KNOWLEDGE AND MANAGEMENT STYLES OF DEPRESSION AMONG SELECTED PENTECOSTAL CHURCH LEADERS IN IBADAN NORTH LOCAL GOVERNMENT AREA, OYO STATE

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CERTIFICATION

I certify that this project was carried out by Olufemi Joseph Oyerinde with Matric Number 56737 in partial fulfilment of the requirement for the award of Master of Public Health (MPH) in Health Promotion and Education, University of Ibadan, Ibadan, Nigeria under my supervision.

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DEDICATION

This project is dedicated to Almighty God, the creator of life and to the numerous children in Riverine Communities of Kogi State who have died because of lack of workable health care system.

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ABSTRACT

Depression is one of the major mental health disorders and will rank number one in global burden of disease by year 2030.It manifests in prolong sadness and loss of interest in life activities. The church leaders have no relevant skills required to identify and manage it. Religion plays an important role in the life of an average Nigerian and they will patronize spiritual leaders first before considering professional input. This study investigated the knowledge and management of depression among selected pentecostal church leaders in Ibadan North Local Government Area, (INLGA) Oyo state, Nigeria.

A descriptive cross-sectional survey among 300 selected pentecostal church leaders who are active members of the Nigeria Pentecostal fellowship of Nigeria (PFN) in INLGA Oyo state. Participants were selected by a two-stage sampling techniques. A semi-structured, self-administered questionnaire with an adapted version of Zung self-rating depression scale were used to collect information on socio-demographic status, knowledge, perception, attitude, management styles and ability to recognise depression. A 29-point knowledge scale was used to assess the knowledge of respondents about depression scores between 0-9, 10≤20 and >20 were categorised as poor, fair and good knowledge, respectively. A 14-point perception scale with scores between 0-7 and >7 were categorised as negative and positive perception, respectively. A 12-point attitude scale with scores between 0-6 and > 6 were categorised as negative and positive attitude, respectively. Ability to recognise depression was scored on a 80-point scale using an adapted version of Zung self-rating depression scale with scores between 0-26, 27≤53 and >53 were considered as poor, fair and good ability to recognise depression, respectively, a 19-point practice scale was used to examine the management styles of the respondents on depression, a practice score of between 0-9 and > 9 were considered as poor and good practice, respectively. Chi- square test and Fisher's exact test were used to test the level of significance at p value of 0.05

Most respondents (63.3%) were in the age group of 40-59 years with an average age of 49.5±2.2 years, 56.7% were males and 73.3% on part time engagement, only 7.7% were general overseers. The respondents that had good knowledge of depression were 68.3% with 79.7% having positive perception of depression, 89.3% having positive attitude about depression and 63.3% showing good practice of depression management. However few, 21.09 preached on depression weekly, but most 64.7% had good ability to recognize

depression. There was a significant difference between age, level of education, pastoral rank, years of being church leader and knowledge of depression.

Most respondents had good knowledge of depression, positive perception and attitude towards depression and a good management practice, but this knowledge is not been integrated into the main policy of the church because leaders believed doing so may affect the active faith lives of the member. This study therefore recommends adequate integration of depression knowledge and its management into policy of the church.

Keywords: Pentecostal church leaders, Depression, Faith-based, Management styles

Word count: 478

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GLOSSARY OF ABBREVIATION

PFN	-	Pentecostal Fellowship of Nigeria
PLWHA	-	People Living With HIV and AIDs
WHO	-	World Health Organization
LGA	-	Local Government Area
HIV	-	Human Immunodeficiency Virus
AIDs	-	Acquired Immunodeficiency Syndrome
DALY	-	Disability Adjusted Year

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Depression is one of the major forms of mental health disorder characterized by an intense feeling of sadness that lingers for weeks if not months, with individuals feeling of hopelessness inability to cope with the major stressors of life and loss of interest in daily activities. (Okechukwu & Ajayi, 2016). Depression has ever been a major public health issue affecting over 340 million people globally (Dinas, Koutedakis & Flouris,2011).

By 2020, depression was projected to be the second largest contributor to the burden of disease globally (Moussavi, Chatterji, Verdes, Tandon, Patel & Ustun,2007) and by 2030 it will be largest contributor to the burden of disease worldwide based on the disability adjusted year, DALYs ranking (Jean-Pierre & Mike, 2011). Smith (2014) also reported that the World Health Organization (WHO) ranked depression as 9th behind the prolific killers such as heart disease, stroke and HIV. Its specific prevalence is difficult to identify as a result of the wide variation across the globe ranging from 20-70% (Berger-Greenstein, Cuevas, Brady, Trezza, Richardson & Kean 2007; Sale & Gadanya, 2008; Pence, Reif, Whetten, Leserman, Stangl, Swartz, Thielman & Mugavero, 2007). Depression is one of the most frequent psychiatric complications of Alzheimer disease affecting as many as 50% of patients. Depression has been recognized as a significant public health problem with series of serious adverse consequences for patients and their caregivers (Constantine, Lyketos & Olin, 2020). Depression is associated with several other major diseases around the globe with depressive symptoms as manifestation. About 90% of Alzeimer disease patients suffer psychological disturbance (Constantine *et al*., 2020). It has been reported that Inflammatory bowel disease is worst among people suffering from depression (Lesley, Graff, John, Walker & Charles,2009).

Similarly, a great deal of disability and functional impairment which occurs in chronic health problems are associated with depression (Kesler, Ormel & Demler, 2003). Depression is the most frequently observed psychiatric disorder among HIV/AIDS patients (Rabkin, Remien & Wilson 1994; Ross, 2004) and its major cause among people living with HIV and AIDS (PLWHA) are attributed to different degrees of rejection.

Common mental health disorders like depression and anxiety are as prevalent in low- and middle-income countries as they are in high-income among people living in developed countries (Bromet, Andrade, Hwang, Sampson, Alonso & Girolamo, 2011; Gureje & Laosebikan, 2006 Kessler, Walters, Aguilar-Gaxiola,, Andrade, Borges & Wittchen 2006). Among the low and medium-income countries of the world, Nigeria stands as a case study of lack of adequate knowledge and proper management of depression, the attitudes and beliefs about depression and other mental health disorder were considered to be the reason for this. Gureje, Laosebikan, Ephraim-Oluwanuga, Olley & Kola (2005) explained that stigma and negatives attitude are common in Nigeria .The belief that most mental health issues are caused by a spirit or witchcraft has been widely held by most average Nigerians which makes it difficult to refer people suffering from depression to qualified professionals. Depression affects all age groups with serious devastating effect with disproportionate effect on women thereby contributing to maternal morbidity, poor infant health and loss of economic opportunities (Adewuya, Ola, Aloba, Mapayi & Okeniyi, 2008)

In Nigeria, the prevalence of depression among women is about 10-20 % (Abiodun, 2006). This is much higher among the adolescents who experience major depressed disorder by the age of 19. A study in Australia reported depression in 20% between ages of 12-16 year olds and 27% among 18-24years (Moon, Meyer & Grau 1999).

Even among the medical students in Nigeria, its prevalence is 23.3% (Aniebue & Onyema ,2008), and among Nigerian medical students, the prevalence of depressive symptoms was attributed to sitting for professional exams and academic work related stress (Perera,2005) Perception of lecturers was hostile and unapproachable alongside humiliation from them (Lempp & Seale,2004).It was found out that most medical students who are depressed will result to smoking as a coping mechanism (Okeke, 2004). The prevalence among medical students is much higher in China as 50% (Chan, 1991) and among Brazilian medical students as 49.3% (Porcu, Fritzen & Cesar, 2005).

Faith based organizations have played a pivotal role in ameliorating various health challenges around the world and has served as major health promotion settings to improve the quality of lives of members, Chaplin & Ogedegbe, 2014. Depression which is going to be number one on DALY by the year 2030, (Jean-Pierre et al, 2011) should not

be excluded from such programs. According to Sherry, Samantha, Crystal, Rupa & Joseph, 2008 the Church is positioned to carry out interventions for depression and suicide because of its broad acceptance, its strong history of helping all community members and shaping the religious and cultural understanding about mental health and help-seeking behaviours. Therefore this study will focus on how, understanding the knowledge and management styles of selected leaders among the Pentecostal Churches in Ibadan North Local Government, can help in promoting mental health of church members with a view to reduce the present prevalence of depression and suicide rate in the society.

1.2 Statement of the problem

The prevalence of depression among church members differs across denominational groups as studied among the various religious denomination of older Dutch citizens. Braam, Beekman, Knipscheer, Deeg-Van Den-Eeden& Van-Tilburg (1998) observed that depressive symptoms are more prevalent among the Reformed Calvinists, Roman Catholics and Dutch Reformed in the descending order while social integration and positive self-perception were responsible for the differences among the church members. No local data exist to make this kind of comparison in Nigeria. However, despite the prevalence, depression is widely undiagnosed and partly untreated because of stigma, lack of effective therapies and inadequate mental health resources.

The challenge is more complicated in the Church compare to the general population because theological education does not impact relevant skills required to identify and manage depression by church leaders (McRay, McMinn, Wrightsman, Burnett & Ho, 2001).

In Nigeria, common mental disorders are prevalent but due to stigma and limited number of trained specialists, only 10% often receive care (Iheanacho, Kapadia, Ezeanolue, Osuji, Ogidi, Ike, Patel, Stefanovics, Rosenheck, Obiefune & Ezeanolue, 2016). The church has the resources in her numbers of elders and Pastors but lack the awareness of this problem and they have little knowledge about its management. With some level of training and collaboration, mental health specialists in Nigeria will have enough workforce to address the issue of depression thereby stemming the tides of its consequences –the high prevalence of suicide presently being experienced in Nigeria. However, for this to happen the wrong attitude and beliefs about depression and other mental health disorders must be corrected in the church.

Church involvement in the management of depression was observed by a study conducted by Ezeanolue et al (2013) where care for depression and other mental health issues were studied in a congregational based initiatives tagged "Health beginning initiatives" where volunteer church based health advisors and clergy were trained to screen for people with depression and other mental health issues using a 12-item general health questionnaire and linked them to care.

This study was focused on assessing the knowledge of Church leaders about depression and its management with a view to providing a first line response in psyco-education to the members suffering from depression. McRay *et al,*. (2001) observed that members of the faith communities depend on pastors for spiritual guidance and counseling therefore it will be a good strategy to enroll them in the fight against mental health disorders

However, church leaders' knowledge, attitudes and management of depression could be influenced by the cultural background, type of denomination, level of education, age and years of clerical duty. All these had been anticipated through the conceptual framework of this study to determine the differences in these variables and the factors that shape people's understanding of depression and other mental illness such as gender, education and rural or urban residence. (Wirth & Bodenhausen, 2009)

Finally, since the consequences of depression is dire; there is need to address this global menace considered to be the major risk factor for attempted or completed suicides (Beautrais, Joyce & Mulder,1996) which has been found to be the leading cause of death worldwide (Rockett, Regier, Kapusta, Coben, Miller & Hanzlick, 2012)

1.3 Justification of the Study

In terms of Christian population, it is a good thing to target our intervention on the church, by the year 2020, Christian population is projected to hit 2.7 billion out of 7.0 billion of the total world population. The significance of this to the study is that addressing the health issues of the church population does contributing immensely to the social economic and development of the world.

Why the church leaders? The religious leaders have a very strong influence on their congregation, in some places pastors are seen as demi gods, their words are laws, and members develop a morbid fear of the supreme pastors or religious leaders. For example, Jim Jones influence on his members made them to drink cyanide with promise of

resurrection after three days, Barker, 2003 and David Koresh who brainwashed his member to set themselves on fire to attain instant paradise, Lacayo & Bonfante, 1993. These authors have demonstrated how powerful influence religious leaders can exert on members. Therefore, If we can explore this potential influence of church leaders to promote healthy living among members especially in effective management of depression and mental health in general this will lead to reduction of the burden of diseases among the society.

Why depression? Depression is one of the non-communicable diseases (NCDs), that can be a risk factor for other NCDs such as hypertension, ulcer, and cancer. Church members are not immune from these disease conditions. Just like the greater society church members' various conditions that can predispose them to depression such as poor inter personal relationship, church political process and leadership structure.

- Feelings of rejection among members from the significant others in the church
- Members experience tribalism and all forms of discriminations.
- Poor member care that can lead to abandonment and frustration.
- Group conflicts.
- Poor socio-economic status of some members

Global demand for health workers is increasing due to various health challenges at international, national and local levels, but the present number of professional health workers cannot meet this current demands, there is a need to bring on board additional social groups like the church which have the potential to exert influence on the psychosocial and socio-cultural aspects of health and illness of its members (Ursula E. & Bauer, 2019). Among the recognized health promotion settings namely, school, community, workplace, health centers, religious settings have not been accorded the rightful role to be a health promotion setting, this is not adequate. This study will focus on Church as a possible health promotion setting, because all categories of our target population in the above mentioned settings can be found in the church settings. Church-based health promotion can reach broad populations and have great potential for reducing health disparities, the church can also influence members' behavior at multiple level of change. Therefore, enrolling the church in health promotion is placing behavior change strategies in the hands of people who can motivate and assist one another to adopt healthier lifestyles and become more self-reliant.

The church functions both as a source of social support and a focal point for social networks which are important for healthy living, in fact religious beliefs is a correlate with better health and improved life satisfaction (Christopher, Jason, David, & James, 2001) Study also proved that targeting the church as health promotion can be strategic to health; there was a reduction in the prevalence of cardiovascular disease and lower systolic blood pressure among frequent church attenders (Jeremy, Galia, Yechiel, Oz, Orly & Solomon, 1996)

1.4 Research questions

1. What is the knowledge of depression among church leaders?
2. What are the perceived factors that predispose members to depression?
3. What are the attitudes of church leaders to depression among church members in Pentecostal Churches in Ibadan North Local Government?
4. What are the sources of information on depression available to church leaders?
5. What are the management styles of depression adopted by church leaders?

1.5 Objectives

General Objective

To investigate knowledge and management styles of depression among selected Pentecostal Church Leaders members in Ibadan North Local Government Area

Specific objectives are to:

1. Assess the knowledge of depression among church leaders in Pentecostal churches in Ibadan North local government area.
2. Identify the perception of depression among the selected church leaders of Pentecostal churches in Ibadan north local government area.
3. Determine the attitude of church leaders to depression, among church members in the Pentecostal churches in Ibadan North Local Government
4. Identify the sources of information on depression available to church leaders of Pentecostal churches in Ibadan North Local Government Area.
5. Assess the management styles against depression adopted by church leaders, among members in selected Pentecostal churches in Ibadan North Local Government area

1.6 Research Hypotheses

$H_0$1: There is no significant difference between age and knowledge on depression among church leaders in selected Pentecostal churches in Ibadan North Local Government Area, Oyo State.

$H_0$2: There is no significant difference level of education and perception of depression among church leaders

$H_0$3: There is no significant difference between knowledge of respondents on depression and management style among church leaders

$H_0$4: There is no significant difference between knowledge of respondents on depression and their ability to recognise depression among church leaders.

$H_0$5: There is no significant difference between ability to recognise depression and depression management style among church leaders.

1.7 Variables

Independent

1. Socio-demographic factors

Dependent

1. Management styles of depression
2. Knowledge of depression
3. Perception of depression
4. Attitude of church leaders to depression

1.8. Definitions of Terms

1. Depression: A state of prolonged sadness and lack of interest in life and daily activities
2. Attitudes towards depression: The ways leaders react and respond to members suffering from depression
3. Perceptions towards depression: The ways leaders see depression based on their understanding
4. Management styles of depression: these are the strategies leaders employ to combat depression among members.
5. Knowledge of depression: this refers to what the leaders know about the subject of depression.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview of faith- based Organisation in Health Promotion

Faith based organizations are religious organizations categorized as non-governmental organization which actively participate in health promotion among their member and the society as a whole. They have a history of helping in a wide range of programs such as individual and family counseling, community improvement, sex and health education (Kong et al, 1982). Churches in particular have been noted for providing social networks where members can share moral and financial support among one another (Saunders & Kong,1983) According to Sherry et al,2008 the Church among African Americans were instrumental in conducting suicide prevention programs to reduce suicide rate among the youths.

