Prevalence and Pattern of Depression among the Hadi of Kedarpalli, Bhubaneswar, Odisha

SWAGATIKA SAHOO* AND PRASANNA KUMAR PATRA**

Abstract: Depression is a prevalent form of mental illness. It is a primary cause of disability worldwide and has contributed significantly to the global health burden. Depression's consequences can be lengthy or recurrent, affecting a person's capacity to function and live a fulfilling life. The purpose of this study is to investigate the prevalence of depression among adults in the Hadi community, a Scheduled Caste group in Bhubaneswar, Odisha, by using the Beck Depression Inventory-II. The primary data was gathered from 322 respondents via a structured interview schedule during fieldwork. According to the results of the study, 24.2% of the individuals suffered from mild depression, 27.3% from minimal depression, 28.3% from moderate depression, and 20.2% from severe depression. As per the findings, elderly people, women, the uneducated, people who live in nuclear families, and people whose family members use addictive substances such as Alcohol, Guthka, Pana, and other substances are subjected to a higher rates of depression.

Keywords: Bhubaneswar, Depression, Hadi, Mental health, Scheduled Caste

Introduction

Depressive disorders are characterised by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feeling of tiredness, and poor concentration. Depression can be long lasting or recurrent, substantially impairing an individual's ability to function at work or school or cope with daily life (World Health Organisation, 2017). Mental disorder is

---

* Research Scholar (OURIIP Fellow), PG Department of Anthropology, Utkal University; *E-mail: sgauri8888@gmail.com* (Corresponding author)
** Associate Professor, PG Department of Anthropology, Utkal University; *E-mail: pkpatra@rediffmail.com*

responsible for 12% of the world's disease burden (World Health Organisation, 2017). Depression is a common mental health disorder worldwide, followed by anxiety and schizophrenia, as per the global burden of disease analysis (Whiteford et al., 2013). Due to persistent social stigmas mental illness is often underreported and lacks to obtain medical help and care. Mild anxieties to severe kinds of behavioural disorders are all instances of psychological disorders (Sahithya & Reddy, 2018). According to assumptions of the global burden of disease study, depression will become the second leading risk factor by 2020 (Bohra et al., 2015). Depression is one of the leading causes of disease burden globally and in low-and-middle-income countries. In 2015, depression was the leading source of non-fatal health loss in the world, accounting for 7.5% of the world years lived with disability and 2.0% of the world's disability-adjusted life years (WHO, 2017).

By 2030, depression is expected to be the second leading cause of burden globally, and the third leading cause in Low-and-Middle income countries (Mathers & Loncar, 2006). The worldwide prevalence of depression is reported to be 4.4%. It is more common in women (5.1% vs. 3.6% in men), with a spike in both genders in the 55-74 year age group (WHO, 2017). The number of individuals with depression increased by 18.4% globally between 2005 and 2015 (Global Burden of Disease Study, 2015). Several things contribute to this rising burden, such as high lifetime prevalence (6.5%-21%), growing mental impairment linked to depression (Ustun et al., 2004; Kessler & Bromet, 2013), growing populations and aging, growing recognition across the lifespan, association with chronic illness, suicides, as well as socio-cultural and economic changes (Ferrari et al., 2013).

Depression affects approximately 57 million (18% of the Global estimate) Indians (WHO, 2017). As per the Global Burden of Diseases, 2017 report, 45.7 million Indians suffered from depression; particularly women suffered more than males (Sager et al., 2020). Females (3%), those over the age of 40 (3.5%), and those who dwelled in urban centers (5.2%) were more susceptible to be depressed (Arvind et al., 2019). According to several studies (Kishore et al., 1996; Ferrari et al., 2010; Rao et al., 2014; Behera et al, 2016; Charlson et al., 2016; Mathias et al., 2015; Shidhaye, Gangale, & Patel, 2016), the frequency of depression in India stretched from 1.8% to 39.6%, depending on the research methodology. Many social, economic, cultural, and psychological challenges, mainly altered living patterns along with a lack of support structures in an era of globalisation, urbanisation, and migration, are consistently related to depression in young and middle-aged individuals (WHO, 2017).

Scheduled Castes constitute 16.1% of India's population and 17.1% of Odisha's (Census, 2011). They are the other name for backward castes. They are known as *Dalit* and *Harijans*. The term "Scheduled Caste" was adopted during the drafting of the Indian Constitution, where it has been defined under the Article 341 which explains it as "such castes, races or tribes as are deemed to be Scheduled Castes". The Scheduled Castes are at the base of the socioeconomic hierarchy. They account for the majority of the oppressed and relate to those who were historically outside of the caste system. Scheduled Castes have historically been discriminated against by upper castes; they have never gained social acceptance from the majority of upper caste members. People from Scheduled caste work in jobs such as sweeping, scavenging, and tanning, as well as various minor jobs such as leather workers, weavers, fishermen, toddy tappers, basket makers, washer man and scavengers (Chanabasappa, 2000). Many states have low concentrations of *Dalit* population; many *Dalits* are landless, and initiatives to promote them by providing free land have failed (Raghavendra, 2020). Borooah's (2005) empirical analysis of caste inequalities and development in India found that at least one-third of the income generation gap between upper caste and SC/STs was related to the latter's uneven treatment.

