reliable the instruments while the lesser it is to 1 the lower the reliability.

Since the reliability for this study was close to +1, the instrument could be adjudged to be reliable for this study.

3.7 Reliability

Reliability of the instrument was based on the researches carried out by different authors using the BDI II as an instrument for measuring depression. The studies were able to establish a test-re-test reliability and internal consistencies. Some of the studies are as include the following; In Nigeria, the Beck Depression Inventory is a popular instrument among mental health practitioners. It has also been found to be very useful as a research instrument (Adekambi, A.1986. Awaritefe 1988, concluded that the BDI is reliable for use as a test which taps certain aspect of psychopathology in the Nigerian culture among the literate population and also significant correlations were observed between the BDI and the API.

Miller and Seligman reported a test re-test reliability of 0.74 for normal 31 undergraduates within a three months' interval. The first sample wascomprised of 120 college students; 56% were female and 44% were male. Internal Consistency: An analysis of internal consistency yielded a Cronbach' s alpha of .92 for the outpatients and .93 for the students. Item-total correlationwere perfo rmed on the scores of both samples, yielding significant correlations (at the .05 level) for both groups on all items.

Tests re-test Reliability: A sub-sample (26 patients) of the clinical sample was retested with the BDI-II one week after the first administration. The test-retest reliabilities were calculated, and yielded an average correlation of .93.

3.8 Procedure for Data Collection

The researcher collected an introduction letter from the Department of Educational psychology and counseling which was taken to the Educational zones offices under State Ministry of Education so as to obtain permission for the schools selected to be used. A letter of introduction was given to the researcher by the above mentioned Board which was also forwarded to school principals for their permission. The data collection was done by the researcher with the help of two research assistants who visited each school and administered the questionnaires to the respondents. The questionnaire on Depression Inventory and Academic Performance Test on English and Mathematics was completed taking at least 40 minutes and the completed questionnaire was returned immediately. They were also allowed to have privacy and privilege to ask questions about items they don't understand when completing the questionnaires.

3.9 Procedure for Data Analysis

The data collected were analyzed using statistical package for social sciences (SPSS), descriptive statistics (mean scores, standard deviation), inferential statistics (one sample Pearson Product Moment Correlation (r), Analysis of variance (ANOVA). Mean and standard deviation were used to answer the research questions while Pearson product moment correlation (r) was used to test hypothesis 1, 2, and 3 while ANOVA was used to test hypotheses 4 and 5 at 0.05 significance level. Pearson product moment correlation (r) was used because it helps to show relationship between variables, ANOVA was chosen and used for testing hypothesis that has between three groups and above (Nwague, 1991) while post hoc test was used to show where differences existed.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the analysis of data collected for the study which aimed primarily at investigating the influence of depression on academic performance among secondary school students in Kaduna state. A total of 777 secondary school students from six educational zones of Kaduna state served as respondents that were used for the study. The analysis is presented in three sections. The first section presents a descriptive statistics of frequencies and percentages which determine the distribution of sampled respondents by their gender, age, class and parental marital status. The second section tested five hypotheses. A total of three null hypotheses were tested using the Pearson Product Moment Correlation statistics, and two null hypotheses were tested using Analysis of Variances. All hypotheses were tested at 0.05 level of significance. Summary of findings and discussions on findings were also included in this chapter

4.2 Distribution of Respondents by their Bio Data Variables

Table 4.2.1: Distribution of Respondents by their Bio Data Variables

Variables	Variable options	N	Percentage (%)
Age Group	10-13 yrs.	45	5.8
	14-17 yrs.	488	62.8
	18-21 yrs.	200	25.7
	22-25 yrs.	32	4.1
	26-29 yrs.	12	1.5
	Total	777	100.0
Gender	Male	518	66.7
	Female	259	33.3
	Total	777	100.0
Parental marital status	Married	430	55.3
	Single	331	42.6
	Divorced	4	.5
	Separated	12	1.5
	Total	**777**	**100.0**

Table 4.2.1 above, shows that 45 representing 5.8% of the respondents were within age range of 10-13 years while 488 representing 62.8% were within the age range of 14-17 years as against 200 representing 25.7% that were within the age range of 22-25 years and the remaining 12 representing 1.5% were between 26-29 years. Majority of the respondents were within the age range of 14-17.

The table shows that a total of 518 representing 66.7% of the respondents were males and the remaining 259 representing 33.3% were females. Thus, this implied that majority of the respondents were male.

The table also revealed that parental marital status, 430 representing 55.3% said their parents were married while 331 representing 42.6% said they have single parents as against 4 representing 0.5% that were divorced and the remaining 12 representing 1.5% were separated. This implied that most of the respondent's parents were married.

4.3 Hypotheses Testing

Hypothesis I

HO_1 There is no significant influence of depression on the academic performance among secondary school students in Kaduna State.

Table 4.3.1: Pearson Product Moment Correlation on relationship between depression and academic performance among secondary school students in Kaduna State.

Variables	N	Mean	Std dev	Df	*r*	*P*
Depression	777	23.0232	9.23851	775		
Academic Performance	777	13.3411	4.86567		-0.723*	0.001

. Correlation is significant at the 0.01 level (2-tailed)

Table 4.3.1 showed outcome of the Pearson Product Moment Correlation (r) statistics which revealed that the calculated p value of 0.001 is lower than the 0.05 alpha level of significance with correlation index r level of -0.723($r = -.723$, $p < .05$) at df 775, this implied that the relationship between the two variables is inversely proportional, that is, the higher the academic performance, the lower the depression level and vice versa.

This therefore suggest that significant relationship exist between academic performance and depression among the respondents, that is depression significantly influences academic performance, therefore the null hypothesis which state that there is no significant influence of depression on academic performance among secondary school students in Kaduna State, is rejected.

Hypothesis II

HO_2 There is no significant influence of depression on academic performance among male secondary school students in Kaduna State.

Table 4.3.2: Pearson Product Moment Correlation statistics on relationship between depression and academic performance among male secondary school students in Kaduna State.

Variables	N	Mean	Std.dev	*r*	Df	*P*
Depression (male students)	518	22.4093	8.58378			
Academic Performance				-0.738	516	0.038
(male students)	518	12.7664	4.72242			

***** correlation is significant at the 0.05 level***

Table 4.3.2 above revealed the results of the Pearson Product Moment correlation (r) statistics which showed the mean level of depression of 22.4093, SD of 8.58378 and a mean academic performance of 12.7664, SD of 4.7224 at a Df of 516 and as such the result showed that significant relationship exist between the depression and academic performance among the male students, since the calculated p value of 0.038 was found to be lower than the 0.05 alpha level of significance at a correlation index level of -0.738. The relationship between the two variables is inversely proportional, that is, the lower the

level of depression the higher the academic performance of male students and vice versa. Therefore, the null hypothesis which states that there is no significant influence of depression on academic performance among male secondary school students in Kaduna State is hereby rejected.

Hypothesis III:

HO3: There is no significant influence of the depression on academic performance among the female secondary school students in Kaduna State.

Table 4.3.3 Pearson Product Moment correlation statistics on relationship between depression and academic performance among the female secondary school students.

Variables	N	Mean	Std.dev	*r*	df	*P*
Depression (female students)	259	24.2510	10.33409			
				-0.827	516	0.000
Academic Performance (female students)	259	14.4903	4.95277			

***** Correlation is significant at the 0.05 level***

Table 4.3.3 above revealed the results of the Pearson Product Moment correlation (r) statistics which showed the mean level of depression of 24.2510, SD of 10.33409 and a mean academic performance of 14.4903,SD of 4.95277 at a Df of 516 and as such the result showed that significant relationship exist between the depression level and academic performance among female students, since the calculated p value of 0.000 was found to be lower than the 0.05 alpha level of significance at a correlation index level of -

0.827. The relationship between the two variables is inversely proportional, that is, the lower the depression the higher the academic performance of female students and vice versa. Therefore, the null hypothesis which states that there is no significant influence of depression on academic performance among the female secondary school students in Kaduna State is hereby rejected.

Hypothesis IV:

HO_4 There is no significant differential influence of depression on the academic performance among secondary school students of different age bracket in Kaduna State.

Table 4.3.4 (A): Analysis of Variance statistics on the difference in the academic performance of secondary school students of different age bracket in Kaduna State

	Sum of Squares	Df	Mean Square	*F*	*P*
Between Groups	1003.571	4	250.893	11.152	.000
Within Groups	17368.050	772	22.497		
Total	18371.620	776			

Table 4.3.4 (A) revealed the results of the Analysis of Variance and its Scheffe post hoc tests, the result showed that the calculated p value of 0.000 was found to be lower than the 0.05 alpha, just as the calculated F ratio value of 11.152 was found to be higher than the F critical value of 2.60 at df 776. This shows that significant difference exists in the academic performance of secondary school students of different age bracket in Kaduna State.

Table 4.3.4 (B): Scheffe Post Hoc statistics on the difference in the academic performance of secondary school students of different age bracket in Kaduna State.

Post Hoc test using the Scheffe tests

Age Group	N	Subset for alpha = 0.05	
		1	2
26-29 yrs.	12	7.6667	
22-25 yrs.	32		11.6250
10-13 yrs.	45		11.8222
18-21 yrs.	200		12.4800
14-17 yrs.	488		14.0861
Sig.		1.000	.323

Means for groups in homogeneous subsets are displayed.

In table 4.3.4, the Post Hoc analysis using the Scheffe test showed that the mean academic performance of secondary school students of ages 10-13 years, 14-17 years, 18-21 years, and 22-25 years were placed in the higher subset 2 indicating that their academic performance was higher than that age groups 26-29 whose mean academic performance was placed in the lower subset 1. Therefore, the null hypothesis which states that there is no significant differential influence on the academic performance of secondary school students of different age bracket in Kaduna State is hereby rejected.

Hypothesis V:

HO_5 The hypothesis states that there is no significant differential influence on the academic performance of secondary school students of different home background in Kaduna State.

Table 4.3.5 (A): Analysis of Variance statistics on the difference in the academic performance of secondary school students of different home background in Kaduna State.

