The Review Of
DIABETIC
STUDIES OPEN ACCESS

"Depression Literacy And Depression Stigma Among Adolescent Students"

Mrs. Chintal Purohit[1], Dr.KritagnasinhVaghela[2]

[1]Ph.D.Scholar,Parul Institute of Nursing, Parul University (Author and Corresponding author)
[2]HOD and Professor, Department of Psychiatry Parul Institute of Medical Science &Research, Parul Universiry, Vadodara (PhD Research Guide)
Email ID for Correspondence: chintalpurohit8@gmail.com

ABSTRACT:

Background: A high level of depression literacy encompasses sufficient knowledge and a positive attitude towards depression. Depression is characterized by loss of pleasure, continuous sadness, frustration, irritation and lethargy. The development and maintenance of social and emotional habits are critical for mental health, occur during adolescence.**Aim & Objective:** Aim and Objective of this study is to assess the level of knowledge in Depression literacy and Depression stigma between adolescent as well as the impact of educational interventions on these topics.
Methods and Materials: This study was carried out at selected schools in Rajpipla, Gujarat. After obtaining consent, 400 adolescent students were chosen, and asked to fill the DSS (Depression stigma Scale), D-Lit (Depression Literacy Questionnaire) and the Demographic Characteristics questionnaire. Students received instruction on depressive literacy and stigma, and their post-test results were examined and analysed.**Results:** From 400 participants, 176(44.0%) were 16 year of age,. 212(53.0%) students were Female. 381(95.3%) were Hindu 288(72.05%) students were from 12th grade.63(15.8%) student's father were Government employee. 156(39.0%) Students' mother were self-employed, 210(52.5.0%) Students 'mother were unemployed. 256(64.0%) students were living in joint family, 392(98.0%) students were familiar of Depression with none, for normality test, Kolmogorov – Smirnov test was applied and to compared median between pre and post data Wilcoxon Signed Ranks Test was applied. **DLIT:** Nagative ranks were 19, positive ranks were 379 and there were only 2 ties, test statistic value was -16.300 with p – value < 0.001 (Significance Level). i.e., values for DLIT were significantly increased in the post measure. **DSS PERSONAL:** Nagative ranks were 332, positive ranks were 52 and there were only 16 ties, test statistic value was -14.828with p – value < 0.001 (Significance Level). i.e., values for **DSS PERSONAL** were significantly decreased in the post measure. **DSS PERCIEVED:** Nagative ranks were 349, positive ranks were 45 and there were only 6 ties, test statistic value was -15.397 with p – value < 0.001 (Significance Level). i.e., values for DSS PERCIEVED were significantly decreased in the post measure.Posttest Depression stigma personal score mean 9.34 SD 2.62 and perceived score - Mean 10.18 and SD 3.08Which shows decreased after the intervention.**Conclusions:** It was discovered that Adolescents were having low levels of depression literacy and high levels of stigma. Both of these things were alleviated by educational intervention.

Key words: Depression literacy, Depression stigma, Adolescents, Educational intervention.

INTRODUCTION

Understanding depression as a mental illness and its causes, symptoms, and treatments is known as depression literacy.(1) According to numerous research, the prevalence of Depression among Adolescents varies between 3.2% and 8.9%.(2) According to other research, depression in Adolescents is more common in girls the in boys. Additionally, the incidence of suicidal attempts among adolescents is 7.1 and the prevalence of suicide ideation is 21.1%.(3)

When people are unaware of the signs of depression, they may put off getting treatment, which can make the condition harder to manage. The public in India has a number of misconceptions regarding mental diseases and how they are treated. Because of the stigma attached to depression and mental health treatments, psychiatric interventions are sometimes limited to a tiny percentage of the population, depriving many in need of any assistance. Understanding the numerous therapy techniques can make people feel less afraid and hesitant to ask for help.(4)

About 70% of those suffering from mental diseases do not get any help. Some of the causes are ignorance of the sign and symptoms and treatability of psychiatric disorders, stigma against people with psychiatric diseases, and expectations of discrimination against those who have been diagnosed with such conditions.(5)

The stigma can be personal such as a person's perception of stigma and perceived as attitude towards depression to others. As a person's perception of others' stigmatising behaviour. According to a multicentre international survey, between 20 and 37 percent of Indian depressed people had put off achieving something significant due to fear of prejudice.(6)

Over 5600 Adolescents participated in a five-year school-based adolescent depression education program run by Hess et al. (2004), who found that while students had a basic understanding of depression facts, they lacked knowledge about therapy and symptom identification.(7) Research indicates that adolescents frequently support negative views about mental illness.(8) According to another study, there is not enough research done on the long-term effects of programs meant to increase adolescents' awareness and comprehension of mental health.(9)

Low Mental Health literacy was found to be associated with greater levels of depression in adolescents.(10)According to Rahman et al., school activities were successful in raising community and schoolchildren's awareness of mental health issues. The schoolchildren responded well to the program and told their friends, family, and neighbours about what they had learnt.(11) Another study carried out in Jezan City, Saudi Arabia, found that education intervention programs increased students' understanding and, as a result, decreased the stigma associated with depression among secondary school students.(12)

