

**Knowledge, Attitude, and Health-Seeking Behavior towards Depression among Undergraduate Students of Lead City University, Ibadan, Oyo State, Nigeria**

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**Being a MPH Thesis Submitted to the Department of Public Health, Faculty of Basic Medical and Health Sciences, Lead City University, Ibadan, Oyo state, Nigeria**

**In Partial Fulfillment of the Requirements for the Award of Master Degree (MPH) in Public Health**

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**Certification**

This is to certify that Damilola Joy Lawal with matriculation number LCU/PG/001174 carried out this research work titled “Knowledge, Attitude, and Health-Seeking Behavior towards Depression among Undergraduate Students of Lead City University, Ibadan, Oyo State, Nigeria” in the Department of Public health, Faculty of Basic Medical and Health Sciences, Lead City University, Ibadan, Oyo State, for the award of Master degree in Public Health (MPH) and that this has not been previously submitted.

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## **Dedication**

This research work is dedicated to God Almighty

## **Acknowledgement**

My appreciation goes to Lead City University, Ibadan, for allowing their students participate in this study. I also appreciate the university library for granting me access to the study materials that were used.

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Even though the above mentioned institutions and persons have assisted in the process of this research work, I alone stand responsible for any errors, if any, found in the work.

## Abstract

Depression among University students is an emerging mental health condition with majority failing to seek professional help, this study therefore aimed to examine the knowledge, attitude, and health-seeking behavior, of Lead City University students towards depression. A cross sectional descriptive survey was used to enroll 320 undergraduate students through multistage sampling. The study population was Lead city university undergraduate students. Knowledge of depression was assessed using the depression literacy scale (maximum score = 22 points), attitude towards depression was assessed using the depression stigma scale consisting of nine questions (maximum score = 36 points), while respondents' health seeking behavior was determined using "The attitude towards seeking professional psychological help scale" (maximum score = 10 points). The cut-off for each of the tools was set at 50%. To determine the factors associated with the knowledge, attitude and health-seeking behavior towards depression, Chi-square tests and binary logistic regression analyses were done. A p-value  $\leq 0.05$  was considered statistically significant. The mean age of the 320 Undergraduate students was  $19.36 \pm 2.90$  years, 177 (55.3%) were females, 185 (57.8%) were aged 15-19 years, and 163 (50.9%) belonged to the upper academic level (300-400 level). Overall, 175 (54.7%) had good knowledge of depression, 161 (50.3%) had good health seeking behavior towards depression and 74 (23.1%) had positive attitude towards depression. More than one-half of the proportion of respondents demonstrated good knowledge and good health-seeking behavior towards depression, while less than one-third depicted positive attitude towards depression. Negative attitudes towards depression may be associated with stigmatization of depressed persons and depression may therefore continue to plague the mental health of Undergraduate students at LCU. The management of LCU could improve depression-focused care by identifying students with counseling needs and referring them to professional counselors and psychologists in the university.

**Key Words:** Attitude, Health Behavior, Depression, Knowledge, Mental Health, Undergraduates.

**Word Count: 294**

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## List of Acronyms

<b>Abbreviation</b>	<b>Meaning</b>
ACT	Acceptance and Commitment Therapy
ATSPPH	Attitude towards Seeking Professional Psychological Help
CBT	Cognitive Behavioral Therapy
DBT	Dialectical Behavioral Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
IBM	International Business Machines
ICD	International Classification of Diseases
IPT	Interpersonal Therapy
LCU	Lead City University
SAD	Seasonal Affective Disorder
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

## **Chapter One**

### **Introduction**

#### **1.1 Background to the Study**

##### **1.1.1. Depression**

Depression is a serious contributor to the global burden of disease and affects people in all regions across the world. Presently, it is estimated to affect 350 million people across the world. Depression is the leading cause of disability and was projected to become the 2<sup>nd</sup> most burdensome disease in 2020 and by 2030; it is expected to be the largest contributor to disease burden<sup>1, 2</sup>. Depression is often overlooked and ignored in most African countries<sup>3</sup>. Nigeria has an estimated population of over 200 million, and report by the World Health Organization shows that one in four Nigerians suffer from some form of mental illness. Little attention is being paid to the mental health needs of Nigerians and the level of awareness of Nigerians on Mental Health issues is poor<sup>4</sup>.

University students are a unique group of people experiencing a transitory period from adolescence to adulthood, and this can be one of the most stressful times of a person's life<sup>5</sup>. Among people aged 18-24 years one-half of all health concerns are related to mental illness, they may not only have to face stress related to their academic performance but also tackle adult-like responsibilities without having yet achieved the skills and cognitive maturity of adulthood<sup>6, 7</sup>. Some college students lack the experience to handle emergencies, lack analytical and forecasting skills, and display impulsive behavior or a vulnerable and unstable mood<sup>7, 8, 9</sup>. University students try to fit in, maintain good grades, prepare for the future, and being away from home often causes anxiety, as a reaction to this stress some students get depressed<sup>10</sup>. Depression has been shown to have negative impact on the educational outcomes of university students<sup>11</sup>. The

average age of onset of depression is declining, making depression a particularly salient problem area for university student populations <sup>12</sup>. Previous studies have reported that depression among university students is common around the world <sup>13, 14</sup>. This is a prime time for college administrators to recognize and intervene with mental health issues <sup>15</sup>. Over two thirds of young people do not seek professional help for mental health problems <sup>16</sup>. While there is a growing literature on the mental health literacy of adults, there has not been a growing interest on the mental health literacy of young people in Nigeria <sup>17</sup>. Depression is a prevalent problem among college students across the world and has effects on a students' ability to perform activities of daily life <sup>18</sup>. Depression during student period can badly disrupt the professional future. Depression can lead to suicidal thoughts, suicidal attempts, poor academic achievement, physical complaints, and poor working performance <sup>2</sup>.

Having knowledge about depression plays a very important role in the student's positive attitude and good health seeking behavior towards the illness <sup>19</sup>. One of the barriers to having good knowledge of depression involves lack of mental health awareness within the country which is caused by the general ignorance towards mental health among Nigerians <sup>4</sup>. Very little importance is being placed on the mental health needs of adults and teenagers, creating increasing high levels of stigma, misconceptions about the illness, and poor health seeking behavior <sup>4</sup>. Mental health awareness is important in improving the understanding of mental health conditions such as depression, and increasing access to health care for all those who need it <sup>20</sup>.

## **1.2 Statement of the Problem**

The prevalence of depression as recorded by other studies conducted in Nigerian Universities ranges from 25.2% to 58.2% <sup>21, 22</sup>. The cause of such high prevalence might be because a lot of students who are depressed have no idea they are and as such fail to seek help when they should. It is important for students to know what depression is and how to seek help. Raising depression awareness can help defeat the stigma of the illness and can also help people suffering from it to reach out and get the help that they need to defeat it <sup>23</sup>. When depression is left untreated, it leads to reduced quality of life and can lead to suicide. The disorder has cognitive consequences (e.g., deficits in higher-order executive functioning) that might compromise academic performance and lead to increased risk of failing courses or dropping out of university <sup>2, 24, 25, 26</sup>.

## **1.3 Justification of the Study**

Studies that have been carried out on depression among university students in Nigeria found moderate to high rates of depression, however there was a gap between the respondents who had experienced depression and their willingness to get treatment <sup>21, 22</sup>. Some of the identified barriers to treatment include poor mental health literacy and stigmatizing attitudes towards mental health disorders <sup>27</sup>. Mental health problems such as depression remain prevalent in younger populations, yet, there hasn't been growing literature on the mental health literacy of university students <sup>18</sup>. Only very few studies have been carried out about depression among university students in Ibadan, Nigeria and the depression literacy among Lead City University students is also unknown.

#### **1.4 Aim and Objectives of the Study**

The aim of this study is to examine the knowledge, attitude and health-seeking behavior, of Lead City University students towards depression.

##### **The objectives are to:**

1. To determine the knowledge of depression among LCU students
2. To determine the health-seeking behavior of LCU students towards depression.
3. To assess the attitude of LCU students about depression
4. To determine the factors associated with good knowledge of depression among LCU undergraduate students

#### **1.5 Research Questions**

1. What is the knowledge of depression among LCU students?
2. What is the pattern of health-seeking behavior of LCU students when depressed?
3. What attitude do LCU students have about those with depression?
4. What are the factors associated with good knowledge of depression among LCU students?

#### **1.6 Significance of the Study**

The outcome of this research would help the institution where it was carried out determine the intervention strategies that are needed to improve the mental health literacy of the students within the school, which will play an important role in the students' general wellbeing and health.

#### **1.7 Scope of the Study**

This study was centered on the knowledge, attitude and health-seeking behavior towards depression among Lead City University students towards depression.

#### **1.8 Limitation of the Study**

This study was limited to Lead City University undergraduate students from the first to the fourth year.

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## **Chapter Two**

### **Literature Review**

#### **2.1 Conceptual Review**

##### **2.1.1 General Overview of Depression**

Depression is a mood disorder that causes a prolonged sense of sadness and loss of interest. It can cause a number of mental and physical issues and is also known as major depressive disorder or clinical depression. It affects how people feel, think, and behave. When sad, a person may struggle to carry out regular daily tasks and may question whether it is really worthwhile to live <sup>1</sup>. Globally, 264 million people are suffering from depression. It is a significant public health problem and as of 2021, the prevalence of depression in Nigeria was 3.90% with 7 million reported case <sup>2</sup>. This high level of depression has been linked to high suicide rates as another study by the WHO in 2018 put Nigeria as the 30th country with a high suicidal tendency <sup>3</sup>. Worldwide, it is estimated that 12–50% of college students present at least one diagnostic criterion for one or more mental disorders <sup>4</sup>. A study on depression among students of a Northern University in Nigeria, showed that 58.2% of Nigerian students are depressed <sup>5</sup>. This is rate is higher than what was found in another study carried out among university students in the west which found 25.2% <sup>6</sup>.

Depression is common among university students, this is because college is a stressful environment for most young people and stress is one of the factors that contribute to depression <sup>7</sup>. Poor eating habits, lack of sleep and exercise are triggers for depression among university students, the stress that comes with academics, including financial worries, pressure to get a good job after school, and failed relationships <sup>7</sup>.

### **2.1.2 Forms of Depression**

Depressive illnesses come in a variety of forms and affect both men and women. Major depressive disorder and dysthymic disorder are the most prevalent. Minor depression is also common <sup>7</sup>.

#### **2.1.2.1 Major Depression**

Major depressive disorder, clinical depression, unipolar depression, or just "depression" are other names for major depression. Symptoms include a depressed mood and/or a loss of interest in and enjoyment from routine tasks. Most days, the symptoms are felt, and they endure for at least two weeks. Depression symptoms affect all aspect of a person's life, including job and interpersonal interactions. Melancholic or psychotic depression can be mild, moderate, or severe <sup>8</sup>.

#### **2.1.2.2 Dysthymic Disorder**

Although less severe, dysthymia symptoms are similar to those of major depression. However, dysthymia's symptoms persist for a longer period of time. To be diagnosed with dysthymia, a person must have this milder form of depression for longer than two years <sup>8</sup>. Small-scale depression might also happen. Minor depressive disorder symptoms are comparable to those of major depressive disorder and dysthymia, however they are less severe and/or typically last less time <sup>7</sup>.

#### **2.1.2.3 Bipolar Disorder**

Because a person with bipolar illness experiences episodes of mania and depression interspersed with periods of normal mood, the condition was formerly described as "manic depression." Mania can range in intensity and can be said to be the opposite of depression. Feeling fantastic, having a ton of energy, having racing thoughts and little need for sleep, chatting fast, finding it

difficult to concentrate on tasks, and feeling angry and irritable are all symptoms. This is not just a momentary sensation. Periodically, the person experiences psychotic episodes and loses consciousness. Hallucinations (seeing or hearing something that is not there) or delusions (such as the individual believing they have superpowers) are symptoms of psychosis <sup>8</sup>.

#### **2.1.2.4 Cyclothymic Disorder**

A milder version of bipolar illness is sometimes used to define cyclothymic disorder. The individual experiences persistent mood swings for at least two years, with brief intervals of normalcy (no more than two months) in between episodes of hypomania (a mild to moderate form of mania) and depressed symptoms. Because the duration, severity, and regularity of the symptoms are shorter, less severe, and less frequent, they do not meet the criteria for bipolar disorder or major depression <sup>8</sup>.

#### **2.1.2.5 Seasonal Affective Disorder**

Seasonal Affective Disorder (SAD) is a mood disorder that has a seasonal pattern. Although the exact etiology of the condition is unknown, seasonal variations in light exposure are likely to be a contributing factor. It is characterized by mood swings (either episodes of mania or sadness) that start and stop at a specific season. The most typical type of depression is one that begins in the winter and ends when the season is over. After experiencing the same symptoms every winter for a few years, it is typically identified. People who have SAD are more likely to feel lethargic, sleep excessively, overeat, put on weight, and seek carbohydrates. SAD is uncommon in Australia and more prevalent in nations with shorter days and longer stretches of darkness, such as in the Northern Hemisphere's cold temperature regions <sup>8</sup>.

### **2.1.3 Symptoms of Depression**

The Diagnostic and Statistical Manual of Mental Disorders V (DSM V) states that the presence of five or more symptoms for a period of two weeks, which represents a change from prior functioning, along with either a depressed mood or a loss of interest or pleasure, is what most clearly distinguishes depression <sup>9, 10</sup>. These episodes are characterized by symptoms that last for the majority of the day, almost every day, and may include: sadness, tearfulness, emptiness or hopelessness; angry outbursts; irritability or frustration; loss of interest or pleasure in most or all normal activities, such as sex, hobbies or sports, sleep disturbances, including insomnia or sleeping too much, tiredness and lack of energy, so even small tasks take extra effort, reduced appetite and weight loss or increased cravings for food and weight gain, anxiety, agitation or restlessness, slowed thinking, speaking or body movements, feelings of worthlessness or guilt, fixating on past failures or self-blame, trouble thinking, concentrating, making decisions and remembering things, frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide, unexplained physical problems, such as back pain or headaches <sup>1</sup>.

Many depressed individuals typically experience symptoms that are severe enough to interfere with daily activities including job, school, social interactions, or interpersonal relationships. Some people may experience widespread misery or unhappiness without truly understanding why. Teens may experience symptoms such as melancholy, irritability, anger, a lack of motivation or attendance at school, a sense of being misunderstood and overly sensitive, using alcohol or drugs recreationally, overeating, oversleeping, self-harm, losing interest in daily activities, and avoiding social interaction <sup>1</sup>.

#### **2.1.4 Causes of Depression**

Depression can be brought on by a number of things, such as heredity, trauma, specific medical disorders, and drug or alcohol abuse. Additionally, every person experiences symptoms very differently, changes in appetite, a lack of energy or overall exhaustion, feelings of rage or frustration without a clear cause, trouble sleeping, and/or difficulty focusing are possible symptoms of the condition <sup>11</sup>. Depression may be brought on by a variety of factors, such as poor mood regulation by the brain, genetic susceptibility, traumatic life events, drugs, and health issues. Many of these factors are thought to interact to cause depression <sup>12</sup>.

##### **2.1.4.1 Genetics and Genes**

Depression may be an inherited condition. If a family member suffers from depression, a person may be more likely to develop a depressive condition at some point in their life. It is unknown which specific genes are at play. Many genes are thought to be involved in the development of depression <sup>13</sup>. Genes regulate every aspect of the human body, including the brain. Proteins produced by genes are utilized by biological processes. Different genes switch on and off throughout life in order to produce the proper proteins when needed. However, if the genes don't get it right, they may change the biology of the body and cause an unstable mood <sup>12</sup>. Any kind of stress, such as a missed deadline at work or a medical condition, might throw someone who is genetically predisposed to depression off balance. Numerous genes influence mood, and because our genetic endowments vary, so do our depressions. Researchers are hoping that as they identify the genes responsible for mood disorders and learn more about how they work, depression treatments will become more successful and customized, and patients will get the right prescription for their particular type of depression <sup>12</sup>.

#### **2.1.4.2 Chemicals and Hormones**

Depressive illnesses appear to be significantly influenced by brain chemistry. Magnetic resonance imaging (MRI) and other contemporary brain imaging techniques have demonstrated that the brains of depressed individuals differ from those of healthy individuals. The regions of the brain that control emotion, thought, sleep, food, and behavior don't seem to be operating regularly. Important neurotransmitters, which are the molecules brain cells use to communicate, also seem to be out of balance. However, these visuals do not explain the cause of the depression. The dynamic system that determines a person's mood, perceptions, and how we perceive life is made up of billions of chemical processes. Because of the degree of complexity, it is clear why two people with the same outward signs of depression may have quite distinct internal issues and require very different therapies<sup>2</sup>.

#### **2.1.4.3 Stressful Life Events**

Traumatic life experiences, including as the death of a loved one, losing a job, being ill, ending a relationship, being abused, and living in poverty, can set off depressive episodes<sup>7</sup>. Although not everyone who experiences these challenges goes on to develop a mood illness, stress is a significant factor in depression. Both physical and mental repercussions might be long-lasting after certain incidents. Early losses and emotional stress have been linked to an increased risk of depression, according to researchers. Deeply painful early losses, such losing a parent or having a loved one stop showing affection for you, may reverberate for the rest of your life and manifest as depression<sup>12</sup>.

#### **2.1.4.4 Medical Problems**

Certain conditions can cause stress, which can lead to depression. In some instances, depression occurs before the physical condition and may even be a factor. Up to 10% to 15% of all depressions may be caused by medical conditions or medications, and some medical issues are associated with persistent, substantial mood abnormalities. Depression and heart disease are related, with up to 50% of heart attack survivors reporting feeling down and many experiencing severe depression. Depression has been connected to poorer healing, potential cardiovascular issues, and a higher risk of passing away within the next six months <sup>12</sup>. The following medical conditions have also been associated with depression and other mood disorders: endocrine disorders, such as issues with the parathyroid or adrenal glands that cause them to produce too little or too much of certain hormones, degenerative neurological conditions, such as multiple sclerosis, Parkinson's disease, Alzheimer's disease, and Huntington's disease, stroke, some nutritional deficiencies, such as a lack of vitamin B12, certain immune system diseases, such as lupus, some viruses and other infections, such as mononucleosis, hepatitis and HIV, cancer, erectile dysfunction in men <sup>12</sup>.

#### **2.1.4.5 Depression and Home Background**

Many sad teenagers come from homes with problems, though not all do. A teen's life can be challenging to navigate due to instability at home, as well as the demands of school, love relationships, and even miscommunications in various friendships. A young person's mood can go downward due to a lack of support at home <sup>7</sup>. Parents have the strongest impact in their children's lives, regardless of what they are going through at school, with their friends, or hormonally. A person's home environment can influence all other facets of daily life. If a family member has bipolar disease, depression, alcoholism, or has committed suicide, a teen's chance of

depression rises <sup>7</sup>. If there is unrest and strife at home, the risk also rises. A child's melancholy mood may also have underlying causes such as divorce, a loved one's death, or their extended absence. A 2011 National Institute of Health study discovered that adolescents were more likely to develop a significant episode of depression in adolescence if they had witnessed their parents' relationship instability before the age of five <sup>7</sup>. The same study also found that these kids had a higher risk of having unstable relationships with their own parents. Children who suffered their parents' divorce may experience worsening depressive symptoms into early adulthood. One in four teenagers from military households will have depressive symptoms, according to the National Alliance on Mental Illness. A chemical imbalance in the brain, which is frequently inherited, is what causes depression <sup>7</sup>. However, significant life events or even something seemingly little like a split with a girlfriend or boyfriend might set it off in teenagers. According to the Journal of Adolescent Health, family addiction, any form of abuse, including physical, sexual, and psychological, as well as reasonable or no expectations at all, can cause a chemical imbalance and lead to the depressing and occasionally hopeless symptoms of depression. A teen's home's unpredictability may also make him depressed <sup>7</sup>. An adolescent was more likely to attempt suicide if he moved from home to home frequently, according to a 2009 study from the University of Aarhus in Denmark. In comparison to 32 percent of 43 non-suicidal youngsters, over 55 percent of the youth researchers evaluated who had tried suicide had relocated more than three times. Furthermore, compared to 1.9 percent of non-suicidal children, 7.4 percent of children who were suicidal had moved more than ten times <sup>7</sup>.

#### **2.1.4.6 Depression and Age**

At any age, depressive disorders can develop. Men and women have varied patterns of prevalence for each age group. The largest occurrence is seen in women between the ages of 35

and 45. As men get older, the prevalence increases. Recent trends indicate that depression is spreading to younger age groups, or at least is being diagnosed there more frequently <sup>7</sup>.

In Ireland, 68 percent of those experiencing problems with their emotional, psychological, and mental health are working-age persons (18-64years age group). According to the Canadian National Population Health Survey, men's rates of 12-month melancholy ranged from "too low to report" for those over 65 to a high of 5.2 percent for those between the ages of 12 and 24, the prevalence among women varied by age as well, from 3.1% for those over 65 to 9.6% for those between the ages of 12 and 24. According to age, the Ontario Health Survey discovered comparable variation, this pattern matches research from Australia <sup>7</sup>. An inverse connection between the frequencies of major depression in the children and the age of beginning of major depression in their proband parents was discovered in a research of 6- to 23-year-old offspring of depressed and of normal parents <sup>7</sup>. The highest risk of major depression was seen in children whose parents' severe depression first manifested before the age of 20. The results were particular in that their children's pre-pubertal major depressive onsets accounted for nearly all of the elevated rates. The likelihood of depression developing before the age of 13 was 14 times higher in probands' offspring than in healthy controls. These results were not influenced by the proband or the children's current ages, the children's interview status, the parents' co-morbid conditions, or assortative mating. Future studies on the family genetics of probands with prepubertal severe depression ought to look at the prevalence and types of illness in their biological relatives <sup>7</sup>.

