

A comparative study of depressive symptoms of the adolescents living with biological parents and those living with non-biological parents in abakaliki metropolis in ebonyi state.

¹Sylvester O. Okenyi, ²Matthew Ojone, ³Ezeruigbo Chinwe FS

¹Dept. of Educational Foundations, ESUT Enugu, Nigeria

²Dept of Nursing, Ebonyi State University, (EBSU) Abakaliki, Nigeria

³Dept of Nursing, EBSU Abakaliki, Nigeria

***Corresponding Author:**

Sylvester O. Okenyi

Email: okenyisylve@hotmail.com

Abstract: The focus of the present study was to compare the depressive symptoms among adolescents living with their biological parent and those living with non-biological parent within Abakaliki metropolis. A total of 583 schooling adolescents were purposefully selected. Out of this, 383 live with biological parents: 189 (49%) male, and 194 (51%) female. 200 live with non-biological parents: 62 (31%) male, and 138 (69%) female. A questionnaire of two sections was used: section A-deals with personal demographic data while section B contains Columbia DISC Depression scale with 22 questions and was used for the assessment of depressive symptoms of the respondents. The findings show that the discrepancy in depressive symptoms among adolescents living with their biological parents and those living with non-biological parents is insignificant. There is no disparity in the adolescents' depressive symptoms on gender among adolescents living with biological parents but more common among female than male on those living with non-biological parents. The findings also show that age, gender and class levels of adolescents are not determinant factors for depressive symptoms. Appropriate recommendations were made for concerned parties in this study.

Keywords: Depressive symptoms, adolescents, biological parents, non-biological parents, gender

INTRODUCTION

Early studies in psychoanalysis had presumed that young adolescents did not have the psychological structure (e.g. super ego functions) to truly experience depression [1, 2]. Clinical and empirical evidence [3, 1] have revealed however, that adolescents do indeed suffer from both depressive symptoms and depressive disorders. The fact, however, was that depression in adolescent was overlooked and perhaps ignored possibly because of the disruptive behaviours and other co-morbid disorders that were more salient at this stage of human development than depressive symptoms. The sensitive and strategic importance of the adolescence stage in human development has compelled scholars and psychologists [3, 1] to devote a lot of attention to this crucial phase of human life. These studies have also given a lot of insight into the conceptualization of the adolescence. For instance, Lerner & Spanier [4], defined adolescence as the period within the life span when most of a person's biological, cognitive, psychological, and social characteristics are changing from what is typically considered child-like to what is considered adult-like. World Health Organisation [5] sees adolescence as the period in human growth and development that occurs after childhood and before

adulthood, from ages 10 to 19. Parents and teachers realize the tremendous importance of the adolescent stage in the life of their wards. This tends to explain why this phase in human life is usually handled with utmost care by all stakeholders. The reason being that if proper care and monitoring are lacking in handling the adolescent at this stage the situation could result in such serious psychological challenges as low self esteem, depressive symptoms and other developmental problems.

The role of family relationships and interactional processes as factors relevant to child and adolescent emotional health and the likelihood of depression has received increasing attention over the last decade. Researchers are of the opinion that the most important relationship in a child's life is the attachment to his or her primary caregiver, optimally, the mother [6]. This perhaps is due to the fact that this first relationship determines the biological and emotional 'template' for all future relationships. Parental relationship is generally regarded as very crucial to the level of emotional stability of the adolescents and could constitute a major cause of adolescent depression [7]. Hagen [2] has also noted that the quality of parent-

adolescent relationship do contribute to depressive attitude in adolescence. They suggest that when the quality of parent-adolescent relationship decreases, there is a tendency for relative increase in depressive symptoms.

In the Nigerian cultural context, it has been noted that unwarm relationship is common among adolescents living with non-biological parents [8]. These adolescents suffer from undue negligence, relentless criticism, child abuse, punishments and rigid family rules. In addition, core family members often subject them to undue comparison with other privileged peers. The result is that such adolescents experience low self esteem and in consequence have tendency to suffer from high rate of depressive symptoms.

