FACTORS ASSOCIATED WITH DEPRESSION AND HELP SEEKING BEHAVIOUR AMONG IN-SCHOOL ADOLESCENTS IN IBADAN NORTH LOCAL GOVERNMENT AREA, OYO STATE

By

Mary Olamide MOGAJI

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Certification

I hereby certify that this study was carried out by **Mary O. MOGAJI** in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Nigeria, under my supervision.

SUPERVISOR

Prof. Oyedunni S. Arulogun

B.Ed, M.Ed, MPH, PhD (Ibadan), Dip HIVand Care (Isreal), FRSPH (UK), CCST (Nigeria)

Department of Health Promotion and Education,

Faculty of Public Health,

College of Medicine,

University of Ibadan,

Ibadan, Nigeria

Dedication

This research work is dedicated to God Almighty, the Alpha and Omega.

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ABSTRACT

Depression is one of the significant contributor to the global burden of disease that affect people in all communities across the world and adolescents are not left out. Although, depression among adolescents is well known in other countries, little is known about the magnitude of depression and factors influencing depression among Nigerian adolescents and their help-seeking behaviour for depression. This study was therefore designed to identify factors influencing depression among adolescents in Ibadan North Local Government Area (IBNLGA)and their help seeking behaviour.

The study was a cross-sectional survey. A three stage sampling technique was adopted in selecting 283 students from 12 secondary schools out of the 42 government owned secondary schools in (IBNLGA). Data were collected using validated questionnaire which contained the adapted Beck Depression Inventory II used in measuring depression as well as 12-point knowledge, 9-point attitude, 8-point perceived severity and 10-point perceived benefits scales. A total score 0-9 indicated absence of depression, score between 10-18 indicated mild depression, score between 19-29 indicated moderate depression while score between 30- 63 indicated severe depression. Knowledge score > 8 was categorised as good while attitude score > 5 was categorized as good. A score >4 was categorised as positive perception of severity of depression and score >5 was categorised as positive perception of benefits of help-seeking. Data were analysed using descriptive statistics and infrential statistics of Chi-square and logistic regression with level of significance set at 5%.

Respondents' age was 15.6 ± 1.2 years. Mean knowledge score was 4.6 ± 1.9 with 70.3% having poor knowledge of depression. There is no significant association between knowledge of depression and help-seeking behaviour for depression among the respondents.The mean attitude score was 4.3 ± 1.5 with 79.9% having negative attitude towards depression. More than half (56.2%) of the respondents have depression, of these, 22.9% had mild depression, 21.5% are moderately depressed while 11.8% are severely depressed. Depression among male respondents was found to be 29.0% while 27.2% of the female respondents had depression. Negative self perception and poor family relationship was found to be the factors influencing depression among the respondents. However, these factors did not predict depression among the

respondents. Help was sought for depression from informal sources such as parents (67.7%), friends (50.2%), religious leaders (35.%), and family members (33.3%). Few (22.2%) indicated that they sought help from a mental health professional while 17.9% did not seek help at all for depression. The cost of treatment for depression was significantly associated with help-seeking among respondents.

Depression was found among adolescents studied and inadequate knowledge of depression exist. Inappropriate help-seeking behaviour is practiced among study repondents. Curriculum intergration of mental health literacy is recommended to facilitate identification of symptoms of depression and promotion of appropriate help seeking among adolescents. Schools should be provided with mental health professionals to whom adolescents can seek help when depressed. Also, public enlightment on depression will help to inform parents, religious leaders and other individuals involved in adolescents' health.

Key words: Adolescents, Depression, Help-seeking behaviour

Word count: 491

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ACRONYMS

WHO	-	World Health Organisation
HBM	-	Health Belief Model
BDI	-	Beck Depression Inventory
CDC	-	Center for Disease Control and Prevention
YLDs	-	Years Lost Due to Disability
MDD	-	Major Depressive Disorder
HIV	-	Human Immune-deficiency Virus
AIDS	-	Acquired Immune Deficiency Syndrome

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Depression is a significant contributor to the global burden of disease and affects people in all communities across the world. Today, depression is estimated to affect 350 million people. Depressive disorders often start at a young age; they reduce people's functioning and often are recurring. For these reasons, depression is the leading cause of disability worldwide in terms of total years lost due to disability. The demand for curbing depression and other mental health conditions is on the rise globally (WHO, 2012).

Adolescence is described as a transitional stage from childhood to adulthood, and is a time characterised by major changes in all areas of functioning. Children and adolescents experience various life stresses ranging from catastrophic or traumatic life events, persistent strain and daily hassles (Ang and Huan, 2006). Depression in adolescents is increasing on an alarming rate and statistics on adolescent depression are sobering. One among five may suffer from depression. Depression is detrimental to the psychological well-being of the people including adolescents, which will bring adverse effect to a country's progress (Ruston, Forcier and Schectman, 2002). Although adolescents are generally perceived as a healthy age group, 20% of them in any given year experience mental health problems, most commonly depression and anxiety (WHO, 2003). Depressive disorders are identified as the leading contributor to the burden of disease and injury for children and adolescents (Gore, Bloem , Patton, Ferguson, Joseph, Coffey, Sawyer and Mathers, 2011; WHO, 2012).

Depression in adolesence is associated with a number of negative outcomes including academic difficulties, impaired social relationships, high-risk sexual behaviour and a 30-fold increased risk of completed suicide (Horowitz and Garber, 2006). Depression is a serious problem that impacts every aspect of adolescents' life. It can lead to drug abuse, self-loathing

and pregnancy, violence and even suicide. Depression can destroy the very essence of adolescents' personality causing an overwhelming sense of sadness, despair or anger (Abege, 2014).

Depression in adolescents can be influenced by a range of factors. In a study carried out by Adewuya and Ologun (2006), parental depressive symptoms, adolescents' perception of family function as poor, adolescents' low self esteem, adolescents' problem with peers, adolescents' drinking, female gender and large family size have been identified as factors that influence depression in adolescence. In a similar study carried out by Fatiregun and Kumapayi (2014), significant predictors of depression among in-school adolescents include; not living with parents, not participating in sport, large number of siblings and change in place of residence. Meta-analytic findings also suggest family conflict, parental over involvement, parental warmth, parental hostility and a number of other parenting factors are associated with adolescent depression (McLeod, Weisz, and Wood, 2007; Yap, Pilkigton and Ryan, 2014). The school environment has also been found to exert a significant influence on depression in school-aged children. Adolescents' perceptions of school connectedness, teacher support (Kidger, Araya and Donovan, 2012) and school attainment are associated with adolescent depression (Riglin, Petrides and Fredrickson, 2014).

The high prevalence of depression and the associated risk factors among adolescents are said by some researchers to be related to cultural factors (Zhang, Li, Zou, 2011). Studies have noted differences in the prevalence and associated factors for adolescents' depression symptoms among various races and cultures. Other researchers reported that the occurrence of depression in adolescents might be associated with differences in race and cultural background (Park, Kim,Yim, Jeong, Lee, 2010; Seaton, Caldwell, Sellers, & Jackson, 2010).

Some studies have been conducted in Nigeria on adolescents depression. Some of these studies revealed that depression is present among adolesecents in Nigeria. In a study carried out by Adeniyi, Okafor and Adeniyi (2011), the prevalence of mild to moderate depression among Nigerian adolescents was 23.8%. The prevalence of Major Depressive Disorder

(MDD) in Nigerian adolescents is comparable to those found in Western culture (Adewuya, Ola and Aloba, 2007). A study carried out among adolescents in a rural district in southwest Nigeria reported 21.2% prevalence of moderate depression (Fatiregun et al, 2014).

Previous studies have also shown that despite the high prevalence of depression among adolescents, they do not seek help from appropriate sources. Young people find themselves in a difficult condition with respect to help-seeking for mental health problems. They are dependent on adults, but at the same time seek independence and do not want their parents to know about their problems (Wilson and Deane, 2012). Young people often experience aversive emotions like anxiety, fear, or shame, and at same time lack emotional competence they need to seek help for their problems (Wilson, Deane, Biro, 2003; Rickwood, Deane, Wilson, 2005). They do not know exactly where to seek help, and this may discourage them from seeking help at all (Fortune, Sinclair and Hawton, 2008). Findings from many studies identified barriers to help seeking encountered by adolescents with mental problems. Structural barriers to help seeking include difficulties in accessing services due to financial constraints and hurdles before securing appointment. Personal barrier include stigma, non-recognition of the need for services, lack of knowledge, negative attidudes about professional help available, lack of emotional competence to seek help, negating symptoms, belief that one can solve the problem oneself and preference for other sources of help including informal help from friends and family (Adeosun, Adegbohun, Jeje, Bello and Manuwa, 2015). Studies from both low and high income countries reveal that poor mental health literacy, stigma, embarrassment, ignorance of own illness and financial constraints are key barriers to care for mental problems (Andersson, Schierenbeck, Strumpher, Krantz, Topper, 2013; Gulliver, Griffiths, Christensen, 2010; Brenman , Luitel, Mall, Jordans, 2014)

1.2 Statement of problem

Depression is a mental disorder that manifests as depressed mood, loss of interest in pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite and poor concentration (WHO, 2012). Depression has debilitating effects on individual's health and impairs daily functioning. It also affects both the physical and social well being of an individual. Depression remains the leading cause of suicide and predictions indicate that depression may be the second largest killer after heart disease by the year 2020 (Busari, 2012). Onset of depression occur earlier in life and depression has been found to be prevalent among adolescents.

Adolescence is a transitional period from childhood to adulthood. Adolescents are often thought of as a healthy group. However, they are faced with many health challenges that predispose them to premature death. These include early pregnacy, and child birth, HIV, violence, drug and substance abuse, malnutrition, obesity and depression. Serious health issues that many have in adulthood have their roots in adolescence. Adolescence is a stage characterised by emotional instability citing vulnerability to depression. During adolescence, adolescents go through some changes physically, biologically and emotionally. Also, they seek for self-identification, and form intimation in social relationship and prepare for career (WHO, 2010). Adolescents who have difficulty in adapting to these changes will be faced with conflict that may lead to stress, anxiety and depression as well. Almost half of adolescents have difficulty overcoming stressful situation such as problems with parents, competition with peers to achieve good scores or grades and financial problem (Norfazilah, Hafizah, Siti Zubaidah and Azmawati, 2015). Depression is a recurrent, common disorder that occur more often during adolescence than any other life stage (Zhang et al, 2011). A large body of literature reveals that adolescence is a period of increased vulnerability to stressful life events such as depression (Stark, Hargrave, Hersh, Michelle, Heren and fisher, 2008).

As reported by Melisa, Sodah, Fazel and Paul (2012), World Helath Organization estimates that as many as 20% of worlds's children and adolescents experience mental disorder at some

stage in their lives. Adolescent depression has also been identified as a predictor for depression in adulthood (Lewinsohn and Essau, 2002). The effects of adolescence depression extend beyond the individual. It affects the family and the society at large (Jaycox, Stein, Paddock, Mile, Chandra, Meridith ,Taniellian , Hickey, Burnam , 2009).

Findings from existing literatures show that depression in teens is associated with a wide range of negative health outcomes such as suicide attempt, completed suicides and early pregnancy (Lewinsohn et al, 2002). Omigbodun, Dogra, Esan and Adedokun (2008) reported about 12% prevalence of suicide attempt among adolescents in south west Nigeria. Functional impairment is found to be related to depression severity among adolescents as well as co-existing emotional and behavioural problems (Jaycox et al, 2009). Khasakhala, Ndetei, Mutiso, Mbwayo and Mathai, (2012) reported that children and adolescents with depressive disorders are also at risk of substance use disorders, poor academic performance and impaired pyschosocial functioning. Consquences of depression in adolescents are usually compounded by the high levels of comorbid pyschiatric conditions. Anxiety, conduct and substance use disorder are the most commonly reported psychiatric conditions (Wagner, 2003).

Findings from existing literatures reveal the existence of depression among adolescents. Report from a study carried out in Nigeria among in-school adolescents, reported depression rate of 21.2% (Fatiregun and Kumapayi, 2014). Also, another study conducted by Adeniyi, Okafor and Adeniyi (2011), indicated that the prevalence of mild to moderate depression among Nigerian adolescents was 23.8%. As a result of high prevalence of depression and association with impairment and long-term consequences, depression has been identified as an international priority (WHO, 2012).

Despite the adverse effect of depression on adolescents' development, well-being and everyday functioning, they remain the least likely to seek help when emotional problems arise (Bebbington, Meltzer, Farrell, Jenkins , 2000; Gulliver, Griffiths, Christensen, 2010). Studies conducted in both low and high income countries reveal that poor mental health

literacy, stigma, embarrassment, ignorance of own illness and financial constraints are key barriers to care for mental problems (Andersson, Schierenbeck, Strumpher, Krantz, Toppe, 2013; Gulliver, Griffiths, Christensen, 2010; Brenman, Luitel, Mall, Jordans, 2014). Therefore, this study seeks to identify factors associated with depression among in-school adolescents in Ibadan North Local Government Area and their help seeking behaviour for depression.

1.3 Justification

According to World Health Organization (2012), depression affects more than 350 million people of all ages globally with over 50% not receiving approrpriate care. It is describe as an internationl priority. This study is important for two reasons. First, this study will contribute to the elimination of gap in literature on adolescents' mental health and their help seeking behaviour. Second, this study will help to identify factors associated with depression among adolescents which will help school counsellors and other institutions responsible for adolescents' mental health in reducing the burden of depression among adolescents.

Also, it will help to document the helpseeking behaviour for depression among adolescents which will serve as evidence for orientating and strengthning of health institutions responsible for adolescents' health as well as educational institutions that will help to promote appropriate help seeking behaviour among adolescents. Additionally, the findings from this study can be used by policy makers, programme managers to develop strategic plan to reduce the burden of depression among adolescents.

1.4 Research questions

In order to facilitate attainment of the formulated objectives stated in this study, the following research questions were posed:

1. What is the level of knowledge of in-school adolescents about depression?
2. What are the factors associated with depression among in-school adolescents?
3. What is the helpseeking behaviour for depression among in-school adolescents in Ibadan north local government area?

4. What is the proportion of in-school adolescents having depression in Ibadan North Local Government?

1.5 Broad objective

The broad objective of this study is to investigate factors associated with depression among in-school adolescents in Ibadan North Local Government Area of Oyo State and their help seeking behaviour.

Specific objectives

The specific objectives of this study are to:

1. Assess the level of knowledge of in-school adolescents about depression
2. Identify factors associated with depression among in-school adolescents in Ibadan North Local Government Area
3. Describe the helpseeking behaviour for depression among in-school adolescents in Ibadan North Local Government Area
4. Identify the proportion of in-school adolecents having depression in Ibadan North Local Government Area

1.6 Research Hypotheses

Ho: There is no significant relationship between the experience of depression and parent's marital status

Ho: There is no significant relationship between the experience of depression and father's occupation

Ho: There is no significant relationship between the experience of depression and ability to share problems with family

1.7 Definition of terms

Adolescence : is the period in human growth and development that occcurs after childhood and before adulthood, from ages 10-19 (WHO, 2010).

Depression: Depression is a mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration (WHO, 2012).

Help seeking behaviour: help seeking is defined as a form of coping that relies on other people and involves social relationships and interpersonal skills (Rickwood, Deane, Wilson & Ciarrochi, 2005).

CHAPTER TWO
LITERATURE REVIEW

2.1 Depression among adolescents

One of the mental disorders with a high prevalence is depresssion. Depression according to WHO (2012), is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Depression often comes with symptoms of anxiety. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. Knitzer, Theberge and Johnson (2008) defined depression as a combination of symptoms that interfere with the ability to work, sleep, eat, enjoy with parents and that affects all aspects of work and family life; an illness that frequently starts early in life, that may have a biological component and that produces substantial disability in functioning. Depression is a major contributor to the burden of disease worldwide and is estimated to be the leading cause of disability as measured by Years Lost due to Disability (YLDs) (WHO,2008). It has been estimated that the burden from depression alone is likely to increase to the single biggest burden of all health conditions by 2030 (Melisa, Sodha, Fazel and Paul, 2012).

Based on WHO information cited in Busari (2012), depressive disorders are the fourth leading health problems in the world. This predicts that depressive disorders may become the second most disabling disease of mankind by year 2020. Depression has been identified as a significant contributor to the global burden of disease that affects people in all communities across the world. The World Mental Health Survey conducted in 17 countries revealed that on average about 1 in 20 people reported having an episode of depression in the previous year. Depression is a leading cause of disability that often start at a young age. It reduces individual's functioning and are often recurring (WHO, 2012). As cited by Nancy, Galambos, Bonnie, Leadbeater, and Erin (2004), Depression is a highly treatable problem that often goes undiagnosed or is attributed to the stresses and strains of daily life.

Depression as a mood disorder is classified as: (1) unipolar depression in which an individual suffers only from depression; (2) bipolar depression; in this case, the person suffers from extreme mood swings, that is, depression to the extreme opposite – mania, that is, excessive elation (Amolo and Anyanwu, 2014). Ornstein and Carstensen (1991) as cited in Amolo et al (2014), categorised the causes of both unipolar and bipolar types of depression into endogenous factors and exogenous factors. The endogenous factors are genetic tendencies and bio chemical components. The exogenous factors include stress, events in one's personality traits, lack of social skill, socio-cultural causes, financial hardship, maternal depressive trait and marital stress.

Adolescence has been defined as a transition stage, from early puberty to adult, occurring between the age of 13 to 19 years. In this stage, adolescent will go through some changes such as seeking for self-identification, and forming intimation in social relationship and preparing for career (WHO, 2010). Adolescents who have difficulty in adapting to these changes will be faced with conflict that may lead to stress, anxiety and depression as well. Almost half of adolescents have difficulty overcoming stressful situation such as problems with parents, competition with peers to achieve good scores or grades and financial problem (Norfazilah, Hafizah, Siti Zubaidah and Azmawati, 2015). Depression is a recurrent, common disorder that occur more often during adolescence than any other life stage (Zhang et al, 2011). A large body of literature reveals that adolescence is a period of increased vulnerability to stressful life events such as depression (Stark, Hargrave, Hersh, Michelle, Heren and fisher, 2008). Adolescence being characterised as time of storm and stress has led many researchers to view depression as normal developmental stage (Perou, Bitsko, Blumberg, Ghardour and Gfroerer, 2013). However, it has been documented that children and adolescents do suffer from both depressive symptoms and depressive disorders (Luby, 2009). Graber (2004) observed that adolescent girls consistently have higher rates of depression than adolescent boys. Studies have estimated that depression affects up to 8.3% of older adolescents in the United States (Lewinsohn et al, 2000). It is observed that on any single day, about 2% of school-aged children and about 8% of adolescents meet the criteria

for major depression (Kessler, Avenevoli and Reis, 2001). According to National Institute of Mental Health, in 2014, an estimated 2.8 million adolescents aged 12 to 17 in the United States had at least one major depressive episodes in the past year. This represents 11.4% of the US population. Population based studies that have been conducted on depression in Sub-Saharan African reported a life time prevalence of 3.1%-9.7% (Gureje, Uwakwe, Oladeij, Makanjuola and Esan, 2010; Herman, Stein, Seedat, Heeringa, Moomal and Williams, 2009; Tomlinson, Grimsrud, Stein, Williams and Myer, 2009).

