SOCIO-DEMOGRAPHIC PREDICTORS OF EMOTIONAL HEALTH PROBLEMS AMONG CIVIL SERVANTS IN NSUKKA LOCAL GOVERNMENT AREA OF ENUGU STATE

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Title Page

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Approval Page

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Dedication

This work is primarily dedicated to my God and father in heaven who kept me alive till now, and made it possible for me to get to this point despite all odds, may His name be praised for life. Secondarily, it is dedicated to all going through emotional health problems as a result of life challenges.

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Elufidipe-Olumide, Happinesss A

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Abstract

The study investigated socio-demographic predictors of emotional health problems among the civil servants in Nsukka LGA of Enugu state. Five specific objectives with their corresponding research questions and three null hypotheses were formulated to guide the study. The study adopted cross-sectional survey research design. A sample size of 282 was drawn from the population of 959 using Taro Yamaneôs formula. A two stage sampling procedure were used to draw the sample.Depression Anxiety Stress Scale (DASS-21) and Clinical Anger Scale (CAS) were used for data collection. A total of 282 copies of the questionnaire were administered to the participants, 241 were returned, which gave a return rate of 85 per cent. The 241 copies returned were duly filled out and used for data analysis. Frequencies, percentages and Spearman Rho were used to answer the research questions and logistic regression models were used to test the hypotheses at .05 level of significance. The findings showed that moderate proportion of civil servants experienced depression, anxiety, stress and anger. The Civil servants in Nsukka LGA had mild depression, extremely severe anxiety, severe stress and severe anger.There was a weak positive relationship between educational status, income level, age and emotional health problems (depression, anxiety, stress)among civil servants and a weak positive relationship between income level, age and anger. From the findings only educational status and anger had a weak negative relationship among civil servants. Among the three socio-demographics, only age was found to be associated with an increased likelihood of depression, anxiety and stress thereby significantly predicting depression, anxiety and stress.Income level and educational status were not associated with an increased likelihood of emotional health problems (depression, anxiety, stress and anger) among civil servants in Nsukka LGA. Based on the above findings the author recommended among others that the health educators, governmental and non-governmental bodies, social medias, curriculum planners, administrators among others should organize workshop, in-service training and seminars to help the civil servants in Nsukka LGA to have abetter understanding of emotional health problems and their predictors. .

CHAPTER ONE

Introduction

Background to the Study

Emotional health problems (EHPs) are as old as human race.EHPs were erroneously perceived to be only associated with a set of people, especially the poor and afflicted individuals. However, EHPs seem to be linked with more variables than just affliction and hardship. When there is a consistent negative experience or buildup of emotions especially negative ones, they make it difficult for one function properly, impair wellbeing and precipitate emotional health problems.Emotional health problems are major public health challenge of great concern.Consequently, no group is immune to EHPs, but the risk is higher among the poor, persons with low education, abused girls and women, the elderly, internally displaced persons (IDPs) and refugees (Kuruvilla & Jacob, 2007).

Emotional health problems appear to be on the increase worldwide. It is found out that about 450 million people suffer from EHPs, placing EHPs among the leading causes of ill-health and disability worldwide (World Health Report, 2001).The number of people who suffered EHPs rose from 416 million in 1990 to 615 million in 2013 (Sotodehasl, Malek, & Tamadon, 2015).According to Anxiety and Depression Association of America (2014), globally, an estimated 350 million people of all ages suffer from just depression. For instance, anxiety disorders are the most common EHPs in the United States of America affecting 40 million adults age 18 and older.Unfortunately, there are many individuals who are undiagnosed and therefore do not seek treatment. However, EHPs seem to form a good number of the complaints that are presented in most heath care sectors. Physicians estimated that more than two-thirds of their time is taken by patients whose complaints are emotional rather than medical. These non-medical complaints often stem from depression and anxiety, both of which unfortunately, are widespread(Shelley, 2009).World Health Organization (WHO) (2013) opined that the predominant EHPs worldwide are depression and anxiety. WHO further asserted that up to 90 pererf cent of people diagnosed with EHPs, depression and anxiety in particular are treated in primary health care.

According to Woldetsadik (2015) depression is the leading cause of disability throughout the world and is especially prevalent among low-income African countries, where 75 percent of the people who suffer from EHPs do not have easy access to the mental health care they need. Many emotional health problems among African populations have been tied to poverty, warfare and natural disasters, problems that have displaced 10.5 million sub-Saharan Africans. Moreover, the stigma tied to mental problem is also an obstacle to care. In the sub-

Saharan region, this reaction is deeply rooted in cultural beliefs and associations that some communities make between mental problems and witchcraft.Doran (2018) further noted that in sub-Saharan Africa; a poverty-dense region, there is a relative lack of health care services. This is partly because most healthcare resources are allocated to infectious diseases, 14 percent have emotional health problemsand nearly 10 percent have diagnosable psychiatric disorders. There are several challenges to providing quality mental health services in low and middle-income countries. Two of these include cost and the lack of research and needs based assessments. In most sub-Saharan African countries, mental health treatment facilities are limited in number and often inaccessible.

It is disheartening that in most parts of the developing world including Nigeria, WHO (2003) noted that emotional health is not given needed attention with the same importance as physical health. Rather, emotional health has been largely ignored or neglected.Nigeria is a multi-ethnic state with a myriad of cultures, traditions, customs and beliefs at the center of its worldview. All of these aspects or dimensions of the Nigerian State influence, amongst many matters, the perception of emotional health problems. Specifically, the belief in the supernatural is reinforced in the daily life of many Nigerians. Health is viewed by many as being underpinned by supernatural dimensions (Ojua, Ishor,& Ndom 2013). Thesesupernatural beings or powers (God, gods, good and evil spirits, witches) are believed to be sources of emotional health problems.Nigeria is known to be one of the developing countries in the world that is naturally expected to have a higher incidence rate of EHPs due to prevailing circumstances such as economic down-turn, communal clashes, insecurity, sectarian violence among others. Notwithstanding, EHPs are often evaded in Nigeria, as many people are usually inclined to discussing it openly due to the associated stigma (Bakare, 2014). According to Oyewunmi, Oyewunmi, Iyiola, and Ojo (2015), Tinubu (2016) noted that almost 400 million people are currently suffering from EHPs as a global problem, depression in particular, out of which 12 per cent (48million) are Nigerians.

Furthermore, in Nigeria, EHPs have emerged as serious public health issue, considering the socio-economic situation in the country today. Gureje, Uwakwe, and Udofia (2010) reported that as at 2003, almost one in every ten Nigerians had a diagnosable EHP in the preceding twelve months. This report further showed that 5.2 million Nigerian adults are suffering from an EHP in 2003, the commonest of which are anxiety and depression. In a country like Nigeria which has predominantly youth population of about 56 per cent in the employable age of 16-60 years and an estimated 57.2 million labour force strength; employers especially human resource managers are bound to encounter employees with one EHP or the

other in the workplace. Mental Health Leadership and Advocacy Programme (2012) observed that the reality is that the incidence of EHPs in Nigeria is reaching alarming rate. Owoyemi (2013) reported that relative to a population of about 174 million, 64 million Nigerians are deemed to suffer from one form of emotional health problem or the other. These problems could have been precipitated by factors which may include; the underfunding of emotional and mental health services as well as brain drain syndrome in Nigeriaôs public health care sector (Oyewunmi & Oyewunmi, 2014). This is evidenced by the significant number of Nigerian specialist doctors and nurses who practice overseas (Oyewunmi, Oyewunmi, Iyiola & Ojo, 2015).

Emotional health is better achieved and sustained when emotional needs are met. Every human being has basic needs, getting these needs met is essential to a personôs emotional health. Mackereth (2010) defined EH as a positive state and not just the absence of mental disease or ill-health. Besides,Prophet (2012) defined EH as the ability to control emotions and express them appropriately and comfortably. Most human behaviors reflect an attempt to get their emotional needs met and when these meeds are not or cannot be met, there seem to be a shift from emotional health to emotional health problems. Furthermore, everyone feels sad, worried or upset from time to time, but if these feelings last for a long time or interrupts normal daily activities, then there is interference. These interferencescan get worse, without proper attention they cause emotional health problems (American College of Cardiology, 2012).

Emotional health problem is a common term used for a range of psychological difficulties often related to anxiety, depression, anger and stress. WHO (2001) asserted that EHP can occur when there is a discrepancy between the demands of the environment and an individual ability to carry out and complete the demands. Sodgeman, (2005) defined EHP as an individualôs inability to enjoy life and procure a balance between life activities and effort to achieve psycho-emotional resilience. According to Al-Naggar and Al-Naggar (2012) emotional health problems are defined as feelings of sadness and tiredness in response to life events. National Alliance on Mental Health, (2016) defined EHPs as a condition that impacts a personôs feeling or mood and may affect his or her ability to relate to others or function on a daily basis.

In this study, emotional health problems are defined as the inability to cope with and control the demands of life due to financial limitations arising from non-payment or irregularities in the payment of salaries, lack of promotion, discrimination, maltreatment and lack of job among civil servants.

Emotional health problems are quite complex and manifest in different forms. According to Belson (2002) when normal feelings of sadness worry or upset which occur from time to time lingers and begins to disrupt normal life, they will result in depression, anxiety and anger. Thornicroft,Rose, andHassam (2007) pointed out that the most common forms of EHPs that become overwhelming and interfere with daily routines are depression, anxiety, stress, jealousy, fear and anger. (Kemeny et al. (2011) further noted that EHPs manifest as psychological distress, jealousy, fear, burnout, anxiety and depression. Smith, Segal. and Segal (2011) added that EHPs range from common, mild, temporal anger, jealousy, depression, anxiety, envyand stress to severe long term problems such as loss of sense of reality. Therefore, there is need to restrict the scope of EHPs to the most prevalent forms among the populations including civil servants in Nsukka LGA. The area of interest in this study includes depression, anxiety, stress and anger.

Depression is an EHP that seems common especially among people experiencing challenges of life.It is rampant in the society today with most implicated members of the population neither being aware of it nor seeking help. It is an emotional state characterized by feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness that are inappropriate and out of proportion to health (Hann & Payne, 2003). It is a very common health problem for men and women of all ages (American College of Cardiology, 2012). Depression is a short-term feeling of grief or low energy which has a big impact on life, work, health and friends (American college of Cardiology, 2012). According to National Library of Medicine (2014), depression may be described as feeling sad, unhappy and miserable or down in the dumps. Rashmi, Reis, and Dombeck (2015) pointed out that it is a common, yet a serious medical condition that affects both mind and body; a complex problem creating physical, psychological and social symptoms. Beitner (2015) supported this assertion by stressing that depression is a universal human feeling which everybody experiences from time to time. These feelings are normally connected with identifiable stress factors and they are usually limited in extent and duration. When these symptoms begin to dominate and disrupt life, they are signs of emotional health problems, which may lead to anxiety. In this study, depression is defined as a feeling of sadness, loneliness, deprivation and dejection as a result of the economic situation of the nation. Hence the researcher intends to find out the socio-demographic predictors of depression among civil servants.

Anxiety is the bodyôs natural response to danger, an automatic alarm that goes off when one feels threatened, under pressure, or facing a stressful situation. Clark and Radomsky (2014) opined that anxiety is the brainôs alarm system, an emotion that makes one to respond,

react and protect himself. According to Marsh (2015), anxiety is a word used to incorporate the emotions and the physical sensations one might experience when worried or nervous about something, though usually unpleasant, anxiety is related to the ófight and flightô response ï normal biological reaction to feeling threatened. It is common to feel tensed and nervous while sitting for exams, starting a new job, moving away from home, non-payment of salary to mention but a few**.** In moderation, anxiety is not bad because it helps one to stay alert and focused, spurs to action and motivation to solve problem, but when anxiety is constant or overwhelming, interferes with relationships and activities, it then stops being functional, cross the line from normal productive anxiety into the territory of anxiety disorder (Smith, Robinson & Segal, 2016). In line with this assertion, Marsh (2015) stated that anxiety becomes an emotional health problem when feelings of anxiety are very strong, overwhelming or last for a long time. Beitner (2015) averred that when people experience depression and anxiety over a period of time there is increased tendency for anger to manifest. This is in pact with Americaôs Mental Health Channel (2015) that pointed out that anger is connected with anxiety, for people with emotional health conditions, anger can be simmering below the surface ready to bubble up at a momentôs notice. In this study, anxiety is defined as a state of worry and fear of the unknown due to uncertainties.

Anger is a normal reaction to unwanted and unpleasant situation. American College of Cardiology(2012) stated that anger is a normal reaction to stressful moment which can be useful when there is need to react quickly to danger. The report added that it is appropriate to express anger but when it is expressed often or when there is no reason to be upset, then it becomes an EHP. Carlson (2013) viewed anger as a feeling of displeasure due to real or imagined threat, insult, putdown, frustration or injustice to one or those important to him/her. Anger is a completely natural emotion experienced by all, despite this fact; it can still be unpleasant and lead to irrational behaviour and impaired judgment, potentially resulting in emotional and physical pain (Segal & Smith, 2015). Concealed anger will most likely cause stress. In this study, anger is an outburst of negative emotion due to situational displeasure.

Stress is a normal part of life that can motivate one in its mild dimension. It can come from any situation or thought that makes one feel frustrated, angry or anxious. People see and perceive situations differently, have different coping skills and as a result respond to them differently as well. World Health Organisation (WHO) (2004) opined that stress is the response people may have when presented with work demands and pressures that are not matched with their knowledge and abilities and which challenge their ability to cope. WHO further stated that pressures are acceptable when it keeps workers alert and motivated to work

and learn depending on the available resources and personal characteristics. However, when pressure becomes excessive or otherwise unmanageable, it leads to EHP. Bickford (2005) defined stress as a natural part of life which occurs whenever there are significant changes in life, positive or negative. Gangwar (2017) observed stress as the mental and physical response and adaptation by our bodies to the real and perceived changes. In this study, stress is defined as mental and emotional overwork which results in mental and physical frailty.

The level of these emotional health problems (depression, anxiety, anger and stress) can be described based on the severity. According to Hazelden Foundation (2016) severity of emotional health problems are often defined by its length of duration and the disability it produces. This goes to show that the severity of emotional health problems can be mild, moderate and severe. This study therefore is set to find out the severity levels of EHPs among civil servants in Nsukka LGA.

EHPs do not just manifest, there are certain circumstances, events or factors that trigger them at one time or the other in life. These circumstances, events or factors are called predictors. Predictors can be socio or demographic in nature. Socio is derived from the word sociology which according to American Sociological Association (2018)is the study of the social lives of people, groups, societies and our behavior as social beings, covering everything from the analysis of short contacts between anonymous individuals on the street to the study of global social processes. Processes within a society are the ways in which individuals and groups interact, adjust and establish relationship and pattern of behavior which are again modified through social interactions (Samiksha, 2015).

Socio predictors include educational status, marital status and level of income among others. The demographic predictors include age and gender among others. Center for Disease Control and Prevention- CDC (2011) asserted that there is an association between the prevalence of EHPs and personal factors such as gender, job status, educational status, age, marital status, socioeconomic status and family stability.

Demography is the study of human populations; their size, composition and distribution across space and the process through which populations change.A populationôs composition may be described in terms of basic demographic features; age, sex, family and household status and by features of the populationôs social and economic context; education, occupation, ethnicity, religion, income and wealth (Department of Sociology, 2017). Socio-demographic is the study of people in the society (Ramasawmy, 2012). Americaôs Essential Hospitals (2015) opined that a large and growing body of evidence shows that socio

demographic factors, socioeconomic status (SES) such as income and education can influence health.

Predictors are risk factors, protective factors, promotive factors or vulnerability factors (Gutman & Sameroff, 2004). Predictor is from the word prediction which is a guess about what might happen in the future, based on observations (Science Process Skills, 2012). IN this study predictors are those variables that not deliberately influence emotions negatively causing EHPs.

Socio-demographic predictors of EHPs are therefore defined in this study as risk or protective factors which could be educational status, level of income and age that may in one way or the other have influence on emotional health when manipulated by negative or positive conditions. The socio-demographic predictors; educational status, and level of income and age are the areas of interest in this study. Each of these socio-demographic variables could predict or be linked with the occurrence of EHPs. Hence, these variables will be considered in this study.

Educational status may have a great influence on emotional health status because the knowledge, skill, values and habits acquired helps individuals to manage emotional health properly and appropriately, thereby avoiding emotional health problems. Butler (2002) pointed out that women with higher level of education are less likely to be depressed. There is a significant relationship between the prevalence of common emotional problems and low educational levels (Patel & Kleiman, 2003). This is supported by Feinsten, Sabates, Anderson, Sorhando and Hammond (2006), that maintained that education impacts on social and economic relations in the workplace to improve the relative emotional health of those with autonomy and authority in workplace and reduce that of individuals with less autonomy and authority. Education therefore has the ability to impact upon environmental factors that lead to EHPs especially depression. Cutler and Lleras-Muney (2008) noted that education is associated with better health behaviors, better educated individuals smoke less, engage in less heavy drinking. Children of uneducated parents, grow up to be unhealthy and uneducated parents themselves (Vogyl, 2012). From the above assertions, education gives better chances of acquiring knowledge on how to handle the challenges of life, maintain emotional health, prevent EHPs and the subsequent health challenges. The study intends to ascertain if the assertions made by the above mentioned authors are true with civil servants in Nsukka LGA.

Level of income could be a major predictor of emotional health problems. This is because with more income one is able to provide his or her needs, but with low income, all the desired goals may not be attained leading to negative emotional reactions and problems.

Kuruvilla and Jacob (2007) observed that depression and anxiety are reported to be most prevalent among those with the lowest standard of living. Deaton and Kahneman (2010) asserted that low income has been implicated with such misfortunes as divorce, ill health and loneliness. On the other hand, high income improves emotional evaluation of life but not emotional wellbeing (Deaton & Kahneman 2010). In this study civil servants working in Nsukka Local Government Area are the central focus in finding out whether level of income predicts emotional health problems.

Age has influence on emotional health problem. A child can have emotional health problems from early age and it can continue into adulthood. Deeks, Lambard, Michelmore and Teede (2009) opined that age is associated with health related behaviours. When the emotional health of children and young people are well cared for, they develop the resilience to cope with whatever challenge life throws at them and grow into well rounded adults (Mental Health Foundation, 2015). According to American Psychological Association (2016), there is evidence that some natural body changes associated with aging may increase personôs risk of experiencing EHPs like depression. The report further stated that older adults may sense a loss of control over life due to external pressures such as limited financial resources. This may give rise to negative emotions such as sadness, anxiety, loneliness and lowered self-esteem. This study intends to find out if the adult civil servants in Nsukka L.G.A are vulnerable to EHPs due to ageing. This may be aggravated by poor financial status due to backlog of unpaid salaries to the civil servants.

It was also observed that depression and anxiety are very common EHPs experienced by a good number of people especially the Local Government Civil Servants whose salaries are either owed for a length of time or not paid promptly. Most civil servants are parents, who have needs and dependents. They usually encounter difficulty meeting with their needs when salaries are either owed or not paid promptly. These difficulties seem to eventually precipitate EHPs among them.

Civil servants are classified into federal, state and local government staff and are generally seen and referred to as government paid workers that receive their salaries monthly and consistently. It is disheartening that this is not the case with most civil servants of today, ranging from the federal to the state and then to the LGA level. The situation seems to be worse in LGAs including Nsukka LGA of Enugu State. There are categories of civil servants. According to Okezie and Obi (2004) civil servants are mainly of two categories: lower clerical staff and higher administrative staff. The higher administrative staff is responsible to the political head of department. The lower clerical staff helps the administrative staff and

works under its direct supervision and control. Ekhator (2003) pointed out that five classes of civil servants exist in Nigeria namely; administrative class (the most prestigious class, close to political head, ministers and commissioners), professional class (examples are specialists, doctors, engineers), executive class (general administration, implements policies), clerical class (subordinate staff, performs supportive functions) and manipulative class or auxiliary (semi-skilled, skilled drivers, cleaners, guards among others).

When one says he or she is a civil servant in Nigeria, he or she is classified in a certain manner. Okezie and Obi (2003) asserted that civil servants are characterized by: permanence, impartiality, neutrality and anonymity. Civil servants in Nsukka LGA are experiencing a lot of emotional issues due to non-payment of salaries and they seem not to have job satisfaction as their salaries have not been paid for the past eight months as at the time of this study. For example, some civil servants have no good offices, no incentives, and yet they are mandated to sign in and out each day. They look dejected, frustrated and emotionally down cast. Aigboje (2007) observed that better salaries and allowances, vehicle advances, refurbishing loans, conducive offices and other motivational factors can stimulate productivity and job satisfaction. Job satisfaction will to a large extent help in controlling emotional health problems among civil servants in Nsukka LGA.

LGAs have some provisions made for them by the federal government but these provisions are not enjoyed by them, this is evident in Nsukka LGA. The problem of LGA is that while the functions of LGA are specified in the 4th schedule of the constitution, the LGAs can exercise their authority only in accordance with enabling legislation passed by the states. LGAs are subject to varying degrees of state oversight and control. Local governmentstaff is in many places of lower caliber than state civil servants (Barkan, Gbovega & Stevens, 2001). Furthermore, LGAs are supposed to receive 10 per cent of the stateôs internally generated revenues, but many LGAs do not and therefore, LGAs raise their revenues from fees and licenses. The present constitution of the Federal Republic of Nigeria is vague on the powers of the States and virtually silent on the powers of the LGA (Barkan, Gbovega & Stevens, 2001). This study was anchored on relevant theories.

This study will be anchored on two theories and a model. These theories and model are: James-Lange theory of emotion, Opponent-Process theory of emotion and Job Demand-Resources Model. James-Lange theory was propounded by a psychologist, William James (1884) and Physiologist, Carl Lange (1887). The theory basically states that emotion is equivalent to the range of physiological arousal caused by external events. They were of the view that emotion is not directly caused by perception of an event but rather the bodily

response caused by the event. The relevance to this study is that non-payment of salaries does not trigger emotional feelings, but the interpretation of the brain by the physiological arousal experienced by the individual. It is this effect that leads to EHPs like depression, anxiety and anger.

Opponent-process theory was propounded by a psychologist Richard Solmon and John Corbit (1974). They view emotion as pairs of opposites (fear - relief, pleasure ï pain). They stated that when one emotion is experienced, the other is suppressed. They further stated that the experience of an emotion disrupts the bodyôs state of balance and that basic emotions typically have their opposing counterparts. The relevance to the study is that since emotions have their opposing counterparts, when individuals are faced with unpleasant situations, like nonpayment of salaries and poor working conditions, their pleasure, for instance will be turned to pain manifesting itself in anger, anxiety or other emotional problems. However, if the cause of the emotional problem is taken care of, pleasure will be restored.

Job Demand-Resources Model was propounded by Karasek (1979). According to job demand model, job demands are initiators of health (emotional) impairment process. The main assumption of the model is that every occupation has its own specific risks factors associated with job related stress. Job resources refer to those physical, psychological, social or organizational aspects of the job that are either functional in achieving work goals, reduce job demands and the associated physiological and psychological costs, stimulate personal growth or stimulate learning and development. The relevance to this study is that as staff makes effort to meet up with the job demands and the resources required to achieve the demand is not always available, over time stimulation and vigor to work will start reducing. As stimulation reduces, anger and depression will quietly start taking over. If situation did not change for a long time, EHPs will set in.

Nsukka LGA is one of the oldest LGA in South Eastern Nigeria. It is one of the seventeen LGAs in Enugu StateThe town has a good number of civil servants because of the presence of University of Nigeria Nsukka and Nsukka LGA staff. Nsukka LGA is subdivided into four, Nsukka main, situated at the secretariat, Nsukka East, Nsukka West and Nsukka central. It has been observed that a good number of individuals are depressed, anxious, irritable and angry due to the condition of the country which is having a direct and indirect influence on them as individuals and their families at large. The condition is made worse by the fact that many have nothing doing and the ones believed to be the working class citizens cannot even help themselves, let alone helping others. The staff are faced with numerous challenges ranging from prolonged nonpayment of salaries and un-conducive work

environments. These challenges keep the workers apprehensive due to fear of the unknown. Lack of payment of salaries makes these workers to be unable to meet up with their fundamental needs for shelter, clothing and feeding. Alarmingly, these staff are expected to report to the secretariat daily to sign in and sign out at dismissal. Furthermore, natural incidents such as deaths, sickness, accidents and other unplanned circumstances may occur in the lives of these civil servants. All these can lead to EHPs.

This situation seems so glaring among the civil servants in Nsukka LGA of Enugu State. Little wonder that Oyewunmi, Oyewunmi, Iyiola, and Ojo (2015) pointed out that employers must realize that the emotional and mental constitution is crucial to human performance. The business and management processes (strategy, goal-setting, resourcing etc.) geared towards organizational performance will be futile; unless psychological factors pertaining to employees are evaluated. This is in line with the assertion of Aigboje (2007) as cited by Akinsanya and Akinsanya (2015) that better salaries and allowances, vehicle advance, refurbishing loans, conducive offices and other motivational factors can stimulate productivity and job satisfaction and ultimately prevent EHPs. It is this disheartening scenario among the civil servants that prompted this study that seek to determine the socio-demographic predictors of EHPs among civil servants in Nsukka LGA of Enugu State.

Statement of the Problem

Stable emotional health is the hallmark of every individualôs total health. A common thing about human beings is that they are emotional creatures. The good news is that one can be active in maintaining and fostering emotional health in good and bad times. Moreover, when situations like prompt payment of salaries, good education among others are in place, one is more likely to enjoy emotional health in the midst of the challenges of life. Additionally, having a good attitude to life and stress associated with it helps one to manage emotional issues well and live in emotional health which is the ability to control emotions and express them appropriately. An emotionally healthy person has the capacity to recognize his/her emotions, express them well in order to avoid getting stuck in emotional health problems.

However, the quest for survival through work seem to have increased the EHPs for the civil servants in Nsukka LGA who seem not to be immune to these observed dynamics such as poor remuneration, discriminations, inadequate office accommodation, maltreatment, low educational status among others, these conditions may lead to worry, anxiety, anger and depression which are forms of emotional health problems. It was noted that naturally depression, anxiety among others are common in the general populace but it may be more

pronounced among civil servants due to their responsibility at work and this can have negative effects on their emotional health and productivity.

The current situation facing civil servants in Nigeria including civil servants in Nsukka LGA such as non-payment of salaries and allowances, lack of job satisfaction and promotion among others may expose this category of people to EHPs with adverse health outcomes if not addressed. Studies on mental and physical health problems abound but studies on emotional health problems are scarce especially in local populations such as Nsukka LGA. This is why the researcher is prompted to conduct this study on socio-demographic predictors of emotional health problems among civil servants in Nsukka LGA to find out if educational status, level of income and age could be predictors of emotional health problems among civil servants in LGA. This work, thus, seeks to fill this gap.

Purpose of the Study

The purpose of the study was to investigate socio-demographic predictors of emotional health problems among civil servants in Nsukka LGA of Enugu state. Specifically, the study sought to determine:

1. the proportion of civil servants that experienced various forms of emotional health problems in Nsukka LGA;
2. severity level of EHPs experienced by civil servants in Nsukka LGA;
3. relationship between educational status and EHPs among civil servants in Nsukka LGA;
4. relationship between level of income and EHPs among civil servants in Nsukka LG;.
5. relationship between age and EHPs among civil servants in Nsukka LGA.

Research Questions

The following research questions were posed to guide the study.

1. What is the proportion of civil servants that experience various forms of emotional health problems in Nsukka LGA.
2. What is the severity level of EHPs experienced by civil servants in Nsukka LGA.
3. What is the relationship between educational status and EHPs among civil servants in Nsukka LGA.
4. What is the relationship between level of income and EHPs among civil servants in Nsukka LGA.
5. What is the relationship between age and EHPs among civil servants in Nsukka LGA.

Hypotheses

The following null hypotheses were formulated to guide the study and were tested at0.5 level of significance.

1. Educational status is not a significant predictor of EHPs among civil servants in Nsukka LGA.
2. Level of income is not a significant predictor of EHPs among civil servants in Nsukka LGA.
3. Age is not a significant predictor of EHPs among civil servants in Nsukka LGA

Significance of the Study

The study generated data on the socio-demographic predictors of EHPs among civil servants in Nsukka LGA of Enugu State. The findings will be of immense benefit to the civil servants, administrators, researchers, health educators, curriculum planners, governmental and non- governmental organizations and the society at large. It will help them set out plans on how to cater for the emotional health and wellbeing of the civil servants.

The study generated data on the proportion of civil servants that experience the various forms of emotional health problems. It will be of immense benefit to administrators, Researchers, health educators, curriculum planners and the government. It will assist administrators on how to modify the management and administration of authority on the workers for increased job satisfaction. It will as well maximize productivity and most importantly help them to device a better means of managing the affairs of the staff in order to prevent EHPs among workers. Knowledge is said to be power, knowledge gotten from the findings will spur researchers to carry out research work on other areas of EHPs. Health educators can use the findings of this study to organize seminars and workshops to enlighten people about EHPs. The findings will assist curriculum planners in improving and modifying the curriculum and administration of in-service training of civil servants so that they will have adequate knowledge of EHPs and their socio-demographic predictors. The findings will motivate the government to enact laws and make policies that will guide the treatment given to civil servants while in service which may result in prompt payment of salaries, befitting accommodation, allowances among others to avoid EHPs among civil servants.

The findings on the various forms of EHPs will benefit civil servants, health educators, government and non-governmental organizations. Civil servants will have a clear understanding of the various forms of EHPs and have proper knowledge and understanding of EHPs. Health educators, governmental and non-governmental organizations will use the findings from the study in organizing workshops and seminars to educate civil servants on the forms of EHPs, causes and the ways to develop attitude that will be useful in the prevention of EHPs.

The findings on educational status and its relationship with EHPs will help health educators to give public enlightenment through seminars, workshops and social media on the benefits of education as regards to EHPs. They will likely inform the public that through education, people will be aware of the socio-demographic predictors of EHPs and how best to manage them. Certain measures to be taken to avoid or reduce them to the barest minimum will also be learnt through health education. On the other hand, it will also help the educators to enlighten the uneducated ones on the need for education, even if it is the informal one. This will help them to be able to manage their EHPs more effectively.

The findings on level of income and its relationship with EHPs will benefit the government and administrators who influence the working climate and conditions in which the civil servants function. There are individual differences and reactions to job characteristics. These may have a great deal of influence on the factors to be considered while reviewing or introducing salaries, welfare packages and other incentive programs for civil servants.

The findings on age and its relationship with EHPs could be employed by civil service commission in regulating employment of civil servants, for instance, if it is found that a particular age group is more prone to EHPs. Special training may be organized for them to help them perform better. The findings on age will provide adequate information to curriculum planners. This will enable them to expand the curriculum on emotional health problems, not just for special areas, but for all and sundry.

The theories of anchor which includes James-Lange theory of emotion, opponent process theory of emotion and Job Demand-Resources Model used in this study will be of immense benefit to the administrators and the government to understand the psychological and physiological trauma that the civil servants experience when their working condition are not satisfactory. For instance, according to opponent-process theory, when there is a conducive environment of joy in the workplace, anger which is an EHP will naturally fizzle out. Researchers may investigate more on these theories using them to predict and analyze more studies. The government may adopt these theories in making policies that will benefit the civil servants.

Scope of the Study

The study was delimited to Nsukka Local Government Area. The central focus of this study was on the socio-demographic predictors of emotional health problems of civil servants in Nsukka LGA. The study will examine the following variables such as educational status,

level of income and age. The study also explored James-Lange theory of emotion, opponent-process theory and Job Demand-Resources Model, how they can be applied to this study.

CHAPTER TWO

Review of Related Literature

The review of related literature to this study is organized under the following subheadings:

Conceptual Framework

Emotional health(EH)

Emotional health problems (EHPs)

Socio-demographic predictors of emotional health problems

Civil servants

Theoretical Framework

James-Lange theory

Opponent-process theory

Job demand-resources model

Review of Related Empirical Studies

Summary of Review of Related Literature

Conceptual Framework

This section presents information on the key concepts of this study. These include emotional health, emotional health problems, socio-demographic predictors of emotional health problems and civil servants.

