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# Prevalence and Coping Strategies for Depression Among in-School Adolescents in Ilorin Metropolis, Kwara State, Nigeria

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## Abstract

**Aim:** Adolescent depression is a widespread problem that receives little or no attention. The study looked at depression frequency and coping mechanisms among adolescents enrolled in school in Ilorin City, Kwara state. **Method:** 400 teenagers in total were chosen at random from the group. The "Prevalence and Coping Strategies for Depression among In-School Adolescents Questionnaire" (PCSDIAQ). was used to gather information from the respondents. The study questions were addressed in percentages, and the hypotheses were examined using the t-test and ANOVA statistical methods at a significance level of 0.05. **Findings:** The study's findings showed that more than 30% of in-school adolescents experience fatigue (59.0%), a preference for solitude (50.3%), a lack of interest in or enjoyment from activities (48.8%), and anger (more than 30%) for a few hours each day move so slowly that others might have seen it (39.5%). It was also found that 42.3% of respondents always play games to distract themselves from problems. In comparison, 44.5% of respondents avoided talking to people about their feelings for a short period, criticized themselves (28.8%), isolated themselves (24.5%), avoided social situations until they felt better about themselves (15.8%), constantly blamed others (19.0%), and ignore problems (10.0%). According to the study, there were no appreciable differences in the frequency of depression among adolescents enrolled in school in the city of Ilorin, depending on age, gender, or marital status. Gender and marital status had no significant impact on the coping mechanisms used by in-school adolescents to deal with their depression, while age had a substantial impact. **Conclusion:** These results led to recommendations regarding the requirement for mental health-friendly educational settings where qualified psychotherapists may help depressed in-school teenagers use the optimal coping mechanisms. The study also emphasized the need for regular counseling sessions, particularly before exam times for teenagers and for in-school teenagers from divorced homes, to help them deal with challenging circumstances.

**Keywords**: Depression, Coping Strategy, In-school Adolescents, Ilorin.

## Introduction

Humans experience moods and emotions varying from high to low, which consequently have a tremendous influence on the reasoning and actions of an individual. Adolescence is a transition period from age 10 to 19, with physical, emotional, mental, behavioral, and psychological maturation. These processes carry with them significant changes which may contribute to many mental health issues. Mental health issues such as anxiety, social displacement or disorder, and especially depression in early adolescence often go undiagnosed and untreated in developing countries due to limited access to psychological and psychiatric services and substantial social stigma attached to mental health issues (WHO, 2017). Depression in adolescents is mainly attributed to adverse psychological and behavioral issues, including social phobia, conduct disorder, obsessive-compulsive disorder, oppositional defiant disorder, drug abuse, and manic attitudes, etc.

Adolescence is the distinct period of bio-developmental change in a person's life that bridges childhood and adulthood. It denotes a set of developmental transitions beginning with the onset of puberty and ending during the mid-20s, characterized by maturation of the body, intensification of learning capacity, and emergence of personal identity (Hochberg & Konner, 2020). Adolescents are between 10 and 19 (WHO, 2017).

Depression is a common mental disorder characterized by recurring sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, poor concentration, etc. According to Schrobsdorff (2016), depression is defined as a constant low mood lasting for more than two weeks on many occasions, with symptoms including low self-esteem, loss of drive to pleasurable activities, insomnia, low energy, and confusion. Often, adolescents suffering from depression go unnoticed, which presents more challenges to the sufferer and the people around the individual. Depression varies from simple grief or mourning, which are expected emotional responses to the pain and loss of loved persons or objects (Britannica, The Editors of Encyclopaedia, 2022). Examples of different types of depression include Bipolar Disorder, which was previously known as manic depression. It is a mood disorder where an individual experiences alternating states of depression and mania (abnormal elevation of mood) or hypomania (distinct, though not necessarily abnormal, elevation of mood). While the causes of bipolar disorder are not clearly understood, both genetic and environmental factors are thought to play a role (Anderson et al., 2012);

Major Depressive Disorder (clinical depression): This is a complex and multidimensional condition (Culpepper et al., 2015) that is associated with significant impairment of psychosocial functioning and health-related quality of life. It is diagnosed when an individual has a continuous depressed mood, reduced pleasure in fun activities, feelings

of worthlessness, hopelessness, lethargy, poor concentration, poor appetite, psychomotor retardation or agitation, sleep disturbances, oversleeping, or suicidal thoughts, etc.; and Persistent Depressive Disorder (Dysthymia): also known as (Dysthymia). It is a mental and behavioral disorder, specifically a disorder primarily of mood, consisting of the same cognitive and physical problems as depression but with longer-lasting symptoms (American Psychiatric Association, 2013). While dysthymia is sometimes referred to as low-grade depression, its effects, notably displayed, especially after two years, can have a significant impact on one's quality of life (Miles, 2022). Other types of depressive disorder include situational depression, premenstrual dysphoric disorder (PMDD), substance/medication-induced depressive disorder, postpartum depression, etc.

