**ASSESSMENT OF FACTORS CONTRIBUTING TO INCREASED DEPRESION STATUS AMONG THE YOUTH AGED 18-25 YEARS OF AGE) IN KILEMBE SUB-COUNTY, KASESE DISTRICT, UGANDA**

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**CHAPTER ONE**

**INTRODUCTION**

**Background of the Study**

Depression in youth is a serious public health concern world over (World Health Organization, 2020). Recent epidemiological data show that approximately 11 percent of youth will experience depression (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015), and these episodes are associated with downstream negative consequences later in adolescence for example academic difficulties, risky behavior engagement, non-suicidal self-injury and in adulthood, higher divorce rates, suicidality (Auerbach, Kim, et al., 2014; Auerbach, Tsai, & Abela, 2010; Avenevoli, Knight, Kessler, & Merikangas, 2008). Most notably, an alarming 75 percent of youth experiencing depression will make a suicide attempt in adulthood (Nock, Green, et al., 2013). Despite these unsettling statistics and associated negative consequences, the etiological mechanisms contributing to the onset and maintenance of depression in youth remain unclear, more especially in the developed world.

In the United States of America, as young youth are regularly exposed to interpersonal stressors, Rudolph (2008). He examined stress generation models of depression among the youth realized that exposure to drug use, peer influence, academic workload, hopelessness and lack of certain basic needs contributed to depression among the minority groups in the United States of America. Therefore, Abela, Aydin, & Auerbach (2007) proposed that specific vulnerability factors predict relational, or interpersonal, stressors that in turn, contribute to youth depression. Using this approach, Auerbach, Ho, & Kim (2014) in their study in China found that both cognitive (self-criticism) and interpersonal (diminished social support) vulnerability factors led to interpersonal stressors, contributing to higher levels of depressive symptoms over time among the youth.

Depression is a mental illness, and it is one of the most common health problems for young people in South Africa (WHO, 2020). There is no single cause of depression; life events, hormones, chemical imbalances, and genetics can all play differing roles depending on the individual. While each young person in South Africa will have their own responses to life events, some circumstances that can contribute to anxiety and depression in young people include fights with family or friends, changing schools or starting secondary school, being bullied, experiencing a relationship break-up, recent death, abuse or neglect. In all cases, it is important that depression is diagnosed and treated early (Mandal, & Palchoudhury, 2015).

In Kenya, research has shown that depression and subsequent disorders like anxiety have risen over the years and that stress is a prominent factor contributing to youth depression whereby the impact of pressure to perform at school, and the emotional stress associated young relationships and peer pressure can contribute to increased stress levels and depressive tendencies among young people. The effects of depression, particularly on social interactions and stress levels, lead teens to experiment with drugs like marijuana, pain relievers, and other stimulants.

In a study carried out in Uganda by Kinyanda (2004), it was revealed that poor interpersonal skills, coupled with negative thought processes, can create difficulties for youth negotiating changing relationships with peers and families, searching for autonomy while trying to fit in, and simultaneously trying to succeed in a competitive academic and social environment. In addition, the study by Kizza (2004) indicates that cumulative adverse life events can lead directly to depression among the youth. Depressing life events can include exposure to family or community violence, chronic poverty, child physical and sexual abuse bereavement, or parental divorce or separation.

**Statement of the Problem**

Depression among the youth in Kilembe Sub-County is high (Kilembe Sub County Mental Health Report, 2021) with statistics indicating that 4 in every 10 youth are said to experience depressive symptoms including being sad, feeling grumpy, having trouble sleeping, feeling worthless or guilty, eating more or less than usual and gaining or losing weight. If the depressive symptoms among the youth keep on growing, rate of negative behavioral outcome including violence, theft, isolation, drug and substance abuse as well as suicide will increasing making the area lack competent youth who can drive the socio-economic agenda of the Sub-County. It is against this background that the researcher is motivated to assess factors contributing to increased depression status among the youth in Kilembe Sub-County, Kasese District, Uganda.

**Research Questions**

1. Is poverty a factor contributing to increasing depression among the youth in Kilembe Sub-County, Kasese District, Uganda?
2. Is family instability a factor contributing to increasing depression among the youth in Kilembe Sub-County, Kasese District, Uganda?
3. Is drug use a factor contributing to increasing depression among the youth in Kilembe Sub-County, Kasese District, Uganda?
4. What is the current depression level of the youth in Kilembe Sub-County, Kasese District, Uganda?

