ORIGINAL RESEARCH REPORT

Depression-related knowledge, attitude, and help-seeking behavior among residents of Surulere Local Government Area, Lagos State, Nigeria

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ABSTRACT

Context: Worldwide, depression leads among the causes of ill-health and disability. Therefore, it is a major public health concern. **Aim:** This study was carried out to determine depression-related knowledge, attitude, and help-seeking behavior among residents of Surulere Local Government Area, Lagos state, Nigeria. **Settings and Design:** This was a descriptive cross-sectional study. A total of 422 respondents were recruited using the multistage sampling technique. **Subjects and Methods:** An adapted, pretested, semi-structured, and interviewer-administered questionnaire was used to collect data. **Statistical Analysis Used:** Data were analyzed using EPI Info Version 7 statistical software. **Results:** The proportion of respondents with depressive symptoms such as loss of interest in usual activities was 30.6%. Majority of the respondents had good knowledge of depression (90.0%), positive attitude (93.2%), and good help-seeking behavior (87.9%) toward depression. Marital status was not significantly associated with the presence of depressive symptoms. However, there was a statistically significant association between employment status and the presence of depressive symptoms (P = 0.001) and the help-seeking behavior toward depression (P = 0.013); the level of education on the other hand showed a statistically significant association with both knowledge and attitude (P = 0.003, $P \leq 0.001$, respectively). **Conclusion:** Most of the respondents had good knowledge, positive attitude, and good help-seeking behavior toward depression; however, mental health services may not be readily available. There is therefore a need to ensure the availability of good mental health services as well as public enlightenment on where and how to access these services. These can prove very useful in tackling the rising prevalence of mental health disorders.

Key words: Attitude, depression, depressive symptoms, help-seeking behavior, knowledge, mental health

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INTRODUCTION

In recent times, mental health disorders have become a pressing public health issue, depression being one of the most common of them. Depression is the leading cause of ill-health and disability worldwide.[1] According to the Diagnostic and Statistical Manual of Mental Disorders V (DSM V), depression is mainly characterized by the presence of five or more symptoms for a 2-week period, which represents a change from previous functioning, with the presence of either a depressed mood or loss of interest or pleasure.[2] Other symptoms include significant weight loss when not dieting, or weight gain, sleeplessness or excessive sleepiness, psychomotor agitation or retardation, loss of energy, feelings of worthlessness or guilt, reduced ability to concentrate, and reoccurring thoughts of death or

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suicide. Depression is an important risk factor for suicide, which claims hundreds of thousands of lives each year.[1]

Major depressive disorders contribute to the disease burden allocated to suicide and ischemic heart disease emphasizing the importance of considering depressive disorders as a public health priority.[3] In England, results from the Adult Psychiatric Morbidity Survey showed that one in three adults aged 16–74 (37%) with conditions such as anxiety or depression were accessing mental health treatment in 2014. This figure increased from one in four (24%) as in the earlier survey carried out in 2007.[4] In the United States mental disorders such as depression topped the list of the costliest medical conditions costing about $201 billion, in the year 2013.[5]

In a study conducted in Western Nigeria, households in 21 out of the 36 states were sampled, and 6752 adults aged 18 and above were selected for the study which showed the lifetime and 12-month prevalence estimates of major depressive disorder to be 3.1% and 1.1%, respectively.[6] In another study conducted in Oyo State, Nigeria, among 1105 participants, using the General Health Questionnaire 12 as screening, and subsequently the DSM-IV as diagnostic tools, results showed that the overall prevalence of depression was 5.2% with depression being more prevalent among women than men, i.e. 5.7% and 4.8%, respectively.[7]

Depression causes impairment in functional well-being, decrease in quality of life,[8,9] as well as overall health.[10,11] Depression can cause impairment in a person's role at home, decreased productivity at work, and impairment in relationships and social network.[12] These can result in limitation of daily activities,[11] job insecurities,[13] and increased risk of early mortality due to physical disorders and suicide.[14] Early detection of depression is extremely necessary to reduce the suffering that these problems cause. Depression can be adequately managed, and this explains the need for assessment of adults to determine their knowledge, attitude, and help-seeking behavior toward the illness. There is also a need to determine the proportion of respondents with depressive symptoms within the community and to know the necessary interventions required. This study assessed depression-related knowledge, attitude, and help-seeking behavior among residents of Surulere Local Government Area (LGA), Lagos State.

