

## Ethical Concerns of Depression among Youths: A Socio-Religious Implication in Contemporary Lagos State

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### Abstract

Depression among youths in contemporary Nigeria has become an increasingly prominent social and religious issue. This study explores the ethical concerns surrounding depression, particularly focusing on the socio-religious implications it has in Nigerian society. The study investigates how societal and religious norms shape the perception, treatment, and overall response to youth depression in Lagos State, with a particular emphasis on the stigmatisation of mental health issues, the lack of adequate mental health resources, and the roles religious institutions play in either mitigating or exacerbating these challenges. The study used a quantitative research approach, surveying 300 respondents using a structured questionnaire. The survey focused on their economic stage, socio-physical development, mental formation, and depression experiences. The sample included diverse ethnic groups and religious affiliations. The questionnaire explored attitudes towards depression, religious views on mental health, stigmatisation of depression, and the role of religious institutions in addressing mental health issues. It was discovered that youth depression in Lagos State is common and has an impact on relationships and professional, academic, socio-economic and religious performance, with sobbing, impatience, delusional and behavioural impairments, nagging, suicidal ideation, and mental health decline increasing daily among youths in Nigeria. 93% of the participants seek mental health counselling and therapy, 66.33% from clergy underscores the dual reliance on both clinical and spiritual sources for mental health support, and 48% rely on friends/family for support, counselling and intervention. The research recommended that the Nigerian youths need support through skill development, entrepreneurship, and career advisory programmes. Community awareness campaigns, clergy/cleric training, and peer support groups are also crucial. The government should establish mental health hotlines, teach community leaders, provide education, and integrate mobile health services. Finally, Nigeria's youth depression is influenced by socio-religious dynamics and ethical considerations, necessitating specialised interventions such as youth empowerment, awareness campaigns, clergy training, and readily available mental health infrastructure.

**Keywords:** Mental Health, Youth Depression, Ethical Concerns, Socio-religious Implications, Lagos State, Nigeria.

## Introduction

Youth, a crucial stage between childhood and adulthood, is characterised by independence and active participation in socio-religious and economic decision-making. They contribute to communities and nations in various ways, such as supporting the elderly, leading technological advancements, advocating for justice, and fostering healthy environments. However, their effectiveness depends on employment opportunities, creativity, and religious and socio-inclusive policies (Ogunbiyi, et al, 2025). According to the World Health Organisation, depression, the most prevalent psychiatric condition, is expected to account for 15% of the overall disease burden by 2020 and rank as the second leading cause of disability across all age groups and sexes (Maetz et al., 2006). Depression rates among college students reached an all-time high in 2010—26% for women and 25% for men (Mackenzie, et al, 2010). A study in sub-Saharan Africa revealed that 26.9% of youths may have depressive disorders (Olisaeloka, et al, 2024), with almost 10% qualifying for a psychiatric diagnosis. This prevalence is higher than global estimates (Partap, 2023). Besides depression, other mental health problems are also prevalent, including anxiety disorders (29.8%), emotional and behavioural problems (40.8%), PTSD (21.5%), and suicidal thoughts (20.8%) (Brits, 2021).

Recent research on depression in Nigeria revealed that 21.9% of youths suffer from depression (Alinnor, et al, 2023), with females having a higher rate (21.3%) than males (9.7%) (Edet, 2023). A significant portion of Nigerian adolescents experience mild to moderate depression, with a smaller percentage experiencing severe depression. In southwest Nigeria, 5.1% of youths met the criteria for a major depressive disorder (MDD). Additionally, 12.5% of adolescents have planned, considered, or attempted suicide in the past year (Nzeakah, 2023).

Depression is a complex condition characterised by persistent sadness and loss of interest, often lasting for at least two weeks. It can be classified into major depressive disorder, which is characterised by persistent sadness and loss of interest, and persistent depressive disorder (formerly dysthymia), which is less severe but more chronic. Seasonal Affective Disorder (SAD) is a type of depression that occurs during the fall and winter months, often linked to reduced sunlight exposure. Postpartum depression affects women's mood and ability to care for their newborn. Premenstrual Dysphoric Disorder (PMDD) is a severe form of premenstrual syndrome with mood symptoms that can disrupt daily life. Bipolar disorder involves periods of both depression and mania. Psychotic depression can include psychotic symptoms like hallucinations or delusions. Atypical Depression is a subtype of major depressive disorder characterised by increased appetite, sleepiness, and mood reactivity. Disruptive Mood Dysregulation Disorder (DMDD) is a mood disorder in children involving chronic irritability and frequent temper outbursts. Substance/medication-induced depressive disorder can also be caused by certain substances or medications (Bruce & McPhillips, 2024).