Most study of the role of churches in health promotion focused on orthodox churches especially Roman Catholics and protestants churches, little or none among the Pentecostals churches especially in Nigeria (Thomas, Barbara, Richard &John,1986)
Church-based health promotion is a large scale effort by the church community to improve the health of its members through education, screening, referral, treatment, and group support (Lynda, 1995). Lynda, in her study, explained that the church has always been at the forefront of health promotion actions as seen in the past and present involvement in medical missions, clinics, hospitals, and social programmes. Also, the church has been proactive in shifting from just curative health service to health promotion thus enhancing of the quality of life and health of members. The church has been successful in conducting several health promotion programs over the years such as mental health promotion (Harris, Engster & Dorman 1989).

The important role church play in the care of HIV-positive mothers and children was stated by Hilderbrand & Scott (1991)and confirmed the early work by Solomon(1989) on mobilization of AIDS ministry in the church .Furthermore, there are several other areas that the church has been instrumental in providing health promotion program which include nutrition-education(Baxter,1990),physical fitness program(Hatch, Cunningham,

Woods & Snipes ,1986),substance abuse and unwanted pregnancy intervention program (Hatch & Lovelace,1980),Immigrants program(Brewer & Taran,1984)

2.2 General Knowledge of Depression

Knowledge of depression is the ability of an individual to identify factors that can predispose people to depression, proffer appropriate solution to the disorder and provide prevention methods in the future (Jorm, Korten, Jacomb, Christensen, Rodgers & Pollitt ,1997). In general the authors referred to this concept as "mental health literacy "which according to them is the ability to recognize specific disorder, know how to seek mental health information, knowledge of risk factors, causes of self –treatment, professional help available and attitudes that promote recognition and appropriate help seeking". Lack of Mental health literacy, in particular depression, has been found out to be responsible for the prevalence of depression (Jorm et al, 1997)

Michael & Crowley (2002) observed that the prevalence of depression has remained unaffected despite the many pharmacological and psychotherapeutic advances ascribed to lack of what constitute mental disorder. Among the young adolescents studied by Aluh, Anyachebelu, Anosike and Anizoba . (2018) on the Mental health literacy among adolescents on depression, it was found to be very low with only 4.8% out of 277 participants able to correctly identify depressive symptoms and only 1.5% recommended referral to a professional for management of depression.

2.3 Church and mental health Literacy

According to Jorm et al (1997), mental health literacy is made up of seven attributes; the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes; knowledge of self-treatments; knowledge of professional help available; and attitudes that promote recognition and appropriate help-seeking. It was observed from a study conducted by Jorm et al (1997) that church does not possess a high level of mental health literacy in a study conducted in Australia that out of 2000 subjects studied, only 39% could correctly identify depression, 27% could identify schizophrenia. The same study was repeated in by Lauber, Nordt, Falcato & Rosssler, 2003 and this confirmed the earlier result that there is a gap in knowledge of mental health among churches especially that of depression.

Even in the choice of treatment of depression, mental health professionals prefer the use of antidepressant medication while the church goes for non-medical interventions such as prayer, use of vitamins, minerals and special diets (Jorm et al., 1997).

Similarly, Jodi (2016) studied some parameters that gauged the mental literacy level of some clergy in America and found out that out of 238 clergy sampled, there was no significant difference among mental health literacy scores of Evangelical Protestant, Mainline Protestants, Catholic and historically Black Protestant groups, and their level of education. Geographical locations have no effect on their mental health scores while only mental health training increased the scores. This is an indication that training on mental health is crucial to improve the clergy mental health capability. However, the above finding was opposite to what Wesselmann & Grazizno (2010) studied where the beliefs and knowledge of depression and other mental illness differs across denominational divides. They observed that the Pentecostals or the non-denominational leaders understands depression as a consequence of sinful and immoral behaviour, and adopt a spiritual treatment option such as prayer but the Roman Catholics and other orthodox churches adopt the secular perspective. Although, they failed to study the difference across various protestant denomination looking at the fact that a study by Malony (1998) revealed a diversity across the different protestant denominations.

2.4 Knowledge of Depression Among Church leaders

In sub-Saharan Africa, the general belief is that depression and other mental illnesses have spiritual etiology (Ezeobele, Malecha, Landrum & Symes, 2010). Hence, such individual must seek help from traditional and religious institutions according to the findings of Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher & Mhapp (2010). Moreover, if the church leaders' belief that the cause of the condition presented is purely spiritual, they will see no reason for referral to professionals

In a study carried out in Benin city, Edo state, Nigeria (Igbinomwanhia, James & Omoaregba, 2013) observed that most church members and their family will first approach a clergy man for solution to their mental health challenge but little study has been conducted to determine the knowledge and attitude of church leaders to depression and psychiatric referrals in Nigeria. The authors observed that no benefit could be derived

from church leaders who have little or no knowledge of depression and other mental illness.

In a study by Agara, Makanjuola & Morakinyo (2008) among some of the Syncretic churches in Nigeria like Celestial Church of Christ Lagos state; depression and other mental illness are consequences of evil spirit possession and curses from enemies. In such cases, approach for treatment will not go to the professionals but rather with use of holy water, amulets, prayer and fasting, sacrifices using fruits, clothing materials, candle and occasionally physical restraints. These authors observed that depressive symptoms like undue sadness, loss of interest and reduced activity are attributed to smoking of Indian hemp and treated with counseling alone without professional input while social withdrawal and undue quietness, another symptom of depression, is treated by prayer only.

In contrast to the above opinion by Agara et al (2008), another study was carried out among the Faith-based organizations and some Protestant and Catholics denominations in Benin city, Edo state Nigeria by James , Igbinomwanhia & Omoregbe (2014) where the impact of formal education among this subset of clergy have fused Western biomedical disease models with traditional and spiritual models of disease etiology. In such cases, the clergy will like to cooperate with western style of treatment they have endorsed as the bio-psycho-socio-spiritual approach to depression. However, in this study, 51% still attributed depression to spiritual attack.

Stanford & David (2011) conducted a study among senior Pastors of Baptist General Convention of Texas, America using an online questionnaire method to test their knowledge and perceptions of the causes and potential treatment of depression. The authors found out that the knowledge of depression among these pastors is still scanty. Biological factors alone was said to cause depression, even though they showed the willingness to collaborate with mental health professionals but still hold diverse beliefs about the role of psychosocial and spiritual factors played in the causality of depression. However, Stanford et al, (2011) suggested a better mental health education for the Pastors. In particular, the author observed that most clergy men studied proved that knowledge about depression is affected by their religious beliefs.

Farrell & Goebert (2008) found out that 71% of clergy s were not adequately trained to identify mental health disorders and this affected their referral ability to professional mental health personnel. In the same vein, McRay et al(2001) noted that the clergy do not feel that their seminary education provide any sufficient training in this aspect of depression and some of them showed little or no interest in learning the scientific skills to augment their seminary knowledge to handle those being afflicted with depression. They observed that most clergy do not make use of the service the psychologists offered.

2.5 Knowledge of Depression Among Church Members

It has been generally observed that knowledge of Depression and mental illness among church members has always been shaped by the Faith and the denomination they belong to and that this factors affect their health-seeking behaviours was observed by Adksion-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005 in their study they established the fact that our faith is one the protective factors that can be accessed in times of personal crisis. This issue however, is difficult to deal with in some denomination, where for lack of adequate knowledge of depression and over rating their faith they end up denying the fact of depression altogether. Adksion-Bradley et al, 2005 were also of the opinion that, religious leaders can affect the knowledge of members on major mental illness, this is because they are of the opinion that faith can enter an emotional realm and in the hand of untrained religious leaders, becomes a tool for manipulations and distortions of reality.

Agara et al (2008) also observed that religion plays an important role in the life of the average Nigerian in the areas of psychosocial, economic and health issues. Despite their education, they believe in supernatural and preternatural causes in the etiology of mental illness like depression. They will patronize spiritual healers or traditional healers first before considering any professional input at all. The author identified poverty, poor accessibility to mental health facilities and hospital care, stigma or lack of belief in the efficacy of treatment as consequences of poor knowledge of depression in the church because they have been told that depression and other mental illnesses are caused by spirits (Makanjuola ,2003)

2.6 Attitudes of leaders to depression among members

Zimbardo & Leippe (1991) considered attitude as an evaluative disposition toward someone or something which can influence behavior and guide an individual towards achieving goals but can steer people away from perceived adverse outcomes. Also, attitudes help to efficiently process complex information about social world. However, attitudes can be formed without adequate information on the issues leading to prejudice (Baron, 1992).

Among the studies conducted to assess the attitudes of church leaders to depression among the members and other mental illness include Ikwuka, Galbraith, Manktelow, Chen-Wilson, Oyebode, Muomah & Igboaka. (2016) where negative attitude against depression and mental illness in general were found to be the result of low education, male gender, older age, affiliation to a protestant denomination, not being familiar with the patients, culture, stereotypes and poor mental health knowledge. The authors observed that one major area where negative attitudes towards people with mental illness are in the area of stigmatization. Public stigma resulted in stereotyping people with mental illness as unpredictable, violent, incompetent or retarded. This view was shared by Atilola & Olayiwola (2011) that individual suffering from this illness come to accept their condition and loathe themselves as a result causing them a form of self-stigmatization which affects all the aspect of life. This attitude gave birth to social exclusion and stands as obstacle to administering appropriate treatment (WHO, 2001& Sartorious, 2002). Among some church leaders, people who suffer depression and other mental illness are considered to be under a curse or suffering from their past sin (Agara et al 2008, Eric, Magin, William & Eileen, 2015).Also, from the study conducted by Igbinomwanhia et al,2013 negative attitudes were recorded among the clergies from different religions and denominational backgrounds in Nigeria,70.0% of 107 respondents was recorded to show negative attitudes towards mentally ill persons which includes depression. Stigmatization being the major negative attitudes displayed by the respondents. The study was carried out among people of different faith; Orthodox Christians 29.9%, Pentecostal Christians 53.3%, Syncretic Christians 2.8% and Islam 14.0%. Though the result was not stratified across faith group to know where the bulk of the 70.0% negative attitudes come from, it is a reflection of general public attitudes to any mental illness. The study across various professional groups by Adewuya & Oguntade, 2007 has demonstrated that these negative attitudes is common everywhere.

2.7 Factors leading to depression as perceived by the church members

In the western world, biological explanation has been attributed to the causation of mental illness like depression, this position was put forward by Angermeyer & Matschinger, 2005 which was a confirmation to what Lafuze, Perkins & Avirappattu (2002) had earlier established. They found out that causes of depression and other mental illness can be due to biological factors such as chemical imbalances in the brain, excessive use of drugs and alcohol, inherited genes, psychosocial factors; inconsistent parenting, social pressure and spiritual factors such as spiritual poverty, demonic oppression, personals, and lack of faith.

However, there are different factors church leaders ascribed to causes of depression which are different across denominations where most of the biblical counselors are of the opinion that sin is the principal cause of depression (Powlison, 2000). In a study conducted among the Baptist clergy in Texas America 57.2% of the participants numbering 168, fingered spiritual poverty, demonic oppression, personal sin and lack of faith as factors that predispose men to depression (Stanford et al, 2011). Likewise, some Nigeria clergies held this same view (Agara et al 2008).

Also, in a study conducted by Adewuya & Ologun (2006) among the adolescents in the south-west of Nigeria, depression was attributed to perception of family functioning, family conflicts, depressive symptoms in the parents, adolescent problems with peers, adolescent loss of self-esteem, drinking problem, gender and the size of the family. Among the elderly, Mathuranath, George, Cherian, Mathew & Sarma (2005) found out that this group are predisposed to depression because of the factors such as chronic medical illnesses, loss of cognitive ability, heredity factors and some psychosocial adversity-economic impoverishment, disability, isolation, relocation, care-giving, and bereavement.

Across the three major ethic groups in Nigeria, several factors are attributed to depression and other mental illnesses which also affect their health-seeking behavior, in the North among the Muslim Hausa depression and other mental illness are caused by misuse of substances according to the study conducted by Kabir,Iliyasu,Abubakar&Aliyu,2004 whereas the Yoruba ethnic group that has a mixture of Christians and Muslims and the

Igbos of the predominant Christian faith, the general belief is that mental health issue is caused by supernatural ,biological and psychosocial factors Adewuya&Makanjuola,2008 The perceived factors that are responsible for mental illness like depression can affect the help-seeking behaviors, recommendation of treatment and stigmatization attached to it. (Compton, Esterberg McGee, Kotwicki& Olivia, 2006). This makes adequate knowledge of depression and causative factors among the church leaders to be considered as the first line of help to the depressed in the church (Agara et al 2008)

2.8 Management of Depression

It has been observed that several methods have been adopted to manage depression. They include psychosocial and psychological therapies together with pharmacological intervention. However, Prins, Verhaak & Bensing (2008) observed that most people suffering from depression would prefer psychosocial and psychological therapies over medication but Holon, Stewart & Strunk (2005) found that the most effective treatment of depression many people respond to as treatment in the long run are less than half of people treated which can be sustained for 2 years due to relapse. This implies a combination therapy is advised. The pharmacological approach is in the use of antidepressants that have 35 different types with much work to show how these drugs might alter the natural history of depression (Anderson, Ferrier & Baldwin, 2008). Antidepressants have been considered to be a first- line treatment against depression of moderate severity (Anderson et al 2008). However, antidepressants should be used carefully among the adolescents where connection between its use and suicide has been reported (Hawton, Saunders & O'Connor (2012)

World Health Organization considered the management of depression at the primary health care level as a potent strategy for promoting mental health (WHO, 2001). The primary health centers operated by non-specialist practitioners has been faulted in its management with much inadequacy due to inability to follow proper guidelines for treatment. This is also attributed to poor dosage, poor patient compliance with medication and poor psychotherapy. All these compromise patient outcome (Simon & Von Korff, 1999)

To address this problem, WHO proposed a number of educational strategies focusing on the health care professionals to improve the recognition and management of depression at the primary health care centers Cabana, Rushton & Rush, 2002. Similarly, Gilbody, Whitty, Grimshaw & Thomas,2003) discovered that opportunity to identify cases of depression that are presented in a primary care settings are often missed due to lack of proper education on how to recognize and manage depression by primary health workers. They also observed that recognition and management of depression at the primary care can be enhanced by an improved screening system that will enabled the health workers to identify large number of patients with depressive symptoms.

On the other hand, Katon, Vonkorff,Lin, Unutzer, Simon, Walker & Bush,1997 had earlier proposed a different system for management of depression called population-based model of care which focus on a care system that adequately treat a chronic or recurrent illness with methods such as initial screening and case detection, identifying and tracking those at high risk for relapse and those not following medication regiment ,planned follow up, monitoring outcomes and providing adequate plans to handle resistant and more complex cases. Also, population –based system addresses training for providers of care, education for depressed patient's illness management skills and information system that supports follow up. They concluded that this approach has greatly reduced the prevalence of depression in the target population; the use of this approach can be adopted in cases where pharmacological approach is inadequate.

2.8.1 Management of depression by church leaders

Stanford et al, (2011) observed that Church leaders manage depression indifferent ways. Among church leaders in some protestant denomination like Baptist congregation in America, it was revealed that out of 168 participants,40% will refer their members to a licensed mental health care provider ,39.0% utilize pastoral/spiritual counseling, 21% prefers only prayer for management of depression and other mental health illnesses while 14% offers word of encouragement without any form of Psychotherapy content. About 4% will offer financial support for treatment and another 4% the development of special classes, small group bible studies or support groups for those suffering with mental illness. Among the syncretic churches in Nigeria, the management style is different. In the Celestial Church of Christ, mental illness is managed by the use of holy water, amulets, prayer and fasting, sacrifices and physical restraint. Depressive symptoms are simply

managed by counseling and prayer only. This group has no referral system in place for mentally ill (Agara et al, 2008)

2.8.2 Management of depression among church members

Tepper, Rogers, Coleman & Malony, (2001) studied 406 persons across several denominations regarding the management of depression among church members; and 241 was found to manage depression or any other mental illness by prayer alone, 142 of them will attend religious services, 141 of them indicated worshiping God, 133 of them chose meditation, 123 of them will read scriptures and only 61 will contact a spiritual leader. In a study by Okechukwu et al, (2016) among women with Antenatal depression attending an antenatal clinic in Abeokuta North local Government Area of Nigeria, out of the 314 pregnant women studied with antennal depression:68.9% of them managed the depression by talking to their husband about it,57.3% got treatment from doctors while 52% seek for prayer in the church.

