



Family Coping Strategies in Response to Adolescent Depression: A Study of Low-Resource Settings in Kisumu County, Kenya

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ABSTRACT

Families are witnessing a high prevalence of adolescent depression, possibly because of a weakened societal fabric. It impairs psychosocial functioning and affects the normal activities of adolescents and families. While it is treatable, its prevalence implies inadequacy of available mitigations, attributable to comparatively high cost and shortage of mental health professionals. This suggests that some families may be forced to adopt alternative measures, which have hardly been documented, yet may be beneficial. Guided by Family Resilience Theory, the family coping strategies in response to adolescent depression in low-resource settings were explored. Using an exploratory cross-sectional design, both qualitative and quantitative data were collected from purposively selected parents of depressed 10-19-year-olds as main respondents and key informants comprising psychiatrists, counsellors, and clinical psychologists. Validity and reliability were ensured at a threshold of .88 and .80, respectively. Ethical considerations were ensured. Coping strategies adopted by families were spending time together, praying, and seeking hospital-based treatment. There were reservations seeking non-professionals' help. Study concludes that praying is linked to better adolescent depression outcomes ($r = -.281^{**}, p = .001$); contrary to hospital-based treatment ($r = .198^{**}, p = .024$), due to the existence of barriers to timely and effective treatments. Therefore, there is a need to upscale training programs for primary healthcare providers and community health promoters.

Keywords: Adolescent, Coping, Depression, Family, Strategies

INTRODUCTION

Depression is a significant global health issue among adolescents (World Health Organization, 2024). It negatively affects their health, social relations, and academic performance (American Psychiatric Association, 2024). These symptoms must persist for at least 14 days and represent a significant decline from their previous level of functioning for a positive diagnosis. Despite its impact on adolescents, there is no “one-size-fits-all” treatment strategy to address it (National Institute of Mental Health, 2024).

According to the African Population and Health Research Centre et al. (2022), the highest prevalence of depression globally is among adolescents, yet only less than 10 per cent of adolescents in Kenya who experience depression seek professional services. This was restated by the World Health Organization (2024), which reported that 50 per cent of all mental illnesses in adulthood start by age 14; yet, it is hardly detected and treated in time. Shorey et al. (2022) also noted that 34 per cent of adolescents worldwide aged 10-19 years are predisposed to developing depression. These observations underscore the need for synergy in addressing depression because it is a strong predictor of suicidality (Pharris et al., 2023).

Depression affects adolescent experiences, consequently impacting adulthood and how adults react to daily concerns (Lawson, 2020). They are also at a higher risk of developing depression in adulthood (Henkens et al., 2022). Socioeconomically, depression is costly, and strongly affects their quality of life, and is associated with considerable morbidity and mortality (Cuijpers et al., 2020). Moreover, quantitative estimation of excess depression costs for total direct and indirect costs among adolescents is significantly higher (König et al., 2020). Hence, early identification and proper management of depression among adolescents is of great significance to lower the risk of suicide (Coppola et al., 2019).

Despite increased vulnerability and adverse outcomes of depression (Pharris et al., 2023), much focus has been on the prevalence, clinical measures, access and treatment use, predisposing factors, academic performance, and impact on quality of life. Besides, studies have shown that there has been more focus on rich and democratic societies, at the expense of low- and middle-income countries, where 90 per cent of adolescents reside (Shah et al., 2020). The difficulties are worsened by the scarcity of mental health services, in terms of cost and access



(Institute for Health Metrics and Evaluation, 2021). A study by Shah et al. (2020) also revealed that conventional treatment alone cannot address the global depression crisis. Moreover, studies by Aguirre Velasco et al. (2020) and Owuor et al. (2021) highlighted existence of several barriers in healthcare seeking.

