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Family structure, functioning and well-being of adolescents in secondary schools in Ado-Ekiti metropolis- A cross-sectional study

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Abstract
Objectives: Adolescence is a phase of upheaval and strain that affects overall well-being. Family factors are believed to significantly influence the well-being of adolescents. This study assessed the family structure and functioning of adolescents in school and their association with well-being.
Method: A cross-sectional descriptive survey design was used to collect data from 435 adolescents in secondary schools in Ado-Ekiti, who were selected randomly. A structured, self-administered questionnaire adapted from the Family Assessment Device (FAD) and adolescent well-being scale was used for data collection. Descriptive data were analysed using frequency, percentage, and median scores, while inferential data were analysed using regression. The level of significance was set at $p \leq 0.05$
Results: Results showed that the Majority (78.2%) of school adolescents were from two-parent families. More than half (57.5%) of school adolescents had low levels of family functioning patterns, while approximately 1/3rd (33.6%) had poor well-being. There was a significant association between adolescent well-being and family functioning patterns (OR = 1.31, CI =95%, p = 0.033)
Conclusion: Two-parent family structure was most prevalent among school adolescents. A remarkable number of adolescents experience poor family functioning and well-being, with a significant association between the two variables. Poor family functioning and well-being among adolescents may culminate in poor physical and mental health. School health nurses should pay attention to interventions that can improve family functioning among families of school adolescents.

Keywords: Family structure; Adolescents; Family functioning; Well-being, Schooling

Plain English Summary

This research was conducted among adolescents in public secondary schools in Ado-Ekiti, focusing on their family type, the functioning of their families, and the influence of these factors on their well-being. A representative sample of secondary schools in Ado-Ekiti was carefully selected, primarily concentrating on public secondary schools. Approximately 435 adolescents from these schools were randomly chosen, and data regarding these areas of study were gathered using a questionnaire similar to one employed in previous research. The results indicated that most adolescents lived with both parents. More than half displayed low levels of family functioning, while about one-third experienced poor well-being. The study demonstrated a significant relationship between family functioning and adolescent well-being, indicating that adolescents from families with poor family functioning may experience poor well-being. Based on these findings, it is recommended that school health nurses pay

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greater attention to the well-being of students and implement interventions to improve family functioning among students' families to enhance their overall well-being.

Introduction

The family, a primary social unit of society, influences the well-being of its members. (1). A family's structure and its day-to-day running are associated with the subsequent outcome of the sum of all the activities on the well-being of the family members, especially the children, with particular reference to the adolescent (1). The concepts of family have evolved, and the composition of family members has also changed from the traditional male husband, a female wife with children from a sexual relationship or by adoption (2). This has given room to the evolution of other types of families, such as step-parents, blended families, extended families, same-sex marriages, and other forms of families (2, 3). The emerging forms of family structure have also influenced the functioning of the family differently from what it used to be (4).

According to McMaster's concept of family functioning, the structure and organisation of the family are associated with the quality of behaviour of family members (5). This model identified six major dimensions of family functioning with dysfunctional transactional patterns. The family is a whole from the sum of all its parts, with the ability to resolve issues that threaten the integrity and functional capacity of the family for effective family functioning. Adequacy and appropriateness of communication techniques used, well-defined, assigned roles, displaying appropriate affect over a range of stimuli, affective involvement and behaviour control are all family relational processes that, if applied by the family, should promote the well-being of the family members.

The Sustainable Development Goal 3 (SDG 3) aims to ensure healthy lives and promote well-being for all ages. Adolescents are unique individuals in all societies; their well-being cannot be overlooked as they are in the transition period from childhood to adulthood (6). Promoting and supporting the well-being of adolescents is seen as a personal and societal good (7) that the family has a role in achieving as one of its functions. Well-being is a concept that has been described mainly as subjective, emphasising personal experiences and individual fulfilment with reflection on personal growth, feeling happy, and being satisfied with life (8).

The family structure refers to the composition of the family at a given time and the quality of the relationship between members (9). The structure of the family influences the growth and development of children and youth. Youths staying with their biological parents have been linked with better outcomes that promote positive well-being (9). The structure of the family has also been linked with the processes inherent in its functioning. Studies have shown that having two biological parents promotes stability in the functioning of subsequent children's positive outcomes in the various aspects of growth and development (10, 11, 12). Children living with non-biological parents have been linked with poor parental control and dysfunctional family relationships (13, 14). In Africa, communal living and its associated societal expectations regarding the family are still prevalent in some settings. The Yoruba ethnic group to which Ekiti state belongs in Nigeria is known for its strong family linkages, viz, the behaviour and well-being of offspring of the family within the community regarding the family structure and functioning.

