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Original Article

A qualitative study of understanding depression and help-seeking behavior among rural school-going adolescents in India

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Abstract

Background: Depression is a common mental illness experienced by a high percentage of Indian adolescents but, a little is known on their knowledge of and help-seeking behavior for depression.

Aim: To investigate the school-going adolescents' attitudes towards and help-seeking strategies for dealing with depression.

Methods: In this exploratory qualitative study, data were collected through twelve focus group discussions with one hundred adolescent boys and girls (aged 15–18 years) from six government-run secondary schools of Nalanda district of Bihar, India. Group discussions generated responses on adolescents' understanding and causes of depression, and available help and treatment for depression in their communities. Coding of prominent themes and words from transcribed discussions were entered in NVivo 10 for analysis.

Results: Four themes emerged: (1) adolescents' description of depression, (2) beliefs about adolescent depression; (3) impact of depression; and (4) help-seeking and treatment for adolescent depression. Adolescents used local language terms to describe depression including negative emotions and behavior such as sadness, grumpiness, social withdrawal, and lack of concentration. Both boys and girls agreed that girls experience more depression than boys. Students reported that the first point of contact is mostly the family member followed by a

religious healer due to easy availability and low costs. Adolescents mentioned that mental health care and support should be available in the community and schools.

Conclusion: This study provides important information on adolescents' beliefs, and knowledge of and help-seeking behavior for depression. These findings can provide a structure for developing adolescent mental health intervention.

Keywords: Depression; mental health; adolescents; help-seeking behavior; qualitative; India.

Introduction

Globally, depression is one of the major causes of illness and disability among adolescents (aged 10 to 19 years) [1]. Depression during adolescence comes at a time when boys and girls are in the process of forming their identity apart from their parents, grappling with gender and sexuality issues, and making their independent decisions for the first time in their lives [2, 3]. The systematic reviews on the early-onset of major depressive disorders show that at any given time, up to 15% of children and adolescents have some symptoms of depression; besides, 5% of those meet the criteria for major depressive disorders [2, 4].

With about 253 million adolescent population, every fifth person is between 10 to 19 years in India. A review of Indian studies suggests that the point prevalence of depression ranges from 1.2% to 21% in the clinic-based studies, 3%–68% in school-based studies, and 0.1%–6.94% in community studies [5]. India's National Mental Health Survey, undertaken in 12 states of the country, reported a prevalence of depression as 0.8% among 13-15-years old [6]. A state-wide survey of adolescents in Bihar reported the prevalence of depressive disorders among unmarried boys between 15-19 years of age as 8.9% and unmarried 15-19 years old girls as 19.1% [7]. In a study among secondary school adolescents (aged 14-15-years) from 74 schools in the Nalanda district of Bihar, 60% of adolescents reported symptoms of mild depression, 25% moderate depression, and 3% severe depression [8]. The emotional instability during the

transition period from childhood to adulthood makes adolescents vulnerable to depression. However, a very limited number of studies have examined the distinctive depressive symptoms experienced by adolescents, and the most commonly reported symptoms include diminished mood, lack of interest in daily activities like playing and studying, increased difficulty in concentration, aggravated anger and aggression, pessimism, changed appetite and sleep patterns, worries, and experiences of pains and aches [5].

Depression is a major risk factor for committing suicide, which is among the top three leading causes of mortality in late childhood and adolescence [9]. The majority of suicides in India are by those below the age of 30 years [10]. For example, more than one-third of suicide victims (34.4%) in 2011 were youths aged 15–29 years. It has been also observed that around 90% of those who complete suicide, experience psychological distress, most commonly depression [11].

Over the years, it is recognized that the age of onset of depression is decreasing, and it is now increasingly being recognized in children and adolescents [12]. Previous qualitative studies [13, 14] have explored aspects of adolescents' experiences of depression; however, little is known about the understanding of depression and help-seeking behaviors among Indian adolescents. Qualitative studies can help us understand how adolescents explain their psychological distress and enhance our understanding of adolescent depression. Additionally, these studies can also be useful in exploring the adolescents' response to and coping with mental health problems. Consequently, this understanding of adolescent depression and adolescents' response to depression can inform the development of evidence-based interventions and practice to treat and manage adolescent depression. Therefore, this study was conducted to explore school-going adolescents' understanding of depressive disorders and map the help-seeking behavior.