Emotional health (EH)

Emotional health problems influence health negatively. Consequently, there is need to comprehensively explain explicitly the concepts associated with EHPs in this study. The common thing about human beings is that they areemotional creatures who have the ability to maintain emotional health (EH) in good and bad times and situations. Being emotionally healthy does not mean an individual does not experience life challenges, but the individual considers the challenges as normal with life. Jeanette (2008) asserted that EH is being relaxed with an open mind, open heart, secured, high self-esteem, calm with oneself and others.The author further stated that an emotionally healthy person is assertive. In other words, to be emotionally healthy one must express oneôs emotions in healthy and assertive ways. Mackereth (2010) defined EH as a positive state and not just the absence of mental disease or ill-health. By implication, EH is the degree to which one feels emotionally secured and relaxed in everyday life despite all odds. Prophet (2012) defined EH as the ability to control emotions and express them appropriately and comfortably. According to the Department of Health and Human Services (2013), EH is a childôs growing ability to form strong relationships with others, express and manage emotions, explore the world around him or her

and solve problems. Being emotionally healthy is actually a journey of lifetime. In this study EH is the ability to consider the challenges of life as normal, being able to express emotions in a healthy manner, being relaxed with oneself thereby having a good relationship with others despite all odds.

It is important to note that there is a relationship between mental health and emotional health. Mental health is the ability to properly think and process information while emotional health is the ability to appropriately express feelings. Though the two seem different but an individual cannot have one without the other; this is because the choices made on daily basis involve both mental and emotional processing.Cognitive reasoning (mental) may be influenced by the way one feels (emotional) about a certain situation (McDiarmid, 2014). McDiarmid (2014) further stated that constant streams of information run through the mind; inability to properly filter and process information can become stressful and the inability to properly express or control emotion can also become problematic. Healthyplace (2014) pointed out that emotional health is a state of positive psychological functioning. It can be thought of as an extension of mental health; it is the "optimal functioning" end of the thoughts, feelings, and behaviours that make up both inner and outer worlds of human beings. It includes an overall experience of wellness in what people think, feel, and do through both the highs and lows of life. When EH is affected by specific life events such as poverty, poor educational attainment, problem with relationships and poor remuneration to a large extent, EHPs can result (Mackereth, 2010).

Emotional health problems (EHPs)

Specific events or problems that affect an individual adversely seem to result in emotional health problems. EHPs are common to all ages; some people cope successfully while others do not. Freedman (2003) opined that EHPs are consistent experience of negative emotion that signifies an unsuccessful adaptation to a range of demands. Sodgeman (2005) defined EHP as an individualôs inability to enjoy life and procure a balance between life activities and effort to achieve psycho-emotional resilience. EHP is a common term for a range of psychological difficulties often related to anxiety and depression (Peters, 2008). Karvold (2009) confirmed that EHPs refer to symptoms of anxiety and depression, and are the most common mental health problems especially in childhood. Anxiety and depression actually have a common place in the society today. According to Al-Naggar and Al-Naggar (2012) emotional problems are defined as feelings of sadness and tiredness in response to life events. National Alliance on Mental Health (2016) defined EHPs as a condition that impacts a personôs feeling or mood and may affect his or her ability to relate to others or function on a

daily basis. Emotional health problem can be a short-term reaction to a stressor, such as, painful event and illness (Winconson Physicians Service Insurance Corporation, 2016). Definitions abound on EHPs and all these definitions boil down to one thing which is that EHPs disrupts life.

Emotional health problems seem to be experienced by many people due to diverse reasons ranging from economic situation of the country, immediate family issues, financial limitations due to non-payment of salaries and stressful jobs. These unpleasant situations leave many in an uncontrolled worry that affects them emotionally and subsequently make them not to perform to their optimal capacity. Freedman (2003) opined that EHPs are consistent expression of negative emotions which signifies an unsuccessful adaptation to a range of demands.

When the condition of service is not conducive, it is natural for people at one time or the other to start getting disturbed, when it persists, the disturbances will most likely escalate, causing EHPs. Reynolds (2005) observed that EHPs may result from workplace maltreatment and bullying which involves the tendency of individuals or groups to use persistent or unreasonable behaviour against a co-worker or subordinate. The maltreatment includes such tactics as threats, isolation, overwork, humiliation, emotional abuse. Stoetzer (2010) states that poor interpersonal relationship in the workplace is likely a predictor of EHPs. The workplace has great potential for promoting or hindering the emotional health of individuals. Hence, physical characteristics such as; lighting, ventilation, work space, sanitation and noise levels of the workplace, potentially have psychological effects on employees (Ajala, 2012).Abubakar, Fischer and Arasa (2013) found that culture or practices within organizations could affect emotional health, hence, the need to develop practices that are employee-centric. There are many practices within the Nigerian workplace that could impact the emotional health of employees negatively especially depression. Employees who may have served an organization for several years but do not necessarily possess premium academic qualifications, may harbor the fear of being displaced by younger talents who may have had access to international education and training. This type of situation, which is quite prevalent in Nigeria, has apparent implications on the emotional health of individuals. These situations may likely predict EHPs among the civil servants.

The level of emotional health problems can be determined based on the severity. According to Hazelden Foundation (2016) severity of emotional health problems are often defined by its length of duration and the disability it produces. This goes to show that the severity of emotional health problems can be mild, moderate and severe. This study therefore

is set to find out the severity levels of EHPs among civil servants in Nsukka LGA. Moreover, it is generally known that any individual having one EHP or the other manifests certain signs and symptoms.

There are many signs and symptoms associated with EHPs. Signs and symptoms of EHPs include: significant changes in feelings or behaviour that is out of step with peers at a similar age and stage; persistent separation difficulties or attachment problems with family; being withdrawn, fearful, anxious or upset much of the time; poor-quality play that seems limited and repetitive difficulty managing anger and frustration, frequent tantrums or aggression, difficulty in paying attention, following instructions and completing tasks (Department of Health and Ageing, 2010). Health Grade (2014) observed that fatigue, poor appetite, weight loss, sleep disorder, poor self-image, suicidal ideation, nervousness, instability, erratic thinking, chronic anxiety, exaggerated sense of self-worth, compulsive actions are other signs of EHPs. Harvard Health Publications (2016) noted that symptoms tend to manifest differently at work than they do at home or in other settings. Although symptoms may go unnoticed, the economic consequences are tangible.

A variety of causes are responsible for EHPs among workers including civil servants. Einerson, Hoel, Zapf and Cooper (2003) opined that causes of EHPs include: difficult relationships among workers and management, management bullying, harassment and lack of opportunities or motivation to advancement in skills. The likelihood of individuals developing EHPs is greatly increased when they experience adverse internal circumstances, for instance, poverty, poor environment and problematic family relationships. Other predominant causes of EHPs as noted by Munce, Stansfield, Blackmore and Stewart (2007) are environmental and human relation factors. Munce, Stansfield, Blackmore and Stewart (2007) further made it clear that excess workload, isolation, extension hours worked, toxic work environment and lack of autonomy are causes of EHPs. American College of Cardiology(2012) opined that EHPs are caused by changes in brain chemicals. They are not a character flaw and do not mean that one is bad, weak or going crazy. These types of problems can be triggered by physical stress (such as an illness or injury) or by emotional stress (such as the loss of a loved one). Emotional health problems often arise when the nervous system has been compromised by overwhelming amounts of stress. The body's natural and most efficient method of coping with stress and rebalancing the nervous system is via face-to-face social contact with a trusted person. This is why emotional health is so closely linked with social health; helping oneself involves reaching out to others (Smith, Segal, Robinson,& Segal, 2016). Ofuebe (2014) noted

that pressure due to threats or negative life events can also cause EHPs. The aforementioned can have consequences on individuals.

The diverse causes of EHPs do not occur without making an impact on the individuals concerned. Most times, these impacts are adverse in nature depending on the ability of the concerned individual to control and express their emotion. National Institute of Neurological Disorders and Stroke (2001) asserted that negative emotions such as anger and anxiety increase the risk for poor health outcomes such as cardiovascular disease, while optimism reduces the risk of coronary heart disease. In the same vein, WHO (2003) discovered that emotional functioning is fundamentally connected with physical and social functioning and health outcomes. Depression is a risk factor for cancer, heart disease and anxiety in patients with physical problems and may result in poor compliance and failure to adhere to treatment schedule. Marsh (2015) observed that high level of EHPs and exhaustion that comes from workplace anxiety can directly lead to lower job performance.

EHPs, as already noted include all those health conditions that affect ones emotions and interfere with normal functioning of day to day activities. These health conditions are otherwise referred to as components of EHPs. Harris (2000) noted that emotional disturbances can include depression, excessive stress reactions, and many others and that sometimes the disturbance is not readily visible. Thornicroft, Rose and Hassam (2007) opined that the most common forms of EHPs that become overwhelming and interfere with daily routines are depression, anxiety, anger, stress and fear. Smith, Segal, and Segal (2011) deduced that EHPs among workers including civil servants range from common to mild depression, anxiety, anger, shyness, stress to severe long term problems such as loss of sense of reality. Kemeny et al. (2011) pointed out that EHPs manifest as psychological distress, jealousy, fear, burnout, anxiety and depression. According to Shavers (2014), EHPsinclude internalizing behaviors such as extreme shyness, passivity and withdrawal or psychological concerns like anxiety and depression. Therefore, depression, anxiety, anger and stress are the EHPs that will be focused on, in this study.

Everyone feels sad sometimes, but these feelings usually pass after a while. When one has depression, there is trouble with daily life for weeks at a time or even years. Depression is an EHP that is common especially among people experiencing challenges of life. It is an emotional state characterized by feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness that are inappropriate and out of proportion to health (Hann & Payne, 2003). It is a very common health problem for men and women of all ages (American College of Cardiology, 2012). Depression is a feeling of grief or low energy which has a big

impact on life, work, health and friends (American College of Cardiology, 2012). Depression is a serious illness that needs treatment (National Institute of Health, (2013). According to National Library of Medicine (2014), depression may be described as feeling sad, unhappy, miserable or down in the dumps. Rashmi, Reis and Dombeck (2015) pointed out that depression is a common, yet a serious medical condition that affects both mind and body; a complex problem creating physical, psychological and social symptoms. Beitner (2015) supported this assertion by stressing that depression is a universal human feeling which everybody experiences from time to time. Depression is a common but severe mood disorder that causes severe symptoms that affect how one feels, thinks and handles daily activities, such as sleep, eating and working (National Institute of Mental Health, 2016).

Depression is rampant in the society today with most implicated members of the population neither being aware of it nor seeking help. There are many signs and symptoms of depression experienced by different people at different times. Hann and Payne (2003) opined that the common symptoms of depression are persistent sad mood, feeling of hopelessness and pessimism, loss of interest, or pleasure in ordinary activities, including sex, restlessness, irritability or fatigue, difficulty concentrating, remembering or making decisions, thoughts of death or suicide, persistent symptoms or pains that does not respond to treatment. In agreement National Institute of Health (NIH) (2013) asserted that feeling sad or "empty" feeling hopeless, irritable, anxious, or guilty, loss of interest in favorite activities, feeling very tired not being able to concentrate or remember details, not being able to sleep, or sleeping too much, overeating, or not wanting to eat at all, thoughts of suicide, suicide attempts, aches or pains, headaches, cramps, or digestive problems are the common signs and symptoms of depression. Smith, Saisan and segal (2016) included appetite or weight changes, sleep changes,anger, feeling fatigued, sluggish, and physically drained, the whole body may feel heavy, and even small tasks are exhausting or take longer to complete,anger or irritability, engagement in escapist behavior such as substance abuse, compulsive gambling, reckless driving, or dangerous sports as other signs and symptoms of EHPs

Several factors, or a combination of factors, may contribute to the cause of depression. National Institute of Health (NIH) (2013) observed that people with a family history of depression may be more likely to develop it than those whose families do not have the illness. Loss of a loved one, a difficult relationship, or any stressful situation may trigger depression. European Alliance against Depression (2017) opined that depression results from a complex interaction of social, psychological and biological factors. People who have gone through adverse life events (unemployment, bereavement, psychological trauma) are more likely to

develop depression. Pietrangelo (2015) opined that there is no single cause of depression, brain chemistry, hormones, and genetics may all play a role. Other risk factors for depression include: low self-esteem, anxiety disorder, borderline personality disorder, post-traumatic stress disorder (PTSD), physical or sexual abuse chronic diseases like diabetes, multiple sclerosis, or cancer, alcohol or drug abuse and certain prescription medications can result in depression.Smith, Saisan and Segal (2016) stated that loneliness and isolation, lack of social support, recent stressful life experiences, family history of depression, marital or relationship problems, financial strain, early childhood trauma or abuse, alcohol or drug abuse, unemployment or underemployment, health problems or chronic pain are the causes of depression.

Depression comes in different forms. Knowing what type of depression one has can help manage the symptoms and get the most effective treatment. Smith, Saisan, and Segal (2016) asserted that there are four types of depression including; major depression which is much less common than mild or moderate depression. Atypical depression is a common subtype of major depression with a specific symptom pattern. It responds better to some therapies and medications than others, so identifying it can be helpful. Dysthymia is a type of chronic ñlow-gradeò depression. More days than not, one feels mildly or moderately depressed, although one may have brief periods of normal mood. Seasonal affective disorders (SAD) affects about 1% to 2% of the population, particularly women and young people, caused by the reduced daylight hours of winter for some people. National Institute of Mental Health (NIMH) (2016) classified depression into seven types namely; Major depressive disorder or clinical depression is a common but serious mood disorder. It causes severe symptoms that affect how one feels, thinks, and handles daily activities, such as sleeping, eating, or working. Persistent depressive disorder (also called dysthymia) is a depressed mood that lasts for at least two years. Perinatal depression is much more serious than the ñbaby bluesò (relatively mild depressive and anxiety symptoms that typically clear within two weeks after delivery) that many women experience after giving birth. Women with perinatal depression experience full-blown major depression during pregnancy or after delivery (postpartum depression). The feelings of extreme sadness, anxiety, and exhaustion that accompany perinatal depression may make it difficult for these new mothers to complete daily care activities for themselves and/or for their babies. Psychotic depression occurs when a person has severe depression plus some form of psychosis, such as having disturbing false fixed beliefs (delusions) or hearing or seeing upsetting things that others cannot hear or see (hallucinations). The psychotic symptoms typically have a depressive ñtheme,ò such as

delusions of guilt, poverty, or illness. Seasonal affective disorder is characterized by the onset of depression during the winter months, when there is less natural sunlight. This depression generally lifts during spring and summer. Winter depression; typically accompanied by social withdrawal, increased sleep, and weight gain, predictably returns every year in seasonal affective disorder. Bipolar disorder is different from depression, but it is included in this list because someone with bipolar disorder experiences episodes of extremely low moods that meet the criteria for major depression (called ñbipolar depressionò). But a person with bipolar disorder also experiences extreme high, euphoric or irritable, moods called ñmaniaò or a less severe form called ñhypomania.ò Examples of other types of depressive disorders newly added to the diagnostic classification of DSM-5 include disruptive mood dysregulation disorder (diagnosed in children and adolescents) and premenstrual dysphoric disorder (PMDD).

The good thing about depression is that it is treatable especially when diagnosed early. The major challenge is that people with depression either do not realize they have the problem or they realize it but display denial and fail to seek for help medically. However, understanding the underlying cause of depression may help to overcome the problem. For example, if one is depressed because of a dead end job, the best treatment might be finding a more satisfying career, not taking an antidepressant. If one is new to an area and feeling lonely and sad, finding new friends will probably give more of a mood boost than going to therapy. In such cases, the depression is remedied by changing the situation (Smith, Saisan & segal, 2016). National Institute of Mental Health (NIMH) (2016) opined that depression, even the most severe cases, can be treated. The earlier that treatment can begin, the more effective it is. Depression is usually treated with medication, psychotherapy, or a combination of the two. If these treatments do not reduce symptoms, electroconvulsive therapy (ECT) and other brain stimulation therapies may be options to explore. NIMH (2016) further noted that no two people are affected the same way by depression and there is no "one-size-fits-all" for treatment. It may take some trial and error to find the treatment that works best for each individual. Anxiety and Depression Association of America (ADAA) (2016) submitted that several forms of psychotherapy are effective. Of these, cognitive-behavioral therapy (CBT) works to replace negative and unproductive thought patterns with more realistic and useful ones. These treatments focus on taking specific steps to overcome depression. Treatment often involves facing oneôs fears as part of the pathway to recovery. Interpersonal therapy and problem-solving therapy are also effective.

There are other effective sources of treatment that can be employed in the treatment of depression. Beyond Blue (2014) noted that family and friends can play an important role in recovery by providing support, understanding and help, or just being there to listen. Support groups for people with depression and anxiety can provide an opportunity to connect with others, share experiences and find new ways to deal with challenges. Relaxation training calms the body and mind. E-therapies also known as online therapies or computer-aided psychological therapy can be just as effective as face-to-face services for people with mild to moderate depression. Health professionals; while it is not uncommon for people with depression or anxiety to try to manage their condition themselves, there is no substitute for the advice of a qualified health professional. Maintaining healthy lifestyle by reducing and managing stress levels, cutting down on alcohol and drugs, and taking action early if one starts experiencing symptoms of depression. NIMH (2016) observed other tips that may help during the treatment for depression which include: try to be active and exercise; set realistic goals for oneself; try spending time with other people and confiding in a trusted friend or relative; avoid isolation and always seek help from others; expect gradual mood improvement, not immediate; postpone important decisions, such as getting married or divorced, or changing jobs until one feels better; discuss decisions with others who know the situation well and have a more objective view of the situation and continue to educate oneself about depression. Another commonly occurring EHPs is anxiety.

Anxiety is encountered by everyone in many forms at one time or the other throughout the course of the routine activities. However, the mechanisms that regulate anxiety may break down in a wide variety of circumstances, leading to excessive or inappropriate expressions of anxiety. The intensity depends on individual differences. Kessler, Chiu, Demler and Walters (2005) opined that anxiety disorders are illnesses that cause people to feel frightened, distressed and uneasy for no apparent reason. Left untreated, these disorders can dramatically reduce productivity and significantly diminish an individual's quality of life. Clark and Radomsky (2014) opined that anxiety is the brainôs alarm system, an emotion that makes one to respond, react and protect himself/herself. Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) defined anxiety as a human emotion experienced by everyone in unique ways. Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) further asserted that anxiety refers to the anticipation of some potential threat that may, or may not, happen in the future state. Marsh (2015) emphasized that anxiety is a word used to incorporate the emotions and the physical sensations one might experience when worried or nervous about something. According to Healthy Children (2015) anxiety is a normal reaction to the stresses of life. A

case of the jitters is not necessarily harmful; in fact, it can spur one to be at his/her best. Ordinarily, stressful situations prompt a flurry of brain and hormonal activities, in what is called the fight-or-flight response. Body systems mobilize to meet the challenge, and a person feels more alert, focused and energetic. The authors further noted that an anxiety problem, by contrast, can be incapacitating. It is an illness, one that frequently runs in families. The anxiety may be overwhelming and at times terrifying or it may be relatively mild but incessant, often with no apparent cause. A young person has nearly a one-in-seven chance of developing an anxiety disorder, which is the most common emotional health condition among all age groups.

People also differ in how often, and how intensely, they experience anxiety. For most people, anxiety is a normal and even adaptive occurrence. **N**ormal anxiety is actually beneficial. However, anxiety becomes a problem when it overstays its welcome (duration), and/or is of an intensity or frequency which begins to interfere with a person's functioning and overall well-being. These three factors- duration, intensity, and frequency- distinguish normal, adaptive anxiety from abnormal, pathological anxiety. As such, abnormal anxiety is different from normal anxiety because it is disproportionate to the situation that elicited the anxious response (Jacofsky, Santos, Khemlani-Patel & Neziroglu, 2015). A normal degree of anxiety is part of everyday human experience. Unfortunately, other people may experience anxiety to such a heightened degree that it causes them great distress.Sadly, this level of anxiety can interfere with people's ability to function well. It may affect many important areas of their lives such as work, school, and relationships. When anxiety reaches this level of distress, and results in impaired functioning, one begins to speak of an anxiety disorder. Luckily, experts in the field have come a long way in understanding and treating anxiety problems (Jacofsky, Santos, Khemlani-Patel & Neziroglu, 2015). According to Canadian Mental Health Association (2016), how one thinks and reacts to certain situations can affect anxiety. Some people may perceive certain situations to be more dangerous than they actually are. Consequently, the degrees of perception of particular situations vary with individuals.

There are common symptoms of anxiety that people experience in terms of feelings, behaviors, thoughts, and physical sensations. Nonetheless, it is important to remember that anxiety is a highly subjective experience. Not everyone will experience the same symptoms, nor will each person experience the same intensity of symptom. Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) opined that the physical symptoms are feeling of restlessness, shortness of breath, or a feeling of choking, sweaty palms, a racing heart, chest pain or discomfort, muscle tension, trembling, feeling shaky, nausea and/or diarrhea, "butterflies" in

the stomach, dizziness, or feeling faint, hot flashes, chills, numbness, or tingling sensations, an exaggerated startle response; and sleep disturbance and fatigue. Some of the emotional symptoms are apprehension, distress, dread, nervousness, feeling overwhelmed, panic, uneasiness, worry, fear or terror, jumpiness or edginess. The psychological symptoms of anxiety may include:Problems with concentration, or difficulty with staying on task, memory difficulties, and depressive symptoms such as hopelessness, lethargy, and poor appetite. Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) further asserted that there are the cognitive symptoms of anxiety. Although the content of the thoughts may vary depending on the person and situation, common themes include: "What if it happens?" "I must have certainty." "I can't possibly tolerate not knowing." "People will laugh at me." "I am going crazy." "Oh my God, what is happening to me?" Depending on the nature of the specific anxiety disorder, and a person's own unique anxiety history, the possible worrisome thoughts may vary. National Alliance on Mental Health Illness (NAMI) (2016) further added that anxiety disorders are a group of related conditions, and each with unique symptoms. However, all anxiety disorders have one thing in common: persistent, excessive fear or worry in situations that are not threatening. People can experience one or more of the following symptoms: Emotional symptoms, feelings of apprehension or dread, feeling tense and jumpy, restlessness or irritability, anticipating the worst and being watchful for signs of danger. Physical symptoms: pounding or racing heart and shortness of breath, upset stomach, sweating, tremors and twitches, headaches, fatigue and insomnia, upset stomach, frequent urination or diarrhea. Yates (2016) added that although the experience of anxiety will vary from person to person, feeling stressed, worried, and having anxious thoughts are common symptoms.

Anxiety disorders have been identified by different authors as having types. Few of the classifications will be considered in this study. The types of anxiety disorder as classified by Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) include; Generalized Anxiety Disorder, Phobias (subdivided into agoraphobia, specific phobia and social phobia or social anxiety disorders) and panic disorder. Marsh (2015) added obsessive-compulsive disorders (OCD) and post-traumatic stress disorder (PTSD) to generalized anxiety disorder (GAD), panic disorder and phobias in his classification.

At this juncture, the different types of anxiety disorders will be considered. Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) asserted that people with GAD have uncontrollable, excessive anxiety and excessive worry across several situations. This worry and anxiety happens on more days than not, and persists for six months or more. A person

with GAD finds it very difficult to control or discontinue the worry, or anxiety, despite their best efforts to do so. Excessive anxiety is also referred to as anxious apprehension. This term was coined because anxiety is viewed as an emotion, focused on the future, where a person is preparing to deal with some anticipated negative circumstance. Excessive worry is referred to as apprehensive expectation because the person is always expecting that some sort of terrible event will happen at any moment and that he/she is not safe (Jacofsky, Santos, Khemlani-Patel & Neziroglu,2015). The Australian Psychological Society (2016)asserted that GAD is characterized by persistent and excessive worry, often about daily situations like work, family or health. This worry is difficult to control and interferes with the personôs day-to-day life and relationships. Mental Health America (2016) added that People with GAD have chronic, exaggerated worry about everyday routine life events and activities, with symptoms lasting at least six months; almost always anticipating the worst even though there is little reason to expect it. They have co-occurring physical symptoms, such as fatigue, trembling, muscle tension, headache, or nausea.

Another type of Anxiety Disorder is phobia which is subdivided into agoraphobia, specific phobia and social phobia or social anxiety disorder. Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) observed that agoraphobia is characterized by an intense fear or anxiety that occurs when someone is faced with a situation that is difficult or embarrassing to leave, or where help would be unavailable if they were to experience panic-like symptoms (e.g., becoming dizzy or disoriented). To meet the diagnostic criteria, these reactions must occur in at least two of the following five situations: Using public transportation (cars, buses, trains, ships, airplanes); being in open spaces (parking lot, marketplaces, bridges); being in enclosed places (movie theatre, shops); standing in line or being in a crowd; being outside of the home alone. In line with the above, Australian Psychological Society (2016) asserted that agoraphobia involves intense anxiety following exposure to, or anticipation of, a variety of situations such as public transportation, open spaces, crowds, or being outside of the home alone.

Specific phobia is another type of Anxiety Disorder. Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) opined that specific phobia is the intense fear, anxiety, and avoidance of a specific object or situation (e.g., flying, heights, injections, animals). The Australian Psychological Society (2016) agrees that people with specific phobia experience extreme anxiety and fear of particular objects or situations. Common phobias include fear of flying, fear of spiders and other animals, and fear of injections. Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) noted that social phobia, or social anxiety disorder, is the intense fear,

anxiety, and avoidance of social situations where there is the potential of being scrutinized or negatively judged by others. Exposure to the phobic object or situation will usually precipitate cued (expected) panic. Social anxiety disorder is another type of phobia. The Australian Psychological Society (2016) asserted that in social anxiety disorder the person has severe anxiety about being criticized or negatively evaluated by others. This leads to the person avoiding social events and other public situations for fear of doing something that leads to embarrassment or humiliation.Mental Health America (2016) observed that people with phobias have extreme, disabling and irrational fear of something that really poses little or no actual danger; the fear leads to avoidance of objects or situations and can cause people to limit their lives.

Another type of Anxiety Disorder is Panic Disorder. According to Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) panic disorder is characterized by uncued (unexpected) panic attacks. This diagnosis is not made if the panic attacks are cued or expected. Mental Health America (2016) agrees that the disorder occurs when the person fears having another panic attack. Panic disorder is, therefore, characterized by panic attacks, which are sudden feelings of terror that strike repeatedly and without warning. Physical symptoms include: chest pain, heart palpitations, shortness of breath, dizziness, abdominal discomfort, feelings of unreality, and fear of dying. The Australian Psychological Society (2016) opined thatpanic disorder is characterized by the experience of repeat panic attacks - sudden surges of overwhelming fear and anxiety and physical symptoms such as chest pain, heart palpitations, dizziness, and breathlessness.

Obsessive compulsive disorder (OCD) is another classification of Anxiety Disorder. According to Clark and Radomsky (2014), obsessive compulsive disorder (OCD) is a disorder of the brain and behavior. OCD causes severe anxiety in those affected.Obsessions are typically accompanied by intense and uncomfortable feelings such as fear, disgust, doubt, or a feeling that things have to be done in a way that is ñjust right.ò Compulsions are the second part of obsessive compulsive disorder. These are repetitive behaviors or thoughts that a person uses with the intention of neutralizing, counteracting, or making their obsessions go away. People with OCD realize this is only a temporary solution but without a better way to cope they rely on the compulsion as a temporary escape. The Australian Psychological Society (2016)asserted that individuals with OCD have recurring, persistent, and distressing thoughts, images or impulses, known as *obsessions* (e.g. a fear of catching germs), or feel compelled to carry out certain repetitive behaviours, rituals, or mental acts, known as *compulsions* (e.g. hand-washing). These thoughts and acts can take over a person's life and while people with

OCD usually know that their obsessions and compulsions are an over-reaction, they are unable to stop them. Mental Health America (2016) asserted that people with Obsessive-Compulsive Disorder have anxious impulses to repeat words or phrases or engage in repetitive, ritualistic behavior, such as constant hand washing.

Post-Traumatic Stress Disorders (PTSD) is yet another very important classification of Anxiety Disorder. Psychological Society (2016) referred to Post Traumatic Stress Disorders (PTSD) as a set of symptoms that can occur after exposure to a frightening and traumatic event. Symptoms include a sense of relieving the traumatic event (through óflashbacksô or nightmares), avoidance of places, people, or activities which remind the person of the event, feeling numb or detached from others, having negative thoughts about oneself and the world, feeling irritable, angry, or wound up, and having trouble sleeping. Canadian Mental Health Association (2016) added that frightening situations happen to everyone at some point. People can react in many different ways: they might feel nervous, have a hard time sleeping well, or go over the details of the situation in their mind. These thoughts or experiences are a normal reaction. They usually decrease over time and the people involved can go back to their daily lives, but post-traumatic stress disorder, on the other hand, lasts much longer and can seriously disrupt a personôs life. Mental Health America (2016) submitted that people with Post-Traumatic Stress Disorder have persistent symptoms that occur after experiencing a traumatic event such as war, rape, child abuse, natural disasters, or being taken hostage. Nightmares, flashbacks, numbing of emotions, depression, and feeling angry, irritable, and distracted and being easily startled are common symptoms of PTSD.

Another type of anxiety disorder as Jacofsky, Santos, Khemlani-Patel and Neziroglu (2015) noted is Separation Anxiety Disorder which is characterized by a developmentally inappropriate and excessive fear of becoming separated from a primary attachment figure. The term "attachment figure" simply refers to a person to whom one has a very strong emotional attachment. Separation Anxiety Disorder may affect both children and adults. However, it is more commonly diagnosed in children. Diagnosis requires a developmental and cultural context in order to differentiate what is normal and age-appropriate versus what is disordered. For instance, it is developmentally normal for one year olds to express a high degree of distress when separated from caregivers. It is also normal for children who are just beginning daycare, preschool, or kindergarten to experience significant distress when first separated from their caregivers. Such anxiety reactions normally diminish or go away entirely within a short period of time as children adjust to these new experiences. It is not typical for children's anxiety reactions to persist after they have been at school for a week or two.

It is hard to know why some people experience anxiety and others do not. However, anxiety problems could be caused by varieties of situations and circumstances which people experience at one time or the other in life. Marsh (2015) opined that past or childhood experiences, everyday life and habits like long working hours, physical and mental health can have an impact on the mental wellbeing. For example, a long-term physical health condition, or chronic pain, might make one to be more vulnerable to experiencing emotional health problems such as anxiety, Taking prescription medications or street drugs, including alcohol, can affect emotional health. Marsh (2015) further observed that high levels of emotional problems and exhaustions that come from workplace anxiety can directly lead to lower job performance. According to National Association of Mental Illnesses(NAMI) (2015) scientists believe that many factors combine to cause anxiety disorders which are grouped under genetics and environment. Calm Clinic (2016) in agreement opined that anxiety disorder can be categorized into the two main causes: biology and environment. Biological causes include: genetics, brain activity alterations, deregulation of brain chemistry and medical factors which occurs when some disease or illness affects the brain, causing a disruption in brain chemistry. Environmental causes of anxiety disorders; in this case, environment includes everything that is not genetic - every experience one has, every place one goes, and everything one has been taught. Common environmental causes of anxiety include: Stress, long term stress, like one would experience in a job he or she disliked or in a relationship that was emotionally damaging.

Other environmental causes of anxiety incudes; Upbringing or life experiences and or parenting; life is forged on millions of experiences, and each of these experiences can promote or prevent developing an anxiety disorder. Trauma; especially common in those with PTSD (Post-Traumatic Stress Disorder). Change; some people adapt to change quickly, but many others do not. Canadian Mental Health Association (2016) observed that problems with brain chemistry can contribute to the development of anxiety disorders. Certain neurotransmitters (chemical messengers) in the brain involved in anxiety include serotonin, norepinephrine, and gamma-aminobutyric acid (GABA). Changes in activity in certain areas of the brain are involved in anxiety. Many anxiety disorders run in families and likely have a genetic cause. Certain medical conditions such as anemia and thyroid problems can also cause symptoms of anxiety. As well, other factors such as caffeine, alcohol, and certain medications can cause anxiety symptoms. Traumatic life events such as the death of a family member, witnessing a death, war, and natural disasters such as hurricanes and earthquakes may trigger anxiety disorder.