Coping skills are a critical individual-level aspect of the stress regulation response. Problem-focused coping, that is, the process of taking active steps to remove or circumvent the stressor or to ameliorate its effects, is usually posited as an adaptive, positive way of dealing with stress, especially when individuals view the stressful event as controllable (Folkman & Lazarus, 1988; Compas, 2001; Clark, 2006). On the other hand, emotion-focused methods of coping typically encompass more indirect methods to avoid the stressor or control its emotional impact, such as ignoring, distancing oneself from the stressor, excessive worry, or anger (Folkman & Lazarus, 1988). In addition to coping skills, the school environment could promote mental health and prevention or adversely affect students' mental health and wellbeing (Das, Salam, Lassi, Khan, Mahmood, & Patel, 2016; Aldridge & McChesney, 2018).

In school, students adopt an array of mechanisms to deal with mental health issues, varying from religious support, positive reinterpretation, active coping, planning, and the use of instrumental support (Yusoff, 2010). Other strategies include breathing exercises, regular visits to a counselor, talking to someone, temporary distraction, social networking, frequent exercising, healthy eating, meditation, joining a club, mindfulness, and calming strategies (Giamos et al., 2017). While some adolescents show resilience and resourcefulness in adapting effective coping strategies, approaches such as disengagement, isolation, over-indulgence, grieving, and internalized coping strategies often pose negative consequences to the adolescent's physical health while also aggravating existing mental health conditions (Addy et al., 2021).

Globally, anxiety and depression have been known to be among the significant causes of illness and disability, with higher prevalence among adolescents. It has also been known to be a recognized factor for high rates of self-harm and suicide among adolescents. A WHO report in 2018 estimated a figure of about 1.2 million adolescents die around the world yearly, mostly from preventable or treatable diseases or causes. Mental health conditions, such as depression and anxiety, account for 16% of the global burden of disease and injury in people aged 10–19 (WHO, 2019).

Several researches have been conducted on issues relating to depression among adolescents. For instance, the study of Deepa, Nisha, and Shishir (2020) worked on the prevalence of and factors associated with depression among higher secondary school adolescents of Pokhara Metropolitan, Nepal, and found that more than two-fifths 44.2% of students have depression. The study of Anjuma, Hossain, Sikder, Uddinc, and AbdurRahim (2019) states that information regarding adolescent depression is available primarily for high-income industrialized countries. However, evidence is available for low-resource areas as well. The study also revealed that in the United States, one in nine adolescents is affected by depression in a given year, and an adolescent facing depressive symptoms suffers from subsequent episodes in adulthood.

Similarly, in Nigeria, several researchers have worked on the prevalence and predictors of depression among in-school adolescents. For instance, Chinawa, Manyike, Obu, Aronu, and Odutola (2015), in a study conducted among secondary school students in two states from the eastern part of Nigeria, reported a high prevalence of adolescent depression which they attributed to a family history of depression, parental separation, and other childhood stressors. Mbanuzuru, Uwakwe, Prosper, and Udigwe (2020) researched the prevalence of depressive disorders among in-school adolescents in urban and rural areas in Anambra state and found that the proportion of urban participants identified with depression was significantly higher than that of their rural counterparts of 14.5% and 9.6% respectively. Another study by Oderinde, Dada, Nyemike, and Salihu (2018) researched the prevalence and predictors of depression among adolescents in Ido Ekiti, South West Nigeria, and found that the prevalence of depression among the study population was 16.3%.

