ASSESSMENT OF SOCIO-ECONOMIC STATUS AND MENTAL HEALTH OF ADOLESCENT SCHOOL GIRLS

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ABSTRACT
Adolescents, at the cusp of adulthood, go through a lot of changes not just hormonal but emotional as well. Our education system still lacks a proper mechanism to provide counselling and guidance to students about the mental health issues they go through. To top it all, adolescents also have to endure the pressure of Board exams in India, thus adding in to the stress and anxiety they have to face. According to the 'Mental Health Status of Adolescents in South-East Asia: Evidence for Action', a report published by WHO in April 2017, in 2007, 5.8% population of India was in the age group of 13-15. The report suggested that about 25% adolescents in the country reported being depressed for 2 weeks or more in a row. The percentage of adolescents who reported being in anxiety was 8%. 8% felt lonely most of the times or always and a 10% of the surveyed students had no friends. 11% of those surveyed also admitted to substance abuse. The report also suggested that an active parental involvement reduced the mental health issues, while bullying in school and by peers increased the mental health issues and substance abuse. This study aimed to investigate the mental health status among school going adolescent girls studying in CSI Girls Hr. Sec. School, Pasumalai, Madurai District. The total sample for the study comprised of 50 adolescent girls studying in this school, selected from the universe of 243. Descriptive research design and purposive sampling method was adopted in the present study. An interview schedule and the Mental Health Inventory (MHI) developed by Paul G. Ritvo et. al (1997) with 18 items were administered in this study to collect data. The major findings of the study showed that more than half of the respondents (54%) had low level of anxiety, 52 per cent had high level of depression and more than half of the respondents had low of behaviour control.

Key Words: School Students, Anxiety, Depression, Mental Health, Adolescents Girls.

INTRODUCTION
Young people form precious human resources in every country. However, there is considerable ambiguity in the definition of young people and terms like young, adolescents, adults, young adults are often used interchangeably. World Health Organization (WHO) defines 'adolescence' as age spanning 10 to 19 yr, "youth" as those in 15-24 yr age group and these two overlapping age groups as "young people" covering the age group of 10-24 yr. Adults include a broader age range and all those in 20 to 64 yr. Adolescence is further divided into early adolescence (11-14 yr), middle adolescence (15-17 yr), and late adolescence (18-21 yr). Individuals in the age group of 20 - 24 yr are also referred to as young adults. The National Youth Policy of India (2003) defines the youth population as those in the age group of 15-35 yr.

Adolescence and youth characterization
Youth - the critical phase of life, is a period of major physical, physiological, psychological, and behavioural changes with changing patterns of social interactions and relationships. Youth is the window of opportunity that sets the stage for a healthy and productive adulthood and to reduce the likelihood of health problems in later years. A myriad of biological changes occur during puberty including increase in height and weight, completion of skeletal growth accompanied by an increase in skeletal mass, sexual maturation and changes in body composition. The succession of these events during puberty is generally consistent among the adolescents often influenced by age of onset, gender, duration, along with the individual variations. These changes are also accompanied by significant stress on young people and those around them, while influencing and affecting their relationships with their peers and adults. It

is also an age of impulsivity accompanied by vulnerability, influenced by peer groups and media that result in changes in perception and practice, and characterized by decision making skills/abilities along with acquisition of new emotional, cognitive and social skills. According to the more studies, emotional disorders such as anxiety and depression were found to be the most common mental disorders experienced by young people (Clarke, Pote, 2020). The economic burden associated with mental health disorders during childhood and adolescence is substantially high. In Europe, the economic consequences of child and adolescent mental health disorders are significant in terms of health services, social services, education system, criminal justice system, voluntary services, and productivity costs (Pillas and Selai, 2008).