Understanding the potential causes of anxiety are important, and perhaps even more important is understanding that no matter what caused anxiety, it can always be treated. It does not matter whether the cause of anxiety was biological or environmental - anxiety is a treatable condition. There are countless anxiety causes, but there are also effective anxiety treatments. NAMI (2015) asserted that each anxiety disorder has a different set of symptoms; the types of treatment that a mental health professional may suggest also can vary. However, there are common types of treatment that are used: Psychotherapy, including cognitive behavioral therapy. Medication, including anti-anxiety medication. Complementary health approaches, including stress and relaxation techniques. NAMI (2016) further asserted that practicing self-management strategies, such as allowing specific periods of time for worrying, can free a personôs mind from worry throughout the rest of the day. Someone who becomes an expert on their condition and its triggers gains more control over their day. They also added that the combination of physical postures, breathing exercises and meditation found in yoga (one of the complimentary treatment) have helped many people improve the management of their anxiety disorder. According to Life Extension (2016), once a doctor diagnoses an anxiety disorder, treatment will often integrate several approaches, including but not limited to diet and lifestyle changes, relaxation and massage therapy, psychotherapy, behavioral or cognitive-behavioral therapy, and drug intervention. Folk and Folk (2016) opined that there are many anxiety treatment options. The most effective treatment for anxiety disorder is the combination of good self-help information, support, and personal coaching and therapy by coaches and therapists who have personally experienced and have successfully overcome anxiety disorder and anxiety symptoms in their own lives. Folk and Folk (2016) further stated that having personally experienced and successfully overcome anxiety disorder and anxiety symptoms means not only do they understand ones struggle and how anxiety symptoms feel and can impact a person's life but that they also know how to successfully overcome anxiety unwellness and its symptoms. This personal experience is a valuable asset in the anxiety disorder recovery process. Smith, Robinson and Segal (2016) observed that anxiety disorders respond very well to therapy and often in a relatively short period of time.

The following types of therapy can help within the treatment of anxiety especially panic attacks, generalized anxiety, and phobias. Cognitive-behavior therapy focuses on thoughts or cognitions in addition to behaviours. In anxiety treatment, cognitive-behavioral therapy helps one to identify and challenge the negative thinking patterns and irrational beliefs that fuel anxiety. Exposure therapy for anxiety disorder treatment encourages one to confront his/her fears in a safe and controlled environment. Through repeated exposures to the

feared object or situation, either in the imagination or in reality, one gains a greater sense of control. As one faces fear without being harmed, anxiety gradually diminishes. Cognitive-behavioral therapy and exposure therapy are types of behavioral therapy, meaning they focus on behavior rather than on underlying psychological conflicts or issues from the past.

Furthermore, some medications can be used in the management of anxiety. Smith, Robinson and Segal (2016) further observed anxiety medications can be habit forming and cause unwanted side effects. According to Everyday Health (2016) a form of psychotherapy called cognitive behavioral therapy (CBT) often is used to treat anxiety disorders. CBT focuses on changing unhealthy thinking and behavior patterns through talk sessions with a trained therapist. During CBT, the anxious individual works together with a therapist to develop positive techniques for coping with fear, anxiety, and other symptoms. CBT is not a quick fix, it may take up to three or four months before benefits are seen from therapy sessions. Some people receiving CBT also take medications for their anxiety. A type of CBT is called exposure therapy which is used to treat certain phobias. It involves gradually exposing one to a feared situation or object, causing the person to become less fearful over time. National Institute of Health (2016) observed that two specific stand-alone components of CBT used to treat social anxiety disorder are cognitive therapy and exposure therapy. Cognitive therapy focuses on identifying, challenging, and then neutralizing unhelpful thoughts underlying anxiety disorders. Bressert (2016) explained that exposure therapy simply refers to being exposed, very gradually, to social situations that would normally be anxiety-provoking.

Exposure therapy focuses on confronting the fears underlying an anxiety disorder in order to help people engage in activities they have been avoiding. Exposure therapy is used along with relaxation exercises. NAMI (2016) opined that many people find that physical activity is beneficial to their well-being. Some types of mind and body treatments are yoga, exercise (aerobic and anaerobic), meditation and Tai chi. However, all mind and body treatments can improve anxiety

Anger is another EHP that is often experienced by individuals at one time or the other worldwide. It is a normal, healthy emotion. However, it can be a problem if one finds it difficult to keep it under control.Anger is a normal and intense emotion that involves a strong uncomfortable and emotional response to a perceived provocation (Videbeck, 2006). Mental Health Foundation (2008) asserted that anger is one of the most basic human emotions. It is a physical and mental response to a threat or to harm done in the past.Anger is a normal reaction to unwanted and unpleasant situation. Carlson (2013) viewed anger as a feeling of

displeasure due to real or imagined threat, insult, putdown, frustration or injustice to one or those important to him/her. Modern psychologists view anger as a primary, natural, and mature emotion experienced by virtually all humans at times, and as something that has functional value for survival(Day, Mohr, Howells, Gerace & Lim, 2012). Anger is a completely natural emotion experienced by all, despite this fact; it can still be unpleasant and lead to irrational behaviour and impaired judgment, potentially resulting in emotional and physical pain (Segal & Smith, 2015). Anger is a natural and mostly automatic response to pain of one form or another (physical or emotional). Anger can occur when people do not feel well, feel rejected, feel threatened, or experience some loss. The type of pain does not matter; the important thing is that the pain experienced is unpleasant (Mills, 2015). More about anger: Anger is an emotion often characterized by feelings of great displeasure, indignation, hostility, wrath and vengeance. Many times, reacting in anger is how dissatisfaction with life is expressed. It is defined in the Greek language as the strongest of all passions. Anger begins with a feeling that is often expressed in words or actions. Something is felt and it causes a reaction (Meyer, 2016). Rivers (2016) asserted that anger is a part of life. Everybody comes into contact with a person, or a circumstance, that results in the feeling of anger.

Anger is a gift of nature for every individual and could be good when it is properly applied in the right way and at the right time. Child Development Institute (2015) opined that it is believed that to be angry was to be bad, and one is often made to feel guilty for expressing anger. It will be easier to deal with anger if this notion is gotten rid of. The goal is not to repress or destroy angry feelings in people but rather to accept the feelings and to help channel and direct them to constructive ends. Child Development Institute (2015) also noted that parents and teachers must allow children to express all their feelings. Adult skills can then be directed toward showing children acceptable ways of expressing their feelings. Strong feelings cannot be denied, and angry outbursts should not always be viewed as a sign of serious problems; they should be recognized and treated with respect. Smith (2015) asserted that anger is an emotion everyone feels. Despite what some people think, it is normal, okay and healthy to get angry. Unfortunately, too many people see anger as a feeling that is supposed to be avoided. But in reality, it cannot be avoided, because it is a natural emotion for all. It is simply being human to get angry. Life is just going to make one angry sometimes. But often times anger alerts one of something wrong, for instance; when a partner has been texting someone inappropriately. Smith (2015) further observed that what can make anger a problem is what is done with it. Punching a hole in the wall is a problem; yelling at kids is a problem; obsessing about how someone is hurt is a problem. Anger can be linked to all of

these actions, but really the problem is not the anger, it is what is done with the feeling. Scott (2016) opined that anger in itself is not necessarily a problem, it can be healthy in that it cannot only alert one to issues that may need to be changed but it can also motivate one to make these changes.Studies have shown that due to environmental, genetic, and psychological factors, certain people are more susceptible to anger than others. Some people are noticeably angry, others more internally irritable (Rivers, 2016).

Anger is usually expressed by different people in different ways. This is to say that there are many forms and types of anger, manifested in varieties of ways depending on the disposition and make up of people. According to Mental Health Foundation (2008) people often express their anger verbally. They may shout, threaten, use dramatic words, bombard someone with hostile questions or exaggerate the impact on them of someone elseôs action. Some people who are angry get their own back indirectly by acting the martyr. They get their own way by making other people feel guilty and playing on that guilt. Others develop a cynical attitude and constantly criticize everything, but never address problems constructively. Mental Health Foundation (2008) further asserted that some people internalize their anger. They may be boiling inside and may physically shake, but they do not show their anger in the way they behave when they are around other people. People who internalize their anger may self-harm when they are angry because they find it hard to deal with their emotions. They deliberately harm themselves, usually in secret, as a way of coping with intense feelings they cannot express another way. Self-harm is most common among young people. They may feel it gives them a release from their anger but any relief is only temporary and, like many more obvious ways of expressing anger, self-harming does not solve problems long term. Chronic repression or suppression of anger is counterproductive and, ultimately, futile and dangerous. This is why the culture needs to encourage the acceptance of anger as a natural phenomenon, and teach children, adolescents and young adults how to manage and express it more constructively (Diamond, 2009).

Additionally, anger can be classified into forms namely; Hasty and sudden, settled and deliberate and dispositional anger. According to Day, Mohr, Howells, Gerace and Lim, (2012) three forms of anger are recognized by psychologists: the first form of anger, named "hasty and sudden anger" by Joseph Butler, an 18th-century English bishop, is connected to the impulse for self-preservation. It is shared between both human and non-human animals, and it occurs when the animal is tormented or trapped. The second type of anger is named "settled and deliberate" anger and is a reaction to perceived deliberate harm or unfair treatment by others. The third type of anger is called dispositional and is related more to character traits

than to instincts or cognitions. Irritability, resentment and churlishness are examples of the last form of anger.

There are still other forms of anger. Pagan (2012) opined that anger can be reactive, passive aggressive, avoidant and direct.Reactive; responds immediately to perceived insult or injustice, possibly yelling or even slamming doors. This type of response creates stress on the heart, which is why it has been linked to an elevated risk of cardiovascular disease. Passive-aggressive people spend a lot of time thinking about how they have been wronged, which causes them emotional and physical distress, such as increased pain and anxiety.In avoidantanger one acts as if everything is fine when it is not; can literally make one sick. Internalizing anger damages self-esteem because the individual feels weak and unable to assert his or her own needs, this can contribute to depression. Bottling up anger causes a rush of negative stress hormones in the body, taxing the cardiovascular system.Direct; the individual has no problem admitting when ticked off, but instead of saying whatever pops into mind at that time, there is need to formulate a rational, constructive, and respectful approach before talking. This response is ideal. It shows respect for others' needs and feelings.Psychguides (2016) opined that there is chronic anger, which is prolonged, can impact the immune system and be the cause of other mental disorders. Passive anger;this does not always come across as anger and can be difficult to identify. Overwhelmed anger; this is caused by life demands that are too much for an individual to cope with. Self-inflicted anger; this is directed towards self and may be caused by feelings of guilt. Judgmental anger; this is directed towards others and may come with feelings of resentment. Finally, volatile anger; this involves spontaneous bouts of excessive or violent anger.

Anger is not apparent without any precipitating factor. This factor may be reasonable or unreasonable, but the fact still remains that something triggered the anger in the angry person. People may be angry about certain events, their own actions or other people's actions. Many little things can build up to make people feel that life is unfair and hence anger (American Academy of Family Physicians, 2010). Day, Mohr, Howells, Gerace and Lim, (2012) observed that people feel angry when they sense that they or someone they care about has been offended, when they are certain about the nature and cause of the angering event, when they are certain someone else is responsible, and when they feel they can still influence the situation or cope with it. For instance, if a person's car is damaged, he/she will feel angry if someone else did it (that is another driver rear-ended it). PsychGuides (2016) noted that the leading cause of anger is a personôs environment; Stress, financial issues, abuse, poor social or familial situations, and overwhelming requirements on time and energy can all contribute

to the formation of anger. People are sometimes not aware of what causes their anger, how much anger they are holding inside or how to express anger appropriately. Meyer (2016) opined that anger is the fruit of rotten roots. One of the primary roots of anger stems from the family. Angry people come from angry families because they learn from their role models and carry on the same behavior in their own lives, eventually passing it on to their children. Meyer (2016) added that other roots of anger are jealousy, unmet needs, abuse of any kind, impatience, strife, injustice.

Certain symptoms are glaring when someone is angry. Mills (2005) opined that most people experience a number of physical, emotional and behavioral cues that they can use to let them know when they are becoming upset which include, clenching the jaws or grinding the teeth, headache, stomach ache,increased and rapid heart rate, sweating, especially the palms, feeling hot in the neck and or face, shaking or trembling, dizziness, irritated, sad or depressed, guilty, resentful, anxious , rubbing the head, cupping the fist with the other hand and pacing, acting in an abusive or abrasive manner, craving a drink, a smoke or other substances that relax you, raising your voice and beginning to yell, scream, or cry.Emotional symptoms of anger include constant irritability, rage and anxiety, always feeling overwhelmed, trouble organizing or managing thoughts, fantasizing of hurting oneself or others. Unaddressed anger can put the overall health at risk causing the following physical symptoms are tingling sensation, heart palpitation or tingling of the chest, increased blood pressure, headaches and fatigue (PsychGuides, 2016).

When an individual gets angry for one reason or the other, there are many effects; both physically and physiologically. Glomb (2002) opined that anger expression might have negative outcomes for individuals and organizations as well, such as decrease of productivity and increase of job stress, however, it could also have positive outcomes, such as increased work motivation, improved relationships and increased mutual understanding. A Dual Thresholds Model of Anger in organizations by Geddes and Callister (2007) proposes that two thresholds exist when individuals experience anger in the workplace. The first; ñexpression thresholdò is crossed when an organizational member conveys felt anger to individuals at work who are associated with or able to address the anger provoking situation. The second; ñimpropriety thresholdò is crossed if or when organizational members go too far while expressing anger such that observers and other company personnel find their actions socially and/or culturally in appropriate. Crossing this threshold is a function of both actor behaviour and observer perceptions; thus, there is a type of actor-observer interaction inherent in the model. The thresholds and their placement in relation to each other represent emotion

display rules and norms operating formally or informally within the organizational context. The thresholds also demarcate three forms of workplace anger: suppressed, expressed, and deviant.

Workplace anger manifests in diverse ways. Geddes and Callister (2007) indicated that the higher probability of negative outcomes from workplace anger likely will occur in either of two situations. The first is when organizational members suppress rather than express their anger, that is, they fail to cross the "expression threshold". In this instance, personnel who might be able to address or resolve the anger-provoking condition or event remain unaware of the problem, allowing it to continue, along with the affected individual's anger. The second is when organizational members cross both thresholds "double cross" displaying anger that is perceived as deviant. In such cases, the angry person is seen as the problem, increasing chances of organizational sanctions against him or her while diverting attention away from the initial anger-provoking incident. In contrast, a higher probability of positive outcomes from workplace anger expression likely will occur when one's expressed anger stays in the space between the expression and rudeness thresholds. Here, one expresses anger in a way fellow organizational members find acceptable, prompting exchanges and discussions that may help resolve concerns to the satisfaction of all parties involved. This space between the thresholds varies among different organizations and also can be changed in organization itself. Mental Health Foundation (2008) asserted that releasing the pressure that builds inside is often essential in dealing with problems and moving on. But if anger is not dealt with in a healthy way, it can have a significant effect on daily life, relationships, achievements and mental wellbeing. Unresolved anger can have long-term effects on the body, making it difficult for one to perform routine tasks (PsychGuides, 2016). American Psychological Association (2016) asserted that chronic repression or suppression of anger is counterproductive and, ultimately, futile and dangerous. This is why the culture needs to encourage the acceptance of anger as a natural phenomenon, and teach children, adolescents and young adults how to manage and express it more constructively.

The emotion of anger can be beneficial in diverse ways, especially when it is directed appropriately. Anger when viewed as a protective response or instinct to a perceived threat is considered as positive (Videbeck, 2006). Anger can potentially mobilize psychological resources and boost determination toward correction of wrong behaviours, promotion of social justice, communication of negative sentiment and redress of grievances. It can also facilitate patience. In contrast, anger can be destructive when it does not find its appropriate outlet in expression. Anger, in its strong form, impairs one's ability to process information and

to exert cognitive control over their behaviour. An angry person may lose his/her objectivity, empathy, prudence or thoughtfulness and may cause harm to themselves or others. (Mohr, Howells, Gerace, Day & Wharton,2007). Mental Health Foundation (2008) observed that there are benefits of keeping anger level under control or expressing it in a constructive way. Anger control makes people think more optimistically. Dangers seem smaller, actions seem less risky, ventures seem more likely to succeed, and unfortunate events seem less likely. Angry people are more likely to make risky decisions **(**Abdelkader, 2013).

Sometimes people use masks to cover up the things they do not want anybody to see, thinking that harboring and masking anger keep others from knowing ones real identity. People mask in an attempt to trick others into thinking they are something or someone they are not. People are respected more if they share their real self with others rather than trying to hide everything. After all, people can tell when something is not right. Anger, will eventually find a way to be expressed after all, either in voice tone, body language or attitudes. Some people use the cold-shoulder mask when angry, they may say they have forgiven but they become cold, showing no warmth or emotion in dealing with the offender. These people live a lonely existence. Because they are so afraid of being hurt, they avoid close, meaningful relationships (Meyer, 2016).

Like other emotions, anger is experienced in the body well as in the minds. In fact, there is a complex series of physiological (body) events that occurs as one becomes angry. Mills (2015) asserted that emotions begin inside two almond-shaped structures in the brains which are called the amygdala. The amygdala is the part of the brain responsible for identifying threats to well-being, and for sending out an alarm when threats are identified that result in people taking steps to protect themselves. The amygdala is so efficient at warning about threats, that it gets one reacting before the cortex (the part of the brain responsible for thought and judgment) is able to check on the reasonableness of the reaction. In other words, the brain is wired in such a way as to influence one to act before proper consideration of the consequences of the actions is made. Mills (2015) added that it is not an excuse for behaving badly because some people can, and do control their aggressive impulses and everyone could too with some practice. Instead, it means that learning to manage anger properly is a skill that has to be learned, instead of something one is born knowing how to do instinctively. As one becomes angry the body's muscles tense up. Inside the brain, neurotransmitter chemicals known as catecholamines are released leading to the experience of burst of energy lasting up to several minutes. This burst of energy is behind the common angry desire to take immediate protective action. At the same time the heart rate accelerates, blood pressure rises, and the rate

of breathing increases. The face may flush as increased blood flow enters the limbs and extremities in preparation for physical action. Attention narrows and becomes locked onto the target of the anger. Soon attention is paid to nothing else. In quick succession, additional brain neurotransmitters and hormones (among them adrenaline and noradrenaline) are released which trigger a lasting state of arousal. The individual is now ready to fight.

Besides, it is important to note that the brain has a way of managing anger naturally. Mill (2015) further noted that the same lingering arousal that keeps one primed for more anger also can interfere with the ability to clearly remember details of angry outburst. Arousal is vital for efficient remembering. As any student knows, it is difficult to learn new material while sleepy. Moderate arousal levels help the brain to learn and enhance memory, concentration, and performance. There is an optimum level of arousal that benefits memory, however, and when arousal exceeds that optimum level, it makes it more difficult for new memories to be formed. High levels of arousal (such as are present when angry) significantly decrease ability to concentrate. This is why it is difficult to remember details of really explosive arguments. Long term and intense anger has been linked with mental health problems including depression, anxiety and self-harm (Mental Health Foundation, 2008).

There are few suggestions on how to handle anger, whenever the emotion is provoked. Rivers (2016) observed some ways to deal with anger: Take 5 pause; when anger is bubbles up, step away for a minute, pause, and breathe deeply from the diaphragm. Visualize something relaxing. Do this before having a reaction. Write; a great way to express oneself and release aggression is through writing. Get into the habit of putting pen to the paper and writing out feelings, it can become a very helpful habit in times to come. Communicate; Say what is really desired to say. Listen to what is being said by others, and listen also to what you are wishing to convey. Have a sense of humour; not sarcasm or bitter humour, which is also unhelpful. Have just enough silliness to be able to cool things down to deal with the situation rationally. Exercise; go for a run, a walk or to a spinning class. Do anything that will get rid of that anxious energy that is building up on the inside that might otherwise explode in different areas. Sleep it off; do not deal with things when tired. If grumpy or run down, take a snap. Get some rest; let it cool down. Psychguide (2016) noted that mental health professionals recommend counseling, group therapy sessions and anger management classes as treatment options for anger disorders. The authors further noted that drugs can also be an option, though it depends on individual circumstances.

Stress is a normal part of life that can motivate one in its mild dimension. It can come from any situation or thought that makes one feel frustrated, angry or anxious. Everyone sees

situation differently and has different coping skills, as a result responds to them differently as well. Robbins (2003) summarizes stress as being a dynamic condition in which an individual is confronted with an opportunity, constraint, or demand related to what he or she desires and for which the outcome is perceived to be both uncertain and important. Moorhead and Griffin (2004) defined stress as being a personôs adaptive response to a stimulus that places excessive psychological or physical demands on the individual. This stimulus generally is called a stressor, which is any factor that causes stress. World Health Organization(WHO) (2004) opined that stress is the response people may have when presented with work demands and pressures that are not matched with their knowledge and abilities and which challenge their ability to cope. Civil servants are not left out. WHO (2004) further stated that pressures are acceptable when it keeps workers alert and motivated to work and learn depending on the available resources and personal characteristics. However, when pressure becomes excessive or otherwise unmanageable, it leads to stress. Bickford (2005) defined stress as a natural part of life which occurs whenever there are significant changes in life, positive or negative. According to Moss (2008) stress is defined as any objective condition or any change in the work environment that is perceived as potentially harmful, threatening, challenging, or frustrating, or any set of circumstances related to work that requires change in the individualôs ongoing life pattern. Jon, Randy and De Simone (2009) defined stress as the general term applied to the pressures people feel in life. Okyerefo and Dankwah (2009)in their study defined stress as a condition that leads an individual to perceive a discrepancy, whether real or not between the demands of a situation and the resources of the personôs biological, psychological or social systems.Gangwar (2017) observed stress as the mental and physical response and adaptation by the body to the real and perceived changes. Cohen (2016) defined stress as the bodyôs reaction to a challenge. Though stress is often perceived as bad, it can actually be good in some respects. The right kind of stress can sharpen the mind and reflexes. It might be able to help the body perform better, or help it escape a dangerous situation.

Generally, most people use the word stress to refer to negative experiences that leave people feeling overwhelmed. Cohen (2016) acknowledged that thinking about stress exclusively as something negative gives a false impression of its true nature, however. Stress is a reaction to a changing, demanding environment. Properly considered, stress is really more about the capacity to handle change than it is about whether that change makes one feel good or bad. Wadsworth (2007) avowed that stress is needed; without stress, there would be no productivity or engagement.Thinking about stress as a reaction to change suggests that it is not necessarily bad, and sometimes, could even be a good thing. Some life changes such as

getting a new job, moving in with a new romantic partner are generally considered positive and life-enhancing events, even though they can also be quite stressful. Other life changes such as losing a job or an important relationship are more negative, and also stressful (Mills, Reiss & Dombeck, 2008).

The experience of stress varies in intensity between high and low. How intensely stressed one feels in response to a particular event has to do with how much that is needed to accomplish in order to meet the demands of that situation. Generally speaking, people do not like experiencing the extremes of stress. This is true for each end of the spectrum of stress intensity, both high and low. However, most people do not like a total absence of stress either, at least after a while. There is a word for such a condition: boredom. What most people tend to seek is the middle ground; a balance between a lack of stress and too much stress (Mills, Reiss & Dombeck, 2008).

Some people who are stressed may show relatively mild outward signs of anxiety, such as fidgeting, biting their fingernails, tapping their feet among others. In other people, chronic activation of stress hormones can contribute to severe feelings of anxiety (e.g., racing heartbeat, nausea, sweaty palms, etc.), feelings of helplessness and a sense of impending doom. Thought patterns that lead to stress (and depression, as described above) can also leave people vulnerable to intense anxiety feelings (Mills, Reiss & Dombeck 2008).Mills, Reiss and Dombeckfurther noted that continuous presence of stress hormones in the body may alter the operation and structure of some aspects of the nervous system. More specifically, stress hormones may decrease the functioning of neurons (brain cells) in a region of the brain known as the hippocampus (a part of the brain that is important for laying down new long-term memories) and in the frontal lobes (the part of the brain that is necessary for paying attention, filtering out irrelevant information, and using judgment to solve problems). As a result, people who are chronically stressed may experience confusion, difficulty concentrating, trouble learning new information, and/or problems with decision-making.

Stress is not left out of certain signs and symptoms. Mills, Reiss and Dombeck (2016) enumerated some of the symptoms of stress which include; irritability, hostility, frustration, anger, aggressive feelings and behavior, decreased interest in appearance, decreased concern with punctuality, obsessive/compulsive behavior (trying to cope with unwanted repeated thoughts or obsessions, by engaging in compulsive behavior rituals such as counting, checking, washing), reduced work efficiency or productivity, lying or making excuses to cover up poor work, excessive defensiveness or suspiciousness, problems in communication

social withdrawal and isolation, impulsivity (expressed as impulse buying, gambling, sexual behavior, or similar).

A variety of events and environmental demands cause one to experience stress, including: routine hassles (such as getting the family out the door in the morning, or dealing with a difficult co-worker), one-time events that alter oneôs life (such as moving, marriage, childbirth, or changing jobs), and ongoing long-term demands (such as dealing with a chronic disease, or caring for a child or sick family member). Though different people may experience the same type of events, each of them will experience that event in a unique way. That is, some people are more vulnerable to becoming stressed out than others are in any given situation. An event like getting stuck in traffic might cause one person to become very stressed out while it might not affect another person much at all. Even "good" stressors such as getting married can impact individuals differently. Some people become highly anxious while others remain calm and composed (Mills, Reiss & Dombeck, 2008). Things or situations that cause stress are called stressors. A Stressor is any event or situation that an individual perceives as a threat; precipitates either adaptation or the stress response (Wadsworth, 2007). Individuals react to these stress causing situations in diverse ways. These stressors also affect different people in different ways. Employers and employees alike talk about stress. Stress can come from good and bad experiences.

The effects of stress can be positive or negative on the body depending on oneôs personality and the interpretation that one gives to a stressor. Mills, Reiss and Dombeck (2008) noted that psychoneuroimmunology (PNI) research suggests that chronic stress can lead to or exacerbate mood disorders such as depression and anxiety, cognitive (thinking) problems, personality changes, and problem behaviors. Stress is a highly personalized phenomenon and can vary widely even in identical situations for different reasons (Kiveshnie, Christoff & Christo, 2013). Saeed (2015) opined that the nature of work is changing at a whirlwind pace and stress related illness is a serious menace for people in the work force. How vulnerable one is to becoming stressed out depends on a variety of factors, including biological makeup, perception of the ability to cope with challenges, characteristics of the stressful event (e.g., the "stressor") such as the intensity, timing, and duration; and the command of stress management skills. While some of these factors (such as genetics and often, the characteristics of the stressor itself) are not under ones direct control, some of the other factors are (Mills, Reiss & Dombeck, 2016). According to Cohen (2016) stress produces a physiological reaction in the body. Hormones are released, which results in physical manifestations of stress. These can include slowed digestion, shaking, tunnel vision,

accelerated breathing and heart rate, dilation of pupils and flushed skin. This process is often referred to as the ñfight or flightò response. That is just what it sounds like: The body is poised to either run away from the stressor or stick around and fight against it.

Socio-demographic predictors of emotional health problems

Certain circumstances, events or factors can trigger EHPs at one time or the other in life. These circumstances, events or factors are called predictors. Predictors can be socio or demographic in nature. Socio is derived from the word sociology which according to American Sociological Association (2018)is the study of the social lives of people, groups, societies and our behavior as social beings, covering everything from the analysis of short contacts between anonymous individuals on the street to the study of global social processes. Processes within a society are the ways in which individuals and groups interact, adjust and establish relationship and pattern of behavior which are again modified through social interactions (Samiksha, 2015). Sociology is understanding how human action and consciousness both shape and are shaped by surrounding cultural and social structures (American Sociological Association,2018). Structure of a society refers to the enduring orderly and patterned relationship between the individuals in that society. These patterned relationships are types of groups, associations and institutions (Sociology Guide, 2016).

Socio predictors include educational status, marital status and level of income among others. The demographic predictors include age and gender. Center for Disease Control and Prevention(CDC) (2011) asserted that there is an association between the prevalence of EHPs and personal factors such as gender, job status, educational status, age, marital status, socioeconomic status and family stability.

Demography is the study of human populations; their size, composition and distribution across space and the process through which populations change.A populationôs composition may be described in terms of basic demographic features; age, sex, family and household status and by features of the populationôs social and economic context; education, occupation, ethnicity, religion, income and wealth (Department of Sociology, 2017). Socio-demographic is the study of people in the society (Ramasawmy, 2012). Americaôs Essential Hospitals (2015) opined that a large and growing body of evidence shows that socio demographic factors, socioeconomic status (SES) such as income and education can influence health.

Predictors are either risk factors, protective factors, promotive factors or vulnerability factors (Gutman & Sameroff, 2004). Predictor is from the word prediction which is a guess about what might happen in the future, based on observations (Science Process Skills, 2012).

Socio-demographic predictors of EHPs are therefore, defined in this study as risk or protective factors which could be educational status, marital status, level of income, age and gender that may in one way or the other have influence on EHPs when manipulated by negative or positive conditions. The socio-demographic predictors such as educational status, marital status, level of income, age and gender are the areas of interest in this study. Each of these socio-demographic variables could either predict or be linked with the occurrence of EHPs. Hence, few of these socio-demographic variables/ factors will be considered in this study.

Educational status may have a great influence on emotional health status because the knowledge, skill, values and habits acquired from education can help individuals to manage emotional health properly and appropriately, thereby avoiding emotional health problems. Butler (2002) pointed out that women with higher level of education are less likely to be depressed. There is a significant relationship between the prevalence of common emotional problems and low educational levels (Patel & Kleiman, 2003). This is supported by Feinsten, Sabates, Anderson, Sorhando and Hammond (2006), who maintained that education impacts on social and economic relationships in the workplace to improve the relative emotional health of those with autonomy and authority in workplace and reduce that of individuals with less autonomy and authority. Therefore, education has the ability to impact upon environmental factors that lead to EHPs especially depression. Centre for Educational Research and Innovation (CERI) (2006) noted that those with more education are also more likely to take advantage of health care provision. Moreover, the association of education and some forms of illicit drug use and sometimes alcohol use is found to be positive, i.e. education is associated with increased use.

At times, it seems that the effect of education on individual is not so good depending on the personality. Centre for Educational Research and Innovation (CERI) (2006) noted that it is also important to emphasize that to an extent that education effects on health occur as a result of impacts on features of the self, particularly self-concepts and attitudes, then if the quality of education is not appropriate to the developmental needs of the individual education can have direct injurious effects. Cutler and Lleras-Muney (2008) noted that education is associated with better health behaviors, better educated individuals smoke less, engage in less heavy drinking. Children of uneducated parents, grow up to be unhealthy and uneducated parents themselves (Vogyl, 2012). This lack of education invariably may likely lead to EHPs. Bjelland, Krokstad, Mykletum and Tambs, (2008) in their study to find out whether higher educational level protects against anxiety and/or depression, found out that low educational

levels were significantly associated with both anxiety and depression. The coefficients decreased with increasing age. Higher educational level seems to have a protective effect against anxiety and depression, which accumulates throughout life.Okyerefo and Dankwah (2009) pointed out that in recent times, due to high demand of work output and a sense of professionalism by corporate institutions, more and more workers, are compelled to pursue higher education to better position themselves in the job market, or for economic security. Thus, work overload, and consequently EHPs, stress in particular. Zimmerman, Steven, Woolf, and Amber (2015) opined that educational attainment is associated with greater social support, including social networks that provide financial, psychological, and emotional support. Zimmerman, Steven, Woolf, and Amber (2015)observed that for those confronting life without a good education, individual stressors can accumulate over time and may, in turn, heighten exposure to further EHPs. Zimmerman, Steven, Woolf, and Amber (2015) further noted that life changes, traumas, chronic strain, and discrimination all of which can accompany an inadequate education can be harmful to both physical and emotional health, causing EHPs.

