



The Role of Family Bio-Social Variables in Depression in a Resource-Constrained Environment: A Cross-sectional Study of Ambulatory Adult Patients in a Primary Care Clinic in Eastern Nigerian

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Background: Depression is a family and public health condition that has negative consequences for the victim, family, friends, and society with significant socio-family dysfunction, especially when it is undiagnosed. **Aim:** The present study was aimed at determining the role of family bio-social variables in depression among ambulatory adult patients in a primary care clinic in the Eastern Nigerian. **Materials and Methods:** A clinic-based cross-sectional descriptive study was carried out on 400 adult patients in a primary care clinic in Nigeria. Data were collected using Patient Health Questionnaire-9, Family Assessment Device, Multidimensional Scale of Perceived Social Support and Brief Family Relationship Scale. **Results:** The age of the study participants ranged from 18 to 78 years. There were 40.5% of male and 59.5% of female. The prevalence of depression was 48.5% with the most common pattern being mild depression (32.3%). Depression was significantly associated with unhealthy family functioning ($P = 0.002$), low-acuity family support ($P = 0.039$), family with least cohesion ($P = 0.044$), least expressiveness ($P = 0.013$), and most conflict ($P = 0.013$). The most significant predictor of depression was unhealthy family functioning (Odds ratio = 3.14 [1.82–3.77]; $P = 0.001$). Depressed patients who had unhealthy family functioning were three times more likely to experience depressive illness compared to their counterparts who were from healthy functional family. **Conclusion:** Depression occurred among the study participants and was significantly associated with unhealthy family functioning, low family support, least family cohesion and expressiveness and most family conflict. Assessment of family biosocial factors should be part of the reason for encounter during consultation to unravel family variables that positively or negatively influence depression.

Key words: Adult Nigerians, biosocial variables, depression, family, primary care

INTRODUCTION

Depression is a family and public health problem that causes significant mortality^{1,2} and morbidity with affectations of interpersonal, family, work, social functioning, and health-related quality of life of the victim, especially when it is unrecognized and severe.^{3,4} Depression is defined as a mood or mental disorder that causes a persistent feeling of sadness and loss of interest in pleasurable activities accompanied by an inability to carry out daily activities for at least 2 weeks.¹ It is characterized by arrays of clinical manifestations such as persistent low mood, anhedonia, anergia, weight changes, poor or increased appetite, insomnia or hypersomnia, psychomotor problems, feeling

of worthlessness or excessive guilt, poor concentration, and suicidal ideation.⁵⁻⁷ In operational terms, depression has been defined by various Working Groups for clinical diagnosis using specific set of criteria by diagnostic statistical manual (DSM-V)⁵ and International Classification of Diseases-10.⁶ The diagnostic criteria varied in specific number of symptom counts for diagnosis but generally include core symptoms of depressed mood, anhedonia, and constellations of other symptoms.^{5,6}

Etiopathogenetically, depression is a heterogeneous disorder⁸ that results from complex interactions of psychosocial,

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environmental, and biogenetic factors.⁸⁻¹⁰ Depression has been reported among patients with chronic medical conditions¹¹ such as diabetes mellitus,¹² hypertension,¹³ stroke,¹⁴ chronic pain,¹⁵ HIV/AIDS,¹⁶ cancers,¹⁷ ischemic heart disease,¹⁸ and obesity¹⁹ as well as with factors that increase the risk for these medical conditions. Family biosocial variables have also been documented to affect the psychological and physical constructs of individuals with depressive mental disorder in Nigeria²⁰⁻²² and other parts of the world.²³⁻²⁷ The psychosomatic climate of the family that predisposes to depression include adverse life events like bereavements, loss of job, financial or material resources, dysfunctional relationships and communications, family conflicts, distressed and abusive family environment and psychological trauma.^{28,29} Globally, the burden of depression is increasing^{1,30} and in the year 2010, depressive disorder was the second leading cause of disability-adjusted life years and years of life lived with disability.³¹ In 2017, depression is estimated to affect >300 million people of all ages and a leading cause of disability worldwide affecting more women than men and at its most severe forms can lead to suicide.^{1,2} The Global Burden of Disease Study estimates the point prevalence of unipolar depression of 1.9% for men and 3.2% for women and 1-year prevalence of 5.8% for men and 9.5% for women.³² In 2015, an estimated 16.1 million (6.7% of all adults) adults aged 18 years and older in the United States of America had at least one major depressive episode in the previous 1 year.³³ In India, lifetime prevalence of depression was 5.25% among individuals aged 18 years and above with the current prevalence of 2.68% suggesting that 1 out of 20 adult individuals have suffered from depression in the past with half of them suffering at present,³⁴ while World Health Organization (WHO) reported that about 36% of the Indian population suffers from major depression at some times or the other in their lives.³⁵ In Nigerian survey of mental health, the reported lifetime incidence of major depression in adults aged 18 years and more was 3.1% with 1 year estimate of 1.1%.³⁶ As a global health problem, burden of depression varies considerably depending on where a person lives but an increase of > 18% has been reported between 2005 and 2015 with the WHO leading a 1-year global campaign on depression.¹ This was highlighted by the World Health Day 2017 with the theme “Depression: let’s talk”¹ and World Family Doctors Day 2017 with the theme “Curbing depression.”³⁷ In October 10, 2012, during the World Mental Health Day, WHO and World Federation of Mental Health declared Depression as a global health crisis.³⁸ The goal of the campaign on depression is that there are more people with depression everywhere in the world and those with depressive mental illness should seek and get help.^{1,37,38}