	Sum of Squares	Df	Mean Square	F	P
Between Groups	287.955	3	95.985	4.103	0.007
Within Groups	18083.665	773	23.394		
Total	18371.620	776			

Table 4.3.5 showed the results of the Analysis of Variance and its scheffe post hoc tests, in the Analysis of Variance (ANOVA) tests, the calculated p value of 0.007 was found to be lower than the 0.05 alpha, just as the calculated F ratio value of 4.103 was found to be higher than the F critical value of 2.60 at df 776, This shows that significant difference exists in the academic performance of secondary school students of different in Kaduna State.

Table 4.3.5 (B): Scheffe Post hoc statistics on the difference in the academic performance of secondary school students of different home background in Kaduna State

Parental marital status	N	Subset for alpha = 0.05	
		1	2
Divorced	4	5.0000	
Separated	12		12.6667
Married	430		13.3512
Single	331		13.4532
Sig.		1.000	.984

Table 4.3.5 (B) showed the Post Hoc analysis using the scheffe test which revealed that the mean academic performance of secondary school students of separated, married and single were placed in the higher subset 2 indicating that their academic performance was higher than those from divorced parental background whose mean academic performance was placed in the lower subset 1. Therefore, the null hypothesis which states that there is no significant differential influence of depression on the academic performance of secondary school students of different home background in Kaduna State is hereby rejected.

4.4 Summary of Major Findings

The following are the summary of the major findings.

1. Significant relationship exists between depression and academic performance among secondary school students in Kaduna State. The relationship between the two variables was inversely proportional that is, the higher the depression the lower the academic performance and vice versa.
2. Significant relationship exists between depression and the academic performance of male secondary school students in Kaduna State. The relationship between the two variables was inversely proportional that is, the higher the depression the lower the academic performance and vice versa.
3. Significant relationship exists between depression and the academic performance of female secondary school students in Kaduna State. The relationship between the two variables was inversely proportional that is, the higher the depression the lower the academic performance and vice versa.

4. Significant difference exists in the academic performance of secondary school students of different age bracket in Kaduna State.

5. Significant difference exists in the academic performance of secondary school students of different home background in Kaduna State.

4.5 Discussions

The study found that significant relationship exists between academic performance and depression among secondary school students in Kaduna State. The relationship between the two variables was inversely proportional that is, the higher the academic performance, the lower and the depression level and vice versa. This finding was consistent with study carried out by Hysenbegasi, Hass, and Rowland. (2005), which found out that depression had significant impact on the academic productivity of university students and also reported pattern of increasing interference of depression symptoms with academic performance peaking in the month of diagnosis and decreasing thereafter with the lowest levels reported in 4 to 6 months post- diagnosis Similarly, DeRoma Leach, and Leverett (2009) examined the association between self-reported depressive symptomology and college academic performance, and also found significant and negative relationship between depression and academic performance. In addition, they found that students who reported moderate levels of depressive symptoms demonstrated lower performance within academic environments when compared to those with normal and minimal levels of depression, which is in consistent with the finding of this hypothesis which revealed that significant relationship exists between depression and academic performance among secondary school students

in Kaduna State, and the relationship is inversely proportional, that is the higher the depression, the lower the academic performance and vice versa.

The research revealed that significant relationship exists between depression and academic performance among male secondary school students in Kaduna State. This findings conforms with the study of Winkler, Pjrek, and Kasper 2005 who found that male patients with depression scored significantly higher on irritability, were more prone to overreact to minor annoyances, experienced anger attacks (sudden spells of anger and aggression with physical features similar to panic attacks), had lower impulse control, exhibited greater substance use, and experienced more hyperactive behavior compared with depressed female patients. In contrast to this finding such other behaviours were not established rather only relationship was established where this study found out that significant relationship exists depression and academic performance among male secondary school student in Kaduna State.

Significant relationship exists between depression and academic performance among female secondary school students in Kaduna State. This is similar to a research which suggested that girls are more likely than boys to continue feeling bad after experiencing difficult situations or events, suggesting they are more prone to depression (Hankin, & Abramson, 2001). Another study found that girls tended to doubt themselves, doubt their problem-solving abilities and view their problems as unsolvable more so than boys. The girls with these views were more likely to have depressive symptoms as well. Girls also tended to need a higher degree of approval and success to feel secure than boys (Calvete, and Cardenoso, 2005). One study found that more than 70 percent of depressed

girls experienced a difficult or stressful life event prior to a depressive episode, as compared with only 14 percent of boys (Cyranowski, Frank, Young, & Shear 2000).

In this study there was significant difference between academic performances of secondary school students of different age bracket in Kaduna State. This result was in conformity with Kessler (2007) who reported that the incidence of mental illness among 15 to 24-year-olds was higher than any other age range and that the average age of onset for major depressive disorder was close to 15 years of age. Similarly, in another study, the peak age of depression correlates with the peak years of low self-esteem. However, Feldman & Elliot (1990) also noted that the prime period for low self-esteem was seen in early and middle adolescence with a peak period between the ages of thirteen and fourteen. And in support of this finding also, the Center for Disease Control (CDC) reported that in the United States, approximately 6 to 9 million children and adolescents have serious emotional disturbances (U. S. Public Health Service, 2000).

In another study, Busari (2012) evaluated the relationship between gender, age depression and academic performance among adolescents. She found that depression and academic performance were significantly and negatively correlated, age and academic performance were significantly and positively correlated and females performed significantly better than males. Owens et al. (2012) in their own study investigated the relationship between negative affect, worry, working memory and academic performance, they found that higher levels of anxiety and depression were associated with lower academic performance and concluded that academic performance is reduced in young people with high levels of anxiety or depression as a function of increased test-specific worry that impinges on working memory central executive processes. Similarly,

Frojd Nissinen, Pelkonen, Marttuenb, and Koivisto (2008) reported that depression impair cognitive functioning blocks cognitive sources and many of the academic performance and also homework depends on the ability to sustain attention and concentration, thus depression which is known to disrupt concentration and attention in school is likely to undermine academic performance.

The current study revealed that significant difference exists in the academic performance of secondary school students of different home background in Kaduna State. This finding tends to confirm with Sanford (1996) who revealed that one of the factors that correlate with recurring depression was a negative relationship between adolescents and their fathers along with an inability of the mothers to monitor behavior of their children. Similarly, in support of this finding Allen, Hauser, Eickholt (1994) found out that adolescent depression was seen in higher frequency in families where the children have difficulty establishing their own identity because of negative communication patterns and other dysfunctional family attributes. In another studies carried out by Kenny et.al (1993) also found out that adolescent and young adults who have insecure attachments with their parents were more likely to be depressed and developed anxiety disorders. Secured attachments to parents were predictive of successful social, academic, personal, and psychological functioning.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the whole work, "Influence of Depression on the Academic Performance among Secondary School Students in Kaduna State" contribution to knowledge, conclusion, recommendations as well as suggestions for further studies.

5.2 Summary

The purpose of this study was to analyze the influence of depression on academic performance among secondary school students in Kaduna state. To achieve this, the study was structured into five chapters. Firstly, the general background of the study stressing depression as one of the most common disorders that occur among secondary school students. Depression can have devastating effects on secondary school students who are mostly adolescents. The study had four objectives, four research questions and four research hypotheses which were tested at 0.05 alpha level of significance.

Secondly, the literature review of the study and some of the empirical studies associated with the study was presented under such headings like Concept of depression, Depression in the classroom, Prevalence of Depression, Symptoms of Depression, Forms of depression, Major depressive disorder, Dysthymic disorder, Psychotic depression, Seasonal affective disorder (SAD),

Thirdly, the study designs and methodologies were presented. The study adopted the descriptive survey research design. This design was used because it is non-experimental. Descriptive Survey design helps to describe, record, analyze, and interprets

conditions that exist in a study, and this study intends to assess the influence of depression on academic performance which involves behavior that already exist between and among respondents which they already have the information needed. The population comprised of 777 senior secondary school students in the 12 educational zones viz: - Anchau, Birnin Gwari, Giwa, Godogodo, Kachia, Kaduna, Kafanchan, Lere, Rigachikun, Sabon tasha, Zaria, Zonkwa. The total number of students in the public senior secondary schools in SSS II both male and female that were selected was 777. However, a total of 777 students from six educational zones of Kaduna State were respondents used for the study. The instruments used for the study include 20 items on level of depression stated in scale options of 0, 1, 2 and 3 and the scores in English and mathematics formed the academic performance of the students.

Fourthly, data analysis and discussion of findings was presented and it was observed that the higher the depression the higher the academic performance, the lower the depression the lower the academic performance. There was significant relationship between depression and academic performance of male and female secondary school students. The mean academic performance of secondary school students of ages 10-13 years, 14-17 years, 18-21 years, and 22-25 years were higher than those age groups 26-29 years and the mean academic performance of secondary school students of separated, married and single homes were significantly higher than those students from divorced parental background. Also the first null hypotheses tested revealed that depression significantly influences academic performance, therefore the null hypothesis which state that there is no significant influence of depression on the academic performance among secondary school students in Kaduna state, was hereby rejected. The second hypothesis

revealed that significant relationship exists between depression and academic performance of male students. Therefore, the null hypothesis which states that there is no significant influence of depression on the academic performance among male secondary school students in Kaduna State was hereby rejected. The third hypothesis revealed that significant relationship exists between depression and academic performance among female secondary school students in Kaduna State. Therefore, the null hypothesis which states that there is no significant influence of depression on the academic performance among female secondary school students in Kaduna State is hereby rejected. The fourth hypothesis showed, that significant difference exists in the academic performance of secondary school students of different age bracket in Kaduna State. In the Analysis of Variance (ANOVA) tests, the calculated p value of 0.000 was found to be lower than the 0.05 alpha, just as the calculated F ratio value of 11.152 was found to be higher than the F critical value of 2.60 at df 776. The Post Hoc analysis using the scheffe test showed that the mean academic performance of depressed students of ages 10-13 years, 14-17 years, 18-21 years, and 22-25 years were placed in the higher subset 2 indicating that their academic performance was higher than that age groups 26-29 whose mean academic performance was placed in the lower subset 1. Therefore, the null hypothesis which states that there was no significant differential influence of depression on the academic performance of secondary school students of different age bracket in Kaduna State is hereby rejected. Similarly, hypothesis five, the results of the Analysis of Variance and its scheffe post hoc tests, showed that significant difference exist in the academic performance of secondary school students of different home background in Kaduna State. In the Analysis of Variance (ANOVA) tests, the calculated p value of 0.007 was found to

be lower than the 0.05 alpha, just as the calculated F ratio value of 4.103 was found to be higher than the F critical value of 2.60 at df 776. The Post Hoc analysis using the scheffe test showed that the mean academic performance of secondary school students of separated, married and single were placed in the higher subset 2 indicating that their academic performance was higher than those from divorced parental background whose mean academic performance was placed in the lower subset 1. Therefore, the null hypothesis which states that there was no significant differential influence on the academic performance of secondary school students of different home background in Kaduna State is hereby rejected.