Methods

This exploratory qualitative study was conducted in six co-education government-run secondary schools in the Nalanda district in the state of Bihar, India. The Nalanda district has a population of more than 2.8 million people and a population density of 1,220 inhabitants per square kilometer. Compared with the national average rate of 74%, the district lags in literacy (66%) [15]. Almost all secondary schools in the Nalanda district are run by the State Government's Department of Education.

These six schools were purposively selected based on the student strength (two schools with less than 300 total students; two schools with 301 to 600 total students, and two schools with more than 601 total students). One hundred students (52 boys and 48 girls) from Grades 9 and 10 participated in 12 semi-structured focus group discussions (six each with boys and girls). The authors briefed the school community, including the principal, teachers, and students about the study during the school assembly. Participation in the study was by self-nomination and voluntarily. Participants ranged in age from 15–18 years.

The authors encouraged the participants to share their experiences and opinions of depression, their understanding of depression, words used to describe depression and help-seeking, and treatment for depression in the community. Questions were mostly framed so that the adolescents responded in general and not in a personal manner. The focus group discussions were carried out during school hours in December 2016–January 2017 and on a private location within the school in consultation with school administration. Each focus group discussion lasted approximately 90 minutes, with 8 to 10 participants per group. After every focus group discussion, the authors discussed the construct of (and shift in) our understanding through formal debriefing meetings to make clear our underlying perspectives as it is an important part of the qualitative research. This process also helped in revisiting the group discussion questions and adapt them for future interviews.

After the 8th group discussion, there were no new themes generated from the discussions. Therefore, it was deemed that the data collection had reached a saturation point. We continued data collection for four more discussions, based on an *a-priori* sample of 12 group discussions and also to ensure and confirm that no new themes are emerging. Focus group discussions were conducted in the local language (i.e., Hindi) and were tape-recorded. All the group discussions were transcribed verbatim and then translated into the English language. Subsequently, during each group discussion, a note-taker accompanied the moderator and noted the key discussion points, nonverbal interactions between the moderator and group participants as well as within the group participants. These field notes were attached to the transcripts for coding and interpretation were analyzed in five stages, using the grounded theory approach [16, 17]. First, we checked the group discussion transcripts to assure accuracy. In the second stage, each line of the transcripts was independently coded using open codes by all the authors. The themes covered in the discussion guideline provided the initial coding-framework, which was updated during the open coding process. Codes (or labels) were designated for all content that appeared to represent a thought, feeling, or behavior related to depressive symptoms, understanding of depression, and help-seeking behavior. Differences in the open coding process were resolved by discussions. In the third stage, data were reduced into smaller segments by organizing codes into themes or phenomena and summaries were noted for each theme. In the following stage, we compared the thematic summaries of transcripts with each other. This process also revealed repetitions in codes and themes. In the final stage, a process of mapping and interpretation of themes was undertaken to explain what adolescent boys and girls understand and feel about depression, and what strategies and help-seeking behaviors are used to recover from depression. The mapping of results by themes exemplified the emerging result patterns. Finally, the generated interpretation was compared with the existing literature to check convergence (i.e., our results confirm with the existing evidence) and resent conflicting gaps

or expansion (i.e., generate additional insights). The thematic findings are presented in the results section and the comparisons with existing literature are presented in the discussion section below. Data were managed and coded in the NVivo software (Version 10).

This study was approved by the Institutional Review Board of Sangath. We sought school-level approval from the principals through written consent for adolescent participants. We also sought assent from the adolescent participants.

Results

Data analysis identified 30 open codes that were organized under the following four overarching themes: description of depression, common beliefs about depression, the impact of depression, and help-seeking and treatment of depression. All the themes and vivid and compelling examples of narrative extracts for each theme are discussed below.

Description of depression

Adolescent boys and girls used two-fold interpretations to define depression. They believed that depression develops due to etiological factors and/or experiences of psychosocial adversities such as family violence and abuse, relationship issues with family members and friends, experiences of bullying by peers, persistent poverty, food insecurity, physical illness, and academic problems. Many participants believed that children of parents who have mental health problems are more vulnerable to experience depression compared with children of healthy parents. They mentioned, *"If one of the parents is mentally unstable, then the children are at risk of developing the same condition."* Additionally, a few girls mentioned about discrimination by parents within the family, early marriage, early childbearing, miscarriage, and dowry harassment as factors leading to depression.