Family as an intimate nurturing group is defined in the context of the index patient as a group of individuals connected

to a patient biologically, legally or by choice from whom the patient reasonably expect a measure of support in the form of food, shelter, finance, and emotional nurturing sharing a past, a present, and a future including all who contribute to the family culture.³⁹ There are different types of family, the classification of which can influence depressive illness positively or negatively with implications for development, course, recognition, and treatment.^{23,24,28,29} Research studies have shown that family ecodynamics such as family support, family functionality and family relationship functioning are pertinent predictors of depressive mental illness and play an important role in the causation, treatment, prognosis as well as moderating exogenous depression-related risk factors.²⁰⁻²⁹ Unhealthy family dynamics can lead to family dysfunction, low acuity family support, less cohesion, less emotional expression ability, and more family conflicts that can predispose, promote, perpetuate, and prompt depressive mental disorder.^{28,29,40} In response to the burden of mental health disorders such as depression WHO has identified family and social support as a vital component in caring for patients with the depressive mental illness.^{1,41}

The burden of depression is rising in Nigeria^{42,43} and the cost of its treatment is astronomically beyond the reach of average Nigerian family thus mandating the need for primary prevention through identification of family bio-social risk factors that predispose to depression.²⁰⁻²² The early detection of depression can be enhanced by screening patients who have high index of suspicion and who presented with history of family dysfunction during clinical encounter for other reasons for consultation. There is therefore the need to explore family ecodynamics which will provide the needed buffer to family-engendered depressive illness. This study was therefore undertaken to describe the role of family biosocial variables in depression in a cross-section of ambulatory adult patients in a primary care clinic in Eastern Nigerian.

MATERIALS AND METHODS

Study design

This was a cross-sectional descriptive study carried out on 400 adult patients in May 2017 and June 2017 at the Department of Family Medicine of the Federal Medical Centre (FMC), Umuahia, a tertiary hospital in Abia State, Eastern Nigeria.

Study area and hospital setting

Umuahia is the capital of Abia state, Nigeria. Abia State is endowed with abundant mineral and agricultural resources with supply of professional, skilled, semi-skilled, and unskilled workforce. Economic and social activities are

low compared to industrial and commercial cities such as Onitsha, Port Harcourt, and Lagos in Nigeria. Until recently, the capital city and its environs have witnessed an upsurge in the number of banks, hotels, schools, markets, industries, junk food restaurants in addition to the changing dietary and social lifestyles.

The study was conducted at the Department of Family Medicine of FMC Umuahia, Nigeria. The Department of Family Medicine of the hospital serves as a primary care clinic within the setting of the tertiary hospital. Patients who need primary care are managed and followed up in the clinic while those who need other specialists care are referred to the respective core specialist clinics for further management.

Selection criteria

The inclusion criteria were adult patients aged ≥ 18 years who gave informed consent for the study. The exclusion criteria were critically ill patients, the deaf and dumb.