SUBJECTS AND METHODS

Surulere is one of the 20 LGAs that comprise metropolitan Lagos, Nigeria. It is a residential and commercial LGA located on the mainland of Lagos State, with an area of 27.05 km^2. At the last census in the year 2006, the LGA had a total of 1,274,362 inhabitants with a population density of 47,111 inhabitants per square kilometer.[15] Surulere LGA has 12 administrative wards, 3 local council development areas, 7 public health facilities consisting of 5 functional primary health care centres (PHCs), 1 general hospital, and 1 dental clinic. It also has 80 registered private health facilities,[15] mental health services being available in only a few of them.

A cross-sectional descriptive survey was conducted among adults, 18 years of age and above, and resident in Surulere LGA for at least 6 months before the study. Using the Cochran formula[16] for the estimation of the minimum required sample size for populations >10,000 and a prevalence rate of 50%,[16] a sample size of 384 was calculated. This was increased by 10% to 422 for contingencies such as nonresponse. The multistage sampling technique was used in the selection of participants. In stage one, four of twelve administrative wards were selected by simple random sampling technique using the balloting method. In stage two, five streets were selected from each of the four wards also using the simple random sampling technique by balloting. Stage three involved selection of houses from each street. There were about 40 houses per street, 21 houses were selected per street (23 from the last street) by systematic sampling. Stage four involved the selection of one household from each selected house. In houses occupied by more than one household, the selection of one household was done by balloting. Simple random sampling by balloting was used to select one respondent from all the eligible members of each household.

The data collection tool was a pretested, semi-structured, and interviewer-administered questionnaire, which was administered by 4 trained interviewers. The questionnaire developed was guided by existing literature on the prevalence, knowledge, attitude, and help-seeking behavior of depression using standard tools such as the Patient Health Questionnaire (PHQ-2 and PHQ-9),[17] the Depression Stigma Scale,[18] and the Attitudes Toward Seeking Professional Psychological Help Short Form Scale[19] to determine the proportion of respondents with depressive symptoms, to assess the attitudes and the help-seeking behavior toward depression.

The screening statements were scored according to a 4-point Likert scale, and each statement was graded with the highest score of three for the most severe depressive symptoms and the lowest score of zero indicating an absence of depressive symptoms. The possible minimum and maximum scores for depressive symptoms were 0 and 6, respectively. The presence of depressive symptoms was determined as positive if the respondents scored 50% or more (3/6 or more) while a score <50% (2/6 or less) was considered to be negative for depressive symptoms. Ten questions assessed the knowledge of subjects. The possible minimum and maximum scores for knowledge were 0 and 20, respectively. "Good knowledge" was determined if the respondents answered 50% or more correctly; <50% was categorized as "poor knowledge."

Eight attitude statements were scored according to a 5-point Likert scale, and each statement was graded with the highest score of 5 for the most positive response ranging down to 1 for the least positive. The possible minimum and maximum scores for attitude were 8 and 40, respectively. "Positive attitude" was determined if the respondents scored 50% or more while a score <50% was determined to be "negative attitude." The help-seeking behavior toward depression was assessed using 10 questions. The possible minimum and maximum scores for help-seeking behavior were 0 and 10, respectively. "Good help-seeking behaviour" was determined if the respondents answered 50% or more positively; <50% was determined to be "poor help-seeking behaviour."

Ethical approval was obtained from the Health Research and Ethics Committee of the Lagos University Teaching Hospital. Written informed consent was obtained from each respondent before administration of the questionnaire. Data were collated and analyzed using the EPI-Info Version 7 statistical software (Epi Info™ CDC, Atlanta, GA, USA). The Chi-square and Fisher's exact tests were used to test for associations between categorical variables as applicable. Associations were considered statistically significant if two-tailed probability was <5% (0.05).

Limitations to the study

Due to the sensitive nature of the topic, the interviews lasted long; hence, to be able to collect data according to the sample size, the researchers had to expand the research days to include more days like weekends and holidays.

RESULTS

Majority of the respondents (77.0%) were between the ages 21–40 with the mean age being 27.1 ± 5.5 years. There were more female (62.8%) than male respondents (37.2%). Majority were Christians (76.1%), single (73.7%), and Yoruba (55.0%). Furthermore, majority of the respondents had tertiary education (67.1%) and were employed (78.2%); however, up to 46.4% of them earned <N30, 000 monthly [Table 1].