The issue of depression among architects in Nigeria is becoming increasingly prominent, raising concerns not only for those affected but also for the overall quality of architectural output. Architecture is a demanding profession that blends creativity with technical precision and innovation. In Nigeria, these inherent challenges are made worse by socio-economic and infrastructural problems like unstable electricity, erratic funding, economic uncertainty, and complex bureaucratic systems (Adebayo, 2020). Many architects are left to deal with client expectations that are often unrealistic, tight delivery timelines, and the constant fear of job loss in an overcrowded and underfunded industry (Nwankwo & Ibrahim, 2021). The result is a heightened risk of burnout and mental health decline. However, this challenge is not unique to architecture. Similar stress patterns appear in other demanding professions. For example, healthcare workers such as doctors often work extended hours under pressure, with limited support and poor working conditions—factors that contribute significantly to emotional fatigue and depression (Adetunji & Ogunleye, 2019). Legal practitioners, too, carry the weight of intense workloads and ethical dilemmas that can affect their mental well-being (Okafor, 2021). Teachers and lecturers in the education sector frequently experience professional isolation and high stress due to overcrowded classrooms and lack of institutional support (Eze & Akinyemi, 2020). These parallels reveal that mental health challenges are widespread and often rooted in systemic issues across various industries and institutions.

Given the growing need for knowledgeable, empathic treatment, this poses a special challenge for psychologists. In order to treat the millions of people who suffer from this complicated and incapacitating illness, clinicians and researchers must do sound, scientifically based research and use evidence-based therapy. There are still unanswered concerns regarding the causes, characteristics, and consequences of depression in all of its manifestations after decades of research. Depression is a complicated and multidimensional illness that cannot be adequately described by a single theoretical framework or treated with a single, straightforward prescription. Depression is a common disease among religious people; polls of clergy in the Southeast United States found that 80–85% of them suffer from depression (Kramer, et al, 2007). Even while religion can help prevent sadness (Nelson, et al, 2009), one in five Americans will suffer from depression at some point in their lives (Koenig, 2009).

According to a Brazilian study, self-reported evangelical affiliations were linked to a higher incidence of depressed symptoms, which may indicate that evangelical Christians are more susceptible to depression than the general population (Dalgarrondo, 2008). Pfeifer pointed out that a medical or spiritual counsellor can give hope to those who don't think they have a chance to recover from depression. People who are sad need to be reassured that there are viable ways to overcome their depression and that doing so can aid in personal development. Four components make up therapy for depression: pharmacology (medication), treatment of physical symptoms and activation, practical assistance and support, and counselling (talking, listening, and leading) (Pfeifer, 2014).

### Statement of the Problem

A number of variables, including drug use, family problems, financial struggle, and scandals, have contributed to an increase in the suicide rate worldwide. For individuals between the ages of 15 and 44 (Parra, 2021), depression is the most common cause of disability. Depression can lead to various issues in various aspects of life, including home, work, school, and community, and can negatively impact physical health. It can cause psychological problems such as mood, motivation, self-esteem, anxiety, and suicidal thoughts. Behavioural problems include withdrawal, self-harm, substance misuse, and physical problems like sleep issues, appetite changes, physical aches and pains, heart health issues, and increased vulnerability to infections and diseases. Depression can be mild, moderate, or severe, depending on the number and severity of symptoms. It can also affect the immune system, making individuals more susceptible to infections and diseases. In Nigeria, especially Lagos state, the overall population has a 3.9% prevalence of depression; however, greater rates are seen in some groups, including young adults (25%), the elderly (26.2%), those with HIV/AIDS (20-59%), and patients with chronic diseases (27.5-46%). Depression is more common among these groups than in the overall population or among those who suffer from long-term conditions like epilepsy, leprosy, or stroke (Adeomi, et al, 2021). This study seeks to examine the ethical concerns of depression among youths: a socio-religious implication in contemporary Nigeria.

### Objectives of the study

The main objective of this research is to investigate the ethical concerns of depression among youths: a socio-religious implication in contemporary Nigeria; other objectives include:

1. Investigate the ethical concerns surrounding depression among youths in Lagos, Nigeria.
2. Analyse the socio-religious implications of mental health issues on youths in Lagos, Nigeria.
3. Examine the role of religious institutions in shaping public perceptions and treatment of depression in Lagos, Nigeria.
4. Provide recommendations for improving mental health care practices, focusing on bridging the gap between medical and religious interventions.

### Research Questions

1. What are the ethical concerns surrounding depression among youths in Lagos, Nigeria?
2. How do religious beliefs and practices shape the perception of depression?
3. To what extent do religious institutions contribute to the stigmatisation of depression among youths in Lagos State, Nigeria?

4. What are the socio-religious implications of depression among Nigerian youths in Lagos State?
5. How can mental health services and religious institutions collaborate to better address youth depression in Lagos, Nigeria?

### Scope of the Study

This study focuses on the ethical concerns of depression among youths and its socio-religious implications in contemporary Lagos State, Nigeria.

