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Original Research Article

A qualitative evaluation of youth awareness and perception towards depressive mental disorders through utilization of case-based scenarios

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ABSTRACT

Background: Depression is a major contributor to global suicide rates and often coexists with substance abuse, complicating both treatment and outcomes. WHO reports that 3.8% of the global population suffers from depression, with the onset often occurring in adolescence or early adulthood. According to UNICEF, one in seven adolescents (aged 10-19 years) experiences a mental disorder, with anxiety and depression accounting for 40% of these cases, affecting approximately 166 million adolescents worldwide. In India, the National Mental Health Survey (2015-16) found that 5.3% of the population has experienced depressive disorders. 14% of Indian youth (aged 15-24) frequently feel depressed. Hence this study has been done to assess the awareness among youths regarding depressive mental disorders and their attitudes and perceptions regarding the conditions.
Methods: This study was conducted in an urban area of Meerut district, Uttar Pradesh, India involving 475 youth participants, utilizing a case-scenario based questionnaire derived from the National Survey of Mental Health Literacy and Stigma Youth Boost Survey by Anthony F. Jorm and Nicola Reavley.
Results: The study found that the rate of participants who could correctly identify the various depressive disorders based on the case-based scenarios presented to them were 236 (49.7%) for depression with suicidal ideation, 187 (39.4%) for depression alone, and 140 (29.5%) for depression with substance abuse.
Conclusions: Suicidal ideation increases the likelihood of identifying depression, whereas depression alone is often underrecognized. Substance abuse further complicates the identification of underlying depression, resulting in the lowest recognition rates.

Keywords: Depression, Depressive mental disorders, Mental health literacy, Substance abuse, Suicide, Youth mental health

INTRODUCTION

The global prevalence of depression among youth is a significant public health concern, with far-reaching implications for individuals and societies. Adolescence is a critical period marked by emotional, psychological, and social development, making youths particularly vulnerable to mental health disorders. Depression being one of the most common mental health issues faced by adolescents, often lead to severe consequences if not addressed early.[1] According to a report by UNICEF, one in seven adolescents (aged 10-19 years) globally is affected by a mental disorder, with anxiety and depression making up approximately 40% of these cases, impacting around 166 million adolescents worldwide.[2]

The World Health Organization (WHO) further emphasizes the widespread nature of depression, reporting that 3.8% of the global population suffers from this disorder, including 5% of adults. The onset of depression frequently occurs during adolescence or early

adulthood, a critical period for establishing identity and forming social connections. The burden of untreated depression in youth is profound, as it not only affects academic performance and social relationships but also increases the risk of suicide-a leading cause of death among adolescents.[3] The global age-standardized suicide rate in 2019 was estimated to be 9.0 per 100,000 population.[4]

In the context of India, the situation is equally concerning. The National Mental Health Survey (2015-16) revealed that 5.3% of the Indian population has experienced depressive disorders at some point.[5] Among Indian youth (aged 15-24 years), 14% reported frequent feelings of depression, highlighting the urgent need for targeted mental health interventions.[6] Depression is a significant contributor to the overall burden of disease and a leading cause of suicide globally. Suicide also remains a critical concern in India. According to the NCRB, India recorded over 1,70,924 suicides in 2022 leading to rise of incidence rate of suicide from 10.2 in 2018 to 12.4 per lakh population in 2022. Approximately 2/3rd of the total suicide belonged to the age-group less than 45 years.[7]

Depression in this demographic often coexists with other challenges, such as substance abuse, which complicates both diagnosis and treatment. This comorbidity not only exacerbates the severity of depression but also diminishes the effectiveness of standard treatment approaches, leading to poorer outcomes.[8] The global prevalence of depression with substance abuse is a significant public health concern. Studies indicate that around 20-30% of individuals with substance use disorders also suffer from major depressive disorder. This co-occurrence significantly impacts the prognosis and treatment outcomes for both conditions.[9] In India, the situation reflects the global pattern. Research by Blows et al indicates that about 15-20% of individuals with substance use disorders also experience depression. This comorbidity poses challenges in terms of diagnosis and treatment, often requiring integrated approaches to address both issues effectively.[10]