In Nigeria, studies have shown high levels of ignorance about mental illness and negative attitudes towards individuals with mental disorders. Mental illness, including depression, is often perceived to be a spiritual attack, and consequently, traditional healers and religious leaders are usually the first means of consultation (Omigbodun et al., 2012). From the cited studies and to the best of the researcher's knowledge, there has not been any study on the prevalence and coping strategies for depression among in-school adolescents in Ilorin Metropolis. The question that would therefore come to mind include, among others, the following: What is the prevalence rate of depression among in-school adolescents in the Ilorin metropolis? What are the coping strategies employed by in-school adolescents for their depression? Finding answers to these questions will help to establish empirical evidence on the prevalence and coping strategy employed by in-school adolescents in handling depression and the potential intervention needed. It is against this background that this researcher carried out an investigation into the prevalence and coping strategies for depression among in-school adolescents in Ilorin Metropolis, Kwara

state, Nigeria, to empirically investigate the rate of occurrence of depression, coping strategies employed and examined some of the factors influencing the occurrence of depression among in-school adolescents; these factors include age, gender, and parents marital status.

## Methods

The research design adopted for the study is a descriptive survey. The study population comprised all in-school adolescents in the Ilorin metropolis, Kwara State, Nigeria, while the target population was 400 in-school adolescents drawn from selected secondary schools in the Ilorin metropolis. A simple random sampling technique was adopted to select eight (8) secondary schools in the Ilorin metropolis's four local government areas: Ilorin East, Ilorin West, Ilorin South, and Asa. Among the selected participants, 67.8% (N=271) were females, while 32.3% (N=129) were males. The majority of the participants (75.5%, N=302) fell in the age range of 15 years of age and above, and out of the 400 participants, 91% (N=364) were from intact families, 6.5% (N=26) and 2.5% (N=10) were from divorced and separated home respectively.

The main instrument adopted and employed for data collection in the study was the researchers-designed quiiti onnrrre tltldd rrr vvnnnree and Copnng ataatggsss for Depression among In-hhhool dd onnnnnm' uu iiti onnrrr"" (CCSII QQ), which was developed after reviewing relevant literature on depression. The questionnaire is a 30-item instrument with three sections: A, B, and C. Section A contains the respondents' demographic data, including information on the age, gender, and marital status of parents. In contrast, section B contains items that identify a depressed individual. Section C includes numbered items that focus on the possible coping strategies employed as a defense to depression. The content validity of the instrument was ascertained by five lecturers in the Department of Counsellor Education, University of Ilorin. The instruments were subjected to reliability tests, and 0.81 and 0.86 were obtained, which are high enough as the reliability measure for the instrument. The instrument was designed in a Four-point Likert-type rating scale ranging from the highest point to 4 and the lowest to 1. Since there are 30 items altogether in the instrument, 15 in both sections B and C., the lowest total score obtainable for both sections is 15, and the highest obtainable score would be 60. To score the instrument in this case, the items in section C have been carefully formulated to center on the level of depression and possible negative coping strategies employed by adolescents. Hence, for section B, a client who scores 40 and above was said to have a high level of depression, while a score ranging from 19-39 can be said to have a moderate level of depression, and a score ranging from 0-18 reflects a relatively low level of depression. For section C, a client who scores 40 and above was said to have a negative coping approach or strategies to depression, while a score ranging from 19-39 depicts a neutral or moderate coping strategy for depression, and a score ranging from 0-18 reflects a less harmful approach to depression, hence a positive coping strategy.

The data obtained were analyzed using a t-test and Analysis of Variance (ANOVA).

**Demographic Data**

**Table 1:** Percentage Distribution of respondents Based on Gender

| Gender | Frequency | Percentage |
|---|---|---|
| Male | 129 | 32.3 |
| Female | 271 | 67.8 |
| **Total** | **400** | **100** |

Table 1 shows the distribution of respondents by gender. The table shows 12 (32.3%) respondents were male, while 271 (67.8%) were female. This indicates that female in-school adolescents participated more in the study.

**Table 2:** Percentage Distribution of respondents Based on Age

| Age | Frequency | Percentage |
|---|---|---|
| 10-14 years | 98 | 24.5 |
| 15 years and above | 302 | 75.5 |
| **Total** | **400** | **100** |

Table 2 shows the distribution of respondents by age. The table shows that 98 (24.5%) of the respondents were between 10 and 14 years of age, while 302 (75.5%) were 15 and above. This indicates that respondents 15 years of age and above participated more in the study.