### **2.1.5 Depression and Suicide**

In addition to the 703 000 suicides per year, there are many more suicide attempts. Every suicide is a tragedy that has a profound impact on the survivors, including the families, communities,

and entire nations. Suicide is a lifelong condition and, among people aged 15 to 29, was the fourth highest cause of mortality worldwide in 2019 <sup>14</sup>. Depression is a very common mental disorder and a significant contributor to suicide. Suicidal individuals are overpowered by painful emotions and believe that death is the only option to end their suffering <sup>15</sup>. Suicidal ideas might be brief or persistent, passive or active. People who are depressed frequently start making preparations for their demise, such as giving up valuables or buying a gun. This is quite worrying and needs to be treated very seriously. The majority of people who manage to survive are content with their current state of existence <sup>16</sup>. Suicide is a significant problem for worldwide public health. Suicide is one of the top twenty major causes of death worldwide, accounting for more fatalities than homicide, war, breast cancer, malaria, and other diseases combined. About 60% of those who die by suicide are thought to have had a mood condition, such as serious depression, bipolar disorder, or dysthymia <sup>17</sup>.

### **2.2.1 Mental Health and Depression among University Students**

Delegates at the global conference on students' affairs and services reported that mental health has recently become a global concern for university students, impeding their ability to finish their degrees <sup>18</sup>. Globally, there is an upsurge in mental health issues, although the population of Africa expanded by 49 percent between 2000 and 2015, the number of years lost to disability due to mental and drug use disorders increased by 52 percent over that same period <sup>19</sup>.

A student's capacity to complete activities effectively is hampered by their tendency to be less adept at managing stress and pressure, which has a number of negative effects on their mental health <sup>20, 21</sup>. Taking care of students' mental health can benefit their mental health later in life. Starting college is a significant life step that can be both thrilling and exhausting. In addition to juggling numerous academic and social demands, students must also deal with developmental

difficulties as they adjust to maturity. Students with mental health issues are more likely to leave school early. Untreated mental illness has an impact on relationships, productivity, academic achievement, and substance misuse <sup>22</sup>.

Research has revealed high levels of ignorance regarding mental disease in Nigeria, as well as hostility toward people who have mental disorders <sup>23, 24, 25</sup>. The first line of defense for mental illness is typically traditional healers and religious authorities, which delays access to effective care <sup>25, 26</sup>. By making sure that student mental health is treated as a social issue, we can promote early intervention and active engagement by intervening early at a crucial juncture in young people's lives, long-term risks associated with poor mental health, which can have far-reaching consequences for the next generation <sup>20</sup>.

### **2.2.2 Depression among University Students**

With 264 million individuals impacted, the burden of depression and other mental health issues is increasing internationally. It is a serious and widespread mental health issue. A person with depression may experience severe suffering and perform poorly at job, in school, and in the family. In the worst case scenario, depression can result in suicide <sup>27</sup>. Depression frequently begins in adolescence and is most prevalent in people between the ages of 18 and 25 <sup>28, 29</sup>. University students deal with difficulties, pressures, and worries that can make them feel overwhelmed. This may be due to the environment shift, how they are adjusting to new routines and workloads, how they are adjusting to life with roommates, or how they are working out how to fit in. Some young adults may experience depression during their university years as a result of dealing with these changes during the transition from adolescent to adulthood <sup>30</sup>. According to studies, college is a popular period for many people to exhibit the first signs of depression, and more students than in prior generations are suffering from the condition <sup>31</sup>. In a university-based

investigation In Ethiopia, 46.1% of people reported having depression, which is greater than the prevalence of 25.2% discovered in a research done in Nigeria. Suicide is the third most common cause of death for people between the ages of 15 and 24 and is a risk factor for depression <sup>32</sup>.

### **2.2.3 Depression and Substance Abuse**

According to the National Bureau of Economic Research, 84 percent of the nation's cocaine and 69 percent of the nation's alcohol are consumed by people who have received a diagnosis of a mental disorder at some point in their lives. A dual diagnosis or co-occurring disorder occurs when a person battles both substance misuse and a mental illness. Depression is a psychiatric disease that frequently co-occurs with drug use <sup>33</sup>. The two conditions are inversely correlated, thus those who abuse substances are more prone to have depression and vice versa. To improve their mood or get away from feelings of shame or despair, depressed people may drink excessively or use drugs. However, depressants like alcohol might make people feel more down or exhausted. On the other hand, some people feel depression after using drugs or as they struggle to deal with the affects the addiction has had on their lives <sup>33</sup>.

The use of drugs and alcohol might occasionally seem like a simple fix for those who are depressed and believe there is no end in sight. These drugs might make you feel happier and temporarily relieve any emotional suffering. These substances can, however, develop an addiction. Their body will grow increasingly dependent on their effects as they drink more. Substance misuse over time can worsen depressive symptoms as well as result in long-term health issues like brain damage <sup>34</sup>. According to research, many of the same characteristics that contribute to depression also contribute to substance use problems. For instance, issues with the same brain chemicals and pathways, as well as elements like family history and prior stress, appear to be the root causes of both disorders <sup>34</sup>.

Dopamine levels are known to be lower in depressed individuals, and usage of drugs is also known to affect dopamine levels. The neurotransmitter most closely linked to sadness and other mood disorders is the hormone serotonin. Similar to this, serotonin receptors are altered in alcoholics. Reward circuits in the brain are faulty in patients with specific mental health conditions. The same seems to be true for cocaine addicts, who also exhibit impairment in these reward pathways <sup>34</sup>.

#### **2.2.4 Childhood Stress and Trauma**

A person's likelihood of later developing depression and a substance misuse disorder is also increased by stress and trauma experienced as a child. The loss of a parent, sexual or psychological abuse, domestic violence, and neglect are a few examples of situations that can lead to childhood trauma and stress <sup>35</sup>. Although there is a link between childhood trauma and adult depression, according to the Brain & Behavior Research Foundation, further research is required to determine why these people are more likely to be susceptible to depression. Clinical studies have shown that stress in childhood lowers levels of oxytocin, the "feel-good hormone," which influences sentiments of trust and connection. The hippocampus, a part of the brain that is connected to memory and emotion, is also prone to shrinking in those who experience chronic stress <sup>35</sup>.

The National Child Traumatic Stress Network reports that certain studies indicate that children who have been exposed to trauma, regularly endure stress, or have post-traumatic stress disorder (PTSD), are more likely to abuse drugs. According to studies, between 25% and 75% of persons who had childhood trauma began abusing drugs or alcohol to help them deal with their emotions <sup>35</sup>. Studies have even revealed that these individuals have trouble quitting because doing so causes their negative emotions to resurface <sup>35</sup>. Depression can raise the risk of chronic illnesses,

such as the disease of substance abuse. Up to one-third of those who are clinically depressed abuse drugs or alcohol, to alleviate the emotions of low self-worth, hopelessness, and despair that define this mental health disease, these chemical intoxicants may be used as a kind of self-medication <sup>35</sup>. Numerous elements that affect depression and substance use disorders are linked, according to research. Co-occurring disorders or a dual diagnosis are terms used to describe this. Unbalances in brain chemistry, family history, and past trauma are frequently associated with depression and addiction. Additionally, the physical and psychological impacts of addiction may conceal or exacerbate the symptoms of depression <sup>36</sup>.

### **2.2.5 Connection between Alcoholism & Major Depression**

Major depression and alcoholism have a close relationship. Researchers observed that among 43,093 persons aged 18 and older who participated in a countrywide study, there was evidence that more than 20% of them also fit the criteria for a co-morbid severe depressive disorder <sup>36</sup>. The likelihood of having at least one mood disorder was nearly 40% higher among survey participants seeking treatment for an alcohol use disorder than it was for the general population. Alcohol is a central nervous system depressant that, while it may initially act as a stimulant, quickly makes people feel lethargic, sleepy, and depressed. Alcohol consumption can enhance the likelihood that a depressed person will attempt suicide because it reduces inhibitions and affects judgment <sup>36</sup>. Abuse of alcohol and other drugs can accelerate the progression of a depressive disorder by escalating its symptoms, raising the risk of hospitalization, and interfering with the therapeutic process. If substance misuse is not taken into account and treated concurrently with the depression, patients who are receiving treatment for depression while abusing drugs or alcohol are unlikely to experience therapeutic success <sup>36</sup>. Abuse of substances can affect motivation and reduce the efficacy of treatment interventions. Additionally, there are

potentially harmful interactions between alcohol and narcotics and antidepressant prescriptions. A program that combines mental health and recovery services at the same location with a group of specialists who are cross-trained in both professions is the most efficient way to treat depression <sup>36</sup>.

### **2.2.6 Depression among Men and Women**

Although both men and women experience depression, their readiness to discuss their feelings may differ greatly. Men and women may experience depression in quite different ways, which is one of the causes of this. An estimated 15 million Americans experience depression each year. They are mostly women. Sadly, only about 2/3 receive the assistance they require <sup>37</sup>. In women, depression is fairly typical. In actuality, women are twice as likely as males to have clinical depression <sup>37</sup>. Up to 1 in 4 women are susceptible to experiencing a significant depressive episode at some point in their lives. This might be the case because the majority of depressed males do not seek treatment or exhibit symptoms of depression <sup>37</sup>. Depression can affect both men and women, but the symptoms might vary greatly. Families, acquaintances, and even doctors may not always recognize the anger or aggression as depression symptoms in men since they may appear furious or aggressive rather than sad <sup>38</sup>. Men are also less likely than women to identify depression, discuss it, and seek therapy for it. Yet a lot of males experience depression. While many women appear sad or express melancholy, some males with depression mask their emotions and may appear to be angry, irritated, or aggressive <sup>38</sup>. Men who are depressed may experience extreme fatigue and lose interest in their jobs, families, or interests. Compared to women who are depressed, they can be more prone to have trouble sleeping. Sometimes the signs of mental illness resemble physical ailments. For instance, symptoms of a mental health issue can include a racing heart, constriction in the chest, persistent migraines, or digestive

problems. In comparison to emotional problems, many men are more likely to visit their doctor for physical issues<sup>38</sup>.

To help them deal with their emotional symptoms, some men can turn to drugs or alcohol. Men are also more likely to die by suicide because they frequently utilize more deadly techniques, despite the fact that women with depression are more likely to try suicide. Any man can experience depression at any age. Most depressed men can improve and regain interest in their jobs, families, and hobbies with the proper care<sup>38</sup>.

### **2.2.7 Depression Left Untreated**

Clinical depression that is left untreated is a major issue. Depression that is not treated increases the likelihood of dangerous behaviors like drug or alcohol addiction. Additionally, it can damage relationships, lead to issues at work, and make it challenging to recover from catastrophic illnesses. Clinical depression left untreated can linger for weeks, months, or even years<sup>39</sup>. Physical health suffers significantly as a result of clinical depression. Sleep patterns changing is one of the most obvious signs of clinical depression. Even while inability to get enough sleep is the most frequent issue, occasionally people feel as though they need more sleep and have excessive energy loss. Extreme fatigue, a decrease in energy, trouble concentrating, and difficulty making decisions are some of the symptoms of sleep deprivation that are similar to those of depression<sup>39</sup>. Untreated depression can also lead to irritability, a loss or gain of weight, and feelings of powerlessness and hopelessness. All of these depression symptoms can be managed with the use of depression treatment. Untreated clinical depression in men may result in more aggressive, irrational, and violent conduct than in women. Men who are depressed also run the risk of engaging in risky behaviors like reckless driving and unsafe sex. Men are unaware that physical symptoms of depression might include headaches, stomach issues, and persistent

discomfort. People with depression may become unable to function in their personal, familial, and social lives. If left untreated, clinical depression costs the American economy as much as AIDS or heart disease. Each year, untreated depression results in more than 200 million days missed from work. Untreated depression costs more than \$43.7 billion annually in lost productivity, absenteeism from work, and direct medical expenses<sup>39</sup>.

### **2.2.8 Mental Health Literacy of Depression**

Although depression is treatable, less than 50% of those affected worldwide (and less than 10% in many) receive the care and assistance they require<sup>1</sup>. One of the main obstacles to receiving treatment for mental disorders in general and for depression in particular has been recognized as a lack of mental health literacy (MHL)<sup>28,40,41,42, 43</sup>. Jorm et al coined the term "MHL" in 1997; it refers to knowledge and attitudes about mental illnesses that support their early detection, treatment, and prevention<sup>44, 45</sup>. Greater MHL, according to Jorm's theory, enables people to take action to enhance both their own and others' mental health in the community<sup>43</sup>. This definition places a strong emphasis on the importance of young people and those close to them, such as family members, teachers, and friends, recognizing mental health problems and getting help for management and prevention<sup>43</sup>. It is possible to identify the stigma attached to mental health issues, one of the major obstacles to early detection and intervention, through the assessment of knowledge and beliefs about those issues. The development of interventions targeted at developing mental health literacy as well as the evaluation of these interventions are made possible by analyzing knowledge gaps and false beliefs about mental health concerns<sup>46, 47, 48</sup>. The MHL research has shown that many young people delay or refrain from seeking help due to a number of structural and personal barriers, including fear of the stigma and discrimination associated with depression, an inability to recognize the symptoms of the problems, ignorance of

the existence of help, and a lack of appropriate responses from peers and adults <sup>49, 50</sup>. The ability to self-identify a problem affects obtaining professional treatment, according to a comprehensive review of studies on the factors that prevent people from getting help for all mental health illnesses <sup>51</sup>.

Depression frequently manifests early in life and can continue a very long time <sup>28</sup>. As Jorm and his coworkers have noted, good MHL in young people and their key supporters may improve outcomes for those who suffer from mental disorders, either by facilitating early help-seeking by young people themselves or by assisting adults to recognize early signs of mental disorder and to seek help for the young person <sup>52</sup>. MHL of depression with a young adult focus has been researched elsewhere. According to a research conducted in Hanoi, Vietnam, of 350 undergraduate students (115), 32.0% accurately identified a vignette as depression <sup>53</sup>. Another study found that the majority of respondents thought that full recovery from depression was possible with professional interventions <sup>54</sup>. College students aged 18 to 24 in an African American college could correctly recognize depression symptoms described in a vignette. In order to cure depression, the respondents recommended doctors, university counselors, school psychiatrists, and social workers. This supports earlier study that found people who recognize mental illness are more likely to have favorable opinions toward mental health professionals <sup>55, 56</sup>.

### **2.3.1 Health-Seeking Behavior among University Students**

A "series of remedial measures that individuals do to rectify perceived ill-health" has been described as health-seeking behavior. Data gathered from sources including the length of time between the onset of an illness and making contact with a healthcare provider, the type of healthcare provider patients sought assistance from, the degree to which patients adhere to prescribed treatments, the reasons for choosing a healthcare professional, and the reasons for not

seeking assistance from healthcare professionals, can be used to describe health-seeking behavior<sup>56</sup>. All actions taken to achieve and keep up a healthy physical and mental state are referred to as health seeking behaviors<sup>57</sup>. Behaviors that address any deviation from the healthy condition, such as managing and minimizing the effects and course of an illness, are also included in the category of health-seeking behaviors<sup>58</sup>.

With time, the idea of examining health-seeking behaviors has changed. It is now a tool for comprehending how individuals interact with healthcare systems according to their unique sociocultural, economic, and demographic conditions<sup>56</sup>. At many institutional levels, including the family, community, health care system, and the state, all of these behaviors can be categorized. Understanding health seeking habits of various communities and population groups is vital to battle the high costs of healthcare in areas with expensive health care systems and a large variety of public and private health care service providers<sup>56</sup>.

Health-seeking model: Studies have shown that a person's decision to use a specific medical channel is influenced by a number of socioeconomic factors, including sex, age, women's social position, the type of disease, availability to services, and the service's perceived quality<sup>56</sup>.

### **2.3.1.1 Pathway Model**

The route model was first used by Suchman to outline the steps in the process from symptom recognition to the utilization of specific healthcare services. This approach seeks to pinpoint a logical flow of events. Additionally, it examines the influence of social and cultural influences on this sequence. Using qualitative research techniques, this strategy has mostly been anthropological<sup>56</sup>. The information that a person would be anticipated to process during an illness episode is the focus of Fabrega's theoretical model of disease behavior. This strategy is founded on economics and fundamental decision theory, and the activity is assessed using the

cost-benefit principle. It is critical to see the decision-making processes from this perspective because health-seeking behavior is a social process that requires an individual's engagement with the social network <sup>56</sup>.

### **2.3.1.2 Determinants' Model**

This concept is based on a more quantitative and biomedical method. This approach focuses on highlighting a set of variables which are related with the selection of various types of health services rather than on the actions one would take to maintain or improve health <sup>56</sup>.

The numerous factors of health-seeking behavior can be explained using a variety of models. Population characteristics, health care systems, and the external environment make up Andersen's classification of factors influencing determinants into three primary categories. The health behaviors of the individual and their acceptance of the sick role were the attention of a different researcher. This model excludes the influence of social networks on the decision-making process and focuses solely on an individual's health behavior. It is important to understand how and why some people seek care earlier than others, which is why all of these models of determinants and factors impacting health-seeking behaviors are important. Regarding diseases that demand prompt attention, such models are instructive because they support treatments aimed at reducing transmission and consequences brought on by neglect <sup>56</sup>.

### **2.3.2 Factors That Affect Health-Seeking Behavior**

Types of illnesses: Patients seek various forms of therapy depending on the type of ailment with which they are diagnosed. Additionally, people may choose various medical interventions and medications based on the severity of the identified ailment <sup>56</sup>. It was discovered that people's perceptions of their illnesses whether they thought they were severe or not enough to need

medical attention kept them from seeking care. As treatments were frequently seen as either a waste of money, a lack of money, or a sign of a health worker's poor attitude, poverty also appeared as a significant factor influencing health-seeking behavior<sup>56</sup>.

### **2.3.3 Help Seeking Theory**

According to the help-seeking hypothesis, people go through a set of predictable phases while looking for assistance with their shortcomings. These steps are well-ordered, purposeful cognitive and behavioral actions that each lead to a certain kind of resolution. The two types of help-seeking theories are those that emphasize process similarity and those that emphasize the process' dependence on the issue. Help-seeking behaviors often depend on three categories: intentions to seek help, actual help-seeking behavior, and attitudes (beliefs and willingness) towards getting help<sup>59, 60, 61</sup>.

Formal help-seeking, which engages mental or physical healthcare professionals like counselors, psychologists, and doctors, and informal help-seeking, which involves non-professionals like teachers, parents, friends, or religious leaders, are the two main categories of help-seeking behavior<sup>59</sup>. Teenagers may feel more at ease talking to informal supports like family, friends, and local or religious leaders than to professional services like psychologists and doctors. This may be due to the fact that many young people are not informed about the value or advantages of formal aid seeking. In the global setting, there are less than 25% of people who seek professional assistance for depression. The percentage of people who sought professional assistance within a year of the commencement of their mental illness ranged from 1.6 percent in Nigeria to 17.9 percent in the USA, this is according to a WHO survey of people who used mental health services for anxiety, mood disorders, and drug use disorders. In Ethiopia, 22.9 percent of depressed people reported acting in a way that involved getting professional assistance. There is

little data on the professional help-seeking behavior of people with depression, especially in low-income settings, which is the key factor increasing the burden and complexity of depressive illnesses <sup>62</sup>. One of the reasons people seek professional care for depression is that they believe it to be a treatable illness; yet, a study conducted in Ethiopia found that only 25.66 percent of people receive expert assistance. This is significantly higher than the 16.9% rate of aid seeking recorded among Gureje et al in Nigeria. There are a lot of people who decide against getting treatment for mental health issues. The shame, anticipated expenditures, and the belief that the issue will go away are all frequent causes of underutilization <sup>13</sup>.

#### **2.4.1 Attitude towards Depression among University Students**

Examining attitudes around mental health issues is crucial because they may lead to stigmatization and prejudice of those who experience them <sup>63</sup>. Coercion, withholding assistance, avoidance, and institutionalization within the community are just a few of the ways that discrimination towards those with mental health issues can limit their quality of life and prospects <sup>63</sup>. Additionally, studies have shown that people still prefer to keep their distance from those who are struggling with mental health issues <sup>64</sup>. When someone have a mental health issue, the negative effects of stigma and prejudice may impair their decision to seek help, delaying care and lengthening suffering <sup>52</sup>. Examining attitudes toward mental health issues like depression and anxiety is crucial because it enables us to comprehend the thoughts and feelings that might be at the root of stigma and prejudice against those who experience such issues <sup>52</sup>.

##### **2.4.1.1 Stigma and Mental Illness**

It has been discovered that a significant barrier to receiving appropriate care for those with mental illnesses is the fear of stigmatization <sup>65, 66</sup>. Only around 25% of those who kill themselves while suffering from serious depression were receiving treatment at the time of their death <sup>66, 67</sup>.