Lastly, presented the study's summary, conclusion and recommendations as well as offered some suggestions for further studies. It was recommended among others that students should be taught by professional counselors and psychologist to develop positive opinion instead of indulging in negative thoughts and self- criticism. The academic performance of secondary school students should be closely monitored by professional counselors and psychologist by giving psychological help to students with depression; and professional counselors and psychologist should give more attention to those students from divorced homes that were mostly affected.

5.3 Conclusions

In view of the findings of this study, it was concluded that significant relationship exists between depression and academic performance among secondary school students in Kaduna State; this means that depression affects academic performance of secondary school students. Similarly, it was also deduced that significant relationship exists between depression and academic performance among male secondary school students in Kaduna

State; this means that depression affects academic performance of male secondary school student. It was also deduced that significant relationship exists between depression and academic performance among female secondary school students in Kaduna State; this means that depression affects academic performance of female secondary school student. Furthermore, it was deduced from the study that significant difference exists in the academic performance of secondary school students of different age bracket in Kaduna State this also means that the older the secondary school students the lower their academic performance. And finally, significant difference exists in the academic performance of secondary school students of different home background in Kaduna State; this also means that the academic performances of those that are from divorced homes are affected greatly.

5.4 Contributions to knowledge

The study "influence of depression on the academic performance among secondary school students in Kaduna State Nigeria", contributed to knowledge in several ways among which were;

1. The study contributed in identifying the extent to which depression influences academic performance among secondary school students in Kaduna State and this would help to ensure reduction of depression at all levels of education by providing evidence based data which would be used by authorities in making appropriate educational decisions.
2. The study added more to the existing body of knowledge by exposing teachers to understanding of how depression could hamper with academic performance of secondary school students in Kaduna State. Such knowledge acquired by the

teachers would enable them pay more attention on issues related to why, how, and when does depression affect these students, and this would furthermore help the teachers institute therapy or make appropriate referral where necessary to the professionals.

3. The student would be able to identify and understand the signs, symptoms, and causes of depression and how it influences their academic performance, therefore enable them to take appropriate precautionary measures.
4. The study contributed to knowledge by creating awareness to public schools that depression and other affective disorders should not be ignored most especially among secondary school students.
5. The current prevalence of depression is known from this study.
6. The findings of the study would help people of different field of study most especially counsellors, psychologist, teachers, government and parents.
7. The study stimulated further studies as suggestion for further studies was given.

5.5 Recommendations

Based on the findings of the study, the following recommendations were made:

1. Professional psychologist and counselor should render psychological interventions using cognitive behavioral techniques to counsel secondary school students who are depressed so as to help improve their academic performance.
2. School teachers should help identify male secondary school students with counseling needs and refer them to the professional counselors and psychologist so that these professionals would guide those students by counseling them either

in group or individually to understand themselves in relation to the social and psychological world in which live, and also develop ability to overcome and resolve special problems or common difficulties

3. Schools psychologist and counselor should target depression by teaching coping strategies and this should be targeted towards those female students who are at risk for depression.

4. Professional Counsellors and psychologist, school principals and teachers should work together so as to counsel and expose students of different age groups most especially those within age bracket of 26-29 to the dangers of depression and depressive symptoms which will in turn help in improving their academic performance.

5. School principals, teachers, parents, professional Counselors and psychologist should give more attention to students of different home background so as to recognize the signs of depression early before the depression interfere with the students' interpersonal relationship.

5.6 Suggestions for Further Studies

This study was limited to the influence of depression on academic performance among secondary school students in Kaduna State. The study is by no means exhaustive, further studies can be carried out to increase knowledge. Based on the methodology and findings of this study, the following suggestions were made for further studies, among which are

1. Influence of psycho social and physical variables on the academic activities of senior secondary schools in Zaria metropolis, Kaduna state.

2. The influence of depression on academic productivity among some selected tertiary institutions in Zaria, Kaduna State.

3. Furthermore, this study concentrated on secondary school students and as such there is a need to replicate this study using other populations such as tertiary institutions students and non-student population.

4. If the studies share the same model, the findings of the studies can be applied in order to develop educational programme for these populations as well, and if they have a different model researchers need to identify what similarities and differences exist between the findings of this study and theirs. This effort may guarantee development of effective and professional counseling centers in most of our educational setting across all population of students in Nigeria.

5. The present study used survey research design, it is suggested that a similar study could be carried out using experimental research design and by extension counselling techniques.

REFERENCES

Abramson, L. Y., Metalsky, G. I., & Alloy, L. B. (1989). Hopelessness depression: A theory based subtype of depression. *Psychological Review, 96*, 358-372.

Abramson, L. Y., Seligman, M. E. P., & Teasdale, I. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*, 49-59.

Addis, M.E. (2008). Gender and Depression in Men, *Clin. Psychol. Sci.,Pract* 15(3):153168.

Akinboye, J.O. (1985). Adolescent Personal Data Inventory (APDI). Ibadan: Claverianum Press. Asonibare, J.B. and E. O. Olayonu 1997. "Locus of control, personality type and academic achievement of secondary school students in Offa and Oyun Local governments." *Nigerian Journal of Clinical and Counselling Psychology*, 3(1): 14-23.

Allen, J. (1995). *Coping with trauma: A guide to self-understanding*. Washington, DC: American Psychiatric Press, Inc

Allen, J., Hauser, S., Eickholt, C., Bell, K. & O'Connor, T. (1994). Autonomy and relatedness in family interactions as predictors of expressions of negative adolescent affect. *Journal of Research on Adolescence*, 4, 535-552.

Allen-Meares, P., Oyserman, D., & DeRoos, Y. (2003). Assessing depression in childhood and Adolescence: A guide for social work practice. *Child and Adolescent Social Work Journal*, 20(1), 5-20. Retrieved May 6, 2015 from Academic Search Premier.

American Psychiatric Association (2000), *Diagnostic and Statistical Manual of Mental Disorders*. Forth Ed. Text Revision, Washington D.C.

Bakare, C.G.M. (1975). Some psychological correlates of academic success and failure. *African Journal of Educational Research*, 2 (20), 11-22.

Bebbington P.E. (1998). Sex and depression. *Psychol Med.* 28(1): 1-8.

Bebbington P. E, Dunn G, Jenkins R, Lewis G, Brugha T, Farrell M, Meltzer H. (2003). The influence of age and sex on the prevalence of depressive conditions: report from the National Survey of Psychiatric Morbidity. *International Review of Psychiatry*. Feb-May; 15(1-2): 74-83.

Bebbington, P. E., Meltzer, H., Brugha, T. S., Farrell, M., Jenkins, R., & Ceresa, C. (2000). Unequal access and unmet need: Neurotic disorders and the use of primary care services. *Psychol Med, 30*(6), 1359-1367.

Beck, A. (1970). Cognitive therapy: Nature and relation to behavior therapy. *Behavior Therapy*, 1(2), 184-200.

Beck, A.T. (1976). *Cognitive therapy and the emotional disorders*. New York: International University Press.

Beck, A.T. (1983). Cognitive therapy of depression: New perspectives. In P. J. Clayton, & J. E. Barett (Eds.), *Treatment of depression*. *Old* controversies and new approaches (pp 265-284). New York: Raven Press.

Beck, A. (1991). "Cognitive therapy: A 30-year retrospective." *American Psychologist*, 46: 368-375.

Biabangard, E. (2003). Effectiveness of Lazarus multimodal therapy, Ellis rational emotional therapy and relaxation on decreasing students test anxiety. *Iranian Journal of Psychiatry and Clinical Psychology*, 8, 36-42.

Blackburn, I. M., Bishop, S., Glen, A. I., Whalley, L. J., & Christie, J. E. (1981). The efficacy of cognitive therapy in depression: A treatment trial using cognitive therapy and pharmacotherapy, each alone and in combination. *British Journal of psychiatry*, 139, 181, 189.

Blacksher, E., (2002). On being poor and feeling poor: Low socioeconomic status and the moral self. *Theoretical Medicine*, 3; 455-470

Bodas, J. (2003). The Moderating Role of Anxiety in Predicting Academic Achievement in Children. M.Sc. Thesis, Faculty of Virginia Polytechnic Institute, Virginia State University, U.S.A.

Boeree, C. G. (1998, 2006). Personality Theories: Abraham Maslow. Retrieved from http://webspace.ship.edu/cgboer/maslow.html.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation: Anxiety and anger.* New York: Basic Books.

Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.

Bradford, E., & Lyddon, W. J. (1993). Current parent attachment: It's relation to perceived psychological distress and relationship satisfaction in college students. *Journal of College Student Development, 34*, 256-260.

Boeree, C. G. (1998, 2006). Personality Theories: Abraham Maslow. Retrieved from http://webspace.ship.edu/cgboer/maslow.html.

Bolger, N. (1990). Coping as a personality process: A prospective study. *Journal of Personality and Social Psychology, 59*(3), 525-537.

