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A STUDY ON ASSESSMENT OF KNOWLEDGE REGARDING CAUSES AND EARLY SYMPTOMS OF DEPRESSION AMONG RURAL WOMEN IN A SELECTED COMMUNITY AT SRI GANGANAGAR

Kaushalya [1], Dr. Jyoti Arora [2]

[1] Ph.D. Nursing Scholar, Tantia University, Sri Ganganagar, India
[2] Professor, Tantia University Sri Ganganagar, India

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ABSTRACT

Introduction: Depression is a leading global mental health concern and a major contributor to disability worldwide. Women, particularly in rural areas, are disproportionately affected due to various socio-economic and psychosocial factors. In India, limited mental health literacy, stigma, and lack of access to services contribute significantly to undiagnosed and untreated depression among rural women. This study was conducted to assess the knowledge of rural women regarding the causes and early symptoms of depression in a selected community at Sri Ganganagar. Methodology: A quantitative research approach with a descriptive survey design was adopted. The study was conducted in Netewala Sri Ganganagar. A sample of 100 women aged between 35 to 60 years was selected using a purposive sampling technique. Data were collected through a structured interview schedule comprising two sections: socio-demographic profile and knowledge-based questions on causes and early symptoms of depression. The tool's reliability was established using the split-half method with a reliability coefficient of 0.82. Results: The findings revealed that 55.04% of respondents had knowledge of symptoms, while 48.48% had knowledge of causes. In terms of overall knowledge, 56% had poor knowledge, 31% had good knowledge, and only 13% had excellent knowledge. Awareness about depression was reported by 29% of respondents, with mass media (24%) being the most common source of information. A statistically significant association was found between knowledge level and variables such as age, education, income, occupation, and awareness source. Conclusion: The study highlights a considerable gap in mental health literacy among rural women. Focused educational initiatives and integration of mental health awareness into rural health programs are crucial to empower women with timely recognition and help-seeking behavior.

Keywords: Depression, Rural Women, Knowledge, Early Symptoms, Mental Health Awareness

1. INTRODUCTION

Depression is a prevalent and debilitating mental health disorder that significantly impacts individuals' thoughts, emotions, and daily functioning. Globally, approximately 280 million people are affected by depression, making it a leading cause of disability worldwide.[1] The World Health Organization (WHO) projects that depression will become the leading contributor to the global disease burden by 2030.[2] In India, depression poses a substantial public health challenge, with notable disparities between urban and rural populations. Recent studies indicate that rural individuals are 1.57 times more likely to experience depression compared to their urban counterparts, highlighting significant rural-urban disparities.[3] Furthermore, research conducted in rural South India revealed that approximately one in six adult women suffer from depression, underscoring the heightened vulnerability of rural women to this condition.[4]

Several factors contribute to the increased prevalence of depression among rural women, including socioeconomic disadvantages, limited access to healthcare services, and traditional gender roles that impose substantial caregiving

responsibilities.[5] Additionally, rural women often face barriers such as stigma and lack of awareness, which hinder the recognition and treatment of mental health issues.[6] The COVID-19 pandemic has further exacerbated mental health challenges globally, leading to a 27.6% increase in cases of major depressive disorder in 2020. This surge emphasizes the urgent need for targeted mental health interventions, particularly in vulnerable rural communities.[7]

Assessing the knowledge of rural women regarding the causes and early symptoms of depression is crucial for developing effective public health strategies. Enhanced awareness can facilitate early detection, reduce stigma, and promote timely access to care, ultimately improving mental health outcomes in these communities.