Alterations in family structure resulting from shifts in societal values and norms influence family dynamics, leading to varied conditions that impact adolescent well-being. Our ethnic group is not immune to the global family structure and dynamics shifts (3). The existing literature lacks comprehensive information on the current interrelationship of these variables, as prior studies predominantly originate from developed countries. There is a dearth of explicit information on how living arrangements and family processes affect adolescents' well-being in our setting. Therefore, this study assessed the family structure, family functioning pattern, and the relationship with the well-being of adolescents in public secondary schools in Ado-Ekiti, Ekiti State, Nigeria.

Materials and Methods

The study employed a cross-sectional descriptive survey design; data were collected once across board to determine the family structure, family functioning, and well-being of adolescents in selected public secondary schools in Ekiti State. Ado-Ekiti is the capital city of Ekiti State. Ekiti State is one of the States in the South-West region of Nigeria. The people of Ado-Ekiti are mainly of the Yoruba ethnic group. The study population was both male and female Senior Secondary Schools Students in public secondary schools in Ado-Ekiti. There were 20 public secondary schools in Ado-Ekiti at the time of this study, with an average of 200 students per school. Taro Yamane's formula was used to calculate the sample size. It was derived as $n = N/(1 + Ne^2)$where n is the sample size, N=4000, is the approximate population under study, and e =0.05, which is the margin of error. Following the calculation, the initial required sample size was 364. A 20% non-response rate was added, which

gave a total of 437. Only 435 students participated in the study. A simple random sampling technique was used to select ten out of twenty public secondary schools. Four hundred and thirty-five Senior Secondary Students were selected using a stratified sampling technique. The number of students to be selected (sample) in each school was calculated based on the student count in each school. This is to ensure representation from all strata. Then, the number of students was randomly selected from each stratum. Senior secondary students who were 12 years old and above were the inclusion criteria (15). According to Piaget's cognitive stages of development, children aged 12 and older can engage in abstract thinking and reason about complex ideas (16). Students who were sick, had any form of disability such as lameness, limping, or health challenges/diseases such as sickle cell disease and the like, were exempted from this study. This serves to exclude factors that may influence our findings and to ensure internal validity (17).

A self-administered questionnaire was used to collect data. The questions were structured, closed-ended, and adapted from the general functioning scale of the Family Assessment Device (FAD), which was developed focusing on the McMaster Model of Family Functioning (18). The Adolescents' Well-being Scale was used to assess respondents' well-being (19). The questionnaire contained four sections, viz: Section A elicited information about respondents' socio-demographic characteristics, Section B assessed family structure by asking respondents to select who they lived with. Family structures were categorised into three: adolescents who were not living with both their biological parents, those living with one of their biological parents, and those living with both of their biological parents. Section C had items that measured family functioning; the responses were with Likert scale options of strongly agree, agree, disagree, and strongly disagree, scored as 1,2,3, & 4, or in the reverse order, respectively, depending on the particular question. A higher overall score indicates a dysfunctional family, and a lower score represents a healthy family functioning. Family functioning was classified as low and high functioning following a previous similar study (20Nguyen et al., 2024).

The overall adolescent family functioning categorisation was based on the median score, which was 2.8333. Median score was used because the data is ordinal and skewed/asymmetrical. Adolescents with scores below the median score were grouped as having high family functioning, indicating good (healthy) family functioning, and those with scores equal to or higher than the median score were grouped as having low or dysfunctional family functioning, indicating poor family functioning. The original FAD scale has 60 items that rate family functioning in 7 dimensions (18). The 12-item version used in this study is a brief version of FAD, which is the General Functioning (GF) dimension that measures the overall family functioning of a family. The items on the GF dimension represent the summary of FAD and were generated from psychometric analysis of FAD with 0.86 reliability (20). A previous study used the 12-item FAD to measure family functioning (21). According to McFarlane (22), questions on the GF dimension correlate highly with questions on the other dimensions. Section D comprised items on the adolescent well-being scale. The scale is a self-rating scale that was conceptualised based on the operational definition of depression. This is a pattern of affective behaviour in a child that shows impairment in the child's capability to operate in his/her usual environment. The well-being scale has good psychometric properties when used among community samples (23) and clinical samples (24). Well-being was measured on a Likert scale of 'most of the time', 'sometimes', and 'never'. The adolescent well-being items were scored 0,1, or 2 depending on the nature of the statement and the response. A score of 0 means that the response indicated no concern, 1 indicated a possible concern, and 2 showed that the adolescent was unhappy or had low self-esteem regarding the item. The overall categorisation of the well-being of adolescents was based on their raw scores. A higher score means poor well-being. According to (19) (1980), a score of 13 and above has been claimed to imply a chance of a depressive condition, although the scale is not a diagnostic tool.