The characteristics of a child and adolescent depression is not usually manifested by sadness but irritability, boredom or inability to feel pleasure (Brent and Birhaher, 2002). Depressive symptoms though not a sufficient criteria for the clinical diagnosis of depresssion, seem to be quite stable through adolesence, with individuals who experience depressive symptoms earlier in adolescence being more likely to continue reporting depressive symptoms later in life (Haavisto, Sourander, Multimaki, Parkkola, Santalahti, Helenius, Nikolakaros, Kumpulainen, Moilanen, Piha, 2004; Pine, Cohen, 1999). According to Center for Disease Control (CDC), during adolesence, depressive symptoms are often misdiagnosed as primarily conduct or substance abuse disordrers. Most of the time it is attiributed to normal stress. Adolescence is seen as a sensitive period when youth begin to experience a desire for initimacy, increased social and academic responsibilities. Being a crucial period for mental health problems, cognitions and emotions may develop in a non-efficient way (Hankin, 2006; Kim-Cohen, Caspi, Moffitt, Harrington, Milne, 2003). The report of a prospective study in which a birth cohort individuals were followed for 26 years revealed that 75% of adults at age 26 who met criteria fro major depression, had already presented a depressive disosrder in childhood or adolescence, and only 25% had experience the onset of depression in adulthood (kim-Choen et al, 2003). A similar prospective community study of 274 adolescents reported that one-fourth of formerly depressed adolescents experienced subsequent pure major depression disorder while one-fourth experienced comorbid disorder, and one-fourth remained free from depression recurrence, but experience a non-mood disorder (Lewinsohn, Rohde, Seeley, Klein, Gotlib, 2000). As reported by Abdulmalik, Omigbodun, Wakil and Beida (2013), systematic review of epidemiological studies on the comorbidity of

adolescents depression with other conditions showed that the presence of adolescent depression predicted a twenty-fold increase for the other psychiatric conditions. Comorbidity rate of 23.3% was reported among depressed high school adolescents.

Ornstein and Carstensen (1991) in Amolo et al. (2014) identified the following symptoms of depression:

Loss of Interest and Pleasure

Depressed individual that is suffering from depression has loss of interest and pleasure. The person is usually indifferent to activities which formally provided interest and pleasure including loss of interest in family and friends.

Appetite Disturbance

Loss of appetite is apparent in individuals suffering from depression. However, some people having symptoms of depression might experience increase in their appetite. The apparent loss of appetite may be responsible for weight loss.

Sleep Disturbance

Sleep disturbance known as insomnia is commonly experienced by persons suffering from depression, some however experience the opposite; hypersomnia.

Psychomotor Disturbance

Persons suffering from depression have disfunctioning psychomotor skills and activities. Such psychomotor functions as sitting still, walking, fluency in speech e .t.c

Decrease in Energy Level

Sufferers of depression complain of burn-out, severe fatigue even after having rested and having done no physical task.

Sense of Worthlessness

Sense of hopelessness, helplessness, lack self efficacy, lack self-esteem, self-blame, guilt, and despairing attitude toward almost everything are apparent in individuals suffering from depression.

Difficulty in Concentrating

Depressed individual often complain of conditions such as poor decision making, memory disturbances and being easily distracted.

Thought about Death

Depression triggers thoughts of death and self-harm. A depressed person may be afraid of death, wishes to die, and may attempt suicide.

Depression has a debilitating effect on adolescents' health and overall functioning. Suicide is the most devastating outcome of depressive symptoms during adolescence and is the second cause of death in this age group in Western Europe (Patton, Coffey, Sawyer, Viner, Haller, Bose, Vos, Ferguson and Mathers, 2009). According to Anderson (2002), adolescents who commit or attempt suicide tend to think poorly of themselves, feel hopeless, and have poor impulse control and low tolerance for frustration and stress. Their feelings of depression may be expressed as boredom, apathy, hyperactivity or physical problems. Such adolescents are alienated from their parents and have no one outside the family to turn to. Many of these adolescents are from troubled families with history of unemployment, imprisonment and suicidal behaviours and of abuse or neglect. Depressive symptoms may also affect the process of socialization, family relationships and school performance. Adolescents and children with depressive problems lack interest and concentration which are required for effective education. Depressed individuals also lack emotional intelligence and social skills to adapt in an academic environment, as a result may drop out of school. Depression is a possible cause for school drop-out among children and adolescents in Nigeria (Amolo et al, 2014). Adolescents presenting depressive symptoms are also at increased risk for alcohol or substance abuse and antisocial behaviors (Saluja, Iachan, Scheidt, Overpeck, Sun, Giedd, 2004; Zuckerbrot, Jensen, 2006). Zalsman, Brent, and Weersing (2006), reported that depressed youths are at risk for many co-morbidities, including conduct problems, personality disorders, substance abuse, obesity, interpersonal conflict, unfulfilling social relationships, and educational and occupational underachievement. A systematic review of epidemiological studies on the comorbidity of adolescent depression with other conditions

revealed that the presence of adolescent depression predicted a twenty-fold increased risk for other psychiatric conditions (Angold and Costello, 1993).

2.2 Prevalence of depression among adolescents

Globally, depression rate has been on the increase. Worldwide, approximately 5% of adolescents suffer from depression (Costello, Erkanli and Angold, 2006; WHO, 2012). According to National Institute of Mental Health, in 2014, an estimated 2.8 million adolescents aged 12 to 17 in the United States had at least one major depressive episodes in the past year. This represents 11.4% of the US population. Kessler, Berglund, Delmer, Jin, Merikangas and Walter (2005) reported that, in the United States, approximately 75% of mental disorders present before the age of 24, and 50% begin before the age of 14. Maharajh, Ali and Konings (2006), held the view that the overall rate of adolescent depression varied accross different countries and culture. A study carried out in Sweden reported a depression score of 12.3% among high school students ages 16-17 (Olsson and Von Knorring 1997; Maharajh et al, 2006). Whearas in Guatemala, a high rate of 35.1% adolescent depression was found (Berganza and Aguilar 1992; Maharajh et la, 2006). Also, a study conducted to assess the prevalence of depressive symptoms in a community sample of 13 year old adolescents observed 13.4% prevalence rate (Bulhões, Ramos, Lindert, Dias, and Barros, 2013). Low rates of depression was noted among adolescents in Western Europe, Asia and Australia (Maharajh et la, 2006). In a study conducted among adolescents in four caribbean countries, 52.1% of the respondents reported mild to severe symptoms of depression with 29.1% reporting moderate to severe symptoms of depression (Lowe, Lipps Gibson, Halliday, Morris, Clarke and Wilson, 2014).

Population based studies that have been conducted on depression in Sub-Saharan African reported a life time prevalence of 3.1%-9.7% (Gureje, Uwakwe, Oladeji, Makanjuola and Esan, 2010; Herman, Stein, Seedat, Heeringa, Moomal and Williams, 2009; Tomlinson, Grimsrud, Stein, Williams and Myer,2009). The prevalence of depression in low and middle income countries have been reported to be similar to that of the developed countries. The prevalence of depressive symptoms among adolescents in Nairobi public secondary schools

was reported to be 26.4% (Khasakhala et al, 2012). The prevalence of depression among Nigerian adolescents has been estimated at 6–12% (Adeniyi, Okafor, & Adeniyi, 2011; Adewuya, Ola, & Aloba, 2007; Omigbodun, Dogra, Esan, & Adedokun, 2008). Report from a study carried out in Nigeria among in-school adolescents, reported depression rate of 21.2% (Fatiregun and Kumapayi, 2014). Also, another study conducted by Adeniyi, Okafor and Adeniyi (2011), indicated that the prevalence of mild to moderate depression among Nigerian adolescents was 23.8%.

2.3 Factors that associated with depression among adolescents

Depression in adolescents can be influenced by a range of factors. Previous studies have identified various factors that are associated with depression among adolescents. Parental depressive symptoms, adolescents' perception of family function as poor, adolescents' low self esteem, adolescents' problem with peers, adolescents' drinking, female gender and large family size have been identified as factors that influence depression in adolescence. Also, significant predictors of depression among in-school adolescents include; not living with parents, not participating in sport, large number of siblings and change in place of residence, family conflict, parental over involvement, parental warmth, parental hostility, school environment, adolescents' perceptions of school connectedness, teacher support, school attainment, and cultural factors. (Adewuya et al, 2006; Fatiregun et al, 2014; McLeod, et al 2007; Yap et al, 2014; Kidger, et al 2012; Riglin et al, 2014; Zhang et al, 2011). Family dysfunction, extreme care and concern from parents about children's study, and academic performance, higher academic pressure, poor relationship with others, negative self perception and lack of social support have been reported to be among the risk factors for depression in adolescents (Huang, Xia, Sun, Zhang & Wu, 2009; Thorsteinssonm Ryan & Steinbjornsdottir, 2013). Previous studies reported significant relationship between academic stress and depression among adolescents (Ang & Huan, 2006; Bjorkman, 2007).

Gender

Literatures have consistently reported female gender as a factor that influence depression among adolescents. Bulhoes et al (2013) reported that prevalence of depressive symptoms

was more than twice common in girls as in boys. Adewuya et al (2006); Fatiregun et al (2014) also reported female gender as a risk factor for depression among adolescents. Sex differences in the prevalence of depressive symptoms among adolescents can be explained by biological changes coupled with puberty, sex role diffrentiation between male and female adolescents, cognitive functioning or as a result of the way females socialize and their greater vulnerability to stress in social relationships (Bulhoes et al, 2013; Hater & Whitesell, 2002; Hankin, 2006; Feldman 2007).

Self-esteem

Self esteem is the ability to be assured of one's own abilities, talents, worth, value as well as having personal acceptance, approval and respect of one's self. Depression and low self esteem occur disproportionately with high prevalence among adolescents (Orth, Robbins & Meier, 2009). According to Mruk (2006), low self-esteem correlates with irrationality, blindness to reality, rigidity, fear of the new and unfamiliar, low self-worth, lack of self-confidence, social-anxiety, depression, feelings of inadequacy, inappropriate conformity or inappropriate rebelliousness, defensiveness, an overly compliant or controlling behaviour and fear of hostility toward others. High self-esteem correlates positively with rationality, realism, intuitiveness, creativity, independence, flexibility, ability to manage change, willingness to admit mistakes, benevolence and cooperation. Low self concept about academic performance, physical appearance, social interaction and athletic performance was found to be associated with depression (Robles-Pina, Defrance & Cox, 2008). Dixomryale (2005) observed that low self esteem contributes to the development of a poor or negative self image. This implies that, adolescents with low self esteem may report higher levels of depression. According to Siyez (2008), self esteem influence certain behaviours during developmental stage in adolescence. Therefore, low self esteem is a predisposing factor for depression. Adewuya et al (2006) in a study carried out to determine factors associated with depressive symptoms among Nigerian adolescents, reported that low self esteem is one of the factors that influence depressive symptoms. In a similar study conducted by Abege (2014) to determine the association between self esteem and depression among adolescents in Markudi secondary schools found that high self esteem has a significant but negative influence on

depression while low self esteem shows a positive relationship with depression. Also, Okwaraji, Aguwa and Shiweobi-Eze (2016) reported a relationship between low self esteem and depression among a sample of Nigerian adolescents. Studies have revealed that adolescents who maintain positive self esteem report more positive affective states, greater wellness, more life satisfaction and fewer depressive symptoms (Dixomrayle, 2005; Terna, 2014)

Negative life events

childhood sexual abuse (Chen et al., 2006), sexual abuse in the previous year (Patel and Andrew, 2001); physical abuse (Afifi, 2006) and exposure to domestic violence (Hindin and Gultiano, 2006) were associated with significantly higher levels of depressive symptoms. Critical life events have also been reported to be a pre-morbid risk factors in 70% of depressed children and adolescents. Chronic stresses such as lack of freindship and attention, low attractiveness, problems in social relationships can trigger depression in children and adolescents (Eley & Stevenson, 2000; Mehler-Wex & Kolch, 2008). Richardson et al (2005) explained that children and adolescents that experience negative life events such as family conflict, low socioeconomic status and loss of family or loved ones are more likely to report depression than those who do not. In a study carried out among 373 chinese adolescents from grades 7-9 reported that 44.8% had symptoms of depression 3 years after an earthquake (Pan, Liu, Liu, Tang, Dong, Cui, Xu, 2013). Unhappy childhood increases chance of having a depressive symptoms (Joules, Williams & Thompson, 2014).

Socio economic status

Poverty and social disadvantage are strongly associated with depression. Growing up in a poor household increases the risk of exposure to a number of adversities that are risk factors for depression, such as malnutrition, violence, poor education and living in a neighbourhood that is characterised by limited social networks (Fisher and de Mello, 2011). According to Joe, Joe & Rowley (2009), children and young people from low income households or from families of high socioeconomic status, ethnic minority groups, rural communities are potentially more vulnerable to depressive symptoms. Children from families of low financial

status are susceptible to both depression and suicidal thoughts (Moj, Warchol-Biederman & Samborski, 2012). Living in a disadvantaged neighbourhood was found to be predictor for depression among first to sixth grade korean pupils (Lee, Kim, McCreary, Park, Jun & Yang, 2012).

Family factor

family plays a pivotal role in child's development. The econonmic, social, spiritual condition, liability condition and status of family have been reported to play a pivotal role in children and adolescents'mental health status (Zgambo, Kalembo, Guoping and Honghong, 2012). Hagin (2011) opines that the quality of parent-child relationship do contribute to depressive attitude in adolescence. This connotes that when the quality of parent-adolescence relationship decreases, there is a tendency for relative increase in depressive symptoms. Studies have revealed that composition of the family exposes children to risk of depressive symptoms. Dong, Wang, Ollendick, (2002); Yu and Seligman (2002), observed that children from divorced and single-parent families report higher levels of anxiety and depression compared to children from nuclear and stem familes. Lower family cohesion, higher conflict, poor quality of family relationships and conflicts with parents lead to higher level of depression (Sun, Hiu, Watkins, 2006; Greenberger, Chen, Tally and Dong, 2000; Yu et al, 2002). Greenberger et al (2000) observed that strong positive family relationships reduces symptoms of depression. Studies has shown that children and adolescents who live without parents report higher levels of depressive symptoms than those with parents around them (Wang, Yan, Hiu and Juan, 2011). A survey of Filipino adolescents that have witnessed violence between their parents revealed that depressive symptoms were more prevalent among those who had witnessed parental domestic violence than those who had not (Hindin and Gultianom, 2006). Percieved unfair treatment among siblings have been reported to increase depressive symptoms for a child (Shanahan, McHale, Crouter, and Osgood, 2008; Richmond, Stocker, and Rienks, 2005; Vogt-Yuan, 2009). Khasakhala et al (2012) held the view that positive and constructive communication between parents and their children allows for conflict resolution. Percieved rejection by mother was highly associated with depressive symptoms. Also, perceived under-protective father was associated with depressive

symptoms. Adolescents who had mothers that had experienced trauma and parented with authoritarian style reported more depressive symptoms (Leslie and Cook, 2015).

Parental depression

Studies have found that 20% to 50% of youths wih a family history of depression or mental health disorders have depression in early childhood or adolescence (Kovac, Devlin, Pollock, Mukerji, Richards, 1997; Richardson and Katseneilenbogen, 2005) Bulhoes et al (2013) reported that adolescents whose parents reported receiving diagnosis of depression at some point in their lives were more to report depressive symptoms. Having a parent with history of major depression is one of the strongest predictors of depression in youths (Hankin, 2006). Parents who are depressed may have difficulties responding to their children's emotional environment and/or to practicing effective parenting skills (Resitifo and Bögel, 2009). Garber & Kane (2009) observed that depression in parents increases the likelihood of children developing insecure attachment, which is another risk factor for depression. Additionally, children may be more likely to be exposed to stressful events as a result of their parents' conditions which may also increase the risk of depression (Abela, Skitch, Auerbach, and Adams, 2005).

Health status

Studies have revealed that depression could be related to health status. Molzon, Hullman, and Eddington (2011) observed that adolescents with allergies are at risk for exprerіencing higher rates of depressive and anxious symptoms than healthy adolescents. Young people living with parents experiencing chronic or acute illness are faced with elevated risk for depression (Molly & Jenkinson, 2012). Kim et al. (2014) reported a depression rate of 20% in adolescents attending HIV/AIDS clinics.

Social support

Mental health problems are prevalent among adolescents in vulnerable environments and are significantly associated with family support and neighborhood connection (Cheng, Li, Lou, Sonenstein, Kalamar, Brahmhatt, Delany-moretlwe, Jejeebhoy, Olumide and Ojengbede,

2014) . Social support is a form of social capital that individuals can draw upon to help them cope with daily stressors (Dominguez & Watkins, 2003). Previous studies have documented positive associations between social support and psychological well being among adults and youths (Hussong, 2000; Newman, Newman, Griffen, O'Connork & Spas, 2007). Another study found an inverse association between social support and depression (Newman et al, 2007; Pierce, Russell, Frone, Copper and Mudar, 2000). Social support may help protect youths against the negative effects of stressors and promote more positive mental outcomes (Hussong, 2000; Newman et al, 2007).