2.8.3 Effects of depression

Depression affects all aspects of human life, Physiological, Psychosocial, Relationships, behavioral and cognitive ability. Burke,2003 put depression in its social context and described it as a disease which not only affect the depressed but everyone connected with them, the author observed that depression has negative effects on children, husbands or partners and family. He further explained that children of depressed women can suffer socially, psychologically, and reduced cognitive ability. Mor, Guadagnol & Wool, 1987 has documented the effect of depression on caregivers to terminally ill patients, in their study people in this category suffer serious emotional conflict, strain and guilt. Also cognitive ability was observed to be affected by depression from the study conducted by Ali, Rodney & Glenn, 2002 where they discovered that depression symptoms had an adverse effect on immediate recall of new information and the ability of the brain to acquire these information.

Late-life depression is a public-health problem in the United States with tremendous health and economic implications. According to the study conducted by Dick, Foroud Flury, Bowman, Miller, Rau & Glitz, (2003) an estimated 2 million of America's 35 million older adults have a depressive illness, and another 5 million have sub-syndrome or minor depression. The consequences of untreated depression in older adults include

increased mortality, suicidal ideation, and decreased functional abilities (Cook, Pearson, Thompson, Black, & Rabins, 2002; Fröjdh, Håkansson, Karlsson, & Molarius, 2003). Studies examining the effect of depression on health care costs found that depressed elderly patients also have significantly higher healthcare costs than do non-depressed elders, regardless of chronic morbidity (Katon, Lin, Russo, &Unutzer, 2003).

In Nigeria, the recent study on depression by Jamison, McGee, Oseni, Perng, Sato, Tanaka, & Vakis, 2018 has revealed an astronomical increase in depression where 1 out 5 Nigerians about 22% were discovered to be suffering from chronic depression, with tendency for suicide and serious socio-economic implications never so anticipated in the history of this country. There is therefore a need for urgent interventions to stem this tide which will be the focus of this study.

2.9 Conceptual Framework

The PRECEDE is an acronym that stands for predisposing, reinforcing and enabling constructs in educational environmental diagnosis and evaluation. This theory helps to understand the causal factors of any given public health behavior. The three key concepts of this model are explained below:

The Predisposing factors: They are factors which motivate or provide a reason for behaviour; they include knowledge, attitudes, cultural beliefs, perceived needs and abilities and readiness to change. In this study, selected Pentecostal leaders can demonstrate positive behaviour at managing depression among members if they have adequate knowledge, positive attitudes and good perceptions of depression

The Enabling factors: These are what enable persons to act on their predispositions; these factors include available resources, accessibility, money, time, supportive policies, assistance, and services. With availability of resources and good organisational policies the leaders can be adequately trained to manage depression effectively among members

Reinforcing factors: This is which come into play after behaviour has been initiated. They encourage repetition or persistence of behaviours by providing continuing rewards or incentives e.g. Social support (family, peers), health care workers, law enforcement, and the media. The outcome of this study has been to see Church leaders taking a front burner in helping to reduce the prevalence of depression among members, access to information from media, internet, and the Professionals in the field of mental health will go a long way to enhance this behaviour.

Application of the model.

Numerous studies have supported the positive impact the PRECEDE model has had on the effectiveness of health promotion programs. Some of these studies include preventive behaviors for type 2 diabetes mellitus in high-risk individuals (Moshki, Dehnoalian, & Alami, 2017), health promotion options for breast cancer survivors (Tramm, McCarthy, & Yates, 2012), fitness-emphasized physical activity and heart-healthy nutrition education program for elementary school children Espinoza, Ayala & Arredondo,2010), internet based weight management program for young adults (Kattelmann, White, Green et al, 2014), among others.

Using the various constructs of model, it will be applied to the current research as follows:

i. Predisposing factor: The various factors that motivate the respondents (Church leaders around Ibadan North Local Government) to practice preventive measures against depression, will be assessed. This includes knowledge, attitudes and perception of depression. Action or inaction about preventive measures against depression are linked to those predisposing factors.

ii. Enabling factors: These are what enable the respondents to act on their predisposing, to facilitate proper action on preventive measures against depression. These will include; some denominational policy, past experience with depressed members of the church, health services and other resources that aid their recognition and management of depression.

iii. Reinforcing factor: They include what encourages the practices of preventive measures to be persistent and consistent among the respondents. They include the training of the religious leaders on mental health, some demographic variables; Age, duration of clerical service types of denomination, educational level, reinforced information from media and health care service.

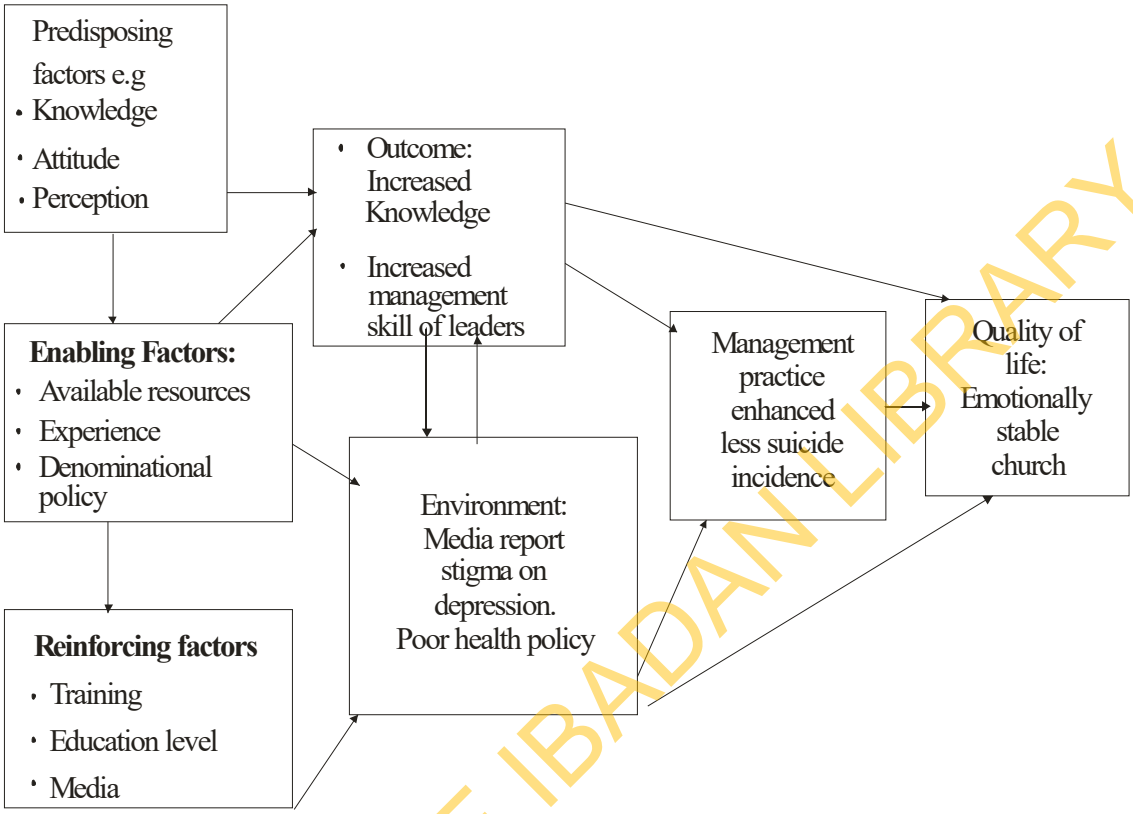

Figure 2.1: Precede model

Source: Moshki, Dehnoalian, & Alami, 2017

CHAPTER THREE

METHODOLOGY

3.0 Introduction

In this section, the type of research design that this study will employ, research participants, sampling method, instruments, data collection procedures, validity and reliability of the test, statistical treatment and analysis of data and ethical issues are discussed.

3.1 Study design

A descriptive cross-sectional survey using semi structured questionnaires was employed in this study. In this design, the researcher collects an in-depth data across a cross-section of the participants to investigate the subject matter at a particular point in time. It is described as a snapshot of the outcome and the characteristics associated with it, in the specific time. It focused on studying and drawing inferences from existing differences between people, subjects, or phenomena, in this case the selected Pentecostal leaders in Ibadan north local government.

3.2 Study area

Ibadan North is a Local Government Area in Oyo State, Nigeria. Its headquarters stood at Agodi in Ibadan. The postal code of the area is 200. It has an area of 27 km² and a population of 856,988 according to the Oyo State Government in 2017. It also has its administrative headquarters located in the town of Agodi bustling academic and economy activities with the presence of the First Premier University in Nigeria, the University of Ibadan, founded in 1948, and The Polytechnic, Ibadan in 1970 creates an aura of lively place to live in. Ibadan North is a town and a Local Government Area in Oyo State headquartered in Agodi which is the notable town in the area, comprising the subdivision of the wards. This local government area was created to ensure that resources coming from the upper tier government are used efficiently and effectively and services are provided in accordance with the best value principles to best meet the needs of the people at the grassroots level. It is one of the five Local Government Area carved out of the defunct Ibadan Municipal Government in 1991. The Local Government Area covers a landmass of 132.500 square kilometers with a population density of 2,626 persons per square kilometers. Using a growth rate of 3.2% from 2006 census, the 2010 estimated population

for the Local Government area is put at 347,998. Ibadan North local government area is subdivided into 12 wards and the local government is governed by an elected chairman and 12 councilors, one elected from each ward.

3.3 Study population

The study population included both male and female church leaders in different Pentecostal churches in Ibadan North local government, Ibadan, Oyo state, Nigeria. Conducting this study among this population enabled us to know the knowledge and management of depression by church leaders and their members in the selected churches

3.4 Inclusion criteria

The inclusion criteria for the study include church leaders from Pentecostal churches who understands English or interpreted to them in Ibadan north local government who gave consent to participate in the study.

3.5 Exclusion Criteria

The exclusion criteria would be leaders of others churches not from Pentecostal church, members of Pentecostal churches who are not leaders and leaders of Pentecostal churches who did not give consent to participate in the study work.

3.6 Sample size determination

Sample size for this study would be estimated from the Leslie kish formula of

$$N = \frac{Z^2pq}{d^2}$$

Where;

N = Minimum sample size

Z = Standard normal deviation set at 1.96 normal deviation

p = Prevalence rate of 22% (Jamison et al, 2018)

d = degree of precision at 5% (0.05)

q = 1-p (1- 0.22)

Therefore, $N = \frac{(1.96^2 \times 0.22 \times 0.78)}{(0.05)^2} = \mathbf{263.684 = 264}$

In order to accommodate non-response, a rate of 10 % will be considered as

290/(1-0.9)= 293. This was however rounded up to 300 to get a round figure in estimating 10% for pretest.

3.7 Sampling technique

The eligible participants were selected through a two-stage sampling techniques:

The total number of the registered Pentecostal churches in Ibadan north local government area were obtained from the Pentecostal Fellowship of Nigeria (PFN) secretariat Oyo state. The number of Pentecostal churches in each ward were obtained seven wards /Zones in all. A proportionate sampling were used to select the number of respondents from the Pentecostal churches within each ward, however in situation where this was not feasible due to lack of documentation, we ensured that respondents were recruited from all wards purposively.

3.7.1 Sampling procedure

Stage: 1

Among the Mega churches

$$\frac{\text{Population of the church}}{\text{Total population of the PFN members}} \times 300$$

Total (Estimated) Population 50,000
No of zones = 7

Stage 2:
Among smaller Pentecostal Churches
("mushroom")
By Zones:

$$\frac{\text{Total No of PFN Churches in zone}}{\text{Total No of PFN Churches in the Seven zones}} \times 300$$

Each of this zones are controlled by zonal leaders, each leader was contacted and delivered Questionnaires shared at Random with the churches at the zonal level. This how over 300 respondents were sampled.

3.8 Instrument for Data collection

The instrument used in this study was a semi structured questionnaire with both open ended and close ended questions, to assess the knowledge and management of depression among the research respondents. The questionnaire was developed using information obtained from literature on depression and its management. The instrument for the study

have five (5) sections: the first section was designed to bring out data on socio-demographics characteristics of the respondents. The second section was designed to assess the level of knowledge of respondents relating to depression while the third section was meant to collect information on the perception of depression among church leaders. The fourth section focused on the attitude of church leaders towards depression and fifth section was meant to collect information on the management of depression among church leaders in Ibadan North Local Government Area

3.9 Validity of Instrument for Data Collection

In ensuring the validity of the instrument, content validity will be ensured by ensuring the theme from the specific objectives form the sub-headings in the section of the instrument apart from section 1 which focused on the socio-demographic characteristics of the respondents. Construct validity would be assured by making sure variables in the theoretical framework are represented in the instrument for this study. Face validity will also be considered and ensured double barrel questions or any ambiguous questions will not be included in the instrument.

Extensive literature reviews was done with simple language and clarity of questions were ensured. The drafted copy of the proposed instrument had undergone independent review from peers and experts in the field. Supervisor's review was used to finalize the instrument.

3.10 Reliability of Instrument

The reliability of the instrument was determined by pre-testing 10% of the sample size of 300; which came up to 30 respondents, among leaders of Pentecostal churches in Ido local government precisely at Ologuneru. Therefore Copies of the instrument was administered to thirty (30) respondents. The information gathered was checked for errors and completeness. Each of the questionnaires was given serial number and a coding guide was developed for entry of the data collected into the computer software. The data was then subjected to descriptive statistics. The overall reliability coefficient which is also called Cronbach Alpha statistical test was calculated and with reliability equals or greater than 0.7 the instrument was considered reliable. However, from the responses of the respondents, the instrument was reviewed and ambiguous questions was removed. Also, questions considered by the respondents not to be appropriate were revised after the pretest.

3.11 Data collection procedure

The data collected by the researcher with the assistance of the research assistants who have been trained prior to the administration of the instrument by the research participants. The church leaders were met by the principal investigator together with the assistance of the research assistant to provide correct and understandable information to them about the research. This was considered to be essential in order to obtain informed consent from the participants. The informed consent forms were distributed among the research participants after they have been informed fully about the study. After the questionnaires have been filled by the respondents, the researcher checked for completeness and errors before leaving the church location of the data collection.

3.12 Data management and analysis

The questionnaires were given serial number for easy entry and recall. A coding and scoring guide were developed along with the data collection tool in order to facilitate its analysis. Statistical Package for social Sciences (IBM/SPSS) version 25 was used to analyse the data obtained from the questionnaires. Using the scoring and coding guide, the data collected were carefully entered into the statistical software and analysed using descriptive statistics such as frequency, percent, mean, standard deviation, charts and inferential statistics such as Chi-square and Fisher's Exact tests to measure significant difference between sex, marital status, age ,education level and management of depression among the study population. The results obtained from the SPSS analysis were summarised and presented in tables, figures and charts. A 29-points knowledge scale was used to assess the knowledge of respondents about depression and knowledge scores between 0-9,>9≤20 and >20 were categorised as poor, fair and good knowledge, respectively. A 14-point perception scale with score 0-7 and >7 were categorised as negative and positive perception, respectively. A 12-point attitude scale with score 0-6 and >6 were categorised as negative and positive attitude, respectively. Ability to recognize depression was scored on a 80-point scale using an adapted version of Zung self-rating depression scale with scores between 0-26,>26≤53 and >53 were considered as poor, fair and good ability to recognize depression, respectively. Finally, a 19-point practice scale was used to examine the management styles of the respondents on depression, a practice score of between 0-9 and >9 were considered as poor and good practice, respectively. Chi square test and Fisher's exact test were used to test the statistical significance between

socio-demographic variables and knowledge and management styles of depression at p-value of 0.05

3.13 Ethical considerations

Ethics approval was obtained from the Oyo State Ministry of Health Ethics Review Committee to ensure the study meets all the principles and national guidelines in research involving human participants.