1.1. NEED OF THE STUDY

Globally, the World Health Organization (WHO) estimates that over 350 million people suffer from depression, making it one of the leading causes of disability worldwide.[8] Notably, women are nearly twice as likely as men to be affected by depression, due to a complex interplay of biological, psychological, and social factors.[9]

In India, the situation is particularly concerning among rural women who face a disproportionate burden of depression. A community-based study conducted in rural Puducherry revealed that 15% of women aged 18–59 exhibited depressive symptoms, with contributing factors including low education levels, separation from spouse, and limited access to mental health resources. These findings highlight the importance of contextual and culturally sensitive mental health strategies for underserved populations.[10]

Rural women are uniquely vulnerable due to socioeconomic constraints, traditional gender roles, social isolation, and limited access to mental health services. Domestic violence, lack of social support, and caregiving burdens further increase their susceptibility to mental illness. Despite the growing prevalence, depression among rural women is frequently underdiagnosed and undertreated due to stigma, lack of awareness, and absence of trained healthcare professionals in rural areas.[11]

Given this backdrop, there is a compelling need to assess the knowledge of rural women regarding the causes and early symptoms of depression. Improved awareness can lead to early identification, timely interventions, reduced stigma, and better mental health outcomes.[12] Educating women at the grassroots level is not only essential for their individual well-being but also crucial for enhancing the health of their families and communities. This study aims to address this gap by exploring knowledge levels and promoting mental health literacy among rural women.[13]

1.2. AIM OF THE STUDY

To assess the knowledge regarding the causes and early symptoms of depression among rural women in a selected community at Sri Ganganagar.

2. METHODOLOGY

2.1. RESEARCH APPROACH

A quantitative research approach was adopted for the present study to assess the knowledge regarding causes and early symptoms of depression among rural women in a selected community at Sri Ganganagar.

2.2. RESEARCH DESIGN

The study utilized a descriptive survey design to collect data systematically from a sample of rural women and analyze their level of knowledge concerning depression.

2.3. OBJECTIVES OF THE STUDY

1) To study the existing level of knowledge of women in rural areas regarding the causes and early symptoms of depression in a selected community at Sri Ganganagar.
2) To find out the association between the level of knowledge and selected socio-demographic variables regarding causes and early symptoms of depression among rural women.

3) To develop an information booklet on causes and early symptoms of depression.

2.4. RESEARCH VARIABLE

The research variable in this study is the knowledge regarding causes and early symptoms of depression.

2.5. SETTING OF THE STUDY

The study was conducted at Netewala Sri Ganganagar.

2.6. POPULATION AND SAMPLE

The target population consisted of women aged between 35 to 60 years residing in Netewala Sri Ganganagar. A sample size of 100 women was selected based on inclusion criteria.

2.7. SAMPLING TECHNIQUE

A purposive sampling technique was employed to select participants who fulfilled the eligibility criteria.

2.8. SAMPLING CRITERIA

1) Inclusion Criteria

- Women aged between 35–60 years living in the rural area.
- Women who can understand Hindi or English.
- Women who are willing to participate in the study.

2) Exclusion Criteria

- Women who were not available at the time of data collection.

2.9. DEVELOPMENT OF THE TOOL

The tool used for data collection was a structured interview questionnaire, which included two sections:

Section I – Demographic Profile

This section consisted of 10 items related to the socio-demographic characteristics of the participants, including age, education, occupation, income, religion, marital status, type of family, family history of depression, exposure to information about depression, and the source of information (if any).

Section II – Structured Knowledge Questionnaire

This section comprised 50 “Yes” or “No” type questions related to causes and early symptoms of depression. The items were categorized under:

- Part A: Causes of depression
- Part B: Early symptoms of depression

2.10. RELIABILITY OF THE TOOL

To establish the reliability of the tool, the split-half method was used, and the data was analyzed using the Spearman-Brown Prophecy formula through the test-retest method. The reliability coefficient obtained was 0.82, indicating a high level of consistency and reliability of the instrument for the present study.

3. RESULT

3.1. DESCRIPTION OF THE DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

The present study included 100 rural women aged between 35 to 60 years residing in Netewala Sri Ganganagar. The demographic data were collected using a structured interview schedule and are described as follows:

1) Age Distribution

The majority of the respondents (33%) belonged to the age group of 51–55 years, followed by 27% in the 35–40 years group, 20% in the 46–50 years group, and 18% in the 41–45 years group. A minimal 2% of respondents were in the 56–60 years age group.