In addition to helping to lower mortality, raising awareness of depression's symptoms and signs and facts about its frequency and prevalence may also lessen the financial burden that the disease's morbidity places on society. It might as well lower those infamously high and agonisingly high rates of youth suicide fatalities by educating people on who can assist depressed patients, how to get aid, and when someone really needs support.(13)

OBJECTIVES

- To assess the level of Depression literacy and Depression stigma among adolescent students.
- To Evaluate the effectiveness of educational intervention on depression literacy and stigma

MATERIAL AND METHODS:

This Research study was carried out in selected schools at Rajpipla, Gujarat. After obtaining their consent, 400 Adolescent school students were selected using simple Random Sampling technique. After being selected based on the inclusion criteria, participants were asked to complete the Performa, which included Section A: Sociodemographic Variables. This section asked about demographics like age, sex, religion, family type, class grade, mother's and father's occupations, as well as information about their familiarity with depression (if they or a family member, friend, or relative has experienced depression).- Depression Literacy Questionnaire, Section B-The D-Lit evaluates depression-specific mental health literacy. There are 22 true-or-false questions on the survey. Each question has three possible answers:

"true," "false," or "don't know." One point is given for each accurate response. Higher scores indicate greater mental health literacy regarding depression. D-Lit topics cover the symptoms, management, course, and duration of depression as well as how depression differs from other mental diseases.The Depression Stigma Scale (DSS), Section C the purpose of the Depression Stigma Scale is to quantify the stigma attached to depression. Its two subscales assess perceived and personal stigma, two distinct forms of stigma. The Personal Stigma Subscale asks respondents to rate their personal agreement with nine statements regarding depression in order to gauge stigma in their own attitudes towards the condition. Respondents were informed to indicate what they feel the majority of other people believe about nine statements in order to gauge their perspective of how others view depression in the Perceived Stigma Subscale. Each item's response is scored on a five-point scale, with zero denoting "strongly disagree" and four denoting "strongly agree." Higher scores indicate higher stigma associated with depression.Following the pretest, students received an educational intervention that included a 30-minute lecture about depression. Introduction, risk factors, causes, symptoms, therapies,mental health services available, suitable channels for seeking assistance. Ten minutes of interactive discussion about the five prevalent myths of depression. Following the presentation of each myth and a question regarding the students' thoughts, the instructor corrected the myth.Brochure Distribution: Recognising depression, its causes and risk factors, and knowing when to seek help Display Posters: Posters featuring mental health slogans related to depression was positioned in conspicuous locations across the schools. A post-test was carried out and evaluated.

RESULTS:

The findings indicated that 176 (44.0%) of the 400 participants were aged 16 years old, 153 (38.5%) were aged 17 years old, and 71 (17.0%) were 18 years old. of the students, 188 (47.0%) were male and 212 (53.1%) were female. There were 12 (3.0%) Muslims and 381 (95.3%) Hindus. Two (0.5%) were of another religion (Shikh) and five (1.3%) were Christians. Of the students , 288 (72.05%) were in the 12th grade, and 112 (28.0%) were in the 11th.The fathers of 63 students (15.8%) worked for the government, 60 students (15.0%) were having private job, 254 students (63.5%) were self-employed, and 23 students (5.8%) were unemployed.14 (3.5%) of the students' mothers worked for the government, 18 (4.5%) for the private sector, 156 (30.0%) for themselves, and 210 (52.5%) were unemployed.

29 (72.5%).2 students (0.5%) had a deceased mother. 2 students (0.5%) lived with extended family.142 students (35.5%) lived in nuclear families, while 256 students (64.0%) lived in extended families. 4 students (1.0%) were familiar with depression with peers, while 2 students (0.5%) were familiar with depression with relatives.2 students (0.5%) were familiar with depression with a relative, while 392 students (98.0%) were familiar with depression with none. The Kolmogorov-Smirnov test was used to check for normality, and the Wilcoxon Signed Ranks test was used to compare the median between the pre and post data. DLIT: There were just two ties, negative ranks were 19, and positive ranks were 379. The test statistic value was -16.300, and the p-value was less than 0.001 (Significance Level). DLIT levels, for example, increased considerably in the post-measure. DSS PERSONAL: There were only 16 ties, 332 negative ranks, 52 positive ranks, and a test statistic value of -14.828 with a p-value < 0.001 (Significance Level). For example, DSS PERSONAL values dropped considerably in the post-measure.DSS PERCEIVED: There were only 6 ties, 349 negative ranks, and 45 positive ranks. The test statistic value was -15.397, and the p-value was less than 0.001 (Significance Level). For example, DSS PERCIEVED values were considerably lower in the post-measure.

Table – 1: Distribution of students According to their demographic profile.