Given that depression is a product of complex interactions (World Health Organization, 2023), family environment and relationships can be strong predictors for better interventions (Dardas et al., 2018), because of their critical role in nurturing adolescents. Türk et al. (2021) also observed that adolescents often used more avoidant and negative coping strategies. This study was therefore, guided by Family Resilience Theory, as propounded by Froma Walsh. The theory emphasizes existence of strengths and adaptive capacities of families facing adversity, which can be maximized by building on existing resources (Walsh, 2021). As reiterated by Kasdi and Saifudin (2024), conditions for resilience comprise situations of significant difficulties and existence of resources for facing difficulties. These help in facilitating adaptation, avoiding negative outcomes, and successfully adapting to new situations. Family resilience, thus, comprises both processes and products of coping and adaptation as key functionalities of the family unit (Walsh, 2023), to facilitate transformation and growth, thus enabling families to be more resourceful when faced with challenges. It underscores the natural healing processes whereby families can resolve problems (Zhu et al., 2023). This theory provides a better understanding of how families in low-resource settings cope with challenges while underscoring the dynamic interplay between individual, family, and contextual factors in shaping resilience outcomes.

As part of the sociocultural strategies, Ridao et al. (2021) observed that parental beliefs play a significant role in the psychosocial adjustment of adolescents. Moreover, knowledge of family perceptions, social values, and norms is important because it enhances understanding of the relationship between religious and spiritual beliefs and behaviour (Astrachan et al., 2020). Therefore, as pointed out by Agwu et al. (2018), strategies adopted should align with cultural values because effects of spirituality on depression are bidirectional, and the way religious beliefs are used to cope with distress affects the outcomes of depression (Lucchetti et al, 2021). This underscores the importance of integrating acquired knowledge and experience in understanding existing circumstances.

According to Cardinali et al. (2019), social support buffers the relationship between stress and well-being; thereby, lowering the incidence of suicidal ideation and other risky behaviours among adolescents in Italy. Similarly, social cohesion, religious values, and social care were outlined as being vital in coping among millennial Muslim families in Indonesia (Kasdi & Saifudin, 2024). In a study of caregivers for individuals with schizophrenia in South Africa, Seseane (2019) found that they faced stigma but leaned on resilience and faith, with families turning to hope during difficult times. A study by Benca-Bachman et al. (2020) on African Americans in North Carolina showed that enhanced psychosocial support is vital for individuals with depression in coping effectively. While it underscores the importance of social support, the findings are limited it was focused on individual as opposed to the collective family. Additionally, Mahfouz (2020) found that many secondary school principals choose to spend more time with loved ones in response to stressors, although this focus on a adult job-related stress differs from the dynamics experienced by adolescents.

From the foregoing, it is evident that depression is treatable using psychotherapy and antidepressants, but they are hardly accessible to families and adolescents also hardly use them. Besides, there are mixed reactions because of other studies by Zhao and Hu (2022) and Okafor et al. (2022) also reveals that a considerable number of people often seek alternative treatment services. Therefore, a focus on the family coping strategies intensifies the exploration of contextually-viable strategies as suggested by Weisz et al. (2019). This could help save the workforce and social productivity of future generations because, according to McGorry et al. (2022), more than 48 per cent of adolescents with mental illnesses hardly complete high school; hence, a predictor of high future dependency and unstable families and societies. It is on this basis that this study sought to explore the family coping strategies adopted in response to adolescent depression in low-resource settings in Kisumu County, Kenya.

RESEARCH METHODOLOGY

This study adopted an exploratory cross-sectional research design and a convergent mixed-method approach. This approach is recommended for social and health science problems, due to the complexity of such phenomena under study (Dubey & Kothari, 2022).

Study Location



The study was done in Kisumu County, which lies within longitudes 33° 20'E and 35° 20'E, and latitudes 0° 20'South and 0° 50'South. The county was considered viable for the study because it had the lowest disability adjusted life years (DALYs) at 2.06 per cent among those aged between 15-49 years; while at the same time, had 5th highest deaths attributable to depression-related self-harm at 10.1 per cent, as per reports of Institute for Health Metrics and Evaluation (2021). This reflects possibility of inadequacies in depression mitigation in the study area.

Target Population

Main respondents were parents of the 10-to-19-year-olds having diagnosed with depression during the time of study or, in not more than the past 12 months before the time of study, because they had greater recall accuracy as reported by Dunlop et al. (2019). Parents were considered ideal because of the emotional bond with adolescents (Cardinali et al., 2019). Key informants were mental health professionals comprising counsellors, social workers, clinical psychologists, and psychiatrists.

Sampling and sampling technique

The study purposively sampled 130 parents from a database of 6,598 adolescents who had been diagnosed with depression from January 2023 to January 2025 in the study area. Purposive sampling enabled gaining deeper insights by recognising that the specific set of respondents were more knowledgeable about the phenomenon or had lived experiences (Fox et al., 2023). Key informants were purposively selected because of their expertise.