It must be noted however, that emotional challenges and depressive tendencies are not exclusive to children from non-biological parents. Depression is a common psychiatric disorder among adolescents in all regions of the world [9] and it is characterized by feelings of sadness, anxiety, fear, guilt, anger, contempt and confused thinking [8]. It was predicted that depressive disorders would become the first leading cause of disease burden by 2015 [10]. Similarly, depressive disorder is also a common mental health problem among adolescents worldwide with the lifetime prevalence of 20–25% [11]. Globally, prevalence rates of adolescent depression range from 0.4-14.2%. A Southwest Nigeria prevalence study reported a prevalence of 12.6 %, which is at the upper end of the globally reported range [11]. This rise in the prevalence is often associated with many factors such as physical or emotional detachment by the primary caregiver, parental separation or divorce [12]. Given its vast personal and social impacts, depressive symptoms create significant demands on individuals, care givers, teachers and the society as a whole (National Institute of health and Care Excellence (NICE)[22].

The present researchers were constrained to look into the issue of depressive symptoms in the secondary schooling adolescents in this particular part of the world not only because of its likely impact on learning but because there is paucity of research in Ebonyi state which has Abakaliki as its capital city.

Statement of the Problem

The current depressing socioeconomic condition of Nigeria and the rapidly growing urban population arising from the migration to the cities of internally displaced persons (IDP) in some parts of the country have brought about an increasing rise in the rate of non-biological parenting in Nigeria. This type of parenthood however, is still viewed negatively in most parts of Nigeria. This negative perception of children from non biological parents in parts of Nigerian tends to indicate that children brought up in such family

structures may be suffering from inadequate attention, support and recognition from teachers, peers and the society at large when compared to children brought up by their biological parents. Indeed children brought up by non biological parents are often stigmatized and this may adversely affect their emotional stability. The situation obviously may perhaps result to other behavioural problems like depression, indiscipline, drug abuse and poor academic achievement. As true as the above claims might sound, researchers are yet to gather sufficient research data to prove the discrepancy in the prevalence of depressive symptoms, for example, among secondary school adolescents living with their biological parents and those living with their non-biological parents within Abakaliki metropolis, hence the basis for the present study.

LITERATURE REVIEW

A commendable amount of study has been carried out on depressive symptoms in adolescent in other climes. A report from a study by Siyez [13] shows that girls experience decline in mood at age 12 whereas in boys the decline generally begins at age 14. Studies in new Zealand have found that the prevalence of depression increases with age in adolescence, with a three-fold increase post puberty, and about equal prevalence among boys and girls until 15-years, after which there appears to be a greater prevalence in females [14]. The average age of depression onset is 14 years old. By the end of their teen year, 20% of teens will have had depression [15]. After that time, with the transition from middle school to high school; they tend to have a decline in depressive symptoms, until at least the age of 16. At early age, girls are confronted with issues like dating and sex [16].

Sajjadi et al, [15] reported in their Investigation on “A Systematic Review of the Prevalence and Risk Factors of Depression among Iranian Adolescents” the emergence of a strong female predisposition toward depression after puberty.” Although the reasons for this post-pubertal onset are not fully understood, Gender difference in tendency to depression starts to appear at the age of 12-13 [17].

Bean, Barber, & Crane [18] state that, adolescents with unipolar depressive disorders experience less supportive and more conflictual relationships with each of their parents than do healthy adolescents. Parent-adolescent relationships are related to sub-diagnostic symptomatology in much the same way, moreover, as they are to depressive disorder.

Most of the studies cited here were carried outside the immediate domain of the present researchers. It is hoped that the findings of the present study will not only indicate how the variables studied prevail locally but will go a long way in enriching other studies already done on the phenomenon.

Purpose of the Study

In broad terms the purpose of the study was to:

Compare the level of depressive symptoms of the schooling adolescents living with biological parents and those living with non-biological parents. Variables of gender, age and class levels were also examined in this direction.

HYPOTHESES

The main hypothesis of this study is:

There is no significant difference in the level of depressive symptoms between adolescents living with

biological and those living with non-biological parents. Variables of gender, age and class levels were also examined and tested as shown in the Data Analysis.