Frequency and percentage					
		No. of students	%	Valid Percent	Cumulative Percent
Age (Year)	16	176	44.0	44.0	44.0

	17	153	38.3	38.3	82.3
	18	71	17.8	17.8	100.0
	Total	400	100.0	100.0	
Gender	Female	212	53.0	53.0	53.0
	Male	188	47.0	47.0	100.0
	Total	400	100.0	100.0	
RELIGION	Christian	5	1.3	1.3	1.3
	Hindu	381	95.3	95.3	96.5
	Muslim	12	3.0	3.0	99.5
	Shikh	2	0.5	0.5	100.0
	Total	400	100.0	100.0	
Class	11	288	72.0	72.0	72.0
	12	112	28.0	28.0	100.0
	Total	400	100.0	100.0	
FATHER'S OCCUPATION	Government	63	15.8	15.8	15.8
	Private	60	15.0	15.0	30.8
	self employed	254	63.5	63.5	94.3
	Unemployed	23	5.8	5.8	100.0
	Total	400	100.0	100.0	
MOTHER'S OCCUPATION	Death	2	0.5	0.5	0.5
	Government	14	3.5	3.5	4.0
	Private	18	4.5	4.5	8.5
	self employed	156	39.0	39.0	47.5
	Unemployed	210	52.5	52.5	100.0
	Total	400	100.0	100.0	
FAMILY TYPE (JOINT/NUCLEAR/EXTENDED)	Extended	2	0.5	0.5	0.5
	Joint	256	64.0	64.0	64.5
	Nuclear	142	35.5	35.5	100.0
	Total	400	100.0	100.0	
FAMILIARITY WITH DEPRESSION	family member	2	0.5	0.5	0.5
	Friend	4	1.0	1.0	1.5
	No	392	98.0	98.0	99.5
	Relative	2	0.5	0.5	100.0
	Total	400	100.0	100.0	

Diagram – 1:

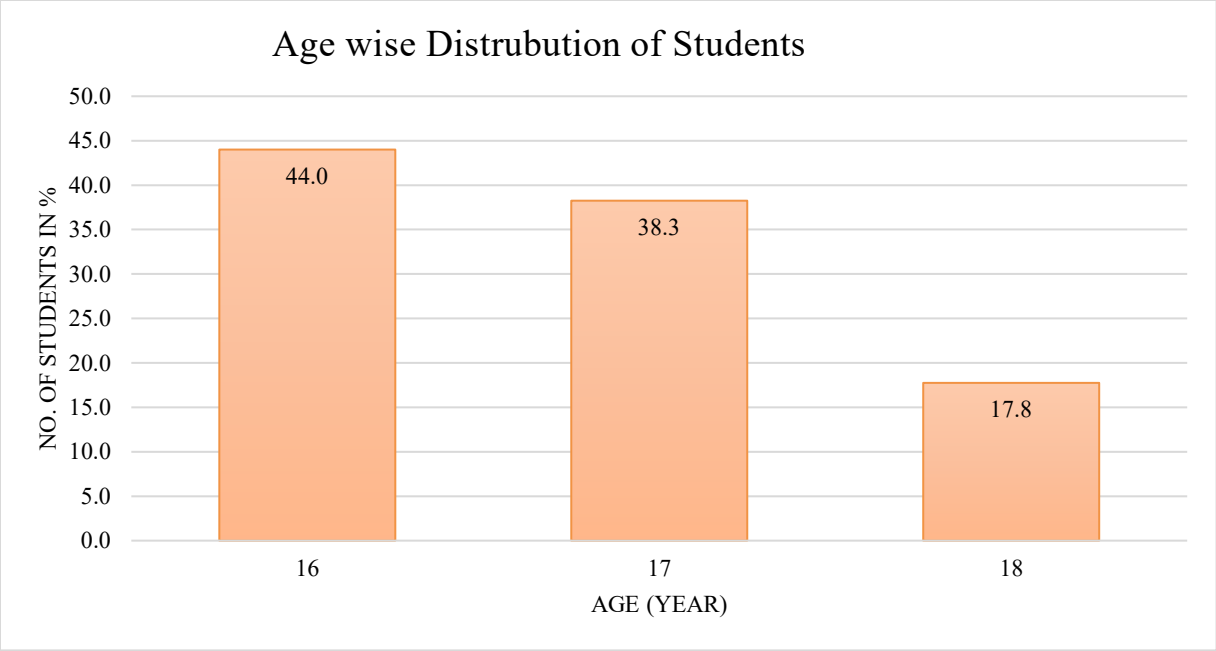

Figure 1: Frequencies for age
Figure -1 Out of 400 participants, 176 (44.0%) were aged 16 years old, 153 (38.0%) were aged 17 years old, and 71 (17.0%) were 18 years old.