Content validity of the questionnaire was ensured by experts in the field of study. This is to ascertain the appropriateness of the items used to measure the main constructs of the study. The reliability of the questionnaire was ensured by pre-testing the questionnaire with some senior secondary school adolescents selected from schools who were not included in the study, which was 20% of the sample size. This was to test the internal consistency of the questionnaire. The reliability coefficient was generated using Cronbach's alpha coefficient, with a coefficient of 0.76, indicating that the questionnaire was reliable.

The procedure for data collection commenced with an initial visit to the schools selected for the study. School heads, teachers, and students were informed about the purpose of the study. The class register was used to select respondents. Respondents were thoroughly screened using the inclusion and exclusion

criteria. The selected students were given letters to take home to inform their parents. Schools were revisited two weeks later for data collection. Questionnaires were administered to students who had parental consent and assent for participation in their classes after an adequate explanation of how to complete the questionnaires. Students were made to sit down in their classrooms, the questionnaire was distributed, and they were given time to fill it out. Questionnaires were retrieved immediately after their completion. Research assistants, with the help of teachers who served as support, checked that all items on the questionnaire were filled out while retrieving them from respondents. To avoid missing data, our questionnaire was made simple and clear. No missing data was found.

The data collected were analysed with the Statistical Package for Social Sciences (SPSS) version 25. Descriptive analysis of sociodemographic characteristics of respondents, family functioning, and well-being of respondents was presented in frequencies and percentages using tables. The Chi-square test and Logistic Regression Analysis were used to determine the association between family functioning and the well-being of adolescents. Also, the association between socio-demographic characteristics/family structure and well-being of adolescents was analysed using the Chi-square test and Logistic Regression, all at a 0.05 significance level. This helps to identify if the associations persist and to quantify the strength and nature of the relationship.

Results

Table 1 shows the socio-demographic characteristics of the respondents. The overall mean age of the respondents was (15.6±1.50). More than half (65.2%) were in the age group of 15-17 years. The majority (91.5%) came from the Yoruba ethnic group. More than half (78.2%) lived with their two biological parents (male husband and female wife). Most respondents (78.2%) were living with their two biological parents.

Table 1: Distribution of Socio-demographic Characteristics of Adolescents

Socio-demographic characteristics of respondents		Frequency (n=435)	Percentage % (100)
Age group (mean= 15.6 ±1.50)	12-14	107	24.6
	15-17	283	65.1
	18-20	45	10.3
Ethnicity	Yoruba	398	91.5
	Hausa	3	0.7
	Igbo	7	1.6
	Fulani	2	0.5
	Others	25	5.7
Class	SS1	138	31.7
	SS2	165	37.9
	SS3	132	30.3
Gender	Male	205	47.1
	Female	230	52.9
Religion	Christianity	363	83.4
	Islam	71	16.3
	Traditional	1	0.2
Parent living with (Family structure)	My two parents	340	78.2
	One of my parents	54	12.4
	People who are not my biological parent	41	9.4
Number of people in your family	Less than 3	47	10.8
	3-5 people	157	36.1
	Above 5	231	53.1
Adolescents' position among siblings in the family	First child	139	32.0
	Second child	112	25.7
	Third child	77	17.7
	Fourth child	66	15.2
	Fifth child	37	8.5
	Above the Fifth child	4	0.9

The family functioning pattern of the adolescents (Table 2) showed that almost half (46.7%) agreed that planning family activities was difficult because they misunderstood each other. About

one-third (32.0%) agreed that they could not talk to each other about the sadness they felt. Less than half (42.1%) agreed that they avoided discussing their fears and concerns. Also, less than half agreed that the family had lots of bad feelings.