In the meanwhile, suicide can be avoided despite its alarmingly high occurrence. Unfortunately, a lot of depressed people do not seek professional care, even if they may be exhibiting severe symptoms, in part due to the stigmas attached to mental illnesses in society. Stigma is acknowledged as a major factor in discrimination, having an impact on social interactions and potentially limiting one's capacity for employment <sup>66, 68</sup>. Therefore, because they are frequently blamed for their issues, people with mental illness may feel ashamed and alone <sup>66, 69</sup>. Stigmatization of mental health frequently takes the shape of stereotypes, emotional responses, status loss, and discrimination <sup>66</sup>. The stigmatization of those who suffer from mental illness is pervasive not just in one nation. Researchers from a variety of academic and cultural backgrounds have done a lot of study to show the negative consequences and ramifications of social stigmatizing those with mental illness <sup>66</sup>. In a global poll of more than 229 nations (including dependencies), roughly 7% of respondents in developed nations believed that people with mental illness were more violent, but twice as many respondents in underdeveloped nations held the same opinion. Furthermore, about 7% of individuals in developed nations thought that those who suffer from mental illness might never fully recover <sup>66, 70</sup>. People with mental illnesses of any kind are frequently stigmatized as violent, incompetent, and needing to be kept away from the public.

Studies have also revealed that stigmatizing beliefs about mental illness may exist even among medical professionals. According to survey responses from 1414 psychiatrists in Brazil, 43 percent of them were classified as having "severe stigma" because they believed that those with schizophrenia didn't have the necessary skills to obtain a driver's license <sup>66</sup>. Only around 33 percent were thought to have favorable opinions toward those who suffer from schizophrenia. Similar results were found in a study conducted in Nigeria, which revealed that 80% of the

country's medical professionals surveyed said they would not marry someone who has a mental illness, 64.1 percent would be hesitant to date someone who has been hospitalized for a serious mental disorder, 59 percent would find it difficult to maintain a friendship with someone who has a mental illness, and 47.8 percent did not think a former mental patient is just as trustworthy as the average person <sup>66, 71</sup>. As a result, those who suffer from mental illness must contend not just with their symptoms but also with unjustified stigma from those around them. Poor mental health knowledge is a significant contributor to the stigmatization of people with mental illness <sup>66</sup>. Cultural values, widely practiced religious affiliations in the community, and economic issues may all have an impact on mental health literacy. Reduced social stigma and increased mental health literacy have a high correlation, according to the findings of multiple studies <sup>66</sup>. According to the findings of a poll conducted in Germany among more than 5000 people, persons who were familiar with mental illness were less likely to view those who had schizophrenia or significant depression as hazardous <sup>66</sup>. The misconceptions around mental illness may have their roots in prehistoric ideas. When the cultural histories and social mores of various Asian nations were compared, it was discovered that "lack of mind-body dualism, somatization, the medicalization of psychiatric diseases, spiritual and religious beliefs, and family orientation" were frequently used to describe mental illness. Additionally, during one or more eras in many Asian civilizations, mental diseases were frequently notably associated with evil, taboos, and some (direct or inherited) divine punishment. This ideology, meanwhile, was not exclusive to Asian societies. According to a research in Nigeria that looked at the pervasive stigma in that country, the idea that mental illness is a spiritual disorder makes those who have it seem dangerous and undesirable. Similar to this, it has been noted that the notion that mental illness results from wrongdoing may "elicit condemnation rather than understanding or empathy" <sup>66, 71</sup>. In order to

educate the public about mental health, several modes of intervention, such as awareness-raising campaigns and entertainment education, have thus been specifically created in a number of nations, particularly in recent years. These, however, must battle with the persistent media distortions that support derogatory preconceptions of those with mental illnesses <sup>66</sup>.

#### **2.4.1.2 Stigmatization of Mental Illness in Nigeria**

Many Nigerians believe that drug usage and paranormal forces are the main causes of mental illness, according to several research <sup>66</sup>. According to a survey on attitudes toward mental illness in southwest Nigeria, abuse of drugs and alcohol (72.3 percent) and witchcraft/sorcery/evil spirits (65.5 percent) were the most frequently endorsed causes, followed by God's will/divine retribution (50.1 percent) <sup>66, 71</sup>. Similar findings were made in Northern Nigeria, where drug abuse was found to be the main contributor to mental disease, with supernatural powers coming in second. Similar perceptions were found among the Igbos, according to a study conducted in the southeast. The researchers concluded that, in light of their findings, an increase in the quantity and caliber of resources and facilities for people with mental illnesses may not alter these beliefs <sup>66, 72</sup>. Despite cultural differences, these beliefs also appear to be prevalent in Nigeria. Socioeconomic status is one variable that can be associated with mental health literacy in Nigeria. According to a study, rural residents were more likely to support several supernatural factors than urban residents (54.4 percent vs. 44.6 percent), despite the fact that urban residents were more likely to do so (50.0 percent vs. 38.4 percent) <sup>66, 71</sup>. People who reside in rural areas are frequently from lower socioeconomic classes and have access to less-quality education than city dwellers, who are mainly from middle- and upper-class backgrounds <sup>66, 71</sup>. The findings may therefore imply that socioeconomic position may, in part, affect how people perceive mental illness.

Investigating how the concept of mental illness is expressed in Nigerian languages is essential if one is to properly comprehend how Nigerians view it. It is impossible to deny the importance of language in culture. One of the main semiotics theorists, Roland Barthes' approach examines the connection between language and culture <sup>66</sup>. The relationship between a connotative signifier and a connotative signified can only be described by reference to a larger social field, a social field that is structured by class interests and values, according to Barthes' semiotics model <sup>66</sup>. The three main languages spoken in Nigeria are Yoruba, Igbo, and Hausa. A person with serious mental diseases is referred to as a "mahaukaci," "onye ara," and "werey", in Hausa, Igbo, and Yoruba Nigeria, which translate to "crazy person" in English. Other types of mental diseases are typically referred to as "mental issues" or are simply defined as such <sup>66</sup>.

Over 60% of respondents in a research in southeast Nigeria said they thought mental health "did not exist along a continuum" <sup>66, 72</sup>. To put it another way, "people are either mad or not mad" <sup>76</sup>. In this definition, a "crazy person" is someone who wanders the streets aimlessly, dresses shabbily, speaks incoherently, typically to no one in particular, and exhibits sporadic violence. According to a study done in the north, the most common signs of mental diseases were anger and destructiveness, talkativeness, eccentric conduct, and wandering, in that order <sup>66</sup>. As a result, it is considered rude to inquire about someone's mental state or to imply that they could be. In fact, depending on the speaker's tone, implying that someone might have a "mental condition" could be considered disrespectful. Though many studies in Nigeria concentrate on severe mental illness, a few studies have looked at depression stigmatization with a primary focus on youth. This may be predicated on the idea that because the majority of efforts have been directed at Nigerian adults, adult literacy regarding mental illness has supposedly improved overall. According to a study on how Nigerian adolescents perceive depression, the majority mistakenly

categorized depression as a physical condition (26.1%), maltreatment/physical or sexual abuse (15.0%), "thinking too much" (13.6%), an emotional problem (14.3%), or stress (11.8%)<sup>66, 73</sup>. Results from a similar survey conducted among teenagers in Nigeria, found that 71.0% of the respondents mistook depression for emotional stress, an emotional problem, and worry. Additionally, 76.3 percent found it difficult to differentiate between "normal" reactions to dysphoria and clinical depressive symptoms<sup>66, 74</sup>.

#### **2.4.1.3 Stigma towards Depression**

A person experiences stigma when they are viewed negatively due to a certain trait or attribute, such as their skin tone, ethnic heritage, a physical or mental handicap. Discrimination is defined as when someone receives unfavorable treatment as a result of their mental disorder<sup>75</sup>. People with mental health issues may be stigmatized because of misconceptions, misperceptions, misinformation, and unfavorable attitudes. They may be viewed as being dangerous, unusual, or less than other people<sup>76</sup>. Students from highly regarded universities are crucial for the growth of science, technology, and the nation's economy. Their perspective and attitude toward depression may have deep and long-lasting impacts on both them and society at large. Only a small percentage of depressed young students sought professional help for treatment, and stigma around mental health therapy was higher among university students<sup>77</sup>. In addition to being negatively correlated with self-reported suicide ideation and self-injury, stigma at the college and university level is also negatively correlated with medication use, clinic visits, and informal support<sup>78</sup>. 53.3% of participants in a community-based sample study in China reported experiencing personal stigma, while 83.4% reported experiencing perceived stigma<sup>79</sup>. As a reasonable attitude toward depressed university students, stigma is also seen as a barrier to the public's ability to come to an objective understanding, hastening the development of this vicious

cycle. According to a study, college students have a strong desire to avoid social situations where depressed people are present <sup>80</sup>. When someone is defined by their condition rather than who they are as a person, stigma occurs. Instead of being referred to as "a person experiencing psychosis," they can be referred to as "psychotic." The societal stigma and discrimination that those with mental health difficulties face can exacerbate their issues and make it more difficult for them to recover. Due to their fear of being stigmatized, people can decide not to seek the assistance they require. Feelings of shame, hopelessness, and isolation are a few of the effects of stigma, along with reluctance to seek help or treatment, lack of understanding by family, friends, or others, fewer opportunities for employment or social interaction, bullying, physical violence, or harassment, and self-doubt, the conviction that you will never be able to overcome your illness or achieve what you want in life. Self-stigma about asking for assistance prevents someone from receiving treatment for their problems, whether it be counseling therapy or psychiatric management <sup>77, 81</sup>.

### **2.5.1 Factors Associated with Depression among University Students**

An individual who has experienced unpleasant life experiences (unemployment, child abuse, bereavement, or psychological trauma) is more likely to develop depression <sup>82</sup>. Depression is a complex interplay of social, psychological, and biological elements. University students are also affected by other common causes, such as being in a new environment, genetics, personality, and being near 40-year-olds who are depressed. As some students use alcohol or other drugs to cope with stress and other unpleasant emotions, they are also more prone to participate in dangerous behaviors like unsafe sex or using illegal narcotics <sup>30</sup>. Depression among university students can result in unhealthy habits.

Environmental variables based on the negative reinforcement that the young person receives from his or her surroundings, such as failing a test or examination, can occasionally cause depression in adolescents <sup>83</sup>. The majority of students may at some point feel depressed due to psychological distress, poor concentration, stressful exam situations, fear of failure, strict or lax upbringing, financial constraints, a broken home, absent parents, abandonment, rejection, relationship disappointment, and the loss of a parent or loved one, but these issues may not be serious <sup>30</sup>. According to a study done in Malaysia, 29.4% of college students suffer from depression, and some of the risk factors include living off-campus, originating from a lower socioeconomic background, having sleep issues, and having PTSD <sup>84</sup>. Adewuya et al study among Nigerian university students found that among other things, housing issues, having a large family, being a woman, smoking heavily, and drinking heavily are all risk factors for depressive disorders in students <sup>26</sup>.

## 2.6.1 Basic Concept of Depression

### Historical Background

Prior to the late nineteenth century, identifying the broad major disorders was the primary challenge for mental nosology, despite the fact that there was no shortage of specialized classification schemes. The diagnosis of melancholia dates back to Hippocrates, and it continued to be used throughout the medical practices of the Galenic and medieval times. In the past, the phrase had a broader meaning that encompassed a variety of different types of silent insanity. It was connected with the humoral idea of causality, namely with black bile, as its name suggests<sup>85</sup>. The vast majority of psychiatric terminologies have developed over the course of time and are always dependent, at least in part, on language. Later on, the concept of melancholy or despair came to be associated with melancholia. For instance, the well-known book *The Anatomy of Melancholy*, written by the English Renaissance novelist Richard Burton and first published in 1621, is considered to be the first publication to make this association. Although Arateus of Cappadocia and other authors proposed in some ways the oscillation of melancholia and mania in what is now known as bipolar disorder or manic-depressive disease, it was not explicitly characterized until 1854 by the French psychiatrists Falret and Baillarger, who independently came to the same conclusion. Bipolar disorder is also known as manic-depressive illness. The emotion of melancholy was given its own name in the nineteenth century when it was given the label of depression. Jackson and Berrios both provide in-depth explanations of these features as well as the history that came afterwards<sup>85</sup>.

When Kraepelin, working in the latter part of the nineteenth century, drew on the work of his predecessors and simplified it in order to build the framework for the contemporary classification of mental disorders, manic-depressive insanity was one of the fundamental categories that he

identified. The well-known textbook written by Kraepelin went through multiple printings, each of which featured somewhat different perspectives from the author. In the first edition, he classified involitional melancholia as a new category; but, in following editions, he moved it into the manic-depressive category instead. The latter category included not just instances of alternating mania and depression, but also every single instance of mania and what seemed to be every single instance of depression <sup>85</sup>. Kraepelin believed that psychiatric diseases should be seen as disease entities in their own right, each with a unique organic basis and pathology that could be explained using a medical or neurological model. He was of the opinion that manic depression was not usually caused by any form of psychological strain. Although this type of stress may be a factor in the onset of some episodes, it is possible that it is not the primary cause of the condition but rather a trigger mechanism. On the other hand, he was of the opinion that the cause of certain clinical depressions was psychogenic. Although he did not fully explain his position in his classification or how they were to be differentiated from manic-depressive disease with accidental stress, it seemed as though he treated them as a separate group that was relatively small and insignificant, despite the fact that he did not fully explain his position in his classification <sup>85</sup>.

At the same time that Kraepelin and his colleagues were working on constructing a taxonomy of the major mental illnesses in terms of disease entities based on a medical model and organic genesis, another school of European psychiatrists was pursuing a completely different approach. This school was known as the psychoanalytic school of thought. These individuals were the counselors. Freud and Abraham created a hypothesis of the genesis of depression in relation to actual or symbolic losses of a love object by compiling a sensitive collection of data and working

backwards from there <sup>85</sup>. There was a school of thinking that suggested the majority of depressions, if not all of them, were caused by psychological factors.

Patients in institutions who were terminally sick made up the bulk of Kraepelin's and other researchers' case material. The earliest depressed patients to be examined through psychoanalysis were also in a critical state of health. After that, more attention was paid to less severe forms of illness, particularly by psychoanalysts. This trend continued for some time. The recognition of the role that psychological factors play in the development of a variety of diseases has increased. The challenge of how to reconcile novel theories of organic causality with more established ones arose at some point <sup>85</sup>. Adolf Meyer, a Swiss psychiatrist who later became the highly influential head of the Henry Phipps Psychiatric Clinic at Johns Hopkins University, was opposed to the idea of distinct disease entities. Instead, he viewed all psychiatric disorders as reaction types, or psychobiological responses of the organism to stress. Meyer was a proponent of the reaction type model of mental illness. It is necessary to take into account both psychological and organic components. Others favored clinging to a point of view that differentiated between the two types of psychiatric illnesses. On the one hand, there were the psychoses, which were serious disorders that needed to be treated in an inpatient setting and were assumed to have organic causes. On the other hand, neuroses were assumed to be more closely associated with psychological stress and to be more responsive to psychological treatment because they were less severe and did not require hospitalization <sup>85</sup>. The stage was now ready for two competing hypotheses on the categorization of depression, which would later feature prominently in arguments regarding subtypes and would be explored in the appropriate order when the time came.

## 2.6.2 The Concept of Modern Depression

Two formal classifications of depression have been provided by the ICD-10 Classification of Mental and Behavioral Disorders. These classifications are reflective of the majority of psychiatrists' current understanding of depression. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), as well as the Clinical Descriptions and Diagnostic Guidelines (ICD 10), are essentially the same clinical syndrome<sup>85</sup>. This syndrome is defined by the presence of a number of clinical features, but it does not require a specific etiology. It also acknowledges the possibility of both psychological and biological causative factors in a manner that is somewhat Meyerian. The DSM-IV excludes conditions in which the symptoms are "better accounted for by bereavement." This is a vague criterion that has been expanded to specify that the symptoms must not persist for more than two months or be accompanied by severe functional impairment, morbid preoccupation with worthlessness, suicidal ideation, or psychomotor retardation. In addition, the DSM-IV excludes conditions in which the individual has suicidal ideation or suicidal tendencies. There is a debate going on over whether or not this exclusion serves any useful purpose<sup>85</sup>. Studies of symptoms have shown that nonbereavement sadness is surprisingly comparable to bereavement depression. There is a continuing requirement for additional research, particularly on the time period of two months that is prioritized by the DSM-IV classification. These studies ought to investigate whether bereavement depressions manifest differently than other types of depression during this window, and whether they improve or worsen outside of it. Also, they ought to look into whether or not they manifest differently outside of this window<sup>85</sup>.

This definition of depression is mostly medical and syndromal in nature, and it is comparable to the syndromes that are associated with other medical disciplines. This points to a collection of

symptoms and signs that frequently occur together and are thought to reflect a single pathophysiology. This pathophysiology may or may not be recognized at this time, but it may have a variety of causes depending on the circumstances. Some conditions that can be treated by internal medicine are mal-absorption syndrome and congestive heart failure. This is an aspect that is included in the medical theory of disease. In accordance with the dominant school of thought in medicine, every disease possesses a one-of-a-kind etiology, pathophysiology, clinical profile, and, most of the time, a one-of-a-kind treatment <sup>85</sup>. There are a lot of benefits that come along with being able to categorize people according to the illnesses they have. They involve generalizing information at their very core, as the philosopher C. G. Hempel pointed out a good number of years ago. After a patient has received a correct diagnosis, there is a wealth of extra information accessible on a wide range of subjects, such as the underlying mechanisms, the causation, the prognosis, and the best course of action. Because a syndrome at the level described above can have several origins and, as a result, multiple disorders, the term "disease" cannot be used to describe it in its entirety when it comes to its diagnostic status. The circumstances are often more convoluted and murky in the field of psychiatry. There is a chance that multiple diseases will coexist in this population. In most cases, attempts to define pure diseases based on their etiologies have been unsuccessful. This is due to the fact that the causes often appear to be diverse, even within a single case, and not all etiological components have been identified. On the other hand, a syndromal diagnosis does include a number of the benefits that were discussed earlier, including the ability to determine the most effective course of therapy and the prediction of the outcome. Endophenotypes, which depict underlying abnormalities and genetically determined disorders, may start to more closely resemble actual diseases if it is understood how genes are involved in psychiatric disorders <sup>85</sup>.

Traditional methods of disease diagnosis in psychiatry consisted, for the better part of the field's existence, of an authoritative psychiatrist making judgments about and defining diseases based on clinical experience, with little effort expended on exact description or method-based research. This was the case for the majority of the field's history. In contemporary psychiatric nosology, the major strategy for making diagnoses has been reaching a consensus among the members of the committee, which is occasionally supported by relatively limited empirical research<sup>85</sup>. The diagnostic criteria are then established by describing certain symptoms in order to determine the minimum number of symptoms necessary for a diagnosis, in addition to the length, additional conditions, and exclusions of the condition. The DSM-IV includes a list of eight symptoms that must be present in order to make a diagnosis of major depression. Among these symptoms is the presence of at least one of two core symptoms, as well as the duration of two weeks or longer, the presence of clinically significant distress or impairment of function, and the absence of a mixed episode, direct effects of an addictive substance, medication, or other substance, or of a general medical condition, or of bereavement. To be diagnosed with dysthymia, you need to exhibit fewer symptoms for a longer period of time (two years), and you can only choose from a more limited range of symptoms. In contrast to the independent research criteria, which have a reputation for being more stringent than clinical criteria, the ICD-10 depressive episode definitions are not well-defined in the clinical criteria<sup>85</sup>. Because there are two distinct sets of criteria, the Research Criteria are utilized far less frequently, which has a negative impact on the categorization. The DSM-V contains the same eligible symptoms for depressive episodes as the DSM-IV, with the addition of exhaustion, which is included with the other two core symptoms rather than in the extra list. The DSM-IV did not include exhaustion as one of the eligible symptoms for depressive episodes. The minimum number of needed symptoms shifts depending

on the seriousness of the event. Without making mention of mourning, there is a commensurate exclusion rule that lasts for comparable amounts of time and a minimum duration of two weeks. It is essential that you have three out of the more extended list of symptoms that qualifies you for dysthymia <sup>85</sup>.

### **2.6.3 Classification of Depression**

The spectrum of disorders that might cause depression was mapped out a very long time ago. Their sub classification has been the subject of as much debate and investigation as any other psychiatric disagreement. Both of the official programs are comparable to one another, although they are not exactly the same, and both have issues. The DSM-IV is simpler to use, and its two primary subtypes, bipolar disorders and depressive disorders, are easier to understand. Both of these categories have subcategories. This investigation focuses on the most important subtypes of depression (unipolar depression), which are as follows: major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified <sup>85</sup>. Major depressive disorder is further subdivided into single episode disorder and recurring disorder. The most recent episode can be further characterized as chronic, with catatonic features, sad features, unusual features, or an onset postpartum using a number of severity, psychosis, and remission specifiers. Other significant mood disorders include those that are brought on by underlying physiological abnormalities or the usage of substances <sup>85</sup>.