Diagram – 2:

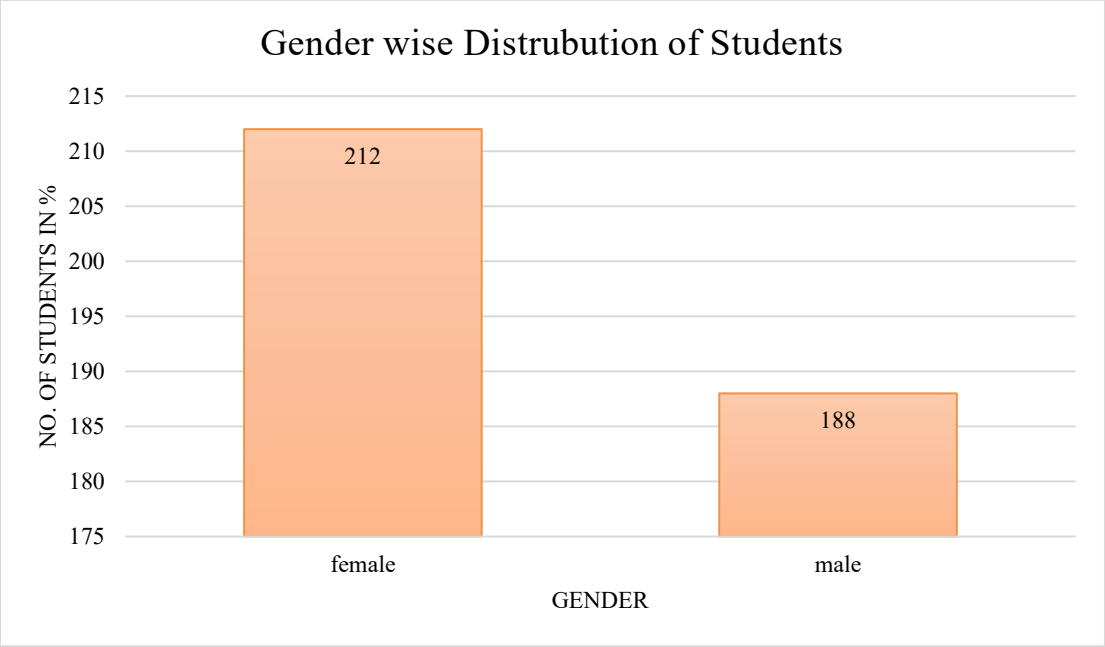

Figure 2: Frequencies for Gender
Figure - 2 shows how frequently participants Gender out of 400. Of the pupils, 188 (47.0%) were male and 212 (53.1%) were female.

Diagram – 3:

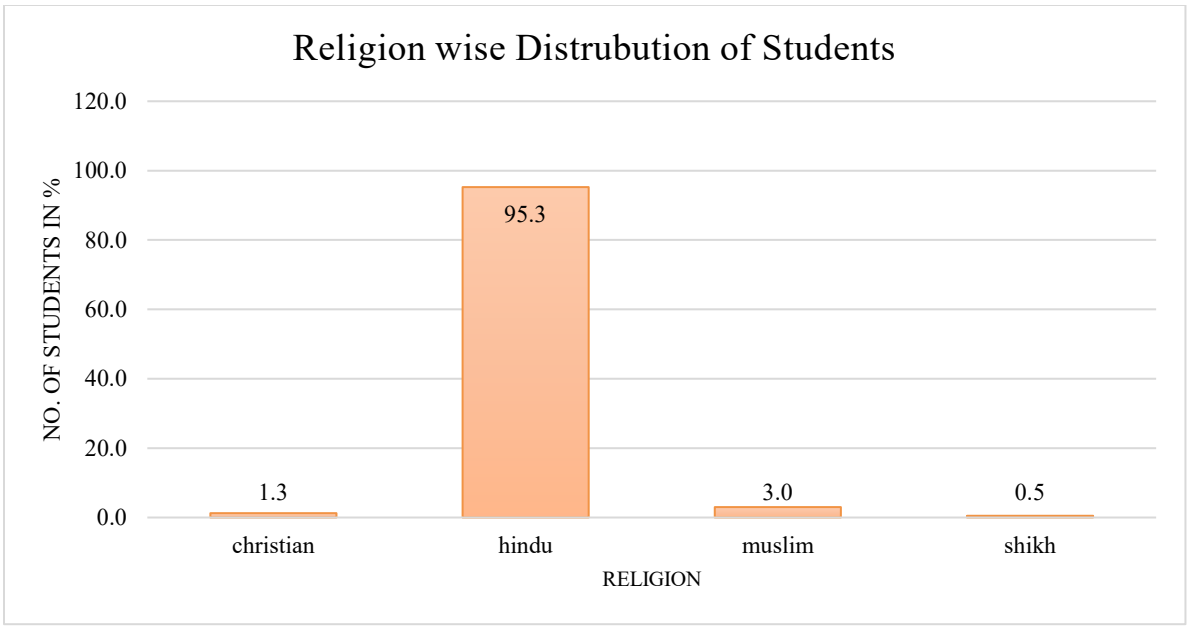

Figure 3: Frequencies for Religion
Figure -3 shows how frequently participants Out of 400,381 people, 95.3% were Hindu, and 12 people, 3.0%, were Muslim. Two (0.5%) were of another religion (Shikh), and five (1.3%) were Christians.