When asked to define the depression, adolescents' responses included varied examples of negative emotional and behavioral symptoms such as sadness, grumpiness or irritability, social

withdrawal, low levels of energy, and lack of concentration. For example, they mentioned: *"You feel unhappy all the time and do not want to do anything", "Something hurts, certain things make you unhappy but you don't know how to share it, you don't know with whom to share it", "You don't feel like doing regular things…studying, talking to friends, going to field… you don't feel like doing nothing", "You do not enjoy anything like you don't want to be with friends, the food tastes bland…nothing makes you happy…you don't feel like sleeping".*

For a few participants, it was difficult to describe depression in words and they associated it with emptiness and not experiencing any emotions. Participants used the following local terms to describe depression: *tanav* (tension), *pareshani* (stress), *chinta* (worries), *mansik thakan (mental* tiredness), and *mansik bhimar*i (mental illness). A few boys and girls also described depression as madness, psycho, mental, and crazy.

Common beliefs about depression

The overall prevalence of depression is estimated at 7% among adolescents in India, with a little difference by the gender-wise prevalence of depression [6]. For example, a recent community study among adolescents reported the prevalence rate of depression as 4.4% and 4.5% among younger adolescent boys and girls (10–14–years–old), respectively in Bihar. However, the burden of depression falls disproportionately on older adolescent girls (15–19–years–old; 14%) when compared with the same aged boys (9%) [7]. It is believed that as many as twice females experience major depression than males, highlighting a major health disparity. When probed on the participants' opinions on gender differences in the experience of depression, both adolescent boys and girls agreed that women experience more depression than men. Most adolescent girls believed that more girls experience depression than boys because the male-dominated society is unequal and unfair towards females and society expects perfection from women in all roles. One of the female participants mentioned, *"Women are burdened with multiple roles, a woman has to perform the role of mother, sister, wife, daughter,*

and so on…a woman has to work at home as well as in the fields whereas a man works only in the fields. Girls are discriminated at every level in the family and society, be it giving food, education, clothing, or anything. Young girls are perceived as a burden and as soon they come of age, parents think of their marriage. A girl's life is difficult in the village compared to boys." A few female participants also mentioned about society's judgemental attitude towards women as one of the reasons for prevalent depression among them. They said, *"Everybody wants a beautiful wife, sister, or daughter. If a girl is fat or dark, she is bullied; nobody cares if she is intelligent. Everyone will say that getting married a fat or dark girl is difficult. This is not the case with boys."*

Male participants in this study attributed the female depression to their dependency on male counterparts and not being able to handle the emotions and feelings. They mentioned, *"Women are dependent on men for everything. A daughter is dependent on her father and in his absence on brother/s. A married woman is dependent on her husband and sons. When things do not go the way women are expecting, they start thinking too much. They are more sensitive than men…women are more emotional. Women start cribbing, complaining, and crying about small things whereas men choose to let it go."* A few boys mentioned, "*Girls do not express their feelings openly. They do not talk about how they feel and keep it to themselves, but boys prefer to share…suppressing the feelings lead to stress and tension among women."*

A few boys and girls also mentioned that young people from lower socio-economic strata of the society (i.e., in terms of income, education, occupation, and caste) are at more risk of experiencing depression than the youth from higher socio-economic groups. They mentioned, *"Young people who are Dalits and Mahadalits (the lower castes in the hierarchy of the Indian caste system) face a lot of difficulties. They are so poor that they don't have the means to meet their needs. They always live under tension (manasik tanav)."*

Impact of depression

When probed about the impact of experiencing depression, i.e., "What happens when a person gets depressed?", many participants mentioned that depression affects feelings, thinking, and daily activities such as sleeping, eating, studying, interacting with friends, and so on. One participant said, *"Some people constantly sleep when they are experiencing tension while others may not be able to sleep. I could not sleep for days when my grandfather passed away. One can also feel tired and fatigued."*

A few participants also mentioned social withdrawal as an impact of experiencing depression: *"Young people with stress or tension do not mingle with family members and friends, they prefer to be alone; they don't want to talk to anyone."*

