



Prevalence and correlates of depressive symptoms among in-school adolescents in a rural district in southwest Nigeria



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A B S T R A C T

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This study was conducted to assess the prevalence and correlates of depressive symptoms among in-school adolescents in a rural district in southwest Nigeria. A cross-sectional survey involving 1713 adolescents from four private and three public secondary schools were selected using a stratified cluster sampling technique. Patient Health Questionnaire (PHQ)-9, with a maximum score of 27, was used to assess the presence (score ≥ 5) and severity (score ≥ 15) of the symptoms of depression. Multiple logistic regression was used to identify the correlates. The prevalence was 21.2%; 5.1% of the respondents had moderately severe to severe depression. Significant predictors included “not living with parents” (OR = 1.69; 95%CI, 1.14–2.38), not participating in sports (OR = 1.45; 95%CI; 1.11–1.92), a large number of siblings (OR = 1.69; 95%CI; 1.11–2.63), and a change in place of residence (OR = 1.46; 95%CI, 1.13–1.88). A need exists to plan and implement health education measures to reduce the burden of the disease.

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Introduction

Clinical depression is more than just a feeling of sadness or a transient state of unhappiness and hopelessness. It is a psychiatric disorder characterized by symptoms of ‘persistent’ feelings of hopelessness, dejection, poor concentration, lack of energy, inability to sleep, and sometimes, suicidal tendencies (Petersen et al., 1993). Depression has been designated as the leading cause of disability and the fourth leading cause of total disease burden worldwide (World Health Report, 2002). Although depressive disorders are relatively rare in childhood, by adolescence the prevalence is estimated between 2% and 50% (Adewuya, Ola, Aloba, Mapayi, & Oginni, 2006). In Nigeria, Adeniyi, Okafor, & Adeniyi (2011) estimated the prevalence of severe depressive symptoms among urban dwelling secondary school adolescents 12–17 years of age to be 5.7%. An earlier report among another group of urban Nigerian adolescents provided a similar prevalence of major depressive disorder (6.9%; Adewuya, Ola, Aloba, Mapayi, & Oginni, 2006). The increasing prevalence of substance abuse, suicide, and other dysfunctional behaviours among adolescents has led to the current concern of depression among youth (Tyrrell & Elliot, 2011).

Adolescent depression has been associated with various factors. Depression occurs more often in the following: females; older adolescents; as a co-morbidity with other psychiatric and physical illnesses; in parents and close relatives; and in adverse family environments, such as divorce; large families, abuse, and neglect. Other factors associated with depression include poor self-esteem, perceived lack of control over negative events, break-up of a relationship, and physical inactivity (Adeniyi et al., 2011; Adewuya et al., 2006). It has been observed that adolescents who develop depression often have

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recurrences in adulthood and undergo a more severe course (Satala, Marttunen, Henriksson, & Lonnqvist, 2002). Depression in this class of individuals is particularly delicate as it often results in lower academic performance, behavioural problems, poor socialization (Lamarine, 1995), and even suicide. Ninety percent of suicides are reported to occur among teenagers with a diagnosable mental illness, with depression being the most common (Tyrrell & Elliot, 2011). Moreover, symptoms of depression in adolescents are often overlooked by parents, teachers, and caretakers, attributing the symptoms to teenage mood swings.

Most of the studies on adolescent depression are from Western cultures, and very few studies on adolescent depression in Nigeria are from urban settings. Although studies have noted differences in the prevalence and associated factors of depressive disorders among races, cultures, and religions, (Scheidt, Overpeck, Wyatt, & et al, 2000), literature searches reveal a limited number of studies on adolescent depression in rural or semi-urban Africa. Rural-urban disparities in the epidemiology of non-communicable diseases have been reported (World Health Organization, 2011). Children in rural settings have been shown to have fewer emotional and behavioural problems than children in urban settings (Cederblad, 1988). The present study was thus conducted to assess the prevalence of depressive symptoms among in-school adolescents and identify some demographic factors that may be associated with depressive symptomatology among selected in-school adolescents in a rural setting in southwest Nigeria.

Methods

Study setting

The study was carried out in the Egbeda Local Government Area (LGA) of Oyo State, southwest Nigeria. Egbeda is one of the 33 LGAs of the state and 1 of 11 LGAs that make up Ibadan metropolis, the capital of the State. Egbeda is a rural LGA located at latitude 7° 21'–8° N and longitude 4° 02'–4° 28' E, with a total area of approximately 191 km² and a population of 281,573 based on the 2006 census (National Population Commission, 2006). Egbeda is subdivided into 11 political wards with >90% comprised of agrarian communities. There were a total of 19,896 in-school adolescents in 68 registered secondary schools, of which 28 were public and 40 were private.

Study design

A cross-sectional study design was used. Participants were in-school adolescents between 10 and 19 years of age. We determined that a total of 1367 students would be required to obtain a prevalence of depressive symptoms of 6.9% at an absolute precision of 3.5%, a type 1 error of 5%, and at 95% power, assuming a design effect of 2.

Sampling technique

A stratified cluster sampling technique was used. A list of all secondary schools and the population were obtained. The list was stratified based on the school type into public and private. All schools comprised both genders and day students, except for one private school with boarding students, which was excluded from the list because boarding students are likely to come from other parts of the State or from neighbouring states. The cumulative population per stratum was divided by the total population and multiplied by the estimated sample size to determine the number of students that would be required to participate per stratum. Based on this calculation, four private and three public schools were selected by probability proportional to size. All consenting students between 10 and 19 years of age in the selected schools were recruited for the study.

Data collection

To obtain information from the participants, a self-administered (investigator-assisted) pretested questionnaire, which included sections on socio-demographic data and Patient Health Questionnaire PHQ-9 was used (Kroenke & Spitzer, 2002). The socio-demographic section included age, gender, religion, family structure, change in residence within the last six months, maltreatment status, participation in sporting activities, presence of persistent health conditions and attendant drug use. The PHQ-9 is a self-rating instrument for depression that was developed in 1999 by Spitzer et al. (1994) from the primary care evaluation of mental disorders (PRIME-MD). We used the PHQ-9 to screen for the occurrence and severity of depression, which is strictly based upon the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Nine symptoms were described and the individual responded by indicating how much he/she was bothered by these symptoms during the two weeks prior to the interview. The response to each item was rated 0–3, which enabled us to assess the severity of the disorder. The maximum possible score was 27. Scores of 5–9 indicated mild depression, 10–14 indicated moderate depression, 15–19 indicated moderately severe depression, and ≥ 20 indicated severe depression. The PHQ-9 is one-half the length of most other depression measures and takes only a few minutes to complete. Earlier studies in primary care have shown that the PHQ-9 detects depression with a sensitivity of approximately 90% and a specificity ranging from 77% to 88% when using the cut-offs. The PHQ-9 has been validated in both primary care settings and hospitals (Kroenke & Spitzer, 2002). Recently, the PHQ depression screener was evaluated for detecting major depression among adolescents with a sensitivity of 89.5% and specificity of 77.5% (Richardson et al., 2010).

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