Bowden, M. P., Doughney, J. (2011) The importance of cultural and economic influences behind the decision to attend higher education. *The Journal of Socio- Economics*, 41; 95-103.

Brackney, B.E. & Karabenick S, A (1995). "Psycho- pathology and academic performance: the role of motivation and learning strategies." *Journal of Counselling Psychology*, 42(4): 456-465.

Brand, E., King, C., Olson, E., Ghaziuddin, N. & Naylor, M. (1996). Depressed adolescents with a history of sexual abuse: diagnostic comorbidity and suicidality.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46-76). New York: Guilford Press.

Brown, G. P., Hammen, C. L., Craske, M. G., & Wickens, T. D. (1995). Dimensions of dysfunctional attitudes as vulnerabilities to depressive symptoms. *Journal of Abnormal Psychology, 104*, 431-435.

Burford, S. (1995). What's wrong with this 12-year-old boy? Patient Care, 29, 85-88.

Busari, A. O, Uwakwe, C.B.U (2001). The Effects of Stress Inoculation Training Techniques in the Management of Worry as a Self- Handicapping Strategy in Intellectual Performance. *Nigeria J. Emotional Psychol. Sport Ethics* 3; 6 -12

Busari, A. O. (2012). Evaluating the relationship between gender age depression and academic performance among adolescents. *Scholarly Journal of Education*, 1, 6-12.

Caldji, C., Diorio, J., & Meaney, M. J. (2003). Variations in maternal care alter GABAA receptor subunit expression in brain regions associated with fear. *Neuropsychopharmacology, 28*, 150-159.

Calvete E, Cardenoso O. (2005). Gender differences in cognitive vulnerability to depression and behavior problems in adolescents. *Journal of Abnormal Child Psychology*. Apr; 33(2): 179-192.

Cassady, J. C., & Johnson, R. E. (2002) Cognitive test anxiety and academic performance. Contemporary educational Psychology, 27, 270- 295. http://www.idealibrary.comon

Cassano P, Fava M (2002). Depression and public health, an overview. *Journal of Psychosomatic Research*. Oct; 53(4): 849-857.

Carver, C. S. (2007). Stress, coping, and health. In H. S. Friedman & R. C. Silver (Eds.), *Foundations of health psychology* (pp. 117-144). Oxford: Oxford University Press.

Change in Student Performance Since 2000, (2009) .PISA 2009 Results: Learning Trends, Vol. 5, pag. 77. Children's academic performance. Procedia- Social and Behavioral Sciences, 15; 1204- 1208.

Chapell, M. S., Blanding, Z. B., Takahashi, M., Silverstein, M. E., Newman, B., Gubi, A., & Mccann, N. (2005). Test anxiety and academic performance in undergraduate and graduate students. *Journal* of Educational Psychology, 97, 268-274. doi:10.1037/0022-0663.97.2.268.

Chapman, Alan (2000-2009) David c McClelland's Motivational Needs Theory. Business Balls. http://www.businessballs.com/davidmcclelland.html.

Chaudron L.H, Szilagyi P, G, Kitzman H.J, Wadkins H, I, &Conwell Y. (2004) Detection of postpartum depressive symptoms by screening at well-child visits. *Pediatrics*.Mar; 113(3 Pt 1): 551-558.

Chen, X, Li, B.S (2000). Depression mood in Chinese children: Development significance for social and school adjustment. *Int. J. Behav. Dev*., 24:472-479.

Cohen L, Altshuler L, Harlow B, Nonacs R, Newport D, J, Viguera A, Suri R, Burt V, Hendrick A, M, Loughead A, Vitonis A, F, &Stowe Z. (2006) Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *Journal of the American Medical Association*. Feb 1; 295(5): 499-507.

Cohen, A. (2004). Tests anxiety and its effect on the personality of students with learning disabilities. *Journal of the American Medical Association*. Feb 1; 295(5): 499-507.

Compas, B. E., Grant, K. E., & Ey, S. (1994). Psychosocial stress and child and adolescent depression: Can we be more specific? In W. M. Reynolds & H. F. Johnston (Eds.), *Handbook of depression in children and adolescents* (pp. 509-523). New York: Plenum Press.

Conway K, P, Compton W, Stinson F, S, Grant B, F. (2006). Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*. Feb; 67(2): 247-257.

Cullen, D. (1997). Maslow, Monkeys and Motivation Theory. *Organization*, 355-373

Cyranowski J, Frank E, Young E, & Shear K. (2000). Adolescent onset of the gender difference in lifetime rates of major depression. *Archives of General Psychiatry*. Jan; 57(1): 21-27.

Davis, E. P., Donzella, B., Krueger, W. K., & Gunnar, M. R. (1999). The start of a new school year: Individual differences in salivary cortisol response in relation to child temperament. *Developmental Psychobiology, 35,* 188– 196.

Davison, G. C., & Neale, J. M. (2001). *Abnormal Psychology* (8th ed., pp. 241-243). New York: John Wiley & Sons.

Dearden, K.A., N. G. De La Cruz, B.T. Crookston, L. B. Novilla, & M. Clark. (2005). "Adolescents at risk: Depression, low academic performance, violence and alcohol increased Bolivian teenagers' risk of attempted suicide." *The International Electronic Journal of Health Education*, 8:104-119.

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum

Delaney, L., Harmon, C., & Redmond, C. (2011). Parental education, grade attainment and earnings expectations among university students. *Economics of Education Review*, 30; 1136- 1152.

Derogatis, L. R., Lipman, R. S., & Covi, L. (1977) Manual for the symptoms distress checklist 90 (SCL-90). Baltimore: John Hopkins University School of Medicine, Clinical Psychometrics Research Unit.

DeRoma, V. M., Leach, J. B., & Leverett, J. P. (2009) The relationship between depression and college academic performance. *College Student Journal*, 43, 325-334.

Devane C. L, Chiao E, Franklin M, & Kruep E. J. (2005). Anxiety disorders in the 21st century: status, challenges, opportunities, and comorbidity with depression. *American Journal of Managed Care*. Oct; 11(Suppl. 12): S344-353.

Diamond, J. (2005) *The Irritable Male Syndrome: Understanding and Managing the 4 Key Causes of Depression and Aggression*. Emmaus, PA: Rodale Books.

Dobson, K. S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Consulting Clinical Psychology*, 57, 414-419. doi:10.1037/0022-006X.57.3.414

Dobson, K.S. & P. C. Kendall (Eds.) 1993. *Psycho- pathology and Cognition*. San Diego, CA: Academic Press.

Dowler, E., (2005). *Socio-economic status*. University of Warwick, Coventry, UK.

Dreher J. C, Schmidt P. J, Kohn P, Furman D, Rubinow D, Berman K. F. (2007). Menstrual cycle phase modulates reward-related neural function in women. *Proceedings of the National Academy of Sciences*. Feb 13; 104(7): 2465-2470.

Dryden W., & Neenan M. (2003). *Essential Rational Emotive Behaviour Therapy*. Wiley.

Eccles, J., Midgley, C., Wigfield, A., Buchanan, C., Reuman, D., Flanagan, C., & MacIver, D. (1993). Development during adolescence. *American Psychologist*, 48, 90-101.

Egeli, E., Oghan, F., Ozturk, O., &Harputluoglu, U. (2004). Effect of otorhinolarynhological diseases and socioeconomic status of school performance: a survey study. *International Journal of Pedriatic Otorhinolaryngology*, 68; 883-888.

Elliot, A. J., & McGregor, H. A. (2001). A 2 X 2 achievement goal framework. *Journal of Personality and Social Psychology, 80*, 501-519.

Ellis, A. (1957). Rational psychotherapy and individual psychology. *Journal of Individual Psychology,* 13, 38-44.

Ellis, A. (1962) Reason and Emotion in Psychotherapy. p. 54

Ellis, Albert. (1994). *Reason and Emotion in Psychotherapy*, Revised and Updated. Secaucus, NJ: Carol Publishing Group

Ellis, A. (2001*). Feeling better, getting better, staying better*. Impact Publishers.

Ellis, A. (2001). *Overcoming Destructive Beliefs, Feelings, and Behaviors: New Directions for Rational Emotive Behavior Therapy*. Prometheus Books.

Ellis, A. (2003). Early theories and practices of rational emotive behavior theory and how they have been augmented and revised during the last three decades. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 21(3/4).

Elsenberg, D. (2009). College students—Depression and academic performance. Depression Forums Web Page.

Engir-Demir, C., (2009). Factors influencing the academic achievement of the Turkish urban poor. *International Journal of Educational Development*, 29; 17-29.

Essau, C. A. (2007). Comorbidity of depressive symptoms among adolescents in community and clinical settings. *Psychiatry Res*, *158*(1), 35-42.

Evans, D. L., Foa, E. B., Gur, R. E., Hendin, H., O'Brien, C. P., Seligman, M. E. P., (Eds.). (2005). *Treating and preventing adolescent mental health disorders: What we know and what we don't know, a research agenda for improving the mental health of our youth.* New York: Oxford University Press.

Essex, M. J., Klein, M., Cho, E., & Kalin, N. H. (2002). Maternal stress beginning in infancy may sensitize children to later stress exposure: Effects on cortisol and behavior. *Biological Psychiatry*, *52*, 776-784.

Farooqi, Y. N., Ghanl, R., & Spielberger, C. D. (2012) Gender differences in test anxiety and academic performance of medical students. *International Journal of Psychology and behavioural Sciences*, 2, 38-43.

Feldman, S. & Elliott, G. (1990). Adolescence: Path to a productive life or a diminished future? *Carnegie Quarterly*, 35, 1-13.

Finger, B. (2006). "A study between depression and academic performance." Retrieved 24 April 2006 from http://clearinghouse.missouriwestern.edu/ manuscripts/450.asp.

Folkman, S., & Lazarus, R. S. (1984). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology, 48*, 150-170.

Francis, D. D., Diorio, J., Liu, D., & Meaney, M. J. (1999). Nongenomic transmission across generations in maternal behavior and stress responses in the rat. *Science, 286*, 1155-1158.

