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***Research paper***

# The Effect of SFBGT on the Depression Level Among Indonesian Women Migrant Workers in Malaysia

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**Abstract**

So many surveys have demonstrated that there are high degrees of morbidity due to mental turmoil among immigrants, mainly depression and apprehension. Few of these studies unveil that migrant bond mentally depressed for the reason that they are tensed with jobs that was not at par with their educational status. From this context, the likelihood of those individuals with a higher education qualifications to end up doing deadly jobs are high, hence lower their self-respect. Those Women who involved in reformation and increasing role in international labor migration presently amount to 49.6 percent of all labor migrants worldwide. At this time, Malaysia has 2.9 million acknowledged and about 3 million unacknowledged workers with the majority of them from Indonesia 50.9%. On Asia continent, the largest class of female employment is domestic workers. Nevertheless, the domestic sector is regularly not protected by labor and industrial relations laws in the host countries, which makes this set of migrants labor particularly vulnerable to mistreatment hence the depression. Studies have shown that stressful experiences increase one's susceptibility to diseases and mental health trouble. This research aimed to assess the effectiveness of the interventions using Solution-focused brief group therapy (SFBGT). BDI, the Beck depression inventory tool is employed to the quasi pre-test and post-test methodology to evaluate the depression level of Indonesian women migrant workers in Penang state of Malaysia. The novel significance is that this study will benefit the Indonesian government in policy preparation that can validate her citizens who are principally searching for greener pasture offshore.

***Keywords***: *Depression; Women migrant workers; Solution focused brief group therapy.*

## 1. Introduction

Migrant workers means people that involved in wages action in a state where they are not a native. They are frequently at higher health risks compared to non-migrant workers. These risks are diverse and touch all facets of health, from road traffic accidents to acquaintance to deadly elements, from contagious to lifelong diseases, from emotional shock to insecure sexual practices (1). Migrant workers customarily live in overcrowded poor conditions, eat all manners of food, short of any health scrutiny, get unsatisfactory sleep, and regularly dearth healthcare admission. They are less probably to apply the healthcare system connected to nationals, even when it is offered to them (2). In extensive rapports, they normally return home in a deteriorated health situation than when they departed (3). One prominent health threat of migration is the deterioration of mental health, which has been connected to suicide and more stern diseases like schizophrenia, also death by hanging or suicide, which is more common amid migrants than the citizen.

The United Nation Population Facts set the international migrants total number at 244 million worldwide. Women was claimed to be about 48 percent and 42 percent in Asia (4). Asia is the leading continent in the world with close to 71 million international migrants living in the continent (5). Among all the nations in Asia, Malaysia has the highest number of migrant workers in the whole Southeast Asia, it is put at approximately 20% of the country's labour force(6). At present, it has 2.9 million recognized and almost another 3 million unrecognized workers (6), with the bulk of the workers from Indonesia. It was established that Indonesia has 50.9%, (7). This indicates that 1 in 3 of the workers in Malaysia are migrants (8).

Migrant workers add value to the economies of their host countries, as well as their home country means of transfering funds to boost the economy. Nevertheless, migrant workers habitually enjoy little social defence, have tendency to be poorly educated, have lesser rates of basic health insurance coverage. Their type of job is classified as "3D" jobs (i.e., Dangerous, Difficult, and Dirty) and they are isolated from their friends and family (9, 10). They might probably be abused, e.g., by means of forced labour and trafficking, sexual harassment of female workers, verbal and physical abuse, and long hours working with least possible rest (11). All these factors cause them their sound health and activate depression. Migrant populations are possible to underutilize health facilities and therefore may have a high level of unattended needs for mental healthcare(12-14). Besides, migration procedure itself is threatening and elaborate, so, migrating to unfamiliar cultural locations is observed as a problematic process of cross-cultural adaptation, which is frequently complemented by substantial psychological stress (e.g., homesickness, discrimination, and language difficulties). Hence, migration procedure open up immigrants to a point of risk because of negative sensations such as nervousness and depression as it was pronounced in the acculturative stress theory (15)

Many researchers have pronounced that elevated levels of morbidity is as a result of mental maladies among immigrants, most importantly depression and anxiety (16-18), China (13, 19) and Thailand (20). Moreover, some studies similarly disclose that women are more liable to the mental health problem on migration

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than their men's counterpart (21-23). Conversely, there is simply a handy study that described the depression level of migrant workers in Malaysia and more significantly, none mentioned anything about the low level of Indonesian women migrant workers, thus the importance of this work.