Level of income could be a major predictor of emotional health problems. This is because with more income one is able to provide what he wants, but with low income, all the desired goals may not be attained leading to negative emotional reactions and problems. Kuruvilla and Jacob (2007) observed that depression and anxiety are reported to be most prevalent among those with the lowest standard of living. Dunn, Aknin and Norton (2008) in their social causation theory posits that there is a link between EHP and income by noting that adversity, stress, and reduced capacity to cope related to low income increase the risk of development of EHPs that may invariably lead to mental illness. Deaton and Kahneman (2010) observed that low income has been implicated with such misfortunes as divorce, ill health and loneliness which is an EHP. On the other hand, high income improves emotional evaluation of life but not emotional wellbeing (Deaton & Kahneman 2010). Kahneman and Deaton (2010) opined that household income matters for emotional well-being. Sareen, Afifi, McMillian, and Asmondson (2011) opined that people living in households with the lowest levels of income were more likely to have EHPs than those living in the highest income households. Sareen, Afifi, McMillian, and Asmondson (2011) however, observed that once the basic needs are met (food and shelter), higher levels of income have not been shown to be strongly associated with happiness or decreased risk of emotional health problems. Sareen, Afifi, McMillian, and Asmondson (2011) further noted that it is plausible that a reduction in income might have a short-term effect on increasing EHPs, long-term effect on reducing the

risk for emotional health problems was not captured during the time of the study. Alternatively, Kahneman and Deaton (2010) pointed out that an increase in income may not be associated with improved life satisfaction and happiness. Sareen, Afifi, McMillian, andAsmondson, (2011) noted that it is possible that the relationship between income and EHPs might not be the same during economic recession. For example, a decrease in household income during a period of economic growth may be more stressful for an individual in comparison with a period when there is an economic recession. During the latter circumstances, the individual may take solace in the fact that the change in income is not within his or her control. Zimmerman, Steven, Woolf, and Amber (2015) noted that economic environment facing individuals and households and the stresses induced by material deprivation can affect successful emotional health causing problems that can increase the risk of disease. People with higher education and income are more likely to live in neighborhoods that provide green space (e.g., parks), sidewalks, and other places to enable residents to walk and cycle to work and shopping, exercise, and play outside. This may help to reduce EHPs. Lower-income neighborhoods are also less likely to have commercial exercise facilities. This has a way of causing emotional health problems. Zimmerman, Steven, Woolf, and Amber (2015) further noted that low-income neighborhoods often have fewer good schools, not least because public schools tend to be poorly resourced by low property taxes and cannot offer attractive teacher salaries or properly maintain buildings, supplies, and school safety. Low income exacerbates the emotional pain.

Age has influence on emotional health problem. A child can have emotional health problems from early age and it can continue into adulthood. This could be as a result of the child continuing in such unconducive emotional environment. Oswald and Wilson (2005) opined that age and education act to reduce the risk of depression, as does being male. Charles and Carstensen (2008) acknowledged that in a study where younger and older adults listed to negative comments directed toward them and were asked to voice aloud their responses to these comments, younger adults were more likely to react to these negative comments by making disparaging remarks toward the people speaking and reflecting on what they had just heard. Older adults, in contrast, made few comments about what they had heard and instead made comments that were less negative and focused less on the criticisms. Singh and Misra (2009) stated that the number of older people is increasing throughout the world. As individuals grow older, they are faced with numerous physical, psychological and social role changes that challenge their sense of self and capacity to live happily. Depression and loneliness are considered to be the major problems leading to impaired quality of life among

elderly persons. Singh and Misra (2009) further noted that EHPs especially depression that first develops in later life is more likely to bear some relationship to physical health problems. An older person in good physical health has a relatively low risk of depression. Physical health is indeed the major cause of depression in late life. Deeks, Lambard, Michelmore and Teede (2009) opined that age is associated with health related behaviours. When the emotional health of children and young people are well cared for, they develop the resilience to cope with whatever challenge life throws at them and grow into well rounded adults.

Age in some instances is seen as not having any significant effect on depression. According to Singh and Misra (2009), studies have found that age is not always significantly related to level of depression, and that the oldest of olds may even have better coping skills to deal with depression, making depressive symptoms more common but not as severe as in younger populations. Singh and Misra (2009) also considered another angle to it that as individuals grow older, they are faced with numerous physical, emotional and social role changes that challenge their sense of self and capacity to live happily resulting in EHPs. Depression and loneliness are considered to be the major problems leading to impaired quality of life among elderly persons. (Mental Health Foundation, 2015). Manaf, Mustafa, Rahman, Yusof, and Aziz (2016) observed that emotional health problems are common in old age, but frequently remain undetected and untreated. Emotional health problems in the elderly are the result of a complex interaction of social, psychological and biological factors. According to American Psychological Association (2016), there is evidence that some natural body changes associated with aging may increase personôs risk of experiencing EHPs like depression. The report further stated that older adults may sense a loss of control over life due to external pressures such as limited financial resources. This may give rise to negative emotions such as sadness, anxiety, loneliness and lowered self-esteem. Charles and Carstensen (2010) affirmed that older adults appear to navigate social environments well and use social regulation, particularly social selection, to maintain to relatively high levels of wellbeing. In everyday life, older adults show social and emotional functioning that is equal to or superior to younger adults. Though modest changes have been documented, personality traits also remain largely stable into old age. And in late life, as at earlier times, the experience of negative emotions affects physiological functioning and ultimately physical health. Yet, social and emotional life does change with age. Social networks narrow. Negative emotions become more infrequent (until very old age) and social roles change quantitatively and qualitatively. Investments in meaningful relationships increase. Older adults also describe negative situations in their own lives less negatively. When evaluating the relatively minor but negative daily stressors they

had experienced across the week, older age was related to lower levels of perceived severity (Charles & Almeida, 2007). Even when placed in a similar situation, older adults have more positive appraisals than younger and middle-aged adults (Lefkowitz & Fingerman, 2003; Story et al., 2007).

Civil servants.

Civil servants are classified into federal, state and local government staff and are generally seen and referred to as government paid workers that receive their salaries monthly and consistently. It is disheartening that this is not the case with most civil servants of today, ranging from the federal to the state and then to the LGA level. The situation seems to be worse in LGAs including Nsukka LGA of Enugu State. There are categories of civil servants. According to Okezie and Obi (2004) civil servants are mainly of two categories: lower clerical staff and higher administrative staff. The higher administrative staff is responsible to the political head of department. The lower clerical staff helps the administrative staff and works under its direct supervision and control. Ekhator (2003) pointed out that five classes of civil servants exist in Nigeria namely; administrative class (the most prestigious class, close to political head, ministers and commissioners), professional class (examples are specialists, doctors, engineers), executive class (general administration, implements policies), clerical class (subordinate staff, performs supportive functions) and manipulative class or auxiliary (semi-skilled, skilled drivers, cleaners, guards).

When one says he or she is a civil servant in Nigeria, he or she is classified in a certain manner.Okezie and Obi (2003) asserted that civil servants are characterized by: permanence, impartiality, neutrality and anonymity. Civil servants in Nsukka LGA are experiencing a lot of emotional issues due to non-payment of salaries and they seem not to have job satisfaction as their salaries have not been paid for the past eight months as at the inception of this study, for example, no good offices, no incentives, and yet they are mandated to sign in and out each day. They look dejected, frustrated and emotionally down cast. Little wonder why Aigboje (2007) observed that better salaries and allowances, vehicle advances, refurbishing loans, conducive offices and other motivational factors can stimulate productivity and job satisfaction. Ofuebe (2014) noted that civil servants are loaded with possibilities of making a mess of things and getting fired sometimes, leading to their being on a crossroad of working under pressure to avoid query or punishment. This results in more stress, anxiety and anger.

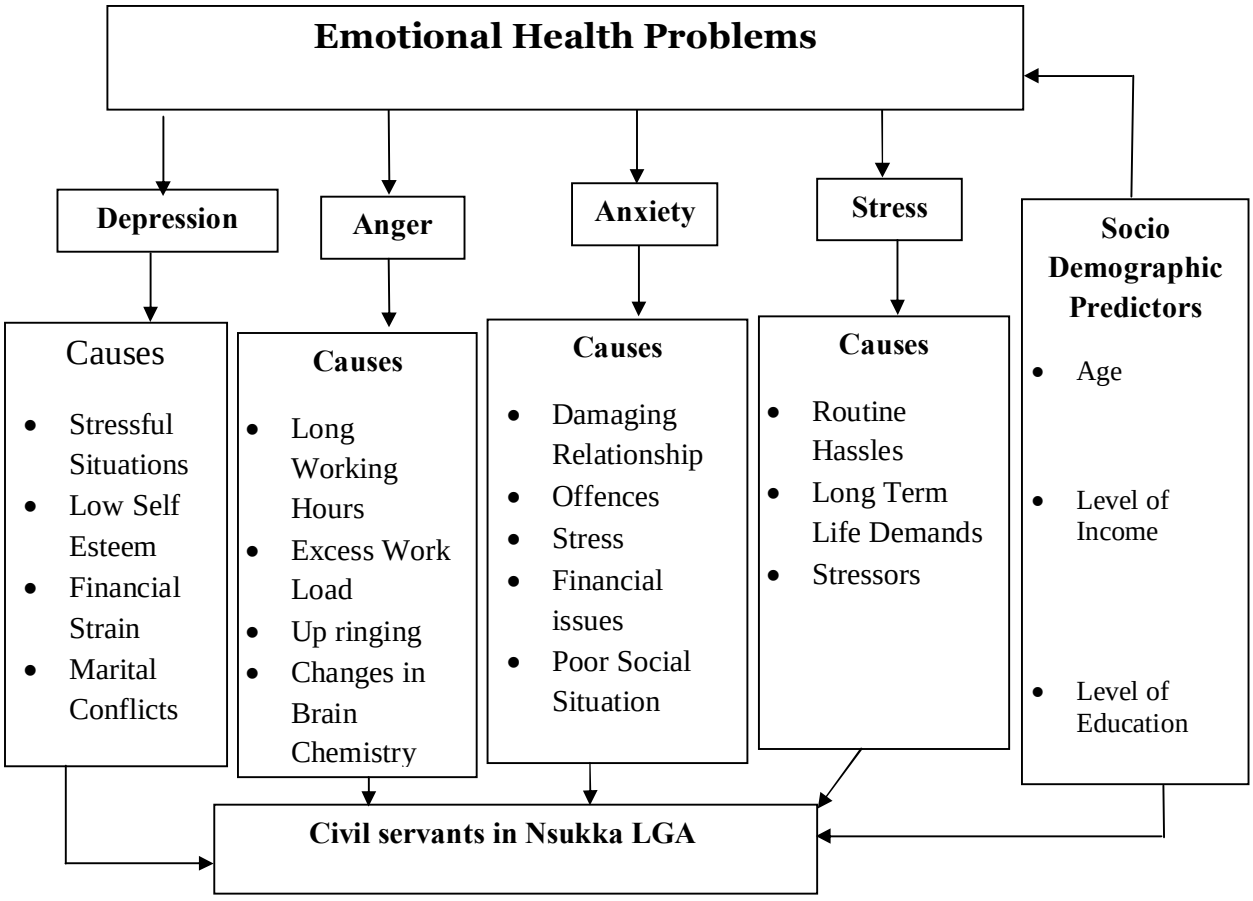

Figure 1: Schematic Representation of Conceptual Framework

The schema above shows EHPs, which include depression, anxiety, anger and stress and the causes of each of the EHPs. The socio-demographic factors (educational status. level of income and age) that predict EHPs among civil servants were also highlighted. However, understanding the cause, psychotherapy and medication can be used to manage these EHPs leading to optimal emotional health.

Theoretical Framework

Two theories and one model related to this study will be reviewed. Theories and models are vital in organizing and interpreting research. Encarta Dictionary (2009) defined theory as the body of rules, ideas, principles and techniques that apply to a subject especially when seen as distinct from actual practice. The theoretical framework of this study will be centered on the following; Jane-Lange theory of emotion, opponent-process theory of emotion and Job Demands-Resources Model.

James-Lange theory.

James-Lange theory was propounded by a psychologist from the United States, William James (1884) and Physiologist from Denmark, Carl Lange (1887). The theory basically states that emotion is equivalent to the range of physiological arousal caused by external events. Theory of Emotion Event ==> Arousal ==> Interpretation ==> Emotion.

The above sequence summarizes this theory. According to the theory, when an event stimulates a person (arousal), the autonomic nervous system (ANS) reacts by creating physiological manifestations such as faster heartbeat, more perspiration, increased muscular tension, and more. Once these physical events occur, the brain will interpret these reactions. The result of the brainôs interpretation is an emotion. In this sense, the theory is likened to the ñfight-or-flightò reaction, in which the bodily sensations prepare a person to react based on the brainôs interpretation of the event and the physiological events.

In his statements, Lange attempted to give a simple explanation of his theory by relating its concept to the concept of common sense. He said that our common sense tells us that if a person encounters a bear, he tends to feel afraid and then he runs. According to Langeôs theory, seeing a bear causes the ANS to stimulate the muscles to get tensed and the heart to beat faster. After such bodily changes, that is the time that emotion of fear emerges. It is as simple as saying that statement A, ñMy heart beats faster because I am afraid.ò is more rational than statement B, ñI am afraid because my heart beats fasterò.

The James-Lange Theory has been criticized by many theorists, including Walter Cannon and Philip Bard who opposed the theory with their own theory of motivation, known as the Cannon-Bard Theory. One of the criticisms emerged from the experiments on rats to test the James-Lange Theory. The theory explains that the emotions depend on the impulses from the periphery, primarily the viscera. However, Cannonôs experiments revealed that the viscera react slowly to stimuli since the viscera are composed of smooth muscles and glands. This means that a person feels the emotion prior to the occurrence of bodily changes. The

experiments on rats and cats also revealed that cutting the visceral nerves has no effect on emotions.

The James-Lange Theory is indeed an important theory as it is one of the earliest theories that provided explanations of the physiologic process of emotion. They were of the view that emotion is not directly caused by perception of an event but rather the bodily response caused by the event. The relevance to this study is that non-payment of salaries does not trigger emotional feelings, but the interpretation of the brain by the physiological arousal experienced by the individual. It is this effect that leads to EHPs like depression, anxiety and anger in individuals.

Opponent-process theory.

Opponent-process theory was propounded by a psychologist Richard Solmon and John Corbit (1974). They view emotion as pairs of opposites (fear - relief, pleasure ï pain). They stated that when one emotion is experienced, the other is suppressed. They further stated that the experience of an emotion disrupts the bodyôs state of balance and that basic emotions typically have their opposing counterparts. Richard Solomon developed a motivational theory (Motivation and Emotion) based on opponent processes. Basically, he states that every process that has an affective balance, (i.e. is pleasant or unpleasant), is followed by a secondary, "opponent process". This opponent process sets in after the primary process is quieted. With repeated exposure, the primary process becomes weaker while the opponent process is strengthened. Opponent-process theory can in principle explain why processes (i.e. situations or subjective states) that are aversive and unpleasant can still be rewarding. For instance, after being exposed to a stressful situation, human participants showed greater physiological signs of well-being than those in the control condition. Self-report measures and subjective ratings show that relief from physical pain can induce pleasant feelings, and a reduction of negative affect. The relevance to the study is that since emotions have their opposing counterparts, when individuals are faced with unpleasant situations, like nonpayment of salaries and poor working conditions, their pleasure, for instance will be turned to pain manifesting itself in anger, anxiety or other emotional problems. However, if the cause of the emotional problem is taken care of, pleasure will be restored.

The Job demands-resources model.

Karasek (1979) propounded a model on job demands and resources. According to job demand model, job demands are initiators of health (emotional) impairment process. The main assumption of the model is that every occupation has its own specific risks factors associated with job related stress. These factors can be classified into two general categories job demand and job resources, thus constituting an overarching model and may be applied to various occupational setting irrespective of the particular demands and resources involved. Job demands refer to those physical, physical, psychological, social or organizational aspects of the job that requires sustained physical and or psychological (cognitive and emotional) efforts or skills and are therefore associated with certain physiological and/or psychological costs. Examples include high work pressure, unfavorable physical environment and irregular working hours. Although job demands are not necessarily negative, they may turn into job stressors when meeting those demands.

Job resources refer to those physical, psychological, social or organizational aspects of the job that are either functional in achieving work goals, reduce job demands and the associated physiological and psychological costs, stimulate personal growth or stimulate learning and development. These job resources may be in form of support from colleagues, job security, feedback, autonomy in the place of work, carrier opportunities. The relevance to this study is that as staff makes effort to meet up with the job demands and the resources required to achieve the demand is not always available, over time stimulation and vigor to work will start reducing. As stimulation reduces, anger and depression will quietly start taking over. If situation did not change for a long time, EHPs will set in.

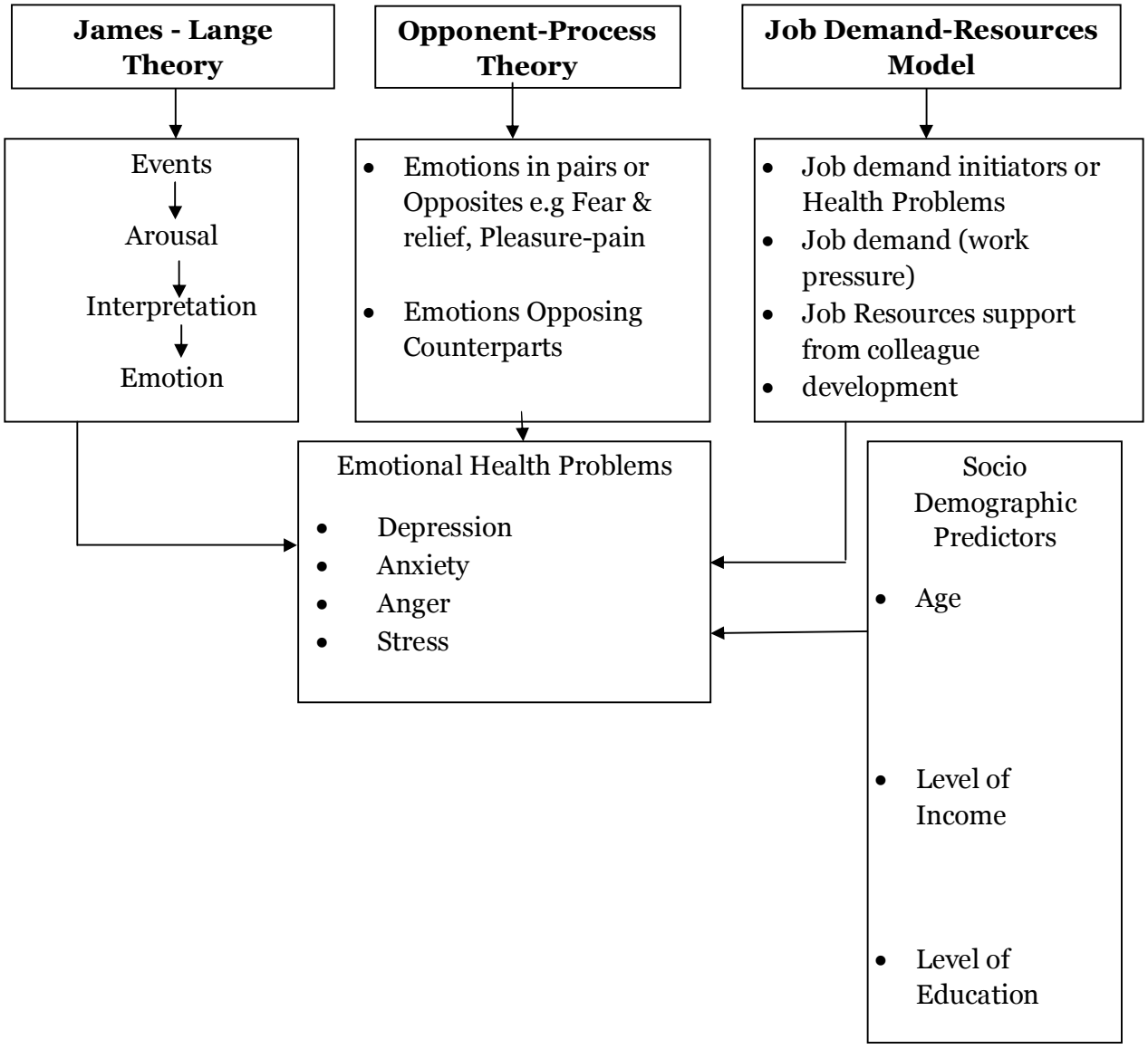

Figure 2: Schematic Representation of Theoretical Frame Work

The schema above shows the theories (James-Lange and Opponent-process) and model (Job Demand-Resources), their tenets or constructs and relationship with EHPs (depression, anxiety, anger and stress). These EHPs are experienced by civil servants. In addition, certain variables such as educational status inherent in civil servants are capable of determining EHPs experience of civil servants. These EHPs can be managed through measures such as understanding the cause, psychotherapy and medication to have optimal emotional health.

Review of Related Empirical Studies

Akhtar-Danesh and Landeen (2007) conducted a study on Relationship between depression and socio-demographic factors**.** This study evaluated the relationship between depression and the socio-demographic factors of age, gender, marital status, education, immigrant status, and income in the province of Ontario, Canada. The sample for the study comprised 12,376 participants. There were 5,660 males and 6,716 females. The data were collected based on unequal sampling probabilities to ensure adequate representation of young persons (15 to 24) and seniors (65 and over). The sampling weights were used to estimate the prevalence of depression in each subgroup of the population. The Canadian Community Health Survey, Cycle 1.2 (CCHS-1.2) dataset were used for data analysis. Statistical package for social sciences (SPSS) version 10 was used for data entry and analysis. Descriptive statistics were used to present distribution of study population. Analysis of variance (ANOVA) and Chi square (χ^2) were used to examine significant associations between variables. A P value< 0.05 was considered statistically significant. The result showed that the highest prevalence rate of depression (14.3%) is seen in the age group of 20 to 24 years and the lowest rate (4.3%) in the age group of 75 years and over, women suffer more from depression than men. Respondents whose education level was less than secondary school have the lowest rate of depression (9.1%); and the highest rate of depression (13.4%) is seen among those with "other post-secondary" education. Its relevance to this study is that it examined the relationship between depression and socio-demographic factors of age, education and income which the present study examined.

Jayasinghe, Giosan, Evans, Spielman and Difede (2008) conducted a study on Anger and Posttraumatic Stress Disorder in Disaster Relief Workers Exposed to The 9/11/01 World Trade Centre Disaster: One-year Follow-Up Study. The purpose of this study was to explore the relationship over time between anger and PTSD in disaster workers involved in the recovery processes at the World Trade Center disaster. Population of this study in this study were 1,040 disaster rescue and recovery workers deployed to the WTC site during or in the aftermath of 9/11/01.Cross-sectional research design was employed in this study. Data was collected using the State-Trait Anger Expression Inventory-2 (STAXI-2), a 57-item, revised version of the State-Trait Anger Expression Inventory (Spielberger, 1988). The Clinician-Administered PTSD Scale is a structured interview that assesses the frequency and intensity of 17 PTSD symptoms and has well-established psychometric properties. Multiple Regression Analyses was used in this study. The result showed that anger severity is statistically

significant.Age significantly predicts anger in PTSD. Its relevance to this study is that it examined anger just as this study examined.

Bjelland, Krokstad, Mykletum, and Tambs, (2008) conducted a study titled Does higher education protect against anxiety and depression? The HUNT study. The aim of this study was to examine whether higher educational level protects against anxiety and/or depression and whether this protection accumulates or attenuates with age or time. In a sample from the Nord-Trøndelag Health Study 1995--1997 (HUNT 2) (N=50,918) of adults, the cross-sectional associations between educational level and symptom levels of anxiety and depression were examined, stratified by age. Cross-sectional research design was employed on this study. The result of the study showed that low educational levels were significantly associated with both anxiety and depression. The coefficients decreased with increasing age, except for the age group 65-74 years. In the longitudinal analysis, however, the protective effect of education accumulated somewhat with time. The discrepancy between these two analyses may be due to a cohort effect in the cross-sectional analysis. Higher educational level seems to have a protective effect against anxiety and depression, which accumulates throughout life. Its relevance to this study is that it examined the relationship between education and EHPs which the present study examined.

Sareen, Afifi, McMillian, and Asmondson (2011) investigated relationship between household income and mental disorders. The objective of the study was to examine the relationship between income, mental disorders, and suicide attempts. The study adopted prospective, longitudinal, nationally representative survey. The setting was United States general population. A total of 34, 653 non institutionalized adults (aged Ó20 years) interviewed at 2 time points 3 years apart. Multiple logistic regressions were used for data analysis. After adjusting for potential confounders, the presence of most of the mental disorders was associated with lower levels of income. Participants with household income of less than $20 000 per year were at increased risk of incident mood disorders during the 3-year follow-up period in comparison with those with income of $70 000 or more per year. A decrease in household income during the 2 time points was also associated with an increased risk of incident mood, anxiety in comparison with respondents with no change in income. The study concluded that low levels of household income are associated with several lifetime mental disorders and suicide attempts, and a reduction in household income is associated with increased risk for incident mental disorders. This study is related to the present study because the study investigated the relationship between income (which is one of the socio-

demographic predictors to be studied) and mental disorder; anxiety which is also one of the EHPs to be studied.

Koçer, Koçer and Canan (2011) studied anger management and factors that influence anger in physicians. The objective was to evaluate anger expression and control in physicians. The physicians of the Düzce School of Medicine were the participants in the study. Physicians were assigned to either an internal medicine or a surgery study group. Each group contained physicians from several specialties. The Spielberger State-Trait Anger Expression Inventory, and the Beck Anxiety and Depression Inventories were administered to all participants. The physicians (n=158) were evaluated and compared with controls (n=105) in terms of anger control and socio-demographic variables. The results showed that anger-control scores were higher in physicians ($p<0.01$) and in those who willingly chose the medical profession ($p<0.05$). Age, number of years as a physician, and the specialty were negatively correlated with anger management in physicians working in the surgical disciplines ($p<0.01$). In conclusion physicians were relatively successful in coping with anger. Age was the major factor affecting anger management in physicians. This present study is related to the present study because it studied anger which is one of the EHPs studied in this present work.

Okwor and Rhode (2012) conducted a study on the influence of demographic factors on stress perceptions of teachers of public secondary schools in Cameroon. They investigated the influence of demographic factors on stress perceptions of teachers of secondary schools, also examined factors causing stress and the influence of gender, educational qualification, experience cultural background, school location and size on stress perceptions of teachers. Using the Ex-post-facto research design, the study sampled 986 teachers from a population of 5482. Data was collected using a 19 ï item questionnaire. Mean and multiple regression analysis were used to answer research question and test the hypothesis at probability level of 0.05. Results revealed thateducational qualification among others do not significantly influence stress as perceived by the teachers in Cameroon. This means that stress perception does not depend on these factors. This present study is related to the present study because it studied the influence of demographic factors on stress which is one of the EHPs to be studied.

Atindanbila, Abasimi, and Anim (2012) conducted a study on work related depression, anxiety and stress of nurses at pantang hospital, Ghana. The study examined the distribution of depression, anxiety and stress among nurses at Pantang hospital with regards to demographic characteristics such as age, gender, rank, duration and hospital unit worked. The study was conducted on the nurses at three Units inthe Pantang Psychiatric Hospital in Accra. The Units were OPD, Wards and Rehabilitation. Cross sectional survey design was employed.

The tool used for the study was the Depression Anxiety tress Scale (DASS) which comprised of depression, anxiety, and stress. A sample of 57 nurses of Pantang Hospital was randomly selected for the study. ANOVA test was used to analyze the data. The results indicated that there was a significant difference in all the emotional states of depression, anxiety and stress with regards to the ages of the nurses and that the higher the age of the nurse the more he or she is exposed to these emotional conditions and the stress level was higher in Rehabilitation Unit as compared to the rest of the Units. The relevance of this study to the present study is that it investigated the effects of age on the EHPs of nurses which this study investigated.

Ofuebe (2013) investigated on emotional health problems and coping strategies of academic staff in universities in Enugu State. The aim was to ascertain the emotional health problems and coping strategies of academic staff in universities in Enugu State. The sample for the study was 669 academic staff. Proportionate stratified random sampling technique was employed. Emotional health problem and coping strategies questionnaire was used for data collection. Descriptive survey design was employed. Data was analyzed using Statistical Package for Social Sciences (SSPS Version 17). ANOVA was used for data analysis. The findings showed that majority of the respondents have moderate proportion (57.5%) and (55.6%) of anger and stress respectively. There was a significant difference ($p<.05$)between the age of academic staff and EHPs (anger, anxiety and depression). This study is related to the present study because it investigated the influence age on EHPs, which the present study investigated.

Akhtar,Khan,Vaidhyanathan,Chhabra,,andKannan(2013) Socio-demographic Predictors of Depression among the Elderly Patients Attending Out Patient Departments of a Tertiary Hospital in North India. This study evaluated the association of some socio-demographic factors with geriatric depression. A cross-sectional study was carried out in the Out Patient Department registration area of a tertiary care teaching hospital in Delhi. Questionnaire based interviews were conducted among the elderly people visiting the hospital. A 15-item geriatric depression scale-Hindi was used to assess depression. Sample size was Six hundred and seventy eight. The age of the subjects ranged from 65 to 85 years. Multiple logistic regression was used for analysis The findings showed that about 61.4% scored positive for depression. Multiple logistic regression analysis revealed that the following were significant ($P<0.05$) independent predictors of depression: Higher age, low educational status financial dependence among others. The study concluded that the prevalence of depression among the study subjects was high.This study is related to the

present study because it investigated whether age predicts depression which is what the present study investigated.

Abbas, Mudassa, Mudassa, Asiy, and Gul (2013) conducted a survey on factors contributing to job satisfaction in Pakistani Workers in Pakistan. The objective was to check the impact of reward and benefit, age, education and experience on job satisfaction. Sample of 120 workers were used for the study. Survey design was employed. Data were collected using questionnaire and analyzed with SPSS. The results showed that training and development has no impact on job satisfaction whereas employee empowerment rewards and job empowerment has a positive impact on job satisfaction. Results on rewards (income) are significant while the other independent variables showed insignificant result. The study is related to this study because it examined the influence of factors such as reward and benefit, age and educational qualification on job satisfaction. When workers are rewarded (receive their income) they have job satisfaction but when not rewarded, there will be no job satisfaction in their workplace, which may invariably culminate to EHPs which has the potential to reduce work productivity.

Anene and Nwafor (2014) examined socio-demographic determinants of occupational stress among secondary school teachers in Anambra State ï Nigeria. Five hypotheses were formulated to guide the study. The population of the study was six thousand and thirty six (6,036) teachers from public schools in the state. The sample of the study consisted of one thousand teachers, made up of four hundred and fifty males and five hundred and fifty females. Stratified random sampling technique was used to draw the sample. The instrument used in this study was a structured questionnaireï Job Related Stress Inventory (JSI). The JSI was developed after a careful and critical identification of the possible factors that could be associated with stress as highlighted by earlier researchers. The instrument was duly validated and had a reliability coï efficient of 0.82. This was done through test ï retest method at three weeks interval. The mean, standard deviation, tï test and analysis of variance. (ANOVA) were used to test the hypotheses at 0.05 level of significance. Teachersô age significantly influence their level of stress exhibition. Teachersô income does not significantly influence the level of stress exhibited by them. Based on the findings it is recommended that teachers should be exposed to positive stress management and copying techniques.

Rahman, Bairagi, and Dey, (2014) conducted a study on the effect of socio-economic status and gender on adolescent anger in Chittagong. The objective was to investigate whether adolescentsô anger varies according to socio-economic status. A total 120 respondents constituted the sample of the study. Among them 60 (50%) adolescents were male and 60 (50%) were female. An adapted Bangla version of ñAdolescent Anger Rating Scaleò (AARS)

was used for measuring adolescentsô anger. Two-stages sampling procedure was used. The test-retest, spilt-half (odd-even) and Cronbach Alpha reliability of the AARS Bangla version are 0.90, 0.75 and 0.78 respectively. Data were analyzed by using mean, standard deviation and two-way analysis of variance (ANOVA). The findings of the present study show that socio-economic status (educational level and income) have strong association with adolescentsô anger. Adolescents with low that socio-economic status (educational level and income) expressed more anger than those with the middle and high socio-economic status (educational level and income).This study is related to the present study because the study investigated the relationship between socio factors and anger which the present study examined.

Shittu, Odeigah, Issa, Olanrewaju, Mahmoud, and Sanni (2014) conducted a study on the Association between Depression and Social Demographic Factors in a Nigerian Family Practice Setting. The aim was to determine the association between depression symptoms and socio-demographic factors in a General Outpatients Clinic in Nigeria. Four hundred newly registered patients who attended the General Out Patients Department (GOPD) of Kwara State Specialist Hospital, Ilorin, Nigeria, were selected by systematic random sampling. The Patients Health Questionnaire-9 (PHQ-9) specifically developed for use in primary care with acceptable reliability, validity, sensitively was used**.**The result showed thatone hundred and seventy eight (44.5%) out of the four hundred respondents were found to have one form of depression or the other. There was minimal depression in 119 (29.8%), mild in 54 (13.4%), moderate in 2 (0.5%), and severe in 3 (0.8%). There was strong statistical association between depression and age group, sex, marital status, level of education, occupation and monthly income, p-values 0.008, 0.000, 0.000, 0.003, 0.000, 0.001 respectively. This study is related to the present study because the study investigated the relationship between depression symptoms and socio-demographics of age, education and income which the present study examined.

