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Short Note

Gender analysis for depression among school children in Hisar district of Haryana

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Abstract

Depression is a serious mental health concern that will touch most people's lives at some point in their life time either directly or through someone close they know. Improved recognition, treatment, and prevention of depression are critical public health priorities. The present study was undertaken on 80 ie.40 males and 40 females of 7th grade students, randomly selected from schools of two villages of Hisar district, Haryana. The age range was 12 to 15 years. Children Depression Inventory (Kovacs 2003) was used to assess the depression level of children. Personal and socio-economic profile was collected using pretested self structured interview schedule. Results of the study highlighted that depression symptoms were prevalent among one fourth of the total sample. The results evidenced statistically that girls were more depressed than the boys. More number of children was depressed in nuclear and high income group families.

Key words: Negative mood, inter-personal problem, ineffectiveness, anhedonia, negative self-esteem.

Depression is one of the most common psychological problems, affecting nearly everyone through either personal experience or through depression in a family member. Depression can interfere with normal functioning, and frequently causes problems with work, social and family adjustment. It causes pain and suffering not only to those who have a disorder, but also to those who care about them. Serious depression can destroy family life as well as the life of the depressed person. Depression is a psychological condition that changes how you think and feel, and also affects your social behavior and sense of physical well-being. We have all felt sad at one time or other, but that is not depression. Sometimes we feel tired from working hard, or discouraged when faced with serious problems. This too, is not depression. These feelings usually pass within a few days or weeks, once we adjust to the stress. But, if these feelings linger, intensify, and begin to interfere with work, school or family responsibilities, it may be depression. The present scenario of adolescents clearly shows that the condition of our youth has significantly deteriorated. Recent studies show that there is significant rise in the problems faced by the adolescents for example, serious emotional disturbances has increased (WHO, 2001). Increased sexual activity in schools, rise in AIDS cases in India and greater use of alcohol consumption has been found. Apart from the above, use of heavy drugs and youth school drop outs has also increased in the recent years (UNICEF, 2001). Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 850 000 lives every year. This gives us the clear image of the struggles that adolescents go through, the problems they face. So providing an experience that would strengthen

adolescent's coping abilities to counter environmental stress and disadvantages with which they sometimes have to cope with while experiencing is an essential need.

According to Soresi *et al.* (2005), childhood and adolescent depression must not be underestimated, as it is associated with dysthymic and anxiety disorders, severe behavioral disorders, and substance abuse. Research has also shown that teenage depression often persists into adulthood, especially if it goes untreated (Kovacs 1996). Depression in children and adolescents is associated with an increased risk of suicidal behaviors. Over the last several decades, the suicide rate in young people has increased dramatically. In 2009, the most recent year for which statistics are available, suicide was the third leading cause of death in 15-24 year olds and the fourth leading cause among 10-14 year olds. NIMH researchers are developing and testing various interventions to prevent suicide in children and adolescents. However, early diagnosis and treatment of depression and other mental disorders, and accurate evaluation of suicidal thinking, possibly hold the greatest suicide prevention value.

Depression can affect anyone. Unfortunately, depression is not always diagnosed, because many of the symptoms mimic physical illness, such as sleep and appetite disturbances. Recognizing depression is the first step in treating it. Once identified, most people diagnosed with depression are successfully treated. But many people with a depressive illness never seek treatment. Those with the most severe depression if go for treatment can get better with treatment. Medications, psychotherapies, and other methods can effectively treat people with depression. Looking at the severity of the problem the study was carried out with objective— To find out the prevalence of depression among boys and girls of rural Haryana.

The sample of the study comprised of 80, 7th grade randomly selected students (40 males and 40 females). The age range was 12 to 15 years. The sample was drawn from Govt. and Private schools of village Rawalwas, Khurd and Kalan, randomly selected from Hisar District of Haryana. The total number of schools sampled for the current study amounted to four schools (Two Government and two private). Data for the study was collected using the individual approach.