3.14 Study Limitations

Limitations

The present study had several limitations necessitating further research, these include the non-inclusion of other Faiths and denominations, making it difficult to generalise this findings across board. However, the Pentecostal churches represent a major bloc within the Christian Association of Nigeria the findings can form a template for future research and health promotion and education .The instruments developed for this study may be too simple and easily reasoned out to arrive at some biased answers given by the respondents which mean this may not be the true test of the parameters under study. The sampling procedure was also affected by poor documentation and church policy by the Pentecostal Fellowship of Nigeria on the total number of churches under each ward, making Proportionate sampling hard to achieve in some cases. To overcome these limitations, steps were taken to ensure that the questionnaire were purposively administered within the seven wards that made up Pentecostal churches in Ibadan North Local Government Area.

CHAPTER FOUR

RESULTS

4.1 Socio-demographics characteristics of respondents

There were three hundred church leaders recruited for the study which many of the respondents (63.3%) age ranged between 40 – 59 years, with an average age of 49.5±2.21 years and more than half (56.7%) were male. majority (77.3%) were married and most (80.0%) as Yoruba as expected due to the study area. most (63.7%) were graduate and just few (2.3%) were in medical and pharmaceutical (Table 4.1a). Only few (7.7%) were general overseer and many (73.3%) had part time engagement which most (84.0%) were not on the church payroll. Many (72.0%) had no other source of income and some (35.7%) had been church leader for more than 12 years. Many (71.7%) did not attend seminary before pastoring and some (38.4%) of those who attended spent 3 years in the seminary (Table 4.1b).

Table 4.1a Socio-demographics characteristics of Respondents (n=300)

	Frequency	Percentage (%)
Age		
20 – 39 years	82	27.3
40 – 59 years	190	63.3
>60 years	28	9.4
Gender		
Male	170	56.7
Female	130	43.3
Marital Status		
Single	63	21.0
Married	232	77.3
Widow	3	1.0
Divorced	2	0.7
Tribe		
Yoruba	240	80.0
Igbo	26	8.7
Hausa	1	0.3
Others	33	11.0
Level of Education		
Primary	9	3.0
Secondary	34	11.3
Graduate	191	63.7
Masters/PhD	66	22.0
Profession		
Medical/Pharmaceutical	7	2.3
Banker	13	4.4
Civil Servant	70	23.3
Others	210	70.0

Table 4.1b Other socio-demographics characteristics of Respondents (n=300)

	Frequency	Percentage (%)
Pastoral Rank		
General Overseer	23	7.7
Pastor	67	22.3
Elder/Deacon	50	16.6
HOD	59	19.7
Others	101	33.7
Church Engagement		
Full time	80	26.7
Part time	220	73.3
Church Payroll		
Yes	48	16.0
No	252	84.0
Other Sources of Income (n=84)		
None	216	72.0
Trading	26	8.7
Employed	23	7.7
Farming	7	2.3
Artisanry	5	1.7
Civil servant	4	1.3
Self employed	3	1.0
Others	16	5.3
Years of been church leader		
0 – 3	69	23.0
4 – 7	54	18.0
8 – 11	70	23.3
>12	107	35.7
Attended seminary before pastoring		
Yes	85	28.3
No	215	71.7
How many years did you spend in the seminary (n=85)		
1	28	33.7
2	11	12.8
3	33	38.4
>3	13	15.1

4.2 Knowledge of respondents on Depression

The mean knowledge score of respondents was 21.3±5.4 on a 29-point scale which few (3.0%) had poor knowledge, some (28.7%) had fair knowledge and majority (68.3%) had good knowledge about depression (Fig 4.1). Majority of respondents (99.3%) have heard of depression, most (80.3%) understood depression as sickness of the mind, many see it as a mood disorder (77.3%) and feeling of prolonged sadness (75.7%) which some (40.0%) see it as a bullying (Table 4.2a). Most (82.3%) knew depression as a health problem while some (34.0%) had a misconception that depression is caused by witchcraft, charms or evil spirits. Almost all the respondents (96.0%) knew patients with depression could breakdown at any time and they knew depression can lead to suicide attempt (94.0%). most (83.7%) knew patients with depression are dangerous to themselves and others, only few (8.3%) said depression responds better to traditional remedies than orthodox treatment and most (81.3%) knew sin is not root cause of depression (Table 4.2b). Many knew depression affect physiological (73.0%) behavioral (78.0%) and most (80.0%) said psychosocial aspect of life. Many (74.3%) said it affects the relationship and only few (14.0%) said it doesn't affect procreation (Table 4.2c). Most knew symptoms of depression include loss of appetite (79.7%), loss of interest (84.7%) while majority (92.3%) said feeling of sadness and almost half (48.0%) agreed to overeating as symptoms of depression. Majority of the respondents (90.7%) said recent misfortune could cause depression and most said lack of money (83.0%) and lack of job (85.3%) (Table 4.2d). Most (83.0%) knew information on depression can be obtained from internet, many (75.0%) said newspaper and journals (68.3%). Also, many knew information about depression can be gotten from professionals (78.7%), church members (60.3%) and television (73.7%) (Table 4.2e).

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Table 4.2a Respondents knowledge on depression (n=300)

	Frequency	Percentage (%)
Depression is sickness of the mind		
Yes	241	80.3
No	11	3.7
Don't know	48	16.0
Depression is mood disorder		
Yes	232	77.3
No	12	4.0
Don't know	56	18.7
Depression is feeling of prolonged sadness		
Yes	227	75.7
No	19	6.3
Don't know	54	18.0
Depression is a bully		
Yes	120	40.0
No	70	23.3
Don't know	110	36.7

Table 4.2b Respondents knowledge on depression (n=300)

	Frequency	Percentage (%)
Depression is a health problem		
Yes	247	82.3
No	38	12.7
Don't know	15	5.0
Depression is caused by witchcraft, charms or evil spirits		
Yes	102	34.0
No	169	56.3
Don't know	29	9.7
Patients with depression can breakdown at anytime		
Yes	288	96.0
No	4	1.3
Don't know	8	2.7
Depression can lead to suicide attempt		
Yes	282	94.0
No	8	2.7
Don't know	10	3.3
Patients with depression are dangerous to themselves and others.		
Yes	251	83.7
No	28	9.3
Don't know	21	7.0
Depression responds better to traditional remedies than orthodox treatment		
Yes	25	8.3
No	223	74.3
Don't know	52	17.3
Sin is the root cause of depression		
Yes	34	11.3
No	244	81.3
Don't know	22	7.3

Table 4.2c Aspect of life affected by depression (n=300)

	Frequency	Percentage (%)
Physiological		
Yes	219	73.0
No	19	6.3
Don't know	62	20.7
Behavioural		
Yes	234	78.0
No	11	3.7
Don't know	55	18.3
Psychosocial		
Yes	240	80.0
No	8	2.7
Don't know	52	17.3
Relationship		
Yes	223	74.3
No	14	4.7
Don't know	63	21.0
Procreation		
Yes	164	54.7
No	42	14.0
Don't know	94	31.3

Table 4.2d Symptoms and Causes of depression (n=300)

	Frequency	Percentage (%)
Loss of appetite		
Yes	239	79.7
No	19	6.3
Don't know	42	14.0
Loss of interest		
Yes	254	84.7
No	14	4.7
Don't know	32	10.7
Feeling of sadness		
Yes	277	92.3
No	3	1.0
Don't know	20	6.7
Over eating		
Yes	86	28.7
No	144	48.0
Don't know	70	23.3
Caused by recent misfortune		
Yes	272	90.7
No	10	3.3
Don't know	18	6.0
Lack of money		
Yes	249	83.0
No	13	4.3
Don't know	38	12.7
Lack of job		
Yes	256	85.3
No	5	1.7
Don't know	39	13.0

Table 4.2e Sources of information on depression (n=300)

	Frequency	Percentage (%)
Internet		
Yes	249	83.0
No	16	5.3
Don't know	35	11.7
Newspaper		
Yes	225	75.0
No	23	7.7
Don't know	52	17.3
Journals		
Yes	205	68.3
No	33	11.0
Don't know	62	20.7
Professionals(Mental Health workers)		
Yes	236	78.7
No	13	4.3
Don't know	51	17.0
Church members		
Yes	181	60.3
No	53	17.7
Don't know	66	22.0
Television		
Yes	221	73.7
No	19	6.3
Don't know	60	20.0

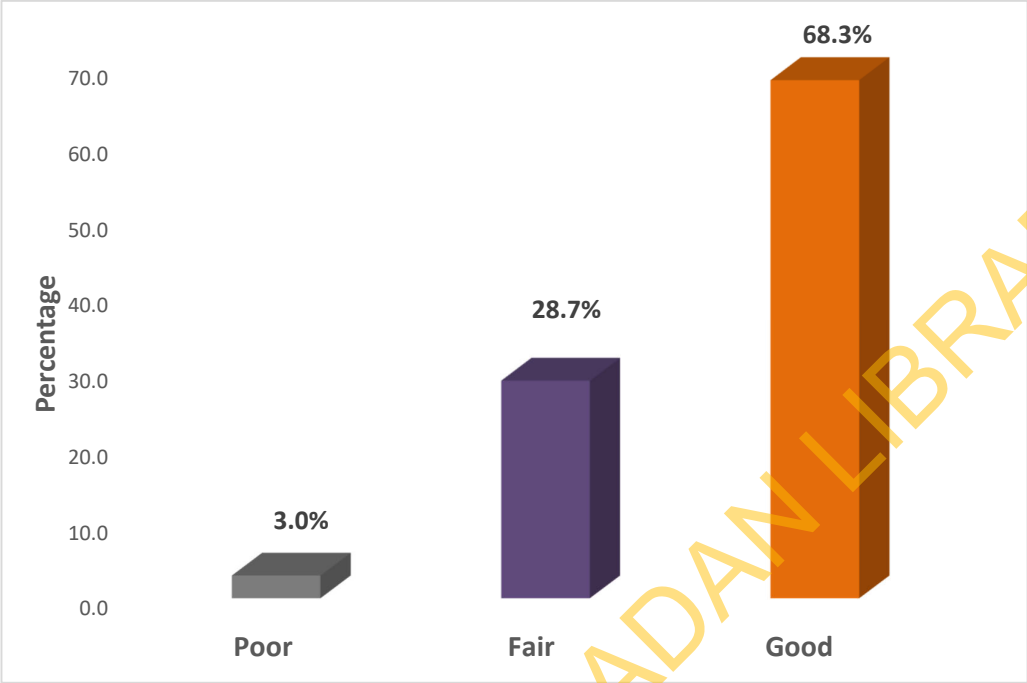

Fig 4.1 Knowledge of respondents on Depression

4.3 Perception of respondents on depression

The mean perception score of respondents was 8.8±1.6 on a 14-point scale which some (20.3%) had negative and majority (79.7%) had positive perception about depression (Fig 4.2). Most (86.0%) agreed that depression affects people of a particular age and almost all of the respondents (96.3%) disagreed that only sick people can be depressed, only single parent experiences expression and Christians cannot be depressed (93.7%). Most (79.3%) agreed depression is an illness that needs attention and more than half (57.7%) agreed depressed people are looking for attention. Most (63.3%) disagreed that going to church regularly can prevent depression and almost all of the respondents (93.3%) disagreed that depressed people are suffering from their sin and becoming depressed is a natural part of becoming old (90.0%). Some (46.0%) agreed that relating with depressed people is tedious and most (85.7%) agreed that anyone can be depressed which more than half (55.0%) disagreed females suffer more from depression than males. Some (61.3%) agreed that clinical depressive disorder cannot be differentiated from unhappiness and some (34.0) disagreed that depression is a sign that one has poor stamina to deal with life difficulties (Table 4.3).

Table 4.3 Perception of Depression (n=300)

	Agree n (%)	Disagree n (%)
Depression affects people of a particular age	42 (14.0)	258 (86.0)
Only sick people can be depressed	11 (3.7)	289 (96.3)
Only single parent experiences depression	11 (3.7)	289 (96.3)
Christians cannot be depressed	19 (6.3)	281 (93.7)
Depression is an illness that needs attention	238 (79.3)	62 (20.7)
Depressed people are looking for attention	173 (57.7)	127 (42.3)
Going to church regularly can prevent depression	110 (36.7)	190 (63.3)
Depressed people are suffering from their sin	20 (6.7)	280 (93.3)
Becoming depressed is a natural part of becoming old	30 (10.0)	270 (90.0)
Relating with depressed people is tedious	138 (46.0)	162 (54.0)
Anyone can be depressed	257 (85.7)	43 (14.3)
Females suffer more from depression than males	135 (45.0)	165 (55.0)
Clinical depressive disorder cannot be differentiated from unhappiness	184 (61.3)	116 (38.7)
Depression is a sign that one has poor stamina to deal with life difficulties	198 (66.0)	102 (34.0)

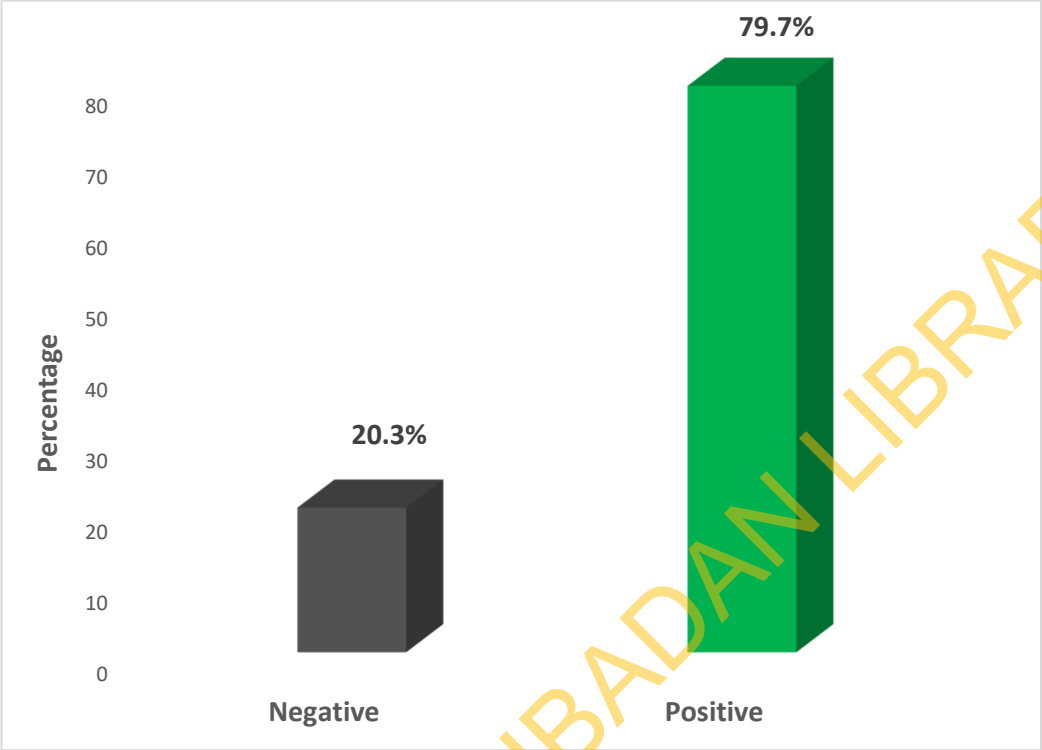

Fig 4.2 Perception of respondents on depression

4.4 Attitude of Respondents towards Depression

The mean attitude score of respondents was 8.7±1.8 on a 12-point scale which few (10.7%) had negative attitude and majority (89.3%) had positive attitude about depression (Fig 4.3). Majority (61.3%) agreed they feel comfortable counseling depressed members and majority (89.0%) disagreed they felt that depressed people are not spiritual. Almost all of the respondents (94.7%) disagreed that only the church overseer can handle depression matters well and most (81.0%) disagreed they prefer doing other ministerial work to counseling the depressed. Only few (6.7%) agreed they cannot counsel anybody on depression, some (30.7%) agreed they are trained on depression matters, that they think everybody should be responsible for how he handles depression (36.7%) and that there is little they can offer to depressed members who fail to respond to profession advice (34.7%). More than half (52.3%) disagreed they think depressed members are more likely to have suffered deprivation in early life than others, many (77.3%) disagreed that members with depression discriminated against by others. However, only few (5.3%) agreed it is not acceptable to talk about depression in in their church and most (83.0%) disagreed that depressed members are fun to be with (Table 4.4).