# 2. Literature Review

## 2.1. Depression

According to the World Health Organization, depression is considered a foremost basis of disease impediment worldwide(24). However, all-encompassing research literature shows that there is comprehensive disparity across nations and ethnic groups in the manner in which depression is elucidated and expressed (25). How people comprehend the cause, indicators, and handling of illness has been mentioned as lay theories, and divergent to the scientific models which is more regularly authorized by professional caregivers in Western societies (26). Connected to these theories are illustrative models defined as sets of concepts about incidents of disease that are held by patients and the practitioners tangled in their treatment.

There was a prediction that depression will be the pro minent source of worldwide disability by the year 2020 (27). Similarly, depression is declared one of the utmost common mental illnesses that has been the world's second principal source of disability, and may affect people of all ages and ethnic groups through all world regions (28, 29). The dominance of depression in Indonesia amongst healthy female and male are 34% and 24%, respectively (30) which are considered higher than the frequency in other countries (31, 32). Additionally, a study even established that 94% of Indonesians were depressed (33). In Malaysia for instance, depression is one of the communal mental disorders as reported by (34). Several studies show that depression in the midst of migrant workers is high and good examples are Mexican migrant workers in USA (Hovey & Magana, 2000) Latino migrant in USA (35), as well as internal migrant workers in China (36-38).

People who go through depression often experience sense of disconnectedness (39). Frasure-Smith, Lespérance (40) recommended that susceptibility to depression may be ascribed to the failure of the individual to cultivate positive self-perceptions. Smith suggested that a personality type branded by self-perceptions noticeable with a optimistic prejudice and high levels of optimism delivered resilience from the experience of depression. Resilience and depression sustain personality type and resilient behaviours offer defence from the experiences of depression. Resilience raises the chances of not being depressed or stressed (41, 42). Thus, resilience is route out of depression or summarily, depression can be minimised by improved resilience. Interventions by means of counselling for depressed women migrant workers has little or less influence that helps to avert, reduce, or cope with depression by increasing resilience. Hence, more study is needed to examine SFBT in the group work therapy to assess its effect on Indonesian women migrant worker who have depression by enhancing their resilience traits.

Scholars established that social patronage and religion activities function as significant factors for comfort of women migrant workers (43-49). In a like manner, some other research scholar perceived that connectedness to others (family or social support) and to God (religious activity) plays a vital role for women migrant workers' capability to cope with depression and anxiety (50-57). Social Support has aided as resilience factors because it contributes to a sense of acceptance and enhanced self-confidence. Many studies found and established that resilience among migrant workers is related to lower depression level (58, 59). But as far as the knowledge of the authors, there are handy literatures on the utilization of SFBGT intervention therapy among the Indonesian women migrant workers that shows depression symptoms in Malaysia.

## 2.2. Solution Focus Brief Group Therapy (SFBGT)

Solution focus brief therapy (SFBT), was invented during the 1980s by de Shazer and Berg. SFBT was developed out of the clinical exercise of Steve de Shazer, Insoo Kim Berg, and other colleagues at the centre for brief family therapy in Milwaukee, winconsin in the early 1980 (60-62).

SFBT is a strengths-based healing intervention that stress on building solutions rather than deciding the problem. The treatment goal is to get clients to swing from concentrating on what is working or could work in the future as fast as possible. The main task of the therapy is to assist the client to envisage how he or she would want things to be different and what it will take to make it ensue. The client should decide the goal and the road to attain it. This notion indicates a key paradigm shift, from concentrating on the problems and shortfalls of an individual to explore how an individual marshals his or her resilient strengths to deal with problems in a time of hardship and subsequently, attains personal growth (63).

