Perceived barriers to help-seeking for depression among secondary school students in Lagos, Nigeria

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Abstract

Objective: In spite of a wide range of effective treatment options, a huge treatment gap persists for depression among adolescents especially in low and middle-income countries. The barriers to help seeking for depression among Nigerian adolescents are currently under-researched. Identifying these barriers is critical to the design of interventions towards better utilisation of mental health services. This study assessed the barriers to help-seeking for depression among adolescent secondary school students in Lagos Nigeria.

Method: Using a cross-sectional study design, 156 adolescent students attending a public co-educational secondary school in Lagos, south-West Nigeria completed a vignette-based questionnaire which assessed barriers to help-seeking for depression. The vignette depicted an adolescent with depression according to the DSM-IV criteria.

Result: The mean age of the participants was 15.9 (± 1.1) years and 49% were males. The most commonly perceived barrier to help-seeking for depression was stigma (50.6%). Other barriers reported included disapproval by families/friends (21.2%), illness-related factors (7.7%), negative attitudes to treatment (7.1%), financial constraint (5.1%), ignorance (3.9%) and preference for spiritual treatment (3.9%).

Conclusion: Stigma, ignorance, misperceptions and negative attitudes to treatment are major barriers to help-seeking for depression among adolescents. Destigmatisation and mental health literacy interventions are crucial steps towards facilitating help-seeking among adolescents with depression.

Keywords: Depression, Barriers to help-seeking, Adolescents, Mental Health Literacy, Stigma, Treatment-gap, school-children, Nigeria

Introduction

Depression is a major psychiatric disorder characterized by persistent low mood, loss of interest in pleasurable activities, low energy level, negative self-worth, hopelessness, lack of concentration, insomnia, poor appetite and weight loss. About 1 out of 5 people suffer from depression in their lifetime, and the onset of this disorder is common in adolescence. Depression is a leading contributor to the global burden of diseases and is projected to become the second most burdensome disorder by the year 2020.

Despite the availability of a wide range of effective treatment options, there is a huge treatment gap for depression especially in developing countries where less than 10% of affected people receive treatment. The Nigerian Survey of mental health and well-being revealed that only 0.6% of those with severe mental health problems including depression and anxiety had received treatment from mental health professionals. The consequences of untreated depression include social isolation, decline in personal care and occupational functioning, deterioration in physical health, poor quality of life and suicide.

Previous research highlighted a number of potential barriers to help-seeking for mental health disorders. These include structural barriers such as dearth of mental health professionals, non-availability of accessible mental health services in the community, and poor mental health care financing. Apart from these structural factors, personal barriers such as stigma, ignorance, lack of confidence in the available treatment modality and poverty may also serve as obstacles to appropriate help seeking. There is a dearth of research on the barriers to help-seeking for depression among adolescents in Nigeria. Understanding the barriers to help-seeking is pivotal to the design of interventions targeted at promoting prompt help-seeking for depression, thereby improving outcomes in affected individuals. Therefore this study assessed the barriers to help-seeking for depression in a sample of adolescent secondary school students in Lagos, Nigeria.
Methods

Study design and setting: The study was a cross-sectional descriptive survey of a sample of adolescent students recruited from a public co-educational secondary school in Lagos, Nigeria. Lagos is located in south-West Nigeria, and is the most populated metropolis in the country.

Ethical consideration: Prior to the commencement of the study, approval was obtained from the Lagos Educational Authority District Office. Informed parental consent and students' assent were also obtained after detailed education about the purpose and nature of the study. The students were assured of their right to refuse to participate or withdraw from the study at any time and that their opting out from the study will not be used against them. A high level of confidentiality was maintained both during and after the data collection.

Sample size determination and sampling technique: The required sample size, N was calculated with the Fisher's formula N = Z²PQ/d² (z, the standard normal deviation = 1.96 at 95% confidence Interval; p, the proportion in the target population estimated to have a particular characteristic i.e. barriers to help-seeking for depression = 90%, based on previous research; Q = 100 - P; d = absolute precision or sampling error tolerated). The formula indicated that a minimum sample of 138 was required. However, 170 participants were recruited in order to cater for possible attrition (20%). The participating students were selected by convenient sampling, from one arm each of senior secondary classes 1 to 3, until the required sample size was obtained.