2) Educational Qualification

Most of the respondents (36%) had studied up to Pre-University level, followed by 26% who had completed high school, 23% with primary education, and 15% who were degree holders.

3) Occupational Status

Among the respondents, 28% were private employees, 26% were involved in daily wage labor, 25% were homemakers, 12% were government employees, and 6% were engaged in self-employment. Only 3% were identified as farmers.

4) Monthly Family Income

Over half of the respondents (51%) reported a monthly family income of less than ₹5,000, while 12% earned ₹5,001–₹10,000, 26% had income between ₹10,001–₹15,000, and 11% earned ₹15,001–₹20,000.

5) Marital Status

A significant majority (84%) of the respondents were married, 12% were widowed, and only 4% were unmarried.

6) Type of Family

About 54% of the respondents were living in joint families, while 46% resided in nuclear families.

7) History of Depression in the Family

The vast majority (91%) of respondents reported no history of depression in the family, whereas only 9% acknowledged a family history of depression.

8) Source of Information Regarding Depression

Among respondents aware of depression (29%), the primary source of information was mass media (24%), followed by health professionals (4%) and relatives (1%).

3.2. OVERALL AND ASPECT WISE KNOWLEDGE OF THE RESPONDENTS

- **Aspect wise Assessment of Mean, S.D and mean% score for the knowledge level**

Table 1 Aspect Wise Assessment of Mean, S.D and Mean% Score for the Knowledge Level

N=100

SL. NO	Area wise	No. of items	Mean	S. D	Mean%
1	Causes	25	12.120	4.4501	48.48
2	Symptoms	25	13.760	4.5905	55.04
3	Overall, Knowledge	50	25.880	8.4987	51.76

The majority of the respondents (55.04%) were having knowledge on symptoms of depression followed by (48.48%) of the respondents had knowledge on causes of depression.

- **Distribution of subjects according to level of knowledge**

Figure 1 denotes level of knowledge among rural women regarding causes and early symptoms of depression. Out of 100 subjects 56% had poor knowledge, 31% had good knowledge and 13% had excellent knowledge.

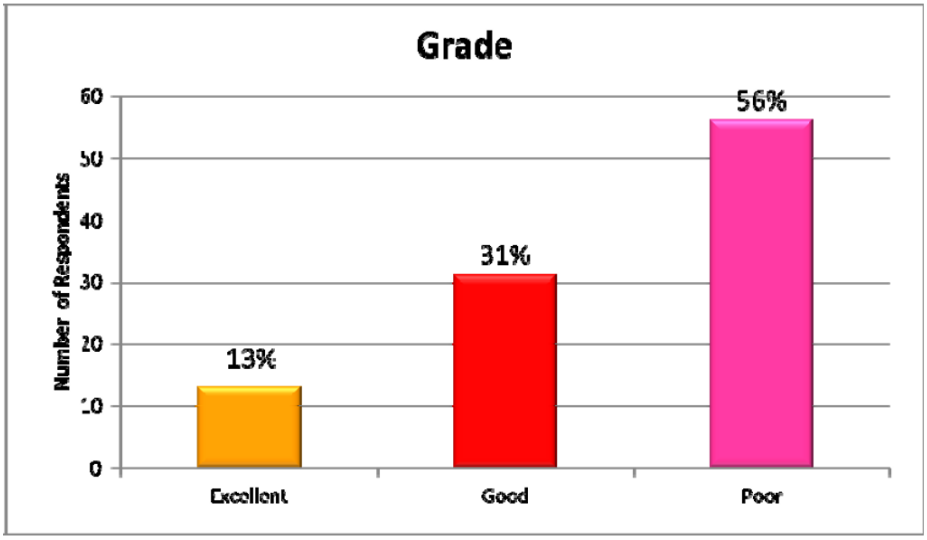

Figure 1 Distribution of Subjects According to Level of Knowledge**.**

- **Association Between Demographic Variables and Knowledge Level of Respondents**

In the present study, the association between the respondents' demographic variables and their level of knowledge regarding the causes and early symptoms of depression was analyzed using appropriate statistical tests.