Table 4.4 Attitude towards Depression (n=300)

	Agree n (%)	Disagree n (%)
I feel comfortable counseling depressed members	184 (61.3)	116 (38.7)
I feel that depressed people are not spiritual	33 (11.0)	267 (89.0)
Only the Church overseer can handle depression matters well	16 (5.3)	284 (94.7)
I prefer doing other ministerial work to counseling the depressed	57 (19.0)	243 (81.0)
I cannot counsel anybody on depression	20 (6.7)	280 (93.3)
I am not trained on depression matters	92 (30.7)	208 (69.3)
I think everybody should be responsible for how handles depression	110 (36.7)	190 (63.3)
There is little I can offer to depressed members who fail to respond to professional advice	104 (34.7)	196 (65.3)
I think depressed members are more likely to have suffered deprivation in early life than others	143 (47.7)	157 (52.3)
Church members are not friendly with depressed members	68 (22.7)	232 (77.3)
It is not acceptable to talk about depression in our church	16 (5.3)	284 (94.7)
Depressed members are fun to be with	51 (17.0)	249 (83.0)

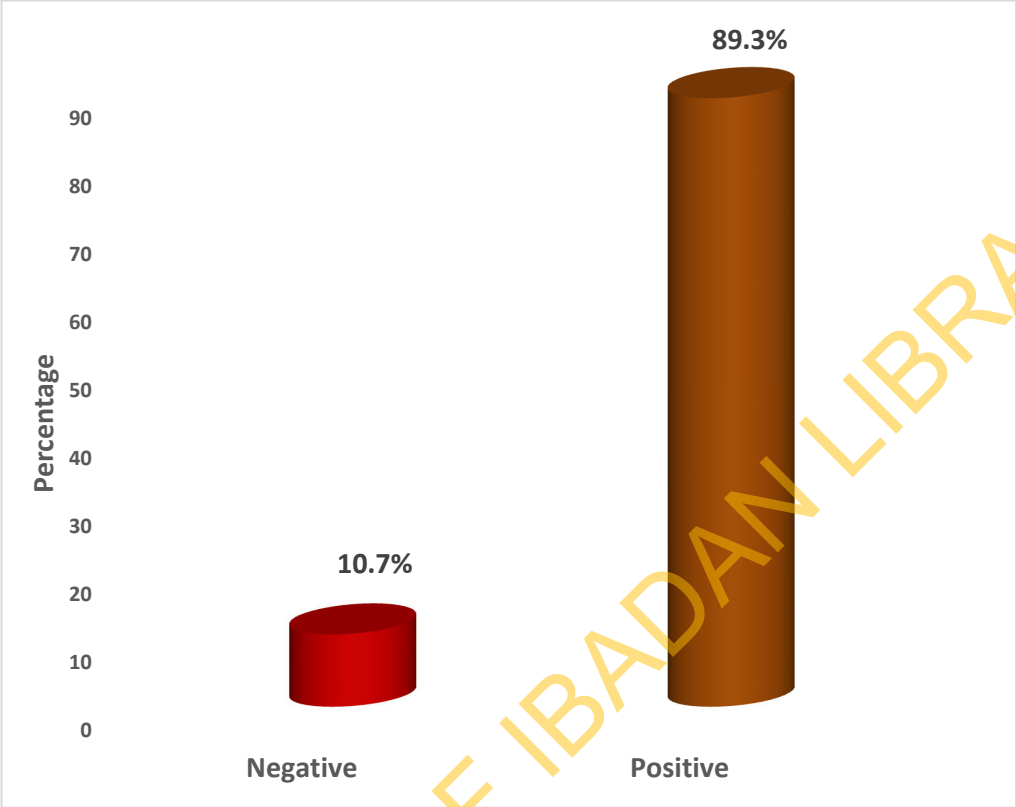

Fig 4.3 Attitude of respondents towards depression

4.5 Respondents Ability to Recognise Depression

The mean ability score of respondents 56.4±6.8 on an 80-point scale which no respondent had poor ability, some (35.3%) had fair ability and majority (64.7%) had good ability to recognize depression (Fig 4.4). Some of the respondents (46.0%) said most of the time a member is depressed when he feels down-hearted and blue but some (60.7%) said a little of the time a member is depressed when he feels best only in the morning. Some (29.0%) said a good part of the time a member is depressed when he experiences crying spell or feel like it, more than half (57.3%) mentioned that a little of time a member is depressed when he agreed that he still eat as much as he used to and majority (62.3%) said a little of the time a member is depressed when he confirms he still enjoy sex. Some (28.3%) agreed that good part of the time a member is depressed when he complains of difficulty sleeping in the night , some (43.0%) mentioned that some of the time a member is depressed when he notice is losing weight and a little of the time a member is depressed when is having trouble with constipation. Few (13.7%) said good part of the time a member is depressed when he complains that his heart beats faster than usual and 17.3% said most of the time, member is depressed when he complains he gets tired for no reason (Table 4.5a). Most (63.7%) agreed that a little of the time a member is depressed when he agrees that his mind is clear as it used to be and a member is depressed when he finds doing things as easy as before (61.7%). Some (34.0%) said most of the time a member is depressed when he complains of restlessness but a few (5.3%) said good part of the time a member is depressed when he agrees he feels hopeful about the future. Some (41.0%) said some of the time, a member is depressed when he feels more irritable than usual and majority (61.0%) agreed that a member is depressed when he finds it easy to make decisions. Only few (2.7%) said most of the time a member is depressed when he feels more useful and needed and a member is depressed when he complains that his life is full (8.0%). Some (46.3%) said most of the time a member is depressed when he feels that others would be better off if he was dead and more than half (52.0%) agreed that a little of the time a member is depressed when he still enjoys the things he used to do (Table 4.5b).

Table 4.5a Ability to recognise depression (n=300)

	A little of the time n (%)	Some of the time n (%)	Good part of the time n (%)	Most of the time n (%)
A member is depressed when he feels down –hearted and blue (sad)	37 (12.3)	71 (23.7)	54 (18.0)	138 (46.0)
A member is depressed when he feels best only in the morning	182 (60.7)	90 (30.0)	14 (4.7)	14 (4.7)
A member is depressed when he experiences crying spell or feel like it	70 (23.3)	71 (23.7)	87 (29.0)	72 (24.0)
A member is depressed when he agreed that he still eat as much as he used to	172 (57.3)	84 (28.0)	32 (10.7)	12 (4.0)
A member is depressed when he confirms he still enjoy sex	187 (62.3)	75 (25.0)	20 (6.7)	18 (6.0)
A member is depressed when he complains of difficulty sleeping in the night	56 (18.7)	78 (26.0)	85 (28.3)	81 (27.0)
A member is depressed when he notice is losing weight	104 (34.7)	129 (43.0)	35 (11.7)	32 (10.7)
A member is depressed when is having trouble with constipation	129 (43.0)	76 (25.3)	71 (23.7)	24 (8.0)
A member is depressed when he complains that his heart beats faster than usual	125 (41.7)	80 (26.7)	41 (13.7)	54 (18.0)
A member is depressed when he complains he gets tired for no reason	97 (32.3)	76 (25.3)	75 (25.0)	52 (17.3)

4.5b Other respondents' ability to recognise depression (n=300)

	A little of the time n (%)	Some of the time n (%)	Good part of the time n (%)	Most of the time n (%)
A member is depressed when he agrees that his mind is clear as it used to be	191 (63.7)	75 (25.0)	27 (9.0)	7 (2.3)
A member is depressed when he finds doing things as easy as before	185 (61.7)	80 (26.7)	24 (8.0)	11 (3.7)
A member is depressed when he complains of restlessness	70 (23.3)	65 (21.7)	63 (21.0)	102 (34.0)
A member is depressed when he agrees he feels hopeful about the future	182 (60.7)	81 (27.0)	16 (5.3)	21 (7.0)
A member is depressed when he feels more irritable than usual	88 (29.3)	123 (41.0)	39 (13.0)	50 (16.7)
A member is depressed when he finds it easy to make decisions	183 (61.0)	82 (27.3)	25 (8.3)	10 (3.3)
A member is depressed when he feels more useful and needed	189 (63.0)	85 (28.3)	18 (6.0)	8 (2.7)
A member is depressed when he complains that his life is full	170 (56.7)	77 (25.7)	29 (9.7)	24 (8.0)
A member is depressed when he feels that others would be better off if he was dead	81 (27.0)	45 (15.0)	35 (11.7)	139 (46.3)
A member is depressed when he still enjoys the things he used to do.	156 (52.0)	75 (25.0)	35 (11.7)	34 (11.3)

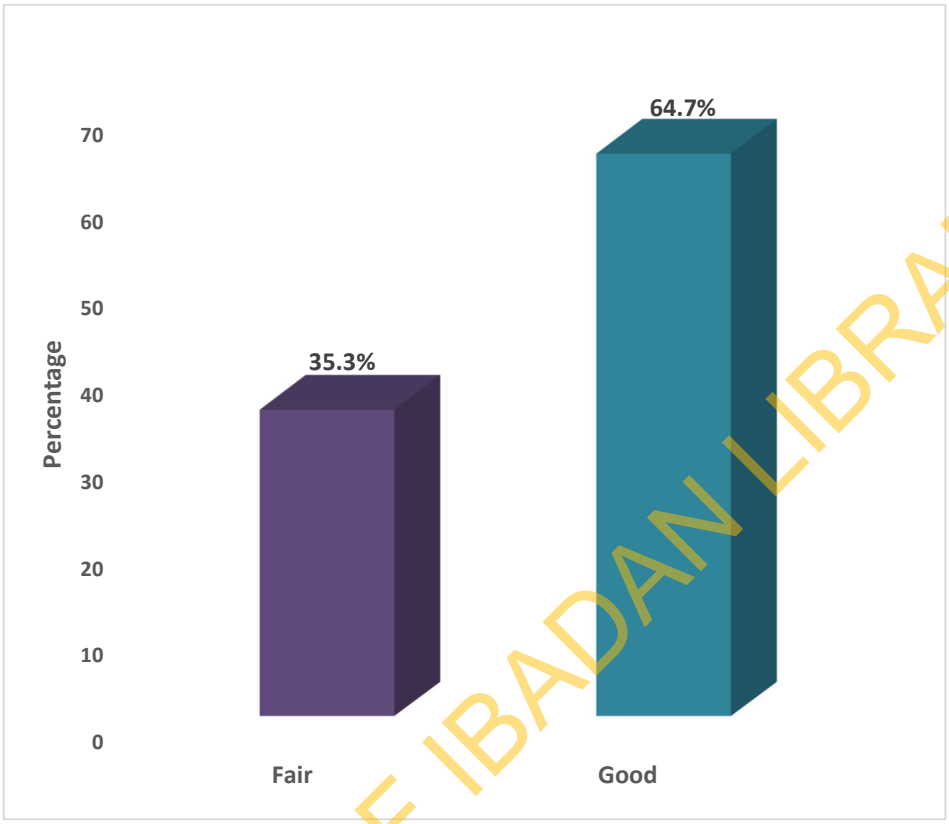

Fig 4.4 Respondents ability to recognise depression

4.6 Management style of depression

The mean management style of respondents 10.4±3.3 on a 19-point scale which some (36.7%) had poor management style and most (63.3%) had good management style about depression (Fig 4.5). Few preached on depression weekly (21.0%), monthly (20.0%), once in three months (17.0%), once in a 6 months (14.3%), yearly (11.3%) and some (25.3%) never did that on the pulpit. Many (73.7%) have counseled any member on depression, only few will recommend fasting to cure a depressed member (17.0%) and the use of holy water to cure a depressed member (11.7%). Majority (73.0%) will recommend some sort of restraints on a depressed member to avoid dangerous actions. Some (40.7%) had referred depressed member to mental health professional, more than half (51.7%) had referred depressed member for counselling and just few (12.7%) had ever referred depressed members to home. Some (28.3%) had formal training on mental health during their degree or seminary training and some (38.0%) provided mental and health services within churches. Only few (16.7%) believed prayer alone is sufficient to address depression among members and most (69.0%) contacted medical professionals on issues of depression (Table 4.6)

Table 4.6a Management Style of Depression (n=300)

	Frequency	Percentage (%)
Preach on depression on the pulpit		
(i) Weekly		
Yes	63	21.0
No	193	64.3
Don't know	44	14.7
(ii) Monthly		
Yes	60	20.0
No	175	58.3
Don't know	65	21.7
(iii) Once in three months		
Yes	51	17.0
No	177	59.0
Don't know	72	24.0
(iv) Once in 6 months		
Yes	43	14.3
No	187	62.3
Don't know	70	23.3
(v) Yearly		
Yes	34	11.3
No	193	64.3
Don't know	73	24.3
(vi) Never		
Yes	76	25.3
No	163	54.3
Don't know	61	20.3

Table 4.6b Other Management Styles on Depression (n=300)

	Frequency	Percentage (%)
Ever counseled any member on depression		
Yes	221	73.7
No	63	21.0
Don't know	16	5.3
Recommend fasting to cure a depressed member		
Yes	51	17.0
No	231	77.0
Don't know	18	6.0
Recommend the use of holy water to cure a depressed member		
Yes	35	11.7
No	248	82.7
Don't know	17	5.7
Recommend some sort of restraints on a depressed member to avoid dangerous actions		
Yes	219	73.0
No	61	20.3
Don't know	20	6.7
Formal training on mental health during your degree or seminary training		
Yes	85	28.3
No	153	51.0
Don't know	62	20.7
Provide mental health services within the church		
Yes	114	38.0
No	140	46.7
Don't know	46	15.3
Believe prayer alone is sufficient to address depression among members		
Yes	50	16.7
No	238	79.3
Don't know	12	4.0
Contact medical professionals on issues of depression		
Yes	207	69.0
No	74	24.7
Don't know	19	6.3

4.6c Referrals of depressed church members (n=300)

	Frequency	Percentage (%)
Mental health professional		
Yes	122	40.7
No	108	36.0
Don't know	70	23.3
Traditional healers		
Yes	27	9.0
No	174	58.0
Don't know	99	33.0
Prayers		
Yes	141	47.0
No	89	29.7
Don't know	70	23.3
Counseling		
Yes	155	51.7
No	88	29.3
Don't know	57	19.0
Home		
Yes	38	12.7
No	161	53.7
Don't know	101	33.7

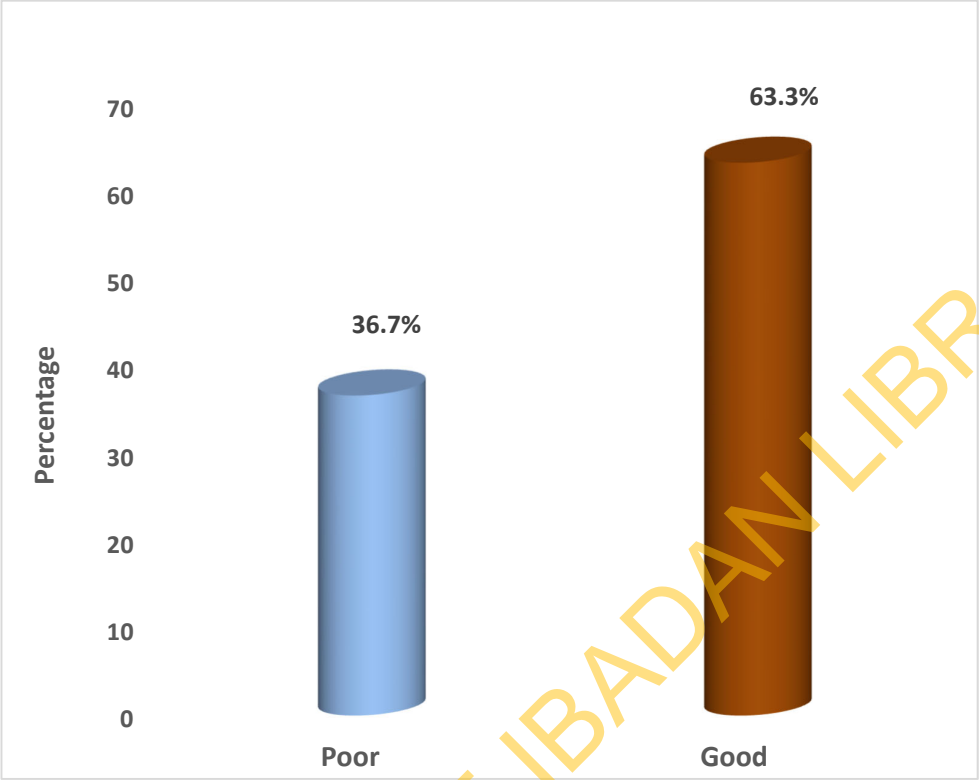

Fig 4.5 Respondents management style of depression

4.7 Test of Hypotheses

Hypothesis 1: There is no significant difference between socio-demographic characteristics and knowledge on depression among leaders in selected Pentecostal churches in Ibadan North Local Government Area, Oyo State.