It is estimated that around 20% of the world's adolescents have a mental health or behavioural problem. Up to 50% of mental, behavioural and psychological problems have their onset during adolescence period. The stress faced by the children and adolescents in current situation is enormous. The empowerment of children adolescents is very essential in today's context in India as there is rapid globalization and urbanization with breaking up of joint families and the traditional social support systems. There is growing evidence of increased psychological problems in children and adolescents especially behaviour problems and suicides. The prevalence rate of psychiatric disorders in India is 12.5% among children aged 0-16 years and 12% among the 4-16 year's children. Suicide death rates in India are among the highest in the world.

Role of Educational Institutions in Mental Health Services

School Mental Health has been a major mental health movement which covers up the large population of children and adolescent, but has been effectively implemented only in metros and not in smaller towns and urban areas in the last four decades. Research publications during the 60s, 70s and 80s reported that mental retardation formed bulk of population attending CGC during that period. While emotional and behavioural disturbances were less identified and referred. The trend has changed. All spectrums of diagnostic categories are now referred and treated at various teaching hospitals, psychiatry departments, paediatric departments, various colleges of social work and large number run by NGOs.

The last three decades has shown highly specialized clinics rendering specialized services to children with learning disability, autism, cerebral palsy and mental retardation mostly in metros and urban areas. Such centers do run the genetic clinic and research in specific disorders. Development clinics for 0 to 3 years age group for various disability groups and multiple disability groups have special focus of identification, assessment and therapy. All these centres are attended by general psychiatrist rendering highly specialized services.

Child Mental Health Policy and School Mental Health programs have provided excellent opportunity to enhance mental health program for children and adolescents. The focus is rightly on preschool children and school based mental health program, which will prevent illness and possibly promote positive mental health. It also ensures that it will reduce behavior disorders in children and prevent adult psychopathology. Effectiveness of child mental health intervention programs will surely help in addressing mental health disorders among adults.

Worldwide increasing attention has been given on primary prevention of mental illness and risk reduction to vulnerability to mental illness. The existing program in the west have shown promising results in enhancing skills of adolescents including positive youth development; prevention of violence; decreased bullying; self-esteem; peer relations; student-teacher relations; improved problem solving; emotional and social awareness. In India, there is no separate comprehensive policy to deal with child mental health issues. The existing policies such as National Health Policy, Integrated Child Development Scheme and National Mental Health Program for India stress the need for developing comprehensive child mental health program and services at various levels. However, in reality much work needs to be done as the existing program restricted to urban setting where it addresses the psychiatric needs of the adolescents in government hospital setting. Many of the mental, behavioural and psychological problems, among children and adolescents can be prevented if it is intervened at an early stage. School-based interventions possess a great potential in reducing the risk factors and increasing the protective factors to promote the mental health and well-being of children and adolescents. A well-timed comprehensive program in the schools using teachers as a facilitators have the potential for building competencies results in yielding high long term returns on investment on children and adolescent. The program was intended with the aim of promoting the mental health of adolescents. The

present project 'Promotion of Mental Health and Psychological Well-Being of Adolescents in Schools' was a novel project initiated with the funding from the District Administration, Kolar, Government of Karnataka (GoK). The current program adopts life skills competency building approach, resiliency, and experiential framework of promoting mental health of adolescents in schools. The aims of the project were to develop a comprehensive school mental health model programme to promote mental health and well-being of adolescents in schools' using teachers as facilitators; to develop a manual for the teachers; test out the manual by training teachers as facilitators to implement program in the schools.

Schools are the secondary sphere of socialization, development, and growth for children. An emphasis on physical health education has existed for more than 100 years, and continues to grow as a part of school curriculum. There has been a renewed emphasis on schools to enhance the mental well-being of young children and their families. Consequently, this has had an impetus on the advocacy of mental health issues in school for holistic development of the youth and preparation of healthy and productive citizens.