According to a study conducted by Sundaram and Tendulkar (2003), the impoverished Scheduled Caste constituted the largest segment of the poor. Even though many steps have been intended to bring them up at par with others, their poor social status still persists. The Dalit community in India is the most persecuted, with a population of approximately 203 million. Discrimination affects broader health determinants like education, employment, income, and housing (Bailey, 2016). Discrimination, social marginalisation, violence, and crime against Dalits are all on the rise, which is 10-20% every year (Human Rights Watch, 2015). Discrimination (Assari, Watkins, & Caldwell, 2015; Matthews et al., 2013), social relationships (Kazi et al., 2006), lower income (Bogard et al., 2001; Eamon & Zuehl, 2001; Gyamfi, Brooks-Gunn & Jackson, 2001), unemployment (Zuelke et al., 2018) and domestic violence (Trevillion et al., 2012) have all been identified as contributing factors to depression in multiple studies.

In Vishakhapatnam, comparative research on anxiety and depression among adolescents from rural and urban areas revealed that anxiety and depression are more prevalent in urban areas than in rural areas (Prabha, Rao, & Kanakabushanam, 2017). In July 2014, a study was performed in Sahaspur and Raipur, administrative blocks of Dehradun district, Uttarakhand, to identify people with depression. It was discovered that people with depression were more likely to be illiterate, classified as Scheduled Caste/ Tribe or Other

Backward Classes, living in temporary material housing, and who had recently taken a loan. The findings demonstrated a clear link between depression in the general population and social, educational, and economic adversity (Mathias et al., 2015).

In India, untouchables are categorised under Scheduled Caste. Hadi community in Odisha is categorised under Scheduled Castes, who were untouchables. The Hadi in Odisha are engaged in occupations like sweeping jobs, drum beating, industrial work and daily wage labourers (Ota & Mohanty, 2015). The mental health problems particularly, depression in Hadi community, where the community was treated as low in the caste hierarchy was interesting to study. The purpose of this study was to look at the prevalence of depression among adults in the Hadi community, a Scheduled Caste group of Kedarpalli, Bhubaneswar, and to see how it related to socio-economic parameters using the Beck Depression Inventory-II scale.

Material and Methods

Area and People

The research field was chosen based on two factors: a) poorer socioeconomic indication and b) a Hadi-dominated area in Bhubaneswar. Ganjam, Khurdha, Cuttack, and Anugul are the most Hadi-populated districts in Odisha. Sweeping, drumming, industrial work, service, and daily wage are their primary occupation. Hadi's population in 2011 was 228712. Males made up 49.7% of the group, while females made up 50.25 % (Ota et al., 2015). Because the study was to be conducted in Bhubaneswar, Kedarpalli, a highly populated slum area where mostly Hadi people resided was chosen. Hadi is an endogamous community that is separated into exogamous gotra like Naga (Cobra), Benga (Frog), Meena (Fish), etc. Theirs is a Patrilocal, Patrilineal, and Nuclear family. The norm of male equigeniture governs the inheritance of paternal property. They practice adult marriage. Monogamy is the accepted norm. Negotiations are used to arrange marriage. Elopement, mutual consent, capture, intrusion, service, and exchange are the other methods of obtaining wives. Their civilisation permits cross-cousin marriage, junior levirate, junior sororate, and remarriage of widows, widowers, and divorcees (Ota et al., 2015).

Tools and Techniques

In February 2020, a cross-sectional study was done in Kedarpalli, a predominantly Hadi community region in Bhubaneswar, to investigate the

prevalence of depression and its link with socioeconomic variables among the adult population (> 18 years of age). The participants in the study were chosen based on their age as well as their informed consent. As a result, 322 people agreed to participate in the interview regarding their mental health. Personal interviews were conducted to gather the study's data. The interview was split into two parts: the first included basic socioeconomic and demographic data, whereas the second included depression-related questions.

The Beck Depression Inventory-II was adopted to collect data on depression, and it was translated into Odia. The BDI-II is a 21-item self-reporting questionnaire that evaluates the whole range of depression symptoms (Beck, Steer, & Brown, 1996). Studies done among the Juang, a Particularly Vulnerable Tribal Group (PVTG) from Odisha, also used BDI-II, as a screening tool to know the prevalence of depression among the community members (Panda et al., 2021). Studies done in community survey in Spain (Lasa et al., 2000) showed that BDI-II is a good instrument for screening depressive disorders in community surveys. As per Segal et al., (2008) BDI-II was used as a self-administered screening tool for depressive symptoms and it was examined in a sample of community dwelling older and younger adults. Participants completed BDI-II, from the Center for Epidemiologic Studies Depression Scale, the Coolidge Axis II Inventory, the Perceived Stress Scale, and the Short Psychological Well-Being Scale. Internal reliability of the BDI-II was found to be good among older and younger adults.

Responses to each of the 21 questions are graded on a scale of 0 to 3. Sadness, pessimism, past failure, loss of pleasure, guilty feelings, punishment feelings, self-dislike, self-criticism, suicidal thoughts, crying, agitation, lack of interest, indecisiveness, worthlessness, loss of energy, changes in sleeping patterns, irritability, changes in appetite, concentration difficulty, tiredness and fatigue and loss of interest in sex were among the 21 components included in the BDI-II. Minimal Depression (0-13), Mild Depression (14-19), Moderate depression (20-28), and Severe depression (29-63) are the four categories of depression severity identified by the BDI-II (Beck et al., 1996). SPSS-20 software was used to analyse the data. To show the prevalence of depression and its association with socio-economic parameters, only descriptive statistics and frequency tables were employed. The study was conducted by taking males and females of different age groups (<25 years, 26-9 years, > 40 years).

Findings

A. Socio-economic profile of the respondents: The Socioeconomic variables of the informants in the following research are mentioned in Table 1.1.