Sample size determination and sampling method

Sample size estimation was determined using the formula⁴⁴ for estimating minimum sample size for descriptive studies using the formula $n = Z^2pq/d^2$ where n = Desired sample size when population is $>10,000$; Z = Standard normal deviate set at 1.96 which corresponds to 95% of confidence limit; P = prevalence of depression in a Nigerian family practice population in Ado-Ekiti Nigeria⁴⁵ ($P = 47.8\%$); d = Desired level of precision was set at 0.05. Substituting in the formula, gave a sample estimate of 384 patients. However, selected sample of 400 adult patients was used to improve the precision of the study.

The eligible patients for the study were consecutively recruited for the study based on the inclusion criteria until the sample size of 400 was achieved.

Data instrumentation

The instrument for data consisted of sections on family demographic variables, Patient Health Questionnaire-9,⁴⁶ General Functioning sub-scale of the Family Assessment Device (FAD),⁴⁷ Multidimensional Scale of Perceived Social Support (MSPSS)⁴⁸ and Brief Family Relationship Scale.⁴⁹ The generic 9-item module Patient Health Questionnaire (PHQ) was used for the assessment of depression.⁴⁶ It consists of the nine DSM-IV criteria for depression and assesses symptoms of depression over the past 2 weeks among the respondents. Each of the nine items is scored: Not at all = 0; several days = 1; more than half the days = 2; nearly every day = 3. The total score is graded thus: 0–4 = No depression; 5–9 = mild depression; 10–14 = moderate depression; 15–19 = moderately severe and >19 = severe depression. The PHQ-9 is standardized

and has comparable sensitivity and specificity with other depression scales^{46,50} and has also been used in Nigerian primary care practice population.^{22,45}

Family functionality was assessed using a 12-item General Functional sub-scale of McMaster Model of Family Functioning-FAD.⁴⁷ The 12-item questionnaire tool consists of six positively worded items and six negatively worded items. Each item is scored on a 4-point Likert scale 1–4 as follows: Strongly agree = 1; Agree = 2; Disagree = 3; and Strongly disagree = 4. Higher scores indicate worse levels of family functioning or problematic functioning. The final score was obtained by summing up the items scores and then divided by 12. In general functioning sub-scales, the final score of ≤ 2.0 meant healthy family functioning while score of >2.0 indicated unhealthy family functioning.

Family support was assessed using a 12-item MSPSS from family, friends, and significant others.⁴⁸ Each item is scored 1–7 as follows: very strongly disagree = 1; strongly disagree = 2; mildly disagree = 3; neutral = 4; mildly agree = 5; strongly agree = 6; and very strongly agree = 7. The scores ranged from 12 to 84 with scores 12–48 = low acuity; 49–68 = moderate acuity and 69–84 = high acuity.

Family relationship was assessed using Brief Family Relationship Scale⁴⁹ which measures the degree of relationship dimensions in family functioning. It consists of subscales of cohesion, expressiveness of emotion, and conflict resolution. Each item is scored 0–3 as follows: 0 = strongly agree; 1 = agree; 2 = disagree; 3 = strongly disagree. The scores for cohesion is 0–7 = most cohesive; 8–14 = moderate cohesive and 15–21 = least cohesive; for expressiveness: 0–3 = most expressive; 4–6 = moderate expressive and 7–9 = least expressive; for conflict: 0–6 = most conflict; 7–12 = moderate conflict and 13–18 = least conflict.

Pretesting of the data collection tool was done at the Family Medicine clinic of the hospital. Five general outpatients were haphazardly used for the pretesting of the data collection instrument which lasted for 1 day. The pretesting was done to assess the applicability of the questionnaire tools. All the patients used for the pretesting of the questionnaire instrument gave valid and reliable responses confirming the clarity and applicability of the questionnaire tools and questions were interpreted with the same meaning as intended.

Operational definition of terms

Operationally, family is defined as anyone or group of people that are related to the patient by birth, marriage, legally, or emotionally or by choice. Family functionality referred to the perception of the behavior of family members in relation to their physical and psychological interactions. Family support referred to the assistance from family members, friends, and

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significant others that will facilitate recovery from depression. The family relationship is the pattern of interaction by which family members help each other to cope with depression situations. Family cohesion referred to a person's perception of the emotional bonding that members of the family have toward one another.

Ethical consideration

Ethical certification was obtained from Health Research and Ethics Committee of the hospital. Informed consent was also obtained from the respondents included in the study.