Literature survey

Al-Zawaadi , Hesso and Kayyali, (2021) have described about various mental health issues and factors associated with negative feelings among adolescents in Greater London. A cross sectional study, using a self-administered questionnaire was done and a convenience sampling method had been used to select the respondents who were school/college-attending adolescents, aged 11to 19 years. Sample size of the study is 199 respondents. A total of 526 out of 1,920 surveys were collected across 18 secondary schools and two colleges, giving a response rate of 27.4%. The results of the study revealed that more than half of the adolescents reported to be either neutral (41.4%), sad (7.8%), or very sad (2.8%), whereas 48% reported to be either happy (35%) or very happy (13%). Difficulties in relationships and hectic schedules were the most stressful situations affecting adolescents' mental health. Discrimination was identified as the main predicting factor with five-fold increase in odds of having negative mental health symptoms. **Bhardwaj et al (2020)** conducted a cross sectional descriptive study to assess depression, anxiety and stress among 288 higher secondary students of government schools of Chandigarh, India using self-administered structured questionnaire. 29.9 per cent had moderate depression, 18.8 per cent had mild depression, 13.9 per cent had severe depression and only 2.4 per cent had extremely severe depression. 44.8 per cent had moderate level of stress. **Mangal et al (2020)** have screened for common mental health problems and their determinants among school-going adolescent girls in Gujarat, India. A cross-sectional study was done among 742 adolescent school girls from one government, one government-aided, and one private school in an urban area in Gujarat. The results showed that nearly half of the respondents (48.78%) screened positive for CMDs which is alarming. Among socio demographic characteristics, the type of school (adjusted odds of private is 1.8 and government 1.6), mother's higher education (3.0), father's less education (3.1), and working mother (1.5) had shown significant association with positive cases of the girls. Among psychosocial factors, abnormal sleep patterns (1.9) and disturbance in studies (2.3) have been found statistically significant for the presence of mental health problems among adolescent girls as per the GHQ score. It was concluded that CMDs such as anxiety, depression, and psychosocial distress were indeed very common among adolescent school-going girls in an urban area of Gujarat, India. **Shukla et al (2018)** ascertained the factors associated with depression among school-going adolescent girls in district Barabanki of Uttar Pradesh. The study was conducted among 2187 school-going adolescent girls (10-19 years) in Barabanki district using multistage sampling. The prevalence of depression was found to be 39.7%. Multiple logistic regression revealed that depression was significantly higher among those residing in rural areas and those in early and mid-adolescent age group.

Depression was also found to be significantly higher among those whose mothers were educated up to primary or to inter college. It is concluded that a significant proportion of school-going adolescent girls were suffering from depression, which reflects the need for reinforcement and strengthening of school-based mental health screening programs. **Riya (2017)** studied about mental health of school going adolescents studying at a private higher secondary school in Tiruchirappalli District. Descriptive research design had been adopted and 100 school going adolescents were chosen by adopting simple random sampling method. For measuring the study variable mental health battery developed by Arun Kumar Singh and Alpana Sen Gupta in 2000 has been used. Questionnaire method was adopted to collect the required data from the respondents. The results revealed that less than half of the

adolescents (47%) have moderate level of mental health, more than one fourth (28 percent) of the school going adolescent have high level of mental health and one fourth(25 percent) of the school going adolescent have low level of mental health.

METHODOLOGY

The researcher has attempted to study the level of mental health among the school going adolescent girls in Madurai. The objectives of the study were to know the socio-economic profile of adolescent girls and to observe the various aspects of mental health in adolescent life. The researcher had adopted descriptive research design for the present study in order to describe the level of mental health among school going adolescents in Madurai district. The universe of the study comprises of adolescent girls studying in CSI. Girls Hr. Sec. School, Pasumalai, in Madurai District and the total strength in higher secondary session is 243. The lists of the students were obtained from the respective schools which served as the sampling frame. Simple simple random sampling method was applied and selected 50 students from the universe. The researcher has used standardized tool for collecting the data for the present study the first part of the interview schedule included the questions pertaining to personal and academic related matters. Mental Health Inventory (MHI) developed by Paul G. Ritvo et. al (1997) has 18 items were administered in this study to collect data. The scores obtained were subject to statistical treatment using proper statistical techniques. The data collected for the study was subjected to appropriate statistical analysis using SPSS. Both descriptive and inferential statistics were applied.

