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IMPACT OF LIFE SATISFACTION ON DEPRESSION AMONG CHILDLESS MARRIED INDIVIDUALS IN SOUTHWESTERN NIGERIA.

[1]Stephen I. Babatunde Ph.D, [2]Oluwafisayo A. Adebimpe Ph.D & [1]Adebisi P. Adeotan

[1]Department of Psychology, Olabisi Onabanjo University, Ago-Iwoye, Ogun State
[2]Ladoke Akintola University of Technology (LAUTECH) , Ogbomosho, Oyo State.
(Corresponding Email: babatunde.stephen@oouagoiwoye.edu.ng; +234 803 857 9822).

ABSTRACT

Depression has a significant role in the overall world disability, and populations who are under constant psychosocial stress are more vulnerable. Nigeria's strong pro-natalist norms create a strong value for fertility which makes childlessness an important area of psychological distress. There is a high prevalence of infertility depression among childless couples of the South Western Nigeria, but there has not been a study of the role that life satisfaction plays in depressive outcome in this group. This study was based on uncovering the association between life satisfaction and depression in childless married persons, whether higher life satisfaction possessed a protective outcome against depression. A cross-sectional survey was undertaken among 200 purposively sampled married couples, without a child, from Oyo, Ogun, and Lagos states. The participants complete a questionnaire containing demographic profile, Beck Depression Inventory-II (BDI-II) and the Satisfaction with Life Scale (SWLS) scales. The data was analysed using descriptive statistics, Pearson's correlation, chi-square and simple linear regression at a significance level of $p < .05$. Results demonstrated that a significant number of proportions of the participants (58.0%) reported clinically significant depressive symptoms (BDI-II $\geq$ 20). Pearson's correlation demonstrated that there was a strong negative correlation between life satisfaction and depression, $r(198) = -.62$, $p < .001$. Moreso, the results of the regression analysis demonstrated that life satisfaction predicted significantly levels of depressive symptoms, $B = -0.72$, $\beta = -.62$, $t = -11.70$, $p < .001$; and explaining 40.7% of the variance in depressive symptoms; $R^2 = .407$.The results identify life satisfaction as a primary protective factor against depression among childless married people in Southwestern Nigeria, it was suggested that enhancing life satisfaction through culturally sensitive interventions may serve as an effective approach to reducing depressive symptoms in this population.

Keywords: *life satisfaction, depression, childlessness, infertility, Nigeria, marital well-being, mental health*

INTRODUCTION

The prevalence and dramatic impairment of depression are a major global mental health concern affecting more than 280 million people worldwide, and adding significantly to the disability burden (World Health Organization [WHO], 2023). In the situation when confronted with long term psychosocial stress, such as infertility and lack of children, vulnerability for depression increases dramatically. Although there is a wide range of information concerning depression among different populations, the particular relation between depression and life satisfaction among childless married couples from pro-natalist societies like Nigeria where the cultural expectations about childlessness are high is understudied. Infertility defined as failure to conceive within 12 months of regular unprotected sex, affects 15–25% of the world's sexually active couples of reproductive age (Mascarenhas et al., 2021). However, in sub-Saharan Africa generally and in Nigeria in particular, epidemiological research shows that there is high infertility up to 30.3% among which secondary infertility is the most common dominant type (Okonkwo et al., 2023). In societies highly obsessed with parenthood, the infertile and the childless in such societies suffer severe psychological tortures (Adebara et al., 2023). Studies reveal that the psychosocial disorder associated with infertile has more to do with social factors arid stigma, marital expectation, and community perceptions of childbearing, and less with biological reasons (Ogunyemi & Ayinde, 2022). If childlessness appears in marriage it may challenge normal gender division of roles in the marriage, and put it under stress, leading to low self esteem, guilt, and on going sadness (Ha & Park, 2022). In Nigeria, and more so in women, the perception of the society that infertility is a personal or spiritual failure adds pressure to the minds of the victims, thereby worsening the possibility of coming down with major depression (Okonkwo et al., 2023).