The results indicated a significant association between the level of knowledge and selected socio-demographic variables such as: Age, Education, Occupation, Monthly Family Income

These findings suggest that respondents with higher educational backgrounds, certain age brackets, specific occupational categories, and better income levels demonstrated a relatively higher knowledge regarding depression. This may be attributed to their increased exposure to information and better access to educational or healthcare resources.

On the other hand, variables like religion, marital status, type of family, and history of depression in the family did not show a statistically significant association with knowledge levels. This indicates that these factors might not play a direct role in influencing awareness levels related to depression in this population.

However, the study found a statistically significant association between knowledge level and:

Awareness/Information about depression

Source of information (mass media, health professionals, relatives, etc.)

These findings reinforce the importance of effective information dissemination strategies. Respondents who had prior exposure to mental health education—particularly through mass media or professional sources—demonstrated better understanding of the causes and early symptoms of depression.

4. DISCUSSION

The current study revealed that rural women had a mean knowledge score of 55.04% on symptoms of depression and 48.48% on its causes. This suggests that participants were slightly more aware of how depression manifests than of its underlying causes. This trend is consistent with findings from a study conducted in Tamil Nadu, which found that knowledge of symptoms was significantly higher than knowledge of causes among rural women, emphasizing the need for cause-based health education.[14]

In the present study, 56% of respondents had poor knowledge, while only 13% demonstrated excellent knowledge. This is closely aligned with the results of a study in Gonda, Uttar Pradesh, where 62% of rural women were found to have poor knowledge and only 18% had good knowledge of depression.[15]

The awareness level in the current study was low, with only 29% reporting any prior knowledge about depression. This is in line with findings from a rural community study in Maharashtra, where just 25% of women reported having heard of depression, and even fewer could correctly identify early symptoms.[16]

Regarding sources of information, the study showed that mass media (24%) was the most common source, while only 4% were informed by health professionals. These findings are echoed in a Puducherry-based study by Selvaraj et al. (2020), which found that mass media was the primary source of mental health knowledge in rural areas, while health professional contact remained minimal.[10]

These comparative studies reinforce the conclusion that rural women in India generally have low mental health literacy, with a preference for informal information channels like TV and radio. The consistent pattern across multiple studies highlights the urgent need for structured educational interventions, preferably delivered through both mass communication and primary healthcare systems, to improve awareness of depression's causes and early symptoms.

5. CONCLUSION

Depression remains a significant public health concern, particularly among women in rural communities where access to mental health education and services is limited. Despite being a treatable condition, depression often goes unrecognized and untreated due to poor awareness, stigma, and lack of resources. Rural women, in particular, face compounded challenges due to their socioeconomic vulnerabilities, caregiving responsibilities, and cultural norms that often discourage open discussions about mental health.

This study emphasizes the importance of understanding mental health literacy among rural women, especially concerning the causes and early symptoms of depression. Addressing the knowledge gap through targeted educational strategies can contribute to early identification, timely intervention, and reduced burden of disease. Health professionals, educators, and community workers play a crucial role in promoting awareness at the grassroots level.

Furthermore, integrating mental health education into primary healthcare and community outreach programs can help reduce stigma and empower women to seek timely care. Strengthening health communication through mass media, as well as involving family members and local support systems, can also enhance the effectiveness of mental health awareness efforts. Overall, improving mental health literacy among rural women is essential for building healthier communities and promoting emotional well-being.

CONFLICT OF INTERESTS

The authors certify that they have no involvement in any organization or entity with any financial or non-financial interest in the subject matter or materials discussed in this paper.

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