Recognition of loss of interest and lack of concentration as a result of depression were also verbalized by a few boys and girls. One boy mentioned, *"When I am under tension for a long time, I cannot think clearly. I don't feel like doing anything and find it difficult to concentrate; I find it difficult to pay attention to my teachers in the classroom."*

A few participants mentioned about suicidal ideation and attempts of suicide among young people. One female participant said, *"When the things go beyond control, and young people feel that nothing can be done, then some try to commit suicide."*

Help-seeking and treatment for depression

Many participants believed that depression does not require medical care. They reasoned that "being depressed" is, most of the time, a consequence of everyday life situations, and for this reason, the solutions must be found in the context of everyday life and social relations. Participants brought up that the family, teachers, and overall society constantly stress that the only responsible person who can act on the problem is the person who is experiencing depression. One girl expressed, *"Almost everyone experiences depression, but there is no one*

to go for here. Our teachers and parents always mention that as a growing person, we should learn to deal with our emotions and problems but nobody tells how."

Participants mentioned that young people mostly approach friends to discuss emotional problems and find ways of resolving them. There is, however, a gender difference: boys approach friends to find out ways to forget the problem, while girls prefer to talk about their problems with friends. For male participants, "forgetting about" their problems meant playing games, listening to music, watching movies, and roaming in the village with friends. These activities were perceived as necessary for diverting thoughts and feeling relaxed. A few boys reasoned that "forgetting about" one's problems was a necessary first step to "talk about" the emotional problems. However, for girls, talking about their problems offered a window to understand their situation and to imagine a possible solution. The male participants believed in using the social network to 'normalize' their mental state, whereas female participants were inclined to rely on their friends to generate solutions.

Many boys and girls reported that most parents do not know how to handle the emotional problems of their ward even if they come to know about the problems. One female participant said, *"Though parents are concerned about you, they don't know what could be done to help their child to get over it. They [parents] hardly understand the emotions of their child. For them, it is like a fever or cold but it is not!".*

Both male and female participants perceived seeking help from a teacher or school personnel as less preferred and often as a risk, mainly due to issues related to breach of confidentiality and judgemental attitude of teachers. Participants' responses included, *"They [teachers] might tell parents, other teachers or students," "Some teachers might make fun of [them] in the classroom"*, *"…by nature, most of the teachers are preachy and start adding labels of good and bad"*, and *"they [teachers] might judge the student based on [his/her] problem and this may also affect their assessment in exams."*

The first point of contact by the family for seeking help in severe cases (i.e. crying for no apparent reason, not talking to anyone, loss of sleep for days, not leaving the house, and suicidal ideation) was a quack and/or a religious healer, mainly because they are easily available in the village and costs less than the medical professionals. In addition to the non-availability of professional mental health in rural settings, participants also highlighted the taboo and stigma associated with seeking medical help for mental health problems. The decision to seek help outside the immediate family is taken mostly by the head of the household. They stated, *"There are no trained medical doctors available in villages…one has to go to a district hospital which is far-off and there is no transportation available to reach the hospital…it is also not preferred because people consider the person as "mad"…taking the help of a doctor for a mental health problem is considered as a weakness of the person…mostly, the first-person contacted is areligious healer, mainly because s/he is contacted for multiple reasons including mental health problems. Also, this person is a lot cheaper than a doctor…some of them don't even take money."*

Many participants believed that some aid should be available to young people in the schools as well as in the community to deal with emotional and social problems. They mentioned that more than medicines, trust, and support are the most important needs while dealing with emotional and social problems. Both boys and girls mentioned that they would be the most comfortable with 'mother' 'elder sibling' and 'close-friend/s', talking about their emotional and social problems. Participants were unaware of the concept of counseling and never heard about a counselor or psychiatrist.

When asked, "Would you help a friend in depression?", almost all the participants responded affirmatively, however when further probed on how they would help their friends, the participants could not elaborate on the methods or strategies they would use to help their friend. Participants' responses included, *"I would ask my friend if s/he is okay or if s/he wants to talk*

to me about problems", "I will try and make [him/her] happy by telling a joke", "I don't know what to suggest a friend when [s/he] is sad or unhappy."