Freeman E. W, Sammel M. D, Lin H, &Nelson D. B. (2006) Associations of hormones and menopausal status with depressed mood in women with no history of depression.*Archives of General Psychiatry*. Apr; 63(4): 375-382.

Freeman M. P, Wright R, Watchman M, Wahl R. A, Sisk D. J, Fraleigh L, & Weibrecht J. M. (2005) Postpartum depression assessments at well-baby visits: screening feasibility, prevalence and risk factors. *Journal of Women's Health*. Nov 10; 14(10): 929-935.

Fritz, G. (1995). Child, adolescent depression distinct from the adult version. The Brown University Child and Adolescent Behavior Letter, 11,

Frojd, S. A, Nissinen, E. S, Pelkonen, M.U.I, Marttuenb, M. J, & Koivisto, A. M (2008). Depression and school performance in middle adolescent boys and girls. *J. Adolescence*, 31 : 485-498. DOI : 10.1016/j.adolescence.2007.08.006

Gloaguen, V., Cottraux, J., Cucherat, M., & Blackburn, I. M. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of Affective Disorders*, 49, 59-72. doi:10.1016/S0165-0327(97)00199-7.

Goodyer, I. M., Herbert, J., & Tamplin, A. (2003). Psychoendocrine antecedents of persistent first-episode major depression in adolescents: A community-based longitudinal enquiry.

Gunnar, M. R., & Donzella, B. (2002). Social regulation of the cortisol levels in early human development. *Psychoneuroendocrinology 27*(1-2), 199-220. *Psychological Medicine, 33*, 601-610.

Grant, K. E., Compas, B. E., Stuhlmacher, A. F., Thurm, A. E., McMahon, S. D., & Halpert, J. A. (2003). Stressors and child and adolescent psychopathy: Moving from markers to mechanisms of risk. *Psychological Bulletin, 129*(447-466).

Hall, L. (2007) http://www.self-actualizing.org/articles/Wayne_Dyer_and_Maslow.pdf

Halligan, S., Herbert, J., Goodyer, I. M., & Murray, L. (2004). Exposure to postnatal depression predicts elevated cortisol in adolescent offspring. *Biological Psychiatry, 55*, 376-381.

Halverson J.L (2014) cognitive Therapy for Depression Medline

Hankin B. L, & Abramson L. Y (2001). Development of gender differences in depression: an elaborated cognitive vulnerability-transactional stress theory. *Psychological Bulletin*. Nov; 127(6): 773-796.

Hartas, D. (2000). "Affective disorders and academic performance in students with and without specific learning difficulties: there is relationship?" Paper presented at ISEC 2000, University of Derby, U.K.

Hebb, D. O. (1972) Text book of psychology (3rd ed.). Philadelphia: Saunders. http://www.getselfhelp.co.uk/epictetus.html.

Hinderlie, H. H., & Kenny, M. E. (2002). Attachment, social support, and college adjustment among black students at predominantly white universities. *Journal of College Student Development, 43*(3), 327-340.

Hoffman, E. (2008). Abraham Maslow: A Biographer's Reflections. *Journal of Humanistic Psychology, 48*, 439-443.

Huitt, W. (2007). Maslow's hierarchy of needs. *Educational Psychology Interactive*. Valdosta, GA: Valdosta State University. Retrieved [date] from, http://www.edpsycinteractive.org/topics/regsys/maslow.html

Hysenbegasi, A., Hass, S. L., & Rowland, C. R. (2005) The impact of depression on the academic productivity of university Students. *Journal of Mental Health Policy Economic*, 8, 145-151. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 34-42.

Kahn, J. (1995). Adolescent Depression: An overview. (Available from the University of Utah Neuropsychiatric Institute, 501 Chipeta Way, Salt Lake City, Utah 84108).

Karabenick, S.A. & R. Sharma (1994). "Seeking academic assistance as a strategic learning resource", (pp. 189- 211). in P. Pintrich, D. Brown, and C. Weinstein (eds.), *Students Motivation Cognition and Learning: Essays in Honour of Wilbert J. McKeachie*. Hillsdale, NJ: Erlbaum.

Karabenick, S. A., & Sharma, R. (1994). Seeking academic assistance as a strategic learning resource. In P. R. Pintrich, D. R. Brown & C. E. Weinstein (Eds.), *Student motivation, cognition, and learning: Essays in honor of Wilbert J. McKeachie* (pp. 189-211). Hillsdale, NJ: Lawrence Erlbaum Associates

Kassim, M. A., Hanafi, R. M., & Hancock, D. R. (2008). Test anxiety and its consequences on academic's performance among university students. Advance in Psychology.

Katon W. & Ciechanowski P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research*. Oct; 53(4): 859-863.

Kenny, M. E., Moilanen, D. L., Lomax, R., & Brabeck, M. M. (1993). Contributions of parental attachments to view of self and depressive symptoms among early adolescents.

Kenny, M. E., & Gallagher, L. A. (2002). Instrumental and social/relational correlates of perceived maternal and paternal attachment in adolescence. *Journal of Adolescence, 25* 203-219.

Kenny, M. E., & Rice, K. G. (1995). Attachment to parents and adjustment in late adolescent college students: Current status, applications, and future considerations. *The Counseling Psychologist, 23*, 433-456. *Journal of Early Adolescence, 13*(4), 408-430.

Kendall, P.C., K.D Stark & T. Adam. (1990). "Cognitive deficit or cognitive distortion in childhood depression." *Journal of Abnormal Child Psychology*, 18: 225-270.

Kendall, P.C. & K.S Dobson, (1993). "On the nature of cognition and its role in psychopathology", (pp. 3-17) in K.S. Dobson and P.C. Kendall (Eds.) *Psychopathology and Cognition*. San Diego, CA: Academic Press.

Kessler R. C, Barker P. R, Colpe L. J, Epstein J. F, Gfroerer J. C, Hiripi E, Howes M. J, Normand SL, Manderscheid RW, Walters EE, & Zaslavsky AM. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry*. Feb; 60(2): 184-189.

Kessler R. C, Berglund P, Demler O, Jin R, Koretz D, Merikangas K. R, Rush A. J, Walters E. E, & Wang P. S. (2003) The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *Journal of the American Medical Association*.; 289(23): 3095-3105.

Kessler, R. C., Foster, C. L., Saunders, W. B., & Stang, P. E. (1995). Social consequences of psychiatric disorders, I: Educational attainment. *Am J Psychiatry, 152*(7), 1026-1032.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048-1060.

Khajehpour, M., & Ghazvini, S. D, (2011). The role of the parental involvement affects in Ma, X., (2001). Stability of socio-economic gaps in mathematics and science achievement performance, report says. Toronto Star (1987), Toronto, Canada.

Koplewicz, H. S. (2002). More than moody: Recognizing and treating adolescent depression. New York: Putnam. ISBN: 039914918X.

Krejcie, R.V., & Morgan, D.W., (1970). Determining Sample Size for Research Activities. *Educational and Psychological Measurement*.

Lamarine, R. (1995). Child and adolescent depression. *Journal of School Health*, 65, 390-394.

Lapsley, D. K., & Edgerton, J. (2002). Separation-individualization, adult attachment style, and college adjustment. *Journal of Counseling and Development, 80*, 484-495.

Larsen, R., & Buss, D. M. (2008). *Personality psychology: Domains of knowledge about human nature* (3rd ed.). New York: McGraw Hill.

Lazarus, R. S. (1991). Progress on a cognitive-motivational-relational theory of emotion. *American Psychologist, 46*, 819-834.

Lewinsohn P. M, BiglanT, & Zeiss, A. (1976). Behavioral treatment of depression. In: P. Davidson (Ed.). *Behavioral management of anxiety, depression, and pain*. New York: Brunner/Mazel.

Lewinsohn, P. M. (1974). A behavioral approach to depression. In: R. J Friedman and M. M Katz (Eds). *The Psychology of Depression: Contemporary Theory and Research*. New York: WileY:157-185.

Lopez, F. G., & Brennan, K. A. (2000). Dynamic process underlying adult attachment organization: Toward an attachment theoretical perspective on the healthy and effective self. *Journal of Counseling Psychology, 47*(3), 283-300.

Loveleena R. (2013). Aaron Beck's cognitive behaviour theory. Buzzle.com.

Lupien, S. J., King, S., Meaney, M. J., & McEwen, B. S. (2000). Child's stress hormone levels correlate with mother's socioeconomic status and depressive state. *Biological Psychiatry, 48*, 976-980.

Lynch J., & Kilmartin, C. (1999). *The Pain behind the Mask: Overcoming Masculine Depression*. New York, NY: Haworth Press.

Maslow, A. (1943). A Theory of Human Motivation. *Psychological Review*, 50, 370-396.

McLeod, S. A. (2014). *Maslow's Hierarchy of Needs - Simply Psychology*. Retrieved from http://www.simplypsychology.org/maslow.html#self2

Mandler, G., & Sarason, I. G. (1952). A study of anxiety and learning, *Journal of Abnormal and Social Psychology*, 87, 166-173. doi:10.1037/h0062855

McCarthy, J., Downes, E., & Sherman, C. (2008). Looking back at adolescent depression: A qualitative study. *Journal of Mental Health Counseling*, 30(1), 49-68. Retrieved May 6, 2015 from Academic Search Premier.

McGinn, L. K. (2000). Cognitive behavioral therapy of depression: Theory, treatment and empirical status. *Armenian Journal of Psycho- therapy*, 54, 254-260.

Merrell, K. (2001). Helping students overcome depression and anxiety: A practical guide. New York: Guilford. ISBN: 1572306173.

Mikulincer, M., & Shaver, P. R. (2005). Attachment theory and emotions in close relationships: Exploring the attachment dynamics of emotional reactions to relational events. *Personal Relationships, 12*, 149-168.

Mikulincer, M., Shaver, P. R., & Pereg, D. (2003). Attachment theory and affect regulation: The dynamics, development, and cognitive consequences of attachment-related strategies. *Motivation and Emotion*, *27*(2), 77-102.