1. **Geographical Scope:** This study is limited to Lagos State, Nigeria—a densely populated and culturally diverse region that reflects both the urban and semi-urban experiences of Nigerian youths. The state is home to a wide spectrum of religious communities, making it a suitable environment to explore the socio-religious dimensions of youth depression.
2. **Demographic Scope:** The focus is on youths between the ages of 15 and 40, which aligns with the Nigerian national definition of youth. Both male and female participants from varied socioeconomic backgrounds are considered, in order to capture a holistic view of how depression manifests among the youth in Lagos State.
3. **Thematic Scope:** The study centers on the ethical concerns related to youth depression—such as stigma, neglect, moral judgement, and societal expectations. It also examines the religious implications, especially how religious teachings and pastoral care either contribute to healing or worsen the emotional distress of affected individuals.
4. **Institutional Scope:** The study engages with religious institutions, youth fellowships, mental health advocacy groups, and social workers operating within Lagos. Their roles, responses, and responsibilities in addressing depression among youths are critically assessed.

### Theoretical Framework

Youth depression is a multifaceted disorder influenced by biological, psychological, and social factors. Biologically, it is associated with abnormalities in brain chemistry and function, including imbalances in hormones such as cortisol and neurotransmitters like serotonin, dopamine, and norepinephrine (Bernaras et al., 2019). Brain imaging studies show irregular activity in the frontal lobe, limbic regions, and amygdala, areas responsible for emotion regulation and stress response (Mezulis et al., 2014). Contributing factors include genetics, malnutrition, and early life adversity (Zajkowska, 2021).

From a psychological perspective, theories such as the self-control model suggest that depression stems from poor self-monitoring and irrational self-evaluation (Bernaras et al., 2019). The cognitive theory emphasises the role of negative thinking patterns and cognitive distortions about the self, world, and future (Weedland, 2017). The social signal transduction theory highlights the impact of social stressors like rejection and isolation,

which disrupt neural circuits involved in mood regulation (Sichko, 2021). Other contributing psychological factors include early family disruption, low self-esteem, and poor parental relationships.

Social theories focus on the role of interpersonal relationships. Factors such as social rejection, stress, lack of support, and feelings of inferiority can worsen depression (Rudolph, 2008). Conversely, supportive friendships and warm parent-child interactions can enhance mental well-being and reduce depressive symptoms (Sichko, 2021; Yao & Enright, 2021).

### **Empirical Framework**

In Nigeria, cultural and religious interpretations often influence how youth depression is perceived and treated. Mental health challenges are frequently attributed to spiritual causes or personal weakness, leading many young people to seek religious rather than clinical intervention (Akinbobola, 2019; Okpala, 2020). However, religious coping strategies can also offer emotional relief and psychological support in some cases (Amadi, 2017).

Research indicates that youth depression is prevalent and serious. Birmaher et al. (2016) found that around 11% of adolescents experience a depressive disorder before age 18. A meta-analysis by Gore et al. (2017) identified genetic predisposition, early trauma, peer pressure, and academic stress as major risk factors. Untreated depression can lead to academic failure, substance abuse, and suicidal behaviour, underlining the need for early diagnosis and intervention.

Understanding the aetiology of depression is complex due to its multifactorial nature. While treatments such as psychotherapy and medication are effective in symptom reduction, a clearer understanding of causes could improve outcomes (France et al., 2007). Both treatment methods influence neurochemical pathways and address cognitive distortions, with a combined approach often proving most effective (Dunlop & Nemeroff, 2007).

Family dynamics also play a critical role. Parental depression and family history are major risk factors, with potential generational transmission of vulnerability (Li et al., 2021; Birmaher et al., 1996). Goodman and Gotlib (1999) identified four pathways through which maternal depression may affect children: genetic inheritance, neuroregulatory dysfunction, exposure to maternal negativity, and environmental stress. Additionally, strained father-child relationships contribute significantly to youth depression (Sanford et al., 1995).

From a religious perspective, Islam views depression as a medical condition and encourages seeking both spiritual and professional help. Quranic guidance (e.g., 12:87; 94:5–6) emphasises hope, patience, and reliance on Allah during hardship (Bulut et al., 2021). Practices such as prayer, gratitude, and seeking social support are recommended (Sabry & Vohra, 2013).

Similarly, Christianity recognises emotional struggles through the lives of figures like David and Elijah, who expressed sorrow and sought God's help (Psalm 42:11; 1 Kings 19:4). The Bible encourages believers to rely on God's comfort (Isaiah 41:10), seek wise counsel

(Proverbs 11:14), and support one another in community. While faith is a valuable coping resource, professional support is also affirmed within Christian teachings.

### Research Design

The study employed a descriptive survey design to examine the ethical concerns surrounding depression among youths in Lagos State, Nigeria, with a focus on socio-religious implications. This design allowed for the collection and analysis of relevant data regarding the participants' experiences, beliefs, and attitudes.

### Population of the Study

The target population comprised youths aged 15 to 35 based on depression experiences in religious organisations, educational institutions, and communities within Lagos Mainland, Lagos State. The study also included clergy, youth leaders, and mental health professionals to capture a broad and informed perspective on the issue.

### Sample Size and Sampling Technique

The study involved 300 individuals in total. Religious organisations within Lagos Mainland, Lagos State, were purposefully chosen as part of a multi-stage sample procedure. Religious organisations and youth centres were categorised within these. Participants were then chosen at random from the designated institutions. Included in the final sample were 200 young people (aged and gender-balanced), 50 youth leaders/clergy, and 50 mental health professionals.