**Table 3:** Percentage Distribution of respondents Based on Marital Status of Parents

| Status | Frequency | Percentage |
|---|---|---|
| Separated | 10 | 2.5 |
| Divorced | 26 | 6.5 |
| Intact | 364 | 91.0 |
| **Total** | **400** | **100** |

Table 3 shows the respondents' distribution based on parents' marital status. The table reveals that 10 (2.5%) of the respondent's parents were separated, 26 (6.5%) of the respondent's parents were divorced, and 364 (91.0%) of the respondent's parents were still intact. This indicates that respondents whose parents were still intact participated more in this study.

## Results

**Research Question 1:** What is the prevalence of depression among in-school adolescents in the Ilorin metropolis?

**Table 4:** Percentage Distribution of Rate of Depression among the Respondents

| S/N | As far as I am concerned, for the past two weeks, I usually | Not at all | For a few hours a day | More than half the days | Throughout the day |
|---|---|---|---|---|---|
| **1** | have little interest or pleasure in doing things | 103 (25.8%) | 195 (48.8%) | 62 (15.5%) | 40 (10.0%) |
| **2** | feel hopeless | 254 (63.5%) | 80 (20.0%) | 22 (5.5%) | 44 (11.0%) |
| **3** | have trouble falling or staying asleep, or sleeping too much | 174 (43.5%) | 67 (16.8%) | 115 (28.8%) | 44 (11.0%) |
| **4** | feel tired | 31 (7.8%) | 236 (59.0%) | 102 (25.5%) | 31 (7.8%) |
| **5** | have poor appetite | 223 (55.8%) | 101(25.3%) | 54 (13.5%) | 22 (5.5%) |
| **6** | feel bad about myself or feel that I am a failure | 285 (71.3%) | 39 (9.8%) | 76 (19.0%) | - |
| **7** | have trouble concentrating on things | 165 (41.3%) | 133 (33.3%) | 102 (25.5%) | - |
| **8** | move so slowly that other people could have noticed | 219 (54.8%) | 159 (39.8%) | 22 (5.5%) | - |
| **9** | have thoughts that I would be better off dead | 298 (74.5%) | 102 (25.5%) | - | - |
| **10** | have thoughts of hurting myself in some way | 245 (61.3%) | 133 (33.3%) | 22 (5.5%) | - |
| **11** | feel like giving up on life | 325 (81.3%) | 48 (12.0%) | 27 (5.5%) | - |
| **12** | get angry at everyone | 170 (42.5%) | 185 (46.3%) | 27 (6.8%) | 18 (4.5%) |
| **13** | develop terrible mood swings | 157 (39.3%) | 155 (38.8%) | 66 (16.5%) | 22 (5.5%) |
| **14** | prefer to be alone | 116 (29.0%) | 201 (50.3%) | 48 (12.0%) | 35 (8.8%) |
| **15** | cry me to sleep | 310 (77.5%) | 68 (17.0%) | 22 (5.5%) | - |

Table 4 presents the percentage distribution of the rate of depression among the respondents. The table indicates that for a few hours a day, more than 30% of the in-school adolescents feel tired (59.0%), prefer to be alone (50.3%), have little interest or pleasure in doing things (48.8%), get angry at everyone (46.3%); move so slowly that other people could have noticed (39.8%); develop terrible mood swings (38.8%); have thoughts of hurting myself in some way (33.3%); have trouble concentrating on things (33.3%). Also, for more than half the days, more than 18% have trouble falling or staying asleep or sleeping too much (28.8%), feel bad about themselves or feel that they are a failure (19.0%), while more than 10% feel hopeless (11.0%); have trouble falling or staying asleep, or sleeping too much (11.0%) throughout the day.