Fisher's Exact analysis revealed that there was a significant difference between age, level of education, pastoral rank, years of being leader and their knowledge on depression with p-values of 0.013, 0.010, 0.009 and 0.003 respectively. Thus, we reject the null hypothesis (Table 4.7.1).

Table 4.7.1 Respondents' Socio-demographic characteristics (Age) and knowledge of depression.

Variables	Knowledge Score Category			Df	Fishers Exact	p-value
	Poor	Fair	Good			
Age (Years)						
20 – 39	2 (2.4%)	29 (35.4%)	51 (62.2%)	4	11.877	0.013**
40 – 59	3 (1.6%)	49 (25.8%)	138 (72.6%)			
>60	4 (14.3%)	8 (28.6%)	16 (57.1%)			

Total number of respondents = 300

Table 4.7.1b Respondents' Socio-demographic characteristics (Level of Education) and knowledge on depression.

Variables	Knowledge Score Category				Fishers	p-value
Level of Education	Poor	Fair	Good	Df	Exact	
Primary	2 (22.2%)	1 (11.1%)	6 (66.7%)	6	15.467	0.010**
Secondary	1 (2.9%)	17 (50.0%)	16 (47.1%)			
Graduate	4 (2.1%)	50 (26.2%)	137 (71.7%)			
Master/PhD	2 (3.0%)	18 (27.3%)	46 (69.7%)			
Total number of respondents = 300						

Table 4.7.1c Respondents Socio-demographic characteristic(Pastoral rank) and knowledge of depression

Variables	**Knowledge score category**					
Pastoral Rank	Poor	Fair	Good	Df	Fisher Exact	p-value
General Overseer(23)	0 (0.0%)	3 (13.0%)	20 (87.0%)	8	20.424	0.009**
Pastor(67)	0 (0.0%)	24 (35.8%)	43 (64.2%)			
Elder/Deacon(50)	2 (4.0%)	11 (22.0%)	37 (74.0%)			
HOD(59)	2 (3.4%)	9 (15.3%)	48 (81.4%)			
Others(101)	5 (5.0%)	39 (38.6%)	57 (56.4%)			
The Total number of respondents = 300						

Table 4.7.1d Respondents' Socio-demographic characteristic(Years of been church leader) and knowledge of depression.

Variables	Knowledge Score Category					
Years of been church leader	Poor	Fair	Good,	Df	Fisher exact	p- value
0 - 3	1 (1.4%)	31 (44.9%)	37 (53.6%)	6	18.394	0.003**
4 - 7	0 (0.0%)	17 (31.5%)	37 (68.5%)			
8 - 11	2 (2.9%)	11 (15.7%)	57 (81.4%)			
>12	6 (5.6%)	27 (25.2%)	74 (69.2%)			

***** Statistically significant***

Total number of respondents = 300

Hypothesis 2: There is no significant difference between socio-demographic characteristics and perception on depression among leaders in selected Pentecostal churches in Ibadan North Local Government Area, Oyo State.

Chi Square analysis revealed that there was a significant difference between level of education, years of being leader, attending seminary before pastoring and their perception on depression with p-values of <0.001, 0.024 and 0.033 respectively. Thus, we reject the null hypothesis (Table 4.7.2)

Table 4.7.2 Respondents' Socio-demographic characteristics and perception on depression.

Variables	Perception Score Category		Df	X^2	p-value
	Negative	Positive			
Level of Education*					
Primary	5 (55.6%)	4 (44.4%)	3	26.438	0.000**
Secondary	14 (41.2%)	20 (58.8%)			
Graduate	39 (20.4%)	152 (79.6%)			
Master/PhD	3 (4.5%)	63 (95.5%)			
Years of been church leader					
0 - 3	10 (14.5%)	59 (85.5%)	3	9.313	0.024 **
4 - 7	6 (11.1%)	48 (88.9%)			
8 - 11	22 (31.4%)	48 (68.6%)			
>12	23 (21.5%)	84 (78.5%)			
Attended seminary before pastoring					
Yes	24 (28.2%)	61 (71.8%)	1	4.572	0.033**
No	37 (17.2%)	178 (82.8%)			

***** Statistically significant***
**** Fishers Exact***

Hypothesis 3: There is no significant difference between knowledge of respondents on depression and management style among leaders in selected Pentecostal churches in Ibadan North Local Government Area, Oyo State.

Fisher's Exact analysis revealed that there was a significant difference between knowledge of respondents on depression and their management style with p-values of 0.001. Thus, we reject the null hypothesis (Table 4.7.3)

Table 4.7.3 Respondents' knowledge on depression and their management style

Variables	**Management Category**		**Df**	**Fishers Exact**	**p-value**
Knowledge	**Management Style**				
	Poor	**Fair**			
Poor	5 (55.6%)	4 (44.4%)			
Fair	44 (51.2%)	42 (48.8%)	2	13.246	0.001**
Good	61 (29.8%)	144 (70.2%)			

***** Statistically significant***

Hypothesis 4: There is no significant difference between knowledge of respondents on depression and their ability to recognize depression among leaders in selected Pentecostal Churches in Ibadan North Local Government Area, Oyo State.

Fishers Exact analysis revealed that there was a significant difference between knowledge of respondents on depression and their ability to recognize depression with p-values <0.001. Thus, we reject the null hypothesis (Table 4.7.4).

Table 4.7.4 Respondents' knowledge of depression and their ability to recognize depression

Variables Knowledge	Management Category Ability to recognize Depression		Df	Fishers Exact	p-value
	Fair	**Good**			
Poor	4 (44.4%)	5 (55.6%)			
Fair	47 (54.7%)	39 (45.3%)	2	20.484	0.000**
Good	55 (26.8%)	150 (73.2%)			

***** Statistically significant***

Hypothesis 5: There is no significant difference between ability to recognize depression and depression management style among leaders in selected Pentecostal churches in Ibadan North Local Government Area, Oyo State.

Chi square analysis revealed that there was a significant difference between ability to recognize depression and depression management style with p-values <0.001. Thus, we reject the null hypothesis (Table 4.7.5).

Table 4.7.5 Respondents' ability to recognise depression and depression management style

Variables	Management Category				
Ability to recognize depression	Management Style		Df	X^2	p-value
	Poor	**Good**			
Fair	56 (52.8%)	50 (47.2%)	1	18.441	0.000**
Good	54 (27.8%)	140 (72.2%)			

***** Statistically significant***

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1. Discussion

This study investigated the knowledge, perceptions, attitude and the management styles of depression among selected leaders of Pentecostal churches in Ibadan North Local government area and also assessed their ability to recognize a depressed church member, through an adapted version of Zung self-rating on depression.

5.1.1 Social demographic characteristics and its relevance to the study.

The socio demographics characteristics of the study participants had a lot of influence on the knowledge and the management styles of depression among the 300 respondents sampled, this agreed with earlier work by Writh et al, 2009 that leader's knowledge, attitudes and management of depression are influenced by the cultural background, type of denomination, level of education, age and years of clerical duty. Age group differences was observed to affect knowledge and management styles of depression among the respondents. Scholastics advantage was another factor that enhanced the knowledge and management styles of depression. Leaders with higher education, even without seminary education seemed to do better at this than others with low level of education. It is significant to note that majority of the respondents are in the church leadership on a part time basis, and do not depend on the Church pay roll. This is consistent with the Pentecostals leaders around the world, mega churches appoint Pastors who are already professionals in their fields, to man one parish or the other. In fact if you are a full timer, who do not have any profession, the individual is encouraged to survive by faith or at the mercy of charitable members. This practice makes seminary training optional, everything is about your calling, Faith and spirituality. This is a potential time bomb among the Pentecostal leadership, where the majority of the leaders interpret the bible based on how the 'spirit' leads not on an organized seminary based learning, there is no mutual submission. In the Pentecostal circles faith living is highly exaggerated above reasons and use of intellectualism this has been the bane of Pentecostalism in Nigeria and Africa as a whole.

In addition, the year of clerical duty was also discovered to have impact on leader's knowledge and management of depression this fact was also one of the considerations of Writh et al, 2009.

This study had hypothesized that there is no significant difference between socio-demographic characteristics and knowledge of depression among leaders in selected Pentecostal Churches in Ibadan North Local Government Area but, with Fisher's Exact analysis it has been revealed that there was a significant difference between age, level of education, pastoral rank, years of being leader and their knowledge of depression with p-values of 0.013, 0.010 and 0.003 respectively. Thus we rejected the null hypothesis in this regard.

5.1.2 Knowledge of respondents on depression

The mean knowledge score of respondents was remarkable, higher than 50%. Majority of the respondents displayed good knowledge of depression, some had fair knowledge and some had poor knowledge of depression. This study however stands in contrast to what Farrel et al, 2008 found out among the Baptists clergy sampled that 71% sampled of the clergy felt inadequately trained to recognized mental illness including depression. Why the difference? There is no organized study of the Pentecostal leaders in this part of the world so far, the report of Farrel et al,2008 reflected the knowledge score among the Protestants which Baptist congregation belongs, the recent upsurge in the prevalence of suicide might have had an effect on the knowledge score as seen in this study. Also while Farrel et al, 2008 study focused generally on mental illness which is too broad a topic, the study zero in on depression, which is a trending issue in the society as of today judging from the fact that majority of the respondents had already heard about this subject and probably their curiosities have been aroused. Likewise, the study conducted by McMinn, Runner, Fairchild, Lefler & Suntay, (2005) among the protestants clergy merely focused on referral program to professional mental health and not to gauge the understanding of the pastor's belief and knowledge of depression, but the present study included all these and the management styles of depression among the Pentecostal leaders.

Contrary to the study by Wesselmann et al ,2010 that concluded that depression is viewed among the Pentecostals or the non-denominational clergy in America as a consequence of sinful and immoral behaviour and thus believed that prayer and other spiritual treatment

is sufficient for its treatment, this study had a different conclusion , the respondents does not consider sin as the root cause of depression this differences of opinion can be ascribed to African natural humane treatment of those going through major challenges of life.

It is remarkable that the respondents showed a high score in the symptomatic indicators of depression, described as mood disorder, sickness of the mind and prolonged feeling of sadness some still described depression as bully which is the same description given to it in the study conducted by Shellman, Mokel, & Wright, 2007 to this group depression is not an illness but a form of moral weakness that can be push out. This position can hinder help seeking behavior for the depressed Campton, Esterberg, McGee, Kotwicki & Olivia, 2006 has earlier confirmed this. Most of the respondents, however considered depression as a health problem and requires urgent attention.

This study confirmed the general beliefs that depression is the root cause of suicide, many of the respondents agreed that depression can lead to suicide this lend credence to the study conducted by Rhodes, Bethell, & Bondy, (2006) where they discovered that most suicide ideations have their root from depressive disorders. As it was earlier explained above, the hypothesis that anticipated no statistical significance between Knowledge and some socio-demographic variables was rejected, this study found out that Knowledge of depression of the selected Pentecostal leaders was greatly affected by the socio-demographic variables.

5.1.3 Perception of respondents on depression

The perceptions of the respondents on depression was good on the average but in some specific questions on perception which were fundamental to possessing adequate perception on this subject they found were wanting, whereas previous studies like that of Katona & Watkin, 1995 agreed that depression can affect people of any age .Contrary to this, some of our respondents believed that depression only affects people of a particular age group , that Christians cannot be depressed and that depressed people are merely seeking for attention .This clearly indicate that ,the respondents might have scored high in positive perception in the overall ,but fundamental gaps still exist in the their knowledge and perception about depression. Earlier on .it was pointed out that some Pentecostal leaders in America attributed sin as the root cause of depression, Wesselmann et al, 2010 and spiritualized its treatment, our respondents did not agree to this but in their response

also there are element of over spiritualizing and bias against depression, this is fallacy and sentimentalism a characteristic of most Pentecostal movement in Nigeria.

On the issue of church attendance and prevention of depression, Saunders et al,1983 had observed that attending regular religious meeting can serve as shock absorber to most life problems in that the church provides social networks where members share moral and financial support among one another, however the view of our respondents are slightly different, majority of the respondents do no longer see the church as place of refuge for life challenges when they concluded that going to church regularly cannot prevent depression, this view may be as a result of the recent shift from the fundamental role of the church which is to care for the flock ,to that of milking the flock and manipulating them for mundane reasons, promoting prosperity messages above messages that address the daily challenges of members. This study had earlier hypothesized there was no significant difference between socio-demographic characteristics and perception on depression among leaders in selected Pentecostal churches in Ibadan North Local Government however, the Chi square test analysis revealed a significant difference between level of education, years of being leader, attending seminary before their leadership role and their perception on depression. The null hypothesis was also rejected in this regard.

5.1.4 Attitude of the respondents towards depression

Generally attitudes towards mentally ill persons has been a subject of much studies among several professional groups among the Doctors and health workers Adewuya et al,2007 have demonstrated negative attitudes across various professional groups .Such negative attitudes were again reported by Igbinomwanhia et al, 2013 among the clergies from different religions and denominational backgrounds, where 70.0% displayed negative attitudes towards the depressed and mentally ill in general, out of the107 respondents in that study 53.3% were Pentecostal Christians.

Contrary to the study by Igbinomwanhia et al 2013 attitude towards depression is seems to be generally positive. This difference may arise as a result of the study objectives of the two studies, while Igbinomwanhia et al, 2013 based their study on mental illness as a whole, which is quite broad, the present study simply isolated depression and studied it in particular, the methodology differences can also be a factor in the different results obtained here; Igbinomwanhia et al, 2013 focused their study across different Faiths and

across different denominations, the present study mainly focus on the Pentecostal Christians, Igbinomwanhia et al, 2013 however did not stratified the study to know which group display either positive or negative attitudes. Also, our study area were different, while this study focused on a local government, Igbinomwanhia et al, 2013 focused on the entire Benin City Nigeria with large diversity of opinions. In addition, Kingdon, Vincent, Kinosshita &Turkington, 2008 revealed a positive attitudes towards people with depression or anxiety disorder than those with schizophrenia or other mental health challenges, this further explain why attitudes towards depression is generally positive in this study.