Table 1.1: Socio-economic Profile of the Respondents in the Study Area (N=321)

Socio-economic indicators	*Subgroups*	*N (%)*
Age Group	≤ 25 years	47 (14.6%)
	26-39	114 (35.5%)
	≥40 years	160 (49.9%)
Sex	Male	126(39.3%)
	Female	195 (55.5%)
Family type	Nuclear Family	138 (43%)
	Joint Family	183 (57%)
Family size	≤5 members	159 (49.5%)
	≥6 members	162 (50.5%)
Marital status	Married	279 (86.9%)
	Separated	11 (3.4%)
	Widow/Widower	31(9.7%)
Educational Status	Uneducated	62 (19.0%)
	1st-5th	111 (34.6%)
	6th-10th	140 (43.6%)
	Intermediate/Graduate	9 (2.8%)
Occupational Status	Pension	21 (6.5%)
	Housewife	83 (25.9%)
	Sweeper job	197 (61.4%)
	Unemployed	12 (3.7%)
	Other works	9 (2.5%)
Income Status	0	97 (30.2%)
	≤100000	168 (52.3%)
	≥100000	56 (17.4%)
Substance consumed by self	Guthka, Pana, Bhanga	121 (37.7%)
	Alcohol and others	98 (30.5%)
	Nothing	102 (31.8%)
Substance consumed by family members	Guthka, Pana, Bhanga	77 (24%)
	Alcohol and others	175 (54.2%)
	Nothing	70 (21.8%)

The participants in the study belonged to the age group from 18 to 75 years old and were differentiated into three (≤ 25 years, 26-39, ≥40 years) groups.

14.6% of the total responses were under the age of 25, 35.5% of the respondents were between 26-39 years and 49.9% of the respondents were between 40 years and above. There were 39.3% males and 55.5% females in the study. Most of the respondents were from joint families (57%), with only 43% from nuclear families. Above 49.5% of the participants lived in a small family of one to five members; while 50.5% lived in a family of more than six members. Among the respondents 86.9% were married, 3.4% were separated and 9.7 % belonged to the widow/widower category. About 34.6% had studied from 1st-5th grade, 43.6% had studied till 10th grade, 2.8 % had completed Intermediate/Graduate and 19.0 % were uneducated i.e. they had not received any formal education. Nearly 61.4% of the respondents did the sweeper's job. 6.5% and 25.9% and 3.7% of the respondents are the data for persons who got pensions, for housewives, and for the unemployed, respectively. 2.5% of the interviewers did other work. About 30.2% of the respondents did not have any earnings; the yearly income of 52.3% of the respondents was less than 100000 and 17.4% of the respondents' income was more than one lakh. 37.7% of the respondents consumed substances like Guthka, Pana, and Bhanga. 30.5% of the respondents consumed alcohol and other things and 31.8% of the respondents did not consume anything. 24% family members of the respondents consumed Guthka, Pana, 54.2% alcohol and other things, and 21.8% consumed nothing.

B. Prevalence of Depression among Hadi Population: The frequency of depression among the Hadi adult population is shown in the table 1.2, along with numerous social and economic aspects. In the study, 28.3% of the participants had moderate depression, 27.3% had minor depression, 24.2 % had mild depression, and 20.2% had severe depression. Minimal depression (53.2%) was common among those under the age of 25, 32.4% among those between 26-39, and 16.2% among those aged 40 and above. Adults between the ages of 26-39 reported mild depression (29.8%). Respondents aged 40 and above showed a higher rate of moderate (31.8%) and severe (30%) depression. Male members showed more minimal depression (42.8%) as compared to female members (16.9%). In contrast to male respondents, female respondents had more mild (25.6%), moderate (30.7%), and severe depression (25.6%). Respondents living in a joint family showed high minimal (28.4%) depression in comparison to the respondents living in a nuclear family (26%), while moderate (28%) and severe (21.7%) depression was high among the respondents living in the nuclear family.

Respondents living in a family having 6 or more family members had high moderate depression (29.6%). 30.8% of married persons reported minimal

depression and 25% of widows/widowers faced mild depression where a high prevalence of severe depression was found among the separated participants (70%). Minimal depression (39.2%) was more prevalent among the respondents who studied between 6th-10th standard. Individuals who studied Intermediate/ Graduate showed high range of moderate depression (44.4%) and no severe depression (0%). The prevalence of severe depression (47.5%) was high among uneducated respondents. In terms of occupation and depression, severe depression (47.3%) was higher among the individuals who got a pension. Mild depression was high among housewives and the prevalence of moderate depression (31.3%) was high among unemployed and individuals who did other work.

Based on yearly income, mild depression (30.9%) and moderate depression (28.8%) were high among the respondents who did not have any income. Minimal depression (32.5%) was high among individuals with a yearly income of less than one lakh. Severe depression (32.7%) was found higher among individuals whose annual income was more than one lakh. Minimal depression was found to be high (48.8%) among the respondents consuming alcohol and other substances, while moderate (34.7%) and severe (34.7%) depression was found to be high in respondents consuming Guthka, Pana, and Bhanga. Respondents whose family members consumed no addictive substances were found to have high minimal depression (39.1%), whereas respondents whose family members consumed alcohol and other substances reported high mild (30.2%) and severe (22.2%) depression. Participants whose family members consumed *Gutkha* (chewable tobacco)*, Pana* (beetle leaf), and *Bhanga* (locally available intoxicant leaf paste) showed moderate depression (32.4%).