**Research Question 2:** What are the coping strategies employed by in-school adolescents for their depression?

**Table 5:** rrr eentgge sss trbbution of Rpppondnnts' ppp rsssion Copnng ataatggsss

| S/N | When depressed, I usually | Not at all | Rarely | A little bit | Always |
|---|---|---|---|---|---|
| **1** | criticize me | 169 (42.3%) | 76 (19.0%) | 115 (28.8%) | 40 (10.0%) |
| **2** | ignore my problems | 152 (38.0%) | 160 (40.0%) | 48 (12.0%) | 40 (10.0%) |
| **3** | isolate me | 63 (15.8%) | 172 (43.0%) | 98 (24.5%) | 67 (16.8%) |
| **4** | take alcohol to make myself feel better | 382 (95.5%) | - | - | 18 (4.5%) |
| **5** | use drugs to forget my problems | 382 (95.5%) | - | - | 18 (4.5%) |
| **6** | blame other people all the time | 226 (56.5%) | 165 (41.3%) | 76 (19.0%) | 9 (2.3%) |
| **7** | play games to forget my problems | 98 (24.5%) | 44 (11.0%) | 89 (22.3%) | 169 (42.3%) |
| **8** | cry to sleep | 324 (81.0%) | 76 (19.0%) | - | - |
| **9** | stay out of reach in order to be alone | 138 (34.5%) | 142 (35.5%) | 27 (6.8%) | 93 (23.3%) |
| **10** | shun people out till I feel better about myself | 142 (35.5%) | 177 (44.3%) | 63 (15.8%) | 18 (4.5%) |
| **11** | become suicidal all of a sudden | 347 (86.8%) | 22 (5.5%) | 22 (5.5%) | 9 (2.3%) |
| **12** | do not talk to people about how I feel | 125 (31.3%) | 22 (5.5%) | 178 (44.5%) | 75 (18.8%) |
| **13** | dwell in my problems till I feel almost worthless | 284 (71.0%) | 76 (19.0%) | 22 (5.5%) | 18 (4.5%) |
| **14** | hurt myself | 307 (76.8%) | 71 (17.8%) | 13 (3.3%) | 9 (2.3%) |
| **15** | do nothing | 217 (54.3%) | 129 (32.3%) | 45 (11.3%) | 9 (2.3%) |

Table 5 presents the percentage distribution of coping strategies employed by the respondents to overcome. The table indicates that 42.3% of the respondents always play games to forget their problems. In comparison, 44.5% of the respondents for a little bit do not talk to people about how I feel, criticize myself (28.8%), isolate myself (24.5%), shun people out till I feel better about myself (15.8%), put the blame on other people all the time (19.0%); ignore my problems (10.0%).

**Hypotheses Testing**

Six alternative hypotheses were formulated and tested for this study. The hypotheses were tested using a t-test and Analysis of Variance statistical methods at a 0.05 level of significance.

**Hypothesis One:** There is a significant difference in the prevalence of depression among in-school adolescents in Ilorin metropolis based on age

**Table 6:** Mean, Standard Deviation, and T-value of the Rate of Depression among the Respondents Based on Age

| Age | N | Mean | SD | Df | Cal. T-value | Crit. t-value | p-value |
|---|---|---|---|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 10-14 years | 98 | 19.47 | 2.40 | 398 | 9.71* | 1.96 | .000 |
| 15 years and above | 302 | 28.02 | 8.59 | | | | |

Significant, p<0.001

Table 6 shows that the calculated t-value of 9.71 is greater than the critical t-value of 1.96 with a corresponding p-value of .000, less than the 0.01 significance level. Since the calculated p-value is less than the 0.01 significance level, the alternative hypothesis is accepted. This indicates that there is a significant difference in the prevalence of depression among in-school adolescents in the Ilorin metropolis based on age.

**Hypothesis Two:** There is a significant difference in the prevalence of depression among in-school adolescents in the Ilorin metropolis based on gender

**Table 7:** Mean, Standard Deviation, and T-value of the Rate of Depression among the Respondents Based on Gender

| **Gender** | **N** | **Mean** | **SD** | **df** | **Cal. T-value** | **Crit. t-value** | **p-value** |
|---|---|---|---|---|---|---|---|
| Male | 129 | 24.06 | 5.73 | 398 | 3.08* | 1.96 | .002 |
| Female | 271 | 26.81 | 9.29 | | | | |

Significant, p<0.05

Table 7 shows that the calculated t-value of 3.08 is greater than the critical t-value of 1.96 with a corresponding p-value of .002, which is less than 0.05 significance level. Alternative hypothesis two is accepted since the calculated p-value is less than the 0.05 significance level. This indicates that there is a significant difference in the prevalence of depression among in-school adolescents in the Ilorin metropolis based on gender.