Statistical analysis

The data generated were analyzed using software Statistical Package for Social Sciences software version 21 (IBM SPSS, New York, USA). Categorical variables were described by frequencies and percentages. Bivariate analysis involving Chi-square test was used to test for significance of the association between categorical variables. In logistic regression analysis, the dependent (outcome) variable was the depression status, and the independent variables were types of marriage, family size, type of family, family functionality, family support, family cohesion, family expression, and family conflict. The outcomes of interest were assigned number "1" in the logistic regression modeling. In all cases, a value of $P < 0.05$ was considered statistically significant. Odds ratio (OR) which is an indicator of the degree of association of depression with a predictor family biosocial variable was estimated at 95% of confidence level.

RESULTS

The age of the study participants ranged from 18 years to 78 years with the mean age of 38 ± 9.2 years. There were 162 (40.5%) males and 238 (59.5%) females with male to female ratio of 1:1.5. Other family demographic characteristics of the study participants are shown in Table 1. Of the four hundred study participants, one hundred and ninety-four of them had depression, giving a prevalence of 48.5% with the most common pattern being mild depression (32.3%) [Table 2].

Table 3 shows the association between depression and family demographic characteristics. None of the family demographic characteristics was statistically significant. Table 4 shows the association between family function, family support, family relationship, and depression. Family functionality ($P = 0.002$), family support ($P = 0.039$), family cohesion ($P = 0.044$), family expression ($P = 0.039$), and family conflict ($P = 0.013$) were statistically significant.

On logistic regression analysis of family biosocial variables as related to depression, family functionality

Table 1: Family biosocial characteristics of the study participants

Variables	n (%)
Age	
18-39	84 (21.0)
40-59	204 (51.0)
≥60	112 (28.0)
Sex	
Male	162 (40.5)
Female	238 (59.5)
Type of marriage	
Monogamous	386 (96.5)
Polygamous	14 (3.5)
Family size	
1-4	128 (32.0)
≥5	272 (68.0)
Type of family	
Nuclear	240 (60.0)
Extended	160 (40.0)
Family function	
Healthy	274 (68.5)
Unhealthy	126 (31.5)
Family support	
High acuity	192 (48.0)
Moderate acuity	110 (27.5)
Low acuity	98 (24.5)
Family cohesion	
Most cohesive	212 (53.0)
Moderately cohesive	103 (25.8)
Least cohesive	85 (21.2)
Family expressiveness	
Most expressive	218 (54.5)
Moderately expressive	96 (24.0)
Least expressive	86 (21.5)
Family conflicts	
Most conflict	178 (44.5)
Moderate conflict	92 (23.0)
Least conflict	130 (32.5)

(OR = 3.14 [1.82–3.77]; $P = 0.001$); family support (OR = 2.63 [1.56–10.84]; $P = 0.025$); family cohesion (OR = 1.93 [1.12–4.20]; $P = 0.031$); family expression (OR = 5.15 [4.06–7.26]; $P = 0.016$) and family conflict (OR = 2.47 [1.92–4.80]; $P = 0.005$) were statistically significant while other variables were not statistically significant [Table 5]. The most significant family biosocial predictor of depression

Table 2: Prevalence and pattern of depression among the study participants

Variables	<i>n</i> (%)
Prevalence of depression	
Depressed	194 (48.5)
Not depressed	206 (51.5)
Pattern of depression	
Mild	129 (32.3)
Moderate	58 (14.4)
Moderately severe	5 (1.3)
Severe	2 (0.5)

Table 3: Association between depression and family demographic characteristics

Variables	Depression status		χ^2	<i>P</i>
	Depressed, <i>n</i> (%)	Not depressed, <i>n</i> (%)		
Type of marriage				
Monogamous	182 (93.8)	204 (99.0)	8.13	0.219
Polygamous	12 (6.2)	2 (1.0)		
Family size				
1-4	84 (43.3)	44 (21.4)	6.33	0.560
≥5	110 (56.7)	162 (78.6)		
Type of family				
Nuclear	75 (38.7)	165 (80.1)	4.65	0.304
Extended	119 (61.3)	41 (19.9)		

was family functionality. A significantly higher proportion of patients with depression (56.6%) had unhealthy family functioning compared to their counterparts from healthy family functioning (43.4%). Depressed patients from unhealthy family functioning were three times more likely to have depression compared to their counterparts who were from healthy functional families (OR = 3.14 [1.82–3.77]; *P* = 0.001).