Table 1: Sociodemographic characteristics of respondents (*n*=422)

Variable	Frequency(%)
Age (years)	
<21	80 (19.0)
21-40	325 (77.0)
41-60	12 (2.8)
>60	5 (1.2)
Mean±SD	27.1±5.5
Gender	
Male	157 (37.2)
Female	265 (62.8)
Religion	
Christian	321 (76.1)
Islam	96 (22.7)
Traditional	2 (0.5)
Others	3 (0.7)
Marital status	
Single	311 (73.7)
Married	101 (23.9)
Divorced/widowed	10 (2.4)
Ethnicity	
Igbo	130 (30.8)
Yoruba	232 (55.0)
Hausa	25 (5.9)
Others	35 (8.3)
Level of education	
No formal education	3 (0.7)
Primary	5 (1.2)
Secondary	112 (26.5)
Tertiary	283 (67.1)
Others	19 (4.5)
Employment status	
Employed	330 (78.2)
Unemployed	92 (21.8)
Estimated monthly income (*n*=330)	
≤N30,000	153 (46.4)
N30,001-N60,000	87 (26.4)
N60,001-N90,000	20 (6.0)
N90,001-N120,000	27 (8.2)
>N120,000	43 (13.0)

Knowledge of respondents about depression

Majority (90.0%) of the respondents had heard of depression. The most frequent source of information was social media (41.6%) followed by the school (24.7%) then friends (22.6%) and the television (19.5%). In terms of knowing what depression was, 61.1% knew of it as a medical mental illness. However, 22.9% indicated depression as the same thing as sadness, as high as 70.3% related depression with weakness of character and 63.4% rightly related depression with biological changes in the brain. The majority were able to correctly identify symptoms of depression (>90%). Regarding the treatment of depression, more than half the respondents (57.6%) indicated that psychiatrists could help manage depression. However, 9.2% indicated that there were traditional or religious healers who could treat depression, while 33.2% knew nothing of how to find help for a person suffering from depression [Table 2]. Majority of the respondents (90.0%) had overall good knowledge of depression [Table 3].

Attitude of respondents toward depression

The statement to which the highest number of respondents disagreed to was "A person with depression should best keep it a secret" (to which 64.5% of respondents strongly disagreed and 17.9% disagreed). This was followed by the statement "It is best to avoid people with depression, so you don't become depressed yourself" (to which 58.7% of respondents strongly disagreed and 21.6% of respondents disagreed, but 5.8% agreed). While 49% disagreed that depression did not need to be treated by a specialist but could rather be overcome by oneself, 4.5% agreed with this statement.

Table 2: Knowledge of depression

Variable	Frequency (%)
Awareness of depression (*n*=422)	380 (90.0)
First source of information* (*n*=380)	
Social media	158 (41.6)
School	94 (24.7)
Friend	86 (22.6)
Television	74 (19.5)
Meaning of depression* (*n*=380)	
Depression is the same thing as sadness	87 (22.9)
Depression is a medical mental illness that causes strong feelings of sadness over a long period of time	232 (61.1)
Depression is related with weakness of character	267 (70.3)
Depression is related with biological changes in the brain	241 (63.4)
Symptoms of depression* (*n*=380)	
Persistently sad, anxious, or empty moods	353 (92.9)
Loss of pleasure in usual activities	354 (93.2)
Treatment of depression* (*n*=380)	
Treated by a specialist (psychiatrist)	219 (57.6)
Traditional/religious "healers" exist	35 (9.2)
Know nothing of its treatment	126 (33.2)

*Multiple responses allowed

Table 3: Prevalence of depressive symptoms, overall knowledge, attitude, and help-seeking behavior toward depression

Variable	Frequency (%)
Symptoms of depression (*n*=422)	129 (30.6)
Symptoms of major depression (*n*=422)	83 (19.7)
Personal experience of depression (*n*=380)	107 (28.1)
Knowledge (*n*=380)	
Good	342 (90.0)
Poor	38 (10.0)
Attitude (*n*=380)	
Positive	354 (93.2)
Negative	26 (6.8)
Help-seeking behavior (*n*=422)	
Good	371 (87.9)
Poor	51 (12.1)

The statement to which the highest number of respondents agreed to was "People with depression can cheer up if they wanted" (to which 11.1% strongly agreed and 39.5% agreed). This was followed by the statement "A politician with depression must never be voted for" (to which 22.6% strongly agreed and 18.7% agreed). Some respondents also agreed to the statement "Depression is a sign of personal weakness" (to which 11.1% strongly agreed and 28.4% agreed) [Table 4]. Majority of the respondents (93.2%) had an overall positive attitude toward depression and those who suffer from it [Table 3].