Instrument

Respondents were interviewed by the researcher to get information of their age, gender, household income, family size, type and ordinal position. Academic achievement in terms of percentage of marks secured in last exam was collected from the school records. Depression was measured with the help of Children Depression Inventory (Kovacs, 2003) designed for screening of depressive symptoms in children and teenagers between the age 7-17 years. The scale consists of five sub scale i.e 1) Negative Mood reflects sad feeling like crying, worry 2) Interpersonal Problems reflects problems difficulties in interaction with people 3) Ineffectiveness reflects negative evaluation of one's ability. 4) Anhedonia reflects endogenous depression like loss of energy, problem with sleep and appetite, and a sense of isolation. 5) Negative Self-Esteem reflects low self esteem, self dislike, feeling of being unloved, and tendency to have thought of suicide.The scale consists of 27 items, scored on a 3 point scale ranging from 0 = once in a while, 1 = many times and 2 = all the times. For each item, the individual is asked to select the statement that best describes his or her feelings. Participants were asked to choose one answer from each group that best described them for the past two weeks. Items were summed and 'T' score given in test against raw score for different age group and sex were calculated. Categories were formed using 'T' score as given in the Kovacs (2003) inventory. According to Kovacs the CDI has acceptable internal consistency with cronbach alpha .7962.

Data Analysis

SPSS programme was run to analyze the data. Descriptive statistics was used to describe the background information and main variables to the study. Pearson correlation was computerized to examine the relationship between depression and selected

demographic variables. Independent sample t-test was used to examine gender differences in depression.

The respondents of the study ranged from11-15 years equally representing both males and females. The maximum percentage (95%) of respondents were, ≤ 13 years of age. Majority of them having 1st or 2nd ordinal position in family. Sixty five per cent respondents had moderate performance in the academics (table1). Based on table 2, a large percentage of respondents were from middle and high caste and nuclear family system (56.25%). A large percentage of fathers had formal education from middle to senior secondary (76.25%); while about 48.75 percent mothers compared to fathers had education up to senior secondary. Comparatively higher percentage of mothers was illiterate against fathers.

Table 1. Personal profile of the respondents

Sr. No.	Variables	n=80	(%)
1	Age		
	≤ 13	76	95.00
	≥ 14	04	5.00
2.	Sex		
	Male	40	50.00
	Female	40	50.00
3	Ordinal position		
	Ist born	29	36.24
	IInd born	23	28.87
	IIIrd born	14	17.50
	IVth & above	14	17.50
4	No. of siblings		
	Single child	26	32.50
	2 siblings	23	28.75
	Upto4 siblings	24	30.0
	≥ 5siblings	07	08.75
5	Academic achievement		
	Average (≥ 40%)	12	15.00
	Moderate (upto 60%)	52	65.00
	High (≥ 60%)	16	20.00

About 75 percent mothers were housewives against almost 55 per cent fathers who were involved in farming, business or service. Nearing fifty percent children were from moderate income family earning up to Rs. 10,000 per month. One fourth of total families had monthly income above 10,000.

Table 2. Family profile of the respondents

Sr No.	Variables	n=80	(%)
1	Caste		
	Low	28	35.00
	Middle	17	21.25
	High	35	43.65
2	Family type		
	Nuclear	45	56.25
	Joint	23	28.75
	Extended	12	15.00
3	Family size		
	Small (upto5)	33	41.25
	Medium (6-7)	36	45.00
	Large (>7)	11	13.75
4	Father's education		
	Illiterate	19	23.75
	Middle	24	30.0
	Senior sec.	37	46.25
5	Mother's education		
	Illiterate	41	51.25
	Middle	26	32.50
	Senior sec.	13	16.25
6	Father's occupation		
	Labour	35	43.75
	Farming	29	36.25
	Business	10	12.50
	Service	06	07.50
7	Mother's occupation		
	House wife	60	75.00
	Labour	20	25.00

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Table 3 indicated that 76.25 per cent children had average depression which means not depressed followed by 21.25 per cent having above average depression, whereas, about 2.50 per cent respondents had severe depression. On different aspects of depression i.e. negative mood, interpersonal problems, ineffectiveness, anhedonia and negative self esteem, 65.00, 63.75, 78.75, 67.50, 83.75 per cent were of normal level and 30.00, 26.25, 21.25, 31.25. 16.25 per cent had above average depression respectively. Only 5.00 per cent had severed negative mood, 10.00 per cent faced severe interpersonal problems and one child had severe anhedonia problem. Gender comparison highlighted that comparatively more females had above average (27.50%) and severe depression (5.00%) against male respondents (15.00% & 0.00% respectively). The results are consistent with the study conducted by Uba *et al.* (2010) which reported that 12.80 per cent respondents were depressed against 87.20 per cent non depressed respondents. Saluja *et al.* (2004) also found that eighteen percent of youths reported symptoms of depression. A higher proportion of females (25.00%) reported depressive symptoms than males. Prevalence of depressive symptoms increased by age for both males and females. Results also got support from another study reported by Saime and Sharma (2011) who reported that 8.33 and 10 per cent respondents had poor and very poor mental health conditions.