Mufson, L., & Fairbanks, J. (1996). Interpersonal psychotherapy for depressed adolescents: A one-year naturalistic follow-up study. Journal of the American Academy of Child and Adolescent Psychiatry, 35, 1145-1155

Mufson, L., & Moreau, D. (1999). Interpersonal psychotherapy for depressed adolescents (IPT-A). In Russ & Ollendick (Eds.), Handbook of psychotherapies with children and adolescents (pp. 239-253). New York, NY: Kluwer Academic/Plenum.

Mufson, L., & Moreau, D. (1998). Interpersonal psychotherapy for adolescent depression. In J. C. Markowitz (Ed.), Interpersonal psychotherapy (pp. 35-66). Washington, DC: American Psychiatric Press

Mufson, L., Moreau, D., Weissman, M. M. (1996). Focus on relationships: Interpersonal psychotherapy for adolescent depression. In E. D. Hibbs & P. S. Jensen (Eds.), Pyschosocial treatments for child and adolescent disorders (pp. 137-155). Washington, DC: American Psychological Association.

Mufson, L., Moreau D., Weissman, M. M., Wickramaratne, P., Martin, J., & Samoilov, A. (1994). Modification of interpersonal psychotherapy with depressed adolescents (IPT-A): Phase I and II studies. Journal of the American Academy of Child and Adolescent Psychiatry, 33, 695-705

Mufson, L., Weissman, M. M., Moreau, D., & Garfinkel, R. (1999). Efficacy of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, 56, 573-579

Moreau, D., Mufson, L., Weissman, M. M., & Klerman, G. L. (1991). Interpersonal psychotherapy for adolescent depression: Description of modification and preliminary application. Journal of the American Academy of Child and Adolescent Psychiatry, 30, 642-651

Moilanen, D. L. (1993). Depressive information processing among non- clinic

Moilanen, D. L. (1995). Validity of Beck's cognitive theory of depression with non-referred adolescents. *Journal of Counseling and Development,* 73, 438-442.

Moilanen, D. L. (1995). Validity of Beck's cognitive theory of depression with nonreferred adolescents. *Journal of Counseling & Development, 73,* 438-442.

Munk-Olsen T, Laursen T. M, Pederson C. B, Mores O, & Mortensen P. B. (2006). New parents and mental disorders. *Journal of the American Medical Association*. Dec 6; 296(21): 2582-2589.

Ndirangu, G. W., Muola, J. M., Kithuka, M. R., & Nassiuma, D. K. (2009). An investigation of the relationship between test anxiety and academic performance in secondary schools in Nyeri District, Kenya. *Global Journal of educational Research*, 8, 1-7.

Newman, J. L., Fuqua, D.R., Gray, E. A., &Simpson, D. B. (2006). Gender Differences in the Relationship of Anger and Depression in a Clinical Sample. *J Couns Dev.* 84:157.

New model revises role of self-esteem. (1995, November). The Addiction Letter, 11, 5.

Nolen-Hoeksema S, Larson J, & Grayson C. (1999). Explaining the gender difference in depressive symptoms. *Journal of Personality and Social Psychology*; 77(5): 1061-1072.

Nwague, J. A. (1991). An Introduction to Educational Research and Statistics. Published by Steve Printing Press Ltd. Kaduna, Nigeria.

O'Connor, D., & Yballe, L.. (2007). Maslow Revisited: Construction a Road Map of Human Nature. *Journal of Management Education*, 31(6), 738-756. Retrieved January 21, 2010, from ABI/INFORM Global. (Document ID: 1392302941).

Okwilagwe, E. A. (2001). "A causal model of undergraduate students' academic achievement." *Evaluation Research*. 1(1): 129-1

Oler, M. (1994). Depression, suicidal ideation, and substance use among adolescents: Are athletes at less risk? *The Journal of American Medical Association*, 272, 781-785.

Owens, M., Stevenson, J., Hadwin, J. A., & Morgate, R. (2012). Anxiety and depression in academic performance. An exploration of the mediating factors of worry and working memory. School Psychology International. doi:10.1177/0143034311427433

Papalia, D. E., & Olds, S. W. (1988). *Psychology*. New York: McGraw Hill Book Company.

Pennebaker, J. W. (2000). Psychological factors influencing the reporting of physical symptoms. In A. Stone, J. S. Turkkan, C. A. Bachrach, J. B. Jobe, H. S. Kurtzman & V. S. Cain (Eds.), *The science of self-report: Implications for research and practice* (pp. 299–315). Mahwah, N: Lawrence Erlbaum Associates.

Pintrich, P.R. & B. Schrauben (1994). "Students motivational beliefs and their cognitive engagement in classroom academic tasks", (pp. 149-184). in D. Schunk and J. Meece (Eds.), *Student Perceptions in The Classroom: Causes and Consequences*. Hills- dale, N. J: Erlbaum.

Rafiq, R., Ghazal, S., & Farooqi, Y. N. (2007). Test anxiety in students: Semester vs annual system. *Journal of Behavioural Sciences*, 17, 79- 95.

Rana, R. A., & Mahmood, N. (2010). The relationship between test anxiety and academic achievement. *Bulletin of Education and Research*, 32, 63-74.

Rapee, R. M. (1997). Potential role of childrearing practices in the development of anxiety and depression. *Clinical Psychology Review, 17*(1), 47-67.

Rao, U. (1994). Adolescent depression may lead to depression later in life. The Brown University Child and Adolescent Behavior Letter, 10, 3.

REBT particularly follows Korzybski in this respect..." Albert Ellis (2010) in *The Albert Ellis reader: A guide to well-being using rational emotive behavior therapy*, p. 306. Google Books preview retrieved August 18.

Regier D. A, Rae D. S, Narrow W. E, Kaebler C. T, & Schatzberg A. F. (1998). Prevalence of anxiety disorders and their comorbidity with mood and addictive disorders. *British Journal of Psychiatry*. 173(Suppl. 34): 24-28.

Redmond, B.F. (2010). Need Theories: What Do I Want When I Work? *Work Attitudes and Motivation*. The Pennsylvania State University World Campus

Reynolds, R. M., Walker, B. R., Syddall, H. E., Wood, P. J., Phillips, D. I. W., & Whorwood, C. B. (2001). Altered control of cortisol secretion in adult men with low birthweight and cardiovascular risk factors. *Journal of Clinical Endocrinology & Metabolism, 86*, 245250.

Robertson, D. (2010). *The Philosophy of Cognitive-Behavioural Therapy: Stoicism as Rational and Cognitive Psychotherapy*. London: Karnac. ISBN 978-1855757561. http://books.google.co.uk/books?id=XsOFyJaR5vEC&lpg.

Rohan K. J, Lindsey K. T, Roecklein K. A, & Lacy T. J. (2004). Cognitive-behavioral therapy, light therapy and their combination in treating seasonal affective disorder. *Journal of Affective Disorders*. 80: 273-283.

Ross L. E, & Steiner M. (2003). A Biopsychosocial approach to premenstrual dysphoric disorder. *Psychiatric Clinics of North America*. 26(3): 529-546.

Rossello, J., & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. Journal of Consulting and Clinical Psychology, 67, 734-745.

Royle, M., & Hall, A. (2012). The Relationship Between McClelland's Theory of Needs, Feeling Individually Accountable, and Informal Accountability for Others. *International Journal of Management and Marketing Research, 5.*, 21-44

Rubinow D. R, Schmidt P. J, & Roca C. A. (1998). Estrogen-serotonin interactions: Implications for affective regulation. *Biological Psychiatry*. 44(9): 839-850.

Rush, A. J., Beck, A. T., Kovacs, M., & Hollon, S. (1977). Comparative efficacy of cognitive therapy and pharmacotherapy in the treatment of depressed outpatients. *Cognitive Therapy Research*, 1, 17- 37. doi:10.1007/BF01173502

Salami, S.O. (1999). *Generalized Self-Efficacy Questionnaire*. Ibadan: Department of Guidance and Counselling, University of Ibadan, Ibadan.

Salami, S.O. (2004a). "Relationship between psycho- pathology and vocational interests among school- going adolescents in Nigeria." *International Journal for the Advancement of Counselling*. 26(2): 163-175.

Salami, S.O. (2004b). "Affective characteristics as determinants of academic performance of school going adolescents: Implications for counseling practice". *Sokoto Education Review*, 7: 145-160.

Salmela-Aro, K., Nurmi, J., Saisto, T., & Halmesmaki, E. (2001). Goal reconstruction and depressive symptoms during the transition to motherhood: Evidence from two cross-lagged longitudal studies. *Journal of Personality and Social Psychology, 81,* 1144-1159.

Sandro, C., (1987). Schools urged to get parents involved Family participation aids academic

Sanford, M. (1996). Which teens will still be depressed a year later? The Brown University Child and Adolescent Behavior Letter, 12, 5.

Santor, D. A., & Kusumakar, V. (2001). Open trial of interpersonal therapy in adolescents with moderate to severe major depression: Effectiveness of novice IPT therapists. Journal of the American Academy of Child and Adolescent Psychiatry, 40, 236-240

Sarason, I. G. (1975). Test anxiety, attention and the general problem of anxiety. In C. D. Spielberger, & I. G. Sarason (Eds.), *Stress and anxiety*. Washington DC: Hemisphere.

Sarason, S. B., Davidson, K. S., & Lighthall, F. F. (1960). *Anxiety in elementary school children*. New York: Wiley.

Sato, T., & McCann, D. (2000). Sociotropy-autonomy and the Beck Depression Inventory. *European Journal of Psychological Assessment, 16,* 66-76.

Schmidt P. J, Nieman L. K, Danaceau M. A, Adams L. F, & Rubinow D. R. (1998). Differential behavioral effects of gonadal steroids in women with and in those without premenstrual syndrome. *New England Journal of Medicine*. Jan 22; 338(4): 209-216.

Schwartz, A., & Schwartz, R. (1993). Depression: Theories & treatments. New York: Columbia University Press.