Poor peer relationship

According to Adegoke (2003), peer groups have a strong influence on adolescents'decisions in their belief about life, sexual and relationship decisions. He added tha adolescents thirst for belongingness and this makes them to attach themselves to a particular group without considering the benfits or consequences of joining such group. During adolescence, sources of attachement come from non-familia relationships at school such as with peers and friends (Kubik, Lytle, Birnbaum Murray & Perry, 2003). The change in social expectations and reactions of others to the adolescents puberty development are mostly challenging for adolescents entering the process without support from peers in similar situations (Kaltiala, Heino, Kosunen, Runpela, 2003). As adolescents grow, they express a clear preference for spending time with peers and school is a major environment for adolescents' mental health development (Garnefski, 2009). Findings from a study conducted to determine the relationship between poor peer support revealed that poor peer relationship among adolescents was significantly associated with depression (Norfazilah, Hafizah, Siti and Azmawati, 2015).

Physical inactivity

Adeniyi et al (2011) reported that more severe depressive symptoms were linked with lower levels of physical activity among adolescents. In a study carried out among Norwagian adolescents, emotional symptoms at age 18-19 years in both male and female were inversely associated with physical inactivity at age 15-16. Female adolescents had higher depression

scores and lower physical activity compared to male (Adeniyi et al, 2011). Tao, Xu, Kim, Sun, Su and Huang (2007) opines that regular participation in physical activities not only benefit adolescents by strengthening the muscles, improving bone mass, sustaining oxygen uptake, reducing risk of caridiovascular and other chronic diseases, but helps to improve self esteem, increase self conciousness and reduce anxiety and stress. Hence, low to moderate intensity physical activity is a protective factor against depression and psychotic symptoms.

Academic stress

Globally, academic matters have been reported to be a major source of stress among adolescents (Brown Tenfel, Birch and kancherla, 2006; Ang & Huan, 2006). Poor academic performance is an important factor that influence educational stress among adolescents (Bjorkman, 2007). Previous studies from developed countries reported significant association between educational stress among students attending secondary schools and mental health problems such as depression, anxiety and suicidal ideation (Ang &Huan, 2006; Bjorkman, 2007). Many academic related factors such as academic underachievement, long homework hours, failure in an examination have been found to be associated with depression and behavioural problems among adolescents (Anderman 2002; Chen & Lu 2009; Liu & Tein, 2005). Jayanthi, Thirunavukarasu & Rajumar (2015) stated that adolescents who had academic stress were 2.4 times higher at risk of depression than adolescents without academic stress.

2.4 Concept of Help-Seeking

Help-seeking is an important coping behaviour that involves actively seeking out assistance from formal or informal sources for a problem or concern (Fallon & Bowles, 2001). It is about communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience (Rickwood, Deane, Wilson & Ciarrochi, 2005). According to Rickwood et al (2005), helpseeking is a form of coping that relies on other people, and involves social relationships and interpersonal skills. Help can be sought from a different sources of varying levels of formality. ***Informal help-seeking*** is from informal social relationships, such as

friends and family. ***Formal help-seeking*** is from professional sources of help; that is, professionals who have a recognised role and appropriate training in providing help and advice, such as mental health and health professionals, teachers, youth workers, and clergy. Help can also be sought from sources that do not involve direct contact with other people, such as the internet.

According to World Health Organization, help seeking is defined as any action or activity carried out by a young person who perceives herself/himself as having a need for personal, psychological, affective or health-related assistance or services, with the purpose of relieving or addressing this need in a positive way. This includes seeking help from formal services, for example, clinic services, counsellors, psychologists, medical staff, traditional healers or youth programmes as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community. The "help" provided might consist of an actual service (e.g. a medical consultation or counselling session), a referral for a service provided elsewhere or might simply be talking to another person about the need in question (WHO, 2007).

Previous research has shown that young people are more likely to seek help from informal sources such as friends and family rather than formal sources. Adolescents commonly seek for informal helpseeking for depression such as talking to/asking advice from friends and family rather than consulting mental health professionals (Adeosun, 2016). Young people with severe problems may actually be less likely to seek help than those with lesser problems (Height, 2001). Youths often seek formal help when informal sources are believed to be ill equipped or unavailable to provide sufficient support (Saunders, Resnick, Hoberman and Blum, 1994). Less than half of adolescents with mental health difficulties are estimated to seek professional help or access mental health service (Bergen, Poirier, Fournier, Roberge, & Barrette, 2005; Mrikangas, He, Burstein, Swendsen, Avenevoli, Case, & Olfson, 2011; Unrau & Grinnel, 2005; Tates,Van Dulmen, Hoogerbrugge, Kamps, & Bensing, 2007). Seeking help can buffer a person's reaction to stress, which may lead to a reduced emotional and behavioural problems (Fallon et al, 2001). Help seeking is an adaptive reaction to stress

that often results in greater personal competency and wellbeing (Wilson & Deane, 2010). Help seeking behaviour of adolescents are fundamental to their mental health wellbeing and have a positive impact across life span (Rickwood et al, 2005). Adolescents may have insufficient coping skills to successfully and independently navigate normative and non-normative, biological, cognitive, interpersonal and environmental changes that occur during their transition to adulthood. Hence, the extent to which they seek from informal and informal sources may distinguish between those who are well adjusted and those who are not (Cause, Mason, Gonzales, Hiraga and Liu, 1994; Sears, 2004).

Categories of Help Seeking Behaviour

i. Help-seeking for specific health needs, including health services (in the formal health care system or via traditional healers and pharmacists), as well as seeking health information. This is generally called "health-seeking" behaviour.

ii. Help-seeking behaviour in times of personal stress or problems, such as in the case of family crises; family violence or victimization by abuse; relationship issues (friends, boyfriend/girlfriend); or acute financial needs or homelessness, among others.

iii. Help-seeking for normative developmental needs, including help in completing school, or help related to vocational orientation/training, or employment seeking; relationship issues, sexuality or puberty; and/or other concerns that are frequently associated with adolescence (WHO, 2007).

2.5 Factors Associated with Adolescents' Help-Seeking behaviours

Age

Previous studies that have investigated age differences in helpseeking behaviours revealed that older adolescents are more likely to seek professional help than younger adolescents (Sear, 2004; Leslie, 2000). During early adolescence, adolescents are more likely to limit self disclosure to parents and other adults but rather place greater importance on attachment with peers and striving for independence (Smetana, Villalobos, Rogge & Tasopoulos-Chen, 2010). Wilson and Deane (2010) held the view that older adolescents report fewer barriers to help

seeking as a result of lowered perceived needs for autonomy and believing that seeking mental health care was helpful.

Gender

Girls are more likely to use social support systems i.e. to seek help than boys, whereas boys more frequently try to manage on their own. Research in various settings, including in some developing countries, also finds that girls are generally more likely to pay attention to health-related issues and use health services (Frydenberg, 1997; Barker, 2000). Studies have consistently reported adolescent help seeking to be gender dependent (Adlaf, paglia-Boak, Beithcher & Wolfe, 2004; Ciarrochi, Wilson, Deane & Rickwood, 2003; Farrand, Parker & Lee, 2007). Gender differences in help seeking can be explained by child rearing practices and gender roles that teaches boys to view help seeking as being contradictory with masculine norms, hence, preventing boys from accepting the weak role often associated with seeking help and suffering from mental health problems (Benenson and Konlnazarian, 2008; Jaycox, McCaffrey, Weidmer Ocampo,Shelley, Blake, Peterson, Kub, 2006; Addis & Mahalik, 2003). According to Blazma and Watkins (1996), the common characteristics of male gender role, such as restricted emotionality, independence, vulnerability and self reliance may be related to negative attitudes towards seeking help. These male gender role and characteristics may lead men to perceive themselves as autonomous problem solver, rather than help seekers (Mackenzie, Gekoski, & Knox, 2006). Unlike male, female gender role socialisation emphasises emotional expression, collaboration and dependence which may lead female to seek help from others for problems (Mackenzie et al, 2006).

Attitude towards help seeking

Adolescents with favourable attitudes towards peofessional helpseeking are more likely to seek help than those with unfavourable attitudes (Vondras &Madey, 2004). Studies have shown that adolescents' decisions to discard professional help could be as a result of belief that treatment will be unhelpful or that people who seek help are weak (Curtis, 2010; Komiti, Judd &Jackson, 2006). Adolescents who associated mental health problem with inferiority are more likely to hold negative attitude toward help seeking (Chrandra & Minkovitz, 2007).

Adolescents with higher depressive symptoms were more likely to have negative attitude toward seeking help (Garland and Zigler, 1994).

Personal Coping Skill

Personal ability to resolve issues and cope with stress is an important factor related to help seeking. Researchers have confirmed that thesubjective meaning a young person attributes to life stresses and normative developmental processes is a major factor associated with whether a particular risk factor has subsequent negative developmental implications, and is related to whether an individual seeks help in a stressful situation (Cohler, 1987). Many researchers affirm that help-seeking and coping are learned behaviours. Young people observe and internalize the ways their parents and other adults around them cope with stress and in which situations their parents tend to seek help. Thus, how adolescents internalize local norms about coping and help-seeking is important. That help-seeking and coping are learned implies that it is possible to influence and encourage them. Frydenberg (1997) suggests that the conditions necessary for the conscious development or learning of coping skills are; self-awareness, motivation to change, and skills to achieve desired outcomes.

Previous Experience in Help Seeking

Adolescents' current help seeking practices is associated with previous help seeking experiences (Murray, 2005). According to Chandra et al (2007), positive help seeking experiences and accurate knowledge of mental health have been found to improve helpseeking attitudes, that is, one's experiences with professionals can correct misconception related to mental health care. Negative experience leads to loss of confidence in persons and services. According to (Frydenberg, 1997), young people often report having turned to social support (persons or institutions) in times of need and lost trust because of the ways those individuals or institutions responded to their need .

Perceived barriers

Del Mauro & William, 2013; Woodhouse, 2006, identified factors that possibly prevent adolescents from seeking help, these include; lack of knowledge of mental health(problem of recognising symptoms and poor mental literacy), concerns for confidentiality, lack of resources (affordability of services, transportation, timely access to service) and belief-based barrier (self reliance, stigma, perceived usefulness of helping sources). Person-related barriers refer to cognitive and emotional factors that prevent individual from deciding to seek help (Saunders, Zygowicz & D'Angelo, 2006). Previous research commonly reports poor mental health literacy in the general population as a barrier to help seeking, including inadequate knowledge and stigmatizing attitudes with regard to depression and its treatment (Barney, Christensen, Jorm & Griffiths, 2006; Jorm, Barney, Christensen, Highet, Kelly & Kitchener, 2006).

The fear of stigma associated with mental health problems prevents individuals experiencing mental health problems from acknowleging their symptoms and thereby seeking appropriate help (Barney, Griffths, Jorm and Christensen, 2006). Self stigma related to helpseeking may involve an individual's belief that they are unacceptable due to having a mental health problem, and they are weak if they seek help (Corrigan, 2004; Vogel, Wade and Wester, 2006). Hence, the more a person perceives seeking help as a weakness or threat to their sense of worth and confidence, the less likely they would be to seek help (Vogel & Wade, 2009)

Perceived benefits

Adolescents may be reluctant to seek professional help because they do not perceive it as beneficial (Janaki, 2011). Moskos, Olson, Halbern & Gray (2007), observed that, belief that professional help is not beneficial may be related to lack of knowledge regarding the effectiveness of receiving professional help. In a study carried out among American Indian aged 15-21years, one in five of the participants reported they avoid seeking help because they believed that nobody could help them (Freedenthal & Stiffman, 2007).

Perceived need for mental help

According to Bergeron, Poirier, Fournier, Roberge and Barrette (2005), perceived need for mental help includes parents'and adolescents'perception of the adolescents' mental wellbeing, ability to face day to day demands and psychological distress. Increased psychological distress has been found to increase adolescents' willingness to seek professional help (Madianos, Zaralondi, Alevizoponlos & Katostaras, 2011). Higher levels of psychological symptom of distress facilitate recognition of the problem, therefore, increase the individual perceived need for help (Wilson, Rickwood & Deane, 2007). Sheffield, Fiorenza & Sofronoff, 2004), held the view that, adolescents experiencing higher levels of sychological distress expressed greater willingness to seek help from both formal and informal sources. Although, some studies suggest that the influence of symptoms of psychological distress on help seeking may be dependent on the problem type (Janaki, 2011). Some studies revealed that adolescents who are at potentially increased risk for depression and suicide are often less likely to seek help (Carlton & Deane, 2000; Wilson et al, 2007; Garland & Zigler, 1994).

2.6 Theoretical framework

ECOLOGICAL MODEL AND HEALTH BELIEF MODEL were used in this study to explain factors associated with depression among adolescents and help-seeking behaviour among secondary school adolescents in Ibadan North Local Government Area, Oyo State.

Health Belief Model

Health Belief Model is one of the most commonly used theory in health education and health promotion to explain and predict health-related behaviours, particularly in regard to the uptake of health services. The Health Belief Model was developed in the 1950s by the U.S. Public health Service as a way of explaining why medical screening programme offered for screening of tuberculosis was not successful despite that it was offered without a charge (Hochbaum, 1988). Health Belief Model seeks to explain how personal perception influence individual's decision to take an action to prevent or control an illness. According to (Stretcher, Rosenstock and Becker, 1988) six main constructs or tenets influence people's decision to take action to prevent or control diseases. They are as follows:

Perceived susceptibility: explains that the greater the perceived risk, the greater the likelihood of engaging in behaviours to decrease the risk. Individuals with low perceived susceptibility may deny that they are at risk for contracting a particular disease.

Perceived severity: explains individual's belief about the seriousness of a disease. This perception is often based on the knowledge or information such individual has about the disease (McCormick, 1999). Adolescents who perceived depression as a serious condition are more likely to seek for help. Adolescents' and parents' perception of adolescent mental well being and increased level of psychological distress may influence perceived severity of depression.

Perceived benefit: refers to individual's opinion of the benefits or usefulness of a new behaviour in decreasing the risk of developing a particular disease. Adolescent's perception of the benefits to be derived from help seeking determines if such individual will seek help. Such benefits include; improved mental health, reduced, reduced stress, resolving one's problem, increased energy, improved sleep, increased social support etc. If the perceived benefits outweigh the barrier, there is likelihood that help would be sought.

Perceived barriers or constraints: refers to individual's assessment or evaluation of the obstacles to adopting a new behaviour. Inadequate knowledge about services available, not knowing who to consult, accessibility to services, past experience with health services, lack of trust, concern for confidentiality, stigma, denial, difficulty in expressing emotion among others are perceived barriers to adolescents help seeking for depression.

Cues to action: these are events, things or people that motivate people to change their behaviour. External influences that promote help seeking for depression among adolescents include information provided or sought by individuals, reminders by significant others such as family members, persuasive communication from family and friends or personal experience.

Self-efficacy: it refers to an individual's perception of his or her competence to successfully perform behaviour. Personal ability to resolve issues determines the likelihood of adolescents' seeking help.

Application of the framework was described in fig 2.1 with reference points in the questionnaire draft. The content of the questionnaire was based on the concepts stated below:

Perceived severity was addressed in Q 93-96

Perceived barrier was assessed in Q 97-104

Perceived benfits was assessed in Q 105-109

Cue to action was assessed in Q 110-114

Ecological model

Ecological model of health behaviour explains the influence of environment on a person's health. According to (Lakhan and Ekundayo, 2013) ecological model includes the following multiple levels of influence:

Intrapersonal level (micro): these are individual characteristics that influence depression among adolescents. these include; knowledge about depression in terms of causes, symptoms, prevention and management. Also, attitude towards depression, belief about severity of depression, gender, and low self esteem may influence depression among adolescents.

Interpersonal level (mezzo): intepersonal processes and primary groups that influence depression among adolescents include family, friends and peers that provide social identity, support and role definition. Family environment chracterised by violence, poor parent-child relationship, unsupportive family environment, poor parenting practices, family dsyfunction, and limited family resources may lead to depression in adolescents. poor peer relationship and support may also lead to adolescents having low self esteem which has been identified has one of the strongest factor that influence depression in adolescents.

Institutional/Organisational level (exo): these are rules, regulations, policies and informal structures which may constrain or promote recommended behaviours. Institutional factors that may influence depression among adolescents include; academic stress, school attainment, school connectedness and adolescents' perception of school environment.

Community level (macro): these are social networks, norms or standards, which exist as formal or informal among individuals, groups and organisations. Community or environment characterised by violence, unrest, limited social network may influence depression in adolescents.

Public policy (chromo level): these are local, state and federal policies and laws that support prevention, early detection, control and management of a disease. Lack of institutional policies or weak laws, lack of educational initiatives and public avoidance of information

sharing about depression may influence depression in adolescents. Policies related to adolescents'depression have not been given proper consideration and priority.