**General Objective**

The general objective of this study is to assess factors contributing to increased depression status among the youth in Kilembe Sub-County, Kasese District, Uganda.

**Specific Objectives**

1. To find out whether poverty is a factor contributing to increasing depression among the youth in Kilembe Sub-County, Kasese District, Uganda.
2. To establish whether family instability is a factor contributing to increasing depression among the youth in Kilembe Sub-County, Kasese District, Uganda.
3. To determine if drug use is a factor contributing to increasing depression among the youth in Kilembe Sub-County, Kasese District, Uganda.
4. To assess the current depression level of the youth in Kilembe Sub-County, Kasese District, Uganda.

**Scope of the Study**

**Geographical Scope:** This study will be carried out in Kilembe Sub-County, Kasese District, Uganda. Kilembe is located in Kasese District, in the Western Region of Uganda, about 11 kilometres (7 mi), northwest of Kasese, the nearest large town. This is about 85 kilometres (53 mi), southwest of Fort Portal, the nearest large city. Kilembe lies about 354 kilometres (220 mi), southwest of the city of Kampala, Uganda's capital. Kilembe measures approximately 8.5 square kilometres (3 sq mi), and lies on the banks of River Nyamwamba, at the foothills of the Rwenzori Mountains. The coordinates of Kilembe, Uganda are: 0°11'53.0"N, 30°00'49.0"E (Latitude:0.198059; Longitude:30.013620).

**Content Scope:** Main focus of this study is to assess factors contributing to increased depression status among the youth in Kilembe Sub-County, Kasese District, Uganda. The independent variable of the study is factors contributing which is indicated by poverty, family instability, and drug use while the dependent variable is depression among the youth.

**Time Scope**: This study will cover a period of 5 months which is from January 2023 to May 2023.

# **Significance of the Study**

**To the Youth**: The study will provide more knowledge about factors contributing to increased depression status among the youth in Kilembe Sub-County, Kasese District, Uganda. Such knowledge can act as basis for change on the side of youth who can use the information to assess how factors such as poverty, family instability and drug use contribute to depression, hence work towards ensuring that they stay away from drug use.

**To the parents**: Findings of this study will provide parents with relevant information about factors contributing to increased depression status among the youth in Kilembe Sub-County, Kasese District, Uganda. Parents can use the findings to help their children in future.

**To the Government**: Findings of this study will provide the local and central governments with information about factors contributing to increased depression status among the youth in Kilembe Sub-County, Kasese District, Uganda. This can be basis for future planning and development of laws suitable to address youth depression.

**To other researchers and scholars**: The study results may act as basis for their future studies since they may use the information as literature or citation.

**Theoretical Framework**

The “learned helplessness” theory of depression by Abramson, Seligman, and Teasdale (2008) proposes that individuals are susceptible to depression because they have pessimistic attribution to neutral events. For example, during a basketball game a player might miss a shot. If they have a pessimistic attributional style, they may believe they missed the shot because they are hopeless. They have attributed this event to a cause that is internal (self-referent), stable (a personality characteristic), and global (likely to affect other situations). In contrast, a player who explains the missed goal as a result of being distracted attributes the failure to a cause that is external, unstable, and specific. Research indicates that a pessimistic attributional style interacts with subsequent negative life events to predict ensuing increases in depressed mood. In general, these findings are applicable to both males and females.

**Conceptual Framework**

This figure shows the study content on factors contributing to increased depression status among the youth in Kilembe Sub-County, Kasese District, Uganda. The independent variable of the study is factors contributing which is indicated by poverty, family instability, and drug use while the dependent variable is depression among the youth.

**Independent Variable Dependent Variable**







Fig 1: Conceptual Framework: Source: Researcher

**Operationalized Likert Scale**

**Poverty:** In this study, it refers to lack of food, money for school fees, medication, cloth, and other basic needs at home hence suspected to cause depression among the youth in Kilembe Sub-County.

**Family instability:** In this study, it refers to family fights, divorce, separation, discrimination and even stigmatization which made the youth develop depression in Kilembe Sub-County.

**Drug use:** In this study, it refers to use of drugs which make the youth develop a feeling of hopelessness, low self-esteem and loose value for life hence resulting to depression.

**Depression among the Youth:** In this study, it refers to youth demonstrating depressive symptoms including being sad, feeling grumpy, having trouble sleeping, feeling worthless or guilty, eating more or less than usual and gaining or losing weight.