Discussion

In the studied Hadi population, according to the BDI-II scale, moderate depression was found to be predominant and a very few were with severe depression. Previous research had also revealed that the frequency of moderate depression was higher in the general population (Aherne et al., 2017). Study done among the Juang, a Particularly Vulnerable Tribal Group (PVTG), also reported to have high rate of moderate depression, in comparison to other levels of depression. The older age group was shown to have a higher prevalence of moderate (31.7%) and severe (30.4%) depression than the younger and middle-aged groups in the current investigation. The WHO has highlighted chronic disease vulnerability, constraints on daily activities, personality features, and life issues such as separation, solitude, divorce, a lack of social support,

Table 1.2: Prevalence of Depression based on Socio-Economic Indicators

Socio-economic indicators		BDI Category								Total
		Minimal Depression (0-13)		Mild Depression (14-19)		Moderate Depression (20-28)		Severe Depression (29-63)		
		N	%	N	%	N	%	N	%	N
Age Group	≤25years	25	53.2	9	19.1	9	19.1	4	8.5	47
	26-39	37	32.4	34	29.8	31	27.2	12	10.5	114
	≥40 years	26	16.2	35	21.8	51	31.8	48	30	160
Sex	Male	54	42.8	27	21.4	30	23.8	15	11.9	126
	Female	33	16.9	50	25.6	60	30.7	52	26.6	195
Family Type	Nuclear	36	26	33	23.9	39	28.2	30	21.7	138
	Joint	52	28.4	44	24.0	51	28	35	19.1	183
Family Size	≤ 5	43	27	40	25.1	43	27	33	20.7	159
	≥ 6	45	27.8	38	23.4	48	29.6	31	19.1	162
Marital Status	Married	86	30.8	68	24.4	82	29.4	43	15.4	279
	Separated	1	10	1	10	1	10	7	70	10
	Widow/ Widower	1	3	8	25	8	25	15	46.9	32
Educational Status	Uneducated	3	4.9	13	21.3	16	26.2	29	47.5	61
	1st-5th	28	25.2	27	24.3	34	30.6	22	19.8	111
	6th-10th	55	39.2	34	24.2	37	26.4	14	10	140
	Intermediate/ Graduate	2	22.2	3	33.3	4	44.4	0	0	9
Occupational Status	Pension	2	10.5	3	15.7	5	26.3	9	47.3	19
	Housewife	20	24.0	26	31.3	23	27.7	14	16.8	83
	Sweeper Job	61	30.8	45	22.7	56	28.2	36	18.1	198
	Unemployed	1	8.3	3	25	4	33.3	4	33.3	12
	Other works	4	44.4	1	11.1	3	33.3	1	11.1	9
Income Status	0	22	22.6	30	30.9	28	28.8	17	17.5	97
	≤100000	55	32.5	38	22.4	47	27.8	29	17.1	169
	≥100000	11	20	10	18.1	16	29.0	18	32.7	55
Substance consumed by self	Guthka, Pana, Bhanga	12	9.9	25	20.7	42	34.7	42	34.7	121
	Alcohol and others	48	48.8	21	21.1	22	22.2	8	8.0	99
	Nothing	28	27.7	32	31.6	27	26.7	14	13.8	101
Substance consumed by family members	Guthka, Pana, Bhanga	25	32.4	12	15.5	25	32.4	15	19.4	77
	Alcohol and others	36	20.5	53	30.2	47	26.8	39	22.2	175
	Nothing	27	39.1	13	18.8	19	27.5	10	14.4	69

and physical health as factors contributing to the rise in depression among the elderly (WHO, 2001). According to studies conducted in Andhra Pradesh (Bodhare et al., 2013) and Tamil Nadu (Sinha, Shrivastava, & Ramasamy, 2013), the elderly population had a greater risk of depression with 44.7% and 57.3% respectively.

Table 1.3: Feeling of separation from family members of different age groups

Age groups	Do you feel separated from your family members		Total (%)
	N (%)	Y (%)	
<25	47 (14.6)	0 (0.0)	47 (14.6)
26-39	111 (34.6)	3 (0.9)	114 (35.5)
>40	58 (18.1)	102 (31.8)	160 (49.8)
Total	216 (67.3)	105 (32.7)	321 (100)

Table 1.3 explains that most of the participants above the age of 40 feel separated from their family members.

Case study 1: While inquiring about the family and marriage life, Mamata Nayak, a 50-year-old lady, said, "*At an early age, my spouse was from a different community, and we wed secretly, When my kids were little, he left me. After divorcing my spouse, I went back to my father's place. After some days, my father passed away. I currently share a home with my brother. Both of my daughters are married. Although my brother and his family are around, I am unable to express my loneliness to them. Why should I be constantly cared for by others? My girls don't come. No one is on my side; my spouse abandoned me; if he had been present, he would have taken care of me. Although I live with them still I feel separated from them.*"

Case Study 1 revealed that the absence of social bonds, such as being cut off from significant relationships, losing a parent, and not having close family ties, can make a person feel sad and lonely. It was also found that those who were in unhappy relationships generally maintained a negative self–perception and had a lower quality of life.

Table 1.4: Dependency on others according to age groups

Age groups	Dependent on Others		Total (%)
	Y (%)	N (%)	
<25	14 (4.4)	33 (10.3)	47 (14.6)
26-39	76 (23.7)	38 (11.8)	114 (35.5)
>40	138 (43.0)	22 (6.9)	160 (49.8)
Total	228 (71.0)	93 (29.0)	321 (100.0)

The above table shows that respondents above the age of 40 are more dependent on others in comparison to respondents in another age category.