5.1.5 Respondent's ability to recognise depression

Zung self- rating depression scale is a tool to identify depression in an individual, on a maximum score of 80, most people with depression score between 50 and 69. This tool was adapted to further test the ability of the Pentecostal leaders to recognize a depressed member by reframing the depression indicators questions and based the ability of the leaders to recognize depressed members based on the rating for individual depression state.

This study found out that the mean ability score of the respondents is more of the respondents showing good ability to recognize depression among the church members indicating less than 40.0% do not possess the requisite ability to recognize when a member is going through depression. This is critical to this study, if a leader cannot recognize a depressed member there is little or nothing he can do prevent serious consequences of depression such as suicide. However, on average the respondents has scored high in the ability to recognize depression, but when we look critically at the respondents responses to critical issues of depression majority has gaps in their ability, for instance the depressive statements like *"a member is depressed when he feels best only in the morning"* a lot of the respondents chose" a little of the time" whereas correct response should be" most part of the time" The same goes to some other important depression statement indicators, this implies that on the average the respondent might have scored high in the ability to recognize depression but fail in critical areas that matters to the ability to recognize depression. This gap must be filled by further training and more enlightenment on the subject.

5.1.6 Management style of depression

From this study, it was found out that the management styles of depression by the Pentecostal leaders sampled can be categorized thus: referral to a mental health professional, Pastoral counseling, Prayer alone, Home remedy, fasting and the use of Holy water to cure depression, this implied that no standardized approach has been agreed upon by the clergy to address the issue of depression, every denomination responds to it based on its beliefs about the subject.

This result was similar to what Stanford et al, 2011 found out in their study on depression management by senior pastors of selected Baptist churches in America, in that study 40% of church leaders refers members to professional mental health practitioners which is similar to findings in this study. from Stanford et al, 2011 study. This could be the basis for a recommendation of active partnership between the clergy and mental health professionals although, this might not be the same across board judging from the fact that other respondents proffered different management options that are irrational and inimical to the psychology of the members going through depression, especially when some respondents recommended some sort of physical restraints on a depressed member to avoid dangerous actions. The use of holy water and fasting to cure depression were earlier corroborated by Agara et al, 2008.

This result however proved that with the best of management practice there is a tendency that, the good practice might be clouded by some African traditional culture.

In addition, it is very obvious that the subject of depression is not a priority topic on these leader's pulpit, few of the respondents preached on depression either weekly, monthly, once in three months, once in six months yearly or never at all. This lack of preaching on depression on pulpit could be a major factor causing increase rate of suicide in the church and society in general. There could be a correlation between messages on depression and rate of suicide. Most of the respondents interviewed agreed unanimously that depression as a subject has never being preached directly on their pulpit but sometimes touched in a general sermon.

Concerning mental health training most of the respondents majority had no previous on mental health training, as a prerequisites for their theological training, this seems to be consistent with the findings by Igbinowahia et al 2012 where 30.8% of the clergies

claimed to have a mental health training and 69.2% do not have any training on mental health. This result will have a serious implication on the ability to understand and manage mental health issue properly and this might serve as our recommendation for training on mental health for the clergy.

Moreover, training on mental health will greatly impact on the leaders ability to manage depression properly this will boost their knowledge about depression, which we earlier hypothesized has no significant impact on the management style of the leaders, but from the Fisher's Exact analysis there was a significant difference between knowledge of respondents on depression and their management styles with p-values of 0.001

5.2 Conclusion

This study has revealed that majority of the leaders had good knowledge about depression, they had positive perception and attitude towards the depressed. However, it is of great concern that most of the church leaders in this study rarely talk about depression on their pulpit, they have the knowledge but it is not been shared adequately with the members, some even go to the extent of banning the mention of the subject of depression in the church, they are of the view that depression must remain a personal issue not a subject to be discussed on the pulpit, to some of them that will undermine living by faith alone and the integrity of the word of God. Denominational policy, sadly does not support the management of depression in some churches. This could explain why the prevalence of depression and suicide still remain very high in our society. Although this study is limited to few selected Pentecostal leaders in Ibadan North local Government the result however can serve as a template to test other faiths and denominations in Nigeria, seeing how important the church is in promoting health, efforts must be put in place to mobilize the faith community to promote health.

5.3 Recommendations

Base on the findings from this study the following recommendation were made

1. More partnership between the mental health professionals and the clergy, this will improve the management of depression among members of the church.
2. Mental health training for the selected leaders, is recommended in other to fill the learning gaps on mental health issues.

3. Mental health courses should be integrated into seminary education, this will prepare the clergy to effectively recognize and manage the member experiencing depression and other mental illness.
4. The silence of the Clergy, on the subject of depression on the pulpit, should be discouraged. The more awareness is created on the pulpit the more knowledgeable members become thus enhancing the help seeking behavior on mental health.

5.4 Implications of findings to Health Promotion and Education.

The implication of this findings for health promotion cannot be over emphasized in that, sharing the knowledge of depression from the pulpit will give the members greater control of the causes of depression and improve their quality of lives. It can also be observed that until there is a support system within the denominational policy for health promotion, achieving a reduction in the prevalence of suicide in our society will be a mirage, a good partnership relationship between the clergy and the mental health professionals will go a long way to improve Health promotion and Education within the church.

The vision of an effective health promotion and education must be at the minds of those who develop the curriculums for Theological education, by creating opportunity for the-would- be clergy to have adequate knowledge of mental health, so that they can become effective in their Pastoral counseling.

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Appendices

Appendix One

Knowledge and Management of Depression by Leaders in selected Pentecostal Churches in Ibadan North Local Government Area, Oyo State

Informed Consent **Serial no:** _____

Dear Respondent,

I am a postgraduate student at the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. The purpose of this study is to gather information about the Knowledge and Management of Depression by Church leaders in some selected Pentecostal churches in Ibadan North Local Government area, Ibadan, Oyo State. Please note that your participation in this study is entirely voluntary. There is no risk in your participation in this study and the result of the study will be communicated to the Christian body for appropriate intervention if needed. Each questionnaire has been given a code number to safeguard your identity. All information supplied will be treated with confidentiality.

Your participation in this study will help position the church as first line of defense against depression and eventually stemmed the tide of suicide in the country. Your willingness to participate implies you have given the consent.

Thanks for your cooperation.

I have read and understood the consent form and voluntarily agree/disagree to participate in the study by ticking [√] in the appropriate box below:

1. Agree [ ] 2. Disagree [ ]

INSTRUCTION: Please give appropriate responses that apply to you in each section.

Church location _____

SECTION A: SOCIO DEMOGRAPHIC DATA

(1) Age i) 20-30 ☐ ii) 40- ☐ iii) ☐

(2) Gender: Male ☐ Female ☐

(3) Marital Status

i) Single ☐ ii) Married ☐ iii)Widow ☐ iv)Divorced ☐

(4)Tribe

i)Yoruba ☐ ii)Igbo ☐ iii) Hausa ☐ iv)Others ☐

(5) Level of Education

i)Primary ☐ ii)Secondary ☐ iii) Graduate ☐ iv) Masters/PhD ☐

(6) Profession

i)Medical/Pharmaceutical ☐ ii) Banker ☐ iii)Civil Servant ☐ iv) Others ☐

(7) Pastoral Rank

i) General Overseer ☐ ii) Pastors ☐ iii) Elders/Deacon(ess) ☐ iv)HOD ☐
v)Other ☐

(8) Church engagement

i)Full time ☐ ii) Part time ☐ iii)Others ☐ iv)Specify _____

(9)Are you on the Church Payroll? I)Yes ☐ ii)No ☐

(10)Any other source of livelihood? Specify _____

(11) How long have you been a church leader?

i)0-3 ☐ ii)4-7 ☐ iii)8-11 ☐ iv)>12yrs ☐

(12) Did you attend seminary school before pastoring/leading the church?

i)Yes ☐ ii)No ☐

(13) If yes, how many years did you spend in the seminary

i)1 year ☐ ii)2 years ☐ iii) 3 years ☐ iv) >3 years ☐

Tick(√) as appropriate.

SECTION B: KNOWLEDGE OF DEPRESSION (ADAPTED FROM KAP QUESTIONNAIRE)

	Knowledge Statement	Yes	No	Don't Know
14	Have you ever heard about depression?			
15	***What do you understand by depression?***			
i	sickness of the mind			
Ii	Mood disorder			
Iii	feeling of prolonged sadness			
iv	is a bully			
16	***Which aspect of life is affected by depression?***			
i	Physiological			
Ii	Behavioural			
Iii	Psychosocial			
iv	Relationship			
v	Procreation			
17	Do you consider depression as a health problem?			
18	Depression is caused by witchcraft, charms or evil spirits?			
19	Patients with depression can breakdown at anytime			
20	Depression can lead to suicide attempt			
21	***Symptoms of depression include***			
i	loss of appetite			
Ii	loss of interest			
Iii	feeling of sadness			
iv	Over eating			
22	***Causes of depression include the following***			
i	Recent misfortune			
Ii	Lack of money			
Iii	Lack of job			
23	***Information on depression can be obtained from***			
i	internet			
Ii	Newspaper			
Iii	journals.			
iv	Professionals			
v	Church members			
vi	Television			
24	Patients with depression are dangerous to themselves and others.			
25	Depression responds better to traditional remedies than orthodox treatment			
26	Sin is the root cause of depression			

Total score obtained……Coding scale……

SECTION C: PERCEPTION OF DEPRESSION

	Perception Statement	Agree	Disagree	Don't Know
27	Depression affects people of a particular age			
28	Only sick people can be depressed			
29	Only single parent experiences depression			
30	Christians cannot be depressed			
31	Depression is an illness that needs attention			
32	Depressed people are looking for attention			
33	Going to church regularly can prevent depression			
34	Depressed people are suffering from their sin			
35	Becoming depressed is a natural part of becoming old			
36	Relating with depressed people is tedious			
37	Anyone can be depressed			
38	Females suffer more from depression than males			
39	Clinical depressive disorder cannot be differentiated from unhappiness			
40	Depression is a sign that one has poor stamina to deal with life difficulties			

Total score obtained……Coding scale……..

SECTION D: ATTITUDE TOWARDS DEPRESSION

	Attitudinal Statement	Agree	Disagree	Don't Know
41	I feel comfortable counselling depressed members			
42	I feel that depressed people are not spiritual			
43	Only the Church overseer can handle depression matters well			
44	I prefer doing other ministerial work to counselling the depressed			
45	I cannot counsel anybody on depression			
46	I am not trained on depression matters			
47	I think everybody should be responsible for he handles depression			
48	There is little I can offer to depressed members who fail to respond to profession advice			
49	I think depressed members are more likely to have suffered deprivation in early life than others			
50	Are members with depression discriminated against by others?			
51	It is not acceptable to talk about depression in our church.			
52	Depressed members are fun to be with			

SECTION E: Adapted Zung self-rating depression scale

Make check mark in appropriate column	A little of the time	Some of the time	Good part of the time	Most of the time
53 .A member is depressed when he feels down –hearted and blue (sad)				
54.A member is depressed when he feels best only in the morning				
55.A member is depressed when he experiences crying spell or feel like it				
56.A member is depressed when he agreed that he still eat as much as he used to				
57. A member is depressed when he confirms he still enjoy sex				
58. A member is depressed when he complains of difficulty sleeping in the night				
59. A member is depressed when he notice is losing weight				
60. A member is depressed when is having trouble with constipation				
61.A member is depressed when he complains that his heart beats faster than usual				
62. A member is depressed when he complains he gets tired for no reason				
63. A member is depressed when he agrees that his mind is clear as it used to be				
64. A member is depressed when he finds doing things as easy as before				
65. A member is depressed when he complains of restlessness				
66. A member is depressed when he agrees he feels hopeful about the future				
67. A member is depressed when he feels more irritable than usual				
68. A member is depressed when he finds it easy to make decisions				
69. A member is depressed when he feels more useful and needed				
70. A member is depressed when he complains that his life is full				

71.A member is depressed when he feels that others would be better off if he was dead				
72. A member is depressed when he still enjoys the things he used to do.				

SECTION F: MANAGEMENT STYLE ON DEPRESSION

	Practice Statement	Yes	No	Don't Know
73	I preach on depression on the pulpit			
	(i)Weekly			
	(ii)Monthly			
	(iii)Once in three months			
	(iv)Once in 6 months			
	(v)Yearly			
	(vi)Never			
74	Have you ever counselled any member on depression?			
75	Will you recommend Fasting to cure a depressed member?			
76	Will you recommend the use of Holy water to cure a depressed member?			
77	Will you recommend some sort of restraints on a depressed member to avoid dangerous actions?			
78	Have you ever referred depressed member to (i) Mental health professional? (ii) Traditional healers? (iii) Prayers? (iv) Counselling? (v) Home?			
79	Do you have formal training on mental health during your degree or seminary training?			
80	Do you provide mental health services within the church?			
81	I believe Prayer alone is sufficient to address depression among members			
82	Do you contact medical professionals on issues of depression?			

Total score obtained……Coding scale……..

Thank you for your time

Appendix Two

Ilana Iwe-Ibeere

IMO ATI ISAKOSO , IREWESI OKAN NIPASE AWON OLUDARI NI AWON ILE IJOSIN PENTIKOSTI TI A YAN NI IJOBA IBILE ARIWA TI ILE IBADAN,NI IPINLE OYO

IBEERE FUN ASE **Nomba idanimo_____**

Eyin Olukopa wa Owon

Mo jẹ ọmọ ile-iwe giga Yunifasiti ti Ile Ibadan ni eka ti ati n risi eto nipa idanilekoo ati igbega eto ilera ti o wan i koleeji ti ati n se itoju pelu oogun,Ni abala ti ohun risi eto ilera awon ara ilu. Idi ti iwadii yii ni lati ṣajọ alaye nipa Imọ ati Isakoso Ibanujẹ nipasẹ awọn oludari ile ijọsin ni diẹ ninu awọn ile ijọsin Pentikosti ti a yan ni agbegbe Ijọba Agbegbe Ariwa,Ti Ile Ibadan, Ipinle Oyo. Jọwọ ṣe akiyesi pe ikopa rẹ ninu iwadi yii jẹ atinuwa patapata. Ko si eewu kankan ninu ikopa rẹ ninu iwadi yii ati pe abajade iwadii naa ni a o ṣọ di mimo fun awonomoleyin Kristi ki won le se eto ti oye lati dawo ikolu **irewesi okan** duro laarin ijo Iwe ibeere kọọkan ni a ti fun nọnba idaabobolati daabo bo idanimọ rẹ. Gbogbo alaye ti o pese yoo ni itọju pẹlu asiri.

Ilowosi rẹ ninu iwadii yii yoo se iranlọwọ lopolopo fun ijo Olorun gegẹ bi olugbeja akọkọ lati gbogun ti oro ibanuje ati igbẹmi ara ẹni ni orilẹ-ede wa. Ifinnu findo yinlati kopa tumọ si pe eti fun wa ni ase lati tesiwaju pelu ibeerewa.
E ṣeun fun ifowosowopo yin.

Mo ti ka iwe ibeere fun ase yi peluoye mo setan lati kopa/ tabi mio kopa ninu iwadi nipa titẹ [√] ninu apoti ti o yẹ ni isalẹ:

1. Fọwọsi [ ] 2. Mi kofowosi [ ]

Alaye Oro: Ibanuje,Irobinuje, Irewesi Okan

ẸKỌ: Jọwọ fun awọn idahun ti o tọ ti o kan si ọ ni apakan kọọkan.