### Research Instrument

Data were collected using a structured questionnaire comprising both closed-ended and open-ended questions. The instrument was divided into four sections:

- Section A: Demographic Information
- Section B: Depression Awareness and Experiences
- Section C: Ethical and Religious Interpretations
- Section D: Access to Support Systems and Interventions

The questions explored personal experiences with depression, perceptions of stigma, religious influences, and ethical concerns.

### Validity and Reliability

To ensure the credibility of the instrument, experts in ethics, psychology, and theology reviewed the questionnaire. A pilot study involving 30 participants was conducted prior to full deployment. Based on feedback, minor adjustments were made. The internal consistency of the instrument was confirmed with a Cronbach's alpha of 0.78, indicating acceptable reliability.

### Procedure for Data Collection

Data collection spanned a six-week period. Printed copies of the questionnaire were distributed during youth fellowships, church and Islamic programmes, and counselling sessions, while digital copies were shared via email and WhatsApp groups. Follow-up interviews were conducted with selected clergy/cleric and counsellors for deeper insights. All participants were informed of the study's objectives and gave consent before participating.

### Method of Data Analysis

1. Descriptive Analysis: Quantitative data were analysed using frequencies, percentages, means, and standard deviations to summarise participant responses. This provided a general overview of the awareness, attitudes, and experiences of depression among the youths studied.
2. Inferential Analysis: To test specific hypotheses and examine statistical relationships:
  - A chi-squared test was used to determine the association between religious affiliation and perception of depression.
  - Independent sample t-tests examined gender differences in stigma perception and willingness to seek help.
  - A one-way ANOVA was conducted to identify significant differences across age groups regarding their ethical understanding of depression.
  - Pearson's correlation coefficient was used to explore the relationship between depression awareness and help-seeking behaviour.

All statistical analyses were performed using SPSS version 26, with significance tested at the 0.05 level. Additionally, thematic analysis was used to interpret open-ended responses and interview transcripts, enriching the quantitative findings with contextual insights.

### Ethical Considerations

The study adhered to standard ethical procedures. Participants' anonymity and confidentiality were ensured throughout the research. Informed consent was obtained, and participation was entirely voluntary. Those who exhibited emotional distress during or after the study were referred to professional counsellors for support.

## Presentation and Analysis of Data

**Table 1: Demographic Characteristics and Socio-economic Status of the Respondents**

| Characteristics                   | Variables           | Frequency | Percentage |
|-----------------------------------|---------------------|-----------|------------|
| <b>Gender</b>                     | Male                | 150       | 50.00      |
|                                   | Female              | 150       | 50.00      |
| <b>Age (in years)</b>             | 18-23               | 112       | 37.33      |
|                                   | 24-29               | 76        | 25.33      |
|                                   | 30-35               | 58        | 19.33      |
|                                   | 36-40               | 54        | 18.00      |
| <b>Marital Status</b>             | Married             | 103       | 34.33      |
|                                   | Single              | 178       | 59.33      |
|                                   | Widowed             | 6         | 2.00       |
|                                   | Divorced            | 5         | 1.67       |
|                                   | Separated           | 8         | 2.67       |
| <b>Highest Educational Status</b> | Postgraduate Degree | 66        | 22.00      |
|                                   | Bachelor Degree/HND | 118       | 39.33      |
|                                   | OND                 | 44        | 14.67      |
|                                   | SSCE                | 38        | 12.67      |
|                                   | JSCE                | 18        | 6.00       |
|                                   | Primary School      | 16        | 5.33       |
|                                   | No Formal Education | 0         | 0.00       |
| <b>Means of Livelihood</b>        | Public Servant      | 38        | 12.67      |
|                                   | Artisan             | 66        | 22.00      |
|                                   | Educationist        | 24        | 8.00       |
|                                   | Medical Personnel   | 30        | 10.00      |
|                                   | Agriculturist       | 18        | 6.00       |
|                                   | Trader              | 118       | 39.33      |
|                                   | Others              | 6         | 2.00       |

**Source: Field Survey, October 2024 – December 2024**

The study sample consisted of 300 respondents, equally distributed by gender with 150 males (50.00%) and 150 females (50.00%). The majority were within the age range of 18–23 years (37.33%), followed by 24–29 years (25.33%), 30–35 years (19.33%), and 36–40 years (18.00%). In terms of marital status, most respondents were single (59.33%), while 34.33% were married, 2.67% separated, 2.00% widowed, and 1.67% divorced. Regarding educational attainment, 39.33% held a Bachelor's Degree or HND, 22.00% had a Postgraduate Degree, 14.67% had OND, 12.67% had SSCE, 6.00% had JSCE, and 5.33% had only Primary School education; none had no formal education. As for their means of livelihood, the largest proportion were traders (39.33%), followed by artisans (22.00%), public servants (12.67%), medical personnel (10.00%), educationists (8.00%), agriculturists (6.00%), and others (2.00%).