Shaver, P. R., & Hazan, C. (1993). Adult romantic attachment: Theory and evidence. In D. Perlman & W. Jones (Eds.), *Advances in personal relationships* (Vol. 4, pp. 29-70). London: Jessica Kingsley.

Son, S. E. (2000). Depression in children and adolescents. American Family Physician, 62(10), 2297-2310. Retrieved May 6, 2015, from Academic Search Premier.

Sotonade, O.A.T. (1997). "A study of psychopathological pattern of some observed Nigerian adolescents." *Nigerian Journal of Advanced Research in Education*, 1(1): 97-109.

Spielberger, C. D. (1980). *The test anxiety inventory*. Palo Alto, CA: Consulting Psychologist Press Inc.

Spielberger, C. D., & Vagg, R. P. (1995). *Test anxiety*. Bristol: Taylor & Francis.

Spielberger, C. D., Gorsuch, R. L., & Lushene, R. E. (1970). *STAI manual*. Palo Alto: Consulting Psychologists Press Inc.

Stuart-Kotze, R. (2009). Motivation Theory. Retrieved from http://www.goal-setting-guide.com/motivation-theory.html

Stuart, J., Rupke, M. D., David Blecke, M., Div, M. S. W., & Majorie Renfrow, M. D. (2006). *Cognitive therapy for depression. American Family Physician*, 73, 83-86.

Sultanoff, B., & Zalaquett, C. (2000). Relaxation therapies. In D. Novey (Ed.), *Clinician's complete reference to complementary & alternative Medicine* (pp. 114-129). New York: Mosby.

Sullivan, R., Wilson, D. A., Feldon, J., Yee, B., Meyer, U., Richter-Levin, G., et al. (2006). Impact on early life experiences on brain and behavioral development. *Dev Psychobiol, 48*(7), 583-602.

Svanum, S. & Z. Zody. (2001). "Psychopathology and college grades." Journal of Counselling Psychology, 48: 72-76.

Tooransposhti, M. G. (2011). A new approach for test anxiety treatment, academic achievement and met cognition. *International Journal of Information and Education Technology*, 1, 221-229.

Tsuang M. T, Bar J. L, Stone W. S, & Faraone S. V. (2004). Gene-environment interactions in mental disorders. *World Psychiatry*. Jun; 3(2): 73-83.

Value Based Management.net. (2009, 3 23). *Abraham Maslow biography - Hierarchy of Needs*. Retrieved September 2, 2009, from Value Based Management.net: http://www.valuebasedmanagement.net/leaders_maslow_hierarchy.html

Wampold, B. E., Mnami, T., Baskin, T. W., & Callen Tiemey, S. (2002). A meta-(re) analysis of the effects of cognitive therapy versus "other therapies" for depression. *Journal of affective disorders*, 68, 159-165. doi:10.1016/S0165-0327(00)00287-1

Weissman, M. M., & Markowitz, J. C. (1994). Interpersonal psychotherapy, current status. Archives of General Psychiatry, 51, 599-606.

Weinstock, L. M., & Whisman, M. A. (2006). Neuroticism as a common feature of the depressive and anxiety disorders: A test of the revised integrative hierarchical model in a national sample. *Journal of Abnormal Psychology, 115*(1), 68-74.

Wetzel, J. W. (1984). *Clinical handbook of depression*. New York: Gardner Press.

Whitley, G. (1996, March). The seductive diagnosis. D Magazine, 84-99.

Whittington, J.L. & Evans, B. (2005). The Enduring Impact of Great Ideas Electronic Version. *Problems and Perspectives in Management*, 2, 114

Winkler, D., Pjrek, E., & Kasper S. (2005). Anger Attacks in Depression – Evidence for a Male Depressive Syndrome. *Psychother Psychosom*. 74(5):303-307.

Wolk, S.I. & Wiseman, M.M. (1995) "Women and Depression" in Oldham, J.M., Riba, M.B. (eds) *Review of Psychiatry* Vol. 14, Washington D.C. American Psychiatric Press, 227.

Zeidner, M. (1998). *Test anxiety: The state of the Art*. New York: Plenum.

Zhao, N., Valcke, M., Desoete, A., & Verhaeghe, J. (2011). The quadratic relationship between socioeconomic status and learning performance in China by multilevel analysis: Implications for policies to foster education equity. *International Journal of Educational Development*, 2011. Kothi, Belanganj, Agra, 1-8.

APPENDICES

AHMADU BELLO UNIVERSITY, ZARIA

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY AND COUNSELLING

QUESTIONNAIRE FOR STUDENTS

Dear Respondents,

I am a postgraduate student of the above mentioned university conducting a research on "Influence of depression on the academic performance among secondary school students in Kaduna state." Kindly assist by providing honest response to the questionnaire items. Be assured that all information supplied will be confidential and will be destroyed after necessary information has been extracted.

Thank you for anticipated co-operation.

Suleiman Jamila Aliyu

APPENDIX I

RESEARCH QUESTIONNAIRE

SECTION ONE

BIO-DATA

Age Group 10-13 ( )

14-17 ( )

18-21 ( )

22-25 ( )

26-29 ( )

Gender MALE ( )

FEMALE ( )

Class SS2 ( )

Parental marital status

Married ( )

Single ( )

Divorced ( )

Separated ( )

APPENDIX II

BECKS DEPRESSION INVENTORY II

Instructions

Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling. Circle the number besides the statement you have picked. If several items or statements in the group seem to apply, equally well circle the highest number for that group. Please be sure you do not pick or choose more than one statement for any group.

1. Mood

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

2. Pessimism

0. I am not particularly discouraged about the future.
1. I feel discouraged about the future.
2. I feel I have nothing to look forward to.
3. I feel the future is hopeless and that things cannot improve.

3. Past failure

0. I do not feel like a failure.
1. I feel I have failed more than the average person.
2. As I look back on my life, all I can see is a lot of failures.
3. I feel I am a complete failure as a person.

4. Loss of pleasure

0. I get as much satisfaction out of things as I used to.
1. I don't enjoy things the way I used to.
2. I don't get real satisfaction out of anything anymore.
3. I am dissatisfied or bored with everything.

5. Guilty Feelings

0. I don't feel particularly guilty
1. I feel guilty a good part of the time.
2. I feel quite guilty most of the time.
3. I feel guilty all of the time.

6. Punishment feelings

0. I don't feel I am being punished.
1. I feel I may be punished.
2. I expect to be punished.
3. I feel I am being punished.

7. Self-Dislike

0. I don't feel disappointed in myself.
1. I am disappointed in myself.
2. I am disgusted with myself.
3. I hate myself.

8. Self-criticalness

0. I don't feel I am any worse than anybody else.
1. I am critical of myself for my weaknesses or mistakes.
2. I blame myself all the time for my faults.
3. I blame myself for everything bad that happens.

9. Suicidal Thoughts

0. I don't have any thoughts of killing myself.
1. I have thoughts of killing myself, but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.

10. Crying

0. I don't cry any more than usual.
1. I cry more now than I used to.
2. I cry all the time now.
3. I used to be able to cry, but now I can't cry even though I want to.

11. Irritability

0. I am no more irritated by things than I ever was.
1. I am slightly more irritated now than usual.
2. I am quite annoyed or irritated a good deal of the time.
3. I feel irritated all the time.

12. Loss of Interest

0. I have not lost interest in other people.
1. I am less interested in other people than I used to be.
2. I have lost most of my interest in other people.
3. I have lost all of my interest in other people.

13. Indecisiveness

0. I make decisions about as well as I ever could.
1. I put off making decisions more than I used to.
2. I have greater difficulty in making decisions more than I used to.
3. I can't make decisions at all anymore.

14. Worthlessness

0. I don't feel that I look any worse than I used to.
1. I am worried that I am looking old or unattractive.
2. I feel there are permanent changes in my appearance that make me look unattractive
3. I believe that I look ugly.

15. Loss of Energy

0. I can work about as well as before.
1. It takes an extra effort to get started at doing something.
2. I have to push myself very hard to do anything.
3. I can't do any work at all.

16. Changes in Sleep Pattern

0. I can sleep as well as usual.
1. I don't sleep as well as 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 several hours earlier than I used to and cannot get back to sleep.

17. Tiredness or Fatigue

0. I don't get more tired than usual.
1. I get tired more easily than I used to.
2. I get tired from doing almost anything.
3. I am too tired to do anything.

18. Changes in Appetite

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 anymore.

19. Weight gain/loss

0. I haven't lost much weight, if any, lately.
1. I have lost more than five pounds.
2. I have lost more than ten pounds.
3. I have lost more than fifteen pounds.

20. Concentration difficulty

0. I am no more worried about my health than usual.
1. I am worried about physical problems like aches, pains, upset stomach, or constipation.
2. I am very worried about physical problems and it's hard to think of much else.
3. I am so worried about my physical problems that I cannot think of anything else.

APPENDIX III

ACADEMIC PERFORMANCE TEST

ENGLISH LANGUAGE

From the word lettered A-D chose the word that has the same consonant sound as the one represented by the letter(s) underlined. An example is given below.

1. Tank
   A. Fetch. B. thumb. C. begged. D. later
2. Cap . A. corpse. B. receipt. C. corps. D. phone.
3. Nice. A. sing. B. column. C. condemns. D. sink
4. Straight. A. trait. B. strong. C. luster. D. center.
5. Knowledge. A. burn. B. course. C. kiss. D. mock

From the words lettered A-D, choose the word that has the same vowel sound(s) as the one represented by the letter(s) underlined.

6. Sick. A. spike. B. sake. C. peak. D. woman
7. Birth. A. colonel. B. bath. C. egg. D. colour.
8. Rude. A. room. B. rout. C. rum. D. role
9. Tight. A. bait. B. bite. C. bit. D. birth
10. Act. A. ample. B. part. C. law. D. class.

In each of the following sentences, the word that receives the **emphatic stress** is written in capital letters. From the questions lettered A-D, choose the one to which the given sentence is the appropriate answer.

11. It rained ALL day yesterday.

A. For how long did it rain yesterday?

B When did it rain all day?