A manic episode, bipolar affective disorder, depressive episode, recurrent depressive disorder, chronic mood (affective) disorders (dysthymia, cyclothymia), other mood (affective) disorders, and unexplained mood (affective) disease are the fundamental classifications used in the ICD-10. The bipolar and the unipolar axes are, without a doubt, the two major axes (single episode, recurrent, persistent). Within a single depressive episode or recurrent depressive episodes, there

are severity subcategories (mild, moderate, severe without psychotic symptoms, with psychotic symptoms, in remission for recurring disorders), as well as an additional specifier for somatic syndrome (melancholia) <sup>85</sup>. By applying systematized criteria and modern notions, DSM-III and ICD-10 were able to perform significantly better than their forerunners, DSM-II (which was substantially more based on psychoanalytic and Meyerian ideas of reaction types) and ICD-9. This was possible due to the fact that DSM-II was substantially more based on reaction types. Structured criteria were used extensively throughout the DSM-III and its subsequent iterations. ICD-10 is not clear in this sense since it has two separate sets of criteria; the clinical criteria are not well-defined, but the research criteria are. Every way of grouping things has its own specific set of disadvantages <sup>85</sup>. They are complex within the bounds of their own classes. Aside from the fact that they are of different nationalities, it would be ideal if they were combined into a single group that could take use of the benefits offered by each member while doing away with the occasional drawbacks associated with each. The distinction between disorders characterized by a single episode and those characterized by recurring episodes is not supported by empirical research, and it is ineffective as a key distinction because all disorders that progress into recurring episodes are initially characterized by a single episode. The DSM diagnostic criteria are superior. The DSM-specification III's for depressions connected with medical problems and substance abuse are ineffective because there is not enough data to suggest that these types of depression are significantly different from other types of depression. This renders the DSM-specification III's for depressions ineffective <sup>85</sup>.

### **2.6.3.1 Psychotic Depression and Melancholia/Somatic Syndrome**

The most contentious debate in the field's history centered on a dualistic theory of depression that distinguished between neurotic or reactive depression on one hand and psychotic or

endogenous depression on the other. In the late 1920s and throughout the 1930s, there were heated debates between those who advocated a dualistic view and those who took a unitary stance, which viewed all depressions as subtypes of a single condition. The debates began in the late 1920s and continued through the 1930s. These discussions were especially contentious in the field of British psychiatry<sup>85</sup>. When World War II broke out, there was a noticeable drop in the level of intensity of the conversation. In the 1960s, it made a comeback under the guise of empirical investigations utilizing multivariate statistics. The language was difficult to understand. Both the term "psychotic" and the term "neurotic" refer to serious conditions that are characterized by delusions and hallucinations, respectively. Typically, a weak personality is associated with the terms "psychotic" and "neurotic." In the context of this discussion, the absence or presence of life stress is referred to as endogenous and reactive, respectively. It was thought that the completely developed notion, which led to the creation of the partial fusion, consisted of three parts, which were as follows: (i) Endogenous clinical picture, or what was referred to in the 1970s as endogenomorphic depression; (ii) the presence of a clinical picture that was characterized by increased severity, occasionally hallucinations or delusions, diurnal variation with morning worsening, delayed insomnia with early-morning waking, greater somatic disturbances such as loss of appetite and weight, psychomotor retardation or agitation; (iii) the absence of life<sup>85</sup>.

Endogenous depression and psychotic depression have developed into two distinct notions throughout the course of time. The official classification system recognizes psychotic depression as a subtype of severe depression, where it has been since the inception of the system. It is possible for it to be characterized by the existence of delusions (particularly if they are mood-congruent) or hallucinations, which is proven by the fact that such depressions react better to

electroconvulsive therapy (ECT) or antipsychotic medicines than they do to antidepressants alone<sup>85</sup>. The endogenous depression and its antithesis are more complicated when it comes to the naming and classification status of the conditions. There is evidence to suggest that this is the case. Research on factor and cluster analysis was undertaken in the 1960s and 1970s, and in the majority of cases, this led to the discovery of a dimension or group. There are times when this aspect is more similar to the psychotic trait than it is to the melancholic trait, and vice versa. In spite of the variety of symptoms it encompasses, neurotic depression did not emerge as a distinct subgroup in any of these studies<sup>85</sup>. The endogenous group is responsible for the majority of cases of dexamethasone nonsuppression and other neuroendocrine abnormalities, such as growth hormone response to clonidine blunting and prolactin response to tryptophan blunting. The best response to electroconvulsive therapy (ECT) is related with psychomotor slowness as well as depressive delusions, all of which are symptoms of psychotic depression. There is a lack of consensus on whether or not the endogenous picture can be used to determine which cases of depression respond favorably to medication rather than a placebo. The boundaries are unclear, mixed cases are common, and component distributions do not consistently and convincingly demonstrate bimodality, which would indicate disease separation. Boundaries are fragile, mixed cases are common, and component distributions do not demonstrate disease separation. The field is hampered by its relationship to severity, its ambiguous language, and the close proximity between melancholia and psychotic depression<sup>85</sup>. The terminology has not been altered in any way. Due to its subtle variety of meanings, previous associations with psychoanalysis, and earlier emphasis on personality and character-related issues, the term "neurotic" has fallen out of favor, particularly in American psychiatry. This is particularly true of the term. Historically, dysthymia was considered to be a mood illness due to the fact that it is a persistent condition that was once

thought to be a form of neurotic depression. In a similar vein, the term "cyclothymic personality" has been replaced by the phrase "cyclothymic disorder," which refers to a kind of mood-related bipolar illness. The term endogenous has been removed from official classification schemes because it is now understood to be a symptom syndrome<sup>85, 86</sup>. The term "melancholia" as it is used in the DSM-III and its predecessors will become neutral once its historical connotation of "black bile" has been eradicated. It seems to be preferred over the word for somatic depression that is used in ICD-10 because it is simpler to use in English and may be readily translated into the adjective gloomy. The term "somatic depression" can also be used to refer to something totally distinct that is connected with somatization or somatic sickness. Despite the fact that it is still regularly debated in research and literature, it is uncertain whether this classification will survive impending updates of the official schemes in the coming years. These updates are expected to occur in the coming years. Recent months have seen the presentation of a convincing case for its continued existence<sup>85, 86</sup>.

The significance of one's geographic location in relation to this distinction has undergone a drastic transformation. Life stress was a crucial component of older depression theories, both endogenous and non-endogenous, and played a role in both. The distinction is currently made on the basis of the symptom patterns, as opposed to the variables that determine the causes<sup>85</sup>. According to the findings of studies, there is not much of a correlation between the markers of life experience and the frequency of depressive symptoms. Even while life stress is a common trigger for depressive episodes, this factor alone is rarely adequate to provide a complete explanation for the episode, which is why it is necessary for there to be involvement from other causes. In three of our own tests, including two in which the data on symptoms and life events were collected by different interviewers, we discovered that there was only a tenuous correlation

between the two factors. A number of studies that compared patients who had the symptom pattern to patients who did not have the pattern found very little difference between the two groups when it came to the frequency of stressful life events that occurred before the onset of symptoms. There are potential for differentiation once depressive episodes become severe and occur on a regular basis. When applied to a sample of depressed females, a melancholic/psychotic score that was based on the prevalence and severity of biochemical and psychotic symptoms revealed that severe life events were significantly less likely to occur in the melancholic/psychotic group. When following occurrences were taken into consideration, only then did it become clear that this significant disparity existed. In a different study involving people with severely recurrent depression, it was discovered that endogenous research diagnostic criteria subtypes, which depend on symptom features, had fewer life events than non-endogenous subtypes did<sup>85, 86</sup>.

### **2.6.3.2 Severity and Minor Depression**

The gravity of the problem requires further thought and evaluation. In ICD-10, it has been upgraded to the status of a significant factor. It is useful as a criterion for episodes given that the severity of the depression has an effect on treatment and that severe depressions often result in worse outcomes than moderate depressions. It is not widely known that a moderate depressive episode according to the ICD-10 is not even close to being considered a mild episode in practice, at least not according to the Research Criteria<sup>85</sup>. Individual symptom classifications and the absence of certain symptoms from the list suggest that individuals who match these criteria often have enough depression to be categorized as major depressives by the DSM-IV. This is supported by the fact that the DSM-IV does not include certain symptoms. In addition to this, the threshold that is utilized to differentiate between serious depression and typical mood changes

has been raised as a result of this. Even though it is determined by the number of symptoms that are present, it is not well-defined because it is difficult to determine when a symptom, especially a daily one, reaches a severe enough condition to be called present. The number of symptoms that are present is what determines whether or not it is present. Even while the problem is not urgent in the clinic, its significance has increased as psychiatric research has become more inclusive of community epidemiology<sup>85</sup>. Studies on the prevalence of depression in communities show that its rates are relatively high. It is not known whether these depressions adequately mirror the characteristics of depression that present themselves for therapy in a medical or psychiatric setting. When conducting research, the use of "symptomatic volunteers" raises similar concerns. Numerous studies have been conducted to investigate the DSM's criteria for clinical depression. This provides evidence in support of the legitimacy of accumulating symptoms; nevertheless, it is questionable as to whether there is a genuine threshold as opposed to a largely arbitrary cutoff on a continuum that may be a little bit too high. When compared to placebo, tricyclic antidepressants begin to perform better in terms of treatment response at a severity level that is somewhat below the cutoff for serious depression. There is a possibility that serotonin reuptake inhibitors number will lower the response threshold<sup>85</sup>.

### **2.6.3.3 Single Depressive Episode versus Recurrent Depression**

The ICD-10 distinction between a single sad episode and recurrent depression is a sharp one, however it is not beneficial to draw this distinction. When considering how infrequently affective illness has traditionally made use of it, its inclusion in ICD-10 came as a bit of a surprise to some people. Unfortunately, the distinction is not meaningful in light of what we have learned about the likelihood of a return of depression over the course of the past 15 years<sup>85</sup>. If a high number of individuals who have their first depressive episode go on to experience numerous episodes

and are later classed as having recurrent depression, then the distinction loses its importance. There is not much of a difference between first depressive episodes and recurrences in terms of other aspects, except for the fact that when the depression has become fairly recurring, the role of life stress becomes less important, the response to therapy becomes weaker, and the risk of recurrence becomes higher. Other than this, there is not much that differentiates first depressive episodes from recurrences <sup>85</sup>. There has been a significant shift in the conceptualization of depression over the course of the past thirty years. In the 1960s and early 1970s, people believed that the condition was episodic, meaning that it would go into total remission and then rarely come back. Since then, follow-up studies of depressive patients who had been hospitalized have showed that at least sixty percent will be readmitted over a period of sixteen years, and rates for recurrence of episodes of any severity that do not necessarily require hospital admission may approach ninety percent. We do not yet know if this holds true for less severe episodes of depression that take place outside of a hospital, and it is likely that many solitary episodes linked to stress take place at the community level. On the other hand, major depression is undeniably a condition that can occur more than once. Due to the possibility of incomplete and partial remission, as well as the prevalence of mild and sub-syndromal disorder in the community, which may ultimately be followed by major episodes, it is now widely accepted to view depression as frequently a chronic disorder that encompasses and varies through a spectrum or continuum. This is because of the possibility that major episodes will ultimately follow milder and sub-syndromal episodes <sup>85</sup>.

Other subtypes: There are also more subtypes to consider. They were not included in any of the previous editions of the DSM, including ICD-10. Given the necessity of avoiding the congestion of formal classifications with the fleeting, this makes a certain amount of sense. The problem is

that many of them are known to be effective and are utilized often by medical professionals, yet there is nowhere to register them. There are a few in the DSM-IV that aren't categorized and seem to be viewed with some apprehension from a clinical perspective. In addition to the subtypes that have been discussed thus far and those that are relevant to the content of the course, the DSM-IV specifiers comprise a total of four different subtypes. The first type is known as postpartum depression<sup>85</sup>. Even while this issue is not limited to mental diseases, it nevertheless has the potential to be severe. Academics and other parties interested in postpartum disorders are currently facing a huge challenge: there is no approved method of registering the disease. It is not possible to ascertain the prevalence of the conditions being treated. It is not possible to use diagnostic information that has been coded in order to identify participants from the past for the purposes of follow-up or other investigations<sup>85</sup>. The ICD-10 has a category (F53) for mental disorders that are associated with pregnancy; however, this category should only be utilized in the event that the criteria for the other diseases are not satisfied. In addition, there is a qualification that is exclusively used in research criteria to indicate disorders related to the puerperium; however, because it is not included in clinical standards, very few people are aware of it. This is because the qualification is not included in clinical standards. There is a non-coded specifier for postpartum onset in the DSM-IV, but it is only applicable to major depression, mania, mixed episodes, or brief psychotic disorder, and the onset criteria of within 4 weeks of delivery is too short. Additionally, the DSM-IV does not include a definition for postpartum psychosis. Case registration data and the findings of other studies indicate that there is currently an increase in onsets that may linger for as long as three months. It is necessary to provide a specifier that can be utilized for any ailment, that can be labeled, and that connects to the onset in the first three postpartum months. In the future, this should be given a high priority in terms of

inclusion. The second qualifying factor is a seasonal affective disorder. In recent years, there has been a lot of research done on SAD and the therapies for it. It is long past due for the relevant authorities to assign a classification to it. Atypical depression, which is marked by increased appetite, tiredness, and other symptoms, has been given a third specifier in the DSM-IV. In this particular instance, there are valid arguments that can be given for both including and excluding something. William Sargent and his coworkers at St. Thomas' Hospital in London are credited as being the ones who initially conceived up the concept. The meaning of the phrase has evolved over the course of time. Rather than emphasizing vegetative symptoms that are directed in the opposite direction from how they typically manifest in endogenous depression, the more recent interpretation places emphasis on non-endogenous depression and later, depression combined with anxiety disorder or anxiety disorder alone. This is in contrast to the early proponents of the term who likely had in mind non-endogenous depression. The concept has traditionally been linked to how well people respond to monoamine oxidase inhibitors (MAOIs). However, there is only a small amount of evidence that atypical depression as it is now defined is connected to a good MAOI response. This evidence comes primarily from one highly regarded research group in the United States <sup>85</sup>. Other findings would suggest to patients who are worried or fearful, but in general, selectivity seems to be lacking. When administered in sufficient quantities, there is evidence to suggest that MAOIs are beneficial in treating a wide variety of depressive disorders. The word does not appear to be used nearly as frequently by clinicians these days as it was in the 1960s and 1970s, at least not in Europe, which may be an indication that its significance is decreasing. The investigation into it is also quite significant. The existence of catatonic symptoms is the fourth specifier that can be used with the DSM-IV. This is rather strange, and it doesn't seem to fit in with the majority of the earlier material at all. In spite of the fact that the

meaning is not entirely obvious, it seems that a significant chunk of the description is suggestive of psychomotor retardation. In spite of the fact that retarded depression has been around for a long time, it has not been shown to be an extremely helpful classification, and it is not particularly stable between episodes. If we did away with this subtype, it would not affect anything negatively <sup>85</sup>. The DSM-IV includes additional preliminary classifications in the appendix of the manual. Since its introduction, which was met with a great deal of enthusiasm but, as time has gone on, has shown that it is not particularly beneficial, the inclusion of recurrent brief depression in the DSM-5 has not been defended, and the disorder consequently receives less focus. The contemporary conceptions of co-morbidity and having two diagnoses make it straightforward to manage mixed anxiety and depression, despite the fact that mixed anxiety and depression are common. Due to the fact that premenstrual dysphoric disorder is not exclusively a depressive disorder, the topic is not included in this review <sup>85</sup>.

#### **2.6.3.4 Transcultural Aspects of Depression**

The Western world and the 20th century are primarily responsible for the development of the modern understanding of depression. This understanding places a significant emphasis on psychological states. Before the beginning of the modern age, Western beliefs had a smaller emphasis on the psychological. Different languages and cultures place an emphasis on a variety of qualities. It was often thought that people from Western culture were more likely to suffer from mood problems than people from other cultures, such as African culture <sup>85</sup>. In general, it seems that this is no longer the case, which is likely because Western psychiatrists were unable to identify the disorder in other cultural and linguistic groups when it was prevalent in those communities. When evaluated by local psychiatrists who are familiar with the culture, language, and metaphors used to express mood, mood disorders might give the impression of being

widespread. It is extremely difficult to verify the equivalence of translated questionnaires and interview instruments, so the rates may vary significantly <sup>85</sup>. However, the exact range of possible variations is unknown at this time. There are multiple possible presentations. Body symptoms are quite prevalent in Zimbabwean people because there is no Zimbabwean phrase that immediately translates to "depression." In a similar vein, it's possible that Chinese subject presentations are more somatic, although there's evidence to suggest that this shifts as people become more Westernized. Hong Kong has shown reduced rates of depression and increased rates of anxiety, which may imply a rerouting of symptoms in comparison to previous epidemiological studies from the United States and other Western nations <sup>85</sup>.

There is also the possibility that other diseases that are specific to one or more cultures could be considered the cultural counterparts of depression. It can be challenging to demonstrate an equivalent level of depression in those who do not have depression. To believe, on the other hand, that these challenges are less significant than those experienced in Western civilizations would be a naive assumption. There is a possibility that there are other non-Western subtypes that are significant enough to merit their inclusion in global diagnostic approaches <sup>85</sup>.

A multitude of intricate ideas are involved with depression. They have developed throughout the course of time, and as a consequence, their definitions have frequently undergone minor adjustments as a result, which is typical in the field of psychiatry. The primary aspects and boundaries of the condition, in addition to their respective functional meanings, are at this point well established <sup>85</sup>. The distinction between bipolar disorder and unipolar disorder was a significant step forward, despite the fact that there are still problems with classification. Because depression is the most prevalent psychiatric condition seen by both psychiatrists and general

practitioners, it is essential to have an understanding of the factors that contribute to its development <sup>85</sup>.

### **2.7.1 Determinants of Depression**

Psychological factors- Depression is linked to psychological factors (including mastery, self-esteem, optimism, negative self-image, current or past mental health conditions, and various other aspects, including neuroticism, brooding, conflict, negative thinking, insight, cognitive fusion, emotional clarity, rumination, dysfunctional attitudes, interpretation bias, and attachment style <sup>87</sup>.

Self-esteem is our opinion of ourselves. We tend to feel better about ourselves and about life in general when we have healthy self-esteem. It improves our ability to deal with life's ups and downs <sup>88</sup>. People who have low self-esteem tend to view themselves and their lives in a more negative and critical light. They also feel less capable of dealing with life's challenges. Low self-esteem frequently begins in childhood. Teachers, friends, siblings, parents, and even the media send us mixed messages about ourselves. For some reason, the message that you are not good enough is the one that sticks with us <sup>88</sup>. Perhaps we struggled to meet other people's or our own expectations. Stress and difficult life events, such as serious illness or bereavement, can have a negative impact on self-esteem. Personality can also play a role. Some people are simply more prone to negative thinking, while others set impossible goals for themselves <sup>88</sup>.

If you lack self-esteem or confidence, you may withdraw from social situations, stop trying new things, and avoid things that are difficult for you. Avoiding challenging and difficult situations may make you feel safe in the short term. This can backfire in the long run by reinforcing your underlying doubts and fears <sup>88</sup>. It instills the unhelpful belief that the only way to cope is to avoid

situations. Living with low self-esteem can have a negative impact on your mental health and lead to issues like depression and anxiety. As a coping mechanism, you may develop unhelpful habits, such as smoking and drinking excessively <sup>88</sup>.

A large-scale review of the links between self-esteem and depression conducted by Swiss researchers Julia Friedrike Sowislo and Ulrich Orth compiled data from 95 studies with samples ranging from children to the elderly. The findings demonstrated that, regardless of gender or age, the effects of low self-esteem on depression were significantly greater than those of depression on self-esteem <sup>89</sup>. The researchers believe that people with low self-esteem are more likely to replay and focus on negative thoughts than people with high self-esteem, putting them at a higher risk of depression. Those with low self-esteem may also encourage others to give them negative feedback, making matters worse for themselves <sup>89</sup>.

Optimism is a way of thinking that involves expecting good things in life. When people face difficulties, optimistic thinking has a direct impact on how they feel about themselves. Even in difficult situations, optimistic people expect good outcomes. The effects of optimism go beyond simply making a person feel better; they also provide an important potential for what people can do when faced with problems. Numerous studies have linked optimism to physical disorders. According to these studies, optimists exhibit more self-care and physical well-being, as well as less pain in chronic illnesses, than pessimists <sup>90</sup>. At the most basic level, optimism is inversely proportional to hopelessness, which is a risk factor for depressive disorders and recognized as a clinical psychology condition. The effects of optimism were sequentially mediated by cognitive and behavioral variables <sup>90</sup>.

Neuroticism, as a relatively stable long-term personality trait, is most closely associated with negative emotions. People with higher levels of neuroticism frequently experience stress reactions accompanied by negative emotions, as well as the long-term consequences of these negative emotions. Several studies have found a link between neuroticism and depressive symptoms and anxiety<sup>91</sup>.

Brooding is a particularly toxic kind of rumination, and it's strongly associated with clinical depression. The self-focus of brooders prevents any genuine attempt to improve circumstances since they perceive their own issues as crippling. It triggers a wide range of unfavorable emotions, which in turn trigger additional ruminative thinking, resulting in a dangerous feedback loop of thought and emotion<sup>92</sup>.