**CHAPTER TWO**

**LITERATURE REVIEW**

This chapter contains the themes that will be used to conduct the study on factors contributing to increased depression status among the youth. Aim of the reviewed literature is to identify the study gaps.

**Poverty as a Factor Contributing to Increasing Depression among the Youth**

Poverty is a global issue, and extreme poverty is a worldwide health problem (WHO, 2020). Statistics indicate that the economic distance between the world's rich and poor countries is increasing (Timimi, 2015), and this disparity of economic resources poses a risk for health by affecting the development of infrastructures to support mental health care. The difference in per capita income between the richest and the poorest countries has accelerated by a factor of five since the late 1800s (Guillen, 2011). Africa and developing countries in Latin America are the poorest, while Japan and South Korea are the richest. When there is more equality in the distribution of resources and wealth within and/or across countries, overall health improves significantly (Castells, 2018).

Poverty has dramatic effects on behavior and emotions, which ultimately impact mental health, especially among vulnerable groups (McMunn, Nazroo, Marmot, Boreham & Goodman, 2021; Rutter & Smith, 2015). Under conditions of economic deprivation, children and adolescents are disproportionately affected because they are disproportionately represented among the poor (University of Michigan). However, the relationship of poverty to mental health is difficult to capture with statistics (Call et al., 2002). Although scholars and clinicians in the area of children's mental health note that the rates of mental health problems have increased significantly among young people in Western society, the ability to detect rising or falling rates is partly a reflection of a country's resources.

Research suggests that poverty may have direct effects on youth mental health. Poverty can also impact quality of life and social adjustment (Wilkins et al., 2014). Frojd, Marttunen, Pelkonen, von der Pahlen, and Kaltiala-Heino (2016) found that youths are aware of economic difficulties in their families, and that this influences their satisfaction with their family and environment. The perception by youths that their parents have financial difficulties has been associated with aspects of youth mental health, suggesting that poverty can have strong direct effects on youth mood states, in addition to the indirect effect through negative changes in the parent–youth relationship. For example, an awareness of parental financial difficulties by Finnish youths was associated with youth girls’ depression and youth boys’ drinking to the point of intoxication (Frojd et al 2016). These youths’ awareness of parental economic hardship was also associated with a reported sense of helplessness, and feelings of shame and inferiority.

Youths from low socioeconomic environments are noted to be at greater risk for teen suicide (Fergusson, Woodward, & Horwood, 2010) and the violence exposure experienced by youths living in high poverty neighborhoods has been associated with increased depressive symptoms, anxiety, and externalizing problem behaviors (Buka, Stichick, Birdthistle, & Earls, 2011).

Poverty also seems to have cumulative effects. Chronic exposure to poverty increases youths’ risks for mental disorders such as depression, behavioral risks such as substance use (Fergusson et al., 2010), early sexual debut (McBride, Paikoff, & Holmbeck, 2013), and criminal activity (Davis, Banks, Fisher, & Grudzinsksa, 2014). Timing of chronic exposure to poverty is important; youth boys exposed to persistent poverty are more vulnerable to poor academic achievement and an increase in behavior problems (Wilkins et al., 2014).

Poverty in childhood and among adults can cause poor mental health through social stresses, stigma and trauma. Equally, mental health problems can lead to impoverishment through loss of employment or underemployment, or fragmentation of social relationships. Although the Fitzpatrick, Piko, Wright, & LaGory, (2015) study in the meta-analysis had substantial heterogeneity in the measurement of socioeconomic status and depression, the investigators found that individuals with low income were at increased odds (1.81) of depression compared with those in the higher income categories.

According to Buckner, Beardslee, & Bassuk, (2014), youth from families living in poverty are 3 times more likely, on average, to suffer from depression conditions, including both externalizing disorders such as conduct disorder, and internalizing disorders such as anxiety, and poor coping skills. Poverty can affect the health of people at all ages. In infancy, it is associated with a low birth weight, shorter life expectancy and a higher risk of death in the first year of life. Children living in poverty are more likely to suffer from chronic diseases and diet-related problems.

The reviewed literature in this sub-section of chapter two provides information on how poverty is a factor contributing to increased depression among the youth in different parts of the world. The researcher has not come across any research or literature addressing the subject of poverty as a factor contributing to depression among the youth in Kilembe Sub-County. It is against this knowledge gap that the researcher seeks to find out whether poverty is a factor contributing to increasing depression among the youth in Kilembe Sub-County, Kasese District, Uganda.