The pervasive nature of depression among adolescents and young adults, coupled with its association with other high-risk behaviours like substance abuse, underscores the need for comprehensive mental health strategies. These strategies should focus on early detection, reducing stigma, and providing accessible mental health services to mitigate the long-term impacts of depression on individuals and society. Till date, there have been numerous studies on the magnitude of the disease, but very little research has been done on awareness about it. This gap in public understanding can no longer be ignored, as awareness is key to early detection, timely intervention, and reducing the overall burden on healthcare systems. Without addressing the knowledge deficit, efforts to combat the disease may fall short, and the potential for prevention and improved outcomes will remain underutilized. Hence, this study has been conducted with the objectives to evaluate the awareness among youths regarding mental depressive disorders and to assess their attitudes and perceptions towards such conditions.

METHODS

The study was conducted in an urban locality of Meerut district, Uttar Pradesh, using a community-based cross-sectional design. The population included youths aged 15 to 25 years, with a total of 2,040 youths residing in the study area. Data collection and analysis were carried out from January to December 2023. The sample size was calculated using a design effect of 1.5 and an anticipated proportion of ability to identify depression correctly at 29.04%, derived from a study by Ogorchukwu et al.[11] With a 95% confidence interval and 5% precision, the required sample size was determined to be 475 participants. A multi-stage sampling method was employed, starting with the random selection of one ward from the 90 wards in urban Meerut. It has 10 localities of which 5 localities were selected using Probability Proportional to Size (PPS) sampling. These localities had a combined youth population of 1,267. The sample size was proportionally allocated across these localities using the formula n1/N1 = n2/N2 = ……constant = 475/1267, (n1 = 475/1267*N1) where n1 represents the number of youths to be selected as study participant from a specific locality and N1 is the total youth population of that locality.

A house-to-house survey was conducted which began with a randomly selected house using the pen-drop method. The consecutive houses were selected from the right of the first house. If multiple eligible youths were found in a household, one participant was chosen randomly, with preference given to older youths. In cases where no eligible youth was present, the adjacent house on the right was surveyed. Participants included in the study were youths aged 15-25 years who consented to participate, while those absent during visits, those who or whose guardians did not give consent, and those displaying hostile behaviour were excluded. Data collection involved a semi-structured questionnaire based on a case-based scenarios designed based on elements from the National Survey of Mental Health Literacy and Stigma Youth Boost Survey V5, with permission from Anthony F. Jorm and Nicola Reavley.[12] Youth is defined as individuals aged 15 to 25 years for this study, aligning with the Youth Boost Mental Health Literacy Questionnaire.

For statistical analysis, data were processed using MS Excel, with Pearson's chi-square test used to assess associations and a p-value of <0.05 is considered as statistically significant. Ethical clearance was obtained from the institutional ethical committee prior to the study's commencement.

RESULTS

The study was conducted among individuals aged 15-25 years residing in the selected area, with a mean age of 18.2 years±3.1 SD. 234 (49.3%) participants belonged to age group 15-17 years, followed by 158 (33.3%) 18-21 years and 83 (17.4%) 22-25 years. The number of male participants 260 (54.7%) were slightly higher than females 215 (45.3%). Educationally, 177 (37.3%) had a middle school education, 130 (27.4%) had a high school education, and 88 (18.5%) had intermediate or diploma qualifications. The majority, 331 (69.7%) belonged to joint families, while 144 (30.3%) came from nuclear families. Socioeconomically, 255 (53.7%) were from the upper lower class, 102 (21.5%) from the lower middle class, and 50 (10.5%) from the upper middle class, with smaller percentages from the lower, 40 (8.4%) and upper classes, 28 (5.9%). Additionally, 47 (9.9%) of participants had medical personnel among their family or friends (Table 2).