A wide definition of life satisfaction, meaning the person's subjective evaluation of his/her general well-being and well-being and contentment, is considered a critical predictor of mental health (Diener et al., 2021). There are many studies showing how life satisfaction and depression affect each other in the opposite directions, and increased dissatisfaction frequently leads to the increased symptoms of depression, while increased depression, in its turn, reduces satisfaction in all aspects of life (Falk et al., 2022). In the case of individuals

who are infertile, the degree to which the individual is a recipient of support, external and internal, determines whether life satisfaction is a protective factor or an amplifying risk. More and more evidence suggests that the quality of marriage and interpersonal support play a huge role in psychological well-being of individuals who suffer infertility (Kim & Lee, 2022). As displayed by Ha and Park (2022), high marital satisfaction in people without children was correlated with depressive symptoms, whereas relationships that were stressful correlated with higher symptom reports. In patriarchal communities such as Nigeria, where the upbringing of children has historically been the responsibility of married couples, the absence of children may actually create a negative influence on the quality of a relationship, lead to emotional distancing, increased relationship strain and depressive symptoms (Adebara et al., 2023).

The incidence of infertility-related depression in Nigeria has been significant despite skinny attention to be paid in exploring the role of life satisfaction in depressive outcomes particularly for childless married persons in the southwestern part of the country. This gap is especially important to attend to in view of the unique socio-cultural setting of infertility and the specific pressures on couples in Nigeria's southwestern part. The Yoruba-speaking regions of southwestern part of Nigeria, where fertility, family lineage, as well as ancestral traditions, are highly critical, create strong societal stigma against people who lack offspring (Ogunyemi & Ayinde, 2022). Thus, considering the cultural, societal forces, effects of infertility on psychological well-being should be considered.

Research often fails to consider men and lump psychological concerns together and does not account for interchange pressures spouses experience. Nevertheless, marital psychological health is mostly influenced by mutual influences – so if one of the partners is distressed then the emotional burden on the other partner naturally increases. APIMs help in understanding the effects of one partner's life satisfaction will also affect depressive symptoms for him or her and also for his or her spouse (Kim and Lee 2022). Lacking results of studies on the relationship of life satisfaction and depression in childless married Nigerians is, however, an outstanding fact in the light of the significance of this field. Current explorations largely focus on fertility issues, from a biological view or on women's depression but neglecting the interplay and the relationship-determined

effects of psychological distress. Culturally informed research on topics such as these is needed in order to help researchers understand what life is like for people in Southwestern Nigeria, where expectations of fertility heavily influence personal well-being (Ogunyemi & Ayinde, 2022).

Research Objectives

To help reduce these concerns, this investigation is concerned with explaining how life satisfaction is related to depression in the setting of childless marriage in Southwestern Nigeria. The specific objectives are:

1. To establish the prevalence of both life satisfaction and depressive symptoms in childless married people among the region.
2. To test if there is a relationship between life satisfaction and depression.

2. Literature Review

2.1 Infertility and the Nigerian Context

The reproductive health problem in Nigeria is often, and quite accurately, diminished by the fact that infertile people are prevalent, and they have cultural, psychological, and social implications that exceed its strict medical terms. This condition, i.e., inability to conceive more than 12 months of unprotected sex, had a prevalence of about 15% to 30% in couples in sub Saharan Africa, according to WHO (World Health Organization, 2023). Hospital-based data in Southeastern Nigeria indicate that secondary infertility is more common than primary infertility and is usually caused by undiscovered infections and history of previous obstetric mishaps (Chike-Obuekwe, Ugwu, & Obi, 2022). In Nigeria, being childless is generally viewed as a failure in marital aspirations, a loss of family nobility and a debasement of a person's social status. In the Yoruba cultural environment of Southwest Nigeria, a childbearing is appreciated as a major personal achievement and a duty to religious and ancestral customs (Ogunyemi & Ayinde, 2022). In retaliation, couples without children – and most clearly women in this position – tend to face stigma, constant observation, and even physical or emotional violence from family, and indeed extended relatives. Such stressors can cause psychological strain and escalates likelihood of depressive symptoms.