Help-seeking behavior of respondents toward depression

Regarding help-seeking behavior toward depression, the statement with the highest acceptance by the respondents was "A person should work out his mental problems; by getting psychological counseling not only as a last resort" (90.5%) and the acceptance of the statement "The idea of talking about problems with a psychologist is a good way to get rid of emotional conflicts" was also high (90.1%). However, the statements with the least acceptance by the respondents was "I would want to get psychiatric attention if I was worried or upset for a long period of time" (65.9%) and the statement "Irrespective of the time and expense involved in psychotherapy it would have much value for a person like me" (73.9%) [Table 5]. Majority of the respondents (87.9%) had overall good help-seeking behavior toward depression [Table 3].

Prevalence of depressive symptoms

The proportion of respondents with depressive symptoms was 30.6%. The proportion of respondents with symptoms suggestive of major depression was 19.7% [Table 3].

Factors associated with depressive symptoms, knowledge, attitude, and help-seeking behavior

There was a statistically significant association between the presence of depressive symptoms and employment status (P = 0.002). The proportion of respondents with depressive symptoms who were employed was higher than that of the unemployed. However, marital status did not show a significant association as expected. The level of education of the respondents showed a statistically significant association with the level of knowledge about depression (P = 0.003). Knowledge of depression was better with increasing level of education. The attitude of the respondents toward depression was significantly associated with their level of education (P < 0.001). The respondents with positive attitudes toward depression were mostly those with secondary and tertiary education. Regarding help-seeking behavior, a statistically significant association was found with age (P = 0.046), level of education (P = 0.013), employment status (P = 0.013), and monthly income (P = 0.009). A higher proportion of employed respondents and those with a higher level of education and monthly income had good help-seeking behavior towards depression [Table 6].

DISCUSSION

Mental health issues such as depression may often go unrecognized although in recent times, awareness about them has improved. The proportion of respondents with depressive symptoms was high at 30.6%. This is contrary to the findings of a study carried out in Oyo state, Nigeria, which reported the prevalence of depression as 5.2%.[7] In this study, 19.7% of the respondents had scores corresponding to symptoms suggesting major depression, similar to a study carried out in Beirut which reported the prevalence of major depression as 19.0%.[20] This similarity may be due to the busy and hectic nature of both urban cities. Concerning the personal experience of depression,

Table 4: Attitude of the respondents toward depression

Variable	Frequency (%)				
	SD	D	N	A	SA
Depression is not a real medical illness	86 (22.6)	105 (27.6)	71 (18.7)	86 (22.6)	32 (8.5)
People with depression can cheer up if they wanted	64 (16.8)	69 (18.2)	55 (14.5)	150 (39.5)	42 (11.1)
Depression could be overcome by oneself hence requires no treatment	207 (49.0)	91 (21.6)	87 (20.6)	18 (4.3)	19 (4.5)
Depression is a sign of personal weakness	80 (21.1)	105 (27.6)	45 (11.8)	108 (28.4)	42 (11.1)
It is best to avoid people with depression, so you don't become depressed yourself	223 (58.7)	82 (21.6)	35 (9.2)	18 (4.7)	22 (5.8)
People with depression are dangerous	86 (22.6)	130 (34.2)	97 (25.5)	51 (13.4)	16 (4.2)
A person with depression should never be employed	158 (41.6)	84 (22.1)	70 (18.4)	42 (11.1)	26 (6.8)
A politician with depression must never be voted for	75 (19.7)	90 (23.7)	58 (15.3)	71 (18.7)	86 (22.6)
A person with depression should best keep it a secret	245 (64.5)	68 (17.9)	27 (7.1)	17 (4.5)	23 (6.1)

SD=Strongly disagree, D=Disagree, N=Neutral, A=Agree, SA=Strongly agree

Table 5: Help-seeking behavior of the respondents

Help-seeking behavior	Frequency (%)	
	Yes	No
If I believed I was having a mental breakdown, my first inclination would be to get professional help (psychotherapy)	336 (79.6)	86 (20.4)
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	336 (79.6)	86 (20.4)
I would want to get psychiatric attention if I was worried or upset for a long period of time	279 (65.9)	144 (34.1)
At some future time, I might want to have psychological counseling	320 (75.8)	102 (24.2)
A person with an emotional problem is not likely to solve it alone; he/she is likely to solve it with professional help	361 (85.6)	61 (14.4)
The idea of talking about problems with a psychologist is a good way to get rid of emotional conflicts	380 (90.1)	42 (9.9)
There is something admirable in the attitude of a person who is willing to get help in dealing with his/her conflicts and fears	371 (87.9)	51 (12.1)
Irrespective of the time and expense involved in psychotherapy, it would have much value for a person like me	312 (73.9)	110 (26.1)
A person should work out his/her mental problems by getting psychological counseling not only as a last resort	382 (90.5)	40 (9.5)
Emotional difficulties, like many things, should not be left to work out themselves	377 (89.3)	45 (10.7)