Table 1: Scenarios presented to the study participants.

Scenarios presented to the study participants
Scenario 1: [Depression] Raju is a 20-year-old who has been feeling unusually sad and miserable for the last few weeks. He feels tired all the time and has trouble sleeping at night. Raju doesn't feel like eating and has lost weight. He can't concentrate on his studies and his marks have dropped. He keeps putting off making any decisions and even day-to-day tasks seem too much for him.
Scenario 2: [Depression with Suicidal ideation] Raju is a 20-year-old who has been feeling unusually sad and miserable for the last few weeks. He feels tired all the time and has trouble sleeping at night. Raju doesn't feel like eating and has lost weight. He can't concentrate on his studies and his marks have dropped. He keeps putting off making any decisions and even day-to-day tasks seem too much for him. Raju feels like he will never be happy again and believes his family would be better off without him. Raju has been desperate and has been thinking of ways to end his life.
Scenario 3: [Depression with Substance Abuse] Raju is a 20-year-old who has been feeling unusually sad and miserable for the last few weeks. He feels tired all the time and has trouble sleeping at night. Raju doesn't feel like eating and has lost weight. He can't concentrate on his studies and his marks have dropped. He keeps putting off making any decisions and even day-to-day tasks seem too much for him. Raju has been drinking a lot of alcohol over the last year, and recently lost his weekend job because of his hangovers.

Table 2: Association of recognition of disorder with socio-demographic factors among the study participants.

Socio-demographic variable		Total N (%)	Recognition of disorder		P value
			Present N (%)	Absent N (%)	
Age groups (in years)	15 – 17	234 (49.3)	184 (78.6)	50 (21.4)	χ^2= 0.4146 df= 2 P value= 0.812765
	18 – 21	158 (33.3)	120 (75.9)	38 (24.1)	
	22 – 25	83 (17.4)	65 (78.3)	18 (21.7)	
	Total N (%)	475 (100.0)	369 (77.7)	106 (22.3)	
Sex	Male	260 (54.7)	205 (78.9)	55 (21.1)	χ^2= 0.4474 df=1 P value= 0.503593
	Female	215 (45.3)	164 (76.3)	51 (23.7)	
	Total N (%)	475 (100.0)	369 (77.7)	106 (22.3)	
Educational qualification	Illiterate	12 (2.5)	0 (0.0)	12 (100.0)	χ^2= 62.1425 df= 5 P value <0.0001
	Primary school	19 (4.0)	14 (73.7)	5 (26.3)	
	Middle school	177 (37.3)	127 (71.8)	50 (28.2)	
	High school	130 (27.4)	106 (81.5)	24 (18.5)	
	Intermediate/diploma	88 (18.5)	73 (82.9)	15 (17.1)	
	Graduate*	31 (6.5)	31 (100.0)	0 (0.0)	
	Post-graduate / Professional*	18 (3.8)	18 (100.0)	0 (0.0)	
	Total N (%)	475 (100.0)	369 (77.7)	106 (22.3)	
Family type	Nuclear	144 (30.3)	97 (67.4)	47 (32.6)	χ^2= 12.7029 df= 1 P value= 0.000365
	Joint	331 (69.7)	272 (82.2)	59 (17.8)	
	Total N (%)	475 (100.0)	369 (77.7)	106 (22.3)	

Continued.