2.2 Depression and Psychological Distress Among Childless Individuals

The connection between infertility and mental troubles, especially depression, is always stressed in science. Comparative study in a Southwestern Nigerian city

shows that infertility women had a high rate (32%) of depression compared to fertile women (10.7%, Obadeji et al., 2020). This psychological tension is most often aggravated by social dictates, marital hopes, and numerous failures to conceive. In this group, depression can manifest as a constant low intensity of mood, short temper, the disorder of the sleep process, hopelessness, and, in the most extreme cases, thoughts of suicide (Rufai, Grema, Bello, & Michael, 2022).

Family stress and cultural perceptions of infertility play a major role in the depression of Nigerian infertile persons. Men are not exempt; Even if male partners might not wish to discuss their emotional fare, they can hold immense shame and self-doubt, which can damage their marriage and personal life.

2.3 Life Satisfaction: A Psychological Buffer

Subjective well-being comprises life satisfaction, which is the fundamental indicator of how people feel about their overall levels of satisfaction with life (Diener et al. 2021). It is the assessment of domains of life such as, health, relations and a sense of purpose, using cognitive judgments. We know it well that more life satisfaction is associated with a reduced probability of depressive symptoms (Falk, Becker, Dohmen, Huffman, & Sunde, 2022). For people who struggle with infertility, high levels of life satisfaction may be a protective factor which would reduce the emotional burden of being childless. In a cross-sectional study with Korean childless couples, Ha and Park (2022) found that a higher life satisfaction was associated with dramatically lower depression scores of the participants. According to the study, it was found that not feeling depressed could be protected by one feeling good about non-commital life domains (from their professional success to social connections and spiritual fulfillment). But in countries like Nigeria where parenthood is so bound up in adult identity, this cushioning mechanism could lose its potency. Ogunyemi & Ayinde (2022) directed that, despite their excellence in aspects of life other than childlessness, Yoruba women in childless marriages could still have low life satisfaction because of the continued pressure from societal pressures favoring motherhood.

2.4 Gaps in Current Research and Implications

Although there is research on the mental health effects experienced due to a conceiving disability, there is also little research on the relation between life

satisfaction and depression levels among impregnated married couples from Nigeria. Most of the study focuses on the women's experience, ignoring the men's, and the dynamics of relationships as a whole. Moreover, the existing research exploring the way in which fertility-related cultural norms construct this relationship is inadequate. Knowledge of this type is needed for developing interventions that are culturally sensitive and facilitate better well-being and lower depression in couples without children. Future studies can take advantage of APIM application to research the bidirectional relations between partners' psychological states and mental condition of partners as suggested by Kim and Lee (2022). Also, involvement of qualitative methods may help to achieve greater insight into how cultural beliefs, as well, as societal expectations influence the personal fulfillment and adaptive strategies in a childless partnership.

METHOD

Design

A cross-sectional descriptive survey design was used which allowed the collection of numerical data from many respondents within a given time. Such an approach enabled us to study the relationships between life satisfaction and depression without manipulating the variables and to obtain a short picture of the psychosocial traits of the study group.

Participants

One hundred and twenty (200) married couples without children (without children) from Oyo, Lagos and Ogun States participated in this research work. Recruitment was done through purposeful sampling from religious and cultural institutions; most were Christian churches (64%), mosques (36%), others included traditional places. Participants were required to fulfill requirements for legal marriage, lack of biological or adopted children, and three years or longer marriage. The mean age of the participants was 3.4 (Standard Deviation = 2.09). Almost two thirds (60.5%) age group 36–45, 20% Females constituted 55% of the sample. Coming in first with a percentage of 35% were traders, followed by civil servants at 20%, while teachers (12.5%), nurses (10%), tailors (7.5%), pharmacists (5%) and sanitation workers each accounted for 5%. Marital duration varied: The sample involved 43% that had been together between 6 to 10 years, 30% for more than 11 years. The majority participants identified as Yoruba (75%), followed by Igbo(20%) and Hausa (5%). Most stayed in the same marriages (80%); 12.5% were divorced, while 7.5% were