Case study 2: I saw Indramani Nayak, a blind woman, 65 years old washing utensils and asked her if she was able to do all the work and if her family members did not stop her from doing household chores. She told me, "*I was born blind. My parents took care of me when they were alive, and once they passed away, my older brother became my guardian. I am taken care of by him and his family. However, no one can care for a disabled person like their parents can. Even though I share a home with my brother and his family, there are moments when I feel like I am a burden to them. I therefore occasionally try to complete household tasks like laundry, housecleaning, and other such tasks. My physical illness made me depend on others, for which I remain sad most of the time.*"

Case Study 2 demonstrated how dependency on others resulted from physical incapacity. As a result of this dependency, older adults were unable to contribute to their own lives as well as the lives of their family, friends, and neighbours. They were also unable to take part in the activities they once did or would have done. They felt like a burden to other people and this perception of themselves depressed them.

Table 1.5: Satisfaction of participants about their health.

Age groups	How satisfied are you with your health				Total (%)
	Very dissatisfied (%)	Dissatisfied (%)	Neither satisfied nor dissatisfied (%)	Satisfied (%)	
<25	0 (0.0)	1 (0.3)	26 (8.1)	20 (6.2)	47 (14.6)
26-39	1 (0.3)	7 (2.2)	80 (24.9)	26 (8.1)	114 (35.5)
>40	5 (1.6)	73 (22.7)	79 (24.6)	3 (0.9)	160 (49.8)
Total	6 (1.9)	81 (25.2)	185 (57.6)	49 (15.3)	321 (100.0)

From above table 1.5, it was found that persons above the age of 40 reported their health. Most of the persons above the age group 40 showed that they were dissatisfied and very dissatisfied with their health condition.

Case study-3: While answering many queries about her physical condition and about her family members, a woman named Shanti Dei, who was 50 years old, said, "*My husband is no longer with us. I and my son are the only two economically active in our home. My son, however, is currently sick and unable to work because of this. I suffered from a knee injury yesterday and won't be able to perform my duties for the next two days* (sweeping job under B.M.C Jagruti). *In addition, I suffer from excessive blood pressure and diabetes. I am concerned because, as daily labourers, we are paid for our work, but we are not paid on days when we don't*

report to work. Neither I nor my son is going to our job for more than two days; we don't have enough money for our treatment. Due to my health condition, most of the time I am unable to attend my duty, which reflects in my family's financial condition, for which most of the time I remain worried."

Case Study 3 indicated that becoming a sweeper in the Hadi community required frequent attendance at one's duties. If anybody was unable to report to work for any reason, their payment for that day would be withheld. When a person or a member of their family was unable to perform their duties because of a physical condition, their salary would be withheld, which harmed their financial situation and was a cause of concern.

Women were more prone than men to suffer from mild (26.3%), moderate (31.1%), and severe (25.8%) depression, this may be due to biological differences in hormonal profiles that influenced mental health disorders risks and symptoms, as well as the course of such diseases and treatment (Schreiber, 1996; Nakamura, 2005; Grigoraidis & Robinson, 2007). Additional work and domestic chores, parenting for children and aging parents, along with abuse and poverty, can all contribute to a woman's depression (Deshpande et al., 2014). The prevalence of depression among women during the postpartum period (PPD) and the factors related to it was found to be 8.57% in a study conducted among women living in the urban slums of Bhubaneswar. Women's depression was linked to religion, literary standing, social position, high parity, newborn sex, and mode of delivery (Mishra, Mohapatra, & Rout, 2020).

Table 1.6: Discrimination in the family

Sex groups	Being a lady, have you been discriminated in your family			Total (%)
	No (%)	Not apply (%)	Yes (%)	
Male	0 (0.0)	126 (39.3)	0 (0.0)	126 (39.3)
Female	2 (0.6)	9 (2.8)	184 (57.3)	195 (60.7)
Total	2 (0.6)	128 (39.9)	191 (59.5)	321 (100.0)

The above table shows that 184 (57.3%) female participants agree that they were discriminated in the family.

*Case study 4:*When I asked a lady named Shardha Nayak, 28 years old that whether her family gave her the priority for making decisions, she said, "*Even though I am the oldest daughter-in-law in my family, my family members have never given me much weight when it comes to making decisions for me and my children. Sometimes I have to accept their choices even though I don't agree with them. For instance, I want to enroll my daughter in an English-medium school so that she can*

advance in her studies, but my family won't let me because they claim we can't afford it and she will ultimately get married and stop helping us. This thing makes me sad."

Case study 4 revealed that Hadi society had a strong patriarchal structure as many other mainstream societies in India. In a patriarchal structure, typically women were not allowed to participate in decisions affecting their own growth or the development of their community at large because they were viewed as belonging to the family that belonged to their father or husband. Even while women did work outside the home in the Hadi community, their options were still limited to either safai karmacharis for the Municipal Corporation or as housekeepers in the private sector. In the Hadi society, it was generally accepted that women would either take care of the household and children at home or work as *safai karmacharis*. A woman who is not the family's leader has no authority to make decisions for herself or her children. Women are more depressed by these circumstances than their male counterparts are.

Table 1.7: Getting co-operation from the life partner

Sex groups	Co-operation from life partner		Total (%)
	N (%)	*Y (%)*	
Male	20 (6.2)	106 (33.0)	126 (39.3)
Female	171 (53.3)	24 (7.5)	195 (60.7)
Total	191 (59.5)	130 (40.5)	321 (100.0)

The above table states that females show that they get fewer co-operations from their life partners.