Application of the framework was described in fig 2.2 with reference points in the questionnaire draft. The content of the questionnaire was based on the concepts stated below:

Individual factors were addressed in Q 16-43

Interpersonal factors were assessed in Q 44-78

Institutional factors were assessed in Q 79-90

2.7 Conceptual framework

Health Belief Model

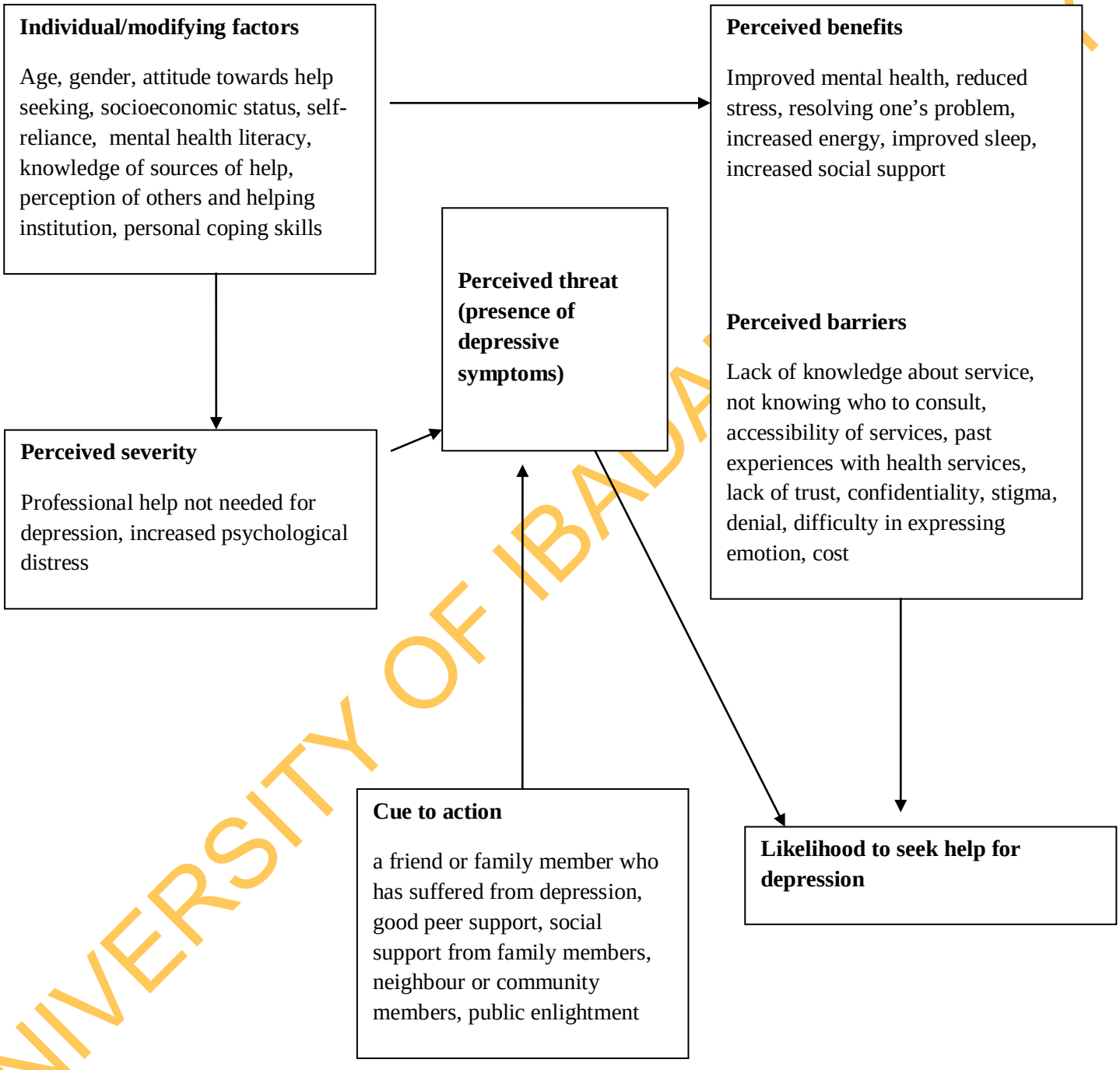

Fig 2.1 Application of Health Belief Model to help seeking behaviour for depression among adolescents.
Source: Self developed

Ecological model

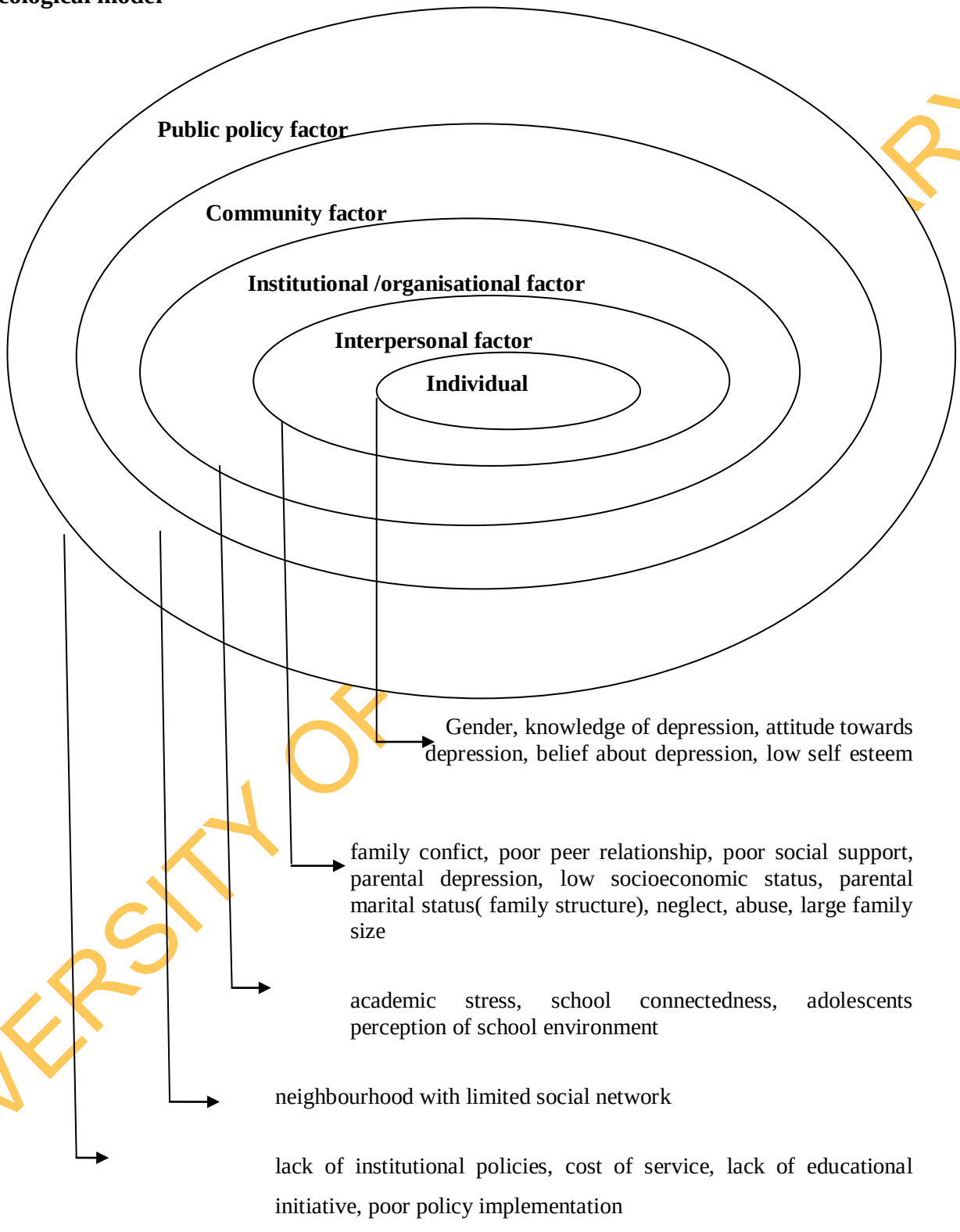

Fig 2.2 Application of Ecological Model to factors associated with depression among adolescents

Source: Self developed

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Research Design

Cross sectional descriptive survey research design was adopted for this study. This design enabled the researcher to collect and analyze the data collected without manipulation.

3.2 Description of study area

Ibadan North Local Government was founded on 27th September 1991. Ibadan North has an area of 27km^2. Ibadan North Local Government Area is located approximately on longitude 8^{o}5' East of the Greenwich meridian and latitude 7^{o}23' North of equators. It comprises of 12 wards. This local government consists of multi-ethnic nationalities predominantly by yoruba, Igbo, Edo, Urhobos, Itsekiri, Hausa and other foreigners from other part of the world. The inhabitants are mostly traders, University and polytechnic lectures, civil servants, students etc. The local government houses several educational institutions such as University of Ibadan, University College Hospital, The Polytechnic Ibadan and several private and public secondary and primary schools. There are 38 public secondary schools and 72 private secondary schools. This advantage puts Ibadan North ahead of other local government in the aspect of educational facilities. It is bounded in the West by Ido and Ibadan North West Local Government, in the East by Lagelu, Egbeda and Ibadan South East Local Government respectively and bounded in the North by Akinyele Local Government. Ibadan North Local Government Secretariat is situated at Agodi Gate Ibadan (Ibor, Anjorin, Ita, Otu, and Bassey, 2011)

3.3 population

The population for this study consisted of in-school adolescents in public secondary schools in Ibadan North Local Government Area. There are 42 registered public secondary schools in Ibadan North Local Government.

3.3.1 Inclusion criteria

The respondents consisted of male and female in-school adolescents in public secondary schools in Ibadan North Local Government Area, Oyo State within the age range of 13-19 years of age.

3.3.2 Exclusion criteria

Out of school adolescents were excluded from this study and adolescents outside the age range. Those above 15 years who do not consent to this study were excluded as well as those below 15 years of age who did not accent to be part of the study. Private schools as at the time of data collection were on end of the session break. Therefore, they were excluded from this study.

3.4 Sample size

The sample size for this research was calculated using Leslie Kish formula of

$$n=\frac{z^2pq}{d^2}$$

where n= minimum sample size required

z = standard normal deviation at 95% confidence level (1.96)

p = 21.2% (Fatiregun and Kumapayi, 2014)

where p= prevalence depression among adolescent = 0.212

q= 1-P = 1- 0.212

d= level of precision at 5% (0.05)

therefore, $n = \frac{(1.96)^2\ 0.212x\ 0.212}{0.05x\ 0.05} = 256.7$

In order to accomodate error, non-responsive rate of 10% was added to the sample size, therefore sample size of 283 was used.

3.5 Sampling technique

A multi stage sampling technique was employed for this study. There are forty-two (42) public secodary schools in Ibadan North Local Government Area. At the first stage, twelve schools (12) were selected using simple random sampling technique by balloting. The

number of respondents that was selected in each school was determined by dividing the total study population sample (283) by the number schools selected (12). At the second stage, simple random sampling was employed in picking classes from arms of classes from SSS1 and SSS2 where respondents were selected. At the last stage, respondents from each class were selected using systematic sampling technique.

3.6 Research instrument

The instrument that was used in this study is a semi-structured questionnaire on factors associated with depression among adolescents and help seeking behaviour for depression. The questionnaire was divided into five sections (A, B, C, D, and E). Section A was used to obtain information on the demographic attributes of the respondents while section B, C, D, and E was used to elicit information on research variables.

Adolescents self esteem was measured using Rosenberg Self-Esteem Scale. Beck Depression Inventory II (BDI-II) was employed in assessment of adolescents' depression. It is a self-report instrument for measuring depression in adults and adolescents aged 13years and older.

3.7 Validity of instrument

Validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are (Joppe, 2000). To ensure the validity of the instruments, the instruments was presented to the researcher's supervisor and other lecturers in the Department of Health Promotion and Education, College Medcine, University of Ibadan and other experts in the field of Health Promotion and Education and related disciplines for content and construct of validity. Comments, suggestions and modifications from the experts was studied carefully to improve the validity of the instrument.

3.8 Reliability of instrument

Reliability is the extent to which a result is consistent over time and an accurate representation of the population under study (Joppe, 2000). To ensure reliability and sensitivity of the instruments, pre-testing is essential to allow the researcher familiarize with

the obstacles that may arise in the process of carrying out the research and also make necessary adjustment before administering the instrument. To obtain the reliability of the instruments, the researcher employed test-retest method. The researcher administered 10% of the validated instruments to secondary school students in Egbeda Local Government Area of Oyo state. The results was subjected to Cronbach-Alpha test with aid of SPSS and a reliability coefficient of more than 0.7 was obtained.

3.9 Procedure for data collection

The researcher obtained a signed letter of introduction from the Head of Department of Health Promotion and Education, Faculty of Public Health, College of Medcine, University of Ibadan for identification and also to have access to the population of the study. Quantitative data was obtained from the students through a questionnaire structured in English Language. Instruction and direction on how to respond to the items in the questionnaire was read to research respondents by the researcher and research assistants for adequate understanding. The researcher administered the instruments personally with the aid of (3) research assistants. The researcher ensured that the research assistants recruited have relevant knowledge of the study. The research assistants were trained on the importance of informed consent and how to seek the consent of the respondents and also ensure confidentiality of information provided by the repondents. The researcher also monitored and supervised research assistants to ensure that questionnaire were properly filled by respondents. The collection of the completed instruments was done on the spot in selected schools. In all, 283 questionnaire were administered but only 279 were retrieved.

3.10 Procedure for data analysis and data management

Copies of the questionnaire were thoroughly scrutinized by the researcher on the field in order to ensure completness and accuracy. The questionnaire were serially numbered and coded for easy identification and recall purposes. Copies of the questionnaire were edited and coded by the researcher using a coding guide. The data was inputed into the computer system for analysis using the SPSS software. Frequency counts was ran to detect missing cases while the data also underwent cleaning. The data was analysed using both descriptive

statistics (frequency count, percentages, bar chart and pie chart) and inferential statistics of Chi-square was used to test the hypotheses at 0.05 level of significance.

Respondents'knowledge score on depression was scored on a 12-point scale. Respondents with total score of 0-5 point were classified as having poor knowledge, between 6-8 point were rated to have fair knowledge and those who scored between 9-12 point were classified as having good knowledge.

Attitude of respondents to depression was score on a 9-point scale and respondents with scores $\leq$ 4 were categorized as having poor attitude while respondents with score $\geq$ 5 were categorized as having good attitude.

Depression was measured in respondents using responses to the Beck Depression Inventory-II. It is a 21-item questions. Items are rated on a 4-point Likert scale ranging from 0-3 giving a maximum score of 63 points. Respondents with a total score of 0-9 indicated absence of depression, score between 10-18 indicated mild depression, score between 19-29 indicated moderate depression while score between 30- 63 indicated severe depression (Okwaraji et.al 2016).

Respondents' self-esteem was measured using responses to Rosenberge self –esteem scale. It is a 10-item question. The scale ranges from 0-30. Scores between 15 and 25 indicate high self-esteem while scores below 15 indicate low self-esteem.

3.11 Ethical consideration

This study followed the basic ethical principles guiding research involving human participants. Ethical approval was sought from Oyo State Ethics Review Committee of the Ministry of Education, Ibadan in order to ensure safety of research participants. Adequate information regarding the study was given to the respondents. Informed consent was obtained from each participants above 15 years of age with their signature or thumb prints appended on the form. Informed assent was obtained from participants below 15 years of age as well as parents or guardians of participants below the age of 15. Participants were assured of the confidentiality of the information obtained from them. All information obtained was used for research purpose only. Participation in the study was made voluntary with permission to withdraw at any time if they so wished without any penalties or loss of

privileges. Research assistants were trained to assist in the distribution and retrival of the questionnaire. Completed questionnaire was kept in a secure safe under lock and key where no other persons would have access to the the information obtained from the respondents.

3.12 Limitation of the study

As at the time of data collection, private schools were on end of the session break. Hence, adolescents in private schools in the local government were not able to participate in this study.

CHAPTER FOUR

RESULTS

The findings from this study are presented in this section. They are organized into the following subsections:

- Socio demographic characteristics
- Knowledge of depression among in-school adolescents
- Factors associated with depression among in-school adolescents
- Help-seeking behaviour for depression among in-school adolescents
- Prevalence of depression among in-school adolescents

4.1 Socio-demographic Characteristics

The ages of respondents ranged from 13 to 19 years with a mean of 15.6± 1.2 years. The majority (53.4%) fell between 16-19 years' age group. Most of the respondents (54.1%) were female. Larger percentages (52.7%) of the respondents were Christians while 82.1% were Yorubas. Most (78.1%) of the respondents' parents were married and staying together and in a monogamous family structure (72.8%). A little below half of the fathers of the respondents (47.3%) and 53.0% of the mother had secondary level of education. The mean number of sibling that the respondents had was 3.8 ± 1.5 years. Majority (64.5%) of respondents' fathers were businessmen while a higher percentage of the mothers (65.6%) were also into business.

Table 4.1: Socio-demographic characteristics of the respondents (N=279)

Socio-demographic Variable	Frequency (N)	Percentage (%)
Sex		
Male	128	45.9
Female	151	54.1
Age at last birthday		
12-15 years	130	46.6
16-19years	149	53.4
Religion		
Islam	131	47.0
Christianity	147	52.7
Traditional	1	.4
Ethnicity		
Yoruba	229	82.1
Igbo	37	13.3
Hausa	13	4.7
Parent's Marital Status		
Single	28	10.0
Married and staying together	218	78.1
Married but not staying together	16	5.7
Divorced	8	2.9
Widow/Widower	9	3.2
Family Structure		
Monogamous	203	72.8
Polygamous	76	27.2
Number of simblings		
1-3 Siblings`	117	41.9
4-6 Sibling	146	52.3
7-9 Siblings	16	5.4

Table 4.2: Parents' level of education of the respondents

Socio-demographic Variable	Frequency (N)	Percentage (%)
Father's Level of Education (N=279)		
No formal education	25	9.0
Primary	19	6.7
Secondary	132	47.3
Tertiary	103	36.9
If tertiary, please specify (N=103)		
OND	13	12.6
HND	13	12.6
B.Sc	6	5.8
M.Sc	9	8.7
No response	62	60.2
Mother's level of education (N=279)		
No formal education	30	10.7
Primary	20	7.2
Secondary	148	53.0
Tertiary	81	29.0
If tertiary, please specify which (N=81)		
OND	7	8.6
HND	10	12.3
B.Sc	5	6.2
M.Sc	5	6.2
No response	54	66.7

Table 4.3: Occupation of parents of the respondents

Socio-demographic Variable	Frequency (N)	Percentage (%)
Fathers occupation		
Civil servant\	61	21.9
Businessman	180	64.5
Artisan	25	9.0
Unemployed	13	4.7
Mothers occupation		
Civil servant	46	16.5
Businesswoman	183	65.6
Artisan	38	13.6
Unemployed	12	4.3

4.2 Knowledge of Depression

The mean knowledge score obtained by the respondents was 4.6 ±1.9. Majority (70.3%) of the respondents had poor knowledge of depression, 28.7% had fair knowledge while only 1.1% of them had good knowledge of depression. More than half (64.9%) of the respondents have heard about depression but only few (28.0%) of them would call depression a disease. Some of the respondents (45.2%) wrongly thought depression is when someone is thinking too much while only very few (12.5%) could rightly identify depression as a mental disorder. More than half (52.0%) of the respondents stated that low self-esteem could cause depression, only 37.3% stated poor family relationship as a cause of depression.

More than half (60.9%) of the respondents believed depression as a medical illness is treatable. About a third (34.1%) of the respondents mentioned loss of interest and pleasure in activities and feel of sadness as symptoms of depression respectively while 21.5% wrongly mentioned high self-confidence as a symptom of depression.