Research studies indicates that SFBT is effective in the treatment of depression (18, 64-67) and due to its effectiveness, it was used to help clients find solutions to marital problems, decision-making anxiety and stress (68), as well as people with substance abuse (69), schizophrenia (70). Solution-focused therapy is piloted with individuals, couples (71) and groups (72).

Solution-focused brief therapy (SFBT) has come to be an extensively used therapeutic approach practiced in a wide range of settings in North America, Europe, and Asia (73). SFBT are well-matched with many important cultural characteristics and help-seeking activities of Asian clients in overall and principally East Asians, which includes the Chinese client that travel to United Stated (74), so it has been engaged to treat migrant in the past.

A study carried out by (75) expantiate on the importance of SFBT in a group setting and established how many of the curative factors that another author, Yalom highlighted as consonant with SFBT. It was stressed that group support is one of such factor. Client who make a commitment in a group setting was assumed to have added motivation to carry through, given that several people have knowledge of their commitment and not just their counsellor. It was established through study that group work within an SFBT structure generate a synergistic impact as the merits of the group therapy are combined with the most effective elements of SFBT. Hence, the clients are persuaded to identify the certain area of their lives that are going well or that are satisfying and rewarding and then apply those competencies to recognized personalized solutions as proposed by (76). Apart from resources and strengths that are explicitly identified for probable useage, group members are able to work together to unravel and highlight added exceptions to problems confronting individual group members (77).

## 2.3. Conceptual Framework

The conceptual framework for this study as shown is figure 1 can be categorized into two variables consisting dependent and independent variables. The dependent variables include depression level, while the independent variable is Indonesian women migrant worker challenges such as the nature of job, the years of migration and family disconnection). Moderating variable is intervention termed Solution Focus Brief Group Therapy (SFBGT).

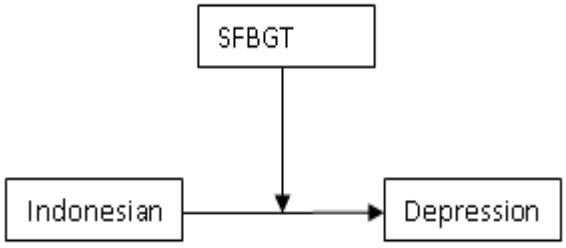


**Fig. 1.1:** Conceptual Framework

a. Relationship between Indonesian women migrant workers' challenges and depression. (Hypothesis1)
b. Moderating effect of SFBGT intervention on depression of Indonesian women migrant workers (Hypothesis 2)

# 3. Methodology

## 3.1. Research Design

Research design of this study is a quasi-experimental pre-test and post-test with comparison group. This is used to examine the differences between Indonesia women migrant workers who received SFBGT and those who do not receive the intervention.The SFBGT was applied by the researcher and two social workers. Both were national qualify counsellors and had experience in working with SFBGT. The depression level was measured before and after intervention and then a follow up test after 3 months. This design follows a past study(75, 78, 79)

## 3.2. Sample Procedure

The participants in this study will be recruited by random sampling through the support of Indonesian embassy in Malaysia where the records of registered and genuine employers of Indonesian women workers will be recovered. The major employers with the largest numbers of Indonesian women workers will be organized and from the industries, consents will be secured for the entire Indonesia women workers. About 500 Indonesian migrant women were considered for pre-test with selective criteria as; the level of depression (BDI), nature of job, age and duration of staying in Malaysia. The questionnaire were distributed to all of them but only 402 were retrieved for analysis.

## 3.3. Data Collection

The data were collected using quantitative data collection method. Quantitative data collection technique is discussed as the gathering of data by using a psychological test tool. Out of the 402 questionaire retrieved, 208 Indonesian women migrant workers had depression symptons. Then out of the 208 respondent with depression symptons. Based on their level of depression symptom, 23 were selected for intervention and control. Those selected were found to be having moderate and severe depression symptons.