**Table 2: Reported Most Common Causes of Major Depression**

| S/N | ITEMS                                      | AGREED       | DISAGREED    | UNDECIDED   |
|-----|--------------------------------------------|--------------|--------------|-------------|
| 1   | Family history of depression               | 160 (53.33%) | 80 (26.66%)  | 60 (20%)    |
| 2   | Family issues/challenges in the home       | 223 (74.33%) | 29 (9.67%)   | 48 (16%)    |
| 3   | Finance                                    | 248 (82.67%) | 41 (13.67%)  | 11 (3.67%)  |
| 4   | Loneliness/Isolation                       | 186 (62%)    | 100 (33.33%) | 14 (4.67%)  |
| 5   | Self-pleasure and/or sexual habits         | 132 (44%)    | 106 (35.33%) | 62 (20.67%) |
| 6   | Demonic influence                          | 164 (54.67%) | 89 (29.67%)  | 47 (15.67%) |
| 7   | A rundown physical condition               | 198 (66%)    | 86 (28.67%)  | 16 (5.33%)  |
| 8   | Excessive drugs/Alcohol use                | 108 (36%)    | 152 (50.67%) | 40 (13.33%) |
| 9   | Physical changes in your body              | 158 (52.67%) | 79 (26.33%)  | 63 (21%)    |
| 10  | Non-appreciation of efforts by the parents | 180 (60%)    | 91 (30.33%)  | 29 (9.67%)  |
| 11  | Others (state)                             | 12 (4%)      | 270 (90%)    | 8 (2.67%)   |

**Source: Field Survey, October 2024 – December 2024**

The data presents responses to various potential causes of emotional and psychological struggles, measured by levels of agreement, disagreement, and indecision. Out of all the items, finance emerged as the most agreed-upon factor, with 248 respondents (82.67%) acknowledging it as a major contributor, followed closely by family issues or challenges in the home, with 223 respondents (74.33%) agreeing. Physical condition or impediment was also significantly acknowledged, with 198 (66%) agreeing. Loneliness or isolation had 186 (62%) agreement, while non-appreciation of efforts by parents and demonic influence had 180 (60%) and 164 (54.67%), respectively. The place of genetic or family heredity concerning depression was noted by 160 (53.33%), and physical changes in the body were similarly acknowledged by 158 (52.67%).

On the other hand, self-pleasure or sexual habits received a lower agreement rate of 132 (44%), with a significant 106 (35.33%) disagreeing and 62 (20.67%) undecided. The least agreed-upon item was excessive drug or alcohol use, with only 108 (36%) in agreement and the highest disagreement at 152 (50.67%). The "Others" category was agreed upon by only 12 respondents (4%), while 270 (90%) disagreed, indicating that the listed factors were largely comprehensive. Across the data, some items, such as finance and family issues, showed overwhelming consensus, while others, like drug use and self-pleasure, revealed divided opinions, highlighting the complexity and multi-dimensional nature of perceived causes of emotional distress among the respondents.

**Table 3: Reported Depressive Symptoms of Participants**

| S/N | ITEMS                        | AGREED       | DISAGREED    | UNDECIDED    |
|-----|------------------------------|--------------|--------------|--------------|
| 1   | Feeling sad                  | 231 (77%)    | 39 (13%)     | 30 (10%)     |
| 2   | Pessimism                    | 164 (54.67%) | 123 (41%)    | 13(4.33%)    |
| 3   | Focusing on past failures    | 196 (65.33%) | 67 (22.33)   | 36 (12%)     |
| 4   | Changes in sleep patterns    | 132 (44%)    | 99 (33%)     | 69 (23%)     |
| 5   | Guilty feelings              | 178 (59.33%) | 87 (29%)     | 35 (11.67%)  |
| 6   | Tiredness or fatigue         | 186 (62%)    | 59 (19.67%)  | 55 (18.33%)  |
| 7   | Self-dislike                 | 68 (22.67%)  | 110 (36.67%) | 122 (40.67%) |
| 8   | Concentration difficulties   | 212 (70.67%) | 67 (22.33%)  | 21 (7%)      |
| 9   | Suicidal thoughts and wishes | 254 (84.67%) | 39 (13%)     | 7 (2.33%)    |
| 10  | Crying                       | 158 (52.67%) | 42 (14%)     | 100 (33.33%) |
| 11  | Agitation                    | 172 (57.33%) | 63 (21%)     | 65 (21.67%)  |
| 12  | Loss of interest             | 170 (56.67%) | 119 (39.67%) | 11 (3.67%)   |
| 13  | Indecisiveness               | 194 (64.67%) | 68 (22.67%)  | 38 (12.67%)  |
| 14  | Loss of energy               | 202 (67.33%) | 83 (27.67%)  | 15 (5%)      |
| 15  | Irritability                 | 157 (52.33%) | 132 (44%)    | 11 (3.67%)   |