**Family Instability as a Factor Contributing to Increasing Depression among the Youth**

A number of the reviews show that youths from violent homes, divorce their relationship with parents, relationship between youths and parenting style have a big role to play in the onset of depression (Rocha et, al, 2013). Studies show that chaotic and violent homes, have enormous effects on the health of youths. Similarly, 50% of depression among young people is attributed to adverse life events from home and community.28 Research has also shown that long term exposure to parental conflict can bring about the onset of depression, parent child relationships, this results in youths developing anxiety and depression as studies has shown. Educational factors including poor academic performance, school change, extracurricular activities, school bullying, and field of education (United Nations, 2014).

A study by McFarlane, Bellissimo, Norman, & Lange, (2014) has shown some of the above factors associated for the onset of depression among young people. Studies indicate adolescence sex inequalities from early adolescence in Europe, Canada, and the USA, where girls consistently have poorer wellbeing indicators, such as self-rated health, psychosomatic complaints or symptoms, and life satisfaction, whereas boys have consistently higher levels of injury and being overweight.46 In the UK, a study of people who had experienced homelessness and other domains of deep social exclusion (e.g. Institutional care, substance misuse, gangs etc.); found majority of respondents had experienced a range of troubled childhoods influenced by school and/or family problems. Many also reported traumatic experiences, such as sexual or physical abuse and neglect. These experiences were most commonly reported by respondents under 25 years of age.

Mueller, & Abrutyn, (2016) demonstrated that the likelihood of developing a conduct disorder among young African American youths was associated with parenting and family factors, but these associations were strongest among families from the most disadvantaged neighborhoods. An experimental study of the effects of neighborhood on mental health demonstrated that parents who stayed in communities with high poverty were more distressed than those who moved to a low-poverty community, and their sons had more problems with anxiety and depression. The mental health impact was greater for youth than it was for their parents. Thus, interventions that singularly address the parent–youth relationship or the youth as an individual rather than the neighborhood context are likely to have a limited effect on youth risk-taking behaviors in communities that are characterized by deprivation.

The reviewed literature in this sub-section of the study provides information on how family instability is a factor contributing to increased depression among the youth in different parts of the world. The researcher has not come across any research or literature addressing the subject of family instability as a factor contributing to depression among the youth in Kilembe Sub-County. It is against this knowledge gap that the researcher seeks to establish whether family instability is a factor contributing to increasing depression among the youth in Kilembe Sub-County, Kasese District, Uganda.

**Drug Use as a Factor Contributing to Increasing Depression among the Youth**

Substance or drug can be defined as anything that has the potential of causing addiction, habituation or altered consciousness. It can also be defined as any chemicals that can change the structure or function of the body. Drugs are used for nutritional or medical purposes following Doctors’ prescription but become potentially hazardous when used for other purposes (Poss, 2016). Substance abuse is a chronic debilitating disease with significant morbidity and mortality which affects individuals and their families. In 2014, about 250 million peoples between the ages 15 and 64 years were estimated to have used an illicit drug (World Drug Report, 2012). One-tenth of people who use illicit drug suffer from drug or substance use disorder like drug dependence. Large number of drug dependents use intravenous drugs and more than 10% of them contract HIV with majority of them suffering from hepatitis C (United Nations Office on Drugs and Crimes, 2018).

According to United Nations Office on Drugs and Crimes (2018), substance abuse is the recurrent use of substance that may cause physical or social harm to the user or others but not associated with any symptoms when the substance is stopped. However, Substance addiction (or dependence) is defined as a compulsive pattern of substance use characterized by a loss of control over the use of the substance and continued use despite the significant substance-related problems and the emergence of a state of physiological need such that a physiological signs and symptoms, known as withdrawal symptoms, occur when access to the drug is prevented (United Nations Office on Drugs and Crimes, 2015). Generally, three things are usually associated with addiction: inability to stop, tendency of increasing dosage or behavior and withdrawal symptoms, those symptoms that develop following abstinence of drug (Barrett et al., 2008).