Cheung and Yip (2015) investigated depression anxiety and symptoms of stress among Hong Kong Nurses: A cross-sectional study. The objective of the study was to examine the weighted prevalence and associated risk factors of depression, anxiety and stress among Hong Kong nurses. A total of 850 nurses aged between 21 and 65 were invited to participate. The study adopted a cross-sectional survey design. The instrument employed for data collection was Depression Anxiety and Stress Scale (DASS 21). Statistical analysis was performed using SPSS Version 23 for the windows platform. Multiple logistic regressions was used to determine significant relationship between variables. Result concluded

that younger age was significantly related with Stress. This study is related to the present study because the study investigated the relationship between depression, anxiety and stress which this study examined and the study also used the same study design with the present study.

Milanovic, Erjavec, Poljicanin, Vrabec, and Brecic (2015) conducted a study on the Prevalence of The aim of this study was to assess the prevalence of patients with unrecognized depression symptoms in general practice and identify associated socio-demographic factors. 769 patients without previous psychiatric disorder who attended their primary care depression symptoms and associated socio-demographic factors in primary health care patients. The study adopted a cross-sectional survey design.Data on patientsô age, sex, level of education, marital andemployment status were collected. All participants completed The Zung Self-Rating Depression Scale.). Lower Zung scores were found in individuals with a higher level of education, who were unmarried, employed or still undergoing education.Multivariate logistic regression model revealed that age ($p<0.001$) was a significant predictors of depression symptoms.This study is related to the present study because the study investigated the relationship between depression, anxiety and stress which this study examined.

Posternak and Zimmerman (2015) conducted a study on Anger and aggression in psychiatric outpatients. This study sought to evaluate the degree of anger and aggression experienced by psychiatric outpatients. 1300 individuals presenting to a psychiatric outpatient practice underwent semi structured interviews to evaluate current DSM-IV Axis I (N = 1300) and Axis II disorders (N = 687). Levels of subjective anger and aggression during the preceding week were assessed in each patient, and the odds ratios were calculated for each disorder. A multiple regression analysis was performed to determine which psychiatric disorders independently contributed to the presence of subjective anger and aggressive behaviour. The result of the finding showed that approximately one half of our sample reported currently experiencing moderate-to-severe levels of subjective anger. This level of anger was found to be comparable to the levels of depressed mood and psychic anxiety reported by our sample.The study relates to the present study because it investigated the level of anger as the present study investigated.

Odedokun (2015) examined differential influence of demographic factors on job burnout among Police Officers in Ibadan, Oyo State. The objective of the study was to investigate demographic factors (age, marital status, educational level and year of experience) and job burnout amongst police officers in Oyo state, Nigeria. The study adopted a survey

research design of ex-post facto type. Multistage random sampling technique was used to select two hundred and twenty (220) police officers from the six area commands in the state. The participants involved forty eight female officers representing 21.8 % and one hundred and seventy two male officers representing 78.1%. The ages of the respondents range from 27 years to 49 years. The participants responded to Maslach Burnout Inventory (MBI=0.87) to measure their level of job burnout. Data were analyzed using analysis of variance (ANOVA) and Duncan post hoc test. Results from the analysis indicated significant differences between marital status, educational level, age, and the concept of job burnout among the police officers. The study relates to the present study because it investigated socio-demographic factors that influenced job burnout (stress) among Police officers which is one of the EHPs this investigated.

Polikandrioti, Goudevenos, Michalis, Koutelekos, Tzialas, and Elisaf (2015) investigated factors associated with depression and anxiety of hospitalized patients with heart failure (HF). The aim of the present study was to explore the factors associated with anxiety and depression experienced by patients hospitalized with heart failure. One hundred and ninety hospitalized HF patients in four public hospitals were evaluated. The data were collected using a specific questionnaire, which, apart from demographic and clinical variables, included the Hospital Anxiety and Depression Scale (HADS). In the total sample, 24.7% and 32.6% of patients were high levels of anxiety, respectively. Simple multinomial logistic regression showed that no characteristic was significantly associated with anxiety. It also appeared that 17.4% of patients had minor and 24.2% major depression. Simple multinomial logistic regression revealed that married patients were 59% less likely to have major depression compared to their unmarried counterparts (OR: 0.41). The research concluded that nurses and physicians must take measures for the identification, assessment and management of anxiety and depression in this clinical population. This study is related to the present study because it investigated some of the levels of EHPs which the present study investigated.

Bhat, Hassan, Shafiq, and Sheikh (2015) investigated onSocio-demographic factors: A major predictor of anxiety and depression among pregnant women. The purpose of the study was to investigate socio demographic factors as major predictors of anxiety and depression among pregnant women. Sample of 47 pregnant women coming to obstetric clinics for their prenatal check-up were used. Hopkins Anxiety Checklist was used to assess anxiety and depression was examined by using a shortened version of CES-D (Centre for Epidemiological Studies-Depression Scale). Cross-sectional design was employed. ANOVA, t-test and

multiple regression techniques were used to analyze the data. Regression analysis revealed that age and income shows significant contribution on anxiety (R = .76, R2= .57). These variables jointly explained 57% variance in the scores on anxiety. THE result indicated that age and monthly income was negatively and significantly related to anxiety, whereas age and qualification shows also a significant contribution to depression (R=.90, R= .81).These variables jointly explained 81% variance in the scores on depression. It was indicated that age, educational qualification and monthly income was negatively and significantly related to depression. The overall findings suggest that demographic factors (age, educational qualification and monthly income) seem to predict a better understanding of the anxiety and depression among pregnant women. This study is related to the present study because it investigated whether age, educational level and level of income will predict EHPs which the present study investigated.

Tearne, Robinson, Jacoby, Allen, Cunningham, Li, and McLean (2016) investigated depression, anxiety, and stresssymptoms in young adult female offspring and associated factors. The study examined the relationship between older parental age and symptoms depression, anxiety, and stress young adult female offspring. The authors used data from the Western Australian Pregnancy Cohort (Raine) Study. The Raine Study provided comprehensive datafrom 2,900 pregnancies, resulting in 2,868 live born children. A total of 1,220 participants completed the short form of the Depression Anxiety Stress Scale (DASS-21) at the 20-year cohort follow-up. Binomial regression analyses with log link and with adjustment for known perinatal risk factors were used to examine the extent to which maternal and paternal age at childbirth predicted continuous DASS-21index scores. In the final multivariate models, a maternal age of 30ï 34 years was associated with significant increases in stress DASS-21 scores in female offspring relative to female offspring of 25- to 29-year-old mothers. A maternal age of 35 years and over was associated with increased scores on allDASS-21 scales in female offspring. The result indicated that older maternal age was associated with depression, anxiety, and stress symptoms in young adult females. This study is related to the present study because it examined older maternal age as one of the factors that is associated with depression, anxiety and stress symptoms. Age in the present study is one socio-demographic predictors of depression anxiety among others investigated.

Manaf, Mustafa, Rahman, Yusof, and Aziz (2016) investigated on the factors influencing the prevalence of mental health problems among Malay elderly residing in a rural community: a cross-sectional study.The aim of this study is to determine the prevalence of mental health problems (depression, anxiety, and emotional stress) and their associated factors

among the Malay elderly in a rural community of Perak, Malaysia. Cross-sectional research design was employed. The Malay elderly aged 60 years and above were selected through convenient sampling to give a total of 230 respondents. The Depression, Anxiety, and Stress Scale (DASS-21) was used to assess the symptoms of depression, anxiety, and stress. Bivariate analyses were performed using chi-square tests and multiple logistic regression analyses were conducted to determine the association between the factors and each of the mental health statuses assessed. The result showed low proportions (27.8%, 22.6%, and 8.7%) of depression, anxiety, and stress respectively among the elderly respondents. This study is related to the present study because it investigated on depression, anxiety, and stress which the present study also investigated on.

Farrer, Gulliver, Bennett, Fassnacht, Kathleen, and Griffiths (2016) investigated demographic and psychosocial predictors of major depression and generalized anxiety disorder in Australian university student. The aim of this study was to examine psychosocial and demographic risk factors for major depression and generalized anxiety disorder (GAD) in a sample of Australian university students.An anonymous web-based survey was distributed to undergraduate and postgraduate students at a mid-sized Australian university. A total of 611 students completed the survey. Analyses were conducted using SPSS Version 22. Binary logistic regression was used to examine the relationship between demographic and psychosocial predictors and presence of major depression or generalized anxiety disorder according to PHQ-9 and GAD-7 clinical cut off criteria. The findings showed that 7.9 % of respondents ($n = 48$) had major depressive disorder on the PHQ-9. 17.5 % of respondents ($n = 107$) had GAD. The risk of depression was higher for students who experienced frequent financial stress (low level of income) and students in their first year of undergraduate study (age). In the final multivariate model, students in their first year of study remained at significantly greater risk of experiencing major depression and financial stress remained significantly associated with greater risk of GAD. This study is related to the present study because it investigated the association of financial stress (level of income) and EHPs and also the proportion of respondents experiencing EHPs which is what the present study investigated.

Tang, Ye, Yan, Chang, Ma, Liu, Li., and Yu (2017) conducted a study on factors associated with trait anger level of juvenile offenders in Hubei province: A binary logistic regression analysis. The objective was to investigate the factors associated with trait anger level of juvenile offenders in Hubei province. A total of 1090 juvenile offenders in Hubei province were investigated by self-compiled social-demographic questionnaire, Childhood

Trauma Questionnaire (CTQ), and State-Trait Anger Expression Inventory-II (STAXI-II). The risk factors were analyzed by chi-square tests, correlation analysis, and binary logistic regression analysis with SPSS 19.0. A total of 1082 copies of valid questionnaires were collected.The result of the finding showed thateducation level of care-taker, family income among others did not predict to high level of trait anger (P>0.05). This study is related to the present study because it investigated the factors associated with anger which the present study also investigated.

Islam and Adnan (2017) conducted a study on socio-demographic factors and their correlation with the severity of major depressive disorder: a population based study. The aim of this study was to assess the socio-demographic characteristics of Bangladeshi Major Depressive Disorder (MDD) patients and to discover their role on the severity of disease.A total of 234 MDD patients (aged 18 to 60 years) were randomly recruited. A retrospective review of the case notes of psychiatry outpatients at Bangabandhu Sheikh Mujib Medical University (BSMMU) was carried out between Sep-Nov 2016. Relevant information was obtained by collection of prescription details from the patients or their relatives by face to face interview.Statistical analysis was performed using the statistical software package SPSS, version 23.0 (SPSS Inc., Chicago, IL). Descriptive data has been given as frequencies and percentages. The result of the finding showed that there was mild depression in 28% (68), moderate in 37% (157), and severe in 14% (34) patients. Correlation analysis shows that age, education, family income are associated with the severity of disease. Moreover, among all significant correlations age is positively correlated with the severity of MDD while education and family income were negatively correlated with the severity of depression.This study is related to the present study because it investigated socio-demographic factor and their relationship with emotional health problems as the present study.

Nisar, Uzair, Khan, and Aktar (2017) conducted a study on the Association of depression with socio-demographic factors in patients undergoing hemodialysis. The aim was to determine the association of depression with socio-demographic factors in patients undergoing haemodialysis.Eighty eight patients undergoing haemodialysis were included. Data were collected using the Hamilton Depression Rating Scale. Demographic data, including age, gender, status within the family, education, duration of dialysis and social support was documented. Patients were graded on the basis of Hamilton scoring.Cross sectional design was used. To compare numerical variable between two groups, independent samples t test was used whereas for the comparison between three groups one way ANOVA was used. Pearson correlation was used to find out correlation between continuous variables.

Alpha value was kept at 0.05. education. The result of the finding showed no association with age (p=0.75and education (p=0.59) Its relevance to this study is that it examined the relationship between depression and socio-demographic factors of age and education which the present study examined.

Summary of Literature Review

The review of related literature conceptualized emotional health problems. EHPs were defined from the literature as individualsô inability to enjoy life and procure a balance between life activities and effort to achieve psycho-emotional resilience. Emotional health problems are also defined as feelings of sadness and tiredness in response to life events. In this study, EHPs are defined as the inability to cope with and control the demands of life due to financial limitations arising from non-payment or irregularities in the payment of salaries, lack of promotion, discrimination, maltreatment and lack of job satisfaction which may be influenced and made worse by certain socio-demographic predictors like educational status, marital status among others.

Furthermore, EHPs are quite complex and manifest in different forms. Forms of emotional health problems reviewed include depression, anxiety, anger and stress. Therefore, there is need to restrict the scope of EHPs to the most prevalent forms among the populations including civil servants in Nsukka LGA. Consequently,depression, ansxiety, anger and stress will be examined in this study.

Additionally, the literature review highlighted causes, signs and symptoms and some forms and types of EHPs. It was noted that certain circumstances, events or factors can trigger EHPs at one time or the other in life. These circumstances, events or factors are called predictors. However, the study focuses on socio-demographic predictors of EHPs. The soco-demographic predictors include educational status, marital status, level of income, age2 and gender. Literature on each of these socio-demographic predictors was individually reviewed.

Two theories and one model relating to EHPs were reviewed. James-Lange theory of emotion, opponent-process theory of emotion and Job Demands-Resources Model were discussed in relation to the study

Subsequently, on the review of empirical studies, many studies were conducted on the prevalence of forms of EHPs. To the best of the researcherôs knowledge, the study carried out on the socio-demographic predictors of emotional health problems both are limited, instead many other factors apart from the socio-demographic predictors are studied. However, there were few studies that examined influence of socio-demographic factors on forms of EHPs. Most of the literatures reviewed studied one EHP with two or more demographic variables.

Owing to the fact that that socio-demographic predictors of EHPs have not been studied among civil servants in Nsukka Local Government Area and coupled with the fact that many workers seem to be suffering from EHPS as a result of the Nations economic condition, a gap is created which makes it appropriate to carry out this study in Nsukka Local Government Area of Enugu State.

CHAPTER THREE

Methods

This chapter presents a detailed description of the research methods that was employed in this study. These include research design, area of the study, population for the study, sample and sampling techniques, instrument for data collection, validity and reliability of the instruments, methods of data collection and analysis.

Research Design

The study adopted cross-sectional survey research design. Lavrakas (2008) stated that cross-sectional survey collects data to make inferences about a population of interest at one point in time, described as snapshots of the populations about which data is collected from. Cross-sectional survey design was used in this study to determine the socio-demographic predictors of EHPs among civil servants in Nsukka LGA. This design was effectively used by Al-Naggar and Al-Naggar (2014) on prevalence and associated factors of emotional disorder among Malaysian university students. Odedokun (2015) also adopted the design to examine differential influence of demographic factors on job burnout among Police Officers in Ibadan, Oyo State. The successful application of the design in the previous and similar studies justifies its adoption in this present study.

Area of the Study

The area of the study is Nsukka LGA of Enugu state. Nsukka L.G.A is one of the 17 L.G.As in Enugu State. The LGA has an area of 1,810 square kilometres and a population 309,633 as at 2006 census (National Population Commission, 2006). Nsukka LGA is bounded in the North by Igbo Eze South and Udenu LGAs, South by Udi and Igboetiti LGAs, West by Uzo Uwani and Kogi state and in the East by Isi Uzo and Enugu East LGAs. Nsukka LGA is made up of about twenty communities. Nsukka indigenes are predominantly farmers and traders. Nsukka indigenes are highly cultural people, they observe several festivals including; Omabe masquerade festival, Onwaeto (3rd moon) festival and others. The major religions are Christianity, Islam and traditional. However, majority of the indigenes are Christians mainly Roman Catholics. The town has a good number of civil servants because of the presence of University of Nigeria, Nsukka. Nsukka LGA is subdivided into four administrative offices, namely: Nsukka main, situated at the secretariat with 504 staff member. Nsukka East situated at Eha-Alumona with 169 staff; Nsukka West situated at Ibagwa-Ani with 241; staff and Nsukka central situated at Isiakpu with 45 staff. The civil servants of Nsukka LGA are made up of different categories of staff: the senior and the junior staff. The staff are faced with

numerous challenges ranging from prolonged non-payment of salaries and un-conducive work environments. These challenges keep the workers apprehensive due to fear of the unknown. Lack of payment of salaries makes these workers to be unable to meet up with their fundamental needs for shelter, clothing and feeding. Alarmingly, these staff are expected to report to the secretariat daily to sign in and sign out at dismissal. Furthermore, natural incidents such as deaths, sickness, accidents and other unplanned circumstances may occur in the lives of these civil servants. All these can lead to EHPs.

Population for the Study

The population for the study will consist of 959 civil servants currently employed at Nsukka LGA. Nsukka LGA is divided into 4 developmental areash with Nsukka main area at the secretariat having 504 staff members and threedevelopmental areas namely: Nsukka East at Eha-Alumona with 169 staff members; Nsukka West at Ibagwa-Ani with 241 staff members; and Nsukka central at Isiakpu with 45 staff members. (Office of the Head of Personnel Management, 2017).

Sample andSample Technique

The sample for this study will consist of 282 civil servants. This was calculated using Taro Yamaneôs formula. Taro Yamaneôs formula is the formula for determining the sample size of any finite population (Yamane, 1967). Taro Yamaneôs formula is represented thus; $n=N/1+N(e)^2$. Where n is the sample size, *N* is the population size, *e* is the level of confidence. A two stage sampling procedure will be used for this study. The first stage will involve the use of proportionate stratified random sampling technique. Proportionate stratified random sampling technique was used when the population is composed of several subgroups that are vastly different in number. The number of participants from each subgroup is determined by the number relative to the entire group (Psychology Glossary, 2017). Proportionate stratified random sampling technique was used to select fifty two (52) percent of the population in Nsukka main as sample. This implied that 148 civil servants was selected. Eighteen (18) percent of the population in Nsukka East was selected. This implied that the selection of 50 civil servants. Twenty six (26) percent of the population in Nsukka West was selected. This implied the selection of 73 civil servants. Four (4) percent of the population in Nsukka Central was selected. This implied the selection of 13 civil servants. The rationale for selecting the stated percentages is based on the proportion of each subgroup in relation to the population of the study. In other words, the size of the subgroups was duly represented in the study to ensure adequate representation of each subgroup.The second stage will involve the use of convenience sampling technique. Convenience sampling technique is considered more

appropriate because it guarantees for the use of any willing participant within the research population, considering the peculiarity of the respondents.

Instrument for Data Collection

Two standardized instruments were used for data collection in this study. The first one is known as Depression Anxiety Stress Scale with 21 items (DASS-21) developed by Lovibond and Lovibond (1995) and the second one is known as Clinical Anger Scale developed by Snell (1995). See Appendix D for the original copies of DASS-21 and Clinical Anger Scale (CAS). The DASS-21 consists of three 7-item self-report scales that measured three constructs (Depression, Anxiety and Stress) with a 4- point rating scale of Never (0 point); Sometimes (1point); Often (2 points) and Almost Always (3 points). The components of EHPs in the instrument were measured thus: Items 1-7 measures depression; Items 8-14 measured anxiety while items 15-21 measured stress.Subscale scores from the shorter questionnaire (DASS-21) were converted to the DASS normative data by multiplying the total scores by 2.

Clinical Anger Scale consists of 21 items that measured anger. Each of the items have statements A, B, C and D. The four statements in each cluster varied in symptom intensity, with more intense clinical anger being associated with statement "D." (e.g., item 1: A = I do not feel angry, B = I feel angry, C = I am angry most of the time now, and D = I am so angry all the time that I can't stand it).Each cluster of statements was scored on a 4-point scale, with A = 0, B = 1, C = 2, and D = 3. Subjects' responses on the CAS were summed so that higher scores corresponded to greater clinical anger (21 items; range 0 - 63).

Therefore, the instrument contained 42 items with three subscales, namely Sections A, B and C. Section A elicited information on demographic data of civil servants; Section B elicited information on depression, anxiety and stress among the respondents using DASS-21 while Section C elicited information on anger using CAS.

Validity of the Instrument.

The instruments were face validated, although they were standardized instruments. The use of CAS and DASS-21 in the Nigerian context requires that the instruments were subjected to face validity by experts. Five experts were used to validate the instrument; three from the Department of Human Kinetics and Health Education, one from Department of Psychology and one from Department of Science Education (Measurement and Evaluation).

Reliability of the instrument

To ascertain the reliability of the instruments in the Nigerian context, the instruments were administered to 30 civil servants in Igboetiti LGA of Enugu State which is not within the study area but shares common characteristics with those respondents in the study area. Cronbach Alpha was used to test the internal consistency of the instrument and the result was .80. However, the reliability coefficient (internal consistency) of the DASS-21 was established by Henry and Crawford (2005). The DASS-21 has a reliability coefficient of .88. This was established using Cronbach Alpha for the sub-scales; the depression scale has a reliability coefficient of .82, anxiety; .92 stresses; .93. The internal consistency of the 21 items on the Clinical Anger Scale was established by Zaidi (2014) and analyzed by means of Cronbach alpha, and yielded reliability coefficients of .94.Therefore, the instruments were adjudged reliable for use in this present study.

Method of Data Collection

The instrument for data collection was administered to the civil servants at the four administrative offices of the LGA by the researcher with the help of five research assistants. Two from Nsukka main, one from Nsukka West, one from Nsukka East and one from Nsukka Central. The research assistants were civil servants working in Nsukka LGA. These assistants were briefed and guided on how to administer and collect the filled questionnaire from respondents. The instrument was administered at the offices during working hours. The workers (via the unit head) were informed about the visit ahead of time. This ensured access to the staff members.

Method of Data Analysis

The completed copies of the questionnaires were properly screened for completeness of responses. The information were coded and answered using Statistical Package for Social Sciences version 22. Research question 1 and 2 were analyzed using frequencies and percentages. The data collected were interpreted using severity ratings as recommended by the developers of DASS-21 and CAS as already described. This implied that scores between 0-9 were interpreted as normal; 10-13 points were interpreted as mild; 14-20 as severe; and 28 points and above as extremely severe. Research questions 3-5 will be analyzed using Spearmanôs Rho to establish relationships between EHPs and the independent variables such as educational status, level of income and age.Spearmanôs Rho computed from sample data measured the strength and direction of a linear relationship between two quantitative variables (Cohen, Manion & Morrison, 2011).Using Jackson (2009) criteria for interpreting correlation coefficient values: .00-.29 were considered as none (.00) to weak relationship; .30-.59 were

considered as moderate relationship; .60-1.00 were considered as strong relationship. Null hypotheses 1-3 were tested using logistic regression statistics. Park (2016) asserted that Logistic regression sometimes called the logistic modelanalyses the relationship between multiple independent variables and a categorical dependent variable.The entire null hypotheses were tested at 0.05 level of significance.

CHAPTER FOUR

Results and Discussion

This chapter presents and discusses the findings on socio-demographic predictors of EHPs among civil servants in Nsukka LGA of Enugu State. Out of the 282 copies of the questionnaires administered, 241 were returned, which gave a return rate of 85 per cent. The 241 copies returned were duly filled and used for data analysis.

Results

The findings of the study are presented in Tables according to the data answering research questions and data testing hypotheses.

Research question one

What is the proportion of civil servants who experienced the emotional health problems in Nsukka LGA. Data answering this question are contained in Tables 1 and 2.

Table 1

Proportion of civil Servants that Experienced Depression, Anxiety and Stress (DAS) (n=241)

S/N	DASS ITEMS	DAS Present f(%)	DAS Absent f(%)
	Depression		
1	I could not seem to experience any positive feeling at all.	147(60.9)	94(39.0)
2	I found it difficult to work up to work up the initiative to do all things	160(66.3)	81(33.6)
3	I felt that I have nothing to look forward to	137(56.8)	104(43.2)
4	I felt down hearted and blue.	152(63)	89(36.9)
5	I was unable to become enthusiastic about anything.	144(59.8)	97(40.2)
6	I felt I was not much as a person.	100(41.5)	141(47.3)
7	I felt that life was meaningless.	127(52.7)	114(47.3)
	Cluster %	**57.3**	**42.7**
	Anxiety		
8	I was aware of dryness in my mouth.	130(54)	111(46.1)
9	I experienced breathing difficulty (e.g. excessive rapid breathing, breathlessness in the absence of physical exertion)	97(40.2)	114(59.8)
10	I experienced trembling.	128(53.1)	113(46.9)
11	I was worried about situations in which I might panic and make a fool of myself.	139(57.7)	102(42.3)
12	I felt I was close to panic	148(61.4)	93(38.6)
13	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing beat).	147(61)	94(39.0)
14	I felt scared without any good reason.	139(58)	102(42.3)
	Cluster %	**55.0**	**45.0**
	Stress		
15	I found it difficult to wind down.	136(56.3)	105(43.6)
16	I tended to overreact to situations	166(68.9)	75(31.1)
17	I felt that I was using a lot of nervous energy.	152(63.1)	89(36.9)
18	I found myself getting agitated.	148(61.4)	93(38.6)
19	I found it difficult to relax.	140(58.1)	101(41.9)
20	I was intolerant of anything that kept me from getting on with what I am doing.	161(66.8)	80(33.2)
21	I felt I was rather touchy.	163(67.6)	78(32.4)
	Custer %	**63.2**	**36.8**
	Overall %	**58.5**	**41.5**

Key

Low proportion = 0-29%
Moderate proportion = 30-59%
High proportion = 60-79%
Very high proportion = 80% and above.

Results in Table 1 show an overall moderate proportion (58.5%) of civil servants experienced DAS. Furthermore, the Table shows that 57.3 per cent of civil servants experienced depression, 55.0 per cent of civil servants experienced anxiety while 63.2 per cent of civil servants experienced stress.

Table 2

Proportion of Civil Servants who Experienced Anger (n=241)

	CAS ITEM	Anger Experience	
		f	%
1	Angry now	166	68.9
2	Anger about future	129	53.5
3	Anger about failure	166	68.9
4	Anger about things	110	45.0
5	Angry-Hostile feelings)	130	53.9
6	Annoying others	182	75.5
7	Angry about self	105	43.5
8	Others cause my misery	176	73.1
9	Wants to hurt others	131	54.4
10	Shout at people	102	42.3
11	Irritated now	147	61.0
12	Social interference	123	51.0
13	Decision interference	123	51.0
14	Alienating others	104	43.2
15	Work interference	109	45.2
16	Sleep interference	160	66.4
17	Fatigue	129	53.5
18	Appetite interference	147	61.0
19	Health interference	123	51.0
20	Thinking interference	154	64.0
21	Sexual interference	166	68.9
	Overall %		**57.9**

Table 2 shows an overall moderate proportion (57.9%) of civil servants experienced anger. Specifically, 75.5 per cent of civil servants annoy others, 73.1 per cent of civil servants felt that others caused their misery, 68.9 per cent were angry now, were angry about being failures and about sexual interference, 66.4 per cent reported anger interference, 64.0 per cent reported thought interference, 61.0 per cent of civil servants reported appetite interference and irritated now.

Research question two.

What is the severity level of EHPs among civil servants in Nsukka LGA. Data answering this question are contained in Tables 3 and 4.

Table 3
Severity Levels of Depression, Anxiety and Stress (n=241)

EHPs	Normal f(%)	Mild f(%)	Moderate f(%)	Severe f(%)	Extremely severe f(%)
Depression	102(43.3)	58(24.1)	57(23.7)	11(4.0)	13(5.4)
Anxiety	81(33.6)	47(19.5)	50(20.7)	31(12.9)	32(13.3)
Stress	148(61.4)	37(15.4)	37(15.4)	15(6.2)	4(1.7)
Cluster%	**45.8**	**19.7**	**19.9**	**7.9**	**6.7**

Data in Table 3 show the severity levels of depression, anxiety and stress among civil servants in Nsukka LGA. The data show that overall, 6.7 per cent and 7.9 per cent of civil servants had extremely severe and severe levels of depression, anxiety and stress while 19.9 per cent and 19.7 per cent had moderate and mild depression, anxiety and stress respectively. Specifically, the table shows that 23.3 per cent of civil servants had moderate depression, 13.3 per cent had extremely severe level of anxiety and 15.4 per cent had moderate level of stress.

Table 4

Severity Level of EHPs (Anger) among Civil Servants. (n-241)

SEVERITY LEVELS

S/N	Items	Minimal Anger f(%)	Mild Anger f(%)	Moderate Anger f(%)	Severe Anger f(%)
1	Angry now	75(31.1)	91(37.8)	42(17.4)	33(13.7)
2	Angry about future	112(46.5)	49(20.3)	56(23.2)	24(10.0)
3	Angry about failure	75(31.1)	37(15.4)	89(36.9)	40(16.6)
4	Angry about things	131(54.4)	36(14.9)	40(16.6)	34(14.1)
5	Angry Hostile feelings	111(46.1)	41(17.0)	53(22.0)	36(14.9)
6	Annoying others	59(24.5)	106(44.0)	29(12.0)	47(19.5)
7	Angry about self	136(56.4)	31(12.9)	32(13.3)	42(14.1)
8	Others cause my misery	65(27.0)	51(21.2)	91(37.8)	34(14.1)
9	Want to hurt others	110(45.6)	68(28.2)	31(12.9)	32(13.3)
10	Shout at people	139(57.7)	45(18.7)	35(14.5)	22(9.1)
11	Irritated vow	94(39.0)	86(35.7)	43(17.8)	18(7.5)
12	Social interference	118(49.0)	75(31.1)	13(5.4)	35(14.5)
13	Decision interference	118(49.0)	64(26.6)	30(12.4)	29(12.0)
14	Alienating others	137(56.8)	57(23.7)	19(7.9)	28(11.6)
15	Work Stress interference	132(54.8)	41(17.0)	38(15.8)	30(12.4)
16	Sleep interference	81(33.6)	106(44.0)	39(16.2)	415(6.2)
17	Fatigue	112(46.5)	49(20.3)	34(14.1)	46(19.1)
18	Appetite interference	94(39.0)	77(32.0)	42(17.4)	28(11.6)
19	Health interference	118(49.0)	69(28.6)	29(12.0)	25(10.4)
20	Thinking interference	87(36.1)	98(40.7)	26(10.4)	31(12.9)
21	Sexual interference	75(31.1)	106(44.0)	27(11.2)	33(13.7)
	Cluster	**43.1**	**27.3**	**16.5**	**13.8**

Data in Table 4 show that overall, 13.8 per cent and 16.5per cent of civil servants had severe and moderate anger while 27.3 per cent and 43.1 per cent of civil servants had mild and minimal anger respectively. However,

specifically, 36.9 and 37.8 per cent had moderate anger about their future and because others caused their misery respectively.

Research question three.

What is the relationship between educational status and EHPs (Depression Anxiety, Stress (DAS) and Anger) among Civil Servants in Nsukka LGA? Data answering these questions are contained in Table 5 and 6.

Table 5

Relationship between Educational Status and DAS among Civil Servants (n=241)

	DASS ITEMS	Rho (ρ)	P-value
	Depression		
1	I could not seem to experience any positive feeling at all.	.05	.417
2	I found it difficult to work up to work up the initiative to do all things	.09	.162
3	I felt that I have nothing to look forward to.	-.14	.025
4	Felt down hearted and blue.	.010	.952
5	I was unable to become enthusiastic about anything.	.05	.463
6	I felt I was not much as a person.	.04	.538
7	I felt that life was meaningless.	.11	.085
	Cluster (ρ)	**.04**	**.496**
	Anxiety		
8	I was aware of dryness in my mouth.	-.02	.751
9	I experienced breathing difficulty (e.g. excessive rapid breathing, breathlessness in the absence of physical exertion)	-.01	.883
10	I experienced trembling.	.07	.255
11	I was worried about situations in which I might panic and make a fool of myself.	.07	.258
12	Felt I was close to panic.	.08	.211
13	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing beat).	-.01	.895
14	I felt scared without any good reason.	.03	.705
	Cluster (ρ)	**.07**	**.295**
	Stress		
15	I found it difficult to wind down.	-.01	.935
16	I tended to overreact to situations	.154	.017
17	I felt that I was using a lot of nervous energy.	.14	.030
18	I found myself getting agitated.	.101	.119
19	I found it difficult to relax	.06	.358
20	I was intolerant of anything that kept me from getting on with what I am doing.	.04	.515
21	I felt I was rather touchy.	.01	.960
	Cluster (ρ)	**.13**	**.044**
	Overall	**.15**	**.278**

Key for interpretation of Strength and direction of Relationship

±.00-.29=No Relationship to Weak Relationship
±.30-.59=Moderate Relationship
±.60-.99=strong Relationship
1.00= Perfect Relationship

Source: Jackson (2009)

Table 5 shows an overall weak positive relationship (ρ=.15, p-value =.278) between educational status and DAS among civil servants. Table 5 further shows that there was a weak

positive relationship between educational status and depression (ρ =.04, p-value=.496), anxiety (ρ =.07, p-value=.295) and stress (ρ =.13, p-value=.044) among civil servants.