Table 4.4: Knowledge of Depression (N=279)

Knowledge Variable	Frequency (N)	Percentage (%)
Awareness about depression		
Yes	181	64.9
No	98	35.1
Would you call depression a disease		
Yes	78	28.0
No	201	72.0
Meaning of Depression		
Inability to sleep	47	16.8
A mental disorder	35	12.5
A stress	71	25.4
Thinking too much	126	45.2
Likely causes of depression*		
low self esteem	145	52.0
over eating	18	6.5
reading too much	18	6.5
poor family relationship	104	37.3
Treatability of Depression as a medical illness		
Yes	170	60.9
No	109	39.1
Symptoms of depression		
Loss of interest and pleasure in activities	95	34.1
High self confidence	60	21.5
Thoughts about death	16	5.7
Ability to concentrate well	20	7.2
Feeling of sadness	95	34.1

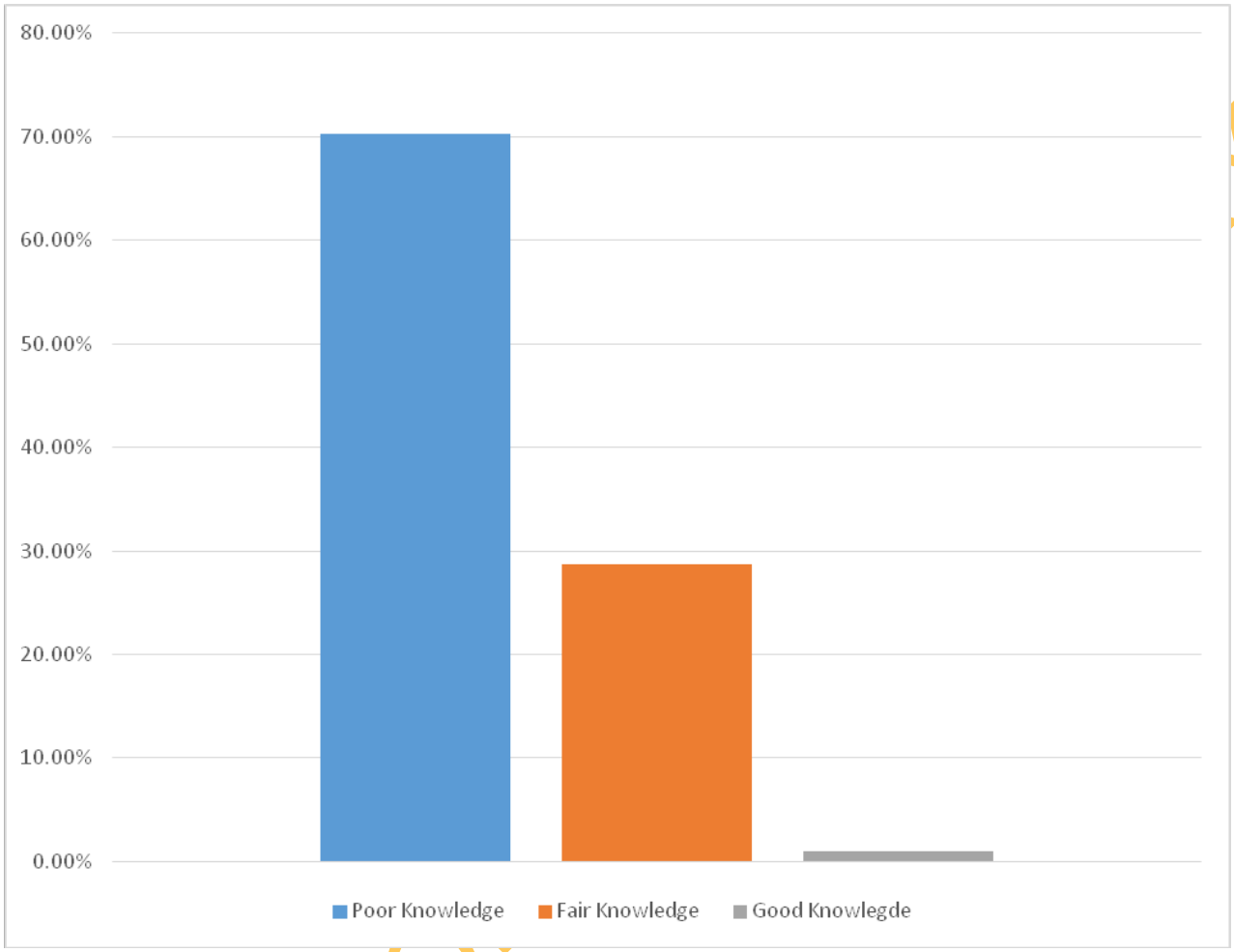

Figure 4.1: Knowledge of depression among in-school adolescents

4.3 Factors associated with Depression

4.3.1 Individual factors

Attitude towards depression

The mean attitude score was 4.3 ± 1.5 with majority of the respondents (79.9%) having a poor attitude towards depression. More than half (55.2%) agreed while 20.8% strongly agreed that depression is part of life with only few (18.3%) disagreeing. More than half (69.9%) agreed that they could handle their emotions themselves.

More than half (56.3%) had a wrong attitude that depression is just a normal stress although more than half (71.2%) believed that people with depression can come out of it if they wanted. More than half (68.1%) stated that depression is a sign of personal weakness while 31.9% of them disagreed. Less than a third of the respondents (27.2%) agreed that meeting with the school counsellor for depression is a waste of time while majority (72.7%) disagreed. More than half (58.4%) of the respondents also had a wrong attitude that depression is not a real medical illness while a little below half (49.1%) stated that they would not tell anyone if they had depression. About half (49.1%) of the respondents also wrongly believed that depression does not require any treatment.

Belief about depression

More than half (52.4%) of the respondents agreed that depression is as serious as any other diseases while less than half 43.3% wrong believed that they could not help it no matter what because depression is hereditary. Majority (62.0%) also believed that biological changes in the brain cause depression while 38.0% disagreed. Most of the respondent (69.5%) believed that going to church or mosque and participating in religious programmes is the first thing to do to treat depression while 67.0% also believed that counselling is as effective as medication in treating depression.

A little less than half of the respondents (43.7%) agreed while 24.4% strongly agreed that they would prefer to discuss what they could do to treat depression/sadness with their spiritual leader. Most of the respondents (75.6%) also agreed that they could change depression by changing their behavior and the percentage also believed that meeting with a school counsellor to talk about their feelings might help their moods.

Self Esteem

Majority of (89.0%) the respondents agreed they were persons of value and at least on equal level with others. Almost all the respondents (91.0%) felt they had a number of good qualities while few (30.1%) admitted that all in all, they were persuaded to feel that they were failures. Most of the respondents (87.5%) stated that they were able to do things as well as most people and a little more than half (60.3%) felt they didn't have much to be proud of. Some of the respondents (81.0%) agreed to taking taking positive attitude toward themselves while on the whole, (87.1%) of the respondents were satisfied with themselves. Majority of the respondents (87.8%) wished they could have more respect for themselves while few (41.9%) certainly felt useless at time and 44.5% admitted to thinking they were no good at all. Most (83.3%) of the respondents have high self esteem while (19.7%) reported low self esteem.

Table 4.5a: Factors associated with Depression - Individual Factors (N=279)

Individual factors associated with depression	Strongly Agree N(%)	Agree N(%)	Disagree N(%)	Strongly disagree N(%)
Attitude towards depression				
Depression is part of life	58(20.8%)	154(55.2%)	51(18.3%)	16(5.7%)
I can handle my emotions my self	61(21.9%)	134(48.0%)	63(22.6%)	21(7.5%)
Depression is just a normal stress	48(17.2%)	109(39.1%)	91(32.6%)	31(11.1%)
People with depression can come out of it if they wanted	71(26.5%)	125(44.8%)	52(18.6%)	28(10.0%)
Depression is a sign of personal weakness	61(21.9%)	129(46.2%)	60(21.5%)	29(10.4%)
Meeting with the school counsellor for depression is a waste of time	20(7.1%)	56(20.1%)	112(40.1%)	91(32.6%)
Depression is not a real medical illness	51(18.3%)	112(40.1%)	69(24.7%)	47(16.8%)
If I had depression, I would not tell anyone	28(10.0%)	72(25.8%)	100(35.8%)	709(28.2%)
Depression do not require any treatment	54(19.4%)	83(29.7%)	87(31.2%)	55(19.7%)
Belief about depression				
Depression is as serious as any other diseases	49(17.6%)	97(34.8%)	88(31.5%)	45(16.1%)
Depression is hereditary, I cant help it no matter what	33(11.8%)	88(31.5%)	100(35.8%)	58(20.8%)
Biological changes in the brain cause depression	49(17.6%)	124(44.4%)	70(25.1%)	36(12.9%)
Going to church or mosque and participating in religious programmes is the first thing to do to treat depression	67(24.0%)	127(45.5%)	58(20.8%)	27(9.7%)
Counselling is as effective as medication in treating depression	74(26.5%)	113(40.5%)	72(25.8%)	20(7.2%)
I would prefer to discuss what I can do to treat depression/sadness with my spiritual leader	68(24.4%)	122(43.7%)	67(24.0%)	22(7.9%)
I can change my depression by changing my behaviour	65(23.3%)	146(52.3%)	54(19.4%)	14(5.0%)
Meeting with a school counsellor to talk about my feelings might help my mood	88(31.5%)	123(44.1%)	45(16.1%)	23(8.2%)

Table 4.5b: Factors associated with Depression - Individual Factors (N=279)

Individual factors associated with depression	Strongly Agree N(%)	Agree N(%)	Disagree N(%)	Strongly disagree N(%)
Self Esteem				
I feel I am a person of value, at least on equal level with others	101(36.2%)	148(53.0%)	26(9.3%)	4(1.4%)
I feel that I have a number of good qualities	129(46.2%)	125(44.8%)	22(7.9%)	3(1.1%)
All in all, I am persuaded to feel that I am a failure	36(12.9%)	48(17.2%)	103(36.9%)	92(33.0%)
I am able to do things as well as most people	92(33.0%)	152(54.5%)	29(10.4%)	6(2.2%)
I feel I don't have much to be proud of	49(17.6%)	119(42.7%)	76(27.2%)	35(12.5%)
I take positive attitude toward myself	90(32.3%)	136(48.7%)	32(11.5%)	21(7.5
On the whole, I am satisfied with myself	99(35.5%)	144(51.6%)	28(10.0%)	8(2.9%)
I wish I could have more respect for my self	100(35.8%)	145(52.0%)	21(7.5%)	13(4.7%)
I certainly feel useless at times	41(14.7%)	76(27.2%)	99(35.5%)	63(22.6%)
At times I think I am no good at all	32(11.5%)	92(33.0%)	88(31.5%)	67(24.0%)

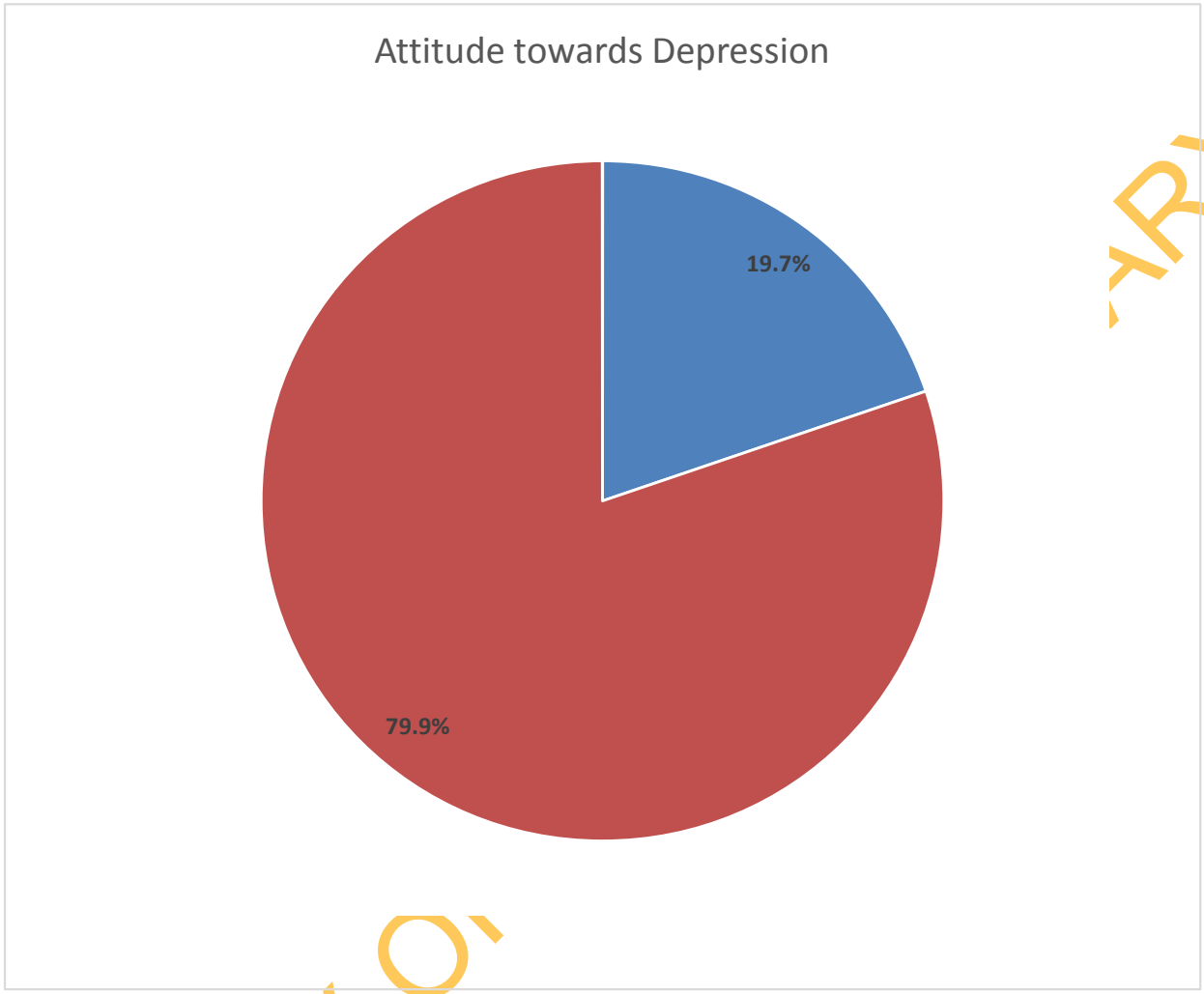

Figure 4.2: Attitude towards Depression

4.3.2 Interpersonal factors

Family relationship

Less than half (46.6%) stated that members of their family really care about each other all the time, 22.6% stated they do most of the time while 10.4% admitted that members of their family very rarely care about each other while 6.8% said members of their family never care about each other.

More than half (53.0%) said they enjoy their families all the time while 22.6%, 13.6%, said they enjoyed their families most of the time and some of the time respectively. Very few (10.8%) of the respondents admitted that they rarely enjoy their families. Few of the respondents (16.8%) stated that they rarely depend on their family while the same percentage stated that they wished they were not part of their family some of the time. About a third (34.4%) stated they get along well with their family all of the time while only 25.1% stated they only get along with their family most of the time. Very few (19.7%) very rarely get along with their families. About a quarter of the respondents (27.6%) stated that members of their family argue too much some of the time while 18.6% said there was no sense of closeness in their family some of the time.

Few of the respondents (15.1%) said they feel like a stranger in their families some of the time while a higher percentage (28.0%) felt their family did not understand them some of time. More than half of the respondents (54.1%) said there is never hatred in their family although 22.9% admitted that there seemed to be a lot of friction in their families some of the time. All other responses are reported in table 4.6

Social support

Most of the respondents (91.4%) said their family really tried to help them while 92.1% stated that they get the emotional support and help they need from their family. Majority (82.1%) said they could talk about their problems with their family while 85.6% also said their family was willing to help them make decisions. A little above half (59.8%) however said they could count on friends and a higher percentage (73.1%) stated they could talk about their problems with their friends. Most of the respondents (79.2%) had a special person with whom they could share their joy and sorrow. Other responses are presented in table 4.6

Table 4.6a: Factors associated with depression - Interpersonal factors (N=279)

Interpersonal factor associated with depression	None of the time N(%)	Very rarely N(%)	Some of the time N(%)	Most of the time N(%)	All of the time N(%)
Family relationship					
The members of my family really care about each other	19(6.8%)	29(10.4%)	38(13.6%)	63(22.6%)	130(46.6%)
I really enjoy my family.	4(1.4%)	30(10.8%)	28(10.0%)	69(24.7%)	148(53.0%)
I can really depend on my family.	20(7.2%)	47(16.8%)	63(22.6%)	55(19.7%)	94(33.7%)
I wish I was not part of this family.	158(56.6%)	37(13.3%)	47(16.8%)	25(9.0%)	12(4.3%)
I get along well with my family	20(7.2%)	36(12.9%)	57(20.4%)	70(25.1%)	96(34.4%)
Members of my family argue too much.	89(31.9%)	55(19.7%)	77(27.6%)	42(15.1%)	16(5.7%)
There is no sense of closeness in my family	133(47.7%)	33(11.8%)	52(18.6%)	36(12.9%)	25(9.0%)
I feel like a stranger in my family	159(57.0%)	39(14.0%)	42(15.1%)	23(8.2%)	16(5.7%)
My family does not understand me	131(47.0%)	30(10.8%)	78(28.0%)	30(10.8%)	10(3.6%)
There is too much hatred in my family	151(54.1%)	53(19.0%)	38(13.6%)	26(9.3%)	11(3.9%)
Members of my family are really good to one another	20(7.2%)	27(9.7%)	31(11.1%0	48(17.2%)	153(54.8%)
There seems to be a lot of friction in my family	107(38.4%)	62(22.2%)	64(22.9%)	34(12.2%)	12(4.3%)
There is a lot of love in my family	13(4.7%)	25(9.0%)	28(10.0%)	62(22.2%0	151(54.1%)
Members of my family get along well together	14(5.0%)	28(10.0%)	50(17.9%)	64(22.9%)	123(44.1%)
Life in my family is generally unpleasant	128(45.9%)	45(16.1%)	44(15.8%)	35(12.5%)	27(9.7%)
My family is a great joy to me	6(2.2%)	26(9.3%)	41(14.7%)	35(12.5%)	171(61.3%)
I feel proud of my family	16(5.7%)	24(8.6%)	33(11.8%)	34(12.2%)	172(61.6%)
My family is a real source of comfort to me	16(5.7%)	26(9.3%)	44(15.8%)	46(16.5%)	147(52.7%)
I feel left out of my family	145(52.0%)	36(12.9%)	59(21.1%)	22(7.9%)	17(6.1%)
My family is an unhappy one	186(66.7%)	32(11.5%)	25(9.05)	23(8.2%)	13(4.7%)

Table 4.6b: Factors associated with depression - Interpersonal factors (N=279)

Interpersonal factors associated with depression	Strongly Agree N(%)	Agree N(%)	Disagree N(%)	Strongly disagreeN(%)
Social Support				
My family and really tries to help me	100(35.8%)	155(55.6%)	13(4.7%)	11(3.9%)
I get the emotional support and help I need from my family	106(38.0%)	151(54.1%)	17(6.1%)	5(1.8%)
I can talk about my problems with my family	96(34.4%)	133(47.7%)	36(12.9%)	14(5.0%)
My family is willing to help me make decisions	88(31.5%)	151(54.1%)	29(10.4%)	11(3.9%)
I can count on my friends when things go wrong	33(11.8%)	134(48.0%)	88(31.5%)	24(8.6%)
My friends really try to help me	64(22.9%)	169(60.6%)	40(14.3%)	6(2.2%)
I have friends with whom I can share my joys and sorrows	78(28.0%)	141(50.5%)	41(14.7%)	19(6.8%)
I can talk about my problems with my friends	64(22.9%)	140(50.2%)	57(20.4%)	18(6.5%)
There is a special person with whom I can share my joy and sorrow	112(40.1%)	109(39.1%)	48(17.2%)	10(3.6%)
have a special person who is a real source of comfort to me	119(42.7%0	124(44.4%)	29(10.4%)	7(2.5%)

4.3.3 Institutional Factors

Academic Stress

Many of the respondents (74.2%) admitted there was too much competition among classmates which brings them a lot of academic pressure while 65.9% also stated that they feel a lot of pressure in their daily studying. More than three quarter (72.8%) said their parents cared about their academic grades too much that it brings them a lot of pressure while more than half (54.8%) also admitted that they were not satisfied with their academic grades. Few of them (26.6%) felt there are too many test/exams in the school.