Wide range of clinical as well as epidemiological studies have demonstrated the link between substance abuse, particularly alcoholism and chronic anxiety disorder and was found to be more common in men than women. In a clinical study by a Kushner et al, about 23-70% of alcoholics have anxiety disorder specifically phobias and neurosis and about 20-45% of patients with anxiety disorder have history of alcoholism. Also, elevated rates of anxiety disorder were found in relatives of patients with alcoholism in many family studies. These findings indicate that alcoholism contribute to the development of anxiety disorders (Katherine et al, 2015). In a study by Sareen et al, (2016) an association between anxiety disorders like social phobia, panic disorder, agoraphobia, specific phobia, and generalized anxiety disorder with chronic use of amphetamines, cocaine, hallucinogens and heroin were established in two American communities (Sareen, Chartier, Paulus, & Stein, 2006). Many studies have shown the relationship between maternal addiction to cocaine, alcohol, or heroin during pregnancy and significant decrease in cerebral reserve capacity and functions and decrease brain size of the newborn with less ability to compensate for the loss of the brain function during adulthood which may progress to neurodegenerative diseases like Alzheimer’s disease and presenile Dementia (Fein & Sclafani, 2014).

A review on substance abuse and depression in youths found that “there is a strong relation between the psychoactive substance use and depression in adolescence” (Gomes et al., 2012). In a study with 98 youths in psychiatric hospitals using the Children’s Depression Inventory and the Rutgers Alcohol Problem-Drinking Index, researchers found “a positive association between depression levels and problems with alcohol in youths, indicating that youth who both suffer from depression and abuse alcohol may be at higher risk for a suicide attempt” with heavier drinkers reporting more depressive symptoms (Danielson, Overholser, & Butt, 2013). Substance abuse is something to look out for among adolescence for it can have a negative impact on depressive symptoms.

Untreated or unrecognized depression lead to over 800,000 suicide deaths every year among young people aged 15-29 years old globally (Armine, 2017). Close to 80% of young people with depression and 75% of this age group who commit suicide due to drug use. Although effective treatments exist for depression, only a few people get access, with less than 10% of affected people in countries receiving such treatment. Depression in young people may be expressed differently from that in adults. It manifests as behavioral disorders (irritability, verbal aggression and misconduct), substance abuse and/or concurrent psychiatric problems and usually starts by age 10-24 years. It is characterized by somatic (generalized bodily) complaints, school difficulties, fatigue, boredom/apathy, disturbed eating, lack of motivation, decreased concentration and anxiety (Yasmin et al, 2012).

The reviewed literature in this sub-section of the study provides information on how drug use is a factor contributing to increased depression among the youth in different parts of the world. Therefore, researcher has not come across any research or literature addressing the subject of drug use as a factor contributing to depression among the youth in Kilembe Sub-County. It is against this knowledge gap that the researcher seeks to determine if drug use is a factor contributing to increasing depression among the youth in Kilembe Sub-County, Kasese District, Uganda.

**Depression among the Youth**

In 2017, the world Health Day had the theme “Depression Let’s talk” bringing attention to its “silent epidemic” globally (Perumal et al., 2017). Depression is a common mental disorder and globally, more than 350 million people of all ages suffer from depression, an increase of 18% from 2005-2015.1 Depression is the leading cause of disability worldwide and is a major contributor to the overall global burden of disease1. According to the WHO, in any given year, 20% of youths experience mental disorders notably depression and anxiety. Depressive disorders account for highest proportion of (8.2%) of the burden in 10-24 years old, with bipolar disorders accounting for (3.8%) in this age group. At its worst, depression can lead to suicide.

Specifically, research by Auerbach, Ho, & Kim (2014) investigated both diathesis-stress and stress generation models of youth depression. The diathesis-stress framework posits that vulnerability factors such as diatheses are dormant in the absence of stress. However, once stress arises, it activates these factors, thereby increasing the likelihood that vulnerable individuals will experience depression. In the Auerbach, Eberhart, & Abela, (2010) prospective study of children and youths, they found robust support for several cognitive diatheses including rumination (Abela, Aydin, & Auerbach, 2007), deficient perceived control (Auerbach, Eberhart, & Abela, 2010), hopelessness (Abela, Gagnon, & Auerbach, 2007) and self-criticism (Adams, Abela, Auerbach, & Skitch, 2009).

The reviewed literature in this sub-section of the study provides information on depression among the youth in different parts of the world, but with no empirical information on the depression status of the youth in Kilembe Sub-County. It is against this knowledge gap that the researcher seeks to assess the current depression level of the youth in Kilembe Sub-County, Kasese District, Uganda.

**CHAPTER THREE**

**METHODOLOGY**

This chapter provides the methods that will be used to conduct the study. It contains the research design, locale of the study, population of study, sample size and sampling procedures, method of data collection and instruments, data collection procedures, data quality control and data analysis techniques.