An innovative therapy for depression deals with the internal conflicts that patients have, such as the struggle between two sides of their personalities (such as "I prefer to feel good than happy"). The person who experiences these conflicts, also known as implicative dilemmas (ID), typically conceals them since they are unaware of them<sup>93</sup>. According to Adrián Montesano's research, those who successfully complete these ID and create narrative reconstructions about themselves are the ones that have less depression-related symptoms. Regardless of the medication or psychological therapy the patient is receiving, professionals must pay attention to the patient's internal conflicts when dealing with cases where depression symptoms persist, according to Montesano<sup>93</sup>.

Rumination has been suggested as both a mediator and a depressive risk factor. When considered as a risk factor, it seems that the connection between rumination and depression is mediated by elements like poor problem-solving skills and a lack of social support. Rumination,

particularly brooding rumination, appears to function as a mediator in the relationship between poor attentional control and depression, for instance. This demonstrates that determinants may take on numerous forms, such as moderators or mediators, risk factors or outcomes, and this is why it can be difficult to separate the various components associated with depression from one another<sup>87, 94, 95, 96</sup>.

Biological factors such as dysregulation of the neuro-endocrine and/or immune systems, and genetics are determinants of depression person who has a parent or sibling with depression has 2 or 3 times greater risk of developing depression compared with the average person (or around 20-30% instead of 10%<sup>87</sup>.

The social determinants of (mental) health, or the circumstances under which people are born, live, learn, work, play, and age, were also the subject of studies. These factors have a big impact on happiness. Age, social or socioeconomic status, social support, financial stress and deprivation, food insecurity, education, employment status, living arrangements, marital status, race, exposure to violent crime as a child, abuse, discrimination, (self)-stigma, ethnicity, and immigrant status, as well as working conditions, adverse or significant life events, illiteracy or health literacy, environmental events, job strain, and the built environment, have all been identified as contributing factors. Structured social capital and social support have also been recognized as determinants<sup>87, 97, 98, 99</sup>.

.Bullying and Depression- Depression can develop as a result of bullying and can have a lasting impact on a child. Bullying is an unwanted or aggressive behavior inflicted by someone who intends to harm or coerce<sup>100, 101</sup>. A bully will use three main avenues: Physical bullying- Physicality is used to assert control. This can be anything from hitting to shoving someone in a

locker or a trash can. Any time someone uses physical force in an aggressive manner, it's considered bullying. If the person being touched doesn't want to be touched and hasn't offered consent, it is off limits in school <sup>101</sup>. Verbal bullying- Verbal bullying can be incredibly harmful to a child's self-esteem, self-worth, and self-confidence. It can be in the form of name-calling, teasing, manipulating, or threatening. Teachers and parents can't always see this happening. Cyberbullying- Cyberbullying has become the most common form of intimidation. It's also the easiest with social media providing the perfect platform. Cyberbullying can look like demeaning photos, cruel comments, hacking into someone's account, sharing personal information with others, and more <sup>101</sup>.

Being bullied during adolescence is common, According to the Centers for Disease Control and Prevention, one in six students will experience bullying on and off school property <sup>101</sup>. The distressing and preventable experience has been associated with mental illness, substance misuse, and suicide risk in adulthood <sup>100</sup>. Bullying is linked to mental health problems like anxiety, depressive and somatic symptoms and can have negative consequences on both an individual and a societal level <sup>102</sup>. Childhood and adolescence are raw times for most people. This is the case even if bullying is not present. The brain isn't fully formed yet, and children are still learning about how to interact with the world around them. They're at an age where they're unsure of who they are, what they stand for, and what matters to them. This makes them particularly vulnerable when it comes to criticism <sup>101</sup>.

The urge to "fit in" is also strong in children and teens. They place a lot of pressure on what their peers think of them. When their self-image is threatened through bullying, a child might feel like they've failed. They might focus less on their schoolwork and more on getting others to like them. This can lead to a drop in grades, which also affects their sense of self-esteem <sup>101</sup>.

Victims of bullying often experience a “snowball effect” of emotions and actions. In the beginning, they might feel confused or hurt. As the bullying increases in frequency, the victim might begin to feel enraged, worthless, and sometimes eventually depressed<sup>101</sup>. While bullying can leave a child with physical bruises that will eventually heal, bullying can also result in long-term behavioral health issues.

Children that experience verbal and physical bullying are at a greater risk of developing depression than children who do not experience bullying. One study found that the consequences of childhood bullying, including depression, can persist even 40 years after the bullying occurred. Depression that results from bullying can cause a wide range of symptoms, and in extreme circumstances, bullying-induced depression can lead to suicide<sup>103</sup>.

### **2.8.1 Mental Health Policies in Nigeria**

Nigeria's first mental health law was enacted in 1916. The statute was renamed the insanity Act of 1958 after it was modified in 1958 to provide judges and medical professionals the power to confine anyone who had a mental condition<sup>104</sup>. In 1991, Nigeria's first mental health policy was created. The elements of it are promotion, prevention, treatment, and rehabilitation<sup>105</sup>.

Sen. Ibiabuye Martyns Yellowe and Dalhatu Tafida submitted a measure in 2003 to create the Mental Health Act, but it was subsequently withdrawn in April 2009 after no considerable progress<sup>104</sup>. The bill was re-introduced to the National Assembly by Hon. Samuel Babatunde Adejare and Hon on March 20, 2013, Solomon Olamilekan Adeola<sup>106</sup>.

The bill was proposed to protect the rights of persons with mental disorders, ensure equal access to treatment and care, discourage stigma and discrimination and set standards for psychiatric

practice in Nigeria. The bill makes provisions for access to mental healthcare and services, Voluntary and involuntary treatment, accreditation of professional and facilities, Law enforcement and other judicial issues for people with mental illness, mechanisms to oversee involuntary admission and mechanism to implement the provision of Mental health Legislations, The bill was also not enacted <sup>105</sup>.

Senator Ibrahim Oloriegbe, who represents Kwara Central Senatorial District in the 9th National Assembly, sponsored a second mental health bill in 2019. The bill, titled the Mental and Substance Abuse Bill, was put forth to address the establishment and regulation of mental health and substance abuse services, to protect the rights of people with mental health issues, and to create a commission for mental health. The bill had a public hearing on February 19, 2020, and since then, no new developments have been noted <sup>104</sup>.

## **2.2 Theoretical Framework**

### **2.2.1 Behaviorist Theory of Depression**

The environment's significance in influencing behavior is emphasized by behaviorism. Focus is placed on observable behavior and the circumstances in which people pick up new behaviors, namely classical conditioning, operant conditioning, and social learning theory. Therefore, a person's interaction with their environment contributes to depression <sup>107</sup>.

The behavioral approach holds that unfit or unfavourable behavior, like depression, is learnt. According to behavioral psychologists, depression can be unlearned because it is a learned behavior. Peter Lewinsohn made the claim that depression is brought on by a confluence of environmental stressors and a deficiency in interpersonal skills in the middle of the 1970s. More specifically, a person has a low rate of positive reinforcement as a result of environmental stresses. When people accomplish something they find enjoyable and gratifying, positive reinforcement happens. The learning theory states that obtaining positive reinforcement enhances the likelihood that people would repeat the kinds of behaviors that earned them that reinforcement <sup>107</sup>. To put it another way, people tend to repeat activities that are rewarded. For instance, many people regularly attend work in order to obtain compensation or insurance benefits. The majority of academically inclined kids study to assure that they will continue to get good grades. In these instances, earning money, receiving perks, and getting good marks all serve as motivators for working and studying.

Lewinsohn asserts that individuals who experience depression are specifically those who struggle with adjusting to the loss of prior positive reinforcement. For instance, a youngster who recently relocated to a new house and as a result lost connection with old friends may lack the social abilities needed to quickly make new acquaintances and may experience depression <sup>108</sup>. In

a similar vein, a man who has lost his job and has trouble obtaining another one may experience depression. Additionally, persons who are sad frequently have an increased awareness of their lack of coping mechanisms, which makes them more likely to blame themselves and isolate themselves from other people (e.g., depressed people may avoid social functions and get even less positive reinforcement than before) <sup>108</sup>. To make matters worse, when family members and social networks feel sorry for them and give them more support because they are "ill," some depressed people start to act depressed, which reinforces their behavior. For instance, some spouses may start doing their partners' duties while the depressed person is still in bed out of compassion for their relationships. Being depressed to avoid having to do such activities could start to seem rewarding if the depressed person wasn't happy to be doing them in the first place. According to research, Lewinsohn's theory may explain the onset of depression in some people, but not in all <sup>108</sup>. In the past, behaviorists primarily concentrated on people's external, directly observable, and measurable behavior and paid little attention to their ideas, perceptions, assessments, or expectations. Not because they were unaware of these inner sentiments and thoughts, but rather because they believed they were largely unimportant to the process of influencing behavior and were too challenging to quantify accurately. In the end, this position was found to be too excessive. Recent studies have demonstrated that internal factors including perceptions, expectations, beliefs, attitudes, self- and other-evaluations, anxieties, desires, etc., do influence behavior and should be taken into account when providing therapy. Because of this, traditional "strict" behavioral techniques to treating depression are no longer as common as they once were <sup>108</sup>.

### 2.2.2 Psychodynamic Theory

In psychiatry and a large portion of clinical psychology in the early 1900s, psychodynamic theory was the dominant school of thinking. It influenced opinions on the best way to carry out therapy <sup>107</sup>. Early theories centered on how the mind interacts with mental, emotional, or motivational forces to develop personality. Psychodynamic theory and psychoanalysis are credited to Dr. Sigmund Freud. He postulated a three-part division of the unconscious mind <sup>108</sup>.

These components comprise:

Id is the region of the brain that is illogical and impulsive and represents instinctual animal desires.

Super-ego, or the judgemental aspect of the ego that serves as a mental representation of social norms

The reasoning portion of the ego works to connect the other two parts.

Freud believed that there could be tension between the aware and unconscious aspects of the mind. Repression results as a result. When you are experiencing repression, you don't even realize that you have certain unsettling motivations, wishes, or goals, yet they nonetheless have a detrimental impact on you. Psychodynamic theories generally claim that in order to overcome repression and reach mental health, a person must successfully settle early developmental issues <sup>107</sup>. Gaining respect, love, thriving in interpersonal interactions, and managing bodily functions are a few examples of these conflicts. A failure to address these conflicts is mental disease. Numerous explanations that fall under the "roof" of psychodynamic theory explain why someone experiences depressive symptoms. In the past, psychoanalysts held that sadness was a result of anger that had been internalized and turned against oneself <sup>107</sup>. To further illuminate this

hypothesis, a typical illustration of how this change was imagined to proceed is suggested. An unpredictable, hostile environment for a child is produced by neurotic parents who are inconsistent (both overindulgent and demanding), lacking in warmth, insensitive, furious, or motivated by their own selfish wants. The child consequently feels isolated, perplexed, powerless, and angry<sup>107</sup>. The kid is aware that the strong parents are the only ones who can keep him or her alive, though. The child repressed their anger toward the parents and turned it within, so that it became an anger aimed towards him or herself, out of fear, love, and guilt. A "despised" sense of oneself emerges. Thinking along the lines of "I am an unlovable and bad person" feels comfortable to the child. In order to deal with perceived flaws that render him or her "unacceptable," the child likewise works to portray a flawless, idealized picture to the parents<sup>85</sup>. The youngster "goes neurotic" because they are torn between the need to act flawlessly to win their parents' affection and the perception that they are unlovable. This implies that they will probably feel extremely nervous or depressed<sup>107</sup>. No matter how hard the child tries, he or she is constantly aware that they are not good enough. This obsessive urge to be liked and persistent inability to be liked can readily expand outside of the context in which it first occurs. A neurotic demand to be adored by everyone, including all friends, family members, coworkers, etc., could develop in the child. Traditional psychodynamic treatment may aim to assist the adult child in understanding the false assumptions that underlie views about goodness and inadequacy, so reducing the desire to punish oneself and strive for perfection<sup>107</sup>. The long history of psychodynamic theory has seen changes. Today, there are numerous modifications of the basic theory. The term "object relations theory" refers to a popular subfield of contemporary psychodynamic theory. This theory explores how individuals conceptualize and visualize their interpersonal connections. In the notion of object relations, persons are represented as "objects"

<sup>107</sup>. Each person experiences, represents, and remembers other people in this way. According to object relations theory, relationships are the only way to fully comprehend a person's emotions, moods, and many other facets of their personalities <sup>107</sup>. Early partnerships tend to set the tone for later relationships, which is a fundamental tenet of the idea. This hypothesis contends that people's difficulties creating accurate pictures of healthy relationships are what lead to depression. Depression is a result of the continual effort depression sufferers go through to keep emotional contact with wanted objects. The anaclitic pattern and the introjective pattern are the two fundamental methods in which this process can proceed. Some therapists could continue to use these categories to categorize various forms of depression even if they are not currently used in the DSM <sup>107</sup>. An individual with anaclitic depression experiences a sense of need on interpersonal connections. They feel sorrow about the potential or actual loss of those connections. This kind is brought on by the breakdown of a caregiver-primary object relationship. It is distinguished by a sense of weakness and powerlessness <sup>107</sup>. An anaclitic depressed person fights fiercely to retain direct physical contact with the thing that satisfies their needs and has severe worries of being abandoned <sup>107</sup>. When a person believes they have failed to live up to their own expectations or the standards of significant others, they may experience introjective despair. This kind results from a severe, relentless, extremely critical superego that instills feelings of failure, guilt, and worthlessness. An individual with introjective depression has crippling anxieties of losing the love, respect, and approval of a wanted object. Psychodynamic theories have always faced harsh criticism for not being eager to put their theories to the test <sup>107</sup>. The term "lack of empiricism" describes this. Recently, though, things have started to shift. Coyne's interpersonal theory of depression, a contemporary variation of psychodynamic theory, has received substantial research. It serves as the foundation for Interpersonal Therapy, or IPT, a

very successful therapeutic approach. Interpersonal theory claims that a depressed person exhibits unfavorable interpersonal traits that make other people reject them. People with depression go through an intensifying cycle where they start to ask for reassurance from others more and more frequently <sup>107</sup>. When these requests are made, the other people either start to think poorly about, shun, and reject the depressed individuals, or they develop depression themselves. As a result of other people's rejection and avoidance of them, the depressive person's symptoms then begin to worsen. People with depression can escape this vicious cycle with the aid of interpersonal therapy <sup>107</sup>.

### **3.2.3 Cognitive Theories of Depression**

The failure of the early behaviorists to take ideas and feelings seriously led to the development of cognitive theories. The cognitive group did not, however, disagree with behavioral principles. These ideas, however, sought to incorporate mental occurrences into the behavioral framework. Cognitive behavioral theories focus on mental processes like thinking and feeling, they are frequently referred to as "cognitive theories." Since they take into account the mental occurrences within the framework of the learning theory, which served as the foundation for the pure behavioral theory, they are referred to as "cognitive behavioral." It serves as the cornerstone of Cognitive Behavioral Therapy (CBT), the most prevalent and well studied type of psychotherapy now available. According to cognitive behavioral theorists, depression is caused by erroneous perceptions and thoughts <sup>109</sup>. These can be picked up socially, as is the case when kids in a dysfunctional home observe their parents struggle to handle traumatic or stressful situations. A lack of experiences that would have allowed for the development of adaptive coping mechanisms could also be the cause. The cognitive behavioral theory asserts that persons who are depressed think in a different way than those who are not sad. They feel melancholy as a

result of this mental difference. For instance, those who are depressed often have a pessimistic outlook on the future, their surroundings, and themselves. They frequently misinterpret facts in negative ways as a result <sup>109</sup>. They also have a propensity to take responsibility for any bad things that occur. It is simple for people with depression to perceive situations as being much worse than they actually are due to their negative thinking and judgmental tendencies. This raises the possibility that these individuals will exhibit depressive symptoms in response to trying circumstances <sup>109</sup>.

### **3.2.6 Bandura's Social Cognitive Theory of Depression**

According to the social cognitive theory (SCT), of psychologist Albert Bandura, a person's behaviors, thoughts, and environment interact to shape who they are. The shape of each puzzle piece can and does influence the shape of the others. Learning ultimately has a big role in shaping human behavior, both direct experience and observation can be used to gain this skill <sup>109</sup>.

Bandura emphasized that individuals with depression have distinct self-concepts than those who do not. People who are depressed often blame themselves heavily for the negative things that happen in their lives. Successes, in contrast, are frequently perceived as the result of uncontrollable outside forces. Additionally, self-efficacy, or the conviction that one can affect one's circumstances, tends to be poor in depressed individuals <sup>109</sup>. People who suffer from depression sometimes set their own goals too high and fail to achieve them because they also have a defective judgement process. Repeated failure worsens people's emotions that they can't alter anything and promotes depression. The locus of control concept developed by Julian Rotter is a crucial psychological topic that is connected to Bandura's notion of self-efficacy. People who have an internal locus of control and a comparatively strong feeling of self-efficacy are said to

have a belief that they can influence and modify their circumstances <sup>109</sup>. People have an external locus of control and a generally low feeling of self-efficacy when they believe that they are mostly at the whim of their surroundings and powerless to change it. To elaborate on the foregoing concept, individuals with depression typically have a low sense of self-worth and an external locus of control <sup>109</sup>.

### **3.2.7 Seligman's Learned Helplessness**

Martin Seligman, a psychologist, and his colleagues "accidentally" found a scenario connected to human depression in 1965. They were researching how fear and canine learning interacted. Observations were made on what transpired when a dog was permitted to avoid an imminent, harmful but non-damaging electrical shock <sup>109</sup>. If they left a specified region of their pen after hearing a tone, they wouldn't experience the shock. In the first experiment, the researcher struck a bell just before the dog experienced a fleeting, mildly unpleasant sensation. The plan was to teach the dog to connect the tone with the shock. Future hearings of the bell would cause the dog to experience dread, causing it to flee or exhibit other fear-related behaviors.

The conditioned dog was placed into a box with two compartments separated by a low fence for the next phase of the studies after it had just learned that hearing the tone represents a warning for an impending shock <sup>109</sup>. The dog could readily see over and leap the barrier, but nothing happened when the researchers rang the bell and applied the shock. As the crew had anticipated, the dog did not jump the fence. Similar to this, nothing happened when they shocked the trained dog without the bell. The dog did nothing but lay down in both instances. When a regular dog was placed in the identical box system by the researchers, it leapt over the fence to the other side right away <sup>109</sup>. It appears that the dog was trained to learn more than only the relationship between tone and shock. It has also discovered that attempting to avoid the shocks is futile. The

dog therefore acquired the ability to be "helpless." Seligman's theory of learned helplessness was developed from this research. Then, using human behavior as a model, this theory was applied to explain depression <sup>109</sup>. Seligman contends that sadness has taught its victims to accept their helplessness. They don't think they have any control on their settings, or in other words, they believe that whatever they do will be futile. The original learned helplessness theory was helpful in explaining why some individuals developed depression, but it was unable to explain why many people did not get depression despite going through numerous painful life situations. With more research, Seligman changed his hypothesis to take into account a person's thinking style when predicting whether they would experience learned helplessness <sup>109</sup>. In contrast to those who were not depressed, he claimed that those with depression had a tendency to employ a more gloomy justification for stressful circumstances. The second group had a tendency to be more upbeat. Let's use the example of someone failing a math test to illustrate this. Such a person might respond by believing one of the following: I am stupid, I'm not good at math, I was unlucky because it was Friday the 13th, The math teacher hates me, The math teacher grades harshly, I was feeling under the weather that day, The math teacher gave a hard test this time, or I didn't have time to study <sup>109</sup>.

A gloomy outlook is characterized by a propensity to see internal, universal, and stable factors as the root causes of unfavorable events. A person with an optimistic outlook is one who tends to see external, particular, and unstable factors as the root of unpleasant events, pessimistic than optimistic styles are more prevalent in people who experience depression. The updated theory states that a gloomy outlook raises the risk of learning helplessness. Continual exposure to inevitable and unpredictable situations can also cause people to adopt a gloomy mindset <sup>108, 109</sup>. Even if they are not initially negative and unmotivated, they eventually become such. This idea

has been modified to claim that hopelessness as well as helplessness are both causes of depression. According to the despair theory, depression is caused by a way of thinking that leads people to blame themselves for bad things that happen to them in their lives, to assume that those things are always to blame, and to over-generalize certain flaws to various aspects of their lives. For instance, "My connection with my child is probably doomed since I am not a good mother because I am not good at creative things." Other cognitive behavioral theorists contend that those who exhibit "depressive" personality features are thought to be more susceptible to depression than other persons <sup>108, 109</sup>. Gloominess, introversion, excessive doubt and criticism of others, intense feelings of inadequacy, and excessive worrying are a few examples of depressive personality traits. Additionally, individuals who act angrily and impulsively on a frequent basis seem to be more susceptible to depression <sup>109</sup>.

### **3.2.8 Sociology of Depression – Effects of Culture**

People's ethnicity and culture are important factors in their health and illness. The role of culture, perception, and context in shaping someone's physical and mental health is the focus of ethno medicine, a new branch of medicine. Previously, it was assumed that depression primarily affected people in developed "Western" countries and that other cultures were immune to the condition <sup>109</sup>. According to ethnomedical studies, this idea may have more to do with cultural perceptions of what symptoms are labeled as a depressive disorder. It also has to do with how depression is recorded for statistical purposes and how depression is perceived in different cultures. In India, for example, a wide range of distress disorders are classified as depressive disorders <sup>109</sup>. However, in Japan, the concept of mental illness is frowned upon, and few people will admit to having it. Without knowing this, one might conclude that Indians suffer from a high rate of depression. They may also believe that people from Japan are unlikely to develop this

condition. Even within the United States, cultural context can influence the number of people suffering from depressive disorders. Black women, for example, have lower rates of depression than white women <sup>109</sup>. Furthermore, recent immigrants to the United States have lower rates of depression than others with presumably more "Western" attitudes and behaviors.