Instrument and procedure: The participants completed a widely used vignette-based questionnaire by self-report. The vignette highlights the features of depression based on the DSM-IV (Diagnostic Statistical Manual) diagnostic criteria: “John is a 15 year old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has troubles sleeping at night. John doesn’t feel like eating and has lost weight. He can’t keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day to day tasks seem too much for him. His parents and friends are very concerned about him” (N.B: The criteria for the diagnosis of major depression in the DSM5 are the same as the DSMIV.)

The specific question regarding barrier to help-seeking was ‘If you have a problem like John, what might stop you from seeking help/treatment’. The response format was open-ended and multiple responses were permitted. The age and gender of the participants were also elicited. The participants were encouraged to ask questions if they needed further clarifications. They were assured of confidentiality and the fact that the questions were for research purposes and not an academic assessment. School teachers introduced the research team to the students and assisted in identifying the classes for selection.

However, the teachers were not present during data collection, and they had no access to the completed questionnaires.

Statistical Analysis: Out of the 170 questionnaires distributed, 156 (91.8%) were adequately completed for analysis. The open-ended responses to the item eliciting perceived barriers in the questionnaire were grouped into categories and tabulated based on similarity of thematic content using templates from previous research on this subject. These categories included structural barriers (e.g. financial constraint, lengthy distance to health service, difficulty in securing appointment/consultation); stigma-related barriers (concern about being viewed negatively, humiliated or embarrassed); barriers related to attitudes and beliefs about treatment/health service (e.g. lack of confidence in the source of help, perception that nothing can help concern about adverse effects of treatment); barriers related to the illness (symptoms, lack of insight/emotional competence to seek help, help negation/resistance); and other barriers including preference for other sources of help, self-reliance (belief that one can handle the problem by oneself), and ignorance.

Two of the researchers independently conducted the assignment into categories before a consensus was reached on further review. Descriptive statistics such as frequencies, percentages or mean values were computed for relevant socio-demographic and perceived barrier variables using IBM-SPSS version 20. Bivariate analysis compared the gender distribution of perceived barriers to help-seeking using chi-square. The level of statistical significance was set at p<0.05.

Results

The mean age of the participants was 15.9 (± 1.1) years and 51% were females. The most frequently perceived barriers to seeking help for depression was stigma (50.6%). Other barriers reported by the students included (Table 1) wrong advice/disapproval by friends or families (21.2%), illness-related factors (7.7%), Negative attitudes/lack of confidence in mental health service (7.1%), Ignorance (3.9%), financial constraints (5.1%), belief in traditional/spiritual healers (3.9%) or self-help (1.3%). Sample qualitative responses on the barriers to help seeking are highlighted in the appendix. There was no statistically significant difference in the pattern of perceived barriers to help-seeking for depression between males and females (Table 2)
Table 1: Perceived barriers to help-seeking for depression among the adolescents

<table>
<thead>
<tr>
<th>Barriers</th>
<th>N=156</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td>Stigma</td>
<td>79</td>
</tr>
<tr>
<td>Illness-related</td>
<td>12</td>
</tr>
<tr>
<td>Negative attitude/beliefs about treatment</td>
<td>11</td>
</tr>
<tr>
<td>Disapproval by friends/families</td>
<td>33</td>
</tr>
<tr>
<td>Preference for spiritual/traditional healing</td>
<td>6</td>
</tr>
<tr>
<td>Financial constraint</td>
<td>8</td>
</tr>
<tr>
<td>Ignorance</td>
<td>6</td>
</tr>
<tr>
<td>Belief in self-help</td>
<td>2</td>
</tr>
</tbody>
</table>

*Total >100% due to multiple responses

Table 2: Association between gender and perceived barriers to help-seeking for depression