School Connectedness

Most of them (92.0%) felt they were close to people at school and majority (94.6%) also felt like a part of their school. Majority (92.5%) were happy to be in their school while most of them (83.9%) felt safe in their school.

Table 4.7: Factors associated with Depression- Institutional factors (N=279)

Institutional factors associated with depression	Strongly Agree N(%)	Agree N(%)	Disagree N(%)	Strongly disagree N(%)
Academic Stress				
There is too much competition among classmates which brings me a lot of academic pressure	53(19.0%)	154(55.2%)	56(20.1%)	16(5.7%)
I feel a lot of pressure in my daily studying	57(20.4%)	126(45.2%)	75(26.9%)	21(7.5%)
My parents care about my academic grades too much which brings me a lot of pressure	89(31.9%)	114(40.9%)	59(21.1%)	17(6.1%)
I am not satisfied with my academic grades	43(15.4%)	110(39.4%)	96(34.4%0	30(10.8%)
I always lack confidence with my academic scores	42(15.1%)	82(29.4%)	114(40.9%)	41(14.7%)
It is very difficult for me to concentrate during classes	24(8.6%)	63(22.6%)	129(46.2%)	63(22.6%)
I feel there is too much homework	22(7.9%)	49(17.6%)	139(49.8%)	69(24.7%)
I feel that there are too many test/exams in the school	27(9.7%)	58(20.8%)	124(44.4%)	70(25.1%)
I feel close to people at school	82(29.4%0	172(61.6%)	21(7.5%)	4(1.4%)
School Connectedness				
I feel close to people at school	82(29.4%)	172(61.6%)	21(7.5%)	4(1.4%)
I feel like I am part of this school	98(35.1%)	166(59.5%)	12(4.3%)	2(0.7%)
I am happy to be at this school	109(39.1%)	149(53.4%)	18(6.5%)	3(1.1%)
I feel safe in my school	99(35.5%)	135(48.4%)	29(10.4%)	16(5.8%)

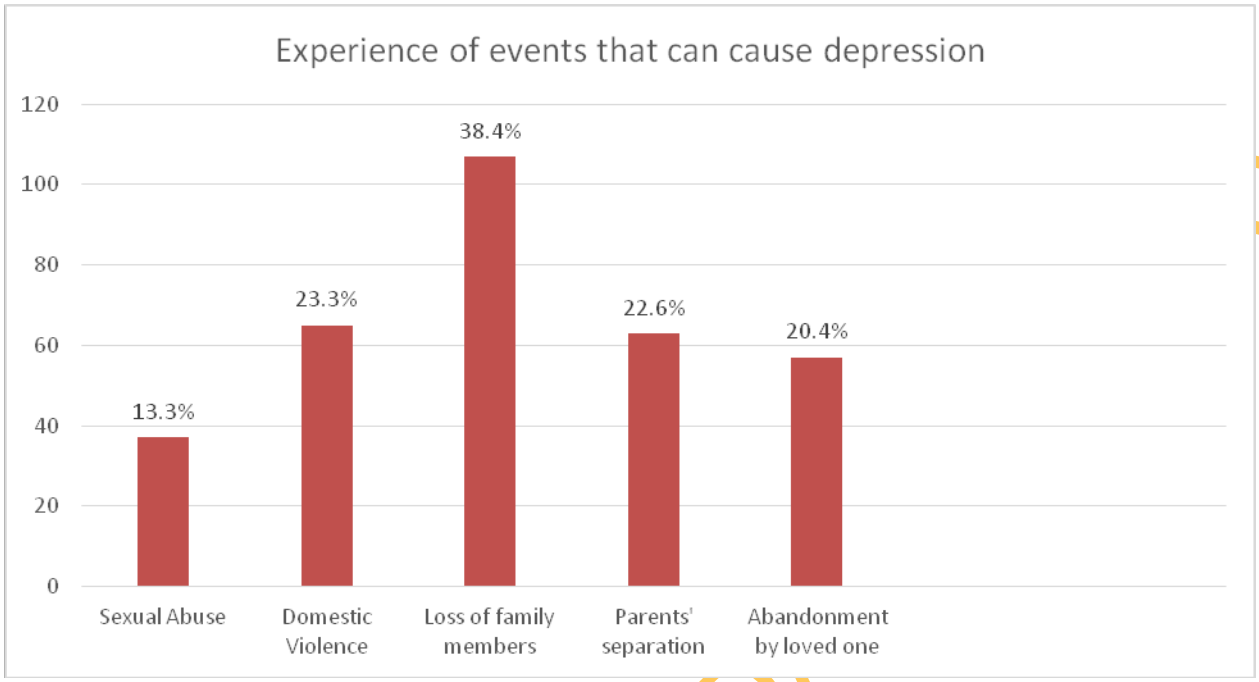

Figure 4.3: Experience of negative life events that can influence depression

4.4 Respondents' Help Seeking Behaviour

A little less than half of the respondents (47.7%) reported that they have had a past experience of depression while 28.0% stated that thye are currently experiencing depression

Perceived Severity of Depression

Most of the respondents (67.0%) did not think depression is a serious illness while few of them (28.7%) felt they didn't need help because they were not depressed. Few of them (38.0%) also believed they could handle their situation themselves and only 29.0% were not worried about their situation. Other responses were presented in table 4.8

Perceived barriers for not seeking help

A significant percentage (43.0%) perceived embarrassment as a barrier while (38.1%) also identified cost as a perceived barrier. Other perceived barriers identified were fear of being labelled crazy (37.3%), lack of knowledge about where to go for help (39.1%), uncomfortability with sharing feelings with another person (39.5%), unwillingness to talk to a counsellor about personal issues (35.2%), fear of the counselor (29.4% and lack of support from family and friends (23.7%).

Perceived Benefits of seeking help

When asked about their perceived benefits of seeking help for depression , majority of the respondents (78.8%) perceived that it would help to reduce stress while 82.5% perceived that it would help to resolve ones problem. A little more than half (56.3%) believed it would help to improve sleep while 72.1% stated that it would help to improve mental health while 75.6% stated that it would help to improve relationship with others

Cues to Action

Majority of the respondents (73.1%) believed that having a friend who is depressed will motivate them to seek help if they have depression but a lower percentage believed 56.7% stated that having a family member who have had depression in the past will motivate them to seek help if they have depression. Other cues to action mentioned were having a friend who encourage(s) me (78.2%) and reading about depression in magazine (63.4%).

Table 4.8: Perceived Severity, barriers, and benefits of Cue to action for help for depression (N=279)

Health Belief	Strongly Agree N(%)	Agree N(%)	Disagree N(%)	Strongly disagree N(%)
Perceived Severity of depression				
I dont think depression is a serious illness	46(16.5%)	141(50.5%)	79(28.3%)	13(4.7%)
I dont need help when I am depressed	22(7.9%)	58(20.8%)	142(50.9%)	57(20.4%)
I can handle my situation my self	30(10.8%)	76(27.2%)	106(38.0%)	67(24.0%)
I am not worried about my situation	14(5.0%)	67(24.0%)	131(47.0%)	67(24.0%)
Perceived barriers for not seeking help				
Feel of Embarassment	39(14.0%)	83(29.7%)	115(41.2%)	42(15.1%)
Cost	26(9.4%)	80(28.7%)	123(44.1%)	50(17.9%)
Fear of being labelled crazy	32(11.5%)	72(25.8%)	124(44.4%)	51(18.3%)
No knowledge of where to go for help	44(15.8%)	65(23.3%)	123(44.1%)	46(16.5%)
Uncomfortable with sharing my feelings with another person	32(11.5%)	78(28.0%)	113(40.5%)	64(20.1%)
I do not want to talk to a counsellor about personal issues	36(12.9%)	62(22.3%)	127(45.6%)	54(19.4%)
Fear of the counselor	28(10.0%)	54(19.4%)	136(48.8%)	61(21.9%)
Lack of support from family and friends	27(9.7%)	39(14.0%)	119(42.7%)	94(33.7%)
Perceived Benefits of seeking help				
Help to reduce stress	86(30.8%)	134(48.0%)	41(14.7%)	18(6.5%)
Help to resolve ones problem	85(30.5%)	145(52.0%)	39(14.0%)	10(3.6%)
Help to improve sleep	60(21.5%)	97(34.8%)	94(33.7%)	28(10.1%)
Help to improve mental health	97(34.8%)	104(37.3%)	52(18.6%)	26(9.4%)
Help to improve relationship with others	89(31.9%)	122(43.7%)	49(17.6%0	19(6.8%)
Cues to Action				
Having a friend who is depressed will motivate me to seek help if I have depression	68(24.4%)	136(48.7%)	59(21.1%)	16(5.7%)
Having a family member who have had depression in the past	54(19.4%)	104(37.3%)	88(31.5%)	33(11.8%)
Having a family member(s) who encourage(s) me to seek help	74(26.5%)	118(42.3%)	64(22.9%)	23(8.2%)
Having a friend who encourage(s) me	85(30.5%)	133(47.7%)	48(17.2%)	13(4.7%)
Reading about depression in magazine	60(21.5%)	117(41.9%)	76(27.2%)	26(9.4%)

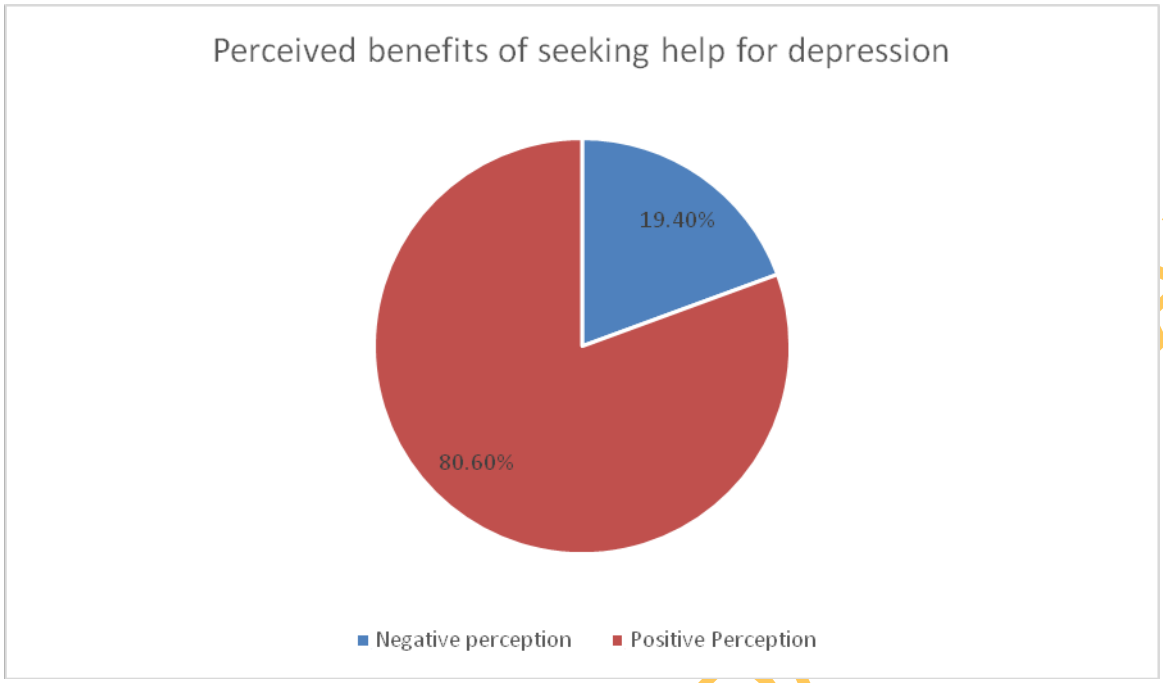

Figure 4.4: Perceived benefits of seeking help for depression

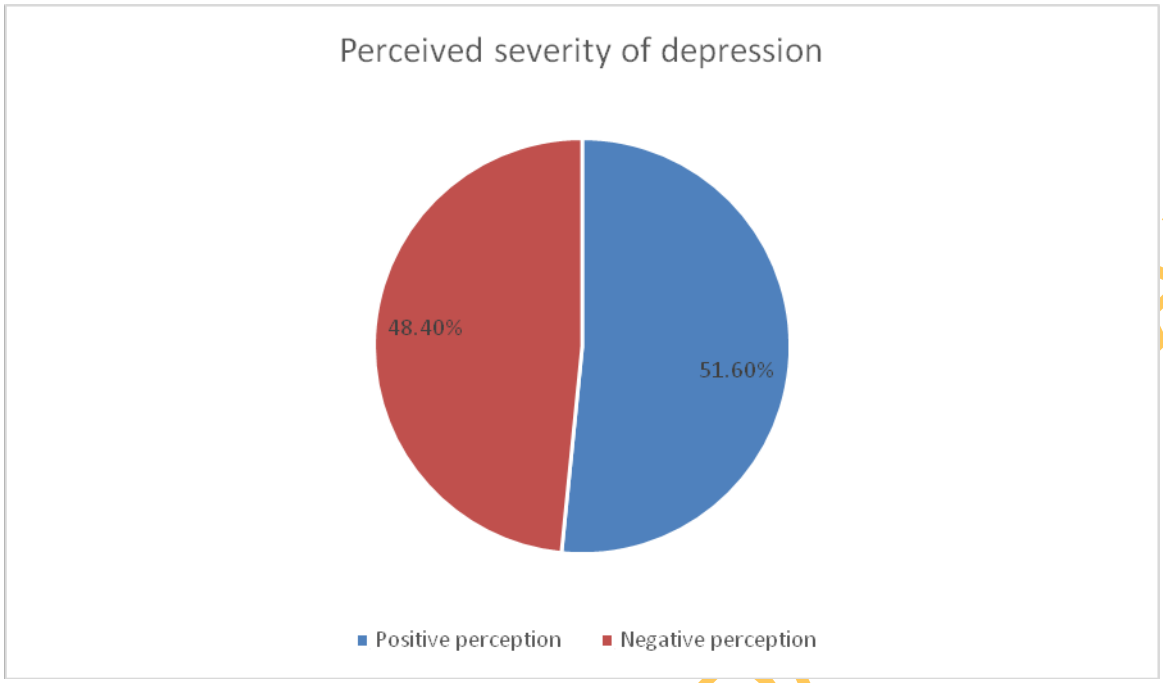

Figure 4.5: Perceived severity of depression

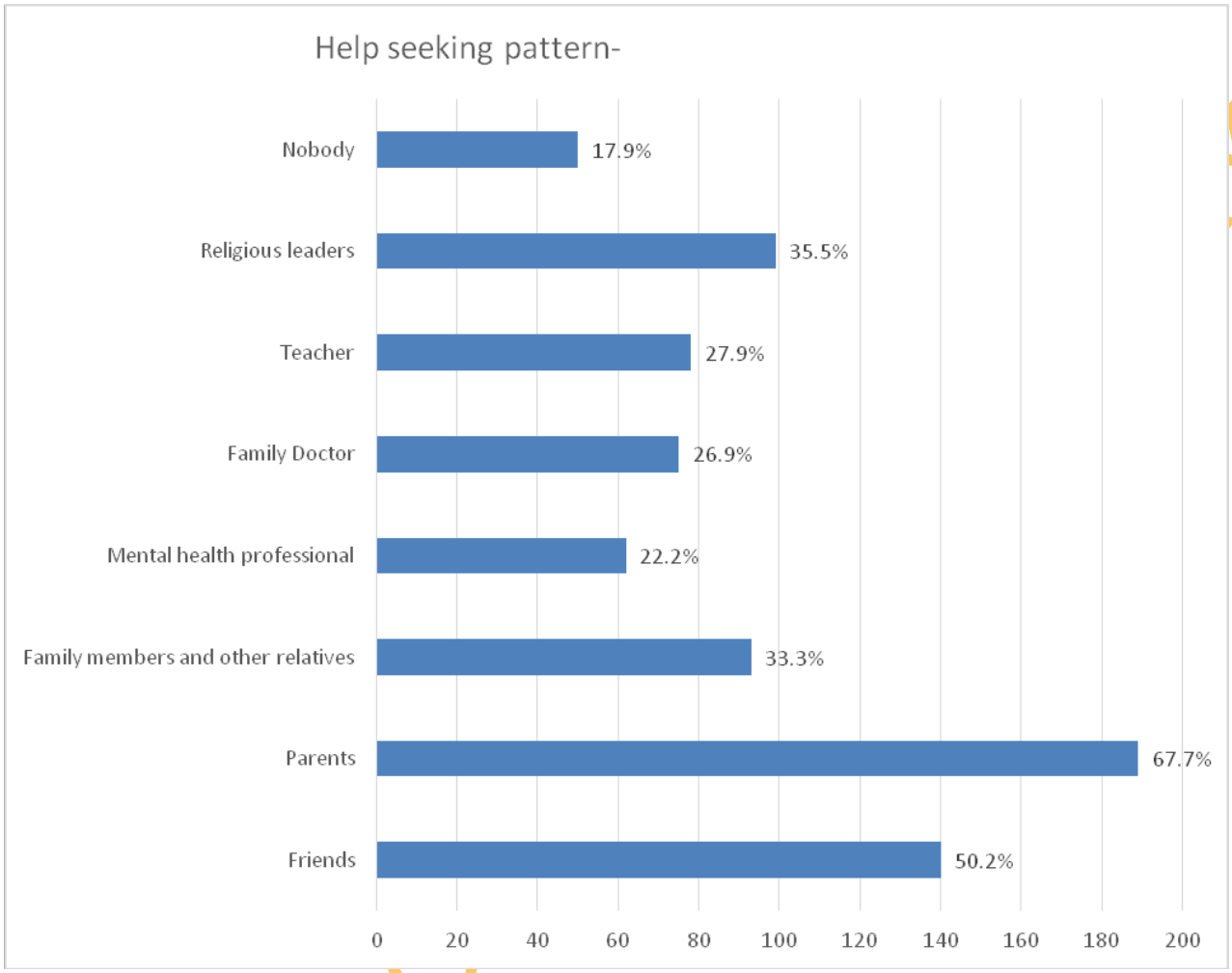

Figure 4.6: Help seeking pattern for depression among respondents

4.5 Respondents' Experience of Depression

More than half (52.3%) of the respondents reported they have not experienced depression in the the past, while (47.7%) stated that they have experienced depression in the past. Majority (72.0%) of the respondents reported that they are not currently experiencing depression, while few (28.0%) reported that they are currently experiencing depression.