C Was it dry all yesterday?

D Did it rain all day last week?

12. The judge CAUTIONED the prosecution witness.

A Who cautioned the prosecution witness?

B Did the judge praise the prosecution witness?

C Did the judge caution the defense witness?

D Did the judge caution the prosecution counsel?

13. The old man is a MESSENGER.

A Who is the messenger?

B Is the young man a messenger?

C Is the old man a messenger?

D Is the old man a typist?

14. Honesty is ALWAYS the best legacy

A Is honesty always the best legacy?

B Is honesty always the worst policy?

C Is honesty seldom the best policy?

D Is honesty the best legacy?

From the word lettered A-D, choose the word that contain the sound represented by the given phonetic symbol.

15.	/e/	A. grateful.	B. breakfast.	C. great.	D. mete
16.	/i/	A. tea	B. dim	C. shape	D. child
17.	/z/	A. rice	B. twice.	C. boys.	D. cross
18.	/k/	A. ocean	B. scene.	C. charade	D. chaos
19.	/^/	A. hat	B. last	C. sun	D. hot.

20. You have to wait till the bell is _____ by the prefect in charge.

A. ringing. B. rung. C. rang.

21. In the library, everybody is _____.

A. being watched. B. been watched. C. been watch

22. The boys have gone home. They _____ to watch the game on television.

A. have. B. will have. C. needed.

23. The guest promised to send the items when he _____ back home.

A. gets. B. got. C. has got.

24. Mr. Hakeem told us last week that the Earth_____ around the sun.

A. is revolving. B. revolved. C. revolves.

25. Because of the hard times many workers live in _____poverty

a. Repulsive
b. Ridiculous
c. Abject

MATHEMATICS

1. The greater of the two roots of the equation (2x-5)(3x+10) =0 is.

   A. -50. B. -10. C. -3. D. 2 ½ E. 5

2. One of the roots of the equation $(n-13)^2=9$ is 10. The other root is.

   A. 4. B. 16. C. 22. D. 68. E. 94

3. Find the value of *k* such that $x^2 + 5x + k$ is a perfect square.

   A. 2 ½ B. 4 ¼ C. 6 ¼ D. 25. E. 100

4. If $0^o \leq 180^o$ and $cos\theta = -0.5$, then $\theta =$ A. 30^o B. 60^o C. 120^o D. 135^o E. 150^o

5. If $\emptyset = 248^o$, which one of the following statement is false.

   A. $\tan\emptyset > 0$ B. $\tan\emptyset = 68^o$ C. $\sin\emptyset < 0$ D. $\sin\emptyset = -sin22^o$ E. $\tan\emptyset > sin\emptyset$

6. The antilog of $\bar{2}.3869$ is

   A. 0.002437. B. 0.02437. C. 0.2437. D. 2.437 E. 24.37

7. Express 0.0078 in standard form.

   A. 7.8×10^{-3} B. 7.8×10^{-2} C. 7.8×10^{1} D. 7.8×10^{2}. E. 7.8×10^{3}

8. Express 4081.0392 to 2 significant figures.

   A. 4100. B. 4081.04. C. 4081.039. D 4080. E. 4000

9. The length of a well is given as 20m to 1s.f. calculate the possible percentage error in this measurement.

   A. $\pm0.25\%$ B. $\pm2.5\%$ C. $\pm5\%$ D. $\pm10\%$ E. $\pm25\%$

10. Estimate which one of the following has the least value.

    A. $\frac{0.256}{48}$ $B.\frac{0.256}{4.8}$ $C.\frac{2.56}{0.48}$ $D.\frac{2.56}{4.8}$ $E.\frac{25.6}{480}$

11. If $2x + 3y = 4$ and $3x - y = 6$, then $x =$

A. 0. B. ½ C. 2/3 D. 1. E2

12. Given that $3x + 7y = 1 \; and \; x - 7y = 19$, then $x + y =$

A. -2 B. -3. C. 3 D. 5 E 7

13. The straight line $x + y = 2$ and the curve $x^2 + y^2 = 10$ intersect at the point (3, -1). They also intersect at the point

A. (-3, 1) B. (-3, -1) C. (3, 1) D. (-1, 3). E. (1, -3)

14. An interior angle of a regular polygon is 5 times each exterior angle. How many sides has the polygon?

a. 15
b. 12
c. 9
d. 6

15. Given that x is an integer, what is the greatest value of x which satisfies $4 - 3x > 24$? A. -7. B. -6. C. -3. D. 6. E. 7

Table 1 shows the ages of some members of a senior school choir.

Age (years)	15	16	17	18
Number of students	5	6	3	1

16. What is the mean age of the students?

A. 15yrs B. 16yrs. C. 16 ½ yrs D. 17yrs E. 18yrs

17. What is the median age in Table 1?

A. 15yrs. B. 16yrs. C. 16 ½ yrs D. 17yrs E. 18yrs

18. The average speed, in km/h, of a car that travels 72km in 45 min is

A. 45. B. 54. C. 64. D. 88. E. 96

19. A fair coin is tossed once. What is the probability of getting a head or a tail? A. 0 B. ¼ C. ½ D. 1 E. 2

20. A die is thrown and a coin is tossed. What is the probability of getting a 1 and a head together? . A. 1/12 B. 1/6 C.1/3 D. ½ E. 2/3

21. Two bags of sugar at ₦x per bag are mixed with three bags of sugar at ₦y per bag. What is the cost of the mixture per bag?

22. The mean of three numbers is 9. The mode is 11. The lowest of the three numbers is A. 3. B. 5 C. 8 D. 9 E. 11

23. Express the true bearing 210^{o} as a compass bearing

A. S30^{o}W B. S30^{o}E C. N30^{o}W D. S60^{o}E E. S60^{o}W

24. Solve $2x - 3 < 5$ A. $x < 1$ B. $x > 1$ C. $x < 2$ D $x < 4$ E. $x > 4$

25. A fair die with faces numbered 1, 2, 3, 4, 5, 6 is rolled. What is the probability of getting a prime number? A. 1/6 B. 1/3 C. ½ D. 2/3 E 5/6.

Answering Research questions

Research Question One: What is the influence of depression on the academic performance of secondary school students in Kaduna State?

Table 4.2.1: Correlation between academic performance and depression among secondary school students in Kaduna State

Variables	N	Mean	Std,dev	Df	Correlation index
Academic Performance	**777**	**13.341**	**4.865**		
				775	**-0.723**
Depression	**777**	**23.023**	**9.238**		

The table 4.2.1 revealed correlation statistics of mean 13.341 and standard deviation of 4.865 for academic performance and mean of 23.023 and standard deviation of 9.238 for depression and a df of 775 to a correlation index of -0,723, which showed that depression influences the academic performance of secondary school students in Kaduna State to a correlation index of -0.723. This implied that the relationship between the two variables was inversely proportional, that is the higher the academic performance, the lower the depression level and vice versa.

Research Question Two: What is the influence of depression on the academic performance of male secondary school students in Kaduna State?

Table 4.2.2: Correlation between depression and academic performance male among secondary school students in Kaduna State

Variables	Gender	N	Mean	Standard deviation	r
Depression	Male	518	22.409	8.583	-0.738
Academic Performance		518	12.766	4.722	

Table 4.2.2 showed the descriptive mean statistics which showed the mean academic performance of male which is 22.409 and standard deviation of 8.583 respectively and r index of -0.738. Thus this showed that relationship exist between depression and academic performance among male secondary school students in Kaduna State.

Question Three: What is the influence of depression on the academic performance of female secondary school students in Kaduna State?

4.2.3 Correlation between depression and academic performance female among secondary school students in Kaduna State

Variables	Gender	N	Mean	Standard deviation	r
Depression	Female	259	24.251	10.334	-0.827
Academic Performance		259	14.490	4.925	

Table 4.2.3 showed the descriptive mean statistics which showed the mean academic performance of male which is 24.251 and standard deviation of 10.334

respectively and r index of -0.827. Thus this showed that relationship exist between depression and academic performance among female secondary school students in Kaduna State.

Question Four: What is the influence of depression on the academic performance of secondary school students of different age bracket in Kaduna State?

Table 4.2.4: Descriptive mean statistics on influence of depression on the academic performance of secondary school students of different age bracket in Kaduna State?

Age groups	N	Mean	Std. Deviation
10-13 yrs.	45	11.8222	4.88871
14-17 yrs.	488	14.0861	5.27370
18-21 yrs.	200	12.4800	3.59363
22-25 yrs.	32	11.6250	2.48544
26-29 yrs.	12	7.6667	.98473
Total	777	13.3411	4.86567

The table 4.2.4 revealed a descriptive mean statistics above which showed that the mean academic performance of depressed students of ages 10-13 years, 14-17 years, 18-21 years, 22-25 years and 26-29 years were 11.822, 14.0861, 12.4800, 11.6250 and 7.6667 respectively, and a standard deviation of 4.88871, 5.27370, 3.59363, 2.48544, and .98473 respectively. This revealed that difference exist in the academic performance of depressed secondary school students of different age bracket in Kaduna State. This also showed that ages 26-29 years have the least academic mean performance compared with the other age groups.

Question Five: What is the influence of depression on the academic performance of secondary school students of different home background in Kaduna state?

Table 4.2.5: Descriptive mean statistics on the academic performance of secondary school students of different home background in Kaduna state

Parental marital status	N	Mean	Std. Deviation
Married	430	13.3512	4.86100
Single	331	13.4532	4.90393
Divorced	4	5.0000	.00000
Separated	12	12.6667	.98473
Total	777	13.3411	4.86567

Table 4.2.5 showed the outcome of the descriptive mean statistics which showed the mean academic performance of depressed students of married, single, divorced and separated are 13.3512, 13.4532, 5.000 and 12.667 respectively, and standard deviation of 4.86100, 4.90303, .00000, and .98473 respectively. Thus the result showed that difference exist in the academic performance of depressed secondary school students of different home background in Kaduna State. This showed that depressed students from divorced parental home had the least academic performance when compared with students from other parental marital status.