separated. Participants were drawn from churches, mosques, and traditional religious institutions for cultural and religious diversity. Inclusion criteria included: The participants must be married legally, that is, not have biological children nor adopted children and be married for at least three years. We used G*Power 3.1 to calculate sample size expecting a medium effect ($f^2 = 0.15$),. Even though 92 minimum participants were required, recruitment went as far as 200 in order to enhance the validity and limit errors in sampling.

Measures

Section A: Sociodemographic Information

This segment obtained information from participants concerning gender, age, religious background, occupation, educational attainment, and length of marriage. These variables were used to depict the sample and were taken as covariates within the statistical analyses.

Depressive symptomatology and its severity were obtained using the administration of the Beck Depression Inventory-II (BDI-

Section B: Depression

II) (Beck, Steer, & Brown, 1996), a 21-item instrument with which depressive symptoms would be assessed. Items are used to obtain typical for depression cognitive, emotional and bodily, symptoms, such as sadness, guilt and exhaustion. Responses to each item on the scale are provided on a 4-point Likert scale ranging from 0 (no symptomatic manifestations) to 3 (severe symptomatic manifestations), at 0-63 possible scores. The higher the score, the greater the severity of symptoms of depression. The BDI-II demonstrates strong internal consistency both among the non-Western populations as well, where reported Cronbach's α values range from .71 to .85 (Kim, 2019). Kim, 2019). Sample items include: "Sadness has become a part of my feelings.' "I am responsible for all misfortunes." "Social activities no longer interest me." BDI-II is widely used in clinical setting and in studies outside the clinic, its validity for the African population justifies its use in measuring depressive symptoms among childless Nigerians.

Section C: Life Satisfaction

The Satisfaction with Life Scale (SWLS) was used to measure life satisfaction (Diener, Emmons, Larsen and Griffin 1985). Respondents assess five questions that cover their general cognitive

evaluation of their life quality. Respondents score every item on a scale from 1 to 7, with lower scores signifying from the lowest 5 to the highest 35. The higher the score means that a person is more satisfied with his or her life. Research confirms high reliability (Cronbach's $\alpha = 0.87$) and validity by construct relative to different populations, including global and African groups (Chang, 2019). Sample items include: "And most of the time, I am living the life I have hoped for." "I have accomplished what is truly the ultimate focus of my life until today." "Overall, I am happy with the way life has worked out for me." The SWLS is commonly recommended as a supplement to clinical tools for measuring well-being and is suitable for all academic and community research in multiracial, non-clinical adults.

Procedure

The university-based ethics review board gave consent before starting the study. The party leaders of the participating religious and traditional institutions also had to issue the required permission. Participants were enlightened with the study and emphasis was put on the significance of maintaining confidentiality along with collecting an abstract written informed consent from them. Respondents completed the questionnaires in private circumstances, supervised and aided by competent research assistants, who could help clarify aspects during their completion. Respondents' participation was not necessary at all, and they were free to quit the study whenever and would not receive any consequences for doing so.

Data Analysis

All the data were compiled using the software called IBM SPSS Statistics, version 27. Demographic variables and key measures were presented using measures of central tendency (mean and standard deviations), as well as frequency and percent statistics. Internal consistency of the BDI-II and SWLS was determined through Cronbach's alpha. In order to find out the association between life satisfaction and depression, the inferential statistics used the application of Pearson's correlation coefficient. Statistical comparisons at the level of independent samples t-test and one way ANOVA were used to determine whether life satisfaction and depression were different among different demographic groups. Eventually, multiple linear regression analysis was applied to determine the ways through which life satisfaction and other factors

affect depression scores. All statistical analysis used a significance level at $p < .05$.