METHODOLOGY

This study was a cross-sectional comparative survey of students (adolescents) from selected government owned secondary schools within Abakaliki metropolis in Ebonyi State, South eastern Nigeria with coordinates 6°15'N 8° 05'E. There are six secondary educational institutions owned by government within Abakaliki Metropolis but to limit gender biasness, only mixed schools were selected with the total number of students 7,098 and 583 (8.23%) were used for the study as shown below Table-1.

Table 1: Studied Schools And Their Corresponding Studied samples

S/N	School	Total Population	Studied population	Percentage studied (%)
1	NSS	927	111	11.97
2	AHS	1,540	166	10.78
3	GTC	1,209	179	14.81
4	USS	3,422	127	3.71
5	MCGSS	464	***	***
6	GHS	586	***	***
	Total	8,148	583	8.21

Note: NSS-Nnodo Secondary School, AHS-Abakaliki High School, GTC-Government Technical College, USS-Urban Secondary School, MCGSS-Modern Comprehensive Girl's Secondary School, GHS-Girl's High School.

The Table -1 above shows the total number of students in the selected schools as 7,098 and 583 (8.23%) were used for the study.

METHOD OF DATA COLLECTION

The researchers went to each school mentioned to administer the questionnaire through personal contact with the students. Owing to the fact that the questionnaire was adopted from a different environmental setting, the researcher explained to the students how to fill the questionnaire so as to avoid or minimize cases of invalidity. The questionnaire is made up of 2 sections: Section A-deals with personal demographic data. Section B contains Columbia DISC Depression scale with 22 questions. This was used for the assessment of depressive symptoms of the respondents.

The instrument was validated and trial tested as required. The reliability estimates were found to be high suggesting high reliability.

Data Analysis

Results obtained were arranged according to the hypotheses of the study and were presented using frequencies and percentages to ease discussions of findings. Chi-square test was used to test for depressive

symptoms among adolescent living with biological parents and those living with non-biological parents: gender and depressive symptoms, class level and depressive symptoms. Analysis of variance (ANOVA) was used to analyze the effect of age and depressive symptoms among the respondents.

RESULT

Data in Table 2 above show that 383 of the studied adolescents live with their biological parents, 189 are male and 194 are female. While 200 are living with non-biological parents with 62 male and 138 female.

The result in Table 3 above shows that the mean responses of adolescents living with biological parents and those living with non-biological parents on depressive symptoms are insignificant. Therefore the main Hypothesis (Null) 1 is accepted.

There is also no significant difference in the mean responses of the adolescents on depressive symptoms due to gender among adolescents living with biological parents but depression (very unlikely, moderately likely, likely and highly likely) is more common among female than male in those living with non-biological parent.

As shown in Table 4 above the χ^2 calculated (4.69) < χ^2 tabulated (7.82) on gender hence; gender does not have any significant influence on respondents' depressive symptoms. The analysis on age shows that, F-ratio is -1.35 and the critical value of

F for 3 and 12 degree of freedom is 3.49. then, the null hypothesis was accepted while test on class level shows that, class levels do not have any significant influence on respondent's depressive symptoms at χ^2 Calculated (4.60) χ^2 < tabulated (7.82)

Table-2: Parental and Gender Figures In the Corresponding Schools

Parent	Gender	School									
		NSS		AHS		GTC		USS		G. Total	
		Fq.	%	Fq.	%	Fq.	%	Fq.	%	Fq.	%
Biological parent	male	24	39	37	36	99	71	29	37	189	49
	female	37	61	66	64	41	29	50	63	194	51
Total		61	100	103	100	140	100	79	100	383	100
Non-biological parent	male	9	18	18	29	25	64	10	21	62	31
	female	41	82	45	71	14	36	38	79	138	69
Total		50	100	63	100	39	100	48	100	200	100
Grand Total		111		166		179		127		583	

Note: Fq-Frequency, %-percentage, G-grand.