Case Study 5: Gauri Nayak, a 30-year-old woman, stated, "*In my family of six, I'm the only one responsible for taking care of all the domestic duties and managing my three children. My husband and the rest of the family do not assist me with domestic chores. They don't cooperate, and my husband fights with me and scolds me for my minor errors*".

Case Study 5 explained how being a housewife was not even regarded as a job in the Hadi society; rather, it was a duty that all women must fulfill. It appeared to be relatively simple because there should be no effort, pressure, travel, or hard work required, yet it was not simple. Taking care of her children, cleaning the house, purchasing, or mending clothing for the family, preparing and storing food for the family, and purchasing items the family needed daily were all responsibilities of a woman. This type of situation became the cause of sadness in women if their husbands refused to cooperate with them, criticise them, and torture them mentally over even their small faults.

Individuals who lived in nuclear families were shown to have greater rates of moderate (28.8%) and severe (21.6%) depression. A study in North-East India discovered that people living in a nuclear family were even more depressed than those living in a joint family, owing to a lack of social support after the joint family broke up (Kalita et al., 2017). Women who had separated showed a high prevalence of severe depression (70%). Studies have showed that lower financial and social resources of separated individuals, loss of income in case of women and loss of support in case of men led to depression (Biotteau et al., 2019). Study done among the South Indian population also witnessed the prevalence of high depression in separated women (Poongothai et al., 2009). The frequency of severe depression (48.6%) was found to be high among the uneducated in the study.

According to a study conducted in Uttarakhand, India, people with a poor level of education had a higher frequency of depression (15.6%) than those who were educated (Mathias et al., 2015). Previous studies had showed that lower level of depression was found among the persons who got pension (He et al., 2021), while the results in this study were conflicting. Pensioners in the Hadi community were more likely to suffer from serious depression (50%). This may be due to the low income/no income of the family members which indirectly put a burden on the persons who got a pension and their family's future after their death made them more depressed. Mild (30.9) and moderate depression (28.9) were high among the individuals who had no income. It had been demonstrated to be a promoter of poverty and frequently proceeded periods of depression (Olesen, et al., 2013; Alloush, 2018). It had been found in the study that respondents had high minimal (38.6%) depression whose family members were consuming no addictive substances. Addiction and family relationship disruption had been identified in studies, with severe psychological and physical consequences on family members such as depression, anxiety, and stress (Lander et al., 2013; Jhanjee et al., 2014; Bortolon et al., 2016).

Tables 1.3, 1.4, and 1.5 list a few factors that contribute to depression in older persons, including being apart from family members, being dependent on others, and physical issues. The tables show that aging and a lack of intimate family ties made older persons unhappy, and that dependence on others due to physical or financial limitations also contributes to depression.

Tables 1.6 and 1.7 highlight a few explanations for why women experience depression at a higher rate than men. Both the table and the data indicate that women may experience poor mental health if they live in a patriarchal society where women are viewed as less valuable than men, where they believe that

their future lies solely in taking care of the home and not in education, and receive little support from their husbands and family.

Conclusion

The Hadi in Kedarpalli showed signs of moderate depression, according to the current investigation. The older age group, women, those who belonged to nuclear families, women who were divorced, those with limited education, and participants who got pensions, all displayed moderate to severe depression.

According to the study, loneliness while among family members, physical limitations, and dependency on others, all contributed to sadness among older persons. This may be a result of problems adjusting to the younger generation. Furthermore, living in a rigid patriarchal atmosphere where men were treated as the head of the family and women were not assisted by family members or the spouse in household tasks made a woman unhappy. Due to the study's reduced sample size, its applicability is confined. Additionally, the BDI-II excludes some characteristics of depression that other measures might be able to measure.

Limitations

BDI-II was taken to study the level of depression. Sometimes, it became difficult to complete the interview or the whole schedule as participants became emotional and started crying and they couldn't complete their response. Many a times, participants were not willing to participate as recalling past experiences were emotionally draining for them. Some didn't participate in the study as they were otherwise preoccupied.

Acknowledgment

Reference

Aherne, D., Fitzgerald, A., Aherne, C., Fitzgerald, N., Slattery, M., & Whelan, N. (2017). 'Evidence for the treatment of moderate depression: a systematic review'. *Irish Journal of Psychological Medicine*, 34(3), 197–204.

Alloush, M. (2018). *Income, psychological well-being, and the dynamics of poverty: Evidence from South Africa.*

Arvind, B. A., Gururaj, G., Loganathan, S., Amudhan, S., Varghese, M., Benegal, V, Rao, G.N., Kokane, A.M., Chavan, B.S., Dalal, P.K., &...Shibukumar, T.M. (2019). Prevalence

and socioeconomic impact of depressive disorders in India: multisite population-based cross-sectional study. *BMJ open*, 9(6), e027250.

Assari, S., Watkins, D. C., & Caldwell, C. H. (2015). 'Race attribution modifies the association between daily discrimination and major depressive disorder among blacks: the role of gender and ethnicity'. *Journal of Racial and Ethnic Health Disparities*, 2, 200-210.

Bailey, E., Moore, J., & Joyner, S. (2016). 'A new online strategy in teaching racial and ethnic health and health disparities to public health professionals'. *Journal of Racial and Ethnic Health Disparities*, 3, 413-422.

Beck, A. T., Steer, R. A., Ball, R., & Ranieri, W. F. (1996). 'Comparison of Beck Depression Inventories-IA and-II in psychiatric outpatients'. *Journal of Personality Assessment*, 67(3), 588-597.