According to ethnomedical research, cultural differences in focusing on oneself and one's place within a social group are related to the amount of depression that occurs. Some of this difference stems from a culture's individualistic vs. collectivistic orientation. Individuals are ideally viewed in Western cultures as independent, separate people striving for individual achievement and success <sup>109</sup>. Other cultures, on the other hand, value the family or society over the individual. In such cultures, personal happiness is frequently sacrificed for the good of the larger group. Individuals within such cultures are given little consideration. In traditional Asian cultures, for example, it is common for one family member to work hard and share a paycheck with the entire extended family <sup>109</sup>. According to some authors, because people from collectivistic cultures are not encouraged to place a high value on personal gratification, they do not spend much time feeling frustrated about their lack of personal success. As a result, a lack of self-focus can lead to a reduction or absence of the development of depressive disorders. Our culture also shapes our rules regarding our specific responsibilities and obligations (to ourselves, others, and the institutions with which we live) <sup>108, 109</sup>. On the one hand, someone who comes from a culture where family obligations are expected and demanded may feel restricted, powerless, and limited.

A person from the same culture, on the other hand, may view family obligations as a way to feel needed, useful, and competent. People's self-concept and mood are shaped by their feelings and thoughts about powerlessness and usefulness. Gender roles are rigid in some cultures, and

expected behavior is defined <sup>108, 109</sup>. Men's lives exist primarily outside the home, whereas women's roles are primarily domestic. In these cultures, women are not permitted to leave their homes unless accompanied by a male family member, and men are not permitted to enter the kitchen. If someone from this culture is exposed to a social stressor that forces a change in roles or a challenge to this typical set-up (such as the death of a spouse), this stress can lead to depression <sup>108, 109</sup>. For example, if a husband (from a culture with rigid gender roles) loses his wife, he will be unable to care for his children's daily needs such as feeding, bathing, and so on. Similarly, if a wife loses her husband, she will not know how to provide financial support for her family and may be discouraged from even attempting to do so. If both parents are unable to meet their children's needs, they may begin to view themselves as worthless or useless <sup>109</sup>.

Cultural identity frequently influences the extent to which a specific individual exhibits physical symptoms of depression. In other words, some cultures are more comfortable reporting physical rather than mental depressive symptoms. Many Chinese people suffering from depression, for example, report bodily discomfort, feelings of inner pressure, and symptoms of pain, dizziness, and fatigue <sup>109</sup>. Similarly, Japanese people suffering from depression frequently complain of stomach, headache, and neck pain. Even in Western countries where depressive disorders are more "acceptable," some chronic conditions (chronic pain, fibromyalgia, chronic fatigue syndrome) may be more physical manifestations of a mood disorder than actual physical problems, according to researchers. Some researchers have even proposed classifying fibromyalgia (a condition characterized by widespread pain, tenderness, and fatigue) as a "depressive disorder spectrum." At the same time, it is important to note that depressive disorder can be caused by fibromyalgia <sup>109</sup>.

Some cultures may regard depression symptoms as normal emotional reactions to specific life events. Some cultures, for example, may expect the grieving process to last longer than the one-year period considered acceptable in the West <sup>109</sup>. Individuals from these cultures may find it strange that a Western psychologist would consider two years of mourning for a deceased spouse to be a sign of a mental health problem. Other cultures may recognize that depression symptoms are problematic. However, the causes that they believe are causing these symptoms do not make sense to people from other cultures. Patients, for example, may reject explanations for symptoms that are commonly accepted by clinicians in favor of explanations that are accepted within the patient's culture <sup>109</sup>. For example, a Chinese patient seen in a Western country may reject the idea that depression is caused by a chemical imbalance in the brain. Instead, they might accept an explanation based on energy flows or other traditional Chinese medicine concepts. These patients may respond best to mental health professionals who can describe the cause of symptoms and related suffering in culturally sensitive language <sup>109</sup>.

Cultural differences in help-seeking behavior may influence depression treatment. Non-Westerners, for example, frequently use practitioners from their own culture to treat "illness" and Western-trained physicians to treat "disease." People with depression may not seek mental health care for depressive symptoms if emotional disturbances are not considered within the scope of disease <sup>109</sup>. In Western societies, having a depressive disorder is more socially acceptable, and more people from these cultures are willing to seek help. Other cultures, on the other hand, frequently stigmatize mental illness. As a result, people and their families may deny mental illness in order to avoid being labeled as "crazy." Others may regard the term "major depressive disorder" as morally repugnant, shameful, and meaningless. Someone who comes from this culture may actively resist treatment for depressive disorders. Cultures also differ in how much

they rely on or incorporate complementary and alternative medicine practices such as herbs, meditation, yoga, or other approaches into prescribed depression treatments <sup>109</sup>. Individuals from some traditional cultures may reject Western antidepressant medications while accepting herbal, acupuncture, or exercise prescriptions. A person's biological makeup can also be influenced by their cultural background. People from different parts of the world have different gene patterns and, often, different disease patterns to which they are susceptible. These genetic differences can influence whether or not people experience depression when under stress. Antidepressant medication response can also be influenced by a person's genetic background <sup>109</sup>.

### **3.2.9 Cognitive Behavioral Therapy for Depression**

Two different individuals, Aaron Beck, a psychiatrist, and Albert Ellis, a clinical psychologist, independently invented the modern form of cognitive behavioral therapy (CBT). Around the same time, in the late 1950s and early 1960s, Beck and Ellis both started working on their respective interpretations of the therapy. Both variations of the therapy are based on the same fundamental principle, which states that people's cognitive processes, which include their thoughts and their predetermined judgments, occur first and are responsible for their emotional responses <sup>109</sup>. To put it another way, how people think about an event after it has occurred is the primary factor that affects how they feel about the event. People can develop depression when they get into the habit of viewing life's challenges and opportunities through a pessimistic and partial lens. As a direct consequence of this, they are almost always subjected to having bad sentiments and emotions.

To be more specific, cognitive behavioral therapists theorize that depression is brought on by a combination of an unhelpful dysfunctional thinking process and maladaptive habits that are triggered by that thought process. These two factors work together to bring about depression.

Because these beliefs and actions are learnt, persons who have depression can also learn new abilities that are more adaptable, which can enhance their mood and increase their capacity to cope with the inconveniences and stressors they face on a daily basis. Another fundamental principle behind CBT is the belief that if a person modifies their thoughts and behaviors, a more upbeat state of mind will naturally follow <sup>109</sup>.

The cognitive component of cognitive behavioral therapy (CBT) is gaining the ability to recognize erroneous patterns of thinking and to form judgments. These recurring ways of thinking are also referred to as negative or dysfunctional schemas, as well as basic beliefs. People's core beliefs are the primary assumptions they've made about themselves and the world, and these assumptions shape how people see both of these things. People become accustomed to thinking in these fundamental ways to the point that they cease noticing such methods of thinking and stop challenging them <sup>109</sup>. To put it another way, core beliefs are the unchallenged underlying themes that control the perceptions of a person who suffers from depression. A person who suffers from depression may, for instance, entertain the thoughts "I am unlovable" or "I am inadequate and useless." Because these ideas are not called into question, people act as though they are existing in the world and possessing the truth <sup>109</sup>. People's fundamental worldviews act as a prism through which they view the wider world. The formation of related attitudes, norms, and assumptions that are derived from core ideas is referred to as "intermediate beliefs," and it is influenced by the formation of core beliefs. People who suffer from depression often have fundamental ideas that are pessimistic and unreal, which, in turn, causes them to have a majority of thoughts that are pessimistic and unrealistic. Continuing with the previous illustration, a person who suffers from depression may come to believe that "It is horrible to be unloved," as our example demonstrated earlier, the rule that "I must satisfy everyone" and the

premise that "If I please everyone, then people will love me" could be considered part of the intermediate belief<sup>108,109</sup>.

People's "automatic thinking" can be influenced by their intermediate beliefs, which in turn might influence how they interpret a given scenario. These are the actual ideas or pictures that people find themselves experiencing when they wander through their minds. The term "automatic thoughts" refers to thoughts that come to mind in reaction to a specific circumstance. They are impromptu and not the product of analyzing a predicament or engaging in the logical deliberation that comes about when an individual focuses their attention<sup>109</sup>.

The majority of the time, we are completely oblivious to the fact that our minds are constantly producing thoughts that are known as automatic thoughts. This is not because they are things that happen without our conscious awareness; rather, it is because we have become so accustomed to them that we no longer notice them<sup>108, 109</sup>. Automatic thoughts have an effect on feelings as well as behaviors, and they can even trigger physical responses. To extend the previous illustration, if a friend of the person suffering from depression does not return a phone call, the person suffering from despair may conclude that their buddy dislikes them because they are not calling them back<sup>97</sup>. It's possible that she will never have the thought to come up with an alternative, less unreasonable explanation for the lack of a callback, such as "he must be really busy today." Because the natural idea that "he hates me" is not questioned, our sad person begins to feel disliked, and thus their depression level increases to<sup>109</sup>. Even though the automatic thoughts that individuals with depression have are completely distinct from one another, there are evident patterns of depressive automatic thoughts that are common in the minds of many people who have depression. The following is an example of a common pattern of negative and unreasonable automatic thoughts:

The act of constantly preparing oneself for the worst-case scenario is known as catastrophizing, for instance, someone who anticipates being reprimanded or dismissed when the supervisor makes a phone call.

Exaggerating the unpleasant features of an experience while downplaying or ignoring the favorable aspects is an example of filtering. As an illustration, a person may concentrate on the additional labor that was required for a promotion rather than on how pleasant it is to actually obtain the promotion.

The act of reflexively accepting blame when something unfavorable occurs despite the fact that you had nothing to do with the cause of the adverse event is known as personalizing. For instance, the person believes that "It's either because I'm a lousy friend or an extremely dull person that he didn't return my call. I was the reason why he did not call."

(Over) The act of perceiving individual upsetting incidents as evidence that all subsequent situations would be upsetting in the same way is known as generalizing. A person in this position can believe that having one poor day means that the rest of the week is wrecked even though it has just been one day.

The practice of viewing things in either black or white (all negative or all positive) terms rather than searching for the nuances of gray in between, for instance, rather than saying, "I need to study harder next time, but hey - I did quite decent regardless!" one can say, "I missed two questions on my exam, ergo I am stupid."

The act of allowing one's feelings about an event to take precedence over one's rational views about the events that took place during the event is known as emotionalizing. It's possible for someone to think to themselves, "I feel so stupid that it's evident that I'm a stupid person."

People develop dysfunctional beliefs through the development of dysfunctional thinking processes. They are illogical and have no foundation in the real world. They do not constitute an objective or impartial observation. In light of the fact that such ideas are not very well connected to reality, they have a tendency to appear very warped when contrasted with reality <sup>99</sup>. People typically have nothing except dysfunctional ideas to help them make sense of the things that occur in their lives, so they cling to those beliefs for dear life. The assumptions that are contained inside dysfunctional beliefs lead to the formation of snap judgments, which are referred to as cognitive appraisals. The eventual result of these evaluations is that they are prejudiced and unreasonable. People go to their own evaluations of the stressful situations they find themselves in to choose how they should react. When they do, they see that the circumstances appear to be simply terrible, even more so than they actually would look if some reality checks were carried out. They respond to what they perceive to be a real or imagined catastrophe, and then they feel the symptoms of depression <sup>109</sup>.

Activating experiences are situations that a person views as immediate sources of unhappiness, such as relationship problems, work stresses or dissatisfaction, memories of early childhood traumas, and other similar circumstances. These experiences are represented by the letter "A" in Ellis's theory. The letter "B" represents the illogical, self-defeating beliefs that are the root of the sadness that a person is experiencing. The letter "C" stands for "Consequences," which refers to the depressive symptoms and bad feelings that develop as a direct result of holding harmful beliefs. The cognitive therapist will point out that people's erroneous beliefs are the cause of their low mood, despite the fact that the activating experiences may have been traumatic or unpleasant. In other words, the problems that arise are not caused by the circumstances themselves but rather by the responses that individuals have to those circumstances <sup>108, 109</sup>.

Cognitive therapists will teach patients how to Dispute (for example, the "D step") the irrational beliefs that they hold in order for them to be able to develop positive psychological Effects (the "E step") of rational beliefs. This will take place during therapy sessions. Even though Ellis proposed the ABCDE method, a therapist who follows Aaron Beck's version of cognitive behavioral therapy (CBT) would instruct clients using much the same process. Cognitive behavioral therapists educate their patients to recognize irrational beliefs, argue against them, and then challenge and change them <sup>109</sup>. Teaching patients how to methodically ask and answer a set of questions aimed to pull out whether particular views have any basis is an important component of the disputing process. Questions such as "Is there any evidence for this belief?" are good examples of debating questions. What evidence is there that contradicts this belief? If you were to give up this notion, what would be the worst thing that might happen? What is the best that may possibly occur? Patients who have had CBT training for a number of sessions acquire how to check their own thoughts and carry out the arguing process independently outside of their scheduled therapy sessions <sup>109</sup>. In order to continue with our example, a cognitive therapist would take an automatic thought that was created by our individual with depression, such as "everyone hates me," and help her investigate the reason for why she thinks that way. It's possible that the therapist will inquire as to whether or not the patient's perception that she is unloved is literally accurate. He would push her to make a list of people who loved or liked her and give examples of those people. After then, he would explain that the notion that she is absolutely unlovable is not accurate and that, as a result, it is not something that should be taken seriously <sup>108, 109</sup>.

In the behavioral component of cognitive behavioral therapy (CBT), the goal is to replace habits that are contributing to depression with behaviors that are more beneficial. The therapist will

evaluate the patient to identify whether or not the issue is with the patient's behaviors or whether or not the patient appears to struggle with coping or other abilities <sup>99</sup>. The therapist will next make suggestions on alternative behaviors that are deemed to be more suitable. The patient will also be taught coping skills by the therapist, which may have been lacking previously. For instance, the therapist may suggest that the patient participate in regular physical activity, pick up a new hobby, or sign up for a social organization <sup>108, 109</sup>. In addition to this, they can recommend making regular use of techniques such as breathing, relaxation, or visual imagery. Patients who have grown reclusive or secluded may benefit from being encouraged to spend time with people or to engage in physical activity. CBT therapists may also employ additional approaches to assist patients improve, such as role-playing (practicing new behaviors while in session), having the person practice new behaviors outside of the treatment session, training in assertiveness and communication, and other strategies <sup>109</sup>.

Patients participating in CBT have assignments to complete at home during the duration of their treatment. In most cases, students are expected to record their ideas, behaviors, and feelings in a journal as part of their assigned homework. In addition to this, written recordings of the individual's efforts to practice new abilities or strategies for coping will be included in the log. Clients keep a journal of the transformations that take place when they practice new ways of thinking or behaving, or as they revert to more familiar ways of thinking <sup>108</sup>. Patients can experiment by trying out new skills and seeing (by looking at their logs and homework assignments) how these changes positively impact their mood. As negative patterns become clearer, patients can experiment by trying out new skills <sup>109</sup>.

CBT therapists assist persons suffering from depression in learning how to simplify difficult activities by breaking them down into smaller, more manageable parts, in addition to minimizing

the quantity of negative thoughts and behaviors that they experience. If they do this, there is a greater chance that they will be successful in completing things that, when they are depressed, feel like they are too difficult to accomplish. For instance, if a person with depression finds the idea of preparing an entire meal to be overwhelming, he or she may be encouraged to complete whatever portion of the larger work they feel capable of completing <sup>109</sup>. On a given day, he can take pride in the fact that he prepared one of the courses for the meal. Patients' avoidance and anxiety can be reduced by teaching them to take control of their negative anticipations and concerns surrounding tasks, either by contesting those expectations or by breaking down the chores into little manageable chunks. This will lead to more satisfying accomplishments, which in turn will improve mood, drive desire, and boost self-confidence to attempt new things.

Individual and group formats of cognitive behavioral therapy, as well as outpatient and inpatient treatment options, are all available to patients in need <sup>108</sup>. The duration of treatment protocols supported by research is typically between 12 and 16 weeks, and patients attend therapy appointments once per week. However, in order to tailor the treatment to the requirements of individual patients, the frequency and total number of sessions can be increased or decreased <sup>108</sup>.

People who are eager to discuss and make goals, as well as those who desire short-term techniques that are symptom-focused are suitable candidates for cognitive behavioral therapy (CBT) <sup>109</sup>. People who engage in CBT have to make a commitment to assessing their progress and practice their abilities outside of the sessions. People who have difficulty thinking about their own thought process may not be excellent candidates for cognitive behavioral therapy (CBT). People who despise rational debate and argument used to explore the appropriateness or veracity of their beliefs are not typically a good fit for it either. Last but not least, it is not a good fit for people who are looking for a therapist who is less directive, or for people who are

unwilling to monitor their thinking, behavior, and feelings outside of their scheduled therapy sessions <sup>109</sup>.

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**Chapter Three**  
**Methodology**

**3.1 Research Design**

A cross sectional, descriptive study design was used for this study.

**3.2 Population of the Study**

The study was conducted among Undergraduate students at LCU. As of May 2021, a total of 3,840 Undergraduate students distributed across 10 faculties and 84 departments.

**Table 3.1 Total Number of Faculties and Departments in LCU, May 2021.**

<b>Faculties</b>	<b>Departments</b>
Faculty of Social and Management Sciences	16
Faculty of Applied Sciences	14
Faculty of Arts and Education	10
Faculty of Communications and Information science	9
Faculty of Natural and Applied Sciences	8
Faculty of Public health	7
Faculty of Engineering	7
Faculty of Environmental design and Management (Built environment)	6
Faculty of Clinical sciences	5
Faculty of Law	2

**3.2.1 Sample Size Calculation**

The sample size was determined using the Kish and Leslie formula (1965) for cross-sectional studies<sup>2</sup>.

$$n = \frac{Z^2 PQ}{D^2}$$

Where

Z= 1.96 corresponding to confidence level of 95%

P= estimated prevalence rate = 25% (Prevalence rate among undergraduate students in Obafemi Awolowo University) <sup>3</sup>

$$Q= 1- P$$

D= the level of error accepted = 0.05

$$n = \frac{1.96^2 \times 0.25 (1-0.25)}{0.05^2}$$

$$n = \frac{3.8416 \times (0.25) \times (1-0.25)}{0.0025}$$

$$n = \frac{0.7203}{0.0025}$$

$$n = 288$$

To account for a 10% non- response rate

$$\frac{1}{1-f} \quad f=10\%$$

$$\frac{1}{0.9} \times n$$

$$\frac{1}{0.9} \times 288 = 320$$

The estimated minimal sample size will be 320.

### **3.3.1 Sample and Sampling Techniques**

To select the proposed sample, information regarding the total number of students, faculties and departments was obtained from student affairs through a letter of request written to the Registrar's office. The reason for the collection of this data is to be able to select eligible respondents from the total population of students.

A multistage sampling procedure was used in selecting the proposed sample.

- i. The first stage involved using a simple random sample technique to select 4 out of the 10 faculties using a table of random numbers generated on Excel. The selected faculties were Faculty of Arts and Education, Faculty of Environmental Design and Management, Faculty of Natural and Applied sciences, Faculty of Social and Management Sciences.
- ii. At the second stage, a simple random sampling technique was used to select 3 departments from the faculty of Social and Management sciences, 1 department from the faculty of Arts and Education and 2 departments from each of the other 2 selected faculties through a random number generator, making it a total of 8 departments.
- iii. At the 3<sup>rd</sup> stage, simple random sampling technique was used to select 320 students from the selected departments. i.e., 40 students and an average of 10 per level from each of the 8 departments.
- iv. At the fourth stage, a list with the total number of students in each level (100-4001) was obtained from the course reps, thereafter a simple random sampling technique was used to select 10 students from the list obtained in each level of study (1001 – 4001), this was done for each of the selected departments. Thus, 40 students were enrolled per department.

### **3.4 Description of Research Instruments**

The data collection instrument was a semi structured, and self-administered questionnaire. It was administered by the researcher.

The first section described respondents' socio-demographic characteristics.