**Source: Field Survey, October 2024 – December 2024**

The dataset provides a comprehensive overview of participants' responses to a series of depression-related indicators, assessed through levels of agreement, disagreement, and indecision. Notably, a substantial proportion of respondents agreed to experiencing core symptoms commonly associated with depression, including suicidal thoughts and wishes (84.67%), feelings of sadness (77%), difficulty concentrating (70.67%), loss of energy (67.33%), and rumination on past failures (65.33%). These findings reflect a significant presence of cognitive and emotional disturbances within the surveyed population. Symptoms such as tiredness or fatigue (62%) and indecisiveness (64.67%) further underscore the impact of depressive experiences on motivation and executive functioning. Conversely, the item on self-dislike recorded the lowest agreement rate (22.67%) alongside the highest proportion of undecided responses (40.67%), potentially indicating ambivalence, denial, or stigma associated with self-directed negative evaluations. Similarly, the high rate of indecision concerning crying (33.33%) and sleep disturbances (23%) may reflect personal, cultural, or spiritual factors that influence emotional expression and self-reporting. Mixed responses to pessimism and irritability suggest individual variability in symptom manifestation or recognition. Overall, the data highlight the prevalence of depressive symptoms among respondents, while also pointing to nuanced areas—such as self-perception and emotional regulation—where cultural, theological, or psychosocial dynamics may mediate the acknowledgement of distress.

**Table 4: Effects of Depression on an Individual Youth**

| S/N | ITEMS                      | AGREED       | DISAGREED   | UNDECIDED   |
|-----|----------------------------|--------------|-------------|-------------|
| 1   | Delusions                  | 198 (66%)    | 89 (29.67%) | 13 (4.33%)  |
| 2   | Hallucinations             | 186 (62%)    | 67 (22.33%) | 47 (15.67%) |
| 3   | Speech disorders           | 194 (64.67%) | 83 (27.67%) | 23 (7.67%)  |
| 4   | Thinking disorders         | 272 (90.67%) | 21 (7%)     | 7 (2.3%)    |
| 5   | Impairment of intelligence | 188 (62.67%) | 41 (13.67%) | 71 (23.67%) |
| 6   | Writing peculiarities      | 160 (53.33%) | 90 (30%)    | 50 (16.67%) |
| 7   | Disorganized behaviour     | 296 (98.67%) | 3 (1%)      | 1 (0.3%)    |
| 8   | Suicide tendency           | 228 (76%)    | 60 (20%)    | 12 (4%)     |

**Source: Field Survey, October 2024 – December 2024**

The data presented reflects respondents' perceptions of various psychological and behavioural symptoms. A significant majority, 98.67%, agreed that disorganised behaviour is a notable concern, with only 1% disagreeing and 0.3% undecided. Thinking disorders also received a high level of agreement at 90.67%, while 7% disagreed and 2.3% were undecided. Suicide tendency was acknowledged by 76% of the respondents, with 20% in disagreement and 4% undecided. Delusions were agreed upon by 66% of participants, while 29.67% disagreed and 4.33% were undecided. Similarly, 64.67% agreed on the presence of speech disorders, 27.67% disagreed, and 7.67% remained undecided. Hallucinations were recognised by 62% of the respondents, but they also had a relatively high rate of disagreement (22.33%) and undecided responses (15.67%). Impairment of intelligence was agreed upon by 62.67%, while 13.67% disagreed and a notable 23.67% were undecided. Writing peculiarities had the lowest level of agreement at 53.33%, with 30% disagreement and 16.67% undecided, indicating greater uncertainty or variability in perception regarding this item. Overall, while most respondents agreed with the listed symptoms, levels of disagreement and indecision varied across items, suggesting differing levels of awareness or acceptance of specific psychological manifestations.

**Table 5: Approaches to Dealing with Depression Symptoms**

| S/N | ITEMS                                                                                   | AGREED       | DISAGREED    | UNDECIDED  |
|-----|-----------------------------------------------------------------------------------------|--------------|--------------|------------|
| 1   | Received mental health counseling for depression                                        | 272 (90.67%) | 14 (4.67%)   | 14 (4.67%) |
| 2   | Received counseling from members of the clergy/cleric                                   | 199 (66.33%) | 53 (17.67%)  | 48 (16%)   |
| 3   | Received counseling from other professionals (e.g., psychologists, doctors, counselors) | 280 (93.33%) | 3 (1%)       | 17 (5.67%) |
| 4   | Prefer to go to Pastor/Imam for counseling                                              | 266 (88.67%) | 23 (7.66%)   | 11 (3.67%) |
| 5   | Prefer informal help from friends/family rather than professionals                      | 187 (62.33%) | 112 (37.37%) | 1 (0.3%)   |
| 6   | Pastor/Imam was involved during personal depression experience                          | 218 (72.67%) | 49 (16.33%)  | 33 (11%)   |
| 7   | Pastor/Imam showed care to others experiencing depression                               | 284 (94.67%) | 9 (3%)       | 7 (2.33%)  |

**Source: Field Survey, October 2024 – December 2024**

The survey data reveals significant insights into individuals' experiences and preferences concerning mental health counselling, particularly in relation to religious and professional support. A vast majority of respondents (90.67%) reported having received mental health counselling for depression, indicating a high level of engagement with mental health services. Notably, 93.33% received counselling from other professionals such as psychologists, doctors, or counsellors, while 66.33% reported receiving counselling from members of the clergy or other religious leaders. When it comes to preferences, 88.67% expressed a preference for going to a pastor or imam for counselling, which underscores the prominent role religious leaders play in mental health support. Additionally, 62.33% indicated a preference for informal help from friends or family over professional counselling, suggesting the continued importance of social and familial support networks. Furthermore, 72.67% of respondents acknowledged the involvement of a pastor or imam during their personal experience with depression, and an overwhelming 94.67% agreed that religious leaders showed care to others experiencing depression. These findings collectively highlight the dual reliance on both professional and faith-based mental health support systems, with a strong affirmation of the care and involvement of religious leaders in addressing issues of depression within the community.