Behera, P., Sharan, P., Mishra, A. K., Nongkynrih, B., Kant, S., & Gupta, S. K. (2016). 'Prevalence and determinants of depression among elderly persons in a rural community from northern India'. *The National Medical Journal of India*, 29(3), 129.

Biotteau, A. L., Bonnet, C., & Cambois, E. (2019). 'Risk of major depressive episodes after separation: The gender-specific contribution of the income and support lost through union dissolution'. *European Journal of Population*, 35, 519-542.

Bodhare, T. N., Kaushal, V., Venkatesh, K., & Anil Kumar, M. (2013). 'Prevalence and risk factors of depression among elderly population in a rural area'. *Perspect Med Res*, 1(1), 11-15.

Bogard, C. J., Trillo, A., Schwartz, M., & Gerstel, N. (2001). 'Future employment among homeless single mothers: The effects of full-time work experience and depressive symptomatology'. *Women & Health*, 32(1-2), 137-157.

Bohra, N., Srivastava, S., & Bhatia, M. S. (2015). 'Depression in women in Indian context'. *Indian Journal of Psychiatry*, 57(Suppl 2), S239.

Borooah, V. K. (2005). 'Caste, inequality, and poverty in India'. *Review of Development Economics*, 9(3), 399-414.

Bortolon, C.B., Signor, L., Moreira, T.D.C., Figueiró, L.R., Benchaya, M.C., Machado, C.A., Ferigolo, M. and Barros, H.M.T., (2016). 'Family functioning and health issues associated with codependency in families of drug users'. *Ciencia & Saude Coletiva*, 21, pp.101-107.

Chandramouli, C., & General, R. (2011). 'Census of India 2011'. *Provisional Population Totals. New Delhi: Government of India*, 409-413.

Chanabasappa, B. S. (2000). *Caste system*. Retrieved April, 4, 2018.

Charlson, F. J., Baxter, A. J., Cheng, H. G., Shidhaye, R., & Whiteford, H. A. (2016). 'The burden of mental, neurological, and substance use disorders in China and India: A systematic analysis of community representative epidemiological studies'. *The Lancet*, 388(10042), 376-389.

Deshpande, S. S., Kalmegh, B., Patil, P. N., Ghate, M. R., Sarmukaddam, S., & Paralikar, V. P. (2014). 'Stresses and disability in depression across gender'. *Depression research and treatment*, *2014*.

Eamon, M. K., & Zuehl, R. M. (2001). 'Maternal depression and physical punishment as mediators of the effect of poverty on socioemotional problems of children in single-mother families'. *American Journal of Orthopsychiatry*, 71(2), 218-226.

Ferrari, A. J., Charlson, F. J., Norman, R. E., Patten, S. B., Freedman, G., Murray, C. J., ... & Whiteford, H. A. (2013). 'Burden of depressive disorders by country, sex, age, and year: findings from the global burden of disease study 2010'. *PLoS Medicine*, 10(11), e1001547.

Grigoriadis, S., & Erlick Robinson, G. (2007). 'Gender issues in depression'. *Annals of Clinical Psychiatry*, 19(4), 247-255.

Gyamfi, P., Brooks-Gunn, J., & Jackson, A. P. (2001). 'Associations between employment and financial and parental stress in low-income single black mothers'. *Women & Health*, 32(1-2), 119-135.

He, H., Xu, L., & Fields, N. (2021). 'Pensions and depressive symptoms of older adults in China: the mediating role of intergenerational support'. *International Journal of Environmental Research and Public Health*, 18(7), 3725.

Human Rights Watch. (2015). '*World report 2015: Events of 2014'*. Policy Press.

India, I. (2017). 'World Health Day 2017: Depression-Let's talk'. *Indian J Soc Psychiatry*, 33, pp.5-6.

Jhanjee, S. (2014). 'Evidence based psychosocial interventions in substance use'. *Indian Journal of Psychological Medicine*, 36(2), 112-118.

Kalita, K. N., Hazarika, J., Sharma, M., Saikia, S., Patangia, P., Hazarika, P., & Sarmah, A. C. (2017). 'Sociodemographic correlates of unipolar and bipolar depression in North-East India: A cross-sectional study'. *Indian Journal of Psychological Medicine*, 39(1), 46-51.

Kazi, A., Fatmi, Z., Hatcher, J., Kadir, M. M., Niaz, U., & Wasserman, G. A. (2006). 'Social environment and depression among pregnant women in urban areas of Pakistan: importance of social relations'. *Social Science & Medicine*, 63(6), 1466-1476.

Kessler, R. C., & Bromet, E. J. (2013). 'The epidemiology of depression across cultures'. *Annual Review of Public Health*, 34, 119-138.

Kishore, J., Reddaiah, V. P., Kapoor, V., & Gill, J. S. (1996). 'Characteristics of mental morbidity in a rural primary health centre of Haryana'. *Indian Journal of Psychiatry*, 38(3), 137.

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). 'The world report on violence and health'. *The Lancet*, 360(9339), 1083-1088.

Lander, L., Howsare, J., & Byrne, M. (2013). 'The impact of substance use disorders on families and children: from theory to practice'. *Social Work in Public Health*, 28(3-4), 194-205.

Lasa, L., Ayuso-Mateos, J. L., Vázquez-Barquero, J. L., Dıez-Manrique, F. J., & Dowrick, C. F. (2000). 'The use of the Beck Depression Inventory to screen for depression in the general population: a preliminary analysis'. *Journal of Affective Disorders*, 57(1-3), 261-265.

