Mental Health & Prevention 11 (2018) 47–53

Contents lists available at ScienceDirect

Mental Health & Prevention

journal homepage: www.elsevier.com/locate/mhp

A brief school based, awareness program for depression and suicidal behaviours in Indian youth

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ARTICLE INFO

Keywords:
Awareness program
Depression
School going youth
Suicidal behaviours

ABSTRACT

Background: There is a significant gap with respect to the prevalence of depression, suicidal ideation and help seeking among youth in India. In this background, the current study attempts to examine the effect of a brief universal school based awareness program in reducing depression and suicidal behaviours among youth in schools.
Method: Stratified random sampling was used to select educational institutions. The intervention adopted a single group pre and post assessment design. Youth studying in 8 to 12 grades from public and private institutions were included (8–10 grades, n = 168; 11 and 12, n = 205). The tools used were: Demographic Data Sheet, Scale for Suicidal Behaviours, Beck Depression Inventory-II, and Suicide Probability Scale. Classroom based two session interventions were carried out in group format in the selected classes of 7 institutions. Descriptive statistics, RMANOVA, chi square test, 't' and Mann whitney U tests were used to analyse the data.
Results: There was a significant reduction in depression, suicidal ideas and attempts, and suicidal probability scores. However, there was no change in the severity category for both depression and suicidal probability. Older youth showed better improvement on depression and suicidal ideation compared to their younger counterparts. Females showed better improvement on depression, suicidal ideation, hostility and suicidal probability compared to males. Significant improvement was seen for youth having higher scores on depression.
Conclusion: The study provides preliminary evidence for usefulness of a brief school based awareness program for depression and suicidality, a common mental health problem among adolescents in India.

1. Introduction

Prevalence of depression increases dramatically during adolescence (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Saluja et al., 2004). Life time prevalence of depression in adolescents in India is 12.1%–15.1%; mild depression—19–40%, moderate to severe depression—12–30%, and subclinical depression—18% (Gupta & Basak, 2013; Mohanraj & Subbaiah, 2010; Singhal, Manjula, & Vijaysagar, 2016). Depression has a significant adverse impact on school performance, family relations, socialization, and increases vulnerability to future depressive episodes, substance abuse, suicide, psychosocial impairment and antisocial behaviours (Birmaher et al., 1996; Frojd et al., 2008; Glied & Pine, 2002). Depression is often associated with suicidal ideation and attempts. Severity of depression and hopelessness are found to significantly contribute to suicidal attempts (Ang & Huan, 2006; Fordwood, Asarnow, Huizar, & Reise, 2007; Sanjeev, Sharma, Kabra, Shalini, & Dogra, 2004; Spirito, Valeri, Boergers, & Donaldson, 2003).

Suicide is a leading cause of death among youth in India accounting for about a quarter of all deaths in males and 50–75% deaths in females aged 10–19 years (Aaron et al., 2004). Female gender and older adolescents are found to be at higher risk (Das et al., 2008; Sarkar, Sattar, Gode, & Basannar, 2006). Life time suicidal ideation and attempt is found to be 21.7% and 9% in adolescents and 15% and 9% in young adults (Sidhartha & Jena, 2006; Singh, Manjula, & Philip, 2012).

There is significant gap between prevalence of depression and help seeking among youth in India. Reasons include lack of knowledge of mental illness and availability of help, not considering it as a medical illness, and stigma of help seeking (Dev, Gupta, Sharma, & Chadda, 2017; Ogorchukwu, Sekaran, Nair, & Ashok, 2016). However, most adolescents reported willingness to participate in an intervention program if carried out in the school set up and in group format (Singhal, Manjula, & Vijaysagar, 2014)

Preventive interventions for depression are largely carried out in

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https://doi.org/10.1016/j.mhp.2018.07.001
Received 30 April 2017; Received in revised form 16 April 2018; Accepted 9 July 2018
Available online 10 July 2018
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school set up as they address the issues such as feasibility; stigma of help seeking for psychological problems; perceptions about mental health professionals; access to help, and familiarity of set up (Manassis et al., 2010; McGorry, Purcell, & Hickie, 2007). Though universal preventive interventions are known for their small effect sizes, acceptance of these programs are better and even the small immediate change is considered a bigger contribution towards prevention (Corrieri et al., 2013). Brief universal intervention addressing social skills and peer support carried out in Japan reduced the depressive symptoms compared to control group and the gains were maintained up to 2–3 years (Sato, Shin-ichi, Togasaki, Ogata, & Sato, 2013). Similarly, Interpersonal Psychotherapy-Adolescent Skills Training (Young & Mufson, 2003), Beyond Blue Program in Australia (Sawyer et al., 2010) were effective in reducing depressive symptoms. However, the effect sizes of most of these programs continue to be small at later follow-ups (Rivet-Duval, Heriot, & Hunt, 2011). Review of the depression prevention interventions in adolescents showed that cognitive–behavioural universal prevention interventions were found to be effective in decreasing depressive symptomatology (Carnevale, 2013). A large Cochrane data base systematic review on effectiveness of educational interventions in prevention of depression found that the risk of depressive disorder reduced immediately after the intervention and in some studies the gains were maintained up to 12 months (Merry et al., 2011).