28.1% of the respondents indicated that they or a family member had experienced depression, which is contrary to a study carried out in Australia in which over half of the respondents (58%) reported that they or a family member had experienced depression.[21] This finding of the current study is unsurprising as many in Nigeria, because of the associated stigma, would not readily admit to having an experience of a psychiatric disorder.

The overall knowledge of the respondents concerning depression was high, with 90.0% having good knowledge. This is similar to a study carried out in Canada which reported a high proportion (75.6%) of the respondents with an overall good knowledge of depression.[22] This could be attributed to the increasing awareness campaigns on depression on social media platforms. Majority (41.6%) of the respondents indicated social media as their most frequent source of information about depression, supporting the fact that social media has increased the awareness about depression. The school follows next (24.7%) as a common source of information about depression. A smaller proportion of the respondents (22.9%) could not differentiate depression from sadness. This is similar to a study carried out in Australia which reported that less than half the respondents could not differentiate depression from sadness.[21] Majority of the respondents (70.3%) related depression with weakness of character contrary to a study carried out in Canada which reported that 43% of the respondents related depression with weakness of character.[22]

Among the respondents, at least 78.2% could recognize symptoms of depression. This is similar to the findings of a study carried out in Penang, Malaysia, which reported that 76.9% of the respondents could recognize three or more symptoms of depression.[23] This is probably due to the increased awareness about depression as observed recently. About half (49.0%) of the respondents indicated that depression does not need to be treated and can be overcome by oneself without referring to a specialist, contrary to a study carried out in Canada which reported that only 28% of the respondents believed in dealing with depression by oneself.[22] This may be accounted for by the difference in the way psychiatric care is perceived in Nigeria compared to a developed country like Canada. Majority of the respondents (57.6%) indicated that professionals such as psychiatrists could help manage depression, though a higher proportion, this supports the Canadian study in which 35.0% of respondents were in complete agreement that health professionals are an appropriate intervention for depression, further buttressing the point that psychiatric care is quite acceptable in the west.

This study indicated that majority of the respondents (93.2%) had a positive attitude toward depression. This is contrary to a study carried out in Istanbul, Turkey, which reported

Table 6: Factors associated with depressive symptoms, knowledge, attitude, and help-seeking behavior

Sociodemographic variable	Depressive symptoms, frequency (%)		χ^2	df	*P*
	Present (*n*=129)	Absent (*n*=293)			
Marital status					
Single	96 (30.9)	215 (69.1)	0.05	2	0.975
Married	30 (29.7)	71 (70.3)			
Divorced/widowed	3 (30.0)	7 (70.0)			
Employment status					
Employed	113 (34.2)	217 (65.8)	9.62	1	0.002
Unemployed	16 (17.4)	76 (82.6)			
Sociodemographic variable	**Knowledge, frequency (%)**		χ^2	df	*P*
	Good (*n*=342)	Poor (*n*=38)			
Level of education					
No formal education	1 (50.0)	1 (50.0)	17.87		0.003*
Primary	1 (100.0)	0 (00.0)			
Secondary	83 (89.3)	10 (10.7)			
Tertiary	244 (92.1)	21 (7.9)			
Others	13 (68.4)	6 (31.6)			
Sociodemographic variable	**Attitude, frequency (%)**		χ^2	df	*P*
	Positive (*n*=354)	Negative (*n*=26)			
Level of education					
No formal education	2 (100.0)	0 (0.00)	29.96		<0.001*
Primary	0 (0.00)	1 (100.0)			
Secondary	92 (98.9)	1 (1.08)			
Tertiary	246 (92.8)	19 (7.17)			
Others	14 (73.7)	5 (26.3)			
Sociodemographic variable	**Help-seeking behavior, frequency (%)**		χ^2	df	*P*
	Good (*n*=371)	Poor (*n*=51)			
Age (years)					
<21	85 (81.0)	20 (19.0)	7.99		0.046*
21-40	269 (89.7)	31 (10.3)			
41-60	12 (100.0)	0 (0.0)			
>60	5 (100.0)	0 (0.0)			
Level of education					
No formal education	2 (66.7)	1 (33.3)	12.66		0.013*
Primary	2 (40.0)	3 (60.0)			
Secondary	101 (90.2)	11 (9.8)			
Tertiary	249 (88.0)	34 (12.0)			
Others	17 (89.5)	2 (10.5)			
Employment status					
Employed	297 (90.0)	33 (10.0)	6.20	1	0.013
Unemployed	74 (80.4)	18 (19.6)			
Estimated income per month (*n*=330)					
<N30,000	144 (94.1)	9 (5.9)	13.48		0.009*
N30,001 - N60,000	71 (81.6)	16 (18.4)			
N60,001 - N90,000	16 (80.0)	4 (20.0)			
N90,001 - N120,000	25 (92.6)	2 (7.4)			
>N120,000	41 (95.4)	2 (4.6)			