RESULTS

Prevalence of Depressive Symptoms and Life Satisfaction

Hypothesis 1 (H1) stated that childless married individuals in Southwestern Nigeria would report moderate to high levels of depressive symptoms and varying levels of life satisfaction. Descriptive analysis using the Beck Depression Inventory-II (BDI-II) and Satisfaction with Life Scale (SWLS) confirmed this.

Table 1: Prevalence of Depression and Life Satisfaction Levels (N = 200)

Category	n	Percentage (%)
Depression: Minimal (BDI-II < 14)	17	8.5%
Depression: Mild (BDI-II = 14–19)	47	23.5%
Depression: Moderate (BDI-II = 20–28)	62	31.0%
Depression: Moderately Severe (BDI-II = 29–35)	43	21.5%
Depression: Severe (BDI-II ≥ 36)	11	5.5%

As shown in Table 1, 58.0% of participants reported clinically significant depressive symptoms (BDI-II ≥ 20). Specifically, 31.0% (n = 62) of the respondents fell within the moderate range, 21.5% (n = 43) within the moderately severe range, and 5.5% (n = 11) within the severe range. An additional 23.5% (n = 47) exhibited mild symptoms, and only 8.5% (n = 17) reported minimal symptoms.

Table 2: ***One-Sample Z-Test for Proportion of Clinically Significant Depression (N = 200)***

Variable	Observed n	Proportion (%)	Test Proportion	z	p-value	Conclusion
Clinically significant depression (BDI-II ≥ 20)	116	58.0%	0.50	2.29	.011	Significant ($p < .05$); greater than 50%

Using one sample z-test for proportions, we wanted to determine if the number of subjects with clinically significant depressive symptoms in this sample (BDI-II ≥ 20) was greater than 50%. The results presented a statistically significant impact, $z = 2.29$, $p = .011$, in which 58.0% showed greater depression levels than expected. This finding adds weight to Hypothesis 1 with a considerable mental health burden among childless married population.

Crosstab Analysis of Depression and Life Satisfaction Levels

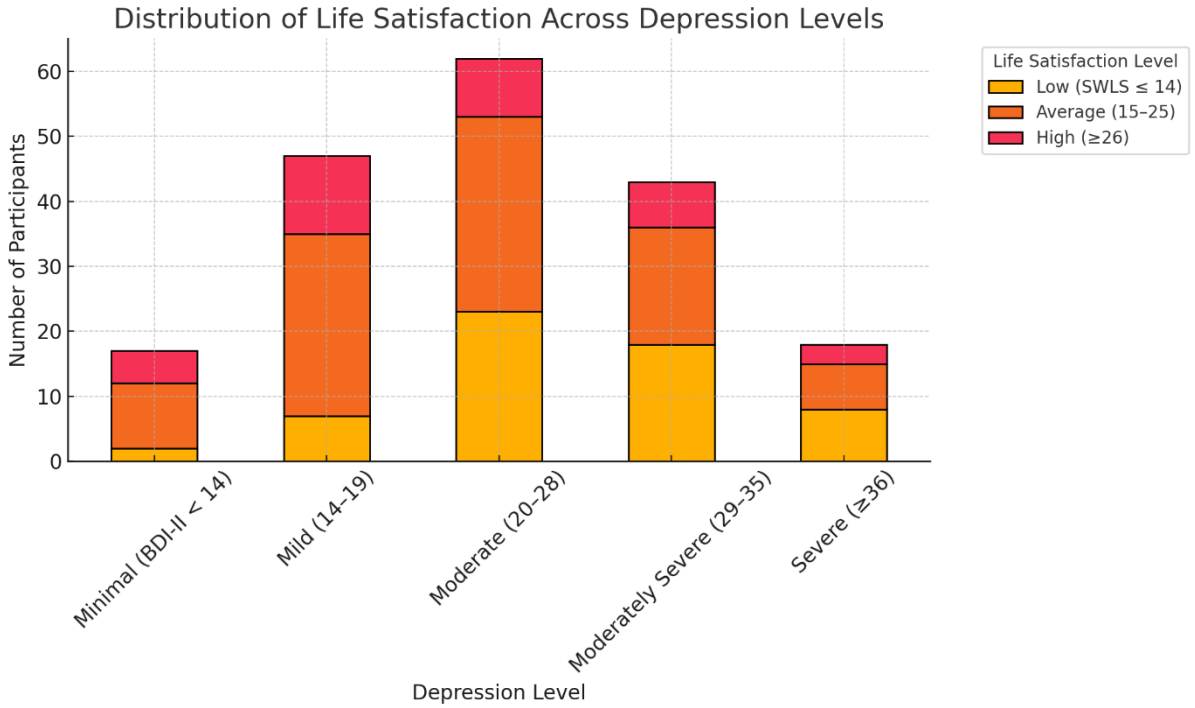
To further explore the relationship between depression and life satisfaction, a cross-tabulation was performed to examine the joint distribution of individuals across five levels of depressive symptoms and three categories of life satisfaction. Results are presented in Table 3.