## 3.4. Research Instrument

The Beck Depression Inventory-Second Version (BDI-II) is authenticated, reasonable, quick, and most commonly used because of the fact that it is a self-evaluating scale to measure depression (80). BDI scales contains 21 items encompassing the entire symptoms of depression such as sadness, despair, guilt, frustration, feeling failure, discontent and bored, suicidal desire, frequency of crying, feelings of being punished, self-hatred, self-blame, inability to take decision and social isolation.
The Indo BDI-II is a dependable and lawful instrument to evaluate depression, both in the physically healthy general population and in Coronary Heart Disease (CHD) patients. BDI-II is a recommended measure of depression for Indonesian general population. According to the literature, the consistency of the Indo BDI_II, Cronbach's alpha, appraised on all participants, was .90 for the entire score (21 items) of the Indo BDI-II scale, .80 for the cognitive factor (7 items), and .74 for the affective factor (5 items) .81 for the somatic factor (9 items), These values show acceptable level of high internal consistency. Cronbach's alpha of the Indo BDI-II per group according to the study was .90 for healthy participants, .91 for depressed patients and .87 for CHD patients, and (81).

## 3.4. Treatment Plan

The SFBGT treatment encompassed 6 sessions and each session lasted about 90 min and it was done weekly. The intervention was designed in a way that concentrated on the present and future orientation of the women migrant workers. Using focused language, miracle and scaling questioning, the intervention was intended to help the women realize their potential to find suitable means of coping with their difficulties.

## 3.5. Analysis of Data

The data were analysed using descriptive and content method. Descriptive analysis of this study is assessed by the mean and percentage of BDI scale testing. The data analysis is identified by the percentage of Depression in the pre-test, post-test 1, post-test 2, post-test 3. SPSS 20.0 IBM was used to analyse the descriptive, regression and correlation of the data collected.

# 4. Result and Finding

The descriptive result shows that in term of age of all the respondents, those Indonesian migrant women withing the age range of 18-28yrs recorded 83.2 %, while those in the age range of 29-39 yrs recorded 12.5%. Those in the age range of 40-49 yrs has 4.3 %. The table 1(see the appendx) shows the age descriptive result and the frequency. In respect of education level, those with elementary education has 10.6 % and those with high school recorded 83.7 % while those that had college and university degree has 5.8 %. This is shown in the Table 2 (appendix).
Among the respondents with depression, the singles recorded 85.6%, compare to the married respondents that has 8.2 %. Those respondents that are widowed have 6.3 %. This is shown in Table 3 of the appendix.
Relative to their occupation, the domestic helper has 14.9% while factory workers recorded 85.1 %. The 14.9 % of the domestic workers have moderate and severe depression symptons. Table 4 in the appendix shows it.
Their period or time in Malaysia proved that respondents that spent between 0-1 yr in Malaysia have 41.8 %, from 2-4 yrs have 45.2 % while above 5 yrs have 13.0 %. Table 5 shown the percentage and frequency.
In term of the depression level of all the frequency, those respondents with minimum depression is 15.4 %, mild depression is 39.4 %,moderate depression has 27 while those with severe depression has 17.3 %. Table 6 in the appendix shows the result.

## 4.1. Relationship between the Variables

The regression result of the relationship between age and depression shows that there is a very weak relationship between the ages of the respondents and their depression value. The pearson correlation value shows that r = .164. This signify a very weak positive relationship with the depression level. The adjusted $r^2$ is 0.022 which explain how much of the total variation in the dependent variable that age can explain, this is very very low. Meanwhile, the statistical significant value (sig. Level = 0.009) which indicate that $p \leq .0005$ which is less than 0.05. This means that overall, through regression model statistics, age of all the respondents is significant to the depression level although, it is a very weak relationship. (See Table 7).
The result of the relationship between education and depression revealed that r = -.256 which signify a negative type of relationship which mean the higher level of depression are associated with lower level of education. The adjusted $r^2$ = .065. The statistical significant value, sig. Level = 0.000, which really mean that $p \leq .0005$. Table 8 show the test result.
The relationship between marital status and depression show that r = .167 indicates a positive relationship between marital status and

depression, although very weak in the level of significant. The adjusted $r^2$ = .023. Statistic significant value is .008 meaning that $p \leq .0005$. Table 9 shows the result.