**Research Design**

This study will apply both quantitative and qualitative research approaches. In addition this study will use a descriptive research design. The quantitative approach will be used to collect and analyse numerical data. Descriptive research design will help describe the situation as it is at the time of the study in terms of how poverty, family instability and drug use contribute to increased depression among the youth. The quantitative approach will enable the overall summary of the study variables based on numerical description of the objectives.

**Locale of the Study**

This study will be carried out in Kilembe Sub-County, Kasese District, Uganda. Kilembe is located in Kasese District, in the Westen Region of Uganda, about 11 kilometres (7 mi), northwest of Kasese, the nearest large town. This is about 85 kilometres (53 mi), southwest of Fort Portal, the nearest large city. Kilembe lies about 354 kilometres (220 mi), southwest of the city of Kampala, Uganda's capital. Kilembe measures approximately 8.5 square kilometres (3 sq mi), and lies on the banks of River Nyamwamba, at the foothills of the Rwenzori Mountains. The coordinates of Kilembe, Uganda are: 0°11'53.0"N, 30°00'49.0"E (Latitude:0.198059; Longitude:30.013620). The study will be carried out in this area because of the increasing cases of depression among the youth.

Kilembe Sub-County approximately has a total of over 30,000 residents who dwell in a total of over 3,500 households. The area residents depend more on livestock crop farming. They as well carry out small scale business operations and engage themselves also in mining (Kasese DC, 2023).

**Target Population**

This study will target youthful persons aged between 18 and 25 years in Kilembe Sub-County of Kasese District. This group of respondents is targeted for this study because the study is directly addressing their problems and will ensure that they provide the much needed data for the study. According to the report from the Youth Leader of Kilembe Sub-County (2023), the area has a total of 861 youth aged between 18-25 years of age.

**Sample Size**

**Sampling procedure**

This study will apply a simple random sampling technique. Thus, a simple random technique through lottery approach will be used whereby the researcher will prepare 861 pieces of papers indicated numbers 1,2,3,-----861, put them in a container and visit the youth during Youth Forums organized by the Youth Leadership of the Sub-county whereby she will request the youth persons aged 18-25 years to pick a paper each. Those who will pick papers indicated numbers 1,2,3----273 will be included in the study by answering a questionnaire while those who will pick papers indicated numbers 273 to 861 will be excluded from the study. This is because simple random sampling eliminates the problem of biasness when collecting data as it offers an equal chance for each of the respondents to be part of the study.

**Data Collection Methods and Instruments**

**Data collection methods:**

According to Creswell (2015), a questionnaire survey can be used to investigate the characteristics, behaviors, or opinions of a group of people. The study will employ this method because it is time and cost effective and also provide a sense of physical evidence (Creswell, 2014). Thus, the study will be able to collect much data within a very short time. Therefore, in this study, a questionnaire survey method will be used in this study because it permits the collection of large amounts of data from a large population in a short period of time making it less costly compared to other methods.

**Self-administered questionnaire**

A self-administered questionnaire containing closed-ended questions will be used as the research instrument in this study. In this study, the questionnaire will consist of three sections: Section is the introduction section, A will capture data on demographic characteristics of the respondents, Section B will capture data on objective questions and section B will contain respondents’ suggestion open ended question. A four point Likert Scale will be used to measure the study variables in the questionnaire.

**Validity and Reliability**

The data quality control will be achieved by ensuring the validity and reliability of the data collection instruments.

**Validity**

Content validity will be used since it focuses on the extent to which the content of an instrument corresponds to the content of the theoretical concept it is designed to measure (Amin, 2004). He further states that for an instrument to be accepted as valid, the average index should be 0.7 or above. The researcher with experts in terms of the supervisors and panel member will scrutinize the instruments and identified the relevant items to make corrections prior to data collection. The content validity index (CVI) will then be computed as follows;

**Reliability**

A pretest of the questionnaire will be carried out from 20 youth from Nyamwamba. The Statistical Package for Social Scientists (SPSS) will be used to determine the reliability of the instrument. According to this study, a reliability coefficient of 0.7 and above is regarded as reliable and consistent according to Cronbach’s Alpha, (1951) as cited b Gill, Stewart, and Chadwick (2018).