Table-3: Relationship Between The Parental Factor And Gender Among Adolescents

Depressive symptoms and adolescent with biological and non-biological parents					p-value 0.05
	VU	ML	L	HL	
Biological p.	61(55.18)	138(139.93)	131(128.11)	53(59.78)	X^2 cal 4.30 X^2 tab 7.82
Non-biological p.	23(28.82)	75(73.07)	64(66.90)	38(31.22)	
Gender and depressive symptoms among adolescents living with biological parent					
Male	26 (23.6868)	57(58.3708)	55 (52.4491)	24 (23.6867)	X^2 cal 0.56 X^2 tab 7.82
Female	39 (37.5065)	81(79.6292)	69 (71.5509)	32 (32.3133)	
Gender and depressive symptoms among adolescents living with non-biological parent					
Male	3 (26.67)	27 (36.36)	18(25.68)	12 (34.21)	%
Female	11 (73.33)	49 (63.64)	55 (74.32)	25 (65.79)	

NOTE: VU Very likely, ML moderately likely, L likely, HL highly likely

Table-4 Relationship Between Demographic Variables And Depressive Symptoms In Adolescence

	VU	ML	L	HL		
Gender					X^2 cal 4.69 X^2 tab 7.82	p-value 0.05
Male	31(36.3088)	105(93.7976)	80(81.2624)	36(40.6312)		
Female	53(47.6913)	112(123.2024)	108(106.7376)	58(53.3688)		
Total	84	217	188	94		
Age						
Source of variation	df	SS	MSS		F ratio -1.35 F critical 3.49	
Between group	3	-9033.313	-3011.10			
Within group	12	26729.250	2227.44			
		15	17695.937			
Class level						
Junior	34(31.2659)	89(79.2813)	64(72.5815)	30(33.8714)	X^2 cal 4.60 X^2 tab 7.82	
Senior	50(52.7341)	124(133.7187)	131(122.4185)	61(57.1287)		
Total	84	213	195	91		

DISCUSSION

Adolescence and Depressive Symptoms

The discrepancy between adolescents living with their biological parent and those living with their non-biological parents on depressive symptoms is insignificant. The lack of significant differences between gender scores was an unexpected outcome.

The result however, seems to agree with the finding in [15] which indicated that economic hardships could trigger negative parent-children interactions. According to Parritz & Troy [19], depression is caused by "the acquisition and reinforcement of maladaptive behaviors, the lack of opportunity to learn adaptive or appropriate behaviors, and/or unavailable or inadequate

reinforcement of those adaptive or appropriate behaviors". Gender difference among the group was investigated and it was found out that, the prevalence of depression is more common in female than in male. This report is correlated with Sajjadi et al [15] study which says that, depression is generally more common among girls. These differences are probably affected by factors such as biological, psychological, social, and cognitive ones [15].

Gender does not have any significant influence on respondent's depressive symptoms. This result contradicted the finding of Sajjadi et al. [15] that, there is emergence of a strong female predisposition toward depression after puberty although the reasons for this post-pubertal onset are not fully understood; Gender difference in tendency to depression starts to appear at the age of 12-13 [19].

Age is not a determinant factor on respondent's depressive symptoms. This disagreed with the study in New Zealand that the prevalence of depression increase with age in adolescence, with three-fold increase post puberty, and about equal prevalence among boys and girls until 15-years, after which there appears to be a greater prevalence in females [20]. This rise in the prevalence is associated with many factors such as physical or emotional detachment by the primary caregiver, parental separation or divorce [21].

The finding signifies that, class level does not have any significant influence on respondent's depressive symptoms. This could be as a result of non-biological relationship between the students in the class and social interaction in class is not a determinant of adolescent's depressive symptoms.

CONCLUSION AND RECOMMENDATION

The difference in depressive symptoms among adolescents living with their biological parent and those living with non-biological parent is insignificant. There is no impact variation in the adolescent's depressive symptoms on gender among adolescents living with biological parents. But there is great variation in depressive symptoms among male and female living with non-biological parent (i.e. more common among female than male). In addition, age, gender and class level of adolescent are not determinant factors for depressive symptoms in adolescence. Based on the findings of this study general education on how to handle adolescents of different parental backgrounds so as to provide them with enabling environment that will make for stable emotional condition is recommended. Further academic research in the general population and particularly among adolescents staying with their biological parents and non-biological parents in other parts of the country is also recommended.