The other sections of the questionnaire used was guided by existing literature on knowledge, attitude, and health-seeking behavior of depression using standard tools such as the

- i. Depression Literacy scale by Prof Kathleen Griffiths Centre for Mental Health Research. This tool consists of 22 true or false questions which assessed the knowledge of Undergraduate students towards depression, the questions were graded with “True/ False/ Don’t know” options. The correct answers were given a score of “1” and incorrect questions were scored “0”. The items were summed to get a total score of correct answers (maximum score = 22) <sup>4</sup>. A cut off score of 50% was used, and all respondents who scored greater than 50% were said to have good knowledge of depression, those who scored  $\leq$  were said to have poor knowledge <sup>5</sup>.
- ii. Attitudes Toward Seeking Professional Psychological Help Short Term Scale (ATSPPH) by Fischer and Turner Consists of 10 questions and was used to assess the health-seeking behavior of students towards depression. Scoring was done using a 4-point Likert scale grade from disagree (0) to agree (3). Reverse coding was however done for questions 2, 4, 8, 9, 10, (0 = agree and 3 = disagree) <sup>6</sup>. A total score of 30 was obtainable. The cut off score was set at 50% and all respondents with a score  $\geq$  50% were said to have good health-seeking behavior towards depression. This cut off score was adopted from a previous study where this tool was also used <sup>5</sup>.
- iii. Depression Stigma Scale by Prof Kathleen Griffiths Centre for Mental Health Research. The personal stigma scale which consists of 9 questions, was used to assess the attitude of students towards depression. It was scored on a five-point Likert scale ranging from “0 to 4”, that is, “strongly agree to strongly disagree” options using a 5-point Likert scale graded from “Strongly agree (0)” to “Strongly disagree (4)” <sup>7</sup>. A cut-off of 50% was used

to determine the respondents with positive attitude, and all those who had greater than 50% were said to have positive attitude towards depression. This cut off score was adopted from a previous study where this tool was also used <sup>5</sup>.

### **3.5 Reliability of Research Instrument**

Cronbach alpha = .70 and test reliability = .74 <sup>4</sup>.

### **3.6 Data Collection**

The data was collected using self-administered questionnaire, which was administered by the researcher.

### **3.7 Data Analysis**

The data collected was analyzed using SPSS (version 28.0).

Data on socio demographic variables were analyzed using descriptive statistics (frequencies and percentages, mean, standard deviation). Bivariate and Multivariate analysis were done to determine the factors associated with knowledge, attitude and health seeking behavior of LCU students towards depression. Only variables that weren't significant at the bivariate level were polled into the multivariate level.

### **3.8 Ethical Approval**

Ethical approval for this study was obtained by the Ethical Review Committee, LCU, with the project number LCU-HREC/21/001 (Appendix). Informed consent was obtained from eligible students prior to their enrollment in the study. Participant's confidentiality was ensured and participants were informed of their rights to decline participation in the study.

**Non- Maleficence to participants** – No harm was inflicted on participants because of their participation in this study.

## Endnotes

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## Chapter Four

### Results

#### 4.1. Results

This chapter presents the analysis of data collected for the study which aimed at investigating the Knowledge, Attitude and Health-seeking behavior of depression among Undergraduate students of LCU, Ibadan, Oyo state, Nigeria. A total of 320 students from 4 faculties and 8 departments were the study respondents. The first section presents findings on demographic data in tables and charts. The second section presents findings on the knowledge of depression. The third section shows findings on the health-seeking behavior while the fourth section shows findings on the attitude of the students towards depression.

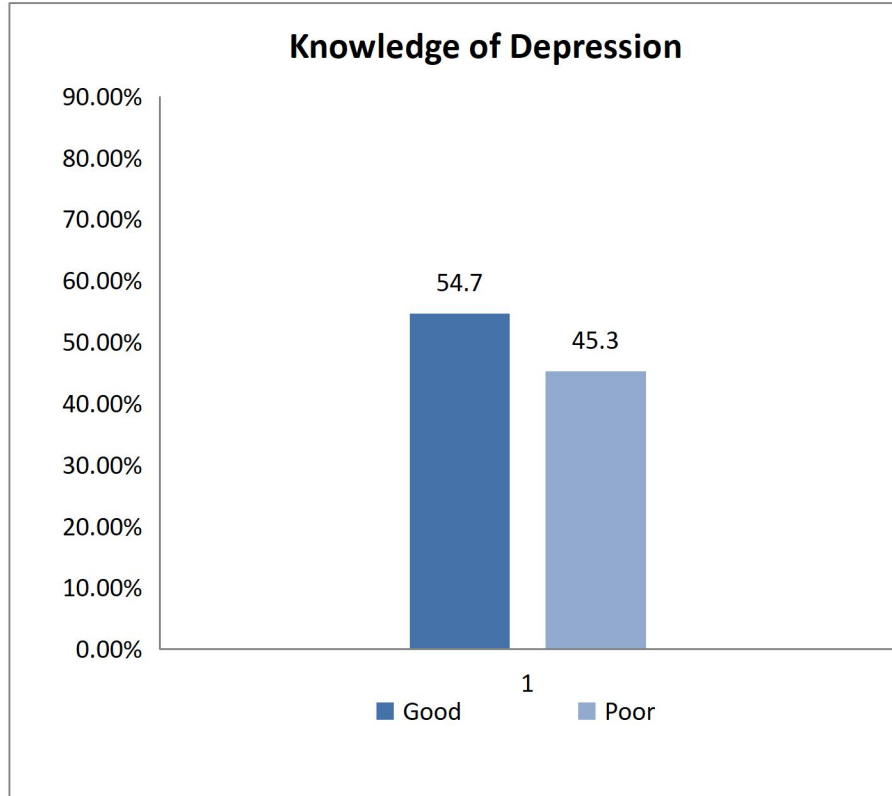
#### 4.2 Socio Demographic and Clinical Characteristics

**Table 4.1** below shows the distribution of socio demographic and clinical characteristics among Undergraduate students of LCU. The mean age of respondents was 19.36 years  $\pm$  2.896 years.

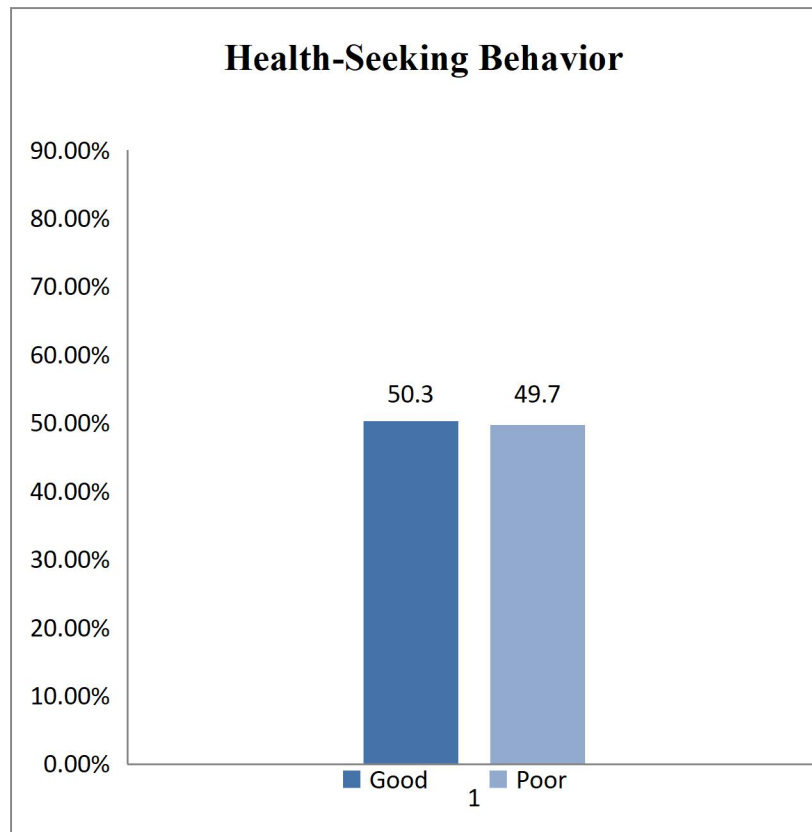
Among them 143 (44.7%) were male, 120 (37.5%) were from the Faculty of Social and Management Sciences, and 185 (57.8%) were between the ages of 15-19 years. Also 49.4% lived within the school premises and 39 (12.2%) had a history of depression.

**Table 4.1 Socio-Demographic and Clinical Characteristics of Undergraduate Students of Lead City University, 2021**

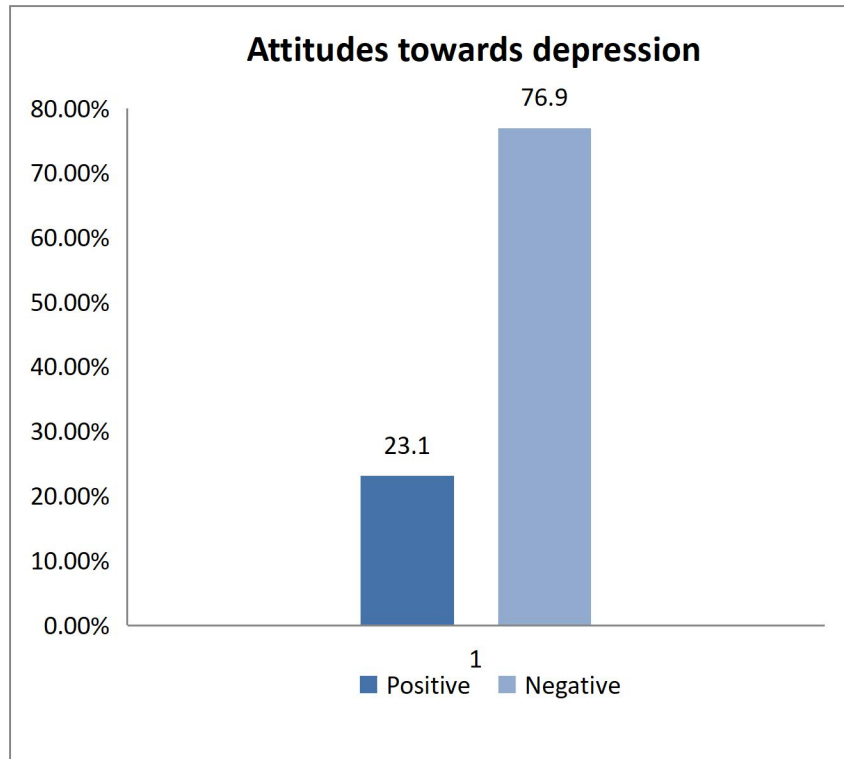
<b>Variables</b>	<b>Frequency</b>	<b>Percentage (%)</b>
<b>Sex</b>		
Male	143	44.7
Female	177	55.3
<b>Age as at last birthday</b>		
Mean ±	19.36 ±2.9	
15-19 years	185	57.8
20-24 years	111	34.7
25-29 years	24	7.5
<b>Faculties</b>		
Social and management sciences	120	37.5
Environmental design and management	81	25.3
Natural and applied sciences	80	25.3
Arts and education	39	12.2
<b>Academic level</b>		
Lower (1001 – 200Level)	157	49.1
Upper (300 – 400Level)	163	50.9
<b>Academic performance</b>		
Very good	139	43.4
Good	151	47.2
Fairly good and below	30	8.4
<b>Living arrangements</b>		
Within school premises	158	49.4
Outside school premises	135	42.2
With parents	27	8.4
<b>Family economic status</b>		
Good	149	46.6
Fair	171	53.4
<b>History of depression</b>		
Yes	39	12.2
No	281	87.8



**Figure 1. Knowledge of Depression among Lead City University Undergraduates, Ibadan, 2021.**



**Figure 2. Health-Seeking Behavior towards depression among Lead City University Undergraduates towards depression, 2021**



**Figure 3. Attitude of Lead City University Undergraduates towards Depression, 2021**

## **4.2 Association between Knowledge of Depression and Socio Demographic and Clinical Characteristics**

Table 4.2 shows that 98 (60.1%) of those in the upper level (300-400level) had good knowledge of depression. Also, 89 (64.0%) of the respondents with “Very good” academic performance had good knowledge of depression compared to 72 (47.7%) with good academic performance and 14 (46.7%) with fairly academic performance and below (Chi-square= 8.664, p value = 0.013)

Furthermore 87 (64.4%) of respondents who lived outside school premises had good knowledge of depression, compared to 73 (46.2%) who lived within school premises (Chi-square=9.785, p-value=0.008). Likewise, 31 (79.5) with a history of depression had good knowledge of depression compared to 144 (51.2%) with no history of depression (Chi-square=11.023, p-value=<0.001)

Figure 2 on the overall knowledge, attitude and health-seeking behavior of the participants, shows that 54.7% of the respondents had good knowledge of depression, while 50.3% had good health seeking behavior and 23.1 had positive attitude towards depression.

**Table 4.2 Association between Knowledge of Depression and Socio Demographic and Clinical Characteristics of Undergraduate Students of Lead City University, 2021**

Variables	Level of knowledge		Chi-square	p-value
	Good Frequency (%)	Poor Frequency (%)		
<b>Sex</b>				
Male	80 (55.9)	63 (44.1)	0.165	0.685
Female	95 (53.9)	82 (46.3)		
<b>Age group (Years)</b>				
15-19	99 (53.5)	86 (46.5)	0.297	0.862
20-24	63 (56.8)	48 (43.2)		
25-29	13 (54.2)	11 (45.8)		
<b>Academic level</b>				
Lower (100-200Level)	77 (49.0)	80 (51.0)	3.961	0.047 <sup>a</sup>
Upper (300-400Level)	98 (60.1)	65 (39.9)		
<b>Academic Performance</b>				
Very good	89 (64.0)	50 (36.0)	8.664	0.013 <sup>a</sup>
Good	72 (47.7)	79 (52.3)		
Fairly good and below	14 (46.7)	16 (53.3)		
<b>Living arrangements</b>				
Within school premises	73 (46.2)	85 (53.8)	9.785	0.008 <sup>a</sup>
Outside school premises	87 (64.4)	48 (35.6)		
with parents	15 (55.6)	12 (44.4)		
<b>Family economic status</b>				
Good	76 (51.0)	73 (49.0)	1.524	0.217
Fair	99 (57.9)	72 (42.1)		
<b>Faculties</b>				
Social and management Sciences	61 (50.8)	59 (49.2)	15.235	0.002 <sup>a</sup>
Environmental design and Management	37 (45.7)	44 (54.3)		
Natural and applied sciences	45 (56.3)	35 (43.8)		
Arts and education	32 (82.1)	7 (17.9)		
<b>History of depression</b>				
Yes	31 (79.5)	8 (20.5)	11.023	< 0.001 <sup>a</sup>
No	144 (51.2)	137 (48.8)		

<sup>a</sup> p-value ≤ 0.05

### **4.3 Association between Health-Seeking Behavior of Depression and Socio Demographic and Clinical Characteristics**

Among the respondents, 72 (50.3%) of the male Undergraduate students had good health-seeking behavior, compared to 89 (50.3%) females (Chi-square = 0.000 p-value = 0.438). In addition, 96 (51.9%) aged 15-19 years had good health-seeking behavior compared to 51 (45.9%) aged 20-24 years (Chi-square = 1.649 p-value = 0.438). In the same vein, 54 (45.0%) students in the Faculty of Social and Management Sciences, had good health-seeking behavior compared to 35 (43.2%) in the Faculty of Environmental Design and Management, and 28 (71.8%) in the Faculty of Arts and Education (Chi-square = 10.892 p-value = 0.012).

Furthermore 18 (46.2%) with a history of depression had good health-seeking behavior compared to 143 (50.9%) with no history of depression (Chi-square = 0.307 p-value= 0.579)

**Table 4.3 Association between Health-Seeking Behavior of Depression and Socio-Demographic and Clinical Characteristics of Undergraduate Students of Lead City University, 2021**

Socio demographic Characteristics	Health-seeking behavior		Chi-square	p-value
	Good Frequency (%)	Poor Frequency (%)		
<b>Sex</b>				
Male	72 (50.3)	71 (49.7)	0.000	0.990
Female	89 (50.3)	88 (49.7)		
<b>Age group (Years)</b>				
15-19	96 (51.9)	89 (48.1)	1.649	0.438
20-24	51 (45.9)	60 (54.1)		
25-29	14 (58.3)	10 (47.1)		
<b>Faculties</b>				
Arts and education	28 (71.8)	11 (28.2)	10.892	0.012 <sup>a</sup>
Environmental design and Management	35 (43.2)	46 (56.8)		
Natural and applied sciences	44 (55.0)	36 (45.0)		
Social and management Sciences	54 (45.0)	66 (55.0)		
<b>Academic level</b>				
Lower (100-200Level)	78 (49.7)	79 (50.3)	0.049	0.825
Upper (300-400Level)	83 (50.9)	80 (49.1)		
<b>Academic Performance</b>				
Very good	79 (56.8)	60 (43.2)	4.586	0.101
Good	70 (46.4)	81 (53.6)		
Fairly good and below	12 (40.0)	18 (60.0)		
<b>Living arrangements</b>				
Within school premises	78 (49.4)	80 (50.6)	0.709	0.701
Outside school premises	71 (52.6)	64 (47.4)		
with parents	12 (44.4)	15 (55.6)		
<b>Family economic status</b>				
Good	77 (51.7)	72 (48.3)	0.208	0.648
Fair	84 (49.1)	87 (50.9)		
<b>History of depression</b>				
Yes	18 (46.2)	21 (53.8)	0.307	0.579
No	143 (50.9)	138 (49.1)		

<sup>a</sup> p-value ≤ 0.05

#### **4.4 Association between Attitude towards Depression and Socio Demographic and Clinical Characteristics**

Among the respondents, 37 (25.9%) males had a positive attitude towards depression compared to 37 (20.9%) females (Chi-square =1.099 p-value = 0.294). Likewise, 35 (29.2%) respondents from the faculty of Social and Management Sciences had positive attitude towards depression compared to 22 (27.2%) from the faculty of Environmental Design and Management, 13 (16.3%) from the faculty of Natural and Applied Sciences, and 4 (10.3%) from the Faculty of Arts and Education (Chi-square= 8.966 p-value= 0.030). Moreover, 5 (12.8%) respondents with a history of depression had a positive attitude towards depression compared to 69 (24.6%) without a history of depression (Chi-square = 2.653 p-value = 0.103). (Table 4.4)

**Table 4.4 Association between Attitude towards Depression and Socio Demographic and Clinical Characteristics of Undergraduate Students of Lead City University, 2021**

Socio demographic Characteristics	Attitude towards depression		Chi-square	p-value
	Positive Frequency (%)	Negative Frequency (%)		
<b>Sex</b>				
Male	37 (25.9)	106 (74.1)	1.099	0.294
Female	37 (20.9)	140 (79.1)		
<b>Age group (Years)</b>				
15-19	46 (24.9)	139 (75.1)	1.019	0.601
20-24	24 (21.6)	87 (78.4)		
25-29	4 (16.7)	20 (83.3)		
<b>Faculties</b>				
Arts and education	4 (10.3)	35 (89.7)	8.966	0.030 <sup>a</sup>
Environmental design and Management	22 (27.2)	59 (72.8)		
Natural and applied sciences	13 (16.3)	67 (83.8)		
Social and management Sciences	35 (29.2)	85 (70.8)		
<b>Academic level</b>				
Lower (100-200Level)	42 (26.8)	115 (73.2)	2.280	0.131
Upper (300-400Level)	32 (19.6)	131 (80.4)		
<b>Academic Performance</b>				
Very good	26 (18.7)	113 (81.3)	2.906	0.234
Good	41 (27.2)	110 (72.8)		
Fairly good and below	7 (23.3)	23 (76.7)		
<b>Living arrangements</b>				
Within school premises	37 (23.4)	121 (76.6)	3.689	0.158
Outside school premises	27 (20.0)	108 (80.0)		
with parents	10 (37.0)	17 (63.0)		
<b>Family economic status</b>				
Good	38 (25.5)	111 (74.5)	0.887	0.346
Fair	36 (21.1)	135 (78.9)		
<b>History of depression</b>				
Yes	5 (12.8)	34 (87.2)	2.653	0.103
No	69 (24.6)	212 (75.4)		

<sup>a</sup> p-value ≤ 0.05

#### **4.5 Factors Associated with the Knowledge of Depression among Undergraduate Students of Lead City University, 2021**

Table 4.5 shows that Undergraduate students in the faculty of Arts and Education had 6 times likelihood to have good knowledge of depression compared to students in the Social and Management Sciences (AOR= 6.373, 95% CI= 2.496-16.270 p= <0.001). Likewise, Undergraduate students in the Natural and Applied Sciences had higher odds of having good knowledge compared to those in Social and Management Sciences (AOR= 1.995, 95% CI= 0.664-2.244, p= 0.521).

Undergraduate students in the upper academic (300-400) level had nearly two times odds of having good knowledge of depression (AOR=1.561, 95% CI= 0.961-2.537 p=0.072). Respondents who lived outside the school premises were nearly two times more likely (AOR= 1.725, 95% CI =1.036-2.873, p=0.036) to have good knowledge of depression compared to those who lived within the school premises. Undergraduate students with 'very good' academic performance were two times more likely to have good knowledge of depression compared to those with 'poor' academic performance (AOR=1.785, 95% CI=0.776-4.173, p=0.173), likewise students with a history of depression had nearly four times odds of having good knowledge of depression compared to those with no history of depression (AOR= 3.559, 95% CI= 1.525-8.305, p= 0.003).