RESULTS OF THE STUDY
Distribution of Respondents by their Socio Democratic backgrounds

S. No	Socio Democratic Variables	Frequency (n=50)	Percentage
1	**Age in years**		
	14	13	26.0
	15	9	18.0
	16	18	36.0
	17	10	20.0
2	**Birth Order**		
	1	17	34
	2	20	40
	3	13	26
3	**Number of Siblings**		
	0	1	2.0
	1	28	56.0
	2	16	32.0
	3	5	10.0
4	**Type of Family**		
	Nuclear	41	82.0
	Joint	9	18.0
5	**Parental Status**		
	Both Alive	43	86.0
	Semi Orphan	6	12.0
	Orphan	1	2.0
6	**Family Monthly Income**		
	Below Rs. 15000/-	42	84.0

	Rs. 15001/- to Rs. 30000/-	6	12.0
	Rs. 30001/- to Rs. 50000	2	4.0
7	**Domicile**		
	Rural	10	20.0
	Urban	40	80.0
8	**Place of Stay**		
	Hostel	10	20.0
	Home	40	80.0
9	**Class of Study**		
	10th Std.	21	42.0
	12th Std.	29	58.0

It is evident from the above table that a sizeable per cent of the respondents (36 %) are 16 years old whereas 40 per cent of the respondents are second child. Nearly majority of the respondents (56 %) are having one sibling. Absolute majority (82 %) of the respondents are hailing from nuclear family. Great majority of the respondents (86%) reported that both their parents are alive and great majority of the respondents (84%) informed that their family monthly income is below Rs. 15,000/-.It is also seen that majority of the respondents (80%) revealed that they are from urban areas and are day scholars and nearly majority of the respondents (58 %) said that they are studying 12th standard.

Distribution of Respondents by their perceived levels of Mental Health

S. No	Variables	Frequency (n=50)	Percentage
1	**Anxiety**		
	Low	27	54.0
	High	23	46.0
2	**Depression**		
	Low	24	48.0
	High	26	52.0
3	**Behaviour Control**		
	Low	28	56.0
	High	22	44.0
4	**Positive Efforts**		
	Low	24	48.0
	High	26	52.0

It is evident from the above table that majority of the respondents (54%) have perceived low level of anxiety, high level (52%) of depression, low level (56%) of behaviour control and high level (52%) of positive efforts. Various studies have also confirmed that the adolescent girls have depression related to their study, relationship with parents, leisure activities and academic performance.

One Way Analysis of Variance between the Monthly family income of the Respondents and their perceived levels of Mental health

Variable	Mean	Sum of Squares	Df	Mean Square	F Value Significance
Anxiety					
Between Groups	G1=17.4524	57.882	2	28.941	3.620
Within Groups	G2=17.6667	375.738	47	7.994	$P<0.05$
	G3=12.0000				

Depression					
Between Groups	G1=16.3810	72.575	2	36.288	1.987
Within Groups	G2=15.0000	858.405	47	18.264	P>0.05
	G3=10.5000				
Behaviour Control					
Between Groups	G1=16.9286	13.714	2	6.857	.521
Within Groups	G2=17.5000	486.786	47	10.357	P>0.05
	G3=14.5000				
Positive Efforts					
Between Groups	G1=11.0714	8.381	2	4.190	.518
Within Groups	G2=11.8333	380.119	47	8.088	P>0.05
	G3=9.5000				

G1=Below Rs.15000/- G2= Rs. 15001/- to Rs. 30000/- G3= Rs. 30001/- to Rs. 50000

It is evident from the above table that there is no significant difference among the Monthly family income of the respondents and their perceived levels of Anxiety, Depression, Behaviour Control and Positive Efforts

Inter-correlation Matrix between the major dimensions of Mental health

Variable	Anxiety	Depression	Behaviour Control	Positive Efforts
Anxiety	1.000			
Depression	.734**	1.000		
Behaviour Control	.363**	.369**	1.000	
Positive Efforts	-.303*	-.306*	.266	1.000

*Significant at 0.05 Level **Significant at 0.01 Level

The findings of the above table revealed that there is no significant relationship between the major sub-dimensions namely anxiety, depression, behaviour control and positive efforts and mental health.