Table 6

Relationship between Educational Status and Anger among Civil Servant. (n-241)

	CAS ITEMS	Rho (ρ)	P-value
1	Angry now	-.10	.123
2	Anger about future	-.115	.075
3	Anger about failure	-.13*	.040
4	Anger about things	-.25**	.000
5	Angry-hostile feelings	-.29**	.000
6	Annoying others	-.18**	.005
7	Angry about self	-.24**	.000
8	Others cause my misery	-.14*	.033
9	Wants to hurt others	-.24**	.000
10	Shout at people	-.32**	.000
11	Irritated now	-.112	.083
12	Social interference	-.22**	.001
13	Decision interference	-.31**	.000
14	Alienating others	-.34**	.000
15	Work interference	-.26**	.000
16	Sleep interference	-.15*	.017
17	Fatigue	-.24**	.000
18	Appetite interference	-.20**	.002
19	Health interference	-.23**	.000
20	Thinking interference	-.29**	.000
21	Sexual interference	-.135	.000
	Overall	**-.02**	**.379**

Table 6 shows that there was a weak negative relationship (ρ =.02, p-value=.379) between educational status and anger among civil servants

Research question Four.

What is the relationship between level of income and EHPs (Depression Anxiety, Stress (DAS) and Anger) among Civil Servants in Nsukka LGA? Data answering these questions are contained in Table 7 and 8.

Table 7

Relationship between income level and DAS among Civil Servants. (n-241)

	DASS ITEMS	Rho (ρ)	P-value
	Depression		
1	I could not seem to experience any positive feeling at all.	.01	.884
2	I found it difficult to work up to work up the initiative to do all things	.01	.937
3	I felt that I have nothing to look forward to.	-.02	.803
4	Felt down hearted and blue.	-.05	.452
5	I was unable to become enthusiastic about anything.	-.02	.771
6	I felt I was not much as a person.	-.05	.459
7	I felt that life was meaningless.	-.02	.809
	Cluster (ρ)	**-.02**	**.375**
	Anxiety		
8	I was aware of dryness in my mouth.	.11	.082
9	I experienced breathing difficulty (e.g. excessive rapid breathing, breathlessness in the absence of physical exertion)	.07	.315
10	I experienced trembling.	.03	.616
11	I was worried about situations in which I might panic and make a fool of myself.	.04	.581
12	Felt I was close to panic.	.04	.967
13	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing beat).	.11	.077
14	I felt scared without any good reason.	.04	.493
	Cluster (ρ)	**.10**	**.234**
	Stress		
15	I found it difficult to wind down.	.04	.549
16	I tended to overreact to situations	.09	.164
17	38. I felt that I was using a lot of nervous energy.	.01	.839
18	39. I found myself getting agitated.	.01	.938
19	I found it difficult to relax	.06	.347
20	I was intolerant of anything that kept me from getting on with what I am doing.	-.02	.757
21	40. I felt I was rather touchy.	.02	.820
	Cluster (ρ)	**.10**	**.369**
	Overall Cluster	**.09**	**.326**

Table 7 shows an overall weak positive relationship (ρ = .09, p-value =.326) between income level and DAS among civil servants.

Table 7 further shows that there was a weak negative relationship between level of income and depression (ρ =-.02, p-value=.375). However there was a weak positive relationship

between level of income and anxiety (ρ =.10, p-value=.234) and stress (ρ =.10, p-value=.369) among civil servants in Nsukka LGA.

Table 8

Relationship between Income and Anger among Civil Servants. (n-241)

	CAS ITEMS	Rho (ρ)	P-value
1	Angry now	-.01	.869
2	Anger about future	.07	.273
3	Anger about failure	.06	.366
4	Anger about things	.01	.837
5	Anger-Hostile feelings	-.01	.874
6	Annoying others	.02	.814
7	Angry about self	.03	.634
8	Others cause my misery	.01	.920
9	Wants to hurt others	.03	.612
10	Shout at people	-.01	.870
11	Irritated now	-.04	.535
12	Social interference	.11	.077
13	Decision interference	.10	.127
14	Alienating others	.06	.362
15	Work interference	-.00	.951
16	Sleep interference	.08	.241
17	Fatigue	.04	.567
18	Appetite interference	.04	.495
19	Health interference	.07	.270
20	Thinking interference	.00	.990
21	Sexual interference	.02	.723
	Overall	**.05**	**.432**

Table 8 shows that there was a weak positive relationship between level of income and anger (ρ =.05, p-value=.432) among civil servants in Nsukka LGA.

Research question Five.

What is the relationship between age and EHPs (Depression Anxiety, Stress (DAS) and Anger) among Civil Servants in Nsukka LGA? Data answering these questions are contained in Table 9 and 10.

Table 9

Relationship between Age and DAS among Civil Servants. (n-241)

	DASS ITEMS	Rho (ρ)	P-value
	Depression		
1	I could not seem to experience any positive feeling at all.	0.4	.528
2	I found it difficult to work up to work up the initiative to do all things	0.9	.175
3	I felt that I have nothing to look forward to.	.76**	.006
4	Felt down hearted and blue.	-.065	.317
5	I was unable to become enthusiastic about anything.	-.064	.320
6	I felt I was not much as a person.	.026	.689
7	I felt that life was meaningless.	.020	.758
	Cluster (ρ)	**.01**	**.927**
	Anxiety		
8	I was aware of dryness in my mouth.	-.07	.273
9	I experienced breathing difficulty (e.g. excessive rapid breathing, breathlessness in the absence of physical exertion)	.11	.079
10	I experienced trembling.	.09	.145
11	I was worried about situations in which I might panic and make a fool of myself.	-.07	.292
12	Felt I was close to panic.	.060	.347
13	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing beat).	.1*	.037
14	I felt scared without any good reason.	.13*	.043
	Cluster (ρ)	**.10**	**.358**
	Stress		
15	I found it difficult to wind down.	.06	.333
16	I tended to overreact to situations	.00	.950
17	I felt that I was using a lot of nervous energy.	.04	.515
18	I found myself getting agitated.	.06	.378
19	I found it difficult to relax	-.015	.820
20	I was intolerant of anything that kept me from getting on with what I am doing.	.01	.910
21	I felt I was rather touchy.	.08	.203
	Cluster (ρ)	**.10**	**.431**
	Overall	**.06**	**.572**

Table 9 shows an overall a weak positive relationship between age and DAS (ρ =.06. p-value =.572) among civil servants. Table 9 further shows that there was a weak positive relationship between age and depression (ρ =.01, p-value=.927), anxiety (ρ =.10, p-value=358) and stress (ρ =.10, p-value=.431) among civil servants.

Table 10

Relationship between Age and Anger among Civil Servants. (n-241)

	CAS ITEMS	Rho (ρ)	P-value
1	Angry now	.20**	.002
2	Anger about future	.19**	.003
3	Anger about failure	.09	.176
4	Anger about things	.19**	.004
5	Angry-Hostile feelings)	.15*	.018
6	Annoying others	.23**	.000
7	Angry about self	.27**	.000
8	Others cause my misery	.19**	.004
9	Wants to hurt others	.19**	.003
10	Shout at people	.20**	.002
11	Irritated now	.11	.101
12	Social interference	.26**	.000
13	Decision interference	.24**	.000
14	Alienating others	.19**	.004
15	Work interference	.23**	.000
16	Sleep interference	.20**	.002
17	Fatigue	.19**	.003
18	Appetite interference	.17**	.009
19	Health interference	.32**	.000
20	Thinking interference	.25**	.000
21	Sexual interference	.21**	.001
	Overall	**.06**	**.332**

*Significant at P < .05. **Significant at P < .001

Table 10 shows that there was a weak positive relationship between age and anger (ρ=.06, p-value=.332) among civil servants.

Hypothesis one

Age is not a significant predictor of emotional health problems (Depression, Anxiety and Stress (DAS) among civil servants in Nsukka LGA. Data testing the hypothesis are contained in Table 11

Table 11

Logistic Regression of Relationship between Age and DAS among Civil Servants in Nsukka LGA (n-241)

							95% C.I. for Exp(B)	
Coefficients	**B**	**SE**	**Wald**	**Df**	**Sig.**	**Exp(B)**	**Lower**	**Upper**
Age	ï 2.339	1.099	4.531	2	.033	0.96	.011	.831
Constant	2.335	1.268	3.392	1	.066	10.328		

Cox and Snell R^2 = .047
x^2 (2) = .104, P = .949 > .05

Results in Table 11 shows that the overall model predicting DAS was not significant, x^2 (2) = .104, p = .949 > .05 with a small effect (variance) in EHPs explained by the logistic model with Cox and Snell R^2 = .047.

Age was found to predict 47% more likelihood of EHPs (OR = .096, 95% CI [.011 -.831], P = .033 < .05) indicating that age was associated with an increased likelihood of EHPs among civil servants in Nsukka LGA.

Hypothesis two

Age is not a significant predictor of emotional health problems (anger) among and servants in Nsukka LGA. Data testing this hypothesis are contained in Table 12

Table 12

Logistic Regression of Relationship between Age and Anger among civil servants (n-241)

							95% C.I. for Exp(B)	
Coefficients	**B**	**SE**	**Wald**	**Df**	**Sig.**	**Exp(B)**	**Lower**	**Upper**
Age	19.473	14.361	.000	1	.999	2.112	.000	.001
Constant	1.730	.293	35.609	1	.000	5.64		

Cox and Snell R^2 = .011
X^2(2) = 2.23, P = .121 > .05

Results in Table 12 shows that the overall model predicting anger was not significant, x^2 (2) .121, P = .121 > .05, with a small effect (variance) in anger explained by the logistic model with a Cox and Snell R^2 = .011. Age was found to predict 11% more likelihood of EHPs (OR = 2.112, 95% C.I. [.000-.001], P = .999 >.05) indicating that age was not associated with an increased likelihood of anger among civil servants.

Hypothesis Three

Level of income is not a significant predictor of DAS among civil servants in Nsukka LGA. Data testing the hypothesis are contained in Table 13.

Table 13

Logistic Regression of Relationship between Level of Income and EHPs among Civil Servants in Nsukka LGA (n-241)

							95% C.I. for Exp(B)	
Coefficients	**B**	**SE**	**Wald**	**Df**	**Sig.**	**Exp(B)**	**Lower**	**Upper**
Level of income	1.856	1.094	2.881	1	.090	6.400	.603	2.309
Constant	.038	.342	.013	1	.911	1.039		

Cox and Snell R^2 = .025
x^2 (4) = .3.901, P = .420 > .05

Results in Table 13 shows that the overall model predicting DAS was not significant, x^2 (4) = .3.901, P = .420 > .05, with s small effect variance in DAS explained by the logistic model Cox and Snell R^2 = .025. Age was found to predict 25% more likelihood of EHPs (Cox = .095, 95%, C.I. [.603-2.309], P = .090>.05), indicating that level of income was not associated with an increased likelihood of DAS among civil servants in Nsukka LGA.

Hypothesis Four

Level income is not a significant predictor of anger among civil servants in Nsukka LGA. Data testing this hypothesis are contained in Table 14.

Table 14

Logistic Regression of Relationship between Level of Income and Anger among Civil Servants in Nsukka LGA (n-241)

							95% C.I. for Exp(B)	
Coefficients	**B**	**SE**	**Wald**	**Df**	**Sig.**	**Exp(B)**	**Lower**	**Upper**
Level of income	.610	.500	1.486	1	.223	.543	.204	1.449
Constant	2.113	.368	33.007	1	.000	8.270		

Cox and Snell R^2 = .016
x^2 (5) = .117, P = 1.00 > .05

Results in Table 14 show that the overall model predicting anger was not significant x^2 (5) = .117 P = 1.00 > .05 with a small effect with a Cox and Snell R^2 = .016. Level of income was found to predict 16% more likelihood of anger (OR = .543, 95%, C.I. [.204 -1.449], P = .223 > .05), indicating that age was not associated with an increased likelihood of anger among civil servants in Nsukka LGA.

Hypothesis Five

Level educational is not a significant predictor of DAS among civil servants in Nsukka LGA. Data testing the hypothesis are contained in Table 15.

Table 15

Logistic Regression of Relationship between Level of Education and DAS among Civil Servants in Nsukka LGA (n-241)

							95% C.I. for Exp(B)	
Coefficients	**B**	**SE**	**Wald**	**Df**	**Sig.**	**Exp(B)**	**Lower**	**Upper**
Level of Education	.176	.651	.075	1	.785	1.195	.334	4.280
Constant	.000	.632	.000	1	1.000	1.000		

Cox and Snell R^2 = .019
x^2 (1) = 1.700, P = .040 < .05

Result in Table 15 shows that the overall model predicting emotional health problems DAS was significant, x^2 (1) = 1.700, P = .040 < .05with a small effect (variance) in DAS explained by the logistic model with a Cox and Snell R^2 = .024. Educational status was found to predict 24% more likelihood of anger. OR = 1.195, 95%, C.I. [.334 -4.280], P = .785 > .05 indicating that educational status was not associated with an increased likelihood of DAS among civil servants in Nsukka LGA.

Hypothesis Six

Educational level is not a significant predictor of anger among civil servants in Nsukka LGA. Data testing this hypothesis are contained in Table 16.

Table 16

Logistic Regression of Relationship between Education Status and Anger among Civil Servants in Nsukka LGA (n-241)

							95% C.I. for Exp(B)	
Coefficients	**B**	**SE**	**Wald**	**Df**	**Sig.**	**Exp(B)**	**Lower**	**Upper**
Level of Education	1.028	.727	1.996	2	.158	2.795	.672	11.632
Constant	20.149	14.879	.000	2	.999	56.367		

Cox and Snell R^2 = .018
x^2 (3) = .652, P = .884 > .05

Results in Table 16 shows that the overall model predicting anger was not significant, x^2 (3) = .652, P = .884 > .05 with a small effect (variance) in anger explained by the logistic model with a Cox and Snell R^2 = .018. Educational status was found to predict 18% more likelihood of

anger (OR = 2.795, C.I. [.672-11.632] P = .158 > .05), indicating that educational status was not associated with increased likelihood of anger among civil servants in Nsukka LGA.

Summary of Major Findings

1. Moderate proportion (58.5%) of civil servants experienced DAS (Table 1).
2. Moderate proportion (57.9%) of civil servants experienced anger (Table 2).
3. On the overall, 6.7 per cent and 7.9 per cent of civil servants had extremely severe and severe levels of depression, anxiety and stress while 19.9 per cent and 19.7 per cent had moderate and mild depression, anxiety and stress respectively. (Table 3).
4. On the overall, 13.8 per cent and 16.5per cent of civil servants had severe and moderate anger while 27.3 per cent and 43.1 per cent of civil servants had mild and minimal anger respectively. (Table 4).
5. There was a weak positive relationship (ρ=.15, p-value =.278) between educational status and DAS among civil servants (Table 5).
6. There was a weak negative relationship (ρ = ĭ .02, p-value=.379) between educational status and anger among civil servants (Table 6).
7. There was a weak positive relationship (ρ = .09, p-value=.326) between income level and DAS among civil servants (Table 7).
8. There was a weak positive relationship (ρ =.05, p-value=.432) between level of income and anger among civil servants (Table 8).
9. There was a weak positive relationship (ρ =.06. p-value =.572) between age and DAS among civil servants.(Table 9).
10. There was a weak positive relationship (ρ =.06, p-value=.332) between age and anger among civil servants.(Table 10).
11. Age was found to predict 47% more likelihood of DAS (OR = .096, 95% CI [.011 -.831], P = .033 < .05) indicating that age was associated with an increased likelihood of DAS among civil servants in Nsukka LGA.
12. Age was found to predict 11% more likelihood of anger (OR = 2.112, 95% C.I. [.000-.001], P = .999 >.05) indicating that age was not associated with an increased likelihood of anger among civil servants.

13. Level of income was found to predict 25% more likelihood of DAS (Cox = .095, 95%, C.I.[.603-2.309], P = .090>.05), indicating that level of income was not associated with an increased likelihood of DAS among civil servants in Nsukka LGA.
14. Level of income was found to predict 16% more likelihood of anger (OR = .543, 95%, C.I. [.204 -1.449], P = .223 > .05), indicating that level of income was not associated with an increased likelihood of anger among civil servants in Nsukka LGA.
15. Educational status was found to predict 24% more likelihood of DAS (OR = 1.195, 95%, C.I. [.334 -4.280], P = .785 > .05) indicating that educational status was not associated with an increased likelihood of DAS among civil servants in Nsukka LGA.
16. Educational status was found to predict 18% more likelihood of anger. OR = 2.795, 95%, C.I. [.672-11.632] P = .158 > .05), indicating that educational status was not associated with increased likelihood of anger among civil servantsu in Nsukka LGA.

Discussion

The findings of this study are discussed under the following headings.

Proportion of civil servants who experienced EHPs.

Level of severity of EHPs among civil servants.

Relationship between socio-demographic factors and EHPs among civil servants

Predictors of EHPs among civil servants.

Proportion of civil servants who experienced EHPs.

Findings in Table 1 showed an overall moderate proportion of civil servants experienced DAS (depression, anxiety and stress). The finding was not surprising because considering the situation in Nigeria, individuals including civil servants are likely to suffer from one emotional health problem or the other including depression, anxiety and stress. The finding was consistent with that of Ofuebe (2013) who found that academic staff in universities in Enugu State had moderate proportion (55.6%) of stress. In addition, the finding was in tandem with the finding of Ivandic, Kamenov, Rojas, Ceron, Nowak and Sabariego (2017) who reported that workers had moderate proportion (41.1%) of anxiety. These consistencies could be as a result of the fact that both studies were carried out on workers who share some common characteristics. The finding was inconsistent with the finding of Akhtar, Khan,Vaidhyanathan, Chabra and Kannan (2013) who reported high proportion (61.4%) of depression among the elderly patients attending

outpatient departments of a tertiary hospital in North India. The finding was also inconsistent with the finding of Farrer, Gulliver, Bennett, Fassnacht, Kathleen,and Griffiths (2016) who reported low proportion of depression (7.9 %) and anxiety (17.5 %) in Australian students. This inconsistency in the findings could be because the studies were carried out in entirely different geographical and cultural backgrounds from those of the present study.

The findings in Table 2 showed an overall moderate proportion of civil servants experienced anger. The finding was not surprising because in the course of data collection the researcher observed the respondents displayed anger in diverse ways. This could be because of their belief that others caused them misery. The finding was in line with that of Ofuebe (2013) who reported that academic staff in universities in Enugu State had moderate proportion (57.5%) of anger. The finding was also in line with the finding of Posternak and Zimmerman (2015) who reported moderate proportion of anger in psychiatric outpatients. This consistency could as well be as a result of the fact that anger as an emotion is experienced by all in any form of adverse condition irrespective of cognitive status. However, it contradicts the findings of Yahaya, Yusoff, Yasin, and Wahab (2018) who reported low proportion (10.7%) of depression which anger is one of the sign and symptom and that of Manaf, Mustafa, Rahman, Yusof, and Aziz (2016) who also reported low proportions (27.8%) of depression (anger).

Level of severity of EHPs among civil servants

Findings in Table 3 showed that overall, civil servants had different percentages of extremely severe, severe moderate and mild depression, anxiety and stress respectively. Mild depression in civil servants was somewhat surprising, due to the fact that these civil servants were observed to be complaining about numerous financial challenges confronting them at home and workplace. However, severe stress and extremely severe anxiety were expected due to the irritable actions and reactions of the respondents observed by the researcher in the course of the study. The finding was in relation with that of Ofuebe (2013) who reported that academic staff in universities in Enugu State had moderate levels of anxiety and stress and that of Polikandrioti, Goudevenos, Michalis, Koutelekos, Tzialas,and Elisaf (2015) who found that hospitalized patients had moderate levels of anxiety. This could be attributed to the prevailing economic situation and uncertainties that surround payment of salaries and other emoluments due to civil servants. The finding is not consistent with Islam and Adnan (2017) who reported higher percentages of patients having mild depression (28 per cent) moderate (37 per cent) and severe

(14 per cent)and Polikandrioti, Goudevenos, Michalis, Koutelekos, Tzialas, and Elisaf (2015) who also reported that higher percentages 24.7% and 32.6% of patients were found to have moderate and severe levels of anxiety,

Findings in Table 4 showed that overall, civil servants had different percentages of severe, moderate, mild and minimal anger respectively. This finding was expectedbecause it was observed that the civil servants were manifesting different forms of anger in the form of refusal to responding to the questionnaire. The finding was in line with Ofuebe (2013) who found that academic staff in universities in Enugu State had moderate levels of anger. This could be as a result of the fact that both respondents were workers who shared some common characteristics. The finding is also in tandem with that of Jayasinghe, Giosan, Evans, Spielman,and Difede (2008) who reported that workers exposed to the 9/11/01 World Trade Centre disaster had severe anger. This severe level of anger could be as a result of massive loss of lives in 9/11/01 and possible losses the civil servants with severe anger might have experienced. Milanovic, Erjavec, Poljicanin, Vrabec, and Brecic (2015) reported 19.38 per cent were mildly, 4.64 per centmoderately, and 0.91 per cent severely depressed (angry).

Relationship between socio-demographic predictors and EHPs among civil servants

Finding from Table 5 showed an overall there was a weak positive relationship between educational status and DAS among civil servants. The result was not expected and was therefore surprising. This is because one will naturally expect a high relationship between educational status and DAS. The finding was however in line with Bhat, Hassan, Shafiq and Sheikh (2015) who reported that there was a positive relationship between educational qualification anddepression among pregnant women. This relationship could be as a result of the fact that both study groups were adults. The finding is at variance with the findings of Islam and Adnan (2017) who reported that educational qualification was negatively related to depression in Bangladesh psychiatric patients. The disparity in the finding could be attributed to the composition of the subjects or participants of both studies. However, another study by Nisar, Uzair, Khan, and Aktar (2017) found that there is no relationship between education and DAS. This could be due to diversities in cultures and beliefs.

Finding fromTable 6 showed a weak negative relationship between educational status and anger among civil servants. The finding was not surprising because one will feel that lower education with all its associated problems can trigger anger and higher education with its varied

exposures can reduce anger. The finding was in line with Islam and Adnan (2017) who reported that there was a weak negative relationship between educational status and depression in Bangladesh psychiatric patients. Although the work was on depression, but it is generally known that one of the symptoms of depression is anger. The finding was in contrast with Jayasighe, Giosan, Evans, Spielman, and Difede (2008) that found there was a significant relationship between anger and PTSD workers in 9/11/01 disaster. This difference was probably because the PTSD workers experienced what could best be explained as a tragedy.

Findings from Table 7 showed a weak positive relationship between income level and DAS among civil servants. The finding was not surprising as it is in line with the common parlance big man, big trouble. The finding was consistent with that of Cheung and Yip (2015) who reported thatthere was a positive relationship between household income and DAS (anxiety and stress) among Hong Kong Nurses. It is however in contrast with the finding of Shittu, Odeigah, Issa, Olanrewaju, Mahmoud, and Sanni (2014) who reported thatthere was a strong positive relationship between monthly income and DAS in a Nigerian family practice setting. Also in contrast with that of Islam and Adnan (2017) who reported that there was a weak negative relationship between family income and DAS.

Table 8 showed a weak positive relationship between level of income and anger among civil servants. The finding was not anticipated given that the anger level experienced in the course of the study was outrageous. It is however in line with the finding of Rahman, Bairagi, and Dey (2014) who reported that income has a strong positive association with anger. The relationship is that both has positive relationships, though the former was weak, possibly as a result of the scale used in the study. This contradicts with the finding of Sareen, Afifi, McMillian, and Asmondson (2011) who reported that income had a negative relationship with mental health problems of which anger is inclusive. This could be due to diversities in cultures.

Table 9 showed a weak positive relationship between age and DAS among civil servants. The finding is anticipated given that as one age a lot of challenges are faced, which could cause emotional health problems. This is in line with Islam and Adnan (2017) who reported that age has a weak positive relationship with DAS. This contradicts with the finding of Cheung and Yip (2015) who reported that age has a negative relationship with DAS. This contrast could be as a result of the fact that different respondents having peculiar characteristics were used in the study.

Table 10 showed a weak positive relationship between age and anger among civil servants. The finding is not anticipated given that anger is naturally expected to reduce with maturity. However, it is in line with Islam and Adnan (2017) who reported that age had a weak positive relationship with anger (depression). This consistency could be because both studies are primarily on relationship between socio-demographics and emotional health problem. The finding was in contrast with the finding of Koçer, Koçer, and Canan (2011) who reported that age was negatively correlated with anger management in physicians and Silove, Rees, Tam, Mohsin, Tay, and Tol (2015) who reported that age was positively correlated with anger. This contrast could be as a result of the nature of the respondents involved.

Predictors of EHPs among civil servants.

Findings in Table 11 showed that age was found to predict 47 per cent more likelihood of DAS indicating that age was associated with an increased likelihood of DAS among civil servants in Nsukka LGA. The finding was consistent with that of Nisar, Uzair, Khan, and Aktar (2017)who reported that age was a significant predictor of DAS in patients undergoing haemodialysis. The finding was also consistent with that of Bhat, Hassan, Shafiq and Sheikh (2015) who reported that age was a significant predictor of DAS among pregnant women. These consistencies could be because emotional health problems cut across all races and cultures. However, the finding was in contrast with the finding of Milanovic, Erjavec, Poljicanin, Vrabec, and Brecic (2015) who reported that age is not a significant predictor of DAS in primary health care patients.

Findings in Table 12 showed that age was found to predict 11per cent more likelihood of anger indicated that age was not associated with an increased likelihood of anger among civil servants. The finding was not expected as anger outburst is naturally expected to reduce with increase in age. The finding was consistent with the finding of Jayasighe, Giosan, Evans, Spielman,, and Difede (2008) that recorded that age significantly predicts anger in DAS patients. It is rather inconsistent with the finding of Koçer, Koçer and Canan (2011) who reported association between physicians age and anger management and Silove, Rees, Tam, Mohsin, Tay, and Tol (2015)who reported that there was an association between age and anger. This inconsistencies could be due to the fact that the studies were carried out in different cultures and with different tools.

Findings in Table 13 showed that level of income was found to predict 25 per cent more likelihood of DAS indicated that level of income was not associated with an increased likelihood of DAS among civil servants in Nsukka LGA. The finding is consistent with the finding of Nisar, Uzair, Khan, and Aktar (2017) who reported status within family which can involve level of income had no association with EHPs in family health setting and the finding of Atindanbila, Abasimi, and Anim (2012) who also reported no association between rank (which denotes level of income) and DAS among nurses at Pantang Hospital. These consistencies could be because much more than level of income; low or high, people need their emotional needs to be met. The finding was at variance with the finding of Shittu, Odeigah, Issa, Olanrewaju, Mahmoud, and Sanni (2014) who reportedstrong statistical association between depression and monthly income. This variation could be due to cultural differences in the population and the tools used in the study.

Findings in Table 14 showed that level of income was found to predict 16 per cent more likelihood of anger, indicating that level of income was not associated with an increased likelihood of anger among civil servants in Nsukka LGA. The finding was not expected because of the high percentage of workers that were angry about failure. The finding was consistent with the finding of Nisar, Uzair, Khan, and Aktar (2017) who reported status within family which can involve level of income had no association with depression (which anger is one of its symptom) in family health setting. However, the finding was inconsistent with the finding of Islam and Adnan (2017) who reported that level of income was associated with depression which anger has an increased tendency to manifest in. This was supported by the assertion of Beitner (2015) that when people experience depression and anxiety over a period of time there is increased tendency for anger to manifest.

Findings in Table 15 showed that educational status was found to predict 24 per cent more likelihood of DAS, indicating that educational status was not associated with an increased likelihood of DAS among civil servants in Nsukka LGA. The finding was not expected because it is believed that education helps to enlighten people and hence, have influence on the emotion of the educated. This is in line with Feinsten, Sabates, Anderson, Sorhando, and Hammond (2006) who maintained that education impacts on social and economic relations in the workplace and Patel, and Kleiman (2003) who noted that there was a significant relationship between the prevalence of common emotional problems and low educational levels (Patel & Kleiman, 2003).

However, it is in line with the findings of Nisar, Uzair, Khan, and Aktar (2017) who found out that education has no association with depression and Okwor and Rhode (2012) that educational qualification has no influence on the EHPs (stress) of teachers. It is rather inconsistent with the finding of Bjelland, Krokstad, Mykletum and Tambs (2008) who reported that low educational levels were significantly associated with both anxiety and depression and Shittu, Odeigah, Issa, Olanrewaju, Mahmoud, and Sanni (2014) who reported that there was a strong association between depression which was one of the EHPs and educational level. These inconsistencies could be due to different groups of people with diverse characteristics.

Findings in Table 16 show that educational status was found to predict 18 percent more likelihood of anger, indicated that educational status was not associated with increased likelihood of anger among civil servants in Nsukka LGA. The finding was expected because most Nigerians display anger irrespective of being educated or not educated. The finding is in line with the findings of Nisar, Uzair, Khan, and Aktar (2017) who found out that education has no association with depression (anger). It is rather inconsistent with the finding of Silove, Rees, Tam, Mohsin, Tay, and Tol (2015) who reported that there was an association between low level education and anger. This inconsistency could be as a result of differences in the population and the tools used in the study.

CHAPTER FIVE
Summary, Conclusion and Recommendations

The primary purpose of this study was to determine the socio-demographic predictors of EHPs among civil servants in Nsukka LGA of Enugu state, Nigeria. The forms of EHPs studied were depression, anxiety, anger and stress and the socio-demographic predictors considered were educational status, level of income and age. In attempt to accomplish the purpose of this study five specific objectives and corresponding research questions were formulated and five null hypotheses were postulated.

The review of related literature to this study is organized under the following headings and subheadings: conceptual framework; emotional health (EH), emotional health problems (EHPs), socio-demographic predictors of emotional health problems, civil servants. Theoretical framework; James-Lange theory, opponent-process theory, job demand-resources model. Review of related empirical studies and summary of review of related literature.

The study adopted cross-sectional survey research design. The population for the study consisted of 959 civil servants currently employed at Nsukka LGA. The sample for this study consisted of 284 civil servants. Taro Yamaneôs formula was used to determine the sample size. Two standardized instruments were used for data collection in this study namely; Depression Anxiety Stress Scale with 21 items (DASS-21) and Clinical Anger Scale (CAS). Standardized instrument was used and hence no validation. Frequencies, percentages and spearmanôs rho were used to analyse the research questions. The null hypothesis were tested using logistic regression at .05nlevel of significance.

Summary

Findingsshowed that moderate proportion of civil servants experienced DAS and moderate proportion of civil servants experienced anger. On the overall, civil servants had different percentages of extremely severe, severe, moderate and mild depression, anxiety and stress respectively and different percentages of severe, moderate, mild and minimal anger respectively. There was a weak positive relationship between educational status and DAS, weak negative relationship between educational status and anger among civil servants. There was a weak positive relationship between income level and DAS and a weak positive relationship between level of income and anger among civil servants. There was a weak positive relationship between age and DAS and a weak positive relationship between age and anger among civil

servants.Age was found to predict 47% more likelihood of DAS indicating that age was associated with an increased likelihood of DAS andwas found to predict 11% more likelihood of anger indicating that age was not associated with an increased likelihood of anger among civil servants. Level of income was found to predict 25% more likelihood of DAS indicating that level of income was not associated with an increased likelihood of DAS and was found to predict 16% more likelihood of anger indicating that level of income was not associated with an increased likelihood of anger among civil servants in Nsukka LGA. Educational status was found to predict 24% more likelihood of DAS indicating that educational status was not associated with an increased likelihood of DAS and was found to predict 18% more likelihood of anger, indicating that educational status was not associated with increased likelihood of anger among civil servants in Nsukka LGA.

Conclusion

On the overall, moderate proportion of civil servants experienced DAS, while moderate proportion civil servants experienced anger. On the overall, civil servants had different percentages of extremely severe, severe moderate and mild depression, anxiety and stress respectively and different percentages of severe, moderate, mild and minimal anger respectively.