Ile ijọsin _____

Abala Alakoko:Alaye lori eto igbesiaye Olukopa

(1) Ọjọ ori i) 20-30 ☐ ii) 40-59 ☐ iii)> 60 ☐

(2) Iseda: (i)Okunrin: ☐ (ii)Obinrin ☐

(3) Ipo igbeyawo

i) Apon ☐ Moloko ☐ iii) Opó ☐ iv) Ikọsilẹ ☐

(4) Ẹya

i) Yoruba ☐ ii) Igbo ☐ iii) Hausa ☐ iv) Awọn miiran

(5) Ipele Ẹkọ

i) Primary ☐ Secondary ☐ iii) Graduate ☐ iv) Masters / PhD ☐

(6) Iṣẹ-oojọ

i) Iṣoogun / Egbogi ☐ ii) Akowe ☐ iii) Ise Ijoba ☐ iv) Awọn miiran ☐

(7) Ipele ipe si iseiranse

i) Olutọju Gbogbogbo ☐ ii) Awọn Pasito ☐ (iii) Awọn àgba / Diakoni ☐

iv) Oludari eka ☐ v) Omiiran ☐

(8) Akoko mi fun ise adari ijo

i) Akoko kikun ☐ ii) Apakan akoko ☐ iii) Awọn elomiran ☐ iv) Salaye_____

(9) Ṣe asan owo fun o bi adari ? i) Bẹẹni ☐ ii) Bẹẹkọ ☐

(10) Orisun miiran ti igbesi aye? Salaye_____

(11) Bawo ni o ti pẹ to ti o jẹ adari ijọsin?

i) 0-3 ☐ ii) 4-7 ☐ iii) 8-11 ☐ iv)> 12yrs ☐

(12) Ṣe o wa si ile-iwe ile-iwe alufaa ṣaaju ki o to ṣe Aṣaaju / dari ijo?

i) Bẹẹni ☐ ii) Bẹẹkọ ☐

(13) Ti Bẹẹni ba jẹ bẹẹ, ọdun melo ni o lo ni ile-ẹkọ giga naa

i) ọdun kan ☐ ii) ọdun meji ☐ iii) ọdun meta ☐ iv)>oju odun meta lo ☐

Fi ami si (√) bi o ti yẹ.

Abala Keji: Imo Nipa , Irewesi Okan

	Gbólóhùn Ìmọ	Bẹẹni	Rara	Mi ko Mọ
14	Nje o ti gbọ nipa , Irewesi Okan			
15	***Kini o loye nipasẹ*** , Irewesi Okan			
i	aisan ti okan			
Ii	Rudurudu ti okan			
Iii	ibanujẹ ti o pẹ			
iv	O jẹ ipanilaya			
16	***Apakan igbesi aye wo ni on gba ikolu*** , Irewesi Okan			
i	Ti ikolu ẹya-ara			
Ii	Ihuwasi			
Iii	Oro ti oni se pelu ironu			
iv	Ibasepo			
v	Ibisi ati riresi			
17	Ṣe o ri , Irewesi Okan bi iṣoro ilera?			
18	Ibanujẹ ṣẹlẹ nipasẹ aje, oogun tabi awọn ẹmi buburu?			
19	Awọn alaisan ti o ni , Irewesi Okan le fọ sanle nigbakugba			
20	Ibanujẹ le ja si igbiyanju igbẹmi ara ẹni			
21	***Awọn aami aiṣan ti*** , Irewesi Okan ***pẹlu***			
i	Ai le Jeun			
Ii	ipadanu oyaya si ise sise			
Iii	Irewesi Okan			
iv	Onjẹun Ju			
22	***Awọn okunfa*** , Irewesi Okan			
i	Ofo igbakugba			
Ii	Aini owo			
Iii	Aini ise			
23	***Bawo ni o se mọ nipa*** , Irewesi Okan			
i	Ori ero aye lu jara			
Ii	iwe iroyin			
Iii	Redio			
iv	Awọn akosemose			
v	Awọn ọmọ ẹgbẹ ile ijọsin			
vi	Telifisiọnu/ Amohun maworan			
24	Awọn alaisan ti o ni jẹ ẹni ti irewesi okan o lewu si ara re ati awọn elomiran.			
25	Ibanujẹ n dahun dara si awọn oogun abinibi ju itọju awon dokita lo			
26	Ese ni onfa irewesi okan			

Apapọ apapọ ti a gba ……Ipele iye ti a gba……

Abala Keta: ERONGBA MI LORI, IREWESI OKAN

	Gbólóhùn Erongba	Mo Gba be	Mi ko gba bee	Emi ko Mọ
27	Irewesi Okan ma nkolu awon eniyan kan tori ọjọ ori won			
28	Awọn eniyan ti o ṣaisan nikan le ni, Irewesi Okan			
29	Awọn enti koloko nikan ni o ni iriri, Irewesi Okan			
30	Awọn Kristiani ko le ni, Irewesi Okan			
31	Irewesi Okan jẹ aisan ti o nilo akiyesi			
32	Awọn eniyan ti o ni, Irewesi Okan n wa akiyesi			
33	Lilọ si ile ijọsin nigbagbogbo le ṣe idiwọ, Irewesi Okan			
34	Awọn eniyan ti o ni , Irewesi Okan n jiya tori ẹṣẹ wọn			
35	Irewesi Okan jẹ ona kan ti afi mo pe ati n di arugbo			
36	Sisopọ pẹlu awọn eniyan ti o ni, Irewesi Okan jẹ inira			
37	Enikeni le ni ibanujẹ			
38	Awọn obinrin jiya diẹ sii lati, Irewesi Okan ju awọn ọkunrin lọ			
39	Arun ibanuje yato si irewesi ọkan			
40	Irewesi Okan jẹ ami pe ako ni agbara lati segun awọn iṣoro aye			

Apapọ apapọ ti a gba ……Ipele iye ti agba ……

ABALA KERIN: IHIHU WASI NIPA IREWESI OKAN

	Gbólóhùn wi wu iwa si	Mo Gba bee	Mi ko gba bee	Emi ko mo
41	Mo setan lati gba awọn ọmọ ẹgbẹ ti o ni, Irewesi Okan nimoran			
42	Mo lero pe awọn to ni , Irewesi Okan kii rin ninu ẹmi			
43	Alabojuto Ile-ijọ nikan le ṣe abojuto awọn ọni ibanujẹ daradara			
44	Mo fẹran ṣiṣe iṣẹ iranse miiran ju ṣiṣe imọran awọn onir, Irewesi Okan lo .			
45	Emi ko le gba ẹnikẹni ni imọran lori , Irewesi Okan			

46	Emi ko ise lori awọn ọrọ , Irewesi Okan			
47	Mo ro pe gbogbo eniyan yẹ ki o ye ole toju irobinuje won			
48	Diẹ ni Mo le fun si awọn ọmọ ẹgbẹ ti o ni , Irewesi Okan ti o kuna lati dahun si imọran onisegun			
49	Mo ro pe awọn ọmọ ẹgbẹ ti o ti jiya nigba ewe wa lee ni, Irewesi Okan			
50	Njẹ awọn ọmọ ijo ndeye si awon omo ijo ti o ni , Irewesi Okan?			
51	Ko ṣe itẹwọgba lati sọrọ nipa, Irewesi Okan ninu ile ijọsin wa.			
52	Awọn ọmọ ẹgbẹ ti o ni , Irewesi Okan jẹ igbadun lati wa pẹlu won			

ABALA KARUN: IDANRAWO RANPE LATI MO OYE MI NIPA, IREWESI OKAN

Ṣe ami ayẹwo ni iwe ti o yẹ	**Díẹ ti akoko naa**	**Diẹ ninu awọn ti akoko**	**Opolopo igba die**	**Opolopo igba**
53 .Ọmọ ẹgbẹ ni, Irewesi Okan nigbati ko layo ti osi ni irewesi okan				
54. Ọmọ ẹgbẹ ni, Irewesi Okan nigbati o ba layo julọ ni owuro nikan				
55. Ọmọ ẹgbẹ ni, Irewesi Okan nigbati o nse bi enipe kosokun				
56.Ọmọ ẹgbẹ ni, Irewesi Okan nigbati o ba gba pe o tun jẹun bi o ti ye				
57. Ọmọ ẹgbẹ ni, Irewesi Okan nigbati o jẹrisi pe o tun gbadun ibalopo				
58. Ọmọ ẹgbẹ kan ni, Irewesi Okan nigbati o kerora ti iṣoro oorun ni alẹ				
59. Ọmọ ẹgbẹ kan ni, Irewesi Okan nigbati o ṣe akiyesi pipadanu iwon				
60. Ọmọ ẹgbẹ kan ba ni, Irewesi Okan nigbati o ba ni iṣoro pẹlu àìrígbẹyà				

61.Ọmọ ẹgbẹ kan ba ni, Irewesi Okan nigbati o kiyesi pe ọkan rẹ nmi ju ti iṣaaju lọ				
62. Ọmọ ẹgbẹ kan ba ni, Irewesi Okan nigbati o kiyesi pe o rẹwẹsi laisi idi				
63. Ọmọ ẹgbẹ kan ni , Irewesi Okan nigbati o ba gba pe ironu ja gaara bi o ti ṣe n ṣe tẹlẹ				
64. Ọmọ ẹgbẹ kan ni , Irewesi Okan nigbati o rii pe ise sise re nlo geere awọn bi ti iṣaaju				
65. Ọmọ ẹgbẹ kan ni , Irewesi Okan nigbati o kiyesi pe ko ni isinmi				
66. Ọmọ ẹgbẹ kan ni , Irewesi Okan nigbati o ba gba pe o nireti ireti nipa ọjọ iwaju				
67. Ọmọ ẹgbẹ kan ni, Irewesi Okan nigbati o ba ripe oti nkara ju ti tẹlẹ lọ				
68. Ọmọ ẹgbẹ kan ni , Irewesi Okan nigbati o ba ri pe o rọrun lati ṣe awọn ipinnu kiakia				
69. Ọmọ ẹgbẹ kan ni , Irewesi Okan nigbati o ba pe aye nilo hun o si wulo jojo .				
70. Ọmọ ẹgbẹ kan ni, Irewesi Okan nigbati on sope igbesi aye rẹ kun fun wahala				
71.Ọmọ ẹgbẹ kan ni, Irewesi Okan nigbati o ba ro pe iku ya ju esin lo				
72. Ọmọ ẹgbẹ kan ni , Irewesi Okan nigbati o tun gbadun awọn ohun ti o ma nse tẹlẹ.				

ABALA KEFA: ISAKOSO, IREWESI OKAN

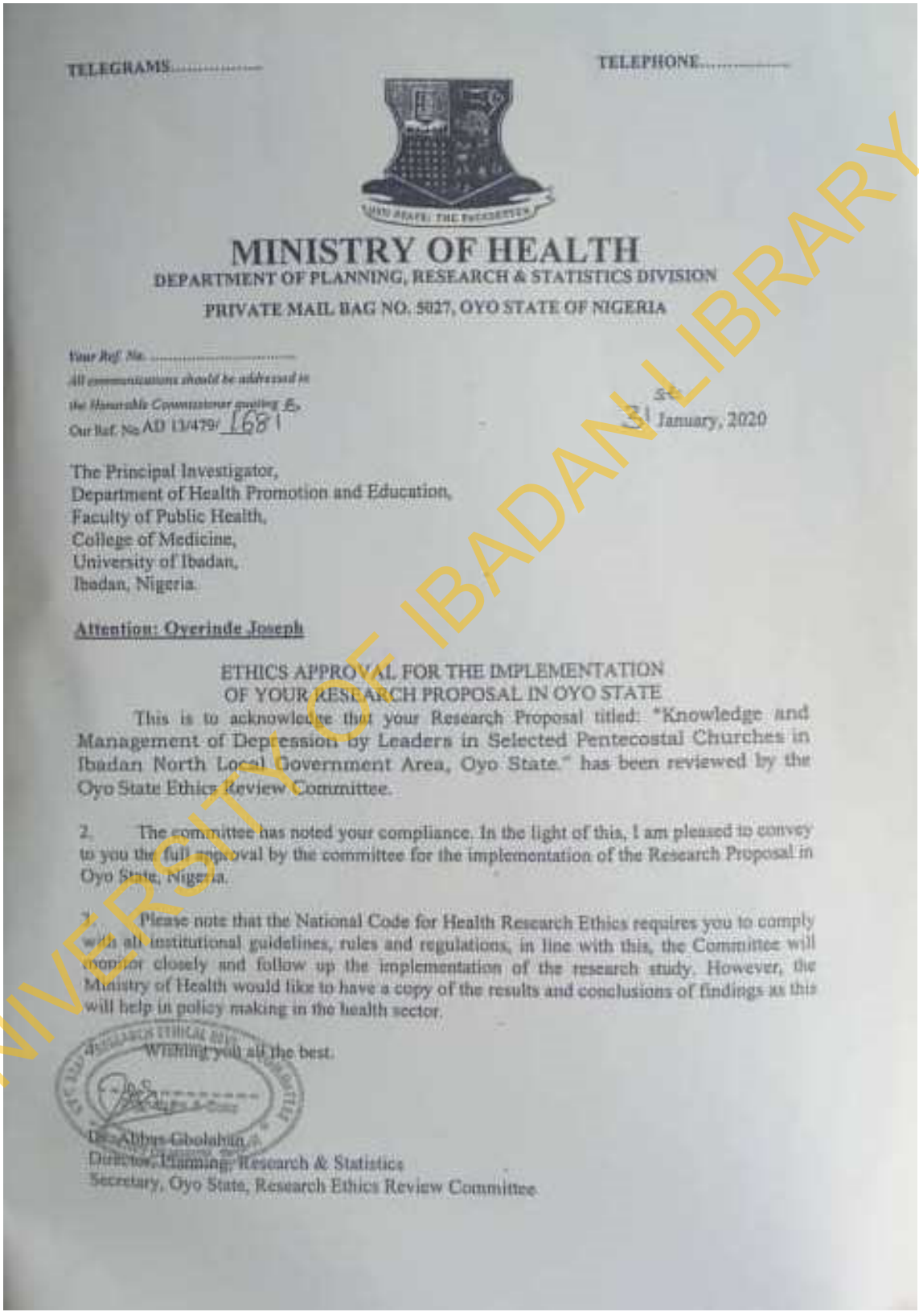
	Gbólóhùn Isakoso	Bẹẹni	Rara	Miko mo
73	Mo n waasu lori, Irewesi Okan lori Pepe			
	(i) Ọsoosẹ			
	(ii)Osoosu			
	(iii)Leekan ni oṣu mẹta			
	(iv)Leekan ni oṣu mẹfa			
	(v)Ni ọdun kọọkan			
	(vi)Rara			
74	Njẹ o ti gbamoran eyikeyi ọmọ ẹgbẹ lori , Irewesi Okan?			
75	Nje elo so pe omo egbe losinu Aawe fun iwosan , Irewesi Okan?			
76	Nje ele ya Omi si Mimo Fun omo egbe fun iwosan , Irewesi Okan?			
77	Nje ele gba ki adi sekeseke fun omo egbe ti oni , Irewesi Okan opolo?			
78	Njẹ o tọka si ọmọ ẹgbẹ ti o ni , Irewesi Okan si (i) Ọjọgbọn ilera Onimọn isegun? (ii) Awọn Babalawo? (iii) Adura gbigba nikan? (iv) Igbaninimoran? (v) Ile ti oti wa?			
79	Ṣe o ni imo deede lori ilera opọlọ lakoko ikeko gboye tabi ikẹkọ alufaa?			
80	Ṣe o pese awọn iṣẹ ilera opọlọ laarin ile ijọsin?			
81	Mo gbagbọ pe Adura nikan ti to lati koju, Irewesi Okan laarin awọn ọmọ ẹgbẹ			
82	Ṣe o kan si awọn oṣiṣẹ isoogun lori ọrọ ti, Irewesi Okan?			

Apapọ ami ti a gba …… Ipele iye ti agba …… ..

E ṣeun fun akoko yin

Appendix Three

Ethical Approval Letter



TELEGRAMS..... TELEPHONE.....

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to the Honorable Commissioner quoting the

Our Ref. No. AD 13/479/1681

31 January, 2020

The Principal Investigator,
Department of Health Promotion and Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Ibadan, Nigeria.

Attention: Oyerinde Joseph

ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Knowledge and Management of Depression by Leaders in Selected Pentecostal Churches in Ibadan North Local Government Area, Oyo State." has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethics Review Committee