Diagram – 4:

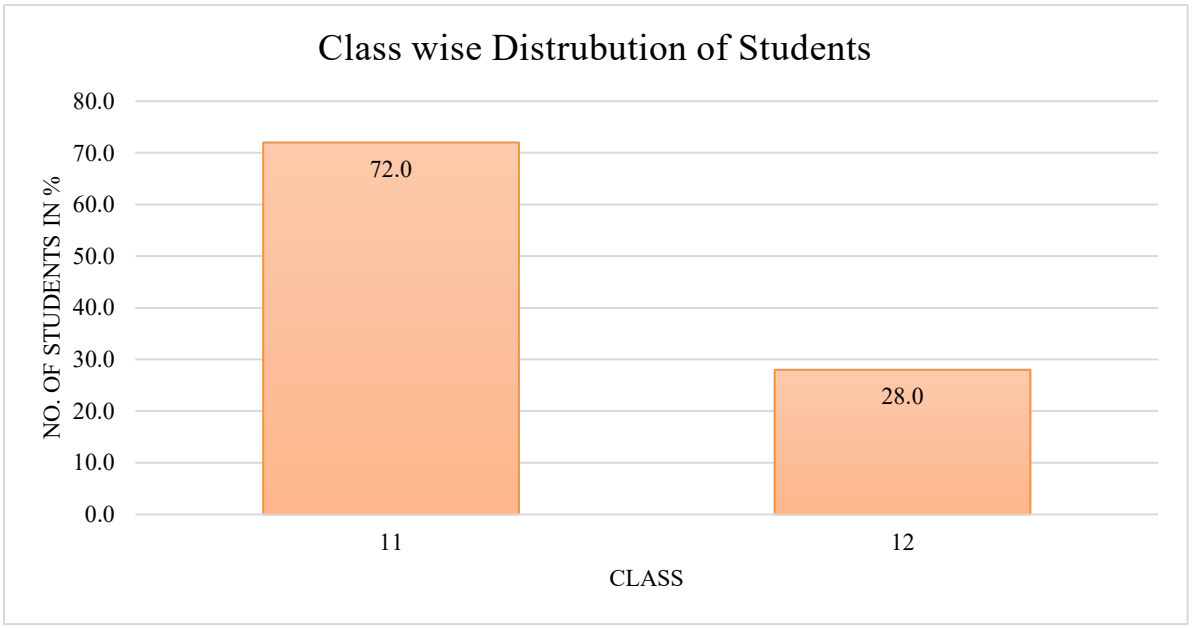

Figure -4 shows the frequency of the participants' class: of the 400,288 students (72.05%) in the 12th grade, 112 students (28.0%) were in the 11th grade.

Diagram – 5:

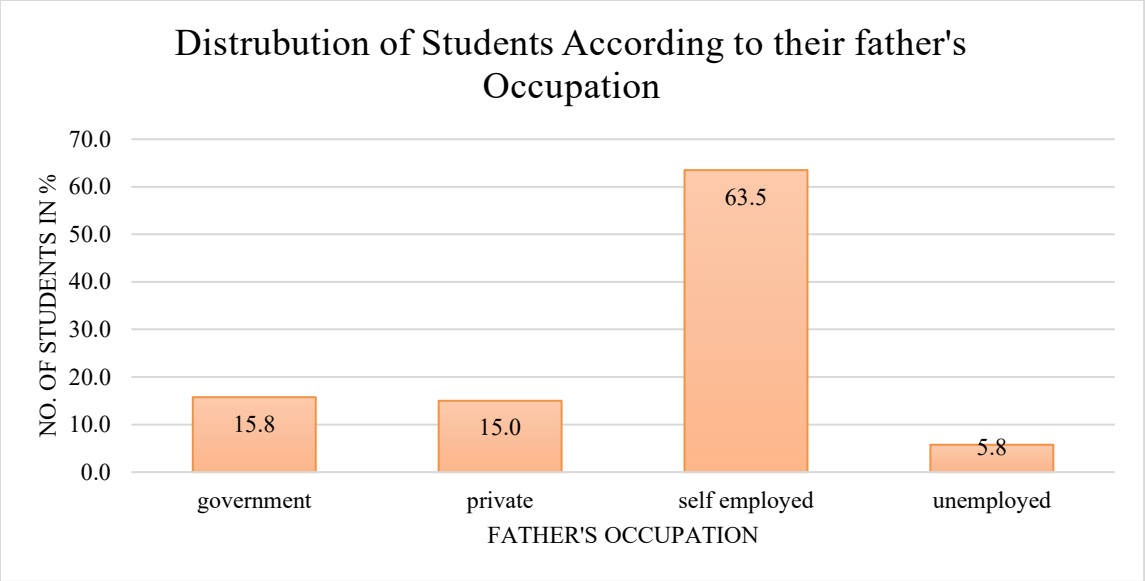

Figure 5: Frequencies for Father's Occupation

Figure -5 demonstrates the prevalence of participating father's occupation: of 400 students, 454 (63.5%) had self-employed fathers, 60 (15.0%) had private sector fathers, 23 (5.8%) had no employment and 63 (15.8%) had government fathers.