Table 3: *Crosstab of Depression and Life Satisfaction Levels (N = 200)*

Depression Level	Low (SWLS ≤ 14)	Average (15–25)	High (≥26)
Minimal (BDI-II < 14)	2	10	5
Mild (BDI-II = 14–19)	7	28	12
Moderate (BDI-II = 20–28)	23	30	9
Moderately Severe (BDI-II = 29–35)	18	18	7
Severe (BDI-II ≥ 36)	8	7	3

Note. BDI-II = Beck Depression Inventory-II; SWLS = Satisfaction With Life Scale. Values are counts of participants.

The moderate depression group (BDI-II = 20–28) according to Table 4 consisted of the largest sample (n = 62) equally divided between low (n = 23) and average life satisfaction (n = 30). From the moderately severe depression group, (n = 18) and (n = 18), most were in the low and average life satisfaction categories, but only seven mentioned high satisfaction (n = 7). Those with minimal depression had the greatest probability of complaining about high or average life satisfaction with 5 individuals in the high category and 10 in the average category. The severe depression group (n = 18) showed a prevalence in low life satisfaction (n = 8), and another smaller proportion (n = 7) in the average satisfaction group, while only three participants reported high life satisfaction. Apparently, individuals with more severe depressive conditions are more commonly in the smaller life satisfaction groups. In contrast, individuals with mild to minimal depression tend to always score above average or average on life satisfaction and well-being. This trend corresponds to the strong inverse relation we found between the severity of depressive symptoms and life satisfaction in our regression and correlation analyses.



Association Between Life Satisfaction and Depression

Hypothesis 2 (H2) proposed that higher life satisfaction would be significantly associated with lower levels of depressive symptoms among childless married individuals in Southwestern Nigeria.

Bivariate Correlation

Preliminary analysis using Pearson's product-moment correlation revealed a statistically significant and strong negative relationship between life satisfaction and depression scores.

Table 4:Means, Standard Deviations, and Correlation Between Life Satisfaction and Depression (N = 200)

Variable	*M*	SD	1	2
1. Depression (BDI-II)	13.1	5.6	—	–.62***
2. Life Satisfaction (SWLS)	18.9	6.2		-

Note. *p < .001.

As shown in **Table 5**, higher scores on the Satisfaction with Life Scale (SWLS) were associated with lower scores on the Beck Depression Inventory-II (BDI-II), **r(198) = –.62, p < .001**.This indicates that participants who were more satisfied with their lives reported fewer depressive symptoms, consistent with theoretical expectations in subjective well-being research.BDI-II scores indicate greater depressive severity; higher SWLS scores indicate greater life satisfaction. Pearson's r was used for bivariate correlation. To evaluate whether life satisfaction significantly predicts depression scores, a simple linear regression was conducted with life satisfaction as the independent variable and depression as the dependent variable.