Socio-demographic variable		Total N (%)	Recognition of disorder		P value
Socio-economic status (acc. to Modified Kuppuswamy, 2022)	Upper	28 (5.9)	20 (71.4)	8 (28.6)	χ^2= 27.92 df= 4 P value <0.00001
	Upper middle	50 (10.5)	50 (100.0)	0 (0.0)	
	Lower middle	102 (21.5)	87 (85.3)	15 (14.7)	
	Upper lower	255 (53.7)	188 (73.7)	67 (26.3)	
	Lower	40 (8.4)	24 (60.0)	16 (40.0)	
	Total, N (%)	475 (100.0)	369 (77.7)	106 (22.3)	
Medical personnel among family/friends	Yes	47 (9.9)	47 (100.0)	0 (0.0)	χ^2= 13.5894 df= 1 P value <0.00001
	No	428 (90.1)	322 (75.2)	106 (24.8)	
	Total, N (%)	475 (100.0)	369 (77.7)	106 (2.3)	

*Cell-values were combined for effective χ2 test

Participants were presented with three scenarios depicting depressive disorders: depression, depression with suicidal ideation, and depression with substance abuse (Table 1). Recognition rates varied with highest correct identification for depression with suicidal ideation 236 (49.7%), followed by depression 187 (39.4%) and 140 (29.5%) for depression with substance abuse. For statistical analysis, recognition of disorder was considered to be present if the participant correctly identified the case-scenario or identified it as other mental disorder. Overall, recognition was highest for depression with suicidal ideation 369 (77.7%) (Figure 1).

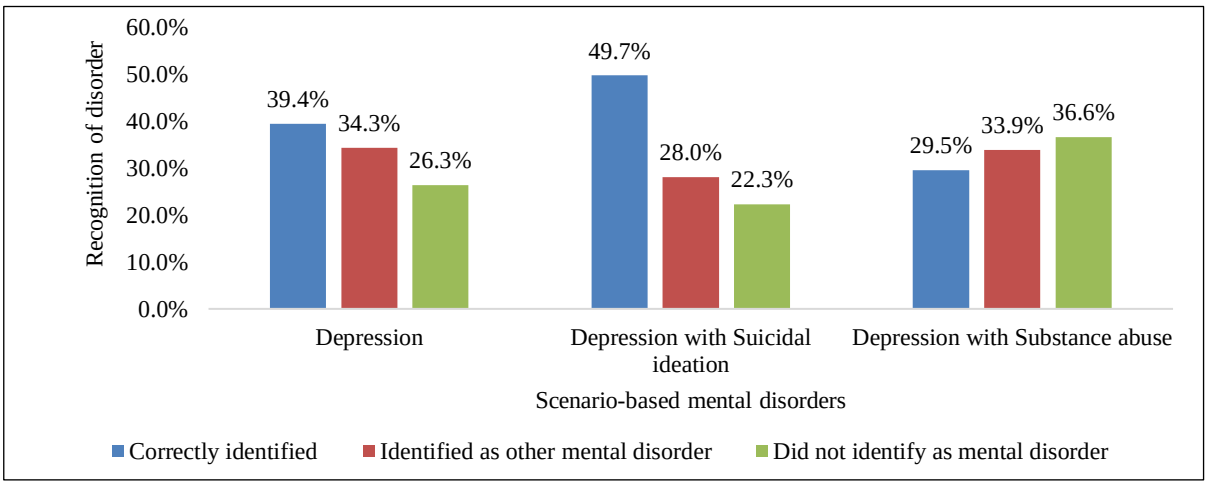

Figure 1: Recognition of disorders based on presented scenarios among the study participants.

Table 3: Attitudes and perceptions towards depressive disorders across different scenarios.