Universal suicide prevention interventions aiming at increasing knowledge, gatekeeper training, stigma reduction and enhancing help seeking are found to be efficacious (Aseltine, James, Schilling, & Glavovski, 2007; Bridge, Hanssens, & Santhanam, 2007; Kataoka, Stein, Nadeem, & Wong, 2007). These interventions led to reduction in suicidal attempts, depressive symptoms and increase in help seeking behaviours. Similarly, `Life lines' a comprehensive school wide suicide prevention program for middle and high school students (Underwood & Kalafat, 2009), `Kognito' for at risk college students (18–25 years old youth) (Albright, Goldman, & Shockley, 2013) implemented across countries resulted in improved knowledge and perceptions about depression, suicides and knowledge of suicide prevention resources. Systematic review of school based suicide prevention interventions found that most studies aimed at improving the knowledge and attitude of students and staff towards suicide. However, there is limited evidence so far on the effectiveness of the available interventions for preventing suicides in youth (Hawton, Saunders & O'Connor, 2012). While only few programs found to reduce suicide attempts, several other programs were found to reduce suicidal ideation, improve general life skills, and change gatekeeper behaviours (Cara et al., 2013). In the Indian context one school based indicated intervention in adolescents with sub clinical depression showed reduction in depressive symptoms, negative cognitions, academic stress and social problem solving at post assessment (Singhal et al., 2014).

Thus the literature on preventive interventions carried out at schools indicates that they were effective in addressing depression, suicidality and also issues of help seeking. Though there are a few studies conducted in the Indian setting looking at the prevalence and risk, there have been limited attempts at interventions for the same. The present study aims to examine the effect of a universal, school based brief awareness program in reducing depressive symptoms, and suicidal behaviours among youth in schools and Pre University Colleges (PUC) and also attempts to examine the differences between school and college sample, and males and females in response to brief intervention. A brief program was planned keeping the practical difficulties of getting time for such interventions in school settings in India. Availability of school counsellors is not uniform across public and private schools in India, thus for the current study schools without counsellors were chosen.

2. Material and methods

2.1. Participants

The sample for the present study (intervention study) is drawn from a larger study which involved two phases: Exploratory and intervention phases. Stratified random sampling was used to select public and private schools in South Bengaluru (1, 2, 3). Out of the list ($N = 768$), 24 schools and colleges were contacted and 7 schools (8–10th grades) and 10 Pre-University colleges (11th and 12th Grades) gave permission to carry out the study. All those adolescents who could speak and read English or Local Language Kannada were included into the study. The exploratory study was carried with a sample of 1428. Among the schools and colleges chosen for exploratory study, those who gave permission to carry out intervention were selected for the intervention study (purposive sampling). Sample in the intervention phase were from 3 schools and 4 PU colleges. The study adopted a single group pre and post assessment design. The classes from these institutions were selected randomly to represent 8–12 grades. The total sample which underwent intervention was 424, where as the sample available for post assessment was 379 (college sample = 205; School sample = 168).

Mean age of the sample ($N = 379$) was 15.35 years. Mean age of the school sample was 14 years and that of college sample was 16.5 years. Sample belonged to lower middle class, nuclear (88%) and intact families (86%). Females (54%) were more in number compared to males (46%). There was no difference between the school and college sample in gender distribution, family composition and socioeconomic status.

2.2. Measures

The demographic details of the participants were obtained using a socio-demographic data sheet.

1. Scale for stress, coping and suicidal behaviours: A scale was prepared and validated (content validity) to assess the areas of stress, coping, and suicidal behaviours among the youth. The tool aimed at introducing the topic of suicidal behaviour in a graduated manner as a part of coping. The steps involved in the development of the tool are as follows: 1. Generation of items by review of literature and the available tools 2. Checking for repetitions, categorising the items and answer options 3. Administration of the tool on 200 adolescents from 8–12th grades from public and private schools 4. Finalising the items based on applicability and frequency of response for a particular item. The items on stress and coping included identifying areas of stress, methods used to cope and extent of success in coping in various areas. For the current paper only information on suicidal behaviours sub domain is considered. The items assessed suicidal ideation, intension, plans, method of attempts, reasons for attempts, whether it was shared with anybody, attitude toward help seeking and sources considered for seeking help. The answer options included yes or no, multiple options and open ended questions.
2. Beck depression inventory-II is a 21 item, 4-point rating scale used to assess depression in individuals aged 13 and over and is composed of items relating to depression symptoms, cognitions as well as physical symptoms. The scores range from 0 to 63; scores 0–13 indicates minimal depression, 14–19 mild depression, 20–28 - moderate depression and 29–63 - severe depression (Beck, Steer, & Brown, 1996).
3. Suicide probability scale (SPS) is a 36-item self-report measure, responded on a 4-point scale, designed as a screening instrument to assess suicide risk in individuals aged 14 and older. Items of the SPS assess four areas: hopelessness, suicidal ideation, negative self-evaluation, and hostility. There are three summary scores: A Suicide Probability Score, a total weighted score and a normalized T-score (Cull & Gill, 1988). Suicidal risk is determined according to T-score range. The risk categories are as follows: 0–24 subclinical, 25–49

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