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>N=77</th>
<th>N=79</th>
<th>χ²</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MALE</td>
<td>FEMALE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma</td>
<td>35 (45.5)</td>
<td>44 (55.7)</td>
<td>1.64</td>
<td>0.201</td>
</tr>
<tr>
<td>Illness-related factors</td>
<td>7 (9.1)</td>
<td>5 (6.3)</td>
<td>0.42</td>
<td>0.518</td>
</tr>
<tr>
<td>Negative attitude to treatment</td>
<td>4 (5.2)</td>
<td>7 (8.9)</td>
<td>0.80</td>
<td>0.371</td>
</tr>
<tr>
<td>Disapproval by friends/families</td>
<td>16 (20.8)</td>
<td>17 (21.5)</td>
<td>0.01</td>
<td>0.909</td>
</tr>
<tr>
<td>Preference for spiritual healing</td>
<td>5 (6.5)</td>
<td>1 (1.3)</td>
<td>2.88</td>
<td>0.198 *</td>
</tr>
<tr>
<td>Financial constraint</td>
<td>5 (6.5)</td>
<td>3 (3.8)</td>
<td>0.58</td>
<td>0.445 *</td>
</tr>
<tr>
<td>Ignorance</td>
<td>4 (5.2)</td>
<td>2 (2.5)</td>
<td>0.75</td>
<td>0.657 *</td>
</tr>
<tr>
<td>Belief in self-help</td>
<td>1 (1.3)</td>
<td>1 (1.3)</td>
<td>0.00</td>
<td>&gt;0.99</td>
</tr>
</tbody>
</table>

*Fisher's correction applied

Discussion
The current study identified the perceived barriers to help-seeking for depression in a sample of secondary school students in Lagos, south west Nigeria. Stigma was the most commonly perceived barrier to help-seeking among the respondents. This result is consonant with previous findings on barriers to mental health help seeking for depression in North America, Europe, Australia, and Asia. In a systematic review of studies spanning two decades of research on perceived barriers to help-seeking for mental disorders among young people, stigma was ranked the greatest barrier to help-seeking.

Stigma encompasses stereotypes, discrimination, social distance and negative attitudes towards individuals who have attributes considered deviant by the society. Similar to findings in other parts of the world, research conducted among both children and adult populations in Nigeria have demonstrated predominantly stigmatising attitudes towards individuals with mental illness. Anticipation of stigma and unfair treatment discourage disclosure of mental health problems and reduce readiness to seek professional help. Negative influence from friends and family members was the 2nd most frequently reported barrier to the treatment of depression in the current study. Ignorance and belief in supernatural causation were also considered barriers by a few respondents. Help-seeking advice offered to others is likely to reflect the attitude, belief and perception of the advisor. In a cultural setting where beliefs about supernatural causation of mental illness are widespread and commonly portrayed in the mass media, it is not surprising that opinion from family or friends would encourage consultation of spiritual healers rather than mental health professionals. This is crucial in light of the evidence that adolescents are more likely to rely on advice from their social network than formal sources of help when they have mental health needs. Factors related to the illness were also cited as potential barriers to help-seeking in the current study. The specific factors highlighted by the respondents included feelings of helplessness,
hopelessness, social isolations, low self-esteem and poor insight. The presence of these features especially hopelessness, may tilt an individual towards contemplation of suicide rather than motivation to seek treatment\(^7\). Lack of insight precludes access to treatment without persistent prompting by others. With the waning of the informal social support characteristic of the extended family system and the trend towards solitary living, illness related factor may become an increasingly important encumbrance to help-seeking for depression in modern-day Nigeria.

Lack of confidence in the mental health system was also considered a hindrance to help-seeking by about 7% of the respondents. This encompassed doubts about the efficacy of available treatment, lack of confidence in the care provider, uncertainties about the side-effect of treatment or fear of breach of confidentiality\(^5, 14\). This indicates that efforts to facilitate help-seeking need to include strategies to address and allay perceived fears about orthodox treatment modalities.