Statements	Responses	Scenario 1 N (%)	Scenario 2 N (%)	Scenario 3 N (%)
One could snap out of it if he/she wanted	Strongly agree	99 (20.8)	95 (20.0)	110 (23.2)
	Agree	293 (61.7)	293 (61.7)	270 (56.8)
	Neither agree nor disagree	61 (12.8)	61 (12.8)	65 (13.7)
	Disagree	22 (4.6)	26 (5.5)	30 (6.3)
	Strongly disagree	0 (0.0)	0 (0.0)	0 (0.0)
This problem is a sign of personal weakness	Strongly agree	76 (16.0)	72 (15.2)	99 (20.8)
	Agree	262 (55.2)	255 (53.7)	239 (50.3)
	Neither agree nor disagree	99 (20.8)	110 (23.2)	99 (20.8)
	Disagree	38 (8.0)	38 (8.0)	38 (8.0)
	Strongly disagree	0 (0.0)	0 (0.0)	0 (0.0)
This problem is not a real medical illness	Strongly agree	84 (17.7)	84 (17.7)	99 (20.8)
	Agree	266 (56.0)	247 (52.0)	243 (51.2)
	Neither agree nor disagree	80 (16.8)	87 (18.3)	80 (16.8)
	Disagree	45 (9.5)	57 (12.0)	53 (11.2)
	Strongly disagree	0 (0.0)	0 (0.0)	0 (0.0)

Continued.

Statements	Responses	Scenario 1 N (%)	Scenario 2 N (%)	Scenario 3 N (%)
One with this problem is potentially dangerous to others	Strongly agree	8 (1.7)	8 (1.7)	23 (4.8)
	Agree	61 (12.8)	61 (12.8)	65 (13.7)
	Neither agree nor disagree	186 (39.2)	186 (39.2)	171 (36.0)
	Disagree	194 (40.8)	194 (40.8)	190 (40.0)
	Strongly disagree	26 (5.5)	26 (5.5)	26 (5.5)
Best to avoid the person so that you don't develop this problem yourself	Strongly agree	11 (2.3)	16 (3.4)	35 (7.4)
	Agree	103 (21.7)	106 (22.3)	106 (22.3)
	Neither agree nor disagree	99 (20.8)	103 (21.7)	87 (18.3)
	Disagree	232 (48.8)	220 (46.3)	217 (45.7)
	Strongly disagree	30 (6.3)	30 (6.3)	30 (6.3)
You would not tell anyone if you had a problem like the vignette	Strongly agree	41 (8.6)	41 (8.6)	53 (11.2)
	Agree	167 (35.2)	167 (35.2)	167 (35.2)
	Neither agree nor disagree	122 (25.7)	122 (25.7)	110 (23.2)
	Disagree	137 (28.8)	137 (28.8)	137 (28.8)
	Strongly disagree	8 (1.7)	8 (1.7)	8 (1.7)

Analysis of socio-demographic factors showed no significant differences in recognition of disorder by age ($p=0.8128$) or gender ($p = 0.5036$). However, educational qualification, family type, and socio-economic status significantly influenced recognition ($p<0.0001$, $p=0.0004$, and $p<0.00001$, respectively). All participants with medical personnel in their social circle recognized the disorders ($p<0.00001$) (Table 2).

Attitudes and perceptions revealed that a majority agreed with the statement "One could snap out of it if he/she wanted" 293 (61.7%) for scenario 1 and 2 and 270 (56.8%) for scenario 3. For all the scenarios, over half agreed that depressive disorders reflect personal weakness and are not real medical illnesses. However, most disagreed with the notion that individuals with such problems are dangerous or should be avoided to prevent developing the same problem. Approximately 167 (35.2%) said they wouldn't disclose such issues if they had them (Table 3).

DISCUSSION

In the current study, three scenarios depicting depressive disorders (depression, depression with suicidal ideation, and depression with substance abuse) were presented to participants aged 15-25 years to assess their ability to recognize these disorders and evaluate their attitudes and perceptions toward such conditions.

