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Depression, Anxiety in Indian Adolescents and their Treatment-seeking Attitudes

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UNICEF claims that India is home to 25.3 crore adolescents: the largest adolescent population in the world, comprising nearly 21% of the total Indian population. The rates of Depressive Disorders and Anxiety Disorders in adolescents, are 14.5% [1] and 24.9% [2] respectively, with minimal variation from rural to urban populations [1].

Psychosocial hindrance is a commonly observed phenomena in the course of adolescence, which usually being transient, is often overlooked as a part of their growing process. Now, when symptoms of depression and anxiety manifest, they are swept under the rug, with the presumption of being fleeting and eventual waning with age. Sometimes, they are even regarded as stubborn and intentionally troublesome behaviour, leading to undue punishment and rebuke of these adolescents. This may precipitate in them a sense of inferiority, inadequacy, subsumed identity, and stifled creativity. Ericson's fifth stage of Identity versus Role Confusion is at work during the stage of adolescence, and improper resolution of conflicts in this stage results in the adolescent being unable to formulate in itself a sense of identity [1,3].

Maximum number of cases of anxiety and depression have been noticed in those who belong to lower socioeconomic strata, irrespective of rural or urban backgrounds. Poorer children have three times higher risk of depressive disorder, than their financially sound counterparts [1]. Various studies support the role of poverty and socioeconomic deprivation as potent risk factors to development of Depressive Disorders. Depression is often called an indicator of societal inequalities. Adolescents hailing from rural areas have been observed to face definite hardships in acquiring appropriate medical attention for their symptoms, as compared to those hailing from urban areas. This can be attributed to scantily distributed mental health resources, lack of awareness and understanding of depressive and anxiety symptoms of adolescents and fearing the ill consequences of association with a psychiatric disorder. Unfortunately, some studies also suggest that when adolescents do seek treatment, many a times health-care workers (HCWs) themselves fail to recognise the symptoms for what they are [4].

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Adolescents who are females are more vulnerable to development of anxiety and depressive disorders than their male counterparts [1]. This can be attributed to the social disparity endured by women in India, particularly exacerbated by abuse, poverty, unequal distribution of opportunities, child trafficking, and the exercising of inhibitory gender roles [3]. Most adolescents acknowledge friends and peers as the primary source of help when distressed with symptoms of depression and anxiety. Parents and teachers feature after friends, followed by other relatives, neighbours, self-help ventures, and non-governmental organisations. Mental health professionals barely make it to the list of ready-reckoners for these adolescents, if at all. Friends being immature themselves, are unable to provide the correct guidance, and may lead these adolescents further astray [3].

Overall, Indians harbour a negative perception for psychiatric illnesses as well as psychiatrists, unanimously across rural and urban establishments [5]. The stigma associated with mental illnesses is a colossal obstacle to the road of recovery and rehabilitation from a mental illness [6]. Parents and caregivers, largely dismissive of psychiatric illnesses, are seen to more happily resort to traditional and religious interventions for their children, than seek medical attention. The negative opinions for psychiatric illness and psychiatrists that they hold, percolate generationally to their children. The side-effects of psychiatric medications are observed in glaring spotlight, while the benefits are left looming in the darkness [5]. Worries about dependency, lethargy, oversedation, weight gain, however invalid, are held superior over the remissions of distress produced by the medicines. General practitioners are preferably consulted to a mental health practitioner, in their quest to alleviate the negative branding associated with visiting a psychiatrist, until absolute dire situations arise [5,7].

Bridging the treatment gap is a critical step which needs to be undertaken. The underutilisation of mental health services poses an important area of redressal. Simultaneously, the scarcity in availability of mental health services in rural areas can not be overlooked [6]. Stigmatisation of mental illnesses can be nipped in the bud if interventions are made at the levels of schools and colleges to increase awareness of mental health [3]. Depressive and anxiety symptoms should be explained by teachers and school counsellors and help-seeking attitudes should be encouraged [8]. Ongoing mental health literacy programmes in schools have shown promising results. The literacy initiatives should also be extended to parents and caregivers, for further effectiveness [9]. Educational institutions and HCWs should encourage active involvement of parents and caregivers in the lives of their adolescents, in order to ensure their holistic development, on not only educational and societal, but also mental and psychological fronts [10].

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