Diagram – 6:

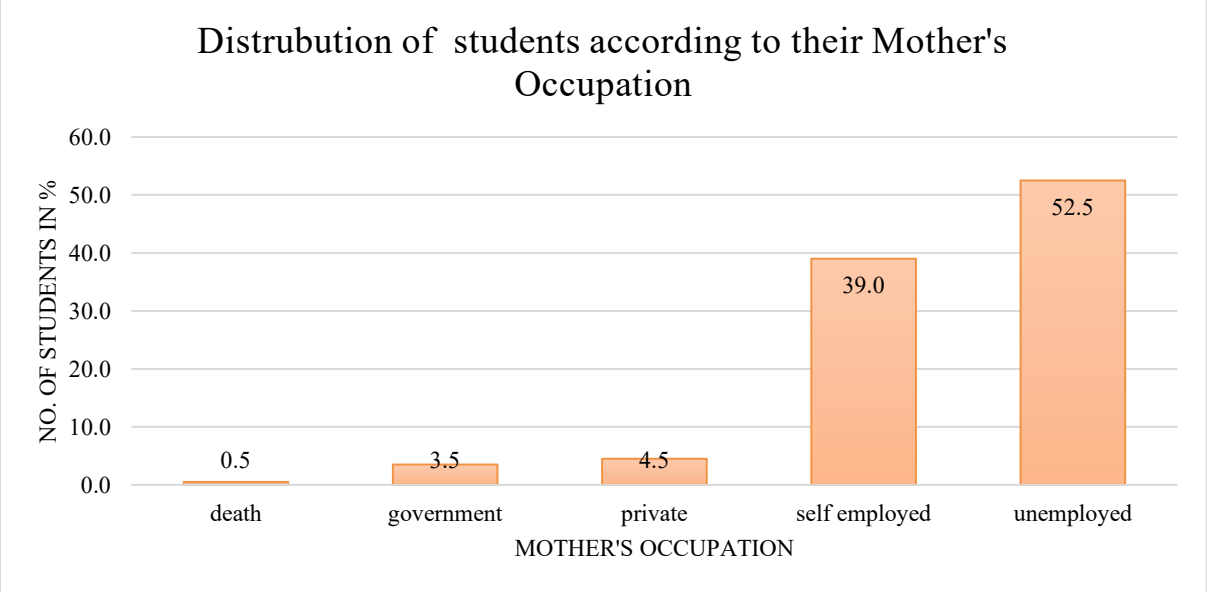

Figure 5: Frequencies of mother's Occupation

Figure -5 shows how frequently participants the occupation of the mother: Of the 400 students, 14 (3.5%) had a government job, 18 (4.5%) were in the private sector, 156 (30.0%) were self-employed, and 210 (52.5%) were unemployed. 29 (72.5%).Two students (0.5%) had a deceased mother.

Diagram - 6:

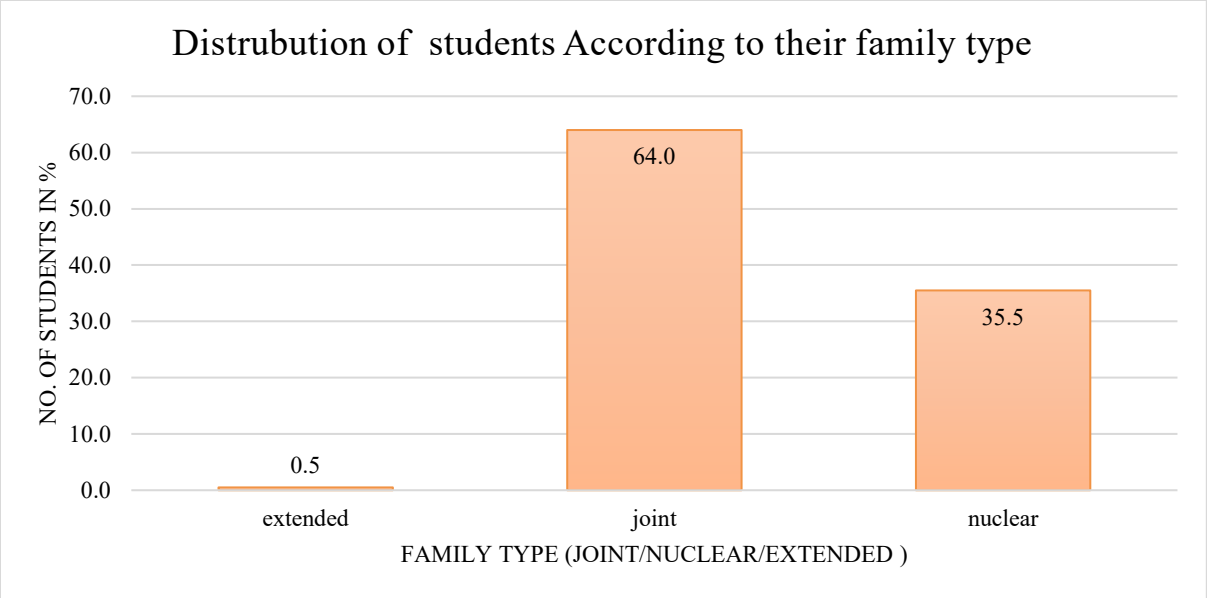

Figure 6: Frequencies for family type

Figure-6 shows how frequently participants' Family type: Two students (0.5%) out of 400 lived with extended family.142 students (35.5%) lived in nuclear families, while 256 students (64.0%) lived in combined families.

Diagram – 7:

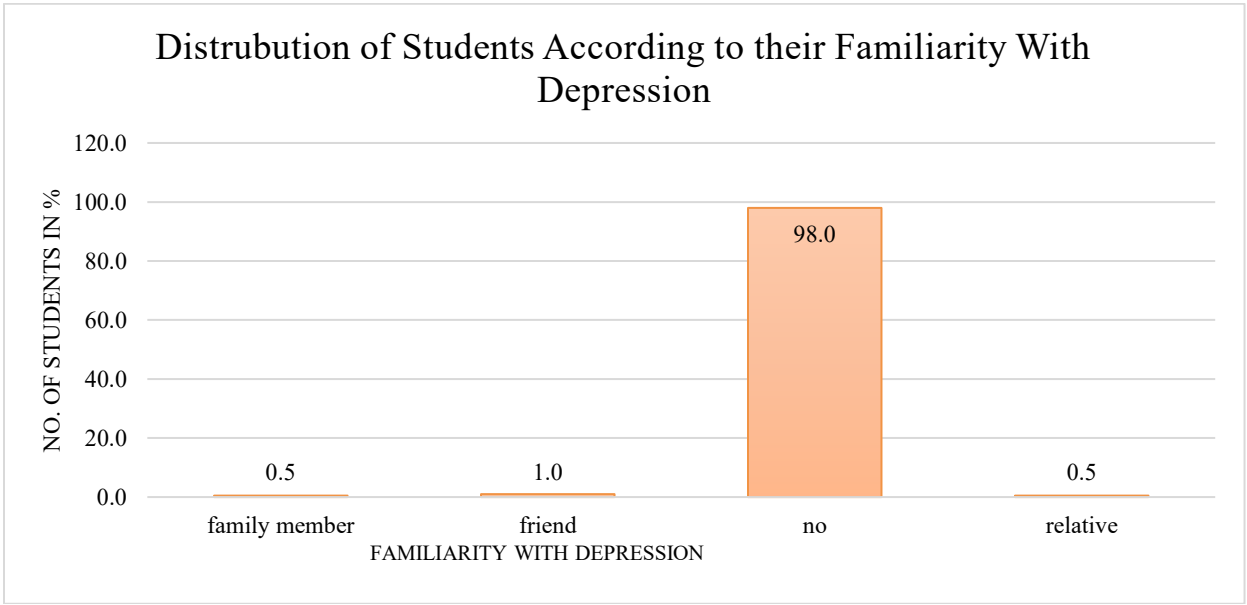

Figure 7: Frequencies for Familiarity with Depression

Figure -7 shows how frequently participants Depression familiarity Out of 400 pupils, 2 (0.5%) were familiar with depression in their families. Two students (0.5%) were familiar with depression with a relative, 392 students (98.0%) were familiar with depression with no one, and 4 students (1.0%) were familiar with depression with peers.

Table – 2: Wilcoxon signed ranks test.

		N	Mean Rank	Sum of Ranks	Z	p- Value
DLIT POST - DLIT PRE	Negative Ranks	19	121.32	2305.00	-16.300	< 0.001 (HS)
	Positive Ranks	379	203.42	77096.00		
	Ties	2				
	Total	400				
DSS PERSONAL POST - DSS PERSONAL PRE	Negative Ranks	332	208.49	69218.00	-14.828	< 0.001 (HS)
	Positive Ranks	52	90.42	4702.00		
	Ties	16				
	Total	400				
DSS PERCIEVED POST - DSS PERCIEVED PRE	Negative Ranks	349	211.24	73724.50	-15.397	< 0.001 (HS)
	Positive Ranks	45	90.90	4090.50		
	Ties	6				
	Total	400				

Conclusion: The Kolmogorov- Smirnov test was used to check for normality and Wilcoxon Signed Ranks test was used to compare the median between the pre- and post-data.

DLIT: Only two ties existed, and the test statistic value was -16.300 with a p-value < 0.001 (Significance Level). The negative ranks were 19, the positive ranks were 379. For example, DLIT values grew considerably in the post-measure.