**Hypothesis Three:** There is a significant difference in the prevalence of depression among in-school adolescents in the Ilorin metropolis based on parents' marital status

**Table 8:** Analysis of Variance (ANOVA) showing the different Rate of Depression among the Rpppondnnts Bddddon rrr ents' aa rutuu ututu

| **Source** | **SS** | **Df** | **Mean Square** | **Cal. F-ratio** | **Crit. F-ratio** | **p-value** |
|---|---|---|---|---|---|---|
| Between Groups | 2292.23 | 2 | 1146.11 | 17.57* | 3.00 | .000 |
| Within Groups | 25896.36 | 397 | 65.23 | | | |
| Total | 28188.59 | 399 | | | | |

*Significant, p<0.01

Table 8 shows that the calculated F-ratio of 17.57 is greater than the critical F-value of 3.00 with a corresponding p-value of .000, less than the 0.001 significance level. The significance level is significant since the calculated p-value is less than 0.05. The alternative hypothesis is accepted. Hence, there is a significant difference in the

prevalence of depression among in-school adolescents in the Ilorin metropolis based on parents' marital status. In order to ascertain where the significant difference lies, Scheffe Post-Hoc was carried out, and the output is shown in Table 9

**Table 9:** Scheffe post-hoc, where the significant difference lies based on Parents' Marital Stats

| **Status** | **N** | **Subset for Alpha = 0.05** | |
|---|---|---|---|
| | | 1 | 2 |
| Separated | 10 | 25.00 | |
| Intact | 364 | 25.30 | |
| Divorced | 26 | | 35.00 |
| Sig. | | .993 | 1.000 |

Table 9 shows that respondents who were separated and still intact had mean scores of 25.00 and 25.30 (in subset 1), respectively, while those whose parents were divorced had a mean score of 35.00 (in subset 2). This implies that the mean score of divorced respondents is greater than the mean scores of other groups and thus contributed more to the significant difference.

**Hypothesis Four:** *There is a significant difference in the coping strategies employed by in-school adolescent for their depression based on gender*

**Table 10:** Mean, Standard Deviation, and T-value of the Respondents' Depression Coping Strategies Based on Gender

| **Gender** | **N** | **Mean** | **SD** | **Df** | **Cal. T-value** | **Crit. t-value** | **p-value** |
|---|---|---|---|---|---|---|---|
| Male | 129 | 26.65 | 6.98 | 398 | 0.68 | 1.96 | .493 |
| Female | 271 | 26.24 | 4.90 | | | | |

Table 10 shows that the calculated t-value of 0.68 is less than the critical t-value of 1.96 with a corresponding p-value of .493, which is greater than 0.05 level of significance. Alternative hypothesis four is rejected since the calculated p-value is more significant than the 0.05 significance level. This indicates that there is no significant difference in the coping strategies employed by in-school adolescent of their depression based on gender.

**Hypothesis Six:** *There is a significant difference in the coping strategies employed by in-school adolescents for their depression based on parents' marital status*

**Table 11:** nn yyysss of rrr nnree (VVVV)) shonnng the dfffrr nnee nn the Rpppondnnts'

Depression Coping Strategies Based on Parents Marital Status

| Source | SS | Df | Mean Square | Cal. F-ratio | Crit. F-ratio | p-value |
|---|---|---|---|---|---|---|
| Between Groups | 90.108 | 2 | 45.05 | 1.41 | 3.00 | .245 |
| Within Groups | 12659.132 | 397 | 31.88 | | | |
| Total | 12749.240 | 399 | | | | |

Table 11 shows that the calculated F-ratio of 1.41 is greater than the critical F-value of 3.00 with a corresponding p-value of .245, which is more significant than the 0.05 significance level. The alternative hypothesis is rejected since the calculated p-value is more significant than the 0.05 significance level. Hence, there is no significant difference in the coping strategies employed by in-school adolescents of their depression based on parents' marital status.

## Discussion

The study revealed that more than 30% of in-school adolescents feel tired for a few hours a day, prefer to be alone, have little interest or pleasure in doing things, get angry at everyone, and move so slowly that other people could have noticed, among others. The finding supports the study of Ghoneim and O'Hara (2016), who found that feelings of tiredness, sadness, disturbed sleep or appetite, and poor concentration are common signs of depression among in-school adolescents. Muneer (2013) also reported losing interest in activities they usually like or becoming isolated and lonely; anxiety, hopelessness, changes in sleep, and suicidal thoughts are common symptoms of depression.