As for the relationship between occupation of the respondents and their depression level, the result revealed that r = .347. Indicating a moderate positive relationship, which can be interpreted as the higher the dirty, dangerous and difficult their job, the higher the depression level. The $r^2$ = .116 while the statistical significant Sig. value is 0.000 imply that $p \leq .0005$. The Table 10 in the appendix show the result.

As per the regression test result between their time of stay in Malaysia and their depression level relationship, the result as shown in Table 9 in the appendix indicates that r = -.065 signify very weak negative relationship. The $r^2$ = - .001 and the statistical significant sig. value is 0.176 indicating that $p \geq .0005$. Table 11 shows the result.

The effect of the interventions, post test 1 and post test 2, on the depression level of Indonesian women migrant workers were shown in Table 12. The result reveal that post test 1 r value = .775 and r value for post-test 2 = .830. The $r^2$ = .559 is recorded for the post-test 2 interventions. The stastistics significant is sig. = .000 which justify that $p \leq .0005$. The interventions is significant on the depression level of all respondents that receive the intervention. This shows the impact of SFBGT. The implementation of SFBGT on the depression victims yields a significant effect on their depression.

## 5. Conclusion

The conclusion of this research study is that the use of SFBGT as an intervention model on Indonesian women migrant workers in Malaysia has a significant effect on their depression level. Also, the study show that there is a very weak positive relationship between age of depression victims with their depression level. In the same vein, a negative type of relationship exists between education level, the duration time of Indonesian migrant workers in Malaysia and their level of depression. While, a weak positive relationship exist between their marital status and their depression level. Meanwhile, a moderate positive relationship exists between their type of occupation and their depression level. Lastly, it can be recommended that a critical look into the effect of SFGBT on the depression level of Indonesia male migrant workers in Malaysia can be done.

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**Table 1:** Age descriptive analysis.

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | 18-28 | 173 | 83.2 | 83.2 | 83.2 |
| | 29-39 | 26 | 12.5 | 12.5 | 95.7 |
| | 40-49 | 9 | 4.3 | 4.3 | 100.0 |
| | Total | 208 | 100.0 | 100.0 | |

**Table 2:** Education descriptive analysis

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Elementary | 22 | 10.6 | 10.6 | 10.6 |
| | High school | 174 | 83.7 | 83.7 | 94.2 |
| | University/College | 12 | 5.8 | 5.8 | 100.0 |
| | Total | 208 | 100.0 | 100.0 | |

**Table 3:** Marital Status

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | single | 178 | 85.6 | 85.6 | 85.6 |
| | married | 17 | 8.2 | 8.2 | 93.8 |
| | widow | 13 | 6.3 | 6.3 | 100.0 |
| | Total | 208 | 100.0 | 100.0 | |

**Table 4:** Occupation type descriptive analysis

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Factory workers | 177 | 85.1 | 85.1 | 85.1 |
| | Domestic helper | 31 | 14.9 | 14.9 | 100.0 |
| | Total | 208 | 100.0 | 100.0 | |

**Table 5:** Time in Malaysia descriptive analysis

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | 0-1yr | 87 | 41.8 | 41.8 | 41.8 |
| | 2-4yrs | 94 | 45.2 | 45.2 | 87.0 |
| | above 5yrs | 27 | 13.0 | 13.0 | 100.0 |
| | Total | 208 | 100.0 | 100.0 | |

**Table 6:** Depression level descriptive analysis

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | 0-13 minimum depression | 32 | 15.4 | 15.4 | 15.4 |
| | 14-19 mild depression | 82 | 39.4 | 39.4 | 54.8 |
| | 22-28 moderate depression | 58 | 27.9 | 27.9 | 82.7 |
| | 29-63 severe depression | 36 | 17.3 | 17.3 | 100.0 |
| | Total | 208 | 100.0 | 100.0 | |

**Table 7:** Regression Correlations between age and depression level

| | | DEPRESSION LEVEL | Age |
|---|---|---|---|
| Pearson Correlation | DEPRESSION LEVEL | 1.000 | .164 |
| | Age | .164 | 1.000 |
| Sig. (1-tailed) | DEPRESSION LEVEL | . | .009 |
| | Age | .009 | . |
| N | DEPRESSION LEVEL | 208 | 208 |
| | Age | 208 | 208 |