Discussion

This study aimed to explore adolescents' understanding of depressive disorders and the potential causes for them; and identifying the help-seeking behavior of rural adolescents and their families in Bihar, India. The early and significant symptoms identified by the adolescents were negative behavioral symptoms including persistent sadness, irritability, social withdrawal, and lack of concentration. Other symptoms mentioned by the adolescents included feelings of shame, feeling lonely, hiding from friends and family, low energy levels, and the lack of interest in carrying day to day activities. A network analysis of depressive symptoms on the data of 13, 035 school-going adolescents from Bihar, measured through Patient Health Questionnaire-9 found that sad mood, sleep problems, and a feeling of failure were highly central symptoms among these adolescents [18]. Our findings corroborate the findings of previous qualitative studies on the experience of young people with depression in high-income countries [14, 19]. For example, as found by Burns and Rapee [20], adolescent girls and boys in our study expressed the signs of depression however, they could not relate these symptoms with personal experiences or to a situation of a friend or peer who was experiencing these symptoms. The diagnostic systems of ICD-10 [21] and DSM-5 [22] lists ‘change in appetite and weight gain/loss’ as the core symptoms of depression. Surprisingly, these symptoms were not discussed by our study participants. This may suggest that Indian adolescents may not associate these symptoms with their experience of depression. However, symptoms like irritability, sleeping problems, difficulty in concentration were strongly associated with the depression and are recognized as a diagnostic criterion in the DSM-5 [22]. Some of these symptoms including irritability, sleeping problems, and negative impact on education were commonly reported in other studies on adolescent depression [14, 18, 19, 23, 24].

The study participants also identified that psycho-social adversities act as a risk factor and can trigger an onset of depressive disorders. Olsson and others [25] also reported that experiencing stressful situations and negative experiences during adolescence can contribute to an onset of depressive disorder. Although the participants majorly used the local terminology to describe depression, their description of depression also included a few stigmatizing labels. Both boys and girls agreed that women are more vulnerable to experience depression than men however, the reasoning offered by girls and boys differed. Female participants believed that women are more vulnerable to experience depression due to gender inequities in the society where male participants believed that women are not capable of handling their emotions like men.

When asked about help-seeking and treatment for depression, the prevalent notion among participants was that it does not require medical intervention as experiencing symptoms of depression is a consequence of everyday life situations. Both boys and girls mentioned friends as their confidante to talk about their emotional problems however boys preferred to talk with friends to forget the problems whereas girls preferred to talk with friends to discuss the problems. In severe cases, the family members preferred to approach the traditional healers to seek help in the absence of medical treatment and relatively low costs. Consistent with the adolescent literature [26, 27], boys and girls in our study viewed trusted individuals–mothers of adolescents or elder sibling– as resources to approach when experiencing emotional and social problems. Participants were unaware of the various health professionals they can reach out to for depression such as counselors and psychiatrists and mentioned that 'trust and support" are core needs of young people while dealing with emotional and social problems.

However, the findings of this study should be interpreted with caution. First, our sample size was small. Second, the interviews were conducted during one-off interaction. Third, the study participants did not involve young adolescents (i.e. aged 10–14 years). Fourth, it is plausible that the adolescents attending public high schools were not representative of the private school

adolescents in the state of Bihar. Finally, participation in our study was voluntary and required parental consent and hence, adolescents who participated in this study may be different than those adolescents who did not participate. Even with these limitations, the findings from the study add to the current understanding of adolescent depression in India. Building on the existing literature [26-29], our findings provide an understanding of depression among adolescent boys and girls from rural India.

To conclude, this study advances scientific knowledge of understanding of adolescent depression, available treatment options, and about barriers to help-seeking and treatment for depression in adolescents in rural India. Adolescents strongly associated social withdrawal, irritability, and sadness as symptoms of depression. These symptoms could be emphasized in the mental health education interventions tailored for adolescents. The findings of this study also provide insights into the level and type of information needed by Indian adolescents on depressive disorders. Our findings suggest that interventions may be tailored to (a) help adolescent's understand behavioral signs that warrant help-seeking; (b) develop appropriate channels for seeking help and treatment for adolescents in the families, communities, and schools; (c) include parents, especially mothers and other family members, schools and peers in mental health promotion and prevention activities for adolescents; and (d) promote treatment-seeking and support for family and friends experiencing psychological distress.

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Declaration of conflicting interests

The authors declared no potential conflicts of interest concerning the research, authorship, and/or publication of this article.

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