Table 2: Distribution of Family Functioning among Adolescents

Variables	Strongly agree N=435	Agree	Disagree	Strongly disagree %= (100)
Planning family activities is difficult because we misunderstand each other	89(20.5)	114(26.2)	144(33.1)	88(20.2)
In times of crisis, we can turn to each other for support	172(39.5)	223(51.3)	24(5.5)	16(3.7)
We cannot talk to each other about the sadness we feel	50(11.5)	89(20.5)	204(46.9)	92(21.1)
Individuals are accepted for what they are	129(29.7)	235(54.0)	56(12.9)	15(3.4)
We avoid discussing our fears and concerns	77(17.7)	106(24.4)	175(40.2)	77(17.7)
We can express our feelings to each other	173(39.8)	212(48.7)	32(7.4)	18(4.1)
There are lots of bad feelings in the family	71(16.3)	105(24.1)	145(33.3)	114(26.2)
We feel accepted for who we are	145(33.3)	204(46.9)	53(12.2)	33(7.6)
Making decisions is a problem in our family	39(9.0)	51(11.7)	159(36.6)	186(42.8)
We can make decisions about how to solve problems	202(46.4)	185(42.5)	37(8.5)	11(2.5)
We do not get along well with each other	38(8.7)	83(19.1)	197(45.3)	117(26.9)
We confide in each other	141(32.4)	234(53.8)	33(7.6)	27(6.2)

The adolescents' well-being (Table 3) indicated that the majority (61.1%) reported they never looked up to things as much as they used to, and more than half (56.8%) reported feeling like crying most of the time. Most of the adolescents (72.2%) stated they never liked talking to their friends and family. The majority (73.6%) reported they never enjoyed the things they do as much as they used to, while less than half (49.2%) claimed they thought life was not worth living most of the time. More than half felt lonely (56.8%) and bored (66.7%) sometimes, while 47.7% said they felt so sad that they couldn't bear it. The majority reported never being good at things they do and never enjoying their food (73.1% and 74.9%, respectively). More than average (56.6%) reported never being easily cheered up, lacking energy, and sleeping very poorly (56.6%, 58.6%, and 50.3%, respectively). Over a third (46.0%) reported having horrible dreams and feeling like leaving home most of the time (46.0% and 41.6%). About a third (33.1%) reported having stomach aches/cramps most of the time.

Table 3: Distribution of Well-being of Adolescents

Variables	Most of the time n(%)	Sometimes n(%)	Never n(%)
I look forward to things as much as I used to	10(2.3)	159(36.6)	266(61.1)
I sleep very well	29(6.7)	187(43.0)	219(50.3)
I feel like crying	247(56.8)	153(35.2)	35(8.0)
I like going out	51(11.7)	243(55.9)	141(32.4)
I feel like leaving home	181(41.6)	154(35.4)	100(23.0)
I get stomach aches/cramps	144(33.1)	239(55.0)	52(12.0)
I have lots of energy	46(10.6)	134(30.8)	255(58.6)
I enjoy my food	15(3.4)	94(21.6)	326(74.9)
I can stick up for myself	200(46.0)	165(37.9)	70(16.1)
I think life isn't worth living	214(49.2)	135(31.0)	86(19.8)
I am good at the things I do	1(0.2)	116(26.7)	318(73.1)
I enjoy the things I do as much as I used to	7(1.6)	108(24.8)	320(73.6)
I like talking to my friends and family	20(4.6)	101(23.2)	314(72.2)
I have horrible dreams	200(46.0)	186(42.8)	49(11.3)
I feel very lonely	101(23.2)	247(56.8)	87(20.0)
I am easily cheered up	43(9.9)	146(33.6)	246(56.6)
I feel so sad, I can hardly bear it	49(11.3)	206(47.7)	180(41.4)
I feel very bored	84(19.3)	290(66.7)	61(14.0)

The overall adolescent family functioning categorisation (Table 4) was based on the median score, which was 2.8333. Adolescents with scores below the median score were grouped as high family functioning, indicating good family functioning, and those with scores equal to or higher than the median score were grouped as low family functioning, indicating poor family functioning. The overall result showed that more than half (57.5%) of respondents had low family functioning. In addition, the overall categorisation of the well-being of adolescents was based on their raw scores (Table 4). Adolescents with scores ≥13 were classified as having poor well-being, while adolescents whose scores were <13 were categorised as having good well-being. The majority (66.4%) had good well-being, while about 1/3rd (33.6%) had poor well-being.