Data collection

Closed and open-ended questionnaires were administered to the main respondents to enhance collection of in-depth data (Naz et al., 2022). The principal researcher and research assistants administered the questionnaires in person because some of the respondents were unable to read or write. An interview guide was used for key informants to enrich data collected by providing finer details (Harris & Brown, 2019).

Experts in the disciplines of Sociology and Psychology were involved in the development and validation process of the instruments. To ensure face, content, and construct validity, expert analyses and panel reviews were done to ensure the questions were relevant and coherent (Fox et al., 2023). The researcher obtained a validity threshold of .88, which is higher than .70, which is recommended by Taherdoost (2016). The research assistants, comprising the community health volunteers, were trained to ensure external validity (Thakur & Chetty, 2020).

Internal consistency reliability was tested, and a Cronbach's Alpha coefficient of .799 was obtained, which is greater than .70, indicating that the scale was adequate (Taherdoost, 2016). Thirty respondents were identified in Kisumu East Sub-County for piloting; a number which, according to Teresi et al. (2022), is considered adequate. Findings from piloting were analysed and used to inform the review and modification of the tools.

Inclusion and exclusion criteria

For a family to participate in the study, there had to be an adolescent, 10-19 years old, staying in the family diagnosed with depression at the time of the study or in the preceding 12 months before the study. Secondly, the identified adolescent must have disclosed to the parent that they have been diagnosed with depression. Thirdly, the respondent must be aged above 18 years and willing to participate in the study, and be a resident of Kisumu County at the time of the study. Fourthly, only the parents willing to participate were included.

Data analysis and presentation

Quantitative data was computed into SPSS version 27.0 and analysed both descriptively and inferentially using frequency counts, percentages, mean, and standard deviation, as well as Spearman Rank Correlation, respectively. Qualitative data was analysed based on the content and themes. The findings were presented using frequency tables, and verbatim.

Data collection procedure and ethical considerations

As part of the data collection procedure, National Commission for Science and Technology license, as well as other approvals from authorities, were obtained. The study also ensured compliance with ethical considerations. Respondents were requested to sign an informed consent form explaining the purpose of the study to show their voluntary acceptance to participate. Through the guidance of Mental Health Officers, some questionnaires were administered within the hospital facilities to avoid breaching privacy of families and due to safety reasons, while others were administered in the homes of the respondents. Data security protocols were ensured.

**RESULTS AND DISCUSSION**

Depression has psychosocial and physiological impacts on adolescents and their families. This was explored in terms of adolescent and family-specific difficulties, and findings summarised as shown in Table 1.

Table 1. Impact of depression on adolescents and family

Statement on the impact of adolescent depression	Never	Slightly	Moderately	Highly	Extremely	Mean	Std. Deviation
Difficult for adolescent to perform their tasks	29 (22.30)	26 (20.00)	39 (30.00)	25 (19.20)	11 (8.50)	2.715	1.247
Difficult for adolescents to relate well with family members	28 (21.50)	22 (16.90)	40 (30.80)	26 (20.00)	14 (10.80)	2.815	1.281
Difficult for adolescents to relate well with people outside the family	33 (25.40)	17 (13.10)	38 (29.20)	30 (23.10)	12 (9.20)	2.777	1.307
Family members no longer relate well with one another	56 (43.10)	21 (16.20)	25 (19.20)	21 (16.20)	7 (5.40)	2.246	1.306
Family members no longer relate well with those outside the family	56 (43.10)	33 (25.40)	17 (13.10)	18 (12.30)	8 (6.20)	2.131	1.266
Family members are no longer able to perform their duties well	59 (45.40)	18 (13.80)	30 (23.10)	16 (12.30)	7 (5.40)	2.185	1.281

Note: Percentage is in parentheses

Table 1 shows that, cumulatively, more than a quarter (27.70%) of the respondents indicated that depression made it either highly or extremely difficult for adolescents diagnosed with depression to perform their tasks. While this portion may seem small, it conveys a notable indication of the challenges adolescents face in effectively performing their duties due to the depressive condition. This can be attributed to sadness, fatigue, difficulty concentrating, and loss of motivation and interest, which may significantly hinder their ability to complete everyday school-based and domestic tasks. Conversely, approximately 2 in every 5 respondents (42.30%) indicated that adolescents experienced either no or slight difficulty in performing their tasks because of depression, suggesting that a larger proportion of adolescents were still able to fulfil their duties despite having depression. It also emerged that, due to depression, slightly less than a third faced moderate difficulties in performing their tasks. The moderate difficulty faced by adolescents when performing their tasks was reflected in the moderate mean of 2.72 and a standard deviation of 1.25, indicating a moderate spread.