**AGE Model Summary**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .164[a] | .027 | .022 | .942 |

a. Predictors: (Constant), Age

b. Dependent Variable: DEPRESSION LEVEL

**Table 8:** Regression Correlations between education level and depression

| | | DEPRESSION LEVEL | Education |
|---|---|---|---|
| Pearson Correlation | DEPRESSION LEVEL | 1.000 | -.256 |
| | Education | -.256 | 1.000 |
| Sig. (1-tailed) | DEPRESSION LEVEL | . | .000 |
| | Education | .000 | . |
| N | DEPRESSION LEVEL | 208 | 208 |
| | Education | 208 | 208 |

**Education Model Summary[b]**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .256[a] | .065 | .061 | .923 |

a. Predictors: (Constant), Education

b. Dependent Variable: DEPRESSION LEVEL

**Table 9:** Regression Correlations between marital status and depression

| | | DEPRESSION LEVEL | MARITAL STATUS |
|---|---|---|---|
| Pearson Correlation | DEPRESSION LEVEL | 1.000 | .167 |
| | MARITAL STATUS | .167 | 1.000 |
| Sig. (1-tailed) | DEPRESSION LEVEL | . | .008 |
| | MARITAL STATUS | .008 | . |
| N | DEPRESSION LEVEL | 208 | 208 |
| | MARITAL STATUS | 208 | 208 |

**Marital Status Model Summary[b]**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .167[a] | .028 | .023 | .941 |

a. Predictors: (Constant), MARITAL STATUS

b. Dependent Variable: DEPRESSION LEVEL

**Table 10:** Regression Correlations between occupation and depression level

| | | DEPRESSION LEVEL | Occupation |
|---|---|---|---|
| Pearson Correlation | DEPRESSION LEVEL | 1.000 | .347 |
| | Occupation | .347 | 1.000 |
| Sig. (1-tailed) | DEPRESSION LEVEL | . | .000 |
| | Occupation | .000 | . |
| N | DEPRESSION LEVEL | 208 | 208 |
| | Occupation | 208 | 208 |

**Occupation Model Summary[b]**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .347[a] | .120 | .116 | .896 |

a. Predictors: (Constant), Occupation

b. Dependent Variable: DEPRESSION LEVEL

**Table 11:** Regression Correlations between time in Malaysia and depression

| | | DEPRESSION LEVEL | TIME IN MALAYSIA |
|---|---|---|---|
| Pearson Correlation | DEPRESSION LEVEL | 1.000 | -.065 |
| | TIME IN MALAYSIA | -.065 | 1.000 |
| Sig. (1-tailed) | DEPRESSION LEVEL | . | .176 |
| | TIME IN MALAYSIA | .176 | . |
| N | DEPRESSION LEVEL | 208 | 208 |
| | TIME IN MALAYSIA | 208 | 208 |

**Time in Malaysia Model Summary[b]**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .065[a] | .004 | -.001 | .953 |

a. Predictors: (Constant), TIME IN MALAYSIA

b. Dependent Variable: DEPRESSION LEVEL

**Table 12:** Regression Correlations between Pre-test depression and post test 1 and post test 2 depression

| | | Depresi pre-test | Depression post test 2 | Depression post test |
|---|---|---|---|---|
| Pearson Correlation | Depresi pre-test | 1.000 | .659 | .775 |
| | Depression post test 2 | .659 | 1.000 | .830 |
| | Depression post test | .775 | .830 | 1.000 |
| Sig. (1-tailed) | Depresi pre-test | . | .000 | .000 |
| | Depression post test 2 | .000 | . | .000 |
| | Depression post test | .000 | .000 | . |
| N | Depresi pre-test | 22 | 22 | 22 |
| | Depression post test 2 | 22 | 22 | 22 |
| | Depression post test | 22 | 22 | 22 |

**Model Summary[b]**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Durbin-Watson |
|---|---|---|---|---|---|
| | | | | | Sig. F Change |
| 1 | .775[a] | .601 | .559 | .570 | .000 |

a. Predictors: (Constant), Depression post test, Depression post test 2

b. Dependent Variable: Depresi pre-test