Table 4: Overall Distribution of Family Functioning and Well-being of Adolescents

Adolescents Family Functioning	**Frequency (N)**	**Percentage (%)**	**Median scores**	**Minimum scores**	**Maximum scores**
High family functioning (<median scores) Healthy family functioning	185	42.5	2.8333	1.75	2.75
Low family functioning (≥ median cores), Dysfunctional family	250	57.5		2.83	4.00
Overall	435	100	2.8333	1.75	4.00
Adolescents' well-being	**Frequency (N)**	**Percentage (%)**	**Scores**	**Minimum scores**	**Maximum scores**
Poor adolescents' well-being (score ≥13)	146	33.6	≥13	14.0	28.0
Good adolescents' well-being (scores < 13)	289	66.4	< 13	2.0	12.0
Overall	435	100	13	2.0	28.0

Table 5 presents the association between family functioning and the well-being of respondents. There is a significant association between family functioning and adolescent well-being (OR = 1.31, 95% CI: 0.77–2.21, p = 0.033). This indicates that low family functioning is associated with poor adolescents' well-being and vice versa. The logistic regression analysis was carried out following a significant association between family functioning and the well-being of adolescents using Chi-square analysis. (See Table 6).

Table 5: Test of Association between Family Functioning and Adolescent Well-being: A Logistic Regression

Variables	**Estimates**	**Std. Error**	**Wald**	**df**	**Sig**	**Odds Ratio**	**Lower C-I**	**Upper C.I**
	0.266	**0.269**	**0.98**	**1**	**0.042**	**1.31**	**0.77**	**2.21**
Poor adolescent well-being (Score≥13	0[a]		0					
High family functioning (< Median scores), Healthy family functioning	1.231	0.299	0.23	1	0.033	3.43	1.91	6.15
Low family functioning (≥ median score), Dysfunctional family	0[a]		0					

*Significant at P<0.05. Dependent Variable: Well-being of Adolescents

Table 6: Association between Family Functioning and Adolescents' Well-being

Variable	**Adolescents' well-being**				
	Poor well-being	**Good well-being**	**χ2**	**df**	**p-value**
Family Function***					
Low	80 (43.2)	105 (56.8)	13.527	1	0.000
High	66 (26.4)	184 (73.6)			

*** significant at p< 0.05

The Association between socio-demographic characteristics and adolescents' well-being was computed using Chi-square statistical analysis. The results showed no significant association between the variables at p<0.05 (See Table 7).

Table 7: Association between Socio-demographic Characteristics and Adolescents' Well-being

Variable	Adolescents' well-being				
	Poor wellbeing	Good wellbeing	χ2	Df	p-value
Age group				2	
12-14 years	37 (34.6)	70 (65.4)	0.549		0.760
15-17 years	92 (32.5)	191 (67.5)			
18-20 years	17 (37.8)	28 (62.2)			
Ethnicity				4	
Yoruba	137 (34.4)	261 (65.6)	3.083		0.544
Hausa	0 (0.0)	3 (100)			
Igbo	2 (28.6)	5 (71.4)			
Fulani	0 (0.0)	2 (100)			
Others	7 (28.0)	18 (72.0)			
Class				2	
SS1	55 (39.9)	83 (60.1)	3.600		0.165
SS2	51 (30.9)	114 (69.1)			
SS3	40 (30.3)	92 (69.7)			
Gender				1	
Male	69 (33.7)	136 (66.3)	0.002		0.968
Female	77 (33.5)	153 (66.5)			
Religion				2	
Christianity	121 (33.3)	242 (66.7)	1.990		0.370
Islam	24 (33.8)	47 (66.2)			
Traditional	1 (100.0)	0 (0.0)			
Family Structure				2	
Who are the people you are living with					
My two parents	108 (31.8)	232 (68.2)	2.289		0.318
One of my parents	22 (40.7)	32 (59.3)			
Non-biological parents	16 (39.0)	25 (61.0)			
Number of people in your family				2	
Less than 3	20 (42.6)	27 (57.4)	3.628		0.163
3-5 people	45 (28.7)	112 (71.3)			
Above 5	81 (35.1)	150 (64.9)			
Your position in the family among siblings				5	
First child	44 (31.7)	95 (68.3)	0.529		0.991
Second child	39 (34.8)	73 (65.2)			
Third child	26 (33.8)	51 (66.2)			
Fourth child	23 (34.8)	43 (65.2)			
Fifth child	13 (35.1)	24 (64.9)			
Above the fifth child	1 (25.0)	3 (75.0)			