Regarding the difficulties faced by adolescents in relating to other family members, nearly a third (30.80%) of the respondents indicated that adolescents in their family experienced high or extreme difficulties. This suggests that depression contributed to strained family relationships for a substantial portion of the adolescents diagnosed with depression. This could be due to increased irritability, feelings of detachment, and loss of interest in activities, which may hinder their ability to connect emotionally, communicate effectively, or engage in social interactions with family members. Moreover, such adolescents may misinterpret social cues, experience increased negativity, and struggle to disengage from negative interactions, leading to a avoidance of social situations. Consequently, this can lead to misunderstandings, hurt feelings, and a breakdown in family dynamics; this may further worsen the depressive situation. Simultaneously, a larger proportion, though fewer than a third (30.80%), experienced moderate difficulties, as indicated by the moderate mean rating of 2.82. On the contrary, 38.40 per cent of the respondents claimed that there were either no or slight difficulties in familial relationships. These findings suggest that a significant proportion of the respondents agreed that depression contributed to strained family relationships. This variation in responses was also confirmed by a standard deviation of 1.28.

As shown in Table 1, cumulatively, depression made it difficult for almost a third (32.30%) of adolescents diagnosed with depression to relate well to people outside the family. The findings suggest that depression contributed to strained out-of-family social relationships. This could be attributed to a combination of emotional withdrawal, difficulty expressing feelings, negative thought patterns, misunderstandings, and increased sensitivity to social rejection. Moreover, stigma, social withdrawal, and misconceptions about depression may contribute to strained relationships and a sense of isolation. About 2 in every 7 respondents (29.20%) indicated adolescents experienced moderate outside family difficulties due to depression. This was evident in the mean rating of 2.78, which was moderate. On the contrary, a significant proportion of about 3 in every 8 (38.50%) respondents



indicated that adolescents in the family either experienced no difficulties or very minimal difficulties outside family social relationships due to depression. These mixed reactions could be evident in the standard of 1.31.

Concerning family-specific difficulties, cumulatively, only 21.60 per cent of the respondents indicated that depression made it either highly or extremely difficult for family members to relate well with one another. While this population may appear small, the findings suggest that depression contributed to strained relationships in the families. This could be attributed to withdrawal of the adolescent, which may create a cycle where their behaviour negatively impacts family relationships, changes in communication patterns, and emotional distress are experienced. Moreover, depressive conditions may bring about misunderstandings, resentment, and a breakdown in healthy communication, hence strained family relationships. On the contrary, about 59.30 per cent of the respondents indicated that their families experienced either no or slightly strained family social relationships. This was confirmed by the low mean rating of 2.25 and standard deviation of 1.31, suggesting that despite an adolescent in the family being diagnosed with depression, it did not contribute to strained social relationships in the majority of the families. This may be due to their ability of the family members to positively approach the situation.

As shown in Table 1, only 18.50 per cent of the respondents indicated that depression made it either highly or extremely difficult for the family members to relate well to people outside the family. While this population is relatively small, it suggests that depression contributed to strained external social relationships. This could be a reflection of a bonded family, whereby, the problems faced by one of the members are shared. This could be due to the stigma associated with depression, causing some families to isolate themselves from other people. In addition to time constraints, taking care of the adolescent diagnosed with depression may be overwhelming and exhausting emotionally, socially, economically, and physically. Consequently, this burnout and reduced physical external social interactions may strain social relationships. On the other hand, slightly 68.50 per cent of the respondents indicated that depression made their family have either no or slightly strained external social relationships. This was confirmed by a low mean rating of 2.13 and standard deviation of 1.27.