*Fisher's exact *P*

the respondents' attitude toward depression as mostly negative[24] and also contrary to a study carried out in western Nigeria which reported widespread negative attitudes toward mental illness.[25] The mostly positive attitudes found in this study could be attributed to the recent proliferation of positive information about depression on social media platforms. Only 31.1% of the respondents agreed to the statement "Depression is not a real medical illness." This is contrary to the findings of a study carried out in India which reported that the majority agreed that "depression is not a real medical illness."[26] Religious or cultural beliefs in disease as spiritual may account for this. A small proportion (10.5%) of the respondents agreed to the statement "It is best to avoid people with depression so you don't become depressed yourself," contrary to other studies which reported mostly

negative attitudes toward depression as was seen in a study carried out in India which reported that about 50% of the respondents expressed that they desired social distance from those suffering from depression.[26] These differences may be attributed to differences in culture between Nigeria and other parts of the world. Another study carried out in Germany reported increased desire for social distance from people with major depression despite an increase in the mental health literacy of the public, further indicating a difference in culture.[27] About 18% of the respondents agreed to the statement "people with depression are dangerous," contrary to another study in Turkey which reported that about 50% of the respondents perceived people with depression as dangerous,[24] while another study carried out in 3 states in western Nigeria reported that 96.5% of the respondents believed people with mental illness were dangerous.[25] This variation in perception might have been informed by the differences in the experiences of people in different societies.

Help-seeking behavior toward depression was mostly good (87.9%) contrary to what was found in Australia where a large percentage of the population reported that they would feel embarrassed to seek help from professionals.[28] This could be attributed to the reduction in the stigma usually associated with mental illness, given improved awareness. Majority (79.6%) of the respondents indicated confidence in finding relief in psychotherapy which is similar to the findings of a study carried out in South Africa which reported that the help-seeking method was more often psychotherapy.[29] Only 9.2% of the respondents indicated that traditional or religious healers could successfully treat depression which is contrary to another study carried out in southwestern Nigeria in which 30% of the respondents indicated traditional healers as capable of successfully treating depression and being their preferred treatment option.[30] This difference in proportion may be due to the more westernized nature of Lagos where traditional beliefs are less emphasized. In this study, the prevalence of depressive symptoms showed statistically significant associations with the employment status of the respondents but not with their marital status. The proportion of respondents with depressive symptoms was similar in single, married, divorced, or widowed respondents. The proportion of respondents with depressive symptoms was higher among employed respondents. This is in keeping with a report released by the World Health Organization which stated that a negative work environment could possibly lead to physical and mental health problems such as anxiety and depression[31] given that people spend most of their waking hours at work.

Respondents' level of knowledge of depression showed statistically significant association with the level of education. The knowledge of depression, as expected, was better with higher levels of education. The respondents' attitude toward depression had statistically significant associations with their level of education. A higher proportion of the respondents with higher levels of education had positive attitude toward depression. This is in line with the observations of a study carried out in Ghana which reported that a higher level of education was associated with positive attitudes toward depression.[32]

CONCLUSION

The proportion of respondents with depressive symptoms was quite high. The respondents' level of knowledge, attitude, and the overall help-seeking behavior toward depression were good as well. However, fewer respondents indicated their desire to seek psychiatric attention if needed possibly due to the associated stigma. This study highlights that depressive symptoms are quite prevalent hence the need for better awareness and knowledge about depression. Improving people's level of education would positively influence their knowledge, attitude, and help-seeking behavior and hence hopefully eliminate stigma. It is important to ensure that help is made readily available by providing mental health services at the PHC level. Furthermore, mental health support should be routinely provided for employees by their employers.

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Conflicts of interest

There are no conflicts of interest.

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