**Data Collection Procedure**

After presenting the research proposal, the researcher will be given an approval letter from the Dean of Bugema University Social Sciences Department and then she will present the letter to the Clerk of Kasese District as well as the LC3 of the Sub-County. Before data collection, the researcher will observe all the recommended standard operating procedures. Thus, the researcher will visit the study field while on a face mask and before distribution of the tools to the respondents. In addition, the researcher will sanitize herself and the respondent.

**Data Processing and Analysis**

Before data analysis, data processing will be carried out whereby cleaning will be done to check correctness and completeness then will be coded using the operationalization codes. Then the data will be entered in the computer for analysis using the Statistical Package for Social Scientists (SPSS) version 26. Then will analyze each objective. Objective 1, 2, 3 and 4 will be analysed by descriptive statistics to process categorical data presented in frequency, percentage distributions, Means (M), and Standard Deviation (SD). The qualitative data will be analysed using thematic analysis that aims to find common patterns across a data set as it involves getting familiar with the data.

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**APPENDICES**

**Appendix A: Questionnaire**

Dear Respondent,

I am **SHEENA SHAINAZ,** a student in Bugema University pursuing a Diploma of Counseling and Psychology in the department of Social Sciences. I am carrying a study on “**ASSESSMENT OF FACTORS CONTRIBUTING TO INCREASED DEPRESION STATUS AMONG THE YOUTH AGED 18-25 YEARS OF AGE) IN KILEMBE SUB-COUNTY, KASESE DISTRICT, UGANDA**”. The study is purely for academic purpose. The information obtained will be treated with great confidentiality. Therefore, I kindly request you to fill in the questionnaire to the best of your knowledge. Thank you for your cooperation.

**SECTION A: PERSONAL INFORMATION**

Please Tick (**√**) where appropriate in the box provided.

1. Gender: Male ( ) Female ( )
2. Age: 18-20 Years ( ), 21-23 Years ( ), 24-25 Years ( )
3. Education: None ( ), Primary ( ), Secondary ( ) Tertiary ( )
4. Marital Status: Married ( ), Not Married ( )
5. Employment status: Employed ( ), Self-employed ( ), Not employed ( ), Peasant Farmer ( )

**SECTION B: OBJECTIVE QUESTIONS**

Please Tick (**√**) where appropriate in the box provided.

4. Strongly Agree 3. Agree 2. Disagree 1. Strongly Disagree

| **Poverty as a Factor Contributing to Depression among the Youth** | **SD** | **D** | **A** | **SA** |
| --- | --- | --- | --- | --- |
| 1. I get stressed when there is no money at home to buy food stuffs |  |  |  |  |
| 1. I am depressed by the kind of house we have at home |  |  |  |  |
| 1. I get depressed when I cannot afford buying cloth for myself |  |  |  |  |
| 1. Having no assets like land at home makes me stressed |  |  |  |  |
| 1. The high level of poverty at home makes me depressed |  |  |  |  |
| **Family Instability as a Factor Contributing to Depression among the Youth** | **SD** | **D** | **A** | **SA** |
| 1. There are cases of domestic violence in my family. This makes me stressed. |  |  |  |  |
| 1. Some of my family members end up divorced. This causes depression to me. |  |  |  |  |
| 1. There are many cases of disagreements at home, and this makes me stressed |  |  |  |  |
| 1. No one cares about the other family member and this contributes to my depression. |  |  |  |  |
| 1. Family instability contributes to my depression as a youth |  |  |  |  |
| **Drug Use as a Factor Contributing to Depression among the Youth** |  |  |  |  |
| 1. When I don’t have money to buy drugs I end up being stressed |  |  |  |  |
| 1. Alcohol hungover makes me depressed in dealing with it |  |  |  |  |
| 1. I get involved in fights when under drug influence and this stresses me. |  |  |  |  |
| 1. I think a lot after using drugs and this affects my mental wellbeing |  |  |  |  |
| 1. Most of the times, drug use makes me depressed. |  |  |  |  |
| **Depression Status among the Youth** | **SD** | **D** | **A** | **SA** |
| 1. I am always sad |  |  |  |  |
| 1. I always isolate myself from other people |  |  |  |  |
| 1. Sometimes I feel like hurting myself |  |  |  |  |
| 1. Sometimes I see life as meaningless |  |  |  |  |
| 1. I take long to fall a sleep |  |  |  |  |

**SECTION C: SUGGESTIONS**

1. What do you think should be done to address the increasing cases of depression among the youth in Kilembe Sub-County?

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