Responses in Table 1 further indicate that only 17.70 per cent of respondents reported that depression made it either highly or extremely difficult for the family to fulfil their duties effectively. This might be due to adolescent's reduced capacity for daily tasks, emotional strain on family members, and potential disruptions to family dynamics and communication. Symptoms of depression, such as fatigue, difficulty concentrating, and loss of interest, can impede their ability to manage personal responsibilities and contribute to household tasks. Conversely, 59.20 per cent of the respondents indicated that there were either no or minimal difficulties in performing duties attributable to depression in an adolescent. This was supported by a low mean rating of 2.18 and a standard deviation of 1.28.

Family coping strategies in response to adolescent depression

To answer the question “Which strategies do families in low-resource settings in Kisumu County use to cope with depressive episodes among adolescents?”, data were collected and findings were presented in Table 2.

Table 2. Family coping strategies in response to adolescent depression

Statement on actions taken	Never	Rarely	Sometimes	Most of the time	Always	Mean	Std. Dev.
Doing nothing about the situation	81 (62.30)	16 (12.30)	20 (15.40)	10 (7.70)	3 (2.30)	1.754	1.114
Praying for the adolescent	16 (12.30)	5 (3.80)	27 (20.80)	27 (20.80)	55 (42.30)	3.769	1.361
Seeking help from a traditional healer	80 (61.50)	13 (10.00)	13 (10.00)	10 (7.70)	14 (10.80)	1.962	1.416
Seeking medical services from the hospital	22 (16.9)	7 (7.70)	38 (29.20)	24 (18.50)	36 (27.70)	3.323	1.399
Spending more time together as a family	13 (10.00)	10 (7.70)	20 (15.40)	37 (28.50)	50 (38.50)	3.777	1.307
Looking for help from others	39 (30.00)	9 (6.90)	32 (24.60)	35 (26.90)	15 (11.50)	2.831	1.409

Note: Figures in parentheses are percentages.

As shown in Table 2, more than half of the respondents (62.30%) agreed that “doing nothing about the situation” was never helpful immediately when a depressive episode occurs. This was supported by a low mean rating of 1.75 and a standard deviation of 1.11, indicating that most respondents are proactive and believe in addressing adolescent issues rather than ignoring them. The low standard deviation also shows a consistent agreement among participants that inaction or silence is not considered a useful approach to coping with adolescent depression within the family. The low mean rating points to a shared belief in the necessity of taking deliberate, supportive actions rather than adopting a passive stance. This indicates that the respondents were concerned with the well-being of the adolescents and that any behaviour perceived as ‘strange’ could prompt them to act, and that non-intervention may worsen the symptoms or feelings of isolation for the depressed adolescent, as noted by the American Psychiatric Association (2024). These findings also concur with Coppola et al. (2019), who underscored the need for early detection and seeking prompt treatment in response to depression among adolescents.

Table 2 shows that a majority of the respondents (42.30%) agreed that always “praying for an adolescent” was a helpful measure taken immediately after they observed depressive symptoms in an adolescent. This perspective was supported by a mean rating of 3.77 and a standard deviation of 1.36, indicating that spiritual or religious coping is very important. The high frequency and mean rating suggest that prayer was deeply integrated in the families and perceived as a meaningful, supportive and potentially comforting response in solving problems. The moderate standard deviation indicates notable variation among respondents. This suggests that a significant proportion of families may resort to spiritual and religious practices such as prayer as a primary response to adolescent depression in the initial stages of awareness of the symptoms. This may be attributable to the sociocultural beliefs of the respondents, which, according to Lucchetti et al. (2021), influence how individuals respond to adversities. This finding agrees with a study by Seseane (2019), who found that caregivers of people living with schizophrenia relied on their faith in God to cope with challenges in caregiving. However, the standard deviation of 1.34 suggests diverse views within the sample, reflecting differences in belief systems, spiritual engagement, or confidence in prayer as an intervention. This was underscored by one of the respondents who, when asked her view concerning who made the most effort in helping the depressed adolescent, the respondents pointed out that among the family members, it was she who was more prayerful as compared to the rest of the family members. This implies that the social well-being of the depressed adolescent and the family at large was a product of her prayerfulness and spirituality.