DSS PERSONAL: There were only 16 ties, 332 negative ranks, 52 positive ranks, and a test statistic value of -14.828 with a p-value < 0.001 (Significance Level). For example, DSS PERSONAL values dropped considerably in the post-measure.

DSS PERCIEVED: Only six ties were found, with 349 negative ranks, 45 positive ranks, and a test statistic value of -15.397 with a p-value < 0.001 (Significance Level). For example, the post-measure DSS PERCIEVED scores were substantially lower.

DISCUSSION:

Numerous studies have found that Educational intervention can increase depression literacy and reduce stigma. According to the data, it is crucial to educate Adolescents about depression because this is when mental problems arises and most people with mental disorders experience their first episode before the age of 18. Stigmatising attitudes may decrease because of information that is taught in schools. Following an educational intervention, this research study will enable and support the improvement of Depression literacy. If this experiment shows encouraging trends, it will help advance larger-scale efforts to lessen the stigma attached to depression, which is desperately needed in this area.

CONCLUSION:

According to the study's findings, most Adolescent students had low depression literacy level and high depression stigma however, these circumstances improved because of educational intervention.

ETHICS DECLARATION AND CONSENT:

After reviewing the study, the Parul University ethics committee gave it ethical approval. Everyone who took part gave their consent.

FUNDING
There was no funding or support for this work from any financial source.

ACKNOWLEDGMENTS
The authors would like to thank the writers of the studies that were cited in this study, Parul University for granting ethics permission, and authorities of selected schools at Rajpipla for making data collection easier. To Professor Kathy Griffiths, who granted permission to use and translate the D-Lit and DSS Questionnaires, additional gratitude is expressed.(14)

CONFLICT OF INTEREST: THE AUTHORS DISCLOSED NO CONFLICTS OF INTEREST.

LIST OF REFERENCES:

1. Al-Shannaq Y, Jaradat D, Ta'an WF, Jaradat D. Depression stigma, depression literacy, and psychological help seeking attitudes among school and university students. Archives of Psychiatric Nursing. 2023 Oct;46:98–106.
2. Nolen-Hoeksema S, Girgus JS. The emergence of gender differences in depression during adolescence. Psychological Bulletin. 1994;115(3):424–43.
3. Andrews JA, Lewinsohn PM. Suicidal Attempts among Older Adolescents: Prevalence and Co-occurrence with Psychiatric Disorders. Journal of the American Academy of Child & Adolescent Psychiatry. 1992 July;31(4):655–62.
4. Swartz KL, Kastelic EA, Hess SG, Cox TS, Gonzales LC, Mink SP, et al. The Effectiveness of a School-Based Adolescent Depression Education Program. Health Educ Behav. 2010 Feb;37(1):11–22.
5. Henderson C, Evans-Lacko S, Thornicroft G. Mental Illness Stigma, Help Seeking, and Public Health Programs. Am J Public Health. 2013 May;103(5):777–80.
6. Lasalvia A, Van Bortel T, Bonetto C, Jayaram G, Van Weeghel J, Zoppei S, et al. Cross-national variations in reported discrimination among people treated for major depression worldwide: The ASPEN/INDIG international study. Br J Psychiatry. 2015 Dec;207(6):507–14.
7. Wahl O, Susin J, Lax A, Kaplan L, Zatina D. Knowledge and Attitudes About Mental Illness: A Survey of Middle School Students. PS. 2012 July;63(7):649–54.
8. Reavley NJ, Jorm AF. Stigmatizing Attitudes towards People with Mental Disorders: Findings from an Australian National Survey of Mental Health Literacy and Stigma. Aust N Z J Psychiatry. 2011 Dec;45(12):1086–93.
9. Armstrong C, Hill M, Secker J. Young people's perceptions of mental health. Child Soc. 2000 Feb;14(1):60–72.
10. Lam LT. Mental health literacy and mental health status in adolescents: a population-based survey. Child Adolesc Psychiatry Ment Health. 2014;8(1):26.
11. Rahman A, Mubbashar M, Gater R, Goldberg D. Randomised trial of impact of school mental-health programme in rural Rawalpindi, Pakistan. The Lancet. 1998 Sept;352(9133):1022–5.
12. Darraj H, Mahfouz MS, Al Sanosi R, Badedi M, Sabai A. The effects of an educational program on depression literacy and stigma among students of secondary schools in Jazan city, 2016: A cluster-randomized controlled trial study protocol. Medicine. 2018 May;97(18):e9433.
13. Swartz KL, Kastelic EA, Hess SG, Cox TS, Gonzales LC, Mink SP, et al. The Effectiveness of a School-Based Adolescent Depression Education Program. Health Educ Behav. 2010 Feb;37(1):11–22.
14. Griffiths KM, Christensen H, Jorm AF. Predictors of depression stigma. BMC Psychiatry [Internet]. 2008 Dec [cited 2025 Mar 29];8(1). Available from: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-8-25