Lipton, R. B., Schwedt, T. J., & Friedman, B. W. (2016). 'GBD 2015 Disease and Injury Incidence and Prevalence Collaborators. Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990-2015: a systematic analysis for the Global Burden of Disease Study 2015'. *Lancet*, 388(10053), 1545-160.

Mathers, C. D., & Loncar, D. (2006). 'Projections of global mortality and burden of disease from 2002 to 2030'. *PLoS medicine*, 3(11), e442.

Mathias, K., Goicolea, I., Kermode, M., Singh, L., Shidhaye, R., & San Sebastian, M. (2015). 'Cross-sectional study of depression and help-seeking in Uttarakhand, North India'. *BMJ Open*, 5(11), e008992.

Matthews, D. D., Hammond, W. P., Nuru-Jeter, A., Cole-Lewis, Y., & Melvin, T. (2013). 'Racial discrimination and depressive symptoms among African-American men: The mediating and moderating roles of masculine self-reliance and John Henryism'. *Psychology of Men & Masculinity*, 14(1), 35.

Mishra, K., Mohapatra, I., & Rout, R.N. (2020). 'An epidemiological study on depression among women during postpartum period in an urban slum of Bhubaneswar'. *Journal of Family Medicine and Primary Care*, 9(9), p.4736.

Nakamura, R. (2005). 'Surgeon general's workshop on women's mental health'. In *Workshop Report, Denver, Colo, USA*.

Olesen, S.C., Butterworth, P., Leach, L.S., Kelaher, M., & Pirkis, J. (2013). 'Mental health affects future employment as job loss affects mental health: findings from a longitudinal population study'. *BMC Psychiatry*, 13(1), pp.1-9.

Ota, A.B., Mohanty, S.C., & Mohanty, B.N. (2020). *Demographic Profile of Scheduled Tribes of Odisha* (1961-2011).

Panda, S. S., Sahoo, S., Kuiti, B. K., Satapathy, K.C., Chinara, M., & Patra, P.K. (2021). 'Prevalence and pattern of depression among the Juang (PVTG) adults of Odisha'. *Adivasi,* 61(1), pp.16-25.

Poongothai, S., Pradeepa, R., Ganesan, A., & Mohan, V. (2009). 'Prevalence of depression in a large urban South Indian population—The Chennai Urban Rural Epidemiology study (CURES–70)'. *PloS One*, 4(9), p.e7185.

Prabha, V.S., Rao, V.B., & Kanakabushanam, G.V.V.S. (2017). 'A comparative study of anxiety and depression among adolescents from rural and urban areas'. *J Med Sci Res*, 5(1), pp.29-32.

Raghavendra, R.H. (2020). 'Literacy and health status of scheduled castes in India'. *Contemporary Voice of Dalit*, 12(1), pp.97-110.

Rao, T.S., Darshan, M.S., Tandon, A., Raman, R., Karthik, K.N., Saraswathi, N., Das, K., Harsha, G.T., Krishna, V.S.T., & Ashok, N.C. (2014). 'Suttur study: An epidemiological study of psychiatric disorders in South Indian rural population'. *Indian Journal of Psychiatry*, 56(3), p.238.

Sagar, R., Dandona, R., Gururaj, G., Dhaliwal, R.S., Singh, A., Ferrari, A., Dua, T., Ganguli, A., Varghese, M., Chakma, J.K., & Kumar, G.A. (2020). 'The burden of mental disorders across the states of India: the Global Burden of Disease Study 1990–2017'. *The Lancet Psychiatry*, 7(2), pp.148-161.

Sahithya, B.R., & Reddy, R.P. (2018). 'Burden of mental illness: A review in an Indian context'. *International Journal of Culture and Mental Health*, 11(4), pp.553-563.

Schreiber, R. (1996). 'Understanding and helping depressed women'. *Archives of Psychiatric Nursing*, 10(3), pp.165-175.

Segal, D. L., Coolidge, F. L., Cahill, B. S., & O'Riley, A. A. (2008). 'Psychometric properties of the Beck Depression Inventory—II (BDI-II) among community-dwelling older adults'. *Behavior Modification*, 32(1), 3-20.

Shidhaye, R., Gangale, S., & Patel, V. (2016). 'Prevalence and treatment coverage for depression: a population-based survey in Vidarbha, India'. *Social psychiatry and psychiatric epidemiology*, 51, pp.993-1003.

Sinha, S.P., Shrivastava, S.R. and Ramasamy, J. (2013). 'Depression in an older adult rural population in India'. *MEDICC review*, 15, pp.41-44.

Sundaram, K., & Tendulkar, S.D. 2003. 'Poverty among social and economic groups in India in 1990s'. *Economic and Political Weekly*, pp.5263-5276.

Trevillion, K., Oram, S., Feder, G., & Howard, L.M. (2012). 'Experiences of domestic violence and mental disorders: a systematic review and meta-analysis'. *PloS One*, 7(12), p.e51740.

Üstün, T.B., Ayuso-Mateos, J.L., Chatterji, S., Mathers, C., & Murray, C.J. (2004). 'Global burden of depressive disorders in the year 2000'. *The British Journal of Psychiatry*, 184(5), pp.386-392.

Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., & Burstein, R. (2013). 'Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010'. *The Lancet*, 382(9904), pp.1575-1586.

World Health Organization, (2001). The World Health Report 2001: Mental health: new understanding, new hope.

World Health Organization, (2017). *Depression and other common mental disorders: global health estimates* (No. WHO/MSD/MER/2017.2). World Health Organization.