As shown in Table 2, a majority of the respondents, though 29.20 per cent, agreed that “seeking medical services from the hospital” was sometimes useful immediately after they observed depressive symptoms in an adolescent. This was supported by a mean rating of 3.32 and a standard deviation of 1.40, suggesting a moderate to strong level of trust in medical services of reliance on hospital-based depressive-care services. Findings suggest awareness of mental health issues and willingness to seek professional help. The spread, as shown by the standard deviation, indicates diversity of access or beliefs about hospitals. The moderate degree of variation in responses implies that while some caregivers frequently utilise medical support, others may do so less often. These findings highlight the perceived usefulness of professional medical intervention, although its adoption may vary based on individual and contextual factors. The findings could be attributable to stigma and discrimination towards adolescents with depressive conditions, which, according to the Kenya Mental Health Policy 2015-2030, may affect the seeking of hospital-based care. This was restated by one of the key informants, who noted, “... most people associate depression with ‘madness’ because depressed persons sometimes get medical care in the same places where those with other mental issues go. This makes people look at them as having mental challenges, people whom people should not associate with ...” (KII-002)

As evident in the sentiments of KII-002, the discrimination and association of depression with other mental challenges, which people perceive to have been caused by witchcraft, is a major obstacle to help-seeking. Seeking medical services can be interpreted as a coping strategy within the family system, aimed at promoting well-being. However, the variability in use suggests that some families may lack access, trust, or awareness of formal mental health services, which could hinder their coping capacity, as also revealed by the Kenya Mental Health Policy 2015-2030.

Of interest also was the observation that 28 (22.30%) respondents were negative as they either never or rarely considered hospitals as ideal for coping with adolescent depression. One respondent said, “... After visiting the doctor, the child sometimes comes home when she is very tough-headed...” (R-006). These sentiments water down the value of seeking hospital-based care, yet they are the most recommended depressive care. This could be



attributed to the perceived tendency that professional care sometimes fails to consider the uniqueness of the families. The relatively high number of respondents who had low regard for hospital-based care could also be due to the high cost they incurred when having to commute to attend follow-up visits in the hospitals, which to some it normally cost more than Ksh. 300/- to and from the hospital per person. Some also argued that the cost of the drugs made it unsustainable to manage. This was underscored by one of the key informants who said that,

“The government expects those with mental illness to also pay for drugs, just like other people with chronic illnesses such as diabetes. They are not considering that those with mental illness are out of touch with the world... now take an example of this lady... (pointing at a client with bipolar who had just visited the clinic while shouting and disorderly) ... how can you expect such a person to buy drugs by themselves, or that they must come with their SHA for them to be assisted...” (KII-003)

Sentiments of key informant KII-003 also indicate the extent to which the government is perceived to have performed dismally when responding to depression, among other mental illnesses. This could be evident even in terms of the number of psychiatrists (2) in the county who are expected to serve the 1,155,574 people of Kisumu County, as well as some neighbouring counties. Moreover, some public facilities had not stocked antidepressants, and the clients were instead advised to purchase the drugs in private pharmacies, which could be comparatively expensive and hardly affordable considering the income levels of the families. Poor stocking of antidepressants was also evident in secondary schools, where adolescents spent much of their lives, as observed by Mahfouz (2020). Findings confirm reports of the Kenya AIDS NGOs Consortium (2019) pointing at the numerous challenges facing mental health in Kenya, including the high cost of management and treatment, the low population of experts because the country has approximately psychiatrist-population ratio of 1:450,000.

As shown in Table 2, a majority of respondents (61.10%) agreed that “seeking help from a traditional healer” was never a useful measure immediately when an adolescent was diagnosed with depression. This sentiment was supported by a low mean rating of 1.95 and a standard deviation of 1.40, indicating a strong overall rejection and lack of confidence with this approach in the use of traditional healing in coping with adolescent depression, albeit with considerable variation in individual responses. This implies that, for most respondents, traditional healing practices are not perceived as appropriate or effective interventions for adolescent depression. The high standard deviation indicates that there may be an increasing perception of it as a medical or psychosocial issue rather than a cultural imbalance. This was inconsistent with the findings of Zhao and Hu (2022), who revealed that the number of adolescents seeking treatment services is extremely low, with a majority seeking alternative care as the primary source of treatment. This could be attributed to the view reported by Owuor et al. (2021) that seeking indigenous healing may be linked to visiting magicians, an aspect which is considered ‘un-Christian’. The relatively high standard deviation could also suggest that some respondents still hold favourable views, possibly influenced by personal experiences with traditional healing, beliefs, and sociocultural backgrounds, as also reported by Astrachan et al. (2020) and Lucchetti et al. (2021). This was also evident in the sentiments of some of the respondents who mentioned that depression was caused by witchcraft; hence backing preference for traditional or indigenous healing. This agrees with the findings of Okafor et al. (2022), who revealed that mental illnesses, of which depression is inclusive, should first be treated using indigenous methods and knowledge systems, with almost half (47.00%) of the respondents discrediting collaboration between conventional and alternative healthcare. The findings suggest a shift from culturally informed social support systems, such as indigenous healing, toward more formal and evidence-based strategies. The findings may also indicate an increasing alignment of families with conventional models of depression care, reflecting an evolving understanding of depression as a condition which could best be addressed through clinical support, rather than traditional rituals or spiritual mediation.