Table 5: Simple Linear Regression Predicting Depression from Life Satisfaction (N = 200)

Predictor	B	SE	β	t	p	R^2	F
Life Satisfaction (SWLS)	–0.72	0.06	–.62	–11.70	< .001	.407	135.90

Note. B = unstandardized regression coefficient; SE = standard error; β = standardized beta coefficient. Dependent variable: depression (BDI-II). Higher SWLS scores reflect greater life satisfaction; higher BDI-II scores indicate more severe depression.

As shown in Table 6, life satisfaction was found to significantly negatively variables on depression scores; Statistical significance was reached, $F(1;198) = 135.90$, $p < .001$, showing that differences in depression are, to a large degree, accounted for by differences in life satisfaction ($B = –0.72$, $SE = 0.06$, $\beta = –.62$). Depression was accounted for by this model in 40.7% explaining a large effect size in studies of psychology (Cohen, 1988). This fact is strongly supportive of Hypothesis 2, and with regard to the married couples without children, it shows that greater life satisfaction not only decreases depressive symptoms but also predicts them.

DISCUSSION

This study examined the relationship between life satisfaction and depressive symptoms among childless married individuals in Southwestern Nigeria. The findings revealed a statistically significant inverse correlation between life satisfaction and depression, and further regression analysis showed that life satisfaction was a strong predictor of depressive symptom severity, explaining over 40% of the variance. These findings contribute to the growing body of literature emphasizing the psychological vulnerabilities of individuals experiencing involuntary childlessness, particularly in cultural contexts where procreation is deeply entwined with personal identity and marital fulfillment.

The observed negative correlation between life satisfaction and depressive symptoms is consistent with prior research that has demonstrated how subjective well-being functions as a protective factor against emotional distress. Koivumaa-Honkanen et al. (2004) found that lower life satisfaction was a significant predictor of subsequent depression and suicide risk in a longitudinal cohort of Finnish adults, underscoring the importance of positive cognitive evaluations of life in maintaining psychological health. Similar patterns were reported by Arslan and Yıldırım (2021), who found that life satisfaction negatively correlated with depressive symptoms and stress levels among Turkish adults, reinforcing the generalizability of this association across cultural settings.

Within the Nigerian context, studies have documented the high emotional toll of infertility. Fatoye et al. (2008) observed that among women seeking fertility

treatment in Southwest Nigeria, rates of anxiety and depression were significantly elevated compared to fertile controls. These findings align with the present study's results, which show that over half of the sampled childless individuals experienced moderate to severe depressive symptoms. Furthermore, the psychological consequences of infertility are often exacerbated by cultural stigma, gendered blame, and intrusive familial expectations. Dyer et al. (2005), in a South African study, concluded that childlessness was linked not only to depression but also to diminished social status and chronic feelings of worthlessness—factors which are similarly prevalent in Nigerian sociocultural systems. The finding that life satisfaction significantly predicted depressive symptoms highlights the potential value of positive psychological interventions in this demographic. Diener et al. (2018) have argued that enhancing life satisfaction through strengths-based and meaning-centered therapy can contribute to reduced depressive symptoms. In clinical practice, such approaches may be particularly relevant for childless couples, as they allow individuals to reframe their identity and purpose beyond the reproductive role traditionally emphasized in many African societies. Importantly, the high prevalence of depressive symptoms reported in this study suggests a critical gap in mental health care access for this group. According to Gureje et al. (2010), despite a relatively high burden of mental illness in Nigeria, most individuals with depression remain untreated due to stigma and systemic limitations in mental health services. This underscores the urgent need for integrating psychological support into fertility care and general marital counseling frameworks.

Additionally, the gender-neutral sampling in this study broadens the discourse on male infertility-related distress. While many studies have traditionally focused on women, recent evidence (Wischmann, 2013) confirms that men also experience depression, shame, and marital dissatisfaction due to infertility—yet their psychological needs are frequently overlooked. The balanced representation in this study thus offers a more holistic view of how life satisfaction and depression intersect in both partners.