Financial constraint was the only structural barrier to help-seeking reported by the adolescents. Payment for mental health services is 'out of pocket' in Nigeria, therefore people with mental health needs may be denied treatment due to lack of funds\(^25\). Other potential structural barriers such as scarcity of qualified mental health specialists, non-integration of mental health into primary care, and isolation of psychiatric services in few urban centres which is out of reach to the majority were not considered important by the adolescents\(^34, 35, 36\). Previous research has shown that adults differ significantly in the perception of barriers to help-seeking for mental health services. Whereas, adults are more likely to perceive cost of care and other structural barriers as important, adolescents tend to rate personal factors such as stigma as more crucial\(^14, 15\).

A major implication of our findings is that policies directed at provision of accessible mental health care alone are not sufficient to guarantee utilisation of services and early intervention for depression until personal barriers such as stigma, ignorance and negative influences are surmounted. This indicates a crucial need for interventions targeted at fighting stigma, and improving mental health literacy among adolescents in Nigeria. Evidence-based interventions in this regard demonstrated in other parts of the world include public awareness campaigns, integration of mental health literacy into the school curriculum and organised contact with users of mental health services\(^36, 39-42\). Similar interventions could be adapted in Nigeria with consideration to cultural competence and feasibility in a resource constrained setting\(^27\). The messages in these campaigns must clearly address stigma, deficits in knowledge about depression and provide detailed information about sources of help seeking. Myths about supernatural causation must be debunked and fears about orthodox care addressed. In order to reach adolescents, the campaigns must be channelled through the appropriate outlets such as social media, mobile phone text messages, and favourite entertainment channels on television, radio and satellite\(^42\). There is also need to provide an all-inclusive mental health insurance scheme to remove barriers to care associated with 'out of pocket payment'.

The current study has a number of limitations. The participants were recruited by convenient sampling from a selected school and the sample size was limited. This may limit generalisation of the results to the general population of Nigerian adolescents. Secondly, the reaction of participants in real-life situations may not be consistent with their responses to the vignette based questionnaire, and case vignettes may not reflect the complexity manifested in real life. Furthermore, socially desirable responses cannot be ruled out. However, participants were assured of the anonymity and confidentiality of their responses. The use of case vignette has also been shown to facilitate communication of the adolescent's opinion with minimal interference from the researcher. In addition, the use of a similar methodology to previous studies conducted in other parts of the world facilitated comparison of our results with extant literature. Overall, this study has provided very valuable information on a subject that has not been previously researched in Africa. Further large scale studies are required to confirm and extend our findings.

Conclusion

Personal barriers such as stigma, disapproval by social network, negative attitudes to treatment and illness related factors were perceived as predominant barriers to help seeking for depression by adolescent students in Lagos Nigeria. These findings indicate the salience of de-stigmatisation and mental health literacy interventions in facilitating help seeking and reducing the treatment-gap for depression among adolescents.

Acknowledgement

All the students who participated in the study and the school teachers for their assistance.

Conflict of interest

The study was funded by the researchers' personal contributions. There was no external technical or financial support, and no known potential conflict of interest.

References

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APPENDIX

Sample responses on the barriers to help-seeking for depression

Stigma-related barrier: "it's a shameful thing so you don't want to expose yourself uyarı “people will laugh at you if they know you have been to mental hospital”, “...they will label you as mental case and run away from you”; 'it's a secret you don't want people to know..."

Barriers related to the illness: “when you are depressed, you don't care...nothing matters”. “You may not think you are sick mentally, so you won't agree to go for treatment” (lack of insight), “When you are sad that way you may prefer to die” (suicidal behaviour) “Because you feel helpless or hopeless, you don't bother whatever happens.”

Negative attitude to treatment: “You are not sure...You don't know if it the treatment will work”, “Sometimes the injections in psychiatric hospital are dangerous...they make people go mad”

Disapproval by family members/friends: “you can't go to hospital yourself, if your family say you can't go, you won't go” “if you want to see a doctor and your parents say no...”, “Your friends or neighbours may discourage you with their advice”