DISCUSSION

This study has shown that the prevalence of depression was 48.5% and depression was associated with unhealthy family functioning, low-acuity family support, least family cohesion, least family expressiveness and most family conflict orientation among the study participants. The prevalence of 48.5% reported in this study is lower than the prevalence of 59.6% reported among family practice patients in Ilesa, Western Nigeria,²¹ but higher than 44.5% reported in Ilorin, Western Nigeria,²² 47.8% in Ado-Ekiti, Western Nigeria,⁴⁵ 45.7% in Port Harcourt, South-south, Nigeria,²⁰

Table 4: Association between family function, family support, family relationship and depression

Variables	Depression status		χ^2	<i>P</i>
	Depressed, <i>n</i> (%)	Not depressed, <i>n</i> (%)		
Family functionality				
Healthy	82 (43.4)	192 (93.2)	11.30	0.002
Unhealthy	112 (56.6)	14 (6.8)		
Family support				
High acuity	52 (26.8)	140 (68.0)	9.56	0.039
Moderate acuity	60 (30.9)	50 (24.3)		
Low acuity	82 (42.3)	16 (7.7)		
Family cohesion				
Most cohesive	54 (27.9)	158 (76.7)	5.62	0.044
Moderately cohesive	62 (31.9)	41 (19.9)		
Least cohesive	78 (40.2)	7 (3.4)		
Family expression				
Most expressiveness	51 (26.3)	167 (81.1)	7.35	0.039
Moderately expressive	63 (32.5)	33 (16.0)		
Least expressive	80 (41.2)	6 (2.9)		
Family conflicts				
Most conflict	108 (55.7)	70 (33.9)	10.20	0.013
Moderate conflict	56 (28.8)	36 (17.5)		
Least conflict	30 (15.5)	100 (48.6)		

Table 5: Logistic regression analysis of family biosocial variables as related to depression

Variables	OR	CI	<i>P</i>
Type of marriage	3.26	0.86-5.03	0.107
Family size	4.35	0.71-6.88	0.302
Type of family	3.79	0.58-5.15	0.289
Family function (unhealthy)	3.14	1.82-3.77	0.001
Family support (low-acuity)	2.63	1.56-10.84	0.025
Family cohesion (least cohesive)	1.93	1.12-4.20	0.031
Family expression (least expressive)	5.15	4.06-7.26	0.016
Family conflict (most conflict)	2.47	1.92-4.80	0.005

OR=Odds ratio; CI=Confidence intervals

and in population-based studies of 19% reported in Oyo state, Western Nigeria⁵¹ and 15.1% in Chennai, South, India.⁵² The high prevalence reported in this study could be a reflection of the epidemiological characteristics of the study population in addition to the degree and pattern of aggregations of predisposing factors of depression among various families and communities in Nigeria. The findings of this study have corroborated previous reports on the burden of depression on Nigerian families²⁰⁻²² and other parts of the world.^{23,25,26} Of

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great concern in Nigeria is that depressed patients and family members do not realize that depression is a treatable disorder with some attributing depressive mental illness to spiritual forces and spells from enemies.⁵³ This could result in healer shopping from one spiritual home to the other thus causing further delay in seeking appropriate care with the worsening of illness experience. Clinicians attending to depressed patients should realize that depression is a family health problem and engage in widespread education of the patients and family members on the recognition of family-related risk factors of depression. It is quintessential for clinicians to appreciate that family influence is omnipresent in depressive disorder and optimal family support, functionality and relationship are a positive buffer to the risk of depression.⁵⁴ It is therefore vital that primary care-oriented family intervention be proactively done before clustering of depression in the family. This appears to be one of the ways patients with depression will benefit from family-oriented care for depression.

Depression was significantly associated with low family acuity. The finding of this study has lent credence to the reports that absence or low level of perceived family and social support is a surrogate predictor of depression and could be used to determine how well a depressive patient would be able to cope with his or her illness and maintain long-term health and wellness states.^{21,27} The role of family and social support for patients with depression cannot be ignored during clinical encounter with depressive patients.²⁷ In as much as depressive illness can prevent the victim from participating in family and social life, adequate family support can buffer the factors that predispose to depression.^{27,55} The physician should provide guide to the patient and family on how to cope with depressive illness, especially the need to talk^{1,56} and readiness to provide help and support to the depressed family member.²⁷ Family members should be encouraged to provide invaluable emotional and diverse support, encouraging the depressed person to change the behavior that prompted the depression. Identifying challenges of family support in depressed patients should lead to search for an effective way for primary and secondary prevention. The support of family members, friends, and significant others can modify the risk factors of depression and facilitate early resolution and return to normal personal, family, and social functions.^{21,28} The finding of this study is, therefore, a clarion call to foster longitudinal support for depressed patients as well as a frequent exploration of the degree of family support aimed at optimizing care for depression.