A majority of the respondents (37.30%) indicated that “spending more time together as a family” was always helpful immediately after depressive symptoms were observed in an adolescent. This perspective was supported by a mean rating of 3.75 and a standard deviation of 1.30, suggesting a generally positive, though somewhat varied, perception of the usefulness of this coping strategy. This implies that many families recognise the value of increased time and presence as a supportive measure when dealing with adolescent depression. Spending more time together may be viewed as a way of strengthening psychosocial bonds, enhancing communication, observing behavioural changes more closely, and creating opportunities for empathy. While not all respondents agreed, the relatively high mean rating shows that “spending more time together as a family” is widely accepted as beneficial in coping with adolescent depression. This finding agrees with Kasdi and Saifudin (2024), that families who

exhibited remarkable social support systems, closeness, and affection were beneficial for adolescents with depression and antisocial behaviour because it boosted their ability to cope with the challenges. In the context of the Family Resilience Theory (Walsh, 2021), this finding aligns with the principle that family connectedness and consistent presence are vital for resilience-building. Spending quality time together enables psychosocial expression, mutual social support, and collaborative problem-solving, which help families cope positively with adolescent depression as well as other adversities as also pointed out by Cardinali et al. (2019). Spending time together can act as a coping and healing mechanism within resilient family systems. This aspect underscores findings of Mahfouz (2020), who found that some secondary school principals, when faced with multiple stressors, often resorted to increasing time spent with their loved ones as a coping strategy, implying that this was a strategy that could be adopted across the educational divides.

When asked to rate the helpfulness of “looking for help from others”, 28.60 per cent of the respondents showed that they never considered it a helpful measure. This was supported by a mean rating of 2.94 and a relatively high standard deviation of 1.58, suggesting a wide range of opinions and a lack of consensus regarding the effectiveness of seeking external support. This implies that there is significant inconsistency or uncertainty among families about the value of reaching out for help beyond the immediate family unit. The mean rating, which is near the midpoint of the scale, indicates a mixed overall perception. Some families may feel confident in managing issues internally, while others may lack trust in external social support systems due to stigma, cultural beliefs, or previous experiences, as also mentioned by Aguirre Velasco et al. (2020), thereby further aggravating the situation because of the inherently poor healthcare-seeking behaviours of most adolescents. The high variability, as evident in the high number of respondents who said that sometimes (26.20%) ‘looking for help from others’ was helpful, further points to mixed reactions, possibly influenced by factors such as access to services, level of mental health literacy, or societal norms around help-seeking behaviour. Some of the respondents commented that sharing problems with others may be counter-productive, as some people may instead start spreading it out, gossiping, and making uncaring sentiments. For instance, one of the respondents whose daughter had attempted suicide but was treated in time and recovered said that the daughter did not want people to know what happened to her; yet at the same time the respondent highly acknowledged the social support she obtained from a friend who gave her valuable insights on how to help the daughter cope with the depressive condition. The mixed reactions raise the concern on whether individuals need to share what could be troubling them and to whom they should they should share it; as well as what information should or should not be shared. This emanates from studies revealing the need to encourage adolescents to seek assistance as a crucial measure for early depressive care and preventing crisis, as stated by Coppola et al. (2019). Based on the Family Resilience Theory (Walsh, 2023), the hesitance to seek help from others may indicate high reliance on internal family strengths, but it may also reflect gaps in the mobilisation of social and institutional resources. As noted by Cardinali et al. (2019) who pointed out that a network of social support is crucial in maintaining control over chronic conditions. This shows that more resilient families tend to access social supportive networks and professional guidance when needed. Therefore, a reluctance to do so could limit the family's coping capacity, particularly in cases where professional mental health intervention is necessary.