The finding also showed that as a way of coping with depression, 42.3% of in-school adolescents always play games to forget their problems, while 44.5% of the in-school for a little bit, do not talk to people about how they feel, criticize themselves (28.8%); isolate themselves (24.5%); shun people out till they feel better about themselves (15.8%); put the blame on other people all the time (19.0%); ignore their problems (10.0%). The finding negates the study of Giamos, Lee, Suleiman, Stuart, and Chen (2017), who stated that adopted coping strategies of depressive people include talking to someone they like, temporary distractions, and giving themselves hope. The finding supports the study of Leonard, Gwadz, Ritchie, Linick, Cleland, and Elliot (2015), who found that some adolescents show resilience and resourcefulness in adapting effective coping strategies, approaches such as shift blame, disengagement, isolation, withdrawal, and over-indulgence.

Hypothesis one revealed that there was a significant difference in the prevalence of depression among in-school adolescents in the Ilorin metropolis based on age. This means that the prevalence of depression among the respondents of different age groups was

different. The finding of this study negates the study of Bolajoko and Adebowale (2020), who found a statistically significant difference in the prevalence of depression among students of different age groups. The significant difference favored the in-school adolescents 15 years of age and above. This could be that in-school adolescents of this age range might face many challenges in making independent choice
s. choiceshesis two also showed that there was a significant difference in the prevalence of depression among in-school adolescents in the Ilorin metropolis based on gender. This implies that the prevalence of depression between male and female respondents was different. The finding of the study supports the study of Maag and Irvin (2005), who found gender differences in the occurrence of depression among teenagers, with female teenagers reported as more depressed gender. The significant difference was in favor of female respondents, which could be that females generally are more emotional than males.

The result of hypothesis three showed that there was a significant difference in the prevalence of depression among in-school adolescents in the Ilorin metropolis based on parents' marital status. This implies that the rate of depression among the respondents from different parental marital statuses was different. The result of Scheffe's post-hoc showed that in-school adolescents whose parents were divorced contributed to the significant difference. The reason could be that parental divorce might serve as a source of depression for in-school adolescents from divorced homes. The finding is in line with the submission of Wauterickx, Gouwy, and Bracke (2006), who asserted that teenagers whose parents get divorced are more likely to develop depression and are also more likely to experience significant depressive symptoms later on in life because of the lack of parental support and relationship.

The result of hypothesis four showed that there was no significant difference in the coping strategies employed by in-school adolescent regarding their depression based on gender. This implies that male and female respondents did not differ in their coping strategies. The finding negates the study of Kelly, Tyrka, Price, and Carpenter (2008), who observed sex differences in coping strategies. Similarly, Li, Digiuseppe, and Froh (2006) found that adolescent girls were more depressed than boys and that girls used more emotion-focused and ruminative coping than boys.

Hypothesis five showed that there was no significant difference in the coping strategies employed by in-school adolescents for their depression based on parents' marital status. This means that employed coping strategies respondents from different parental marital statuses. The finding of this study disagrees with the study of Parikh, Sapru, and Krishna (2019), who found significant differences in coping among urban school-going adolescents from divorced and intact homes.

## Conclusion

Based on the findings of the study, the following conclusions were drawn: for a few hours a day, more than 30% of the in-school adolescents feel tired (59.0%), prefer to be alone (50.3%), have little interest or pleasure in doing things (48.8%); get angry at everyone

(46.3%); move so slowly that other people could have noticed (39.8%) among others. It was also concluded that 42.3% of the respondents always play games to forget their problems. In comparison, 44.5% of the respondents for a little bit, did not talk to people about how they feel, criticize themselves (28.8%), isolate themselves (24.5%), shun people out till they feel better about themselves (15.8%), put the blame on other people all the time (19.0%); ignore their problems (10.0%). The study also showed there were no significant differences in the prevalence of depression among in-school adolescents in the Ilorin metropolis based on age, gender, and marital status. There was no significant difference in the coping strategies employed by in-school adolescent regarding their depression based on gender and marital status, but significant differences were found based on age. The findings of this study imply counseling practice. The study revealed that for a few hours a day, more than 30% of the in-school adolescents feel tired (59.0%), prefer to be alone (50.3%), have little interest or pleasure in doing things (48.8%), get angry at everyone (46.3%); move so slowly that other people could have noticed (39.8%) among others. Depression is common, and in preventing or working with someone with depression, Mental Health Counsellors can help depressive in-school adolescents gain a better understanding of their feelings and thought processes and cope with school, family, and psychological-related stress, which are risk factors for depression. Mental health counselors can train in-school adolescents on different strategies to adopt in preventing and coping with depression.

## Disclosure Statements

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