The study further discovered significant differences (t=2.246 P<.05) in depression scores of male and female respondents. Significant gender differences were also seen on depression sub aspects i.e. ineffectiveness (t=2.432) anhedonia (t=3.867) at 5 percent level of significance (Table 4).The findings of the study illustrated that femals were more depressed than their male counterparts. The present findings are consistent with the study conducted by Uba *et al.* (2010) in Malaysia and with other studies by Nolen (1994) and Willkins *et al.* (2003).

In addition table 5 indicated that about 52.63 percent depressed children were from nuclear family coming from high caste. Further 42.10 per cent

Table 3. Distribution of respondents for depression by gender

CDI categories	Male (40)			Female (40)			Total (80)		
	Average	Above average	Severe	Average	Above average	Severe	Average	Above average	Severe
Negative Mood	27 (67.50)	11 (27.50)	02 (5.00)	25 (62.50)	13 (32.50)	02 (5.00)	52 (65.00)	24 (30.00)	04 (5.00)
Inter Personal Problem	24 (60.00)	15 (37.50)	01 (2.50)	27 (67.50)	06 (15.00)	07 (17.50)	51 (63.75)	21 (26.25)	08 (10.00)
Ineffectiveness	33 (82.50)	07 (17.50)	00 –	30 (75.00)	10 (25.00)	00 –	63 (78.75)	17 (21.25)	00 –
Anhedonia	32 (80.00)	08 (20.00)	00 –	22 (55.00)	17 (42.50)	01 (2.50)	54 (67.50)	25 (31.25)	01 (1.25)
Negative Self esteem	33 (82.50)	07 (17.50)	00 –	34 (86.0)	06 (15.00)	00 –	67 (83.75)	13 (16.25)	00 –
Total child depression	34 (85.00)	06 (15.00)	00 –	27 (67.50)	11 (27.50)	02 (5.00)	61 (76.25)	17 (21.25)	02 (2.50)

Figures in parentheses indicate percentages

Table 4. Gender wise mean differences in depression N=80

CDI categories	Sex 40 (Male) & 40 (Female)	Mean	SD	SE	DF	MD	't'values	P
Negative mood	Male	52.375	10.769	1.702	78	1.950	.792	.005
	Female	54.825	11.235	1.776	77.86			
Interpersonalproblem		Male	51.650	7.757	1.226	78	4.275	1.587
		Female	55.925	15.168	2.398	58.09		
Ineffectiveness	Male	50.325	6.442	1.018	78	3.275	2.432	
	Female	53.600	5.569	0.880	76.401			
Anhedonia	Male	49.725	5.242	0.829	78	5.200	3.867	
	Female	54.925	6.696	1.058	73.754			
Negativeself esteem	Male	47.050	6.872	1.086	78	0.325	0.187	
	Female	47.375	8.598	1.359	74.386			
Total child depression	Male	50.325	5.264	0.832	78	3.600	2.246	
	Female	53.925	8.662	1.369	64.347			

Table 5. Child depression by family profile N=80

CDI categories	Family Type			Caste			Family Income		
	Nuclear	Joint	Extended	Low	Middle	High	Low	Middle	High
Non depressed n=61	35 (57.37)	16 (26.23)	10 (16.40)	21 (34.42)	15 (24.60)	25 (40.98)	15 (24.60)	32 (52.45)	14 (22.95)
Depressed n=19	10 (52.63)	07 (36.84)	02 (10.53)	07 (36.84)	02 (10.53)	10 (52.63)	08 (42.10)	06 (31.58)	05 (26.32)

Figures in parentheses indicate percentages

depressed respondents were from low income group families. Findings of present study are in line with the result reported by Uba *et al.* (2010), Saime and Sharma (2011), and Srividhya (2007).

Conclusion reveals that majority of the respondents were non-depressed and a small percentage was depressed. Girls were found to be more depressed than boys and the differences were statistically significant. The respondents from nuclear family with poor income were comparatively more depressed. The results mark the need for diagnosis and psychological treatment of children at early age when the symptoms of depression are still emerging, so that the situation does not get worse by the time they reach high level and face the pressure of academic achievement, which further leads to danger of suicide, drug addiction etc. and other psychological problem. There is also a need for educating and training the teachers in preliminary diagnosis of depression symptoms and providing referral services.

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