REFERENCES

1. Lerner RM, Kauffman MB; The concept of development in contextualism. *Developmental Review*, 1985; 5: 309-333.
2. Hagen, Edward H; *Evolutionary Theories of Depression: A Critical Review* La Revue Canadienne de psychiatrie, 2011; 56 (12)
3. Abege, Terna; Perceived Parental Care, Self-Esteem and Depression among Adolescents in Makurdi Secondary Schools *Journal of Educational Policy and Entrepreneurial Research (JEPER)* , 2014;1(2):219-226.
4. Lerner RM, Spanier GB; A dynamic interactional view of child and family development. In R. M. Lerner & G. B. Spanier (Eds.), *Child Influences on Marital and Family Interaction: A Life-Span Perspective*. New York: Academic, 1980; 1-20.
5. World Health Organisation WHO; *World Health Statistics*, 2013.
6. Lee VE, Burkam DT, Zimiles H, Ladewski B; Family structure and its effect on behavioral and emotional problems in young adolescents. *Journal of Research on Adolescence*, 1994; 4(3): 405-437.
7. DuBois DL, Hirsch B; Self-esteem in early adolescence: From stock character to marquee attraction. *Journal of Early Adolescence*, 2000; 20(1): 5-11.
8. Adeniyi Ade F, Okafor Nkechi C, Adeniyi Celia Y; *Journal of Child and Adolescent Psychiatry and Mental Health*, 2011; 5 (16).
9. Soenens Bart, Park Seong-Yeon; Perceived parental psychological control and adolescent depressive experiences: A cross-cultural study with Belgian and South-Korean; *Journal of Adolescence*, 2012; 35: 261-272.
10. World Health Organisation WHO; *World Health Statistics*, 2008.
11. Okunola RA, Ikuomola AD; Child labour in fostering practice; a study of Surulere LGA of Lagos state, Nigeria; *Medwell journal*, 2010; 6 (5).
12. Lisa B, Sheeber, Betsy Davis; Adolescents' Relationships with Their Mothers and Fathers: Associations with Depressive Disorder and Subdiagnostic Symptomatology *J Abnormal Psychology*, 2007; 116 (1).
13. Siyez DM; Adolescent self-esteem, problem behaviors, and perceived social support in Turkey. *Social Behavior and Personality: An International Journal*, 2008.
14. Nunley KF; *the Relationship of Self- Esteem and Depression in Adolescence*, 2001.
15. Sajjadi H, Mohaqeqi Kamal, Rafiey H, Vameghi M, Forouzan AS; A Systematic Review of the Prevalence and Risk Factors of Depression among Iranian Adolescents; *Global Journal of Health Science*, 2013; 5(3).
16. Cheng Y; Depression among adolescents, age 13-19 years, attending secondary schools in Trinidad.

-
- Prevalence and associated factors, *Journal of West India Medical*, 2010; 57: 352-359.
17. Gross J, John OP; Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology*, 2003; 85(2): 348-362.
 18. Bean RA, Barber BK, Crane DR; Parental support, behavioral control, and psychological control among African American youth: The relationships to academic grades, delinquency and depression. *Journal of Family Issues*, 2006; 27(10): 1335-1355.
 19. Parritz RH, Troy MF; *Disorders of Childhood Development and Psychopathology* 2nd Ed. Wadsworth Cengage Learning, 2014.
 20. McGee R, Williams S; A longitudinal Study of depression in nine year old children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 1988; 27: 342-348.
 21. Townsend P; *Poverty, social exclusion and social polarization: the need to construct an international welfare state*, Bristol: The Policy Press, 2006; 3-24.
 22. National Institute of health and Care Excellence [NICE], 2009 Year Report, 2009. [https://en.wikipedia.org/wiki/National-Institute-for Health and Care Institute](https://en.wikipedia.org/wiki/National-Institute-for_Health_and_Care_Institute)