Discussion

This study assessed the family structure, family functioning pattern, and the well-being of school adolescents in public secondary schools in Ado-Ekiti, Ekiti State, in South-Western Nigeria. Family structure is a sociodemographic indicator that differentiates youths' living arrangements by the relationships and roles of members with whom they live (9). This study found that most of the adolescents who participated in the study were living in two-parent families, that is, with their biological parents, often referred to as the nuclear family. This is the most prevalent family structure in similar study settings (25, 26), corroborating the societal belief and emphasis on it as the standard family. In the past, extended family structures were prevalent. Due to socio-cultural, political, and economic transformations, the nuclear family structure has gained prominence in contemporary society (3). A few of the adolescents resided with single parents. Traditionally, single parenthood was very scant; where it existed, it was unacceptable, especially for unmarried mothers. However, societal changes in recent times have led to a significant rise in single-parent family structures and have become a pattern in all societies that cannot be ignored (3).

The level of well-being of adolescents is higher among adolescents living with both parents compared with those living with single parents and people who were not their biological parents.

Similarly, a previous study reported that children residing in family arrangements different from those with their two married biological parents exhibited a higher propensity for reporting behavioural issues (14). According to (27). The family structure and domestic environment impact an adolescent's development and may affect their behaviour and health. Children raised in a nuclear family are directly influenced by their biological parents and are equipped to confront life's obstacles. In the African context, nuclear families are essential and regarded as the optimal setting for child-rearing; yet, this family structure may be compromised by the absence of affection, stress, and insufficient emotional support, thus hindering its effectiveness in raising adolescents (27). However, previous studies (9, 28, 29, 30) reported that adolescents from two-parent families did not report better health or well-being than single and step-father families. (1) stated that the different family structures vary in their level of functioning in terms of family cohesion, communication, and flexibility. (9) asserted that the family structure in which a child grows is less important to their well-being, but the level of family functioning in terms of parent-child relationship and family cohesion, and flexibility is what matters.

More adolescents reported a dysfunctional family pattern and its association with their well-being in this study. A comparable study (31) indicated that adolescents exhibiting poor family functioning encountered varying degrees of depression, whereas those with healthy family functioning did not exhibit depressive symptoms. Additionally, a study (32) indicated that effective family functioning is correlated with reduced psychological distress among certain students. This was also corroborated by a survey conducted among undergraduates in China (33). The influence of family functioning and processes on the well-being of members' physical, emotional, and social health cannot be overestimated (34, 35). Adolescent well-being has been positively associated with family functioning (35, 36). The structure of a family may influence its functioning, while family functioning is related to the members' well-being. Good family functioning in terms of effective communication, affective responsiveness, and involvement, including behaviour control, positively impacts adolescents' well-being, whereas poor family functioning in terms of disengagement and chaos in the family system impacts adolescent well-being negatively (29, 37). The family plays a crucial role in influencing the health of its members. The developing adolescent is situated within a network of interconnected family dynamics. A dysfunctional family can pose a potential risk factor for poor well-being.

Limitations of the study

This study was conducted among school adolescents in public secondary schools in Ado-Ekiti, which limits the extent to which the study's findings can be generalised to adolescents in public secondary schools in other parts of the state. Furthermore, this study's findings are based on self-reports from secondary school students. Self-reported data may not accurately reflect objective reality, as they are subjective assessments. The study is cross-sectional; a longitudinal approach is recommended. This would track changes over time and establish causal relationships between variables.

Conclusion

The study concluded that the two-parent (nuclear) family structure is prevalent among selected adolescents. A remarkable number of adolescents experience poor family functioning and well-being, with a significant association between the two variables. School health nurses should pay attention to interventions that can improve family functioning among families of school adolescents.

List of Abbreviations

FAD: Family Assessment Device
GF: General Functioning

Declarations

Ethics Approval and Consent to Participate

Ethical approval for this study was obtained from the Health Research Ethics Committee of the Ministry of Health, Ekiti State, with Protocol number EKHREC/21/12/2022/081. A letter of permission to collect data from schools with number EKSUBEB/ADM/187/67 was also collected from the State Universal Basic Education Board (SUBEB), Ekiti State.

Consent for Publication

Not Applicable

Availability of Data

The data for the results of this study is available and will be made available on request.

Competing Interest

The author(s) declare that they have no competing interests.

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Nil.

Authors' contributions

CBB: Conceptualisation, Supervision, Validation, Writing - review & editing. SMF:

Literature review, Investigation and Reviewing, Manuscript editing. OBO: Literature review, interpretation of data, Writing Original draft, Writing-review & editing. MIA: Methodology, Formal analysis, Data curation and Visualization. All authors read and approved final version of manuscript.

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