The study revealed varying rates of recognition for different depressive disorders. For depression, 39.4% of participants correctly identified the condition. In comparison, similar studies reported identification rates of 23.4% (Lam et al), 29.04% (Ogorchukwu et al), and as low as 7.8% (Saraf et al) and 3.5% (Singh et al).[13,11,14,15] Among university students, correct identification was higher, ranging from 32.0% (Nguyen et al) to 88.5% (Devraj et al), depending on their field of study.[16,17] In this study, 34.3% of participants identified depression as another mental disorder, consistent with findings in similar study, 25.88% in Ogorchukwu et al.[11]

In the current study, the correct identification of disorder was highest for depression with suicidal ideation (49.7%) and lowest for depression with substance abuse (29.5%). This suggests that the severity of suicidal ideation makes it more noticeable and the complexity of substance abuse likely overshadowed the identification of underlying depression, reflecting the challenges in diagnosing co-occurring disorders, as noted in studies by Hunt et al.[18] and Lu et al, which highlighted the difficulty in treating depression combined with substance abuse due to worse outcomes.[19]

The study found that recognition of mental health disorders was significantly influenced by educational qualifications, family background, and socioeconomic status. Participants with higher education or medical personnel in their families had higher recognition rates. Cultural and regional differences also likely contributed to the variability in results, as mental health awareness and stigma vary across different regions.

Attitudes and perceptions toward the presented scenarios were revealing. A significant proportion of participants believed that individuals could overcome depressive disorders if they wanted to (Scenario 1: 61.7%, Scenario 2: 61.7%, Scenario 3: 56.8%). This suggests a lack of understanding of the complexity of mental health conditions, with many perceiving, depression as a temporary emotional state rather than a serious illness. Over half of the participants agreed that depression reflects personal weakness, with slightly higher agreement in Scenario 3 (substance abuse), likely due to the stigma surrounding addiction. Moreover, more than half of participants across all scenario believed depression is not a real medical illness, indicating a significant gap in

mental health literacy. Substance abuse also led to higher levels of perceived danger, with 4.8% of participants strongly agreeing and 13.7% agreeing that individuals with depression and substance abuse were potentially dangerous. This reflects the stigma and fear associated with substance abuse. Additionally, a notable proportion of participants endorsed avoiding individuals with such conditions to avoid "catching" the problem, particularly in Scenario 3. Finally, many participants expressed reluctance to disclose mental health issues, especially in the scenario involving substance abuse, where stigma is more pronounced. This reluctance suggests that stigma remains a significant barrier to seeking care among youth.

Overall, the study highlights the need for improved mental health education, with a particular focus on destigmatizing mental illness and increasing awareness of co-occurring disorders like depression and substance abuse. Enhanced recognition and understanding of mental health conditions, especially among young people, are essential for fostering empathy, reducing stigma, and encouraging timely care.

This study has few limitations. The study relied on self-reported data that could give rise to a potential bias in response where participants may have provided answer that they believe are socially acceptable rather than their true thoughts.

CONCLUSION

The study revealed notable differences in how the youth population (15-25 years) recognized and perceived depressive disorders across various scenarios. While many participants were able to identify depression with suicidal ideation, fewer recognized depression on its own, and an even smaller group was able to identify depression linked with substance abuse. Educational background, family type, socio-economic status, and association with medical personnel were significant factors influencing recognition. However, the prevailing attitudes indicated a lack of mental health literacy and stigmatization of mental disorders, particularly towards depression involving substance abuse. Many participants perceived mental health conditions as personal weakness or not real medical illnesses. These findings stress the need for targeted mental health education to enhance awareness, reduce stigma, and encourage early help-seeking behaviour.

Recommendations

Based on the study findings, it is recommended to implement comprehensive mental health education programs targeting youth to improve the recognition and understanding of depressive disorders. These programs should focus on destigmatizing mental health issues, particularly addressing misconceptions such as viewing depression as a personal weakness or not a real medical illness. Special attention should be given to depression with substance abuse, which had the lowest recognition rates and the highest stigma. Integrating mental health literacy into school and community curriculums can raise awareness and promote empathy, especially among those without medical personnel in their social circles. Additionally, promotion of youth icons to speak-up on mental health issues via personal story telling and encouraging open discussions about mental health within families, especially in nuclear households, and increasing access to mental health services in lower socio-economic groups would be crucial steps toward reducing barriers to help-seeking behaviour among youth.

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