Beck Depression Inventory II (BDI- II) revealed that more than half (56.2%) of the respondents have depression. (22.9%) of the respondents have mild depression, (21.5%) are moderately depressed while few (11.8%) are severely depressed. (29.0%) of the male respondents are depressed while (27.2%) of the female respondents are depressed.

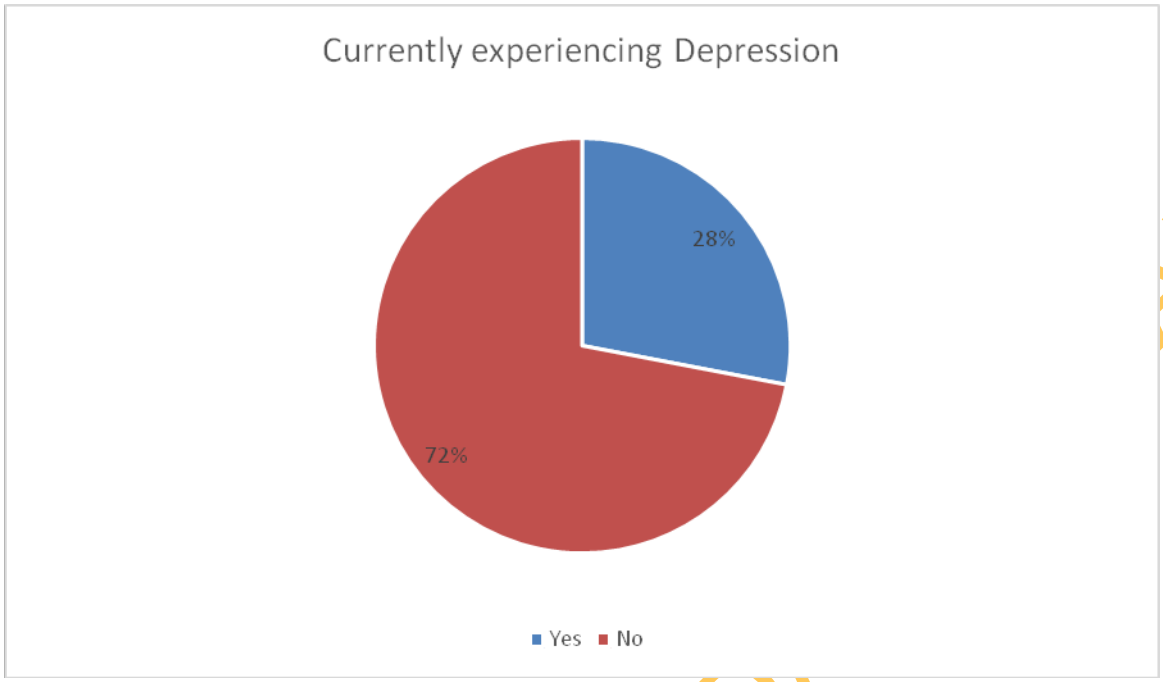

Figure 4.7: Percentage of respondents that self-reported they are currently experiencing depression

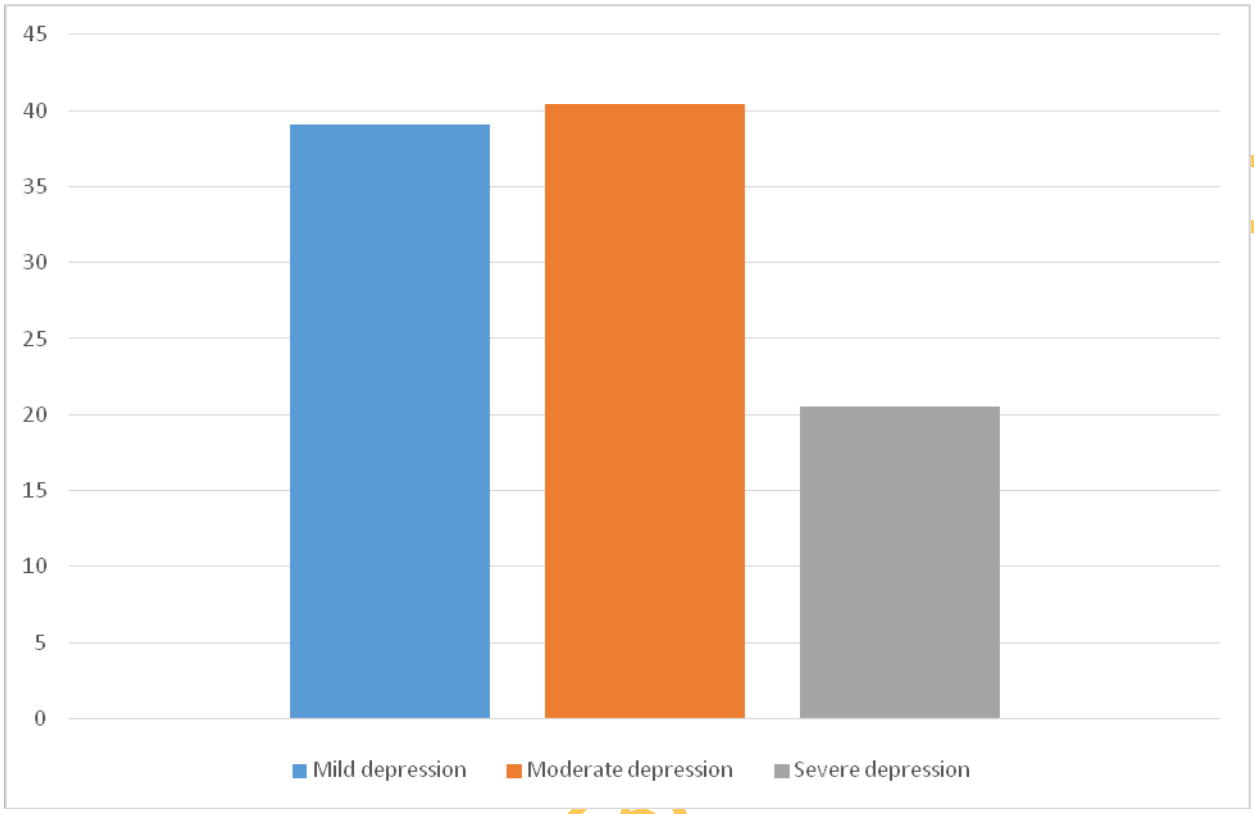

Figure 4.8: Levels of depression among respondents

Table 4.9: Factors significantly associated with depression among respondents

Variable	Depression			X2	Df	P-Value
	Mild	Moderate	Severe			
Feeling of good self-value				**18.663**	**9**	**0.028**
Strongly agree	26	15	5			
Agree	30	35	21			
Disagree	2	10	5			
Strongly disagree	1	1	0			
Care of members of family for one another				**21.732**	**12**	**0.041**
None of the time	2	2	7			
Very rarely	4	8	2			
Some of the time	5	12	5			
Most of the time	15	14	7			
All of the time	33	25	10			
Ability to get along with family				**22.172**	**12**	**0.036**
None of the time	3	9	2			
Very rarely	7	9	6			
Some of the time	8	13	9			
Most of the time	19	12	11			
All of the time	22	18	3			
Too much hatred in my family				**21.928**	**12**	**0.038**
None of the time	32	26	13			
Very rarely	10	16	6			
Some of the time	12	8	4			
Most of the time	1	8	7			
All of the time	4	3	1			
Unhappy family				**35.122**	**12**	**0.000**
None of the time	45	32	17			
Very rarely	7	6	2			
Some of the time	2	10	1			
Most of the time	2	9	7			
All of the time	3	4	4			

Variables from factors that were significantly associated with depression among respondents were pulled and tested using regression analysis. The result revealed that these factors are not predictive of depression among respondents.

Table 10: Regression Analysis of significant factors associated with depression

Variables	B	S.E	Df	Sig	Exp (B)C.I	95% C.I for EXP (B) Lower	Upper
Feeling of good self-value of equal value with others	1.005	.642	1	.117	2.732	.776	9.612
Care of members of family for one another	-.743	.407	1	.068	.476	.214	1.056
Ability to get along with family	-.058	.364	1	.874	.944	.463	1.926
Too much hatred in my family	.414	.534	1	.438	1.513	.531	4.313
Unhappy family	.424	.543	1	.434	1.528	.528	4.427
Marital Status	-.690	.389	1	.076	.501	.234	1.075
Family Structure	.084	.157	1	.594	1.087	.800	1.478

Table 11: Association between Knowledge of depression and health seeking behaviour

Variable	Knowledge of Depression			X2	Df	P-Value
	Poor	Fair	Good			
Feeling that depression is not a serious illness				7.605	2	0.268
Agree	133	53	1			
Disagree	63	27	2			
Belief that help is not needed when depressed				10560	2	0.955
Agree	55	24	1			
Disagree	141	56	2			
Self-handling of depression				4.089	2	0.665
Agree	75	29	2			
Disagree	121	51	1			
Lack of worry about depression				8.702	2	.191
Agree	52	28	1			
Disagree	144	52	2			
Do not seek help because of feel of embarrassment				8.900	2	0.179
Agree	78	42	2			
Disagree	118	38	1			
Do not seek help because of feel of cost				14.485	2	0.025*
Agree	64	40	1			
Disagree	132	39	2			
Do not seek help because of no knowledge of where to go for help				5.070	2	0.750
Agree	71	37	1			
Disagree	123	43	2			

*significant variable

4.6 Test of hypothesis

Hypothesis 1

The Null hypothesis states that there is no sinificant relationship between experience of depression and parent's marital status. Chi-square was used to test for association and the result is presented below

Table 4.12: Relationship between respondents' experience of depression and parent's marital status

Marital Status	Experience of Depression		X2	Df	P-value
	Yes	No			
Married and staying together	97	121	**12.258**	**4**	**0.016***
Single	14	14			
Married but not staying together	7	9			
Divorced	7	1			
Widow/Widower	8	1			

Significant at p<0.05

Decision:

Based on the result shown in Table 4.12, the null hypothesis which stated that there is no significant relationship between experience of depression and parent's marital status was therefore rejected ($p<0.05$). Hence, there is significant association between experience of depression and parent's marital status.

Hypothesis 2

The Null hypothesis states that there is no association between experience of depression and father's occupation. Chi-square was used to test for association and the result is presented below

Table 4.13: Association between respondents' experience of depression and father's occupation

Father's Occupation	Experience of Depression Yes	No	X2	Df	P-value
Civil servant\	38	23	9.355	3	0.025*
Businessman	83	97			
Artisan	8	17			
Unemployed	4	9			

Significant at p<0.05

Decision:

Based on the result shown in Table 4.13, the null hypothesis which stated that there is no significant relationship between experience of depression and father's occupation was therefore rejected ($p<0.05$). Hence, there is significant association between experience of depression and father's occupation.

Hypothesis 3

The Null hypothesis states that there is no association between experience of depression and ability to share problems with family. Chi-square was used to test for association and the result is presented below

Table 4.14: Association between respondents' experience of depression and ability to share problems with family

I can share my problems with my family	Experience of Depression		X2	Df	P-value
	Yes	No			
Strongly Agree	51	45	8.852	3	0.031*
Agree	57	76			
Disagree	22	14			
Strongly disagree	3	11			

significant at p<0.05

Decision:

Based on the result shown in Table 4.14, the null hypothesis which stated that there is no significant relationship between experience of depression and ability to share problems with family was therefore rejected ($p<0.05$). Hence, there is a significant association between experience of depression and ability to share problems with family members.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECCOMENDATIONS

5.1 Socio-demographic characteristics of respondents

The ages of respondents ranged from 13-19 years which is in line with study conducted by Fatiregun and Adewuya, 2014), with a mean age of 15.6± 1.2 years. Majority of the respondents were within the age range of 16-19 years of age.

Majority of the respondents belonged to Yoruba ethnic group, this could be attributed to the fact that the study location is situated in the southwestern part of the country where the Yorubas are the predominant ethnic group as evidenced in Fatiregun et al (2014). More than half (52.7%) of the respondents were christians while (47%) of the respondents were muslims.

Majority (54.1%) of the respondents were female while (45.9%) were male. Most (72.8%) of the respondents are in monogamous family structure and majority (78.1%) of the respondents have their parents married and staying together. Larger percentage of respondents parents were into businesses.

5.2 Knowledge of depression

The findings of this study revealed that respondents have poor knowledge of depression. This is in agreement with what was reported by Adeosun (2016), where larger (75.4%) of the respondents have poor knowledge of depression. Lower rate of depression literacy of the respondents in this study reveals an unmet needs for mental literacy among Nigerian adolescents.

5.3 Factors Associated With Depression

Self-esteem

Negative self perception was found to be significantly associated with depression among the respondents. This is in tangent with previous studies. In a study conducted by, Okwaraji et al

(2016), (32.1%) reported lower self esteem and this was significantly associated with depression among the repondents . Similarly, Dixomryale (2005) stated that lower self-esteem contribute to development of a negative self image which is also a contributory factor to depression in adolescents. further study conducted to determine the association between self esteem and depression among adolescents indicated that adolescents with lower self-esteem were more likely to have depression (Hung, Tze, Ju, Chin, Chi, Shu and Ghengm, 2008).

Family relationship

In this study, poor family relationship was found to be significantly associated with depression among adolescents. The study revealed that Majority of the respondents who had depression reported that they are not happy with their familes and that there are too much hatred in their families. Also, they expressed inability to share their problems with their family members. This finding is in harmony with the findings of previous studies. (Sun et al, 2006) reported lower family choesion, poor quality of family relationships as factors which lead to higher level of depression among adolescents. Fatiregun et al (2014) reported poor family functioning as a factor associated with depression among adolescents in Nigeria. Poor family reltionship was also reported to be associated with depression among adolescents in a study carried out by Hung et. al (2015). A study carried out among Chinese adolescents reavealed that poor family cohesion and conflict were associated with increased risks of depression (Zhang et al, 2011).

Academic stress

In this study, academic stress was not found to be significantly associated with depression among adolescents.This finding is not in tangent with previous studies that reported significant relationship between academic stress and depression among adolescents. Academic stress have been reported to be a major source of stress among adolescents which predispose them to depression (Ang & Huan, 2006; Bjorkman, 2007). Jayanthi, Thirunavukarasu and Rajkuman (2015), in their study reported that adolescents who had

academic stress were 2.4 times higher at risk of depression than adolescents without academic stress.

5.4 Help seeking behaviour

The findings of this study revealed that majortity of the respondents do not perceived depression as a serious illness. This could be attributed to their poor knowledge about causes and symptoms of depression. Hence, not seeking for help from appropriate sources. Embarrasment, lack of knowledge of where to seek help for depression were mostly reported by the respondents. This is consistent with the findings in a study carried out by Del Mauro et.al (2013).

However, majority of the respondents perceived seeking help as beneficial and that seeking for help will reduce their stress and solve their problems. This findings does not agree with previous study that stated that adolescents do not perceive help seeking as beneficial (Janaki, 2011).

Majority of the respondents reported that they seek help for their emotional problems from their parents, friends, and religious leaders. Very few of them seek help from mental health professional while few of them would not seek help from anybody for their emotional problem. This is not suprising considering the fact that most of the respondents have poor knowledge of depression.This finding is in consonant with the findings from previous studies which revealed that young people are more likely to seek help from informal sources such as friends and family rather than formal sources (Adeosun, 2016; Wilson and Deane, 2010).

5.5 Experience of depression

Beck Depression Inventory II revealed that more than half (56.2%) of the respondents have depression that ranges from mild to severe depression. (22.9%) of the respondents have mild depression, (21.5%) are moderately depressed while few (11.8%) are severely depressed. This finding is in harmony with previous studies (Fatiregun et al, 2014) and (Adeniyi et al, 2011). (29.0%) of male respondents are depressed while (27.2%) of female respondents are

depressed. This finding is not in tangent with the findings of previous studies (Adeniyi et al, 2006, Fatiregun et al , 2014) where females were reported to experience depression more than males.

5.6 Implications of findings for health promotion and education

Mental health is essential to good health and wellbeing. Adolescence is a crucial period for promoting healthy development and good mental health. Adolescent mental health is a public health issue that receives less attention especially in low and middle-income countries like Nigeria. There is a compelling need to address adolescent mental health as part of health promotion.

The findings of this study have practical implication for school administrators, counseling psychologist and parents. Mental health promotion for adolescents should be carried out in collaboration with families, schools and communities. This will not only enhance adolescents' mental health, but it will also improve their general health behaviour, social functioning and academic performance.

The school is an important setting for promoting mental health of adolescents. The school provides a platform to reach a large number of adolescent that experience depression. Mental health promotion in schools will facilitate mental health literacy among teachers and students. This will equip the teachers and students with adequate knowledge needed in identification of depressive symptoms and appropriate sources of help. Mental health programme in school should integrate life and problem solving skills that will enable adolescents cope with life stressful situations that might predispose them to depression.