### Discussion of Findings

The majority of respondents (62.66%) are between the ages of 18 and 29, suggesting that depression is common in younger individuals, maybe as a result of stresses from relationships, work, and educational transitions. The decreasing prevalence of depression

in later age groups (30–35, 36–40) may be a sign of improved stability with age or coping mechanisms. Unbiased insights into gendered experiences of depression are provided by the equal distribution, which is distinctive and shows balanced representation (50 percent male, 50 percent female). A high proportion of respondents are educated (61.33% hold degrees), but financial challenges (the top cause of depression) suggest a potential mismatch between education and job satisfaction or financial stability. The majority being traders (39.33%) might indicate self-employment challenges, such as market instability. The research findings reveal that financial and family issues, physical health, and perceived demonic influences are top contributors to depression among youths in Nigeria.

**Financial Issues (82.67%):** This aligns with broader societal issues, reflecting economic struggles in the sampling population. Financial issues and depression can lead to a downward spiral of worsening mental health and increasing financial problems. Stress from debt and other financial issues can cause depression and anxiety. Depression and anxiety can make it difficult to manage money, making it harder to concentrate and pay bills (Robinson & Smith, 2024). Additionally, taking time off work due to depression or anxiety can result in lost income. Therefore, it is crucial to address financial issues and depression to maintain mental health and reduce financial problems.

**Family Issues (74.33%):** This high percentage suggests a strong role of family dynamics in mental health. Family issues can significantly increase the risk of depression in both children and adults. Poor family functioning can lead to increased depression (Wong, et al, 2020), which can result in more family arguments among couples in Nigeria. Factors contributing to depression include low or high levels of family cohesion, high levels of family conflict, maladaptive parent-child communication, unwarm and emotionally unavailable parenting behaviors, and demanding and criticizing intergenerational relationships. These issues can lead to increased depression and a higher likelihood of recurrent family disputes (Bian, et al, 2024).

**Physical Health (52.67%):** A rundown physical condition highlights the potential link between mental and physical well-being based on the findings of this research. Depression can result in physical health concerns such as aches, pains, exhaustion, digestive difficulties, sleep disruptions, and an increased risk of heart disease and other inflammatory illnesses (Trivedi, 2004). Chronic pain in joints, limbs, back, and muscles; exhaustion from a lack of energy; digestive issues such as constipation and irritable bowel syndrome; sleep disruptions due to insomnia; appetite changes; weight loss or increase; and headaches (Villines, 2023). Physical health problems, such as chronic diseases, brain traumas, and heart disease, might raise the risk of depression. People with coronary heart disease, cancer, diabetes, arthritis, stroke, and other chronic illnesses such as hepatitis C, renal disease, HIV/AIDS, and multiple sclerosis are more prone to experience depression. Chronic conditions such as heart disease, cancer, diabetes, arthritis, stroke, and other chronic disorders increase the chance of depression.

**Demonic Influences (54.67%):** This cultural attribution underscores a spiritual interpretation of depression among respondents. It might suggest reliance on faith-based interventions rather than medical help. Some people believe that demonic influences can cause or worsen depression, while others believe it can be caused by other factors like stress, personality, family history, and illness. Some also view demonic activity as a mental health condition, like schizophrenia or suicidal thinking. Some also believe their Christian faith can empower them over demonic influences and mental health issues. In fact, some scholars, such as Scrutton (2020), Trice and Bjorck (2006), Webb and Hedden (2008), and Hartog and Gow, believe that depression in religious contexts may be perceived as the outcome of sin, leading to the assumption that spirituality-enhancing therapies are helpful. This viewpoint has been criticised by evangelical Christians, who frequently show ambivalence about secular therapy and favour faith-based approaches. Depression is frequently described in contemporary Christian self-help books as the result of demonic control, and surveys suggest that more than one-third of Christians would prefer religious therapies for mental health disorders, including depression.

The survey also discovered that prominent signs of depression among Nigerian youths especially in Lagos State include difficulty concentrating (70.67%) and indecisiveness (64.67%), which might have a detrimental influence on academic, relationship, or career performance. Emotional expressions such as irritability (52.33%), crying (52.67%) and impatience (44%) demonstrate the pervasiveness of depressed episodes. Suicidal ideation (84.67%) is a major problem, emphasising the need for preventive measures such as mental health awareness and intervention. Concerning the effects of depression among youths in Nigeria, it was discovered that suicide tendency is 85%, alarmingly high; this underscores the severity of depression's impact in this population. Cognitive/behavioural disorders, delusions (66%), and speech/thinking disorders (64.67%) suggest advanced stages of mental health decline, requiring professional intervention.