On the overall, there was a weak positive relationship between educational status and DAS and a weak negative relationship between educational status and anger among civil servant. On the overall there was a weak positive relationship between income level and DAS and a weak positive relationship between level of income and anger. On overall, there was a weak positive relationship between age and DAS and a weak positive relationship between age and anger among civil servants.

Among the three hypotheses age was the only significant predictor of EHPs (DAS and Anger) among civil servants in Nsukka LGA. Educational levels were not significant predictor of EHPs (DAS and Anger) among civil servants in Nsukka LGA.

Recommendations

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

1. Administrators should modify their management and administration of authority on the workers for increased job satisfaction, emotional health and subsequent productivity.

2. Curriculum planners should improve and modify the curriculum to accommodate the forms of EHPs for the in-service training of civil servants to help them have a good grip of EHPs and their predictors.
3. Government should enact laws and make policies that will guide the treatment given to civil servants while in service, these laws and policies may result in prompt payment of salaries, befitting accommodation, allowances among others to avoid EHPs among civil servants.
4. Civil servants should on their own explore informal means of learning more about various forms of EHPs and their predictors.
5. Governmental and non-governmental organizations should use the findings from the study in organizing workshops and seminars to educate civil servants on the forms of EHPs, causes and the ways to develop attitude that will be beneficial in avoiding EHPs as much as possible.
6. The government and administrators should influence the working climate and conditions in which the civil servants function, including good offices, prompt salary payment among others.
7. The findings on age and its relationship with EHPs could be employed by civil service commission in regulating employment of civil servants, for instance, if it is found that a particular age group is more prone to EHPs. Special training may be organized for them to help them perform better. The findings on age will provide adequate information to curriculum planners. This will enable them to expand the curriculum on emotional health problems.
8. Public health educators should at least organize quarterly workshops and seminars on emotional health education to provide the needed information to civil servants which may to a large extent help to minimize emotional health problems and their predictors.
9. Social medias should disseminate information on the forms of emotional health problems, signs and symptoms that manifest when one is having EHPs and their possible predictors.

Limitation of the Study

The generalizations made with respect to this study are however subject to the following limitations;An important limitation to this study is response bias. This is implied because many

participants did not give true information on their real experiences in relation to emotional health problems.

Suggestions for Further Studies

In view of the findings, the researcher suggests that further studies be carried out on the following areas.

1. Socio-demographic predictors of EHPs among civil servants in other state LGAs.
2. Prevention of emotional health problems among civil servants in the LGA of study.
3. Relationship between personality and emotional health problems.
4. Strategies for improving and maintaining emotional health.

References

Abbas, A., Mudassar, M., Asiy, & Gul, A. M. (2013). Factors contributing to job satisfaction for workers in Pakistani organization. *International Journal of Academic Research in Business and Social Sciences, 3*(1). Retrieved from http://www.hrmars.com/admin/pics/ 1521.pdf.

Abdelkader, F. (2013). *The angry project manager.* Retrieved from http://www.orange-business.com/en/blogs/connecting-technology/project-management/the-angry-project-manager.

Abubakar A, Fischer R., & Arasa, J. (2013). The effects of organizational practices and social norms on self-reported extra-role work behaviour and mental health. *African Journal Business Management,7*(23*).* 2226-2233.

Akhtar-Danesh, N., & Landeen, J. (2007). Relation between depression and socio demographic factors International. *Journal of Mental Health Systems, 1*(4), doi:10.1186/1752-4458-1-4 Retrieved from https://ijmhs.biomedcentral.com/articles /10.1186/1752-4458-1-4

Akinsanya, O. O., & Akinsanya, A. O. (2015). Influence of some demographic factors on job satisfaction on academic staff in tertiary institution in Ogun state, Nigeria. *Journal of Research on Humanities and Social Sciences, 5*(13), 497.

Ajala, E. M. (2012). The influence of workplace environment on workers' welfare, performance and productivity. *The African Symposium,12*(1)*,* 141-149.

Al-Naggar, R. A., & Al-Naggar, D. H. (2012). Prevalence and associated factors of emotional disorder among Malaysian University Students. *InternationalJournal of Collaborative Research on Internal Medicine & Public Health, 4*(7)*,*10-41. Retrieved from http://internalmedicine.imedpub.com/prevalence-and-associated-factors-of-emotional-disorderamong-malaysian-university-students.

American Academy of Family Physicians (2010). *Mental health: Keeping your emotional Health.* Retrieved from https://familydoctor.org/mental-health-keeping-your-emotional-health/.

American Psychological Association-APA (2016). *Anger.* Retrieved from http://www.apa. org/topics/anger/.

Americaôs Essential Hospitals (2015). *Socio-demographic factors and socioeconomic status affecting health outcomes*. Retrieved from http://essentialhospital.org/institute/ socio demographic -factors-and-socioeconomic-status-ses-affect-health-outcomes

American College of Cardiology (2012). *Emotional problems: Depression, anxiety and anger.* Retrieved from https://www.cardiosmart.org/~/media/Documents/ Fact%20Sheets/en/zu 1903.ashx

American Sociological Association (2018). *What is sociology*? Retrieved from http://www.asanet.org/about-asa/asa-story/what-sociology

American Psychological Association (2010). *Stress in America: Key findings*. Retrieved from http://www.apa.org/news/press/ releases/stress/key-findings.pdf.

Anxiety and Depression Association of American (2016) *Facts & statistics*. Retrieved from http://www.adaa.org/about-adaa/press-room/facts-statistics

Anxiety and Depression Association of America (2014). *Facts and statistics*. Retrieved from https://www.adaa.org/about-adaa/press-room/facts-statistics.

American Psychological Association- APA. (2016). *How to recognize and deal with anger*. Retrieved from http://www.apa.org/helpcenter/recognize-anger.aspx

APA (2016). *Stress: The different kinds of stress*. Retrieved from http://www.apa.org/help center/stress-kinds.aspx

Arroba, T., & James, K (2002). *Pressure at work: A survival guide* (2nd Ed.). Maidenhead: McGraw-Hill.

Atindanbila, S., Abasimi, E., & Anim, M. T (2012). A study of work related depression, anxiety and stress of nurses at Pantang Hospital in Ghana. *Research on Humanities and Social Sciences, 2*(9)*,* Retrieved from http:// www.iiste.org

Australian Psychological Society (2012). *Understanding and managing stress*. Retrieved from https://www.psychology.org.au/Assets/Files/StressTipSheet.pdf

Bakare, B. (2014). *Nigeria and the challenge of mental disorder*. Daily Independent Nigeria. Retrieved from: http://dailyindependentnig.com/2014/02/nigeria-and-challenge-of-mental-disorder/

Barkan, J. D., Gboyega, A., Stevens., & Mark (2001). *State and Local Governance in Nigeria: Public sector and capacity building program*. Retrieved from http://info. worldbank.Org/etools/docs/library/5783/State_and_Governance_Nigeria.htm

Beitner, M. S. (2015). *Types of symptoms*. Retrieved from http://psychologydoc.com/ psychiatric%20symptoms.htm

Beyond Blue (2016). *Types of depression.* Retrieved from https://www. beyondblue.org.au /the-facts/depression/types-of-depression

Bhat, N. A., Hassan, R., Shafiq, M., & Sheikh, S. (2015). Socio-demographic factors: A major predictor of anxiety and depression among pregnant women. *Delhi Psychiatry Journal 18*(1), 86-94. Retrieved from http://medind.nic.in/daa/t15/i1/daat15i1p86.pdf

Bressert, S. (2016).*Social Anxiety disorder treatment*. Retrieved from http://psychcentral.com/ disorders/social-anxiety-disorder-treatment/

Bjelland, I., Krokstad, S., Mykletum, A., & Tambs, K. (2008). Does higher education protect against anxiety and depression? The Hunt study. *Social Science & Medicine,66*(6),1334-45. Retrieved from https://www.researchgate.net/publication/5618340Does_higher_education_protect_against_anxiety_and_depression_The_HUNT_study

Bickford, M. (2005). *Stress in work place; A general overview of the causes, the effects and the solutions.* Retrieved from http://www.cmhanl.ca/pdf/wofkplacestress.pdf

Canadian Mental Health Association (2016). *Anxiety disorders*. Retrieved from http://www .cmha.ca/mental-health/understanding-mental-illness/anxiety-disorders/

Calm Clinic (2016). *Anxiety and panic attacks*. Retrieved from *http://www.calmclinic.com /anxiety/causes*

Charles, S., & Carstensen, L. L. (2010). Social and emotional aging. *Annual Review on Psychology 61*, 383ï 409. doi: 10.1146/annurev.psych.093008.100448PMCID

Centre for Educational Research and Innovation (CERI). (2006). *Measuring the effects of education on health and civic engagement: Proceedings of the Copenhagen symposium.* Retrieved from https://www.oecd.org/edu/ innovation-education/37425753.pdf

Clark, D. A., & Radomsky, A. S. (2014). Introduction: A global perspective on unwanted intrusive thoughts. *Journal of Obsessive-Compulsive and Related Disorders, 3*(3), Retrieved from http://www.sciencedirect.com/science/article/pii/S2211364914000128

Charles, S. T. & Almeida, D. M. (2007). Genetic and environmental effects on daily life stressors: More evidence for greater variation in later life. *Psychology & Aging, 22*(2), 331ï 340. Retrieved from http://psycnet.apa.org/psycinfo/2007-07952-01

Charles, S. T. & Carstensen, L. L. (2008). Unpleasant situations elicit different emotional responses in younger and older adults. *Psychology & Aging*, *23*(3), 495ï 504. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/18808240

Carlson, D. (2013*). Overcoming hurts and anger*. Eugene, Oregon: Harvest House Publishers.

Cheung, T., & Yip, P. S. F. (2015). Depression anxiety and symptoms of stress among Hong Kong Nurses: A cross-sectional study. *International Journal of Environmental Research and Public Health 12* 11072-11100.

Child Development Institute (2015). *Anger management for kids & parents*. Retrieved from https://childdevelopmentinfo.com/how-to-be-a-parent/angry_child/

Cohen, M. (2016). *Student guide to surviving stress and anxiety in college & beyond*. Retrieved from http://www.learnpsychology.org/student-stress-anxiety-guide/

Crossman, A. (2017). *How systematic sampling works*. Retrieved from https://www .thought co.com/systematic-sampling-3026732

Cohen, L., Manion, L., & Morrison, K. (2011). *Research Methods in Education (7th ed.).* Abingdon: Routledge.

CDC (2011). Sexuality, sex of sexual contacts and health risk behaviours among students in grades 9-12. *Morbidity and mortality Weekly Report (MMWR). Early Release 60*, 1-33. Retrieved from http://www.cdc.gov/mmwr/ pdf/ss/ss60eo606.pdf

Cutler, D. M. & Lleras-muney, A. (2008). Education and health: Evaluating theories and evidence.In Shoeni, R. F., House, J. S., Kaplan, G. A., & Pollack, H. (Eds). *Making Americans healthier*. Social and Economic Policy as Health Policy. New York. Russell :Sage Foundation. Retrieved from http://ssrn.com/absract=1752685

Deaton, A. & Kahneman, D. (2010). High income improves evaluation of life, but not emotional wellbeing: *Psychological and Cognitive Sciences, 107* (38). Retrieved from http://www.nchi.nlm.nih.gov/PMC/articles /PMC 2944762/.

Department of Health and Ageing (2010). *Identifying emotional and behavioural problems.* Retrieved from http://www.responseability .org/_data/assets/pdf _file/0009/4869/Identi fying-emotional-and-Behavioural-Problems.pdf.

Department of Health and Human Services (2013). *Social and emotional health of children birth to age 8*. Retrieved from https://www.michigan.gov/documents/mdch/A_Guide _for_Families_with_Children_Birth-8_Years_420515_7.pdf

Department of Sociology (2017). *Demography*. Retrieved from https://www.suda.su.se/educa tion/what-is-demography

Deeks, A., Lombard, C., Michelmore, J., & Teeds, I. T. (2009). The effects of gender and age on healthrelated behaviour. *PMC Public Health*, 1-9. Retrieved from http://www. ncbi.n lm. nih.gov/pmc/articles/PMC2713232/pdf/1471-2458-9-213.pdf

Dunn, E. W., Aknin, L. B., & Norton, M. I. (2008). Spending money on others promotes happiness. *Science, 319*(5870),1687-1688. Retrieved from http://www.ncbi.nlm.nih.gov /pubmed/18356530

Diamond, S. (2009*). Anger disorder: What it is and what we can do about it*. Retrieved from https://www.psychologytoday.com/blog/evil-deeds/200904/anger-disorder-what-it-is-and-what-we-can-do-about-it.

Day, A., Mohr, P., Howells, K., Gerace, A., & Lim, L. (2012). The role of empathy in anger arousal in violent offenders and university students. *International Journal of Offender Therapy and Comparative Criminology, 56*(4)*,* 599ï 613. Doi:10.1177/0306624X11 431061

Doran, G. (2018). *Child and adolescent mental health in sub-Saharan Africa*. Retrieved from https://borgenproject.org/mental-health-in-sub-saharan-africa-2/

Ekhator, V. E. (2003).*Rudiments of public administration*. Kaduna: Joyce Graphic Printers and Publishers.

Einerson, S., Hoel, H., Zapf, D., & Cooper, C. L (Eds.). (2003). *Bullying and emotional abuse in the workplace: International perspectives in research and practice.* New York: Taylor & Francis Inc.

European Alliance against Depression (2017). *What you need to know about depression*. Retrieved from https://ifightdepression.com/en/

Farrer, L. M., Gulliver, A., Bennett, K., Fassnacht, D. B., Kathleen, M., & Griffiths, E. (2016). Demographic and psychosocial predictors of major depression and generalised anxiety disorder in Australian University Students. *BMC Psychiatry, 16,* 241. Retrieved fromhttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC4946110/

Federal Republic of Nigeria Official Gazette (15 May 2007). *Legal notice on publication of the details of the breakdown of the National and State provisional totals 2006 Census.*Retrieved from https://en.wikipedia.org/wiki/Nsukka

Feinsten, L., Sarbates, R., Anderson, T. M., Sorhaindo, A., & Hammond, C. (2006). *Measuring the effects of education on health and civic engagement: Proceedings of Copenhagen Symposium*. Retrieved from https://www1.oecd.org/edu/innovation-education/37425753. pdf

Freedman, M. (2003*). Emotions and violence: Shame and rage in destructive conflicts.* Lexington, Mass: lexington Books.

Field, A. (2009). *Discovering statistics using SPSS: Introducing statistical methods 3rd Ed.* Retrieved from https://www.amazon.com/Discovering-Statistics-Introducing-Statistical-Methods/dp/1847879071

Folk, J., & Folk, M. (2016). *Depression*. Retrieved from https://www.nimh.nih.gov/health /topics/depression/index.shtml

Gangwar, H. (2017). *Psychological adaptation of stress*. Retrieved from https:// www.slideshare.net/hariomgangwar35/psychological-adaptation-of-stresspptx1-72163169R

Geddes, D., & Callister R. R. (2007). Crossing the line(s): A dual threshold model of anger In Organizations. *Academy of Management Review, 32*(3), 721-746. Retrieved from https://www.blinn.edu/counseling/Anger.pdf.

Glomb, T. M. (2002). Workplace anger and aggression: Informing conceptual models with data from specific encounters. *Journal of Occupational Health Psychology*, *7*, 20ï 36. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/11827231

Gureje, O., Uwakwe, R., Udofia, O. et al (2010). *Mental disorders among adults: A report of* the National Survey of Mental Health and Wellbeing.

Gutman, L. M., & Sameroff, A. J. (2004). Continues in depression from adolescence to young adulthood: Contrasting ecological influences. *Development and psychotherapy 16*. 967-984.

Hazelden Foundation (2016). Severe mental illness defined by duration and disability. Retrieved from http://www.bhevolution.org/public/severe_mental_illness.page

Hann, D. B., & Payne, W. A (2003). *Focus on Health (6th ed.)*. McGraw-Hill. U.S.A

Harris, P. L. (2000). Understanding emotion. In M. Lewis and J. M. Haviland-Jones (Eds.), *Handbook of Emotions* (2nd ed.) New York: Guilford.

Harvard Health Publication (2016). Mental health problems in the workplace http://www.health.harvard.edu/newsletter_article/mental-health-problems-in-the-workplace

Healthyplace (2015). *What is emotional health? And how to improve it?* Retrieved from http://www.healthyplace.com/other-info/mental-illness-overview/what-is-emotional-health-and-how-to-improve-it/

Healthy Children (2015). Anxiety disorders. Retrieved from https://www.healthychildren.org /English/health-issues/conditions/emotional-problems/Pages/Anxiety-Disorders.aspx

Henry, J. D., & Crawford, J. R. (2005). The short version of the Depression Anxiety Stress Scale (DASS-21): Construct validity and normative data in a Lage non-clinical sample. *BritishJournal of Clinical Psychology, 44*, 227-239.

Ivandic, I,, Kalmenov, K., Rojas, D., Ceron, G., Nowak, D., & Sabriego, C. (2017) Determinants of Work Performance in Workers with Depression and Anxiety. *International Journal of Environmental Research and Public Health.14.* 446.

Islam, R., & Adnan, R. (2017). Socio-demographic factors and their correlation with the severity of major depressive disorder: A population based study. *World Journal of Neuroscience 7*, 193-202.

Jackson, S. L. (2009). *Research methods and statistics: A critical thinking approach (3rd ed.)*. Belmont, CA, USA: Wadsworth, Cengage Learning.

Jacofsky, M. D., Santos, M. T., Khemlani-Patel, S., & Neziroglu, F. (2013). Separation anxiety national alliance on mental illness. 2016 *Mental Health Conditions* Retrieved from: *https://www.nami .org/Learn-More/Mental-Health-Conditions*

Jayasinghe, N., Giosan, C., Evans, S., Spielman, L., & Difede, J. (2008). Anger and posttraumatic stress disorder in disaster relief workers exposed to the 9/11/01 World Trade Centre Disaster: One-year follow-up study. *Journal of Nervous Mental Disorders196*(11). 844-846. Doi:10.1097/NMD.0b013e31818b492c

Jeanette, D. (2016). What is emotional health? An emotional health definition. Retrieved from http://www.drjeanette.com/emotionalhealth.html

Jon, M. W., Randy, L., & De Simone, J. (2009). *Human resource development*. 5(Ed.). New York: Cengage Learning.

Kahneman, D., & Deaton, A. (2010). *High income improves evaluation of life but no emotional well-being*. Retrieved from http://www.pnas.org/content/107/38/16489.full

Karasek, R. (1979). Job demands, job decision latitude and mental strain: Implications for job redesign. *Admin Sci24*, 285ï 308.

Kemeny, M. E., Folks, C., Cavanagh, J. F., Cullen, M., Giese-Davis, J., Jennings, P., Rosenberg, E., L., Gillath, O., Shaver, P. R., Wallace, B. A., Jennings, P., Erika L, Rosenberg., Gillath, O., Phillip R., Shaver, B., Wallace, A., & Ekman, P. (2002). Contemplative emotion training reduces negative emotional Behavior and Promotes Pro-social Responses. *Emotion*. Doi: 10.1037/a0026118.

Kelly, M. N., Tyrka, A. R., Anderson, G. M., Price, L. H & Carpenter, L. L. (2008). Sex differences in emotional and physiological responses to the Trier Social Stress.*Journal of Behavior Therapy and Experimental Psychiatry*. *39*(1), 87-98. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4467692/.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 62*(6)*,* 617-27.

Kuruvilla, A. and Jacob, K.S (2007). Poverty, stress, and mental health. *Indian Journal ofMedical Research 126(4).*273 ï 278. Retrieved fromhttp://www.ncbi.nlm.nih.gov/ pubmed/18032802

Koçer, E., Koçer, A. & Canan, F. (2011). Anger Management and Factors that Influence Anger in Physicians. *Balkan Medical Journal, 28*, 62-68. Retrieved from http://balkanmedical journal.org/sayilar/8/buyuk/pdf_TTF_423.pdf.

Kiveshnie, N., Christoff, J. B., & Christo, A. B. (2013). Causes of stress in public schools and its impact on work performance of educators. *Journal of Social Science, 34*(2)*,* 177-190. Retrieved from http://www.krepublishers.com/02-Journals/JSS/JSS-34-0-000-13-Web/JSS-34-2-000-13-Abst-PDF/JSS-34-2-177-13-1355-Bisschoff-C-A/JSS-34-2-177-13-1355-Bisschoff-C-A-Tx[9].pmd.pdf

Kwakye-Nuako, C. O., Okyerefo, A. A., & Dankwah, J. (2009). Marital status and other causes of stress among non-traditional female students combining work and study: the case of a private tertiary institution. *Ife Psychology IA*, *18*(1)*,* 236-*256. Retrieved from* http://www.iiste.org/Journals/index.php/GLOBUS/article/download/22962/23499

Lambard, M. Kathleen, A., Lee, Gary R., & DeMaris, A. (2003). Union formation and depression: Selection and relationship effects. *Journal of Marriage and Family*, *65*, 953-962. Retrieved from http://aspe.hhs.gov/hsp/07/marriageonhealth/index.htm

Lavrakas, P. J. (2008). Cross-Sectional Survey Design. In: Encyclopedia of Survey Research Methods**.** DOI:http://dx.doi.org/10.4135/9781412963947.n120

Lefkowitz, E. S. & Fingerman, K. L. (2003). Positive and negative emotional feelings and behaviors in mother-daughter ties in late life. *Journal of Family Psychology, 17*, 607ï 617. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/14640809

Life Extension (2016). *Anxiety.* Retrieved from http://www.lifeextension.com/protocols /emotional-health/anxiety/Page-01

Lovibond, S. H. &Lovibond, P. F. (1995). *Manual for the depression Anxiety Stress Scales*. (2nd. Ed.). Sydney: Psychology Foundation. Retrieved from *http://www2.psy.unsw. edu.au*/ dass/pub.html

Mackereth, C. J. (2010). *Emotional health and wellbeing: Strategy for National Health Scheme South of Tyne and Wear*. Gateshead South Tyneside and sunder land. Retrieved from http://www.gateshead.gov.uk/Document library /CBS/Polices and doc/Adutl-Social-cave-General/Emotional-Health-and-Wellbeing-Strategy 2010.pd.f.

Manaf , M. R. A., Mustafa, M., Rahman, M. R. A., Yusof, K. H., & Aziz, N. A. A. (2016). *Factors Influencing the Prevalence of Mental Health Problems among Malay Elderly Residing in a Rural Community: A Cross-Sectional Study.* Retrieved from http://dx.doi.org/10.1371/journal.pone.0156937.

Marsh, L. C. (2015). *What is anxiety*. National Association for Mental Health. Retrieved from http://www.mind.org.uk/media/1892482/mind-anxiety-panic-web.pdf.

McDiarmid, R. (2014). *Understanding mental health*. Retrieved from http://www.myhealthy livingcoach.com/difference-emotional-mental-health/j.

Mental Health Foundation (2008). *Boiling Point Problem: anger and what we can do about it*. Retrieved from https://www.mentalhealth.org.uk/sites/default/files/boilingpoint.pdf

Mental Health Foundation (2015). *Fundamental facts about mental health.* Retrieved from https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2015

Mental Health America (2016). *What is mental illness*. Retrieved from http://www.triadmentalhealth.org/what-is-mental-illness/.

Mental Health Foundation (2008). *Anger: a powerful emotion.* Retrieved from http://www.anger manage.co.uk/pdfs/cooldown.pdf

Meyer, J. (2016). *Dealing with anger Gods way.* Retrieved from http://www.joycemeyer.org/ articles/ea.aspx?article=dealing_with_anger_gods_way

Milanovic, S. M., Erjavec K., Poljicanin T., Vrabec, B., & Brecic, P. (2015). Prevalence of depression symptoms and associated socio-demographic factors in primary health care patients. *Psychiatria Danubina 27*(1). 31ï 37.

Mills, H., Reiss, N., & Dombeck, (2008). *Introduction and the nature of stress*. Retrieved from https://www.mentalhelp.net/articles/introduction-and-the-nature-of-stress/

Mills, H., Reiss, N. & Dombeck (2016). *Stress reduction and management*. Retrieved from http://www.rvcc-inc.org/poc/view_doc.php?type=doc&id=1229&cn=117c

Mills, H. (2015). *Psychology of anger*. Retrieved from https://www.mentalhelp.net/articles/ psychology-of-anger/

Mills, R., & Dombeck. (2008). Mental and emotional impact of Stress. Retrieved from https://www.mentalhelp.net/articles/mental-and-emotional-impact-of-stress/2016

Mohr, P., Howells, K., Gerace, A., Day. A., & Wharton, P. (2007). The role of perspective taking in anger arousal. *Personality and Individual Differences, 43* (3)*,* 507ï 517. doi:10.1016/j.paid.2006.12.019.

Moorhead, G., & Griffin, R. W. (2004). *Organisational behaviour: Managing people and organisations*. New Delhi: Jaico.

Moss, C. A. (2008). *Power of the five elements: Path to healthy aging and stress resistance.* Retrieved from http://northatindiabook s, wordpress.com.

National Institute of Health-NIH (2016). *Anxiety disorders*. Retrieved from https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml.

National Alliance on Mental Illness (2016). *Mental health conditions.* Retrieved from http://www.nami.org/learn-more/mental-Health-conditions

NAMI (2016). *Complementary health approaches*. Retrieved from http://www.nami.org/ Learn-More/Treatment/Complementary-Health-Approaches#mindandbodytreatments

NAMI (2015). *Anxiety disorders*. Retrieved from https://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorders/Treatment

National Alliance on Mental Illness (2016). *Mental health conditions.* Retrieved from http://www.nami.org/learn-more/mental-Health-conditions

National Association of Mental Health Institute (NAMI). (2016). *Mental health conditions.* Retrieved from https://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorderas/Treatment

National Library of Medicine (2014). *Depression*. Retrieved from *https://www.nlm.nih.gov/ medlineplus/depression.html#cat5*

National Population Comission, (2017). Enugu State. Retrieved from http://www.Population .gov.ng/index.php/enugu-state

Nisar, S., Uzair, A.,Khan, M. A., & Aktar, S. (2017). Association of depression with socio-demographic factors in patients undergoing hemodialysis. *Pakistan Armed Forces Medical Journal, 67* (2)*,* 232-37.

National Institute of Mental Health, (NIMH). (2016). *Depression*. Retrieved from https://www.nimh.nih.gov/health/topics/depression/index.shtml.

Odedokun, S. A. (2015). Differential Influence of Demographic Factors on Job Burnout among Police Officers in Ibadan, Oyo State. *Mediterranean Journal of Social Sciences, 6*(3). doi:10.5901/mjss.2015.v6n3s1p520

Ofuebe, J. I. (2014). *Emotional health problems and coping strategies of academic staff in University of Nigeria Nsukka.* Department of Human Kinetics and Health Education. A Published Thesis.

Ojua, T. A., Ishor, D. G., & Ndom, P. J. (2013). African Cultural Practices and Health Implications for Nigeria Rural Development. *International Review of Management and Business Research, 2*(1) 176-183. Retrieved from http://irmbrjournal.com/papers/1367 572222.pdf

Okyerefo, A. A. & Dankwah, J. (2009). Marital status and other causes of stress among nontraditional female students combining work and study: The case of a private tertiary institution. *Ife PsychologyIA*, *18* (1).

Okezie, S. O. & Obi, E. A. (2004). *Public Administration in Nigeria: A Development Approach.* Onitsha: Book Point Ltd

Okwor, F, A. & Rhode, F. E. (2012). Influence of demographic factors on stress perceptions of teachers of public secondary schools in Cameroon. *Social and Behavioral Sciences, (47),* 439 ï 443. Doi:10.1016/j.sbspro.2012.06.677

Oswald, A. J., & Wilson., C. M. (2005). *How does marriage affect physical and psychological health? A survey of the longitudinal evidence.* Retrieved from http://ftp.iza.org/dp 1619.pdf

Oyewunmi, A. E, Oyewunmi, O. A, Iyiolo, O. O., & Ojo, A.Y. (2015). Mental health and the Nigerian work place: fallacies, facts and the way forward. *International Journal if Psychology and Counselling, 7*(7), 106-111. DOI: 10.5897/IJPC2015.0317.

Oyewunmi O. A & Oyewunmi A. E. (2014). Collective bargaining in Nigeriaôs public health sector: Evidence for an inclusive approach. *Res. Human and Social Sciences 4*(23). 20-26. Retrieved from http://www.iiste.org/Journals/index.php/RHSS/article/view/16906

Oyewunmi, A. E., Oyewunmi, O. A,. Iyiola, O. O., & Ojo, A. Y. (2015). Mental health and the Nigerian workplace: Fallacies, facts and the way forward. *International Journal if Psychology and Counselling 7(7),* 106 ï 111.

Pagan, C. N. (2012). *What your anger style says about you*. Retrieved from http://www.prevention.com/mind-body/emotional-health/what-your-anger-style-says-about-you

Park, H. (2013). An introduction to logistic regression: From basic concepts to interpretation with particular attention to nursing domain. *Journal of Korean Academic Nurse 43*(2), 154-164. Retrieved from https://pdfs.semanticscholar.org/3305/2b1d23 63aee3ad290 6121 dcea0aed2a89e.pdf

Peters, M. (2008). *A-Z family medial Encyclopedia* (5th). London; Dorling Kindersley Limited.

Pietrangelo, A. (2015). *Depression and mental health by the Numbers: Facts, statistics, and you*. Retrieved from https://www.healthline.com/health/depression/facts-statistics-infographic#1

Posternak, M. A. & Zimmerman (2015). Anger and aggression in psychiatric outpatients. *Psychiatria Danubina 27*(1). 31-37. Retrieved from https://www.ncbi.nlm.nih. gov/pu bmed/12197446

Polikandrioti, M., Goudevenos, J., Michalis, L. K., Koutelekos, J., Tzialas, D., & Elisaf, M., (2015). Factors associated with depression and anxiety of hospitalized patients with heart failure. *Hellenic Journal of Cardiology, 56(1),* 26-35. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/25701969

Prophet, M. (2012). Emotional health. Retrieved from https://clubfnh.wordpress.com/tag/ emotionnal-health/

Psychguides (2016). *Mental health problems*. Retrieved from http://www.psychguides.com /guides/mental-health-problem-symptoms-causes-and-effects/

Psych Guides (2016). *Anger symptoms, causes and effects.* Retrieved from http://www .psychguides.com/guides/anger-symptoms-causes-and-effects/

Rashmi, N., Reiss, N. S., & Dombeck, M. (2015). *Major depression and other unipolar depressions.* Retrieved from http://www.mentalhelp.net/article/classic-symptoms-of-major-depression/

Rahman, A., Bairagi, A., & Dey, B. K. (2014). The effect of socio-economic status and gender on adolescent anger in Chittagong**.** *Journal of Humanities and Social Sciences 19*(3)*,* 63-68.

Rashmi, N., Reiss, N. S., & Dombeck, M. (2015). *Major depression and other unipolar depressions*. Retrieved from http://www.mentalhelp.net/article/classic-symptoms-of-major-depression/

Research Method in Psychology, (2017). *Stratified Random Sample: Example & Definition.* Retrieved from http://study.com/academy/lesson/stratified-random-sample-example-defini tion-quiz.html

Rivers, E. (2016). *Seven healthy ways you can deal with your anger, control your temper*. Retrieved from http://www.radar.ng/2016/05/7-healthy-ways-you-can-deal-with-your. html

Robbins, T. (2003). *Developing effective school management*. London: Routledge.

Robles, T. F., Slatcher, R. B., Trombello, J. M., & McGinn, M. M. (2014). Marital Quality and health: Meta-Analytic Review. *Psychological Bulletin, 140*(1)*,*http://www.ncbi .nlm.nih *.gov /pubmed/23527470*

Samiksha, S. (2015). *Social processes: The meaning, types, characteristics of social processes.* Retrieved from http://Www.Yourarticlelibraty.Com/Sociology/Social-Processes-The-Meaning-Types-Character istics-of-social-processeses/8545/.