**Table 4.5 Factors Associated with Good Knowledge of Depression among Undergraduate Students of Lead City University, 2021**

Variables	Adjusted Odds ratio	95% Confidence interval		p-value
		Lower	Upper	
<b>Faculty</b>				
Social and Management Sciences	<b>1</b>			
Environmental Design and Management	0.887	0.486	1.620	0.696
Natural and Applied Sciences	1.221	0.664	2.244	0.521
Arts and Education	6.373	2.496	16.270	<0.001 <sup>a</sup>
<b>Academic Level</b>				
Lower (100-200 level)	<b>1</b>			
Higher (300-400 level)	1.561	0.961	2.537	0.072
<b>Living arrangements</b>				
Within school premises	<b>1</b>			
Outside school premises	1.725	1.036	2.873	0.036 <sup>a</sup>
With parents	1.506	0.619	3.664	0.367
<b>Academic Performance</b>				
Very good	1.785	0.776	4.103	0.173
Good	0.942	0.411	2.160	0.887
Fairly good and below	<b>1</b>			
<b>History of depression</b>				
Yes	3.559	1.525	8.305	0.003 <sup>a</sup>
No	<b>1</b>			

<sup>a</sup> p-value ≤ 0.05

#### 4.6 Factors Associated with the Health-Seeking Behavior of Depression among Undergraduate Students of Lead City University, 2021

Table 4.6 below, shows that Undergraduate students in the Faculty of Social and Management Sciences were three times likely to have a good health-seeking behavior compared to those in Faculty of Arts and Education (AOR = 3.345, 95% CI = 1.419-6.819, p= 0.005). Those in the faculty of Environmental Design and Management also had three times odds of having a good health-seeking behavior compared to those in Arts and Education(AOR = 3.111, 95% CI = 1.467-7.630, p= 0.004). Respondents from the Faculty of Natural and Applied Sciences also had 2times odds of having a good Health-seeking behavior compared to those in Faculty of Arts and Education(AOR = 2.083, 95%CI = 0.913-4.752, p= 0.081).

**Table 4.6 Factors Associated with Good Health-Seeking Behavior of Depression among Undergraduate Students of Lead City University, 2021**

Variables	Unadjusted Odds ratio	95% Confidence interval		p-value
		Lower	Upper	
<b>Faculty</b>				
Social and Management Sciences	3.111	1.419	6.819	0.005 <sup>a</sup>
Environmental Design and Management	3.345	1.467	7.630	0.004 <sup>a</sup>
Natural and Applied Sciences	2.083	0.913	4.752	0.081
Arts and Education	<b>1</b>			

<sup>a</sup> p-value ≤ 0.05

#### 4.7 Factors Associated with the Attitude of Depression among Undergraduate Students of Lead City University, 2021

Table 4.7 shows that respondents in Social and Management Sciences were 72% (OR = 0.278, 95% CI = 0.092-0.840, p= 0.023) less likely to have positive attitude towards depression compared to those in Arts and Education. Undergraduate students in the Faculty of Environmental Design and Management were also nearly 70% less likely to have positive attitude towards depression compared to students studying in the Faculty of Arts and Education (Unadjusted OR = 0.306, 95% CI = 0.098-0.963, p= 0.043). Respondents from the Faculty of Natural and Applied Sciences were nearly 40% less likely to have positive attitude towards depression compared to those in Arts and Education (OR = 0.589, CI = 0.179-1.942, p= 0.384).

**Table 4.7 Factors Associated with Positive Attitude towards Depression among Undergraduate Students of Lead City University, 2021**

Variables	Unadjusted Odds ratio	95% Confidence interval		p-value
		Lower	Upper	
<b>Faculty</b>				
Social and Management Sciences	0.278	0.092	0.840	0.023 <sup>a</sup>
Environmental Design and Management	0.306	0.098	0.963	0.043 <sup>a</sup>
Natural and Applied Sciences	0.589	0.179	1.942	0.384
Arts and Education	<b>1</b>			

<sup>a</sup> p-value ≤ 0.05

## Discussion of Findings

### **4.8 Knowledge of Depression among Undergraduate Students at Lead City University and its Association with Socio-Demographic and Clinical Characteristics**

Mental health issues such as depression may often go unrecognized or unnoticed due to poor mental health literacy on depression, and there has been no level of interest on the mental health literacy of young people in Nigeria <sup>1</sup>. The proportion of respondents in this study who had good knowledge of depression was over half (54.7%), this is like findings of a study that was carried out among pharmaceutical students in a university in the eastern part of Nigeria that found a rate of 61.9% with good knowledge of depression <sup>2</sup>. Another study carried out in a university in Lagos state found that more than half 56.5% of the respondents had good knowledge of depression <sup>3</sup>. Contrary to these findings a study carried out among undergraduates in a university in Sri Lanka found a low rate 17.4% with good knowledge of depression<sup>4</sup>. The reason for this difference might be because of varying cultural beliefs and practices, educational system of the country and existing health promotional activities.

Concerning the personal experience of depression, 12.2% of the respondents in this study indicated that they had experienced depression. Contrary to this result a study in Australia found a higher percentage (58%) who indicated that they had experienced depression <sup>5</sup>. The reason for such difference might be associated to the difference in cultural beliefs as many in Nigeria wouldn't want to speak out about their mental health due to the associated stigma as several studies that have been carried out in Nigeria found a high rate of stigma among Nigerians. And fear of stigma among people experiencing mental health problems has been confirmed to stop

them from speaking out about their experiences and getting the diagnosis and treatment they need.

Factors such as respondents' level of education had a significant association with good knowledge of depression and majority of students in the upper (300-400) level had good knowledge of depression compared to those in the lower level. This finding falls in line with a study that was carried out among young people in a high school in Vietnam where the participants' grade level significantly correlated with their mental health literacy of depression<sup>6</sup>. This might be due to the fact that as students attain higher academic levels, they acquire more knowledge and are exposed to a spectrum of information sources. Another factor with a significant association with good knowledge of depression in this study was respondents' academic performance, majority of respondents who had good knowledge of depression in this study indicated that they had 'very good' academic performance, compared to those with 'good' and 'fairly good' academic performances. The reason for such difference might be because those with very good performance read more books, engage themselves in activities that keep them enlightened, and knowledgeable about other fields and areas of learning.

Most of the participants who lived outside school premises had good knowledge of depression compared to those who lived within school premises. This finding might be due to better access to some sources of information that are not allowed within school premises. In addition, Undergraduate students who live off-campus may reside amid people with higher levels of education who are knowledgeable about mental health. They are also more likely to have witnessed awareness campaigns on mental health. This signifies poor promotional efforts on mental health literacy within the school premises.

The faculty of Arts and Education 82.1% had the highest number of respondents with good knowledge of depression, followed by those from Natural and applied sciences. In a study carried out in a university in the eastern part of Nigeria majority of the respondents who had good knowledge of depression were from the faculty of medicine<sup>3</sup>.

#### **4.8.1 Health-Seeking Behavior towards Depression among Undergraduate Students at Lead City University and its Association with Socio-Demographic Characteristics**

The health seeking behavior of participants in this study was 50.3%. However, results of studies examining health seeking behavior of university students from other countries varied. A cross-sectional study on depression conducted among Undergraduate students in Jordan reported that only 13.6% respondents had good health-seeking behavior towards depression<sup>7</sup>. Another study conducted in Australia also found a low rate, where a large proportion (97%) of the respondents indicated that they would rather seek help from family and friends<sup>5</sup>. Contrary to these findings, in Ethiopia a higher rate (78.4%) of health seeking was found among undergraduate students<sup>8</sup>. The reason for the differences might be because of varying levels of mental health awareness and education amongst the countries, as well as varying cultural beliefs and practices.

Majority of the respondents in the upper level (3001-4001) had good health seeking behavior this is similar to a study in Malaysia where the older students had good health seeking behavior<sup>10</sup>. Respondents' faculty had a statistically significant association with their health seeking behavior, with majority of those in the faculty of Arts and education and faculty of Natural and applied sciences having good help seeking behavior compared to those in other faculties.

#### **4.8.2 Attitude towards Depression among Undergraduate Students of Lead City University and its Association with Socio-Demographic Characteristics**

This study found that a low proportion (23.1%) of Undergraduate students have positive attitude towards depression. This is less than what was found in a university in India where 50% had positive attitudes towards depression<sup>11</sup>. Another study carried out among university students in Malaysia found higher levels of stigmatizing attitudes towards people with mental illness among the participants. About 40% of the respondents in this study agreed to the statement “People with depression are unpredictable” this is like what was found in a study carried out in Canada where over 40% of the respondents agreed that ‘people with depression are unpredictable’<sup>12</sup>. The similarity between these findings is however not surprising as it has been found that the stigmatization of people with mental illness is not unique to only one country but widespread across the world especially among young people, due to more mental health campaigns being targeted towards adults in the past.

## Endnotes

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## **Chapter Five**

### **Conclusion**

#### **5.1 Summary of Findings**

The proportion of respondents in this study who had good knowledge of depression was over half, 54.7%. Those who had good health seeking behavior were 50.3% and the respondents who had a positive attitude towards depression were 24.0%.

Factors associated with good knowledge of depression among respondents in this study were students' academic level, living arrangements, and faculty.

#### **5.2 Conclusion**

This study examined depression among undergraduate students, with particular focus on their knowledge, attitude, and health seeking behavior. The specific objectives sought:

- i. To determine the knowledge of depression among Undergraduate students of LCU, Ibadan, Oyo state, Nigeria.
- ii. To determine the pattern of health-seeking behavior towards depression among Undergraduate students of LCU, Ibadan, Oyo state, Nigeria.
- iii. To assess the attitudes towards depression among Undergraduate students of LCU, Ibadan, Oyo State, Nigeria.
- iv. To determine the factors associated with good knowledge of depression among Undergraduate students of LCU, Ibadan, Oyo state, Nigeria.
- v. To determine the factors associated with good health-seeking behavior among Undergraduate students of LCU, Ibadan, Oyo state, Nigeria.

- vi. To determine the factors associated with positive attitude towards depression among Undergraduate students of LCU, Ibadan, Oyo state, Nigeria.

In conclusion, more than half of the participants in this study had good knowledge of depression, with half of the participants also having good health seeking behavior, and a poor proportion showed negative attitudes towards depression. The factors that had a significant association with good knowledge of depression involved participants' level of education, academic performance, faculty, living arrangements and history of depression.

### **5.3 Recommendation**

More than one-half of respondents demonstrated good knowledge and good health seeking behavior towards depression. While less than one-third of respondents' depicted positive attitude towards depression. Negative attitude towards mental health has been attributed to stigma. Those who had negative attitudes towards mental health might be reluctant to seek help and stigmatize those with mental illness. These results suggest an urgent need to improve understanding of MHL of depression, especially attitudes towards depression for undergraduate students in Nigeria.

Although mental health problems are increasing across Nigeria, there are currently not enough interventions to educate the public about them. Various interventions can be considered including

1. The development of short mental health courses for students. Additional information on various mental health issues can also be posted through social media and internet-based resources, like the school's website, students departmental group chat, flyers, posters can

be made. Challenges remain as mental health has never been considered a high priority in Nigeria.

2. The school authority should set up a committee of professional psychologists and counselors within the school which will render psychological interventions on the mental health of students, and improve their mental health literacy, to counsel and expose the students to the dangers associated with depression and the negative attitude towards it, and importance of seeking help when they experience mental health issues.
3. University lecturers could also play a part by identifying students with counseling needs and referring them to the professional counselors and psychologists within the school, so that these professionals will guide the students to understand themselves and their emotions in relation to the social and psychological world in which we live and guide them to develop the ability to overcome and resolve special problems or common difficulties.

#### **5.4 Contribution to Knowledge**

1. This study contributed in identifying the student's knowledge towards depression, knowing this, will help the school pay more attention to the students and prioritize their mental health and make appropriate referrals where necessary to professionals.
2. This study contributed to knowledge by creating awareness about the importance of mental health of the students and the negative effects of depression among students when left untreated.

## **5.5 Suggested Areas for Further Research**

Future studies should focus on faculty specific drivers of knowledge, attitude and behavior of students regarding depression and how to effectively disseminate mental health education among these Undergraduate students

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## Appendices

### Informed Consent

#### Consent Form for Respondents

Dear participant,

Good day, my name is Damilola Joy Lawal, from the department of Public Health, Post graduate studies at Lead City University. I am in the process of writing my Master's thesis and I am conducting a research titled "Depression among undergraduate students: Knowledge, Attitude, and Health-seeking behavior. The purpose of the research is to determine the student's knowledge about depression, examine their attitude, and Health-seeking behavior.

There is no risk associated with participating in this study. This interview will take about 10 minutes to complete. Your responses will be kept strictly confidential.

Your participation in this research project is completely voluntary, and you would not be penalized in any way for declining to participate. You can stop the interview at any time, however, your contribution to this research would be highly appreciated. I implore you to answer the questions to the best of your ability. You can reach me via the email address [Damideen777@gmail.com](mailto:Damideen777@gmail.com) in case you have further questions.

Thank you for your kind gesture.

*I have understood what the study is all about and;*

*Yes, I would like to participate [ ]*

*No, I would not like to participate [ ]*

Signature of respondent: \_\_\_\_\_

Date: \_\_\_\_\_



## RESEARCH QUESTIONNAIRE

**INSTRUCTION: PLEASE SELECT AND TICK THE APPROPRIATE CHOICE**

### **PART A. Socio Demographic**

1. Gender: (a) Male [ ] (b) Female [ ]
2. Age as at last birthday \_\_\_\_\_
3. Academic level: (a) 1001 [ ] (b) 200 [ ] (c) 3001 [ ] (d) 4001 [ ]
4. Department \_\_\_\_\_
5. Academic performance: (a) very good [ ] (b) good (c) fairly good (d) fair (e) poor
6. Living arrangements: (a) within school premises [ ] (b) outside school premises [ ] (c) with parents
7. Family economic status: (a) well off / quite well off [ ] (b) Neither poor nor well off [ ] (c) poor [ ]
8. History of depression (a) Yes (b) No

### **Section B : Assessing the knowledge of undergraduate students towards depression**

9. People with depression often speak in a rambling and disjointed way. 1. True [ ] 2. false [ ]  
3. I don't know [ ]
10. People with depression may feel guilty when they are not at fault. 1. True [ ] 2. false [ ] 3.  
I don't know [ ]
11. Reckless and foolhardy behaviour is a common sign of depression. 1. True [ ] 2. False [ ]  
3. I don't know [ ]
12. Loss of confidence and poor self-esteem may be a symptom of depression. 1. True [ ] 2.  
False [ ] 3. I don't know [ ]

13. Not stepping on cracks in the footpath may be a sign of depression. 1. True [ ] 2. False [ ]  
3. I don't know [ ]
14. People with depression often hear voices that are not there. 1. True [ ] 2. False [ ] 3. I  
don't know [ ]
15. Sleeping too much or too little may be a sign of depression. 1. True [ ] 2. False [ ] 3. I  
don't know [ ]
16. Eating too much or losing interest in food may be a sign of depression. 1. True [ ] 2.  
False [ ] 3. I don't know [ ]
17. Depression does not affect your memory and concentration. 1. True [ ] 2. False [ ] 3. I  
don't know [ ]
18. Having several distinct personalities may be a sign of depression. 1. True [ ] 2. False [ ] 3.  
I don't know [ ]
19. People may move more slowly or become agitated as a result of their depression. 1. True  
[ ] 2. False [ ] 3. I don't know [ ]
20. Clinical psychologists can prescribe antidepressants. 1. True [ ] 2. False [ ] 3. I don't  
know [ ]
21. Moderate depression disrupts a person's life as much as multiple sclerosis or deafness.  
1. True [ ] 2. False [ ] 3. I don't know [ ]
22. Most people with depression need to be hospitalised. 1. True [ ] 2. False [ ] 3. I don't  
know [ ]
23. Many famous people have suffered from depression. 1. True [ ] 2. False [ ] 3. I don't  
know [ ]

24. Many treatments for depression are more effective than antidepressants. 1. True [ ] 2. False [ ] 3. I don't know [ ]
25. Counselling is as effective as cognitive behavioural therapy for depression. 1. True [ ] 2. False [ ] 3. I don't know [ ]
26. Cognitive behavioural therapy is as effective as antidepressants for mild to moderate depression. 1. True [ ] 2. False [ ] 3. I don't know [ ]
27. Of all the alternative and lifestyle treatments for depression, vitamins are likely to be the most helpful. 1. True [ ] 2. False [ ] 3. I don't know [ ]
28. People with depression should stop taking antidepressants as soon as they feel better. 1. True [ ] 2. False [ ] 3. I don't know [ ]
29. Antidepressants are addictive. 1. True [ ] 2. False [ ] 3. I don't know [ ]
30. Antidepressant medications usually work straight away. 1. True [ ] 2. False [ ] 3. I don't know [ ]

**Section C: Assessing the health-seeking behavior of undergraduates towards depression**

Kindly tick the box that describes how strongly you personally agree or disagree with each statement.

**Disagree**   **Partially**   **Partially**  
**disagree**   **agree**   **Agree**

31	If I thought I was having a mental breakdown my first thought would be to get professional help
32	Talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts

33	If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy				
34	There is something to admire about a person who copes with conflicts and fears without going for professional help				
35	I would want to get psychological help if I was worried or upset for a long period of time.				
36	I might want to have psychological counseling in the future.				
37	A person with an emotional problem is not likely to solve it alone; he or she is more likely to solve it with professional help				
38	Given the amount of time and money involved in psychotherapy, I am not sure that it would benefit someone like me.				
39	People should solve their own problems; therefore, getting psychological counseling would be their last resort.				
40	Personal and emotional troubles, like most things in life, tend to work out by themselves.				

**Section D : Assessing the attitude of undergraduate students towards depression**

Kindly tick the box that describes how strongly you personally agree or disagree with each statement.

		Agree	Strongly agree	Neither agree nor disagree	Strongly disagree	Disagree
41	People with depression could snap out of it if they wanted					
42	Depression is a sign of personal weakness					
43	Depression is not a real medical illness					
44	People with depression are dangerous					
45	It is best to avoid people with depression so that you do not become depressed yourself					
46	People with depression are unpredictable					
47	If I had depression I would not tell anyone					
48	I would not employ someone if I knew they had been depressed					
49	I would not vote for a politician if I knew they had been depressed					

## Ethical approval



### Lead City University Research Ethics Committee



**PROJECT TITLE: DEPRESSION AMONG UNDERGRADUATE STUDENTS: KNOWLEDGE, ATTITUDE, AND HEALTH-SEEKING BEHAVIOR IN LEAD CITY UNIVERSITY, IBADAN, OYO STATE, NIGERIA**

**PROJECT NUMBER: LCU-HREC/21/001.**


#### APPROVAL LETTER

The above named proposal has been adequately reviewed; the protocol and safety guidelines satisfy the conditions of LCU-HREC policies regarding experiments that use human subjects.

Therefore, the study under its reviewed state is hereby approved by the LCU-Health Research Ethics Committee.

**Prof. Olusola Ladokun**


*Name of LCU-HREC Chairman*

.....  15-10-2021 .....

*Signature of LCU-HREC Chairman and Date*

**Dr. Folahanmi Akinsolu**

*Name of LCU-HREC Secretary*

.....  15-10-2021 .....

*Signature of LCU-HREC Secretary and Date*

**This approval is given with the investigator's Declaration as stated below;**

**By signing below I agree/certify that:**

1. I have reviewed this protocol submission in its entirety and that I am fully cognizant of, and in agreement with all submitted statements.
2. I will conduct this research study in strict accordance with all submitted statements except where a change may be necessary to eliminate apparent immediate hazard to a given research subject.
  - I will notify the HREC promptly of any change in research procedures necessitated in the interest of the safety of a given research subject.
  - I will request and obtain HREC approval of any proposed modification to the research protocol or informed consent document(s) prior to implementing such modifications.

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*Lagos-Ibadan Express way, Toll Gate Area.  
P.O. Box 30678, Secretariat, Ibadan Oyo State Nigeria.  
Lcu.hrec@lcu.edu.ng*

## **Biodata**

**Name:** Damilola Joy Lawal  
**Address:** Oluyole Extension along Elebu Road, Ibadan  
**Email:** Damideen777@gmail.com  
**Phone number:** 08133539393  
**Date of Birth:** 27<sup>th</sup> of July 1997  
**Nationality:** Nigerian  
**Name of Next of Kin:** Bola Lawal  
**Address of Next of Kin:** Oluyole Extension along Elebu Road, Ibadan

### **Academic & Professional Qualifications:**

July 2017                      Adeleke University, Osun state

*B.Sc. Public Health*

August 2013                Immaculate Hearts Secondary School, Abuja

*SSCE Certificate (Second Class Upper Division)*

April 2007                 Philton Nursery & Primary school, Abuja

*First School-Leaving Certificate*

### **Work Experience:**

Health and Human Services Secretariat, Public Health department, Epidemiology Unit, Federal Capital Territory Administration. (Intern-NYSC)

I was part of the Response team for the Lassa fever outbreak in 2018, January through February. Activities carried out were- investigation of suspected cases of Lassa fever, sensitization of doctors in hospitals in the various local Government Area's in FCT on the disease, how to follow precautionary measures and use the PPE's. Field Assignments. Jan to march, 2018.

**Intern**

(2016) Adewole Clinic and Maternity, Ilorin- Community outreach and mobilization with CHEW's, and Health Educators, Gained practical experience in the treatment of patients with minor injuries and burns, Dispensing of drugs.

**Intern**

(2015) Kwara state general hospital, immunization department Administering of vaccines with nurses.

**Publications:**

Nil-

Date .....

Signature.....

## University Compliance Certification

This is to certify that this thesis by Damilola Joy Lawal with Matriculation Number LCU/PG/001174 in the department of Public Health, Faculty of Basic Medical and Applied Sciences, Lead City University, Ibadan is in full compliance with the approved University's Format and Style.

.....

Name

.....

Date