Self-care, psychotherapy, and medication are all options for treating depression. Early intervention is essential to halting the progression of symptoms. A psychiatrist or other mental health practitioner may prescribe medication, whereas a primary care physician or psychiatrist may offer psychotherapy. Psychodynamic psychotherapy assists people in recognising challenging emotions and the ways in which their behaviour patterns contribute to their issues. Self-care is having a routine, talking to trustworthy people, confronting worries, remaining connected, exercising frequently, eating and sleeping healthily, avoiding alcohol and illegal substances, and participating in fun activities. Additional therapies include electroconvulsive therapy for resistant depression and herbal remedies such as St. John's wort for mild to severe depression. Those going through similar emotions might find support and discourse by joining a support group.

The data showing that 93.33% received counseling from professionals and 66.33% from clergy underscores the dual reliance on both clinical and spiritual sources for mental health support. This aligns with research indicating that individuals often turn to both medical and religious frameworks to cope with psychological distress (Wang et al., 2003). The

integration of mental health professionals and clergy reflects the growing recognition of the importance of culturally and spiritually congruent care (Koenig, 2007). That 88.67% would prefer to seek counseling from a Pastor or Imam indicates a significant preference for religious leadership in mental health matters. Previous studies have shown that religious leaders often serve as first responders to mental health crises, particularly in communities where stigma toward mental illness exists or where access to formal mental health services is limited (Leavey et al., 2007; Milstein et al., 2003). This preference may be rooted in trust, shared values, and the perceived moral authority of religious figures (Chatters et al., 2011). While slightly lower than religious support, 62.33% still preferred family or friends as sources of help. Informal social support is a well-documented protective factor in mental health (Thoits, 2011). However, the lower preference relative to clergy might suggest that religious leaders are perceived as more equipped to handle emotional or existential concerns within a culturally resonant framework (Taylor et al., 2000). With 72.67% reporting that religious leaders were involved during their own depression, and 94.67% noting they observed care shown to others, this data supports prior findings that clergy are not only accessible but actively involved in caregiving roles (Neighbors et al., 1998). Such involvement reflects the pastoral mission of many religious leaders, who often serve as counselors, confidants, and advocates in times of distress (Weaver et al., 2001).

### Recommendations and Conclusion

This study closely follows ethical criteria for research involving human and social issues. Although it is mostly literature-based and incorporates direct human subjects, particularly individuals who have experienced depression, care was made to ensure that secondary data is used responsibly. All sources were correctly mentioned to avoid plagiarism, and sensitive topics like mental health and depression were handled with dignity, secrecy, and respect. The study remains culturally sensitive while upholding moral and ethical norms congruent with Christian and Islamic theology and pastoral ethics. Approval and guidance were sought from suitable academic and religious authorities to ensure the research's integrity and usefulness in both academic and faith-based settings.

To alleviate Nigerian youth financial challenges, skill development programs should be created, which would involve collaborations with local companies or government programs to give skill-based training in high-demand industries such as technology and crafts. Entrepreneurship support should include microloans, mentorship, and business training, while Employment advocacy should push for legislation that promotes young employment. To overcome educational disparities and employment mismatches among Nigerian youths in Lagos State, career advisory programs should be implemented to ensure pupils learn marketable abilities. Continuous learning opportunities should be fostered in competitive domains such as information technology, healthcare, and business, and industry collaborations should be developed to guarantee graduates obtain relevant skills and career possibilities.

Community awareness campaigns that inform people about depression as a medical and psychological condition and its effects on people, training clergy to identify symptoms of depression, and establishing safe spaces for peer support groups to discuss struggles without stigma or judgement are all important ways to combat stigmatisation and bullying, which can lead to depression among the youths in Nigeria. In order to address the high rates of depression-related suicide among Nigerian youth especially in Lagos State, the government should set up mental health hotlines and support services, teach community leaders suicide prevention skills, provide mental health education in schools, offer workshops on coping mechanisms, mindfulness, and emotional resilience, collaborate with nearby psychologists to provide free or inexpensive therapy sessions, and integrate tele-health services for easier accessibility.

Youth depression in Nigeria continues to be a major socio-religious issue. The situation is made worse by the paucity of mental health education in religious contexts and the moral dilemmas raised by the stigmatisation of mental health conditions. Although, the scope of this study is geographically restricted to the Nigerian context especially Lagos State, which may not fully capture the broader African or global perspective on youth depression. The results emphasise how important it is for religious leaders and medical practitioners to work together to address mental health issues. Some religious teachings stigmatise depression and lead people to believe that it is only a spiritual problem, whereas other beliefs provide constructive help. Nigerian culture, and religious organisations in particular, must adopt a more knowledgeable and caring stance on depression. To ensure that young people have access to spiritual and psychological help, this will necessitate adjustments to both religious practices and cultural views.

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