However, while life satisfaction was shown to be a significant predictor of depression, the model explains only part of the total variance, indicating that other psychosocial and structural variables may be influential. For example, previous work by Greil et al. (2011) points to the importance of social support, religious coping, and community involvement as buffers against distress in infertile couples. These unmeasured

variables could help explain variations in depressive severity that life satisfaction alone cannot account for.

Implications for Theory and Clinical Practice

The findings carry important implications for both theory and the clinical psychology profession. Theoretically, the results lend support to cognitive-behavioral and stress-appraisal models of depression, which emphasize the role of perceived life quality in shaping emotional outcomes (Beck, 1967; Lazarus & Folkman, 1984). The study affirms that the cognitive evaluation of life satisfaction—rather than objective marital or fertility status alone—plays a significant role in the development of depressive symptoms. This insight supports the extension of well-being theory in cross-cultural contexts, particularly in societies where cultural norms exert strong pressure on reproductive identity and marital fulfillment.

In terms of clinical practice, the study emphasizes the need for a paradigm shift toward integrative psychological care that prioritizes both symptom reduction and enhancement of life satisfaction. Mental health professionals working with childless individuals must not only address clinical symptoms of depression but also help clients reframe their sense of meaning, purpose, and satisfaction in life beyond childbearing. Interventions such as cognitive restructuring, acceptance-based therapy, and positive psychology approaches may be particularly beneficial in helping clients build resilience and reduce emotional distress linked to infertility or societal stigma. Moreover, routine mental health assessments in reproductive and marital counseling settings should include life satisfaction screening tools. Doing so will enable early identification of at-risk individuals and support the design of holistic, client-centered treatment plans. Practitioners are encouraged to engage in culturally sensitive therapy that acknowledges the lived realities of childless individuals while actively challenging internalized stigma and maladaptive thought patterns related to societal expectations.

Conclusion and Recommendations

This study conducted among childless married individuals in Southwestern Nigeria underscores a significant and inverse relationship between life satisfaction and depressive symptoms. The findings reveal that lower life satisfaction is strongly associated with higher levels of depression, and life satisfaction significantly predicts depressive symptoms, accounting for over 40% of the

variance in depression scores. These results reaffirm the crucial role of subjective well-being in mental health and illustrate how the psychosocial stress of childlessness, when unaddressed, can lead to substantial psychological distress.

The outcomes validate the central hypothesis and highlight that life satisfaction is not merely a passive reflection of lived experience but a powerful psychological buffer that can mediate the emotional toll of socially stigmatized conditions like infertility. This recognition offers a new lens for understanding the dynamics of psychological vulnerability among childless married individuals in culturally pronatalist societies.

Despite its meaningful contributions, this study faced notable limitations. One major constraint was the recruitment of a sufficiently large and demographically diverse sample, which limits generalizability. The sensitive nature of the subject matter—addressing infertility and mental health—may have led to underreporting of depressive symptoms or life dissatisfaction despite ethical safeguards. Furthermore, the study did not control for other potentially confounding factors such as socioeconomic status, religious orientation, spousal support, and previous fertility treatment experiences, all of which may influence both depression and life satisfaction. In light of the findings, the following recommendations are offered for policy and clinical practice:

1. Develop targeted psychological counseling and therapy programs tailored to childless couples, focusing on life satisfaction enhancement and adaptive coping strategies.
2. Establish community-based support groups where affected individuals can share experiences and reduce the burden of social isolation.
3. Implement public awareness campaigns to reduce stigma associated with infertility and promote compassion and inclusion.
4. Encourage social engagement and meaningful activities to improve psychological well-being and prevent depressive episodes.
5. Ensure equitable access to mental health services, integrating these into primary and reproductive health services for couples facing infertility.

Future studies should expand the sample to include more diverse populations across rural and urban regions and incorporate longitudinal designs to track changes in mental health over time. Researchers should explore the mediating roles of

spousal communication, religiosity, and social support in the relationship between childlessness, life satisfaction, and depression. Additionally, clinical trials evaluating the effectiveness of tailored interventions—such as narrative therapy or culturally adapted CBT—for this demographic are needed to translate these findings into impactful clinical strategies.

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