The teachers, school administrators, counsellors and parents should be made aware of the role of parental care in adolescent depression. It is important to educate parents on the need to provide the right parenting care and enabling environment that will foster healthy family relationship. This will help to promote positive self perception and as well ehance self-esteem, thus reducing depression among adolescents (Abege, 2014).

The school counsellors play the critical role in assessment, intervention and prevention of adolescent depression. The school counsellor is saddled with the responsibility of organizing well coordinated programmes that include individual counselling, group counselling, and training of school teachers in early identification of depressive symptoms among students.

5.7 Conclusion

In this study, depression was found to be a prevalent health problem and it is under-recognised among adolescents. Experience of depression among adolescents is growing at an alarming rate which calls for urgent need to put in multiple strategies in addressing mental health issues among adolescents in Nigeria. Prevalence of depression among adolescents shows that there are more to be done in health educating adolescents about depression. Due to poor mental health literacy among adolescents in Nigeria, young people frequently misidentify depression as mere stress and most time do not seek help from appropriate sources. Depression among adolescents was found to be associated with poor family relationship and negative self perception. The government, schools, parents, communities and non-governmental organisations have vital roles to play in improving adolescents' mental health.

5.8 Recommendations

Findings from this study have health promotion and health education implications, hence, there is need to plan and implement health strategies that will help to lessen the burden of depression among adolescents. the following are to be considered in planning and implementation of strategies targeting depression among adolescents:

1. Curriculum intergration of mental health literacy that will facilitate identification of symptoms of depression and promotion of appropriate help seeking among adolescents
2. Adolescents should be provided with life skills and personal development programmes that will help to ehance their problem-solving skills
3. Planning and implementation of school policies that will promote mental health of students

4. Education for parents and the general public about depression will also facilitate identification of symptoms of depression among adolescents and early intervention. Parents need to consider not only the physical health of their children but also their mental health
5. School teachers should be given training on how to recognise signs of emotional distress including symptoms of depression
6. Schools should be provided with professional staff members to whom adolescents can seek help if they are emotionally depressed.

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APPENDIX
INFORMED CONSENT FORM

My name is MOGAJI MARY O. I am a postgraduate student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. The purpose of this study is to investigate FACTORS ASSOCIATED WITH DEPRESSION AMONG IN-SCHOOL ADOLESCENTS AND HELP SEEKING BEHAVIOUR. This study aims at obtaining relevant information from in-school adolescents between the ages of 14-19 years who are schooling in Ibadan North Local Government. The outcome of this study may provide information for the school authority,counsellors, researchers and government that will help to improve adolescents mental health and also improve their helpseeking behaviour. Your response and opinion will be kept confidential and will be used for research purposes only. Your participation in the study is totally voluntary and you may withdraw at any time if you so wish. Please note that you are not to write your name on the questionnaire, also try to give honest answers to the questions, there is no wrong or right answers. Your co-operation will assist in making this research a success. Thanks for your co-operation.

- **Consent**: now that the study has been well explained to me and I fully understand the content of the process, I will be willing to take part in the programme.

  Respondent's signature/ thumb print----------

  Date ----------

INFORMED CONSENT FORM

Dear parent/guardian,

I am a postgraduate student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am conducting a research to investigate FACTORS ASSOCIATED WITH DEPRESSION AMONG IN-SCHOOL ADOLESCENTS AND HELP SEEKING BEHAVIOUR. This study aims at obtaining relevant information from in-school adolescents between the ages of 13-19 years who are schooling in Ibadan North Local Government. The outcome of this study may provide information for the school authority,counsellors, researchers and government that will help to improve adolescents mental health and also improve their helpseeking behaviour.

Your child/ward will be asked to fill a questionnaire. There is no risk to your child from this study. All information will be handled as confidential as possible.Your child's/ward's participation in this study is totally voluntary and you may withdraw at any time without negative consequences.

Please feel free to contact the researcher on this phone number (07037370185) if you have any question about the study. Thanks for your cooperation.

I understand the study described above. I agree to allow my child/ward to participate with his/her assent when possible.

Parent/Guardian signature or thumb print----------

Date----------

STUDENT INFORMED ASSENT FORM

My name is MOGAJI MARY O. I am a postgraduate student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. The purpose of this study is to investigate FACTORS ASSOCIATED WITH DEPRESSION AMONG IN-SCHOOL ADOLESCENTS AND HELP SEEKING BEHAVIOUR. This study aims at obtaining relevant information from in-school adolescents between the ages of 14-19 years who are schooling in Ibadan North Local Government. The outcome of this study may provide information for the school authority,counsellors, researchers and government that will help to improve adolescents mental health and also improve their helpseeking behaviour. Your response and opinion will be kept confidential and will be used for research purposes only. Your participation in the study is totally voluntary and you may withdraw at any time if you so wish. Please note that you are not to write your name on the questionnaire, also try to give honest answers to the questions, there is no wrong or right answers. Your co-operation will assist in making this research a success. Thanks for your co-operation.

I understand what I must do in this study and I want to take part in the study.

Respondent's signature/ thumb print----------

Date ----------

QUESTIONNAIRE

FACTORS ASSOCIATED WITH DEPRESSION AND HELP SEEKING BEHAVIOUR AMONG IN-SCHOOL ADOLESCENTS IN IBADAN NORTH LOCAL GOVERNMENT AREA, OYO STATE

Dear respondents,

I am conducting a research on ***factors influencing depression and help seeking behaviour among in-school adolescents***. I therefore solicit for your cooperation to sincerely respond to the questions. Any information you give will be treated with respect and confidentiality and your responses will be used for research purposes only. Thank you for your time and sincere responses.

Please, tick or fill approriately

SECTION A- Socio Demographic information

Name of school:

Class:

1. Sex: 1. Male [ ] 2. Female[ ]
2. Age at last birthday (in years):----------
3. Religion 1. Islam [ ] 2. Christianity [ ] 3. Traditional [ ] 4. Others (specify)----------
4. Ethnicity: 1. Yoruba [ ] 2. Igbo [ ] 3. Hausa [ ] 4. Others (specify)----------
5. Parents marital status: 1. Married and staying together [ ] 2. Single [ ] 3.Married but not staying together [ ] 4. Divorced (separated) [ ] 5. Widow/ widower [ ]
6. Family structure: 1. Monogamus family [ ] 2. Polygamous family [ ]
7. Number of siblings (brothers/ sisters)----------
8. Parents' level of education: Father: 1. No formal education [ ] 2. Primary [ ] 3. Secondary [ ] 4. Tetiary [ ] please specify (OND, HND, Bsc, Msc etc)----------
   Mother: 1. No formal education [ ] 2. Primary [ ] 3. Secondary [ ] 4. Tetiary [ ] please specify (OND, HND, Bsc, Msc etc)----------
9. Parents'occupation : Father 1. civil servant [ ] 2. businessman [ ] 3. Artisan [ ] 4. unemployed [ ]
   Mother: 1. civil servant [ ] 2. businessman [ ] 3. Artisan [ ] 4. unemployed [ ]

SECTION B

Tick appropriate response

Knowledge of depression

10. Do you know about depression 1.Yes [ ] 2. No [ ]
11. Would you call depression a disease 1.Yes [ ] 2. No[ ]
12. What does depression mean to you ? 1. Inability to sleep [ ] 2. A mental disorder [ ] 3. A stress [ ] 4. Thinking too much [ ]

13. Depression can be caused by 1. Low self esteem [ ] 2. Over eating [ ] 3. Reading too much [ ] 4. Poor family relationship [ ]

14. Do you know anyone with depression 1. Yes [ ] 2. No [ ] if yes, who?----------

15. What usually happen to people who have depression 1. Loss of intrest and pleasure in activities[ ] 2. They have high self confidence[ ] 3. They have thoughts about death[ ] 4. They can concentrate well [ ] 5. They always feel sad [ ]

Tick the appropriate option: SA(strongly agree) A (agree) D (disagree) SD (strongly disagree)

SECTION C - FACTORS ASSOCIATED WITH DEPRESSION

INDIVIDUAL FACTORS

S/N	Attitude towards depression	SA	A	D	SD	
16.	Depression is part of life					
17.	I can handle my emotions my self					
18.	Depression is just a normal stress					
19.	People with depression can come out of it if they wanted					
20.	Depression is a sign of personal weakness					
21.	Meeting with the school counsellor for depression is a waste of time					
22.	Depression is not a real medical illness					
23.	If I had depression, I would not tell anyone					
24.	Depression do not require any treatment					

Score =

S/N	Belief about depression	SA	A	D	SD	
25.	Depression is as seriours as any other diseases					
26.	Depression is hereditary, I cant help it no matter what					
27.	Biological changes in the brain cause depression					
29.	Going to church or mosque and participating in religious programmes is the first thing to do to treat depression					
30.	Counselling is as effective as medication in treating					

	depression					
31.	I would prefer to discuss what I can do to treat depression/sadness with my spiritual leader					
32.	I can change my depression by changing my behaviour					
33.	Meeting with a school counsellor to talk about my feelings might help my mood					

Score=

Self esteem		**SA**	**A**	**D**	**SD**
34	I feel I am a person of value, at least on equal level with others				
35.	I feel that I have a number of good qualities				
36.	All in all, I am persuaded to feel that I am a failure				
37.	I am able to do things as well as most people				
38.	I feel I don't have much to be proud of				
39.	I take positive attitude toward myself				
40.	On the whole, I am satisfied with myself				
41.	I wish I could have more respect for my self				
42.	I certainly feel useless at times				
43.	At times I think I am no good at all				

INTERPERSONAL FACTORS

This questionnaire is designed to measure the way you feel about your family as a whole. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = None of the time 2 = Very rarely 3 = Some of the time 4 = Most of the time 7 = All of the time

Family relationship

44._____ The members of my family really care about each other
45._____ I really enjoy my family.
46._____ I can really depend on my family.
47._____ I wish I was not part of this family.
48._____ I get along well with my family.
49._____ Members of my family argue too much.
50._____ There is no sense of closeness in my family.
51._____ I feel like a stranger in my family.
52._____ My family does not understand me.
53._____ There is too much hatred in my family.
54._____ Members of my family are really good to one another.
55._____ There seems to be a lot of friction in my family.
56._____ There is a lot of love in my family.
57._____ Members of my family get along well together.

58._____ Life in my family is generally unpleasant.
59._____ My family is a great joy to me.
60._____ I feel proud of my family.
61._____ My family is a real source of comfort to me.
62._____ I feel left out of my family.
63._____ My family is an unhappy one.

Tick the appropriate option: SA(strongly agree) A (agree) D (disagree) SD (strongly disagree)

S/N	Social support	SA	A	D	SD
64.	My family and really tries to help me				
65.	I get the emotional support and help I need from my family				
66.	I can talk about my problems with my family				
67.	My family is willing to help me make decisions				
68.	I can count on my friends when things go wrong				
69.	My friends really try to help me				
70.	I have friends with whom I can share my joys and sorrows				
71.	I can talk about my problems with my friends				
72.	There is a special person with whom I can share my joy and sorrow				
73.	I have a special person who is a real source of comfort to me				

Tick any of these that you have experienced in the past or that you are presently experiencing

Negative life events		
74.	Sexual abuse (e.g rape, attempted rape)	
75.	Domestic violence (by parents or other family member)	
76.	Loss of a family member or loved one	
77.	Parents' separation	
78.	Abandonment by loved one	

Score=

Tick the appropriate option: SA(strongly agree) A (agree) D (disagree) SD (strongly disagree)

INSTITUTIONAL FACTORS

S/N	Academic stress	SA	A	D	SD
79.	There is too much competition among classmates which brings me a lot of academic pressure				
80.	I feel a lot of pressure in my daily studying				
81.	My parents care about my academic grades too much which brings me a lot of pressure				
82.	I am not satisfied with my academic grades				
83.	I always lack confidence with my academic scores				
84.	It is very difficult for me to concentrate during classes				
85.	I feel there is too much homework				
86.	I feel that there are too many test/exams in the school				

S/N	School connectedness	SA	A	D	SD
87.	I feel close to people at school				
88.	I feel like I am part of this school				
89.	I am happy to be at this school				
90.	I feel safe in my school				

SECTION D

HELP SEEKING BEHAVIOUR

91. Have you experienced depression in the past 1. Yes [ ] 2. No [ ]

92. Are you currently experiencing depression 1. Yes [ ] 3. No [ ]

Tick the appropriate option: SA(strongly agree) A (agree) D (disagree) SD (strongly disagree)

Perveived severity of depression		SA	A	D	SD
93.	I dont think depression is a serious illness				
94.	I dont need help when I am depressed				
95.	I can handle my situation my self				
96.	I am not worried about my situation				

Which of the following do you feel is a barrier for you not seeking help when you are depressed

Tick the appropriate option: SA(strongly agree) A (agree) D (disagree) SD (strongly disagree)

Perceived barriers for not seeking help		**SA**	**A**	**D**	**SD**
97.	I do not seek help because I feel Embarssed				
98.	I do not seek help because of cost				
99.	I do not see help for depression because I do not want to be labeled crazy				
100.	I do not seek help because I do not know where to go for help				
101.	I dont feel comfortable sharing feelings with another person				
102.	I do not seek help because I do not want to talk to a counsellor about personal issues				
103.	I am afraid of the counsellor				
104.	I do not have support from my family and friends				

S/N	**Perceived benefits of seeking help for depression**	**SA**	**A**	**D**	**SD**
105.	Seeking help for depression will help to reduce stress				
106.	Seeking help for depression will help to resolve ones problem				
107.	Seeking help for depression will help to improve sleep				
108.	Seeking help for depression will help to improve mental health				
109.	Seeking help for depression will help to improve my relationship with others				

Which of the following will motivate you to seek help for depression

Tick the appropriate option: SA(strongly agree) A (agree) D (disagree) SD (strongly disagree)

S/N	**Cue to action**	**SA**	**A**	**D**	**SD**
110.	Having a friend who is depressed will motivate me to seek help if I have depression				
111.	Having a family member who have had depression in the past				
112.	Having a family member(s) who encourage(s) me to seek help				
113.	Having a friend who encourage(s) me				
114.	Reading about depression in magazine				

HELP SEEKING PATTERN

Tick any of these who you have gone to for advice or help in the past two weeks for emotional problem like depression

Help seeking		

pattern		
115.	Friend	
116.	Parent	
117.	Other relative/family member	
118.	Mental health professional (e.g school counsellor, psychologist, psychiatrist)	
119.	Family doctor	
120.	Teacher(classroom teacher)	
121.	Religious leader (e.g pastor, imam, traditional healer)	

122. Mention others not listed above----------

SECTION E

BECK DEPRESSION INVENTORY-II

Name---------- class---------- school---------- age---------- sex---------

Please, read each group of statement carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the **past two weeks, including today.** Do not choose more than one statement for any group.

1.Sadness 0. I do not feel sad 1. I feel sad most of the time 2. I am sad all the time 3. I am so sad or unhappy that I cant't stant it	**12. Loss of interest** 0. I have not lost interest in other people or activities 1. I am less interested in other people or things than before 2. I have lost most of my interest in other people or things 3. It's hard to get intrested in any thing
2.Pessimism 0. I am not discouraged about my future 1. I feel more discouraged about my future than I am used to be 2. I do not expect things to work out for me 3. I feel my future is hopeless and will only get worse	**13. Indecisiveness** 0. I make decisions about as well as ever 1. I find it more difficult to make decisions than usual 2. I have much greater difficulty in making decisions than i used to 3. I have trouble making any decisions
3. past failure 0. I do not feel like a failure 1. I have failed more than I should have 2. As I look back, I see a lot of failures 3. I feel I am a total failure as a person	**14. Worthlessness** 0. I do not feel i am worthless 1. I dont consider myself as worthless as useful as I used to 2. I feel more worthless as compared to other people 3. I feel utterly worthless
4. Loss of pleasure 0.I get as much pleasure as I ever did from	**15. Loss of Energy** 0. I have as much energy as ever

the things I enjoy 1. I dont enjoy things as much as I used to 2. I get little pleasure from what I used to enjoy 3. I cant get any pleasure from what I used to Enjoy	1. I have less energy than i used to have 2. I dont have enough energy to do very much 3. I dont have enough energy to do anything
5. Guilty feeling 0. I dont feel particularly guilty 1. I feel guilty over many things I have done or should have done 2. I feel quite guilty most of the time 3. I fell guilty all of the time	**16. Changes in Sleeping pattern** 0. I have not experienced any change in my sleeping pattern 1. I sleep more than usual 2. I sleep less than usual 3. I sleep most of the day
6. punishment feeling 0. I dont feel I am being punished 1. I feel I may be punished 2. I expect to be punished 3. I feel I am being punished	**17. Irritability** 0. I am no more irritable than usual 1. I am more irritable than usual 2. I am much more irritable than usual 3. I am irritable all the time
7. self dislike 0. I feel the same about my self 1. I have lost confidence in my self 2. I am disappointed in my self 3. I dislike myself	**18. Changes in appetite** 0. I have not experienced any change in my appetite 1. My appetite is less than usual 2.My appetite is greater than usual 3. I have no appetite at all
8. self- criticalness 0. I dont criticize or blame myself more than usual 1. I am more critical of myself than i used to be 2. I criticize my self for all of my faults 3. I blame myself for everything bad that happens	**19. Concentration difficulty** 0. I can concentrate as well as ever 1. I can't concentrate as well as usual 2. It's hard to keep my mind on anything for a very long time 3. I find I can't concentrate on anything
9. Suicidal thoughts or wishes 0. I dont have any thought of killing myself 1. I have thoughts of killing myself, but i would not carry them out 2. I would like to kill myself 3. I would kill my self if I had the chance	**20. Tiredness or Fatigue** 0. I am no more tired or fatigued than usual 1. I get more tired or fatigued more easily than usual 2. I am too tired or fatigued to do a lot of the things I used to do 3. I am too tired or fatigued to do most of the things i used to do
10. crying 0. I dont cry anymore than I used to 1. I cry more than I used to 2. I cry over every little thing	**21. Loss of interest in sex** 0. I have not noticed any recent change in my interest in sex 1. I am less interested in sex than I used to be

3. I feel like crying but I cant	2.I am much less interested in sex now 3.I have lost interest in sex completely
11. Agitation 0. I am no more restless or wound up than usual 1. I feel more restless or wound up than usual 2. I as so restless ore agitated that I it's hard to stay still 3. I am so restless or agitated that I have to keep moving or doing something	