Relationship between family coping strategies and adolescent depression outcomes

To establish the effectiveness of family coping strategies adopted for adolescent depression, Spearman Rank correlation was run, and findings presented in Table 3.

Table 3. Relationship between family coping strategies and adolescent depression

Statement on actions taken	Spearman rank correlation	
Doing nothing about the situation	r	-.169
	p	.054
Praying for the adolescent	r	-.281**
	p	.001
Seeking hospital-based treatment	r	.198*
	p	.024
Looking for help from a traditional healer	r	.321**
	p	.000
Looking for help from others	r	.202*
	p	.021
Spending more time together as a family	r	.177*
	p	.044

The Spearman rank correlation results presented in Table 3 reveal the relationship between family coping strategies and adolescent depression outcomes. "Doing nothing about the situation" showed a weak, but statistically non-significant negative correlation with adolescent depression ($r = -.169$, $p = .054$). Although not statistically significant, this trend suggests that inaction may be associated with slightly improved depressive symptoms.

There was a moderate and statistically significant negative correlation between "praying for the adolescent" diagnosed with depression and adolescent depression outcomes ($r = -.281^{**}$, $p = .001$), indicating that prayers were associated with improved adolescent depression outcomes. This could be because prayer functions as a stabilising psychosocial mechanism within the family unit.

The study found that seeking hospital-based treatment has a weak positive and significant correlation with adolescent depression outcomes ($r = .198^{**}$, $p = .024$), implying that seeking hospital-based treatment tends to have slightly worse outcomes. This may reflect a trend where families resort to medical intervention only when the depressive condition is deteriorating. Despite being medically recommended, the findings show that using it alone is not perceived by families as strongly affecting adolescent depression outcomes, or that their effects are more indirect and long-term.

"Seeking help from traditional healers" had a moderate and more significant positive correlation with adolescent depression outcomes ($r = .321^{**}$, $p = .000$), suggesting that relying on traditional healing was linked to worsening family functioning, especially when performing family duties. The perspective could be attributed to negative experiences with traditional healing, stigma, and cultural beliefs. The strong correlation with disrupted family functioning may reflect strained resources, frustration, or ineffectiveness. Hence, a need for early, culturally sensitive interventions to address clinical and systemic dimensions of adolescent depression.

"Spending more time together as a family" had a very weak and non-significant correlation with adolescent depression outcomes ($r = .177$, $p = .044$), suggesting that while spending more time together is valuable, relying on it alone may be insufficient for reducing negative depression outcomes, unless combined with additional support, which may include therapy and other structured interventions. This indicates that families spending more time together when the adolescent is depressed may lead to conflict if relationships are strained. Moreover, the finding may imply that the quality of the time spent together is more important than the quantity of time spent together.

"Looking for help from others" or non-professionals like friends, relatives, and neighbours had a weak, but significant positive correlation with adolescent depression outcomes ($r = .202^{*}$, $p = .021$), suggesting that seeking help from non-professionals was linked to worsening depressive symptoms. The findings could be attributed to negative experiences of sharing challenges a family is facing with those perceived to be outsiders and non-professionals.

CONCLUSION AND RECOMMENDATIONS

The study concludes that praying was linked to better adolescent depression outcomes ($r = -.281^{**}$, $p = .001$). On the other hand, traditional healing was linked to worse outcomes ($r = .321^{**}$, $p = .000$). Similarly, despite seeking hospital-based treatment being scientifically recommended it was linked to worse outcomes ($r = .198^{**}$, $p = .024$), attributable, to the significant barriers in adolescent mental healthcare treatments. Therefore, the study recommends that Ministry of Health, in collaboration with Kisumu County Government, should upscale training programs for primary care providers and community health promoters in alignment with the cultural belief systems. Besides, they should upscale promotion of a timely response to adolescent depression through enhanced depression awareness campaigns and meaningful family engagement programmes.

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Conflicts of interest

There are no conflicts of interest to be declared.

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