SaIeedH. M. (2015). Killing us softly: The deadly impact of work-related stress https://www.Lin kedin.com/pulse/killing-us-softly-deadly-impact-work-related-stress-m-

Sareen, J., Afifi, T. O., McMillian, K. A., & Asmondson, G. J. G. (2011). Relationship between household income and mental disorders findings from a population-based Longitudinal Study. *Archives of General Psychiatry*, *68(4).,* 419-427. doi:10.1001/archgen psychiatry.2011.15

Sedgeman, I. A. (2005). Health realization/innate health: Can a quiet mind and a posits feeling state be accessible over the lifespan without stress-relief techniques. *Medical Science-Monitor, 11*(12) 47-52. Retrieved from http://www.3pgc.org/downloads/pdf/ Published _MedSciMonit.pdf

Segal, J; & Smith, M. (2016). *Controlling anger before it controls you.* Retrieved from http://www-helpguide.org/article/emotional-health/anger-management.htm

Science Process Skill (2012). *What is a prediction*? Retrieved from https://elsag hirscience.weebly.com/predicting.html

Scott, E. (2016). *Anger problems: Effects of poorly managed anger.* Retrieved from https://www.verywell.com/how-anger-problems-can-affect-your-health-3145075

Shavers, C. A. (2014). Commentary: Emotional problems and depression among children and adolescents in todayôs society. *Open Journal of Depression, 3,* 74-87. http://dx.doi.org/10.4236/ojd.2014.32012

Silove, D., Rees, S., Tam, N., Mohsin, M., Tay, A. K., & Tol, W. (2015). Prevalence and correlates of explosive anger among pregnant and post-partum women in post-conflict Timor-Leste. *BJPsych Open 1*34ï 41. doi: 10.1192/bjpo.bp.115.000190.

Smith, M. A., Robinson C., & Segal, J. (2016). *Anxiety disorders and anxiety attack.* Retrieved from http://www.helpguide.org/articles/anxiety/anxiety-attacks-and-anxiety-disorders.htm

Smith, M., Segal, R., & Segal, J. (2016). .*Improving emotional health*. Retrieved from http://www.helpguide.org articles/emotional health/improving-emotional.htm

Smith, S. & Segal, (2016). Depression symptoms and warning signs. Retrieved http://www.helpguide.org/articles/depression/depression-signs-and-symptoms.htm

Sociology Guide (2016). *Social structure*. Retrieved from http://www.sociologyguide.com/ social-structure

Spielberger, C. D. (1999). *State-trait Anger Expression Inventory-2 (STAXI-2). Professional Manual.* Tampa. FL. Psychological Assessment Resources.

Statistic Brain Research Institute (2015). *Depression demographic breakdown*. Us Census Bureau, Center for Disease Control and Prevention (CDCP). Retrieved from http://www.statisticbrain.com/depression-ststistic/

Story, T. N., Berg, C. A., Smith, T. W., Beveridge, R., Henry, N. J. M., & Pearce, G. (2007). Age, marital satisfaction, and optimism as predictors of positive sentiment override in middle aged and older married couples. *Psychology and Aging*, *24*(4)*,* 719ï 727. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/18179292

Smith, K. (2015). *How to deal with anger*. Retrieved from http://psychcentral.com/blog/archives/2015/03/26/how-to-deal-with-anger/.

Sincero, S. M. (2012). *James-Lange theory of emotion.* Retrieved from https://explorable.com/james-lange-theory-of-emotion.

Solomon, R. L. (1980). The opponent-process theory of acquired motivation: the costs of pleasure and the benefits of pain. *American Psychologist*: *35 (8)*, 691ï 712. doi:10.1037/0003-066X.35.8.691.

Stoetzer, U. (2010). *Interpersonal Relationships at Work.* Retrieved from https://openarchive.ki.se/xmlui/bitstream/handle/10616/39545/thesis.pdf?sequence=1.

Shittu, R. O., Odeigah, L. O., Issa, B. A., Olanrewaju, G. T., Mahmoud, A. O., Sanni, M. A (2014). Association between depression and social demographic factors in a Nigerian family practice setting. *Open Journal of Depression, 3*(1)*,* 18-23.

Stanton, G. (2012). The *health benefits of marriage*. Retrieved from http://www.focusonthefamily.com/about/focus-findings/marriage/health-benefits-of-*marriage.*

Science News (2000). *Comparison of anger expression in men and women reveals surprising Differences. San Francisco*. Retrieved from https://www.sciencedaily.com/releases/2000/01/000131075609.htm

Snell, W. E., Jr., Gum, S., Shuck, R. L., Mosley, J. A., & Hite, T. L. (1995). The clinical anger scale: Preliminary reliability and validity. *Journal of Clinical Psychology, 51,* 215-226.

Singh, A. & Misra, N. (2009). Loneliness, depression and sociability in old age. *Indian Psychiatry Journal, 18*(1), 51ï 55. Doi:10.4103/092-6748.5786.1.

Sotodehasl, N., Malek, F., & Tamadon, M. R. (2015). Vitamin D deficiency and depression: A short review article. *Middle East Journal of Rehabilitation Health, 2*(3) 26-61. Doi:10.17795/Mejrh-26961.

Scott, E. (2016). *Anger problems: effects of poorly managed anger.* Retrieved from https://www.verywell.com/how-anger-problems-can-affect-your-health-3145075

Statistics Solutions (2018). *Complete dissertation*. Retrieved from http://www.statistics solutions.com/using-chi-square-statistic-in-research/

The Australian Psychological Society (2016). *Anxiety*. Retrieved from https://www.psychology.org.au/publications/tip_sheets/anxiety/

The British Psychological Society & the Royal College of Psychiatrists (2011).*Common mental health disorders: Identification and pathways to care.* Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK92254/.

The National Institute of Mental Health (2008). Harvard work outcomes research and cost-effectiveness study. *Journal of Occupational and Environmental Medicine, 50*(4), 468ï 75.

Thornicroft, G., Rose, D., & Hassam, M. (2007). Discrimination in health care against people with mental illness. *International Review of Psychiatry, 19*(2), 113-22. DOI:10.1080/09540260701278937.

Thompson, D. (2010). *Gender differences in emotional health.* Retrieved from http://www.everydayhealth.com/emotional-health/gender-differences-in-emotional-health.aspx.

Tinubu (2016, March 12). 48 Million Nigerians Suffer depression. *Daily Trust Newspapers*.

Travasso, S. M., Rajaraman, D., & Heymann, S. J. (2014). *A qualitative study of factors affecting mental health amongst low-income working mothers in Bangalore, India*. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3922014/. Doi: 10.1186/1472-6874-14-22.

The Australian Psychological Society (2016). *Anxiety*. Retrieved from https://www. psychology.org.au/publications/tip_sheets/anxiety/.

Videbeck., & Sheila, L.(2006). *Psychiatric mental health nursing (3rd ed.).* Lippincott.

Vogyl, T. S. (2012). *Education and health in developing economies*. Retrieved from http://www.princeton.edu/~tvogl/vogl_ed_health_review.pdf

Wadsworth, T. (2007). *Stress management for life: A Research-Based, Experiential Approach.* Retrieved from http://wmhp.cmhaontario.ca/wordpress/wp-content/uploads /2010/03/ WMHP-Guide-Final1.pdf

WHO (2017). *Depression.* Retrieved fromhttp://www.searo.who.int/entity/world_ health _day/2017/depression-factsheet.pdf?ua=1

WHO (2003). *Investing in mental health.* Retrieved from http://www.who.int/metalhealth/ media/investing-mnh.pdf

World Health Organization (2004). *Prevention of mental disorders.* Retrieved from http://www.who.int/mental /evidence/en/prevention_of_mental_disorders_sr.pdfs

WHO (2013). *WHO fact sheets*. Retrieved from http://www.who.int/mediacentre/actsheets /fs396/en/

Woldetsadik, M. A. (2015). *Health care in Sub-Saharan Africa: Challenges and opportunities*. Retrieved from https://www.rand.org/blog/2015/03/mental-healthcare-in-sub-saharan-africa-challenges.html

Winconson Physicians Service Insurance Corporation(2016). *Mental and emotional health problems*. Retrieved fromhttps://provider.tricare4u.com/apps-portal/tricareapps app/static/ healthyliving/mentalemotionalheal thproblems.htm

Yamane, T. (1967). *Statistics: An introductory analysis*, (2nd Ed). New York. Harper & Row.

Yates, W. R. (2016). Anxiety disorders treatment & management. Retrieved from https://www.psychology.org.au/publications/tip_sheets/anxiety/

Yahaya, S.T., Yusoff, M. S. B., Yasin, M.A.M., Wahab, S.F.A (2018*) Prevalence and Associated Factors of Stress, Anxiety and Depression among Emergency Medical Officers in Malaysian Hospitals.* Retrieved from https://www.researchgate.net/publication/324909621_Prevalence_and_Associated_Factors_of_Stress_Anxiety_and_Depression_among_Emergency_Medical_Officers_in_Malaysian_Hospitals

Zimmerman, E. B., Steven, H., Woolf., & Amber .H. (2015). Understanding the relationship Between education and health: A review of the evidence and an examination of U community perspectives. Retrieved from http://www.ahrq.gov/professionals/ education/ curriculum-tools/population-health/zimmerman.html

APPENDIX A

DEPRESSION ANXIETY STRESS AND ANGER SCORE (DASAS) QUESTIONNAIRE

Department of Human Kinetics and Health Education,
Faculty of Education
University of Nigeria
Nsukka
Enugu State.
April 2017.

Dear Sir/Madam,

REQUEST FOR COMPLETION OF RESEARCH QUESTIONNAIRE

I am a student of the above mentioned university, carrying out a research on the **Socio-demographic Predictors of Emotional Health Problems among Civil Servants in Nsukka LGA of Enugu State.** This is in partial fulfillment of the award of M.Ed. degree in Mental and Emotional Health in the above named university.

You are please requested to complete the attached questionnaire to the best of your knowledge as the information sought for are purely for academic purpose. Any information supplied by you would be treated with the strictest confidence.

Thanks,

Yours faithfully,

Elufidipe-Olumide, Happiness A.

PG/M.Ed./14/67316

Kindly fill the questionnaire honestly as possible as any information give here will be treated as confidential and will be used strictly for the purpose of this study.

Section A: Respondent Bio data

Please complete the following information below by ticking ( ) appropriately.

1. Which of the following best describes your age group?
   a. 20-39 years ( )
   b. 40-59 years ( )
   c. 60 years and above( )

2. What is your current level of education
   a. Primary ( )
   b. Secondary ( )
   c. Tertiary ( )

3. What is your level of Income?
   a. Grade Level 1-5 ( )
   b. Grade Level 6-9 ( )
   c. Grade Level 10 and above ( )

SECTION B: Depression Anxiety Stress Scale-21 (DASS-21)

Please read each of the following statements and circle 0, 1, 2, 3 which indicate how much the statement applied to you over the past weeks. There are no right or wrong answers. Do not spend too much time on each statement.

The rating scale is as follows:

0 Did not apply to me at all-NEVER.

1 Applied to me to some degree, or some of the time-SOMETIMES.

2 Applied to me to a considerable degree, or good part of the time-OFTEN.

3Applied to me very much, or most of the time-ALMOST ALWAYS.

N SOAA

1	I could not seem to experience any positive feeling at all.	0	1	2	3
2	I found it difficult to work up to work up the initiative to do all things.				
3	I felt that I have nothing to look forward to.				
4	I felt down hearted and blue.				
5	I was unable to become enthusiastic about anything.				
6	I felt I was not much as a person.				
7	I felt that life was meaningless.				
8	I was aware of dryness in my mouth.				
9	I experienced breathing difficulty (e.g. excessive rapid breathing, breathlessness in the absence of physical exertion)				
10	I experienced trembling.				
11	I was worried about situations in which I might panic and make a fool of myself.				
12	I felt I was close to panic.				
13	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing beat).				
14	I felt scared without any good reason.				
15	I found it difficult to wind down.				
16	I tended to overreact to situations.				
17	I felt that I was using a lot of nervous energy.				
18	I found myself getting agitated.				
19	I found it difficult to relax.				

20	I was intolerant of anything that kept me from getting on with what I am doing.				
21	I felt I was rather touchy.				

SECTION C:

Clinical Anger Scale (CAS)

FEELINGS INVENTORY INSTRUCTIONS: The group of items below inquire about the types of feelings you have. Each of the 21 groups of items has four options.

For example, ITEM 99.... A. I feel fine.

B. I don't feel all that well.

C. I feel somewhat miserable.

D. I feel completely miserable.

For each cluster of items, read and identify the statement that best reflects how you feel. For example, you might choose A in the above example. If so, then you would darken in the letter (A) on the answer sheet next to the item number associated with that group of statements. In this example, that item number would have been "99."

PLEASE BE HONEST IN RESPONDING TO THE STATEMENTS.

1. ..... A. I do not feel angry.

B. I feel angry.

C. I am angry most of the time now.

D. I am so angry and hostile all the time that I can't stand it.

2. ..... A. I am not particularly angry about my future.

B. When I think about my future, I feel angry.

C. I feel angry about what I have to look forward to.

D. I feel intensely angry about my future, since it cannot be improved.

3. ..... A. It makes me angry that I feel like such a failure.

B. It makes me angry that I have failed more than the average person.

C. As I look back on my life, I feel angry about my failures.

D. It makes me angry to feel like a complete failure as a person.

4. ..... A. I am not all that angry about things.

B. I am becoming more hostile about things than I used to be.

C. I am pretty angry about things these days.

D. I am angry and hostile about everything.

5. ..... A. I don't feel particularly hostile at others.

B. I feel hostile a good deal of the time.

C. I feel quite hostile most of the time.

D. I feel hostile all of the time.

6. ..... A. I don't feel that others are trying to annoy me.

B. At times I think people are trying to annoy me.

C. More people than usual are beginning to make me feel angry.

D. I feel that others are constantly and intentionally making me angry.

7. ..... A. I don't feel angry when I think about myself.

B. I feel more angry about myself these days than I used to.

C. I feel angry about myself a good deal of the time.

D. When I think about myself, I feel intense anger.

8. ..... A. I don't have angry feelings about others having screwed up my life.

B. It's beginning to make me angry that others are screwing up my life.

C. I feel angry that others prevent me from having a good life.

D. I am constantly angry because others have made my life totally miserable.

9. ..... A. I don't feel angry enough to hurt someone.

B. Sometimes I am so angry that I feel like hurting others, but I would not really do it.

C. My anger is so intense that I sometimes feel like hurting others.

D. I'm so angry that I would like to hurt someone.

10. .....A. I don't shout at people any more than usual.

B. I shout at others more now than I used to.

C. I shout at people all the time now.

D. I shout at others so often that sometimes I just can't stop.

11. .....A. Things are not more irritating to me now than usual.

B. I feel slightly more irritated now than usual.

C. I feel irritated a good deal of the time.

D. I'm irritated all the time now.

12. .....A. My anger does not interfere with my interest in other people.

B. My anger sometimes interferes with my interest in others.

C. I am becoming so angry that I don't want to be around others.

D. I'm so angry that I can't stand being around people.

13. .....A. I don't have any persistent angry feelings that influence my ability to make decisions.

B. My feelings of anger occasionally undermine my ability to make decisions.

C. I am angry to the extent that it interferes with y making good decisions.

D. I'm so angry that I can't make good decisions anymore.

14. .....A. I'm not so angry and hostile that others dislike me.

B. People sometimes dislike being around me since I become angry.

C. More often than not, people stay away from me because I'm so hostile and angry.

D. People don't like me anymore because I'm constantly angry all the time.

15. .....A. My feelings of anger do not interfere with my work.

B. From time to time my feelings of anger interfere with my work.

C. I feel so angry that it interferes with my capacity to work.

D. My feelings of anger prevent me from doing any work at all.

16. .....A. My anger does not interfere with my sleep.

B. Sometimes I don't sleep very well because I'm feeling angry.

C. My anger is so great that I stay awake 1ð 2 hours later than usual.

D. I am so intensely angry that I can't get much sleep during the night.

17. .....A. My anger does not make me feel anymore tired than usual.

B. My feelings of anger are beginning to tire me out.

C. My anger is intense enough that it makes me feel very tired.

D. My feelings of anger leave me too tired to do anything.

18. .....A. My appetite does not suffer because of my feelings of anger.

B. My feelings of anger are beginning to affect my appetite.

C. My feelings of anger leave me without much of an appetite.

D. My anger is so intense that it has taken away my appetite.

19. .....A. My feelings of anger don't interfere with my health.

B. My feelings of anger are beginning to interfere with my health.

C. My anger prevents me from devoting much time and attention to my health.

D. I'm so angry at everything these days that I pay no attention to my health and well-being.

20. ..... A. My ability to think clearly is unaffected by my feelings of anger.

B. Sometimes my feelings of anger prevent me from thinking in a clear-headed way.

C. My anger makes it hard for me to think of anything else.

D. I'm so intensely angry and hostile that it completely interferes with my thinking.

21. .....A. I don't feel so angry that it interferes with my interest in sex.

B. My feelings of anger leave me less interested in sex than I used to be.

C. My current feelings of anger undermine my interest in sex.

D. I'm so angry about my life that I've completely lost interest in sex.

APPENDIX B

LETTER OF INTRODUCTION FROM THE HEAD OF DEPARTMENT

UNIVERSITY OF NIGERIA, NSUKKA
DEPARTMENT OF HUMAN KINETICS & HEALTH EDUCATION
'mens sana in corpore sano'
Vice-Chancellor: **Professor Benjamin Chukwuma Ozumba,** MD, FRCOG, FACOG, FACS

Our Ref.

UN/FE/HKE/S.19

June 6, 2018

TO WHOM IT MAY CONCER

INFORMATION ON FIELD WORK

The bearer, **ELUFIDIPE-OLUMIDE. Happsiness A.** with Registration Number; **PG/M.Ed/13/67316** is a bona fide Postgraduate student of the Department of Human Kinetics and Health Education, University of Nigeria, Nsukka. She is presently carrying out a study on: **Socio-demographic Predictors of Emotional Health Problems among Civil Servants in Nsukka L.G.A. of Enugu State.**

This is to request your kind cooperation to enable her have access to information in your Institution/Office and provide her with other forms of assistance that may be required.

Thank you.

DEPT. OF HUMAN KINETICS & HEALTH EDUCATION
6 JUN 2018
UNIVERSITY OF NIG
NSUKKA

Professor Joshua E. Umeifekwem
Head of Department

Head of Department: **Professor Joshua E. UMEIFEKWEM** JP, MNAE, MICHPER.SD, MICSSPE, MNAPHER.SD, MNASSM

APPENDIX C

POPULATION/SAMPLE SIZE

Calculation for the Sample Size of the Study

Taro Yamaneôs Formula:

$$n = \frac{N}{1+N\,(e)^2}$$

n=Sample size

N=Population (959)

e= Level of Confidence (0.05)

$$n = \frac{959}{1+959(0.05)^2}$$

$$n = \frac{959}{1+959(0.0025)}$$

$$n = \frac{959}{1+\ 2.3975}$$

$$n = \frac{959}{3.3975}$$

n= 282.26

APPENDIX D

The following symptoms of anger were measured by the CAS items: anger now, anger about the future, anger about failure, anger about things, angry-hostile feelings, annoying others, angry about self, angry misery, wanting to hurt others, shouting at people, irritated now, social interference, decision interference, alienating others, work interference, sleep interference, fatigue, appetite interference, health interference, thinking interference, and sexual interference.

Table 1

Psychometric Properties of the Clinical Anger Scale (CAS)

Clinical Anger Scale Item-Labels	Item-Total Correlations B	M	F	Factor Analysis Loadings Both I	II	Males I	II	III	Females I	II	III
1.Angry now	.74	.83	.68	.76	.23	.59	.55	.31	.75	.22	.19
2.Angry About Future	.70	.74	.65	.60	.37	.36	.77	.24	.55	.20	.41
3.Angry About Failure	.13	.19	.11	.01	.23	.20	.12	.00	-.00	.02	.23
4.Angry About Things	.75	.83	.70	.77	.25	.59	.47	.37	.77	.26	.17
5.Angry-Hostile Feelings	.79	.88	.72	.85	.21	.68	.52	.31	.69	.51	.03
6.Annoying Others	.54	.53	.52	.48	.26	.12	.29	.65	.37	.43	.11
7.Angry About Self	.62	.58	.64	.54	.33	.26	.34	.50	.61	.15	.36

8.Others Cause My Misery	.56	.59	.53	.48	.30	.30	.60	.15	.32	.37	.28
9.Want to Hurt Others	.60	.68	.55	.53	.32	.40	.53	.30	.21	.61	.18
10.Shout At People	.66	.79	.57	.68	.24	.76	.26	.32	.50	.45	.04
11.Irritated Now	.67	.76	.60	.58	.36	.58	.46	.27	.48	.28	.28
12.Social Interference	.57	.58	.59	.46	.38	.24	.35	.48	.31	.55	.20
13.Decision Interference	.73	.80	.68	.52	.55	.60	.36	.43	.30	.51	.44
14.Alienating Others	.76	.83	.70	.73	.31	.77	.31	.32	.58	.45	.17
15.Work Interference	.68	.72	.64	.49	.51	.64	.42	.17	.29	.45	.46
16.Sleep Interference	.69	.76	.63	.42	.63	.51	.36	.47	.33	.25	.63
17.Fatigue	.74	.78	.73	.65	.41	.65	.34	.35	.55	.45	.29
18.Appetite Interference	.59	.65	.58	.34	.59	.66	.14	.29	.26	.24	.60
19.Health Interference	.71	.83	.63	.54	.51	.62	.39	.43	.31	.44	.42
20.Thinking Interference	.63	.76	.56	.41	.54	.54	.38	.40	.14	.52	.40
21.Sexual Interference	.60	.55	.65	.44	.44	.29	-.05	.84	.41	.33	.42
Alpha	.94	.95	.92	.--	.--	.--	.--	.--	.--	.--	.--
Standardized Item Alpha	.94	.96	.93	.--	.--	.--	.--	.--	.--	.--	.--
Eigenvalue	.--	.--	.--	9.53	.59	11.33	.93	.60	8.71	.88	.57
Per cent of Variance	.--	.--	.--	45.40	2.80	54.00	4.40	2.80	41.50	4.20	2.70

Note.N for both males and females = 379; *n* for males = 95; *n* for females = 280. B = both males and females; M = males; F = females. Loading greater than |.50| are

underlined.https://www.researchgate.net/publication/230166706_The_

Clinical_Anger_Scale_preliminary_reliability_and_validity.

Clinical Anger: Construct, Measurement, Reliability, and Validity

William E. Snell, Jr. Scott Gum, Roger L. Shuck, Jo A. Mosley, and Tamara L. Hite 2017

FEELINGS INVENTORY INSTRUCTIONS: The group of items below inquire about the types of feelings you have. Each of the 21 groups of items has four options.

For example, ITEM 99 .... A. I feel fine.
B. I don't feel all that well.
C. I feel somewhat miserable.
D. I feel completely miserable.

For each cluster of items, read and identify the statement that best reflects how you feel. For example, you might choose A in the above example. If so, then you would darken in the letter (A) on the answer sheet next to the item number associated with that group of statements. In this example, that item number would have been "99."

Now go ahead and answer the questions on the answer sheet. Be sure to answer every question, even if you're not sure, and use a #2 pencil. Make sure you select only one statement from each of the 21 clusters of statements.

PLEASE BE HONEST IN RESPONDING TO THE STATEMENTS.

---

1. ..... A. I do not feel angry.
B. I feel angry.
C. I am angry most of the time now.
D. I am so angry and hostile all the time that I can't stand it.
2. ..... A. I am not particularly angry about my future.
B. When I think about my future, I feel angry.
C. I feel angry about what I have to look forward to.
D. I feel intensely angry about my future, since it cannot be improved.
3. ..... A. It makes me angry that I feel like such a failure.
B. It makes me angry that I have failed more than the average person.
C. As I look back on my life, I feel angry about my failures.
D. It makes me angry to feel like a complete failure as a person.
4. ..... A. I am not all that angry about things.
B. I am becoming more hostile about things than I used to be.
C. I am pretty angry about things these days.
D. I am angry and hostile about everything.
5. ..... A. I don't feel particularly hostile at others.
B. I feel hostile a good deal of the time.
C. I feel quite hostile most of the time.
D. I feel hostile all of the time.
6. ..... A. I don't feel that others are trying to annoy me.
B. At times I think people are trying to annoy me.
C. More people than usual are beginning to make me feel angry.
D. I feel that others are constantly and intentionally making me angry.

7. ..... A. I don't feel angry when I think about myself.
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8. ..... A. I don't have angry feelings about others having screwed up my life.
   B. It's beginning to make me angry that others are screwing up my life.
   C. I feel angry that others prevent me from having a good life.
   D. I am constantly angry because others have made my life totally miserable.
9. ..... A. I don't feel angry enough to hurt someone.
   B. Sometimes I am so angry that I feel like hurting others, but I would not really do it.
   C. My anger is so intense that I sometimes feel like hurting others.
   D. I'm so angry that I would like to hurt someone.
10. .....A. I don't shout at people any more than usual.
   B. I shout at others more now than I used to.
   C. I shout at people all the time now.
   D. I shout at others so often that sometimes I just can't stop.
11. .....A. Things are not more irritating to me now than usual.
   B. I feel slightly more irritated now than usual.
   C. I feel irritated a good deal of the time.
   D. I'm irritated all the time now.
12. .....A. My anger does not interfere with my interest in other people.
   B. My anger sometimes interferes with my interest in others.
   C. I am becoming so angry that I don't want to be around others.
   D. I'm so angry that I can't stand being around people.
13. .....A. I don't have any persistent angry feelings that influence my ability to make decisions.
   B. My feelings of anger occasionally undermine my ability to make decisions.
   C. I am angry to the extent that it interferes with my making good decisions.
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   C. More often than not, people stay away from me because I'm so hostile and angry.
   D. People don't like me anymore because I'm constantly angry all the time.
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   B. From time to time my feelings of anger interfere with my work.
   C. I feel so angry that it interferes with my capacity to work.
   D. My feelings of anger prevent me from doing any work at all.
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   B. Sometimes I don't sleep very well because I'm feeling angry.
   C. My anger is so great that I stay awake 1ð 2 hours later than usual.
   D. I am so intensely angry that I can't get much sleep during the night.
17. .....A. My anger does not make me feel anymore tired than usual.
   B. My feelings of anger are beginning to tire me out.
   C. My anger is intense enough that it makes me feel very tired.
   D. My feelings of anger leave me too tired to do anything.
18. .....A. My appetite does not suffer because of my feelings of anger.
   B. My feelings of anger are beginning to affect my appetite.
   C. My feelings of anger leave me without much of an appetite.
   D. My anger is so intense that it has taken away my appetite.
19. .....A. My feelings of anger don't interfere with my health.
   B. My feelings of anger are beginning to interfere with my health.
   C. My anger prevents me from devoting much time and attention to my health.
   D. I'm so angry at everything these days that I pay no attention to my health and well-being.
20. .....A. My ability to think clearly is unaffected by my feelings of anger.
   B. Sometimes my feelings of anger prevent me from thinking in a clear-headed way.
   C. My anger makes it hard for me to think of anything else.
   D. I'm so intensely angry and hostile that it completely interferes with my thinking.

21. .....A. I don't feel so angry that it interferes with my interest in sex.
B. My feelings of anger leave me less interested in sex than I used to be.
C. My current feelings of anger undermine my interest in sex.
D. I'm so angry about my life that I've completely lost interest in sex.

Scoring Instructions for the Clinical Anger Scale (CAS):

The Clinical Anger Scale: Construct, Measurement, Reliability, and Validity.

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Abstract

The purpose of the present investigation was to develop and validate an objective self-report instrument, the Clinical Anger Scale (CAS), designed to measure the syndrome of clinical anger. Several specific analyses were conducted to examine the psychometric properties of the Clinical Anger Scale (CAS). Factor analysis was conducted to examine the factorial validity of the instrument, and reliability coefficients were computed to examine the internal consistency and stability of the CAS. Also, in addition to providing evidence for the convergent and divergent validity of the CAS, an ancillary purpose of the present study was to provide preliminary evidence for its validity by examining some personality, psychopathological symptomology, behavioral, and family environmental correlates of clinical anger. Factor analysis of the Clinical Anger Scale confirmed essentially a unidimensional item structure; reliability analyses also demonstrated adequate alphas (i.e., internal consistency) and test-retest coefficients (i.e., stability) for the CAS; and other results indicated that the CAS was unrelated to social desirability influences. Additional findings indicated that clinical anger was positively associated with several anger-related concepts (e.g., trait anger, state anger, anger-in, anger-out, anger-control). Other results showed that the Clinical Anger Scale was related in predictable ways to men's and women's psychological symptoms, personality traits, and early family environments. These results are discussed in terms of the need to distinguish and to investigate the concept of clinical anger and its therapeutic treatment.

Method

An objective self-report instrument--the Clinical Anger Scale (CAS)--was designed to measure the psychological symptoms presumed to have relevance in the understanding and treatment of clinical anger. Twenty-one sets of statements were prepared for this purpose. In writing these groups of items, the format from one of Beck's early instruments was used to design the Clinical Anger Scale (Beck et al., 1961; Beck, 1963, 1967). The following symptoms of anger were measured by the CAS items: anger now, anger about the future, anger about failure, anger about things, angry-hostile feelings, annoying others, angry about self, angry misery, wanting to hurt others, shouting at people, irritated now, social interference, decision interference, alienating others, work interference, sleep interference, fatigue, appetite interference, health interference, thinking interference, and sexual interference. Subjects were asked to read each of the 21 groups of statements (4 statements per group) and to select the single statement that best described how they felt (e.g., item 1: A = I do not feel angry, B = I feel angry, C = I am angry most of the time now, and D = I am so angry all the time that I can't stand it). The four statements in each cluster varied in symptom intensity, with more intense clinical anger being associated with statement "D." Each cluster of statements was scored on a 4-point Likert scale, with A = 0, B = 1, C = 2, and D = 3. Subjects' responses on `the CAS were summed so that higher scores corresponded to greater clinical anger (21 items; range 0 - 63).

A scoring procedure similar to Beck's (Beck et al., 1996). is used with the Clinical Anger Scale (CAS)--where a clinical anger score in a particular range is labeled in a manner similar to Beck's procedure. That is, clinical interpretation of the CAS scores is accomplished through the following interpretive ranges: 0-13 - minimal clinical anger; 14-19 - mild clinical anger; 20-28 - moderate clinical anger; and 29-63 - severe clinical anger.

Results

These results are presented in several major sections. The first section presents the psychometric analyses of the Clinical Anger Scale. Included in this section are the factor analysis results, the reliability results, and other scale validity results. Section two then presents the gender norms and the ANOVA analyses conducted to examine the effect of gender on the CAS. The third section reports the research evidence for the convergent validity of both the CAS. This section presents the correlations between the CAS and Speilberger's anger-related instruments. Section fourth includes the results of the analyses conducted to examine the relationship between the CAS and the measures of psychological symptoms, personality traits, and unhealthy behaviors (i.e., acting out and neuroticism indexes). The fifth and final section describes the relationship between the CAS and the measure of early family atmosphere, the Family Environment Scale.

Factor Analysis Results

To examine the psychometric properties of the Clinical Anger Scale, a series of factor analyses (principal axis with varimax rotation) were conducted for males and females separately and in combination (using Sample IV). The results are shown in Table 1. An inspection of Table 1 indicates that for the combined group of both males and females, all of the CAS statements (except for item 3) loaded above |.30| on a single factor solution (the eigenvalue for Solution I was 9.53 with 45.4% of the variance being explained). No other factor solution had an eigenvalue greater than 1 (see Table 1). The CAS items were then analyzed for males and females separately. The resulting factor loadings are also shown in Table 1. Again, for both the male and the female analyses, only one factor solution with an eigenvalue greater than 1 was found (for males, the eigenvalue for Solution I was 11.33 and it accounted for 54% of the variance; for females, the eigenvalue for Solution I was 8.71 and it accounted for 41.5% of the variance). Although neither the male nor the female analyses produced more than one factor solution with an eigenvalue greater than 1, it is apparent from Table 1 that some of the secondary solutions were associated with the attitudinal, physiological, and performance manifestations of clinical anger.

Reliability

The internal consistency of the 21 items on the Clinical Anger Scale was analyzed by means of Cronbach alpha, and yielded reliability coefficients of .94 (males and females together), .95 (males only), and .92 (females only). The item-total correlations for these alphas are presented in Table 1. All the item-total correlations exceeded |.30|, except for item 3 (anger about failure) which had item-total coefficients of .13, .19, and .11, respectively, for the total sample, males only, and females only. [Although the item-total coefficient for item 3 was low, it was decided nonetheless to retain this item in the computation of the total CAS score, pending the results of additional investigations on other older samples.] In addition to conducting internal reliability analyses, test-retest analyses were also performed (see Table 2). The correlations between the two administrations of the CAS were .85 (males), .77 (females), and .78 (both males and females).