This study has shown that patients with depression had dysfunctional family when compared with those without depression. Although not every patient with unhealthy family function had depression, their chances are higher

when compared with those with healthy functional family. The finding of this study is in accord with reports that bio-psychosocial environment of the dysfunctional family provides a fertile ground for the emergence and persistence of depression.^{20,24,25,28,52,57} Although evaluation of family functioning among depressed patients can easily be done in clinical practice, identification of potentially family-related modifiable risk factors that are associated with dysfunctional family among the patients with depressive illness is of high clinical value during physician–patient encounter. Nevertheless, the functional family has been found useful in moderating exogenous family-related risk factors of depression and other challenges associated with its manifestations.^{20,22} Since depression destroys and ruins the career of the affected family member as it keeps the depressed person out of family activities, social functions, and work with tremendous effects on family financial, material, and other resources; there is need more than ever before to explore family functionality during clinical encounter with depressive patients. The presence of a dysfunctional family, therefore, predisposes to depression while a functioning family protects against depression and aids in faster and sustained recovery from depressive illness. Physicians should, therefore, ask specific questions on family functionality during consultations with depressed patients to discern overt or covert family dysfunction requiring family-oriented interventions.

Seventy-eight (40.2%), 80 (41.2%) and 108 (55.7%) of the study participants with depression had least family cohesion, least expression of emotion, and most conflict orientation, respectively. This finding agrees with the reports that psychosocial ecology in the setting of abnormal family relationship can prompt depressive illness in the member of the family, especially in the presence of conflict and contentious family interactions.^{23,28,29,40,58} Depression can, therefore, represent a manifestation of maladaptive communication of family-environmental-related stresses and distresses.^{26,28} Although depression affects every individual in different ways and several risk factors of depression exist, the most mind-boggling is lack of expression.^{1,56,59} Depressed patients tend to experience diminished levels of emotional expressiveness which could limit positive communication of symptoms. This lack of expression in depression has spurred WHO to initiate a campaign on depression on World Health Day 2017 with the theme “Depression-Let’s talk.”⁶⁰ Talking to family members, friends, and significant others not only help to treat depression but also prevent its debilitating complications including suicidal ideation, impulses and attempts. There is, therefore, need to explore who to talk to, what to talk when to talk, why to talk which can help to understand the need to talk.^{1,56,59}

Study implications

A depressive disorder is a heterogeneous mental ill-health that has negative consequences for the victims, the family, friends, and society with significant socio-family dysfunction, especially when it is undiagnosed and severe. Depressive patients with the dysfunctional family system are often encountered in the primary care settings, and family dynamics is an integral component of factors that maintain optimum health in the management of depression, especially in the ambulatory care environment. Regular evaluation of family function during a clinical encounter with depressive patients can provide the clinician with additional information on overt and covert family-related factors of depression. This study beckons for holistic care of depressive patients with relative relevance given to family-related factors. A functionally dynamic family not only protects against depression but also contribute to the maintenance of family homeostasis.

Study limitations

The study has some limitations. First, the sample for the study was drawn from Family Medicine clinic of the Hospital. Hence, the findings of this study may not be general conclusions regarding depressive patients attending mental health clinic of the Hospital. More so, the study was hospital-based thus the results of this study may not be general conclusions regarding respondents in the community. Furthermore, the limitations imposed by the self-reported measure of family functionality, family support, and family relationship functioning for the study are recognized by the authors. Despite these limitations, the study provides valuable data that has relevant implications for family-oriented protective and risk factors for depression.

CONCLUSION

Depression occurred among the study participants and was significantly associated with the unhealthy family function, low-acuity family support, least family cohesion and expressiveness and most family conflict interactions. The most significant family biosocial predictor of depression was unhealthy family functioning. Assessment of family biosocial factors should be part of the reason for encounter during consultation with depressive patients to unravel family variables that can positively or negatively influence depressive mental illness.

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Conflicts of interest

There are no conflicts of interest.

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