Correlation between the Age of the Respondents and their perceived levels of Mental Health

Variable	Correlation Value	Significance
Anxiety	.213	P>0.05
Depression	.171	P>0.05
Behaviour Control	-.037	P>0.05
Positive Efforts	-.115	P>0.05

It is seen from the above table that there is no significant relationship between the respondent's age and their perceived levels of anxiety, depression, behaviour control and positive efforts.

Difference between the type of family of the Respondents and Mental Health

Variable	Type of Family	Mean	Standard Deviation	df	't' Value Significance
Anxiety	Nuclear	17.4390	2.79328	48	.746 P>0.05
	Joint	16.4444	3.77859		
Depression	Nuclear	16.0244	4.38456	48	.150 P>0.05
	Joint	15.7778	4.49382		
Behaviour Control	Nuclear	16.8780	3.31055	48	.115 P>0.05
	Joint	17.0000	2.78388		
Positive Efforts	Nuclear	11.0976	2.82670	48	.013 P>0.05
	Joint	11.1111	2.93447		

It is evident from the above table that there is no significant difference between the type of family

of the Respondents and their perceived levels of Anxiety, Depression, Behaviour Control and Positive Efforts.

MAJOR FINDINGS OF THE STUDY

- A sizeable number of the respondents (36 %) are 16 years old and 40 % of the respondents are in the second birth order.
- Nearly majority of the respondents (56 %) are having one sibling.
- Absolute majority (82 %) of the respondents are hailing from nuclear family.
- 86 per cent of the respondents reported that both their parents alive.
- 84 per cent of the respondents informed that their family monthly income is below Rs. 15,000/-.
- 80 per cent of the respondents said that they are from urban areas and are day scholars
- 58 % of the respondents reveal that they are studying 12th standard.
- More than half of the respondents (54%) have low level of anxiety,
- Little more than half of the respondents (52%) have high level of depression,
- More than half of the respondents (56%) have low level of behaviour control
- Little more than half of the respondents (52%) have high level of positive efforts.
- There is no significant association between the class the respondents are studying in and their perceived levels of Anxiety, Depression, Behaviour Control and their Positive Change.
- There is no significant difference among the Monthly family income of the Respondents and their perceived levels of Anxiety, Depression, Behaviour Control and Positive Efforts
- There is no significant relationship between the major sub-dimensions namely anxiety, depression, behaviour control and positive efforts.
- There is no significant relationship between the respondent's age and their perceived levels of anxiety, depression, behaviour control and positive efforts.
- There is no significant difference between the type of family of the Respondents and their perceived levels of Anxiety, Depression, Behaviour Control and Positive Efforts.

SUGGESTIONS

The health professionals and social workers who are working in the area of child and adolescents mental health have significant role in promoting mental health of children. A suitable model may be developed and replicated in their settings which would help in integration of program in schools.

- Development of a comprehensive mental health model has to be promoted for the Promotion of Mental Health and Psychological Well-Being of Adolescents in Schools.
- Using teachers as trainers to implement these programme in the schools after an intensified training of trainers.
- Using structured program and activities with participatory experiential approach.
- Promoting Mental Health and Well-Being of adolescents through enhancing psychosocial skills and resiliency as outcomes.

CONCLUSION

School based interventions program have been increasingly recognized as effective means of promoting mental health of students and prevent the development of unhealthy behaviour. Programs focussed on competence enhancement of children and adolescents produced long lasting positive effects on mental, social, and behavioural domains. A universal comprehensive school promotive mental health programme to be designed to reduce risks and enhance psychosocial competencies and resiliency of adolescents in schools found to be feasible and acceptable by teachers. The findings from the study suggest that trained teachers can effectively deliver mental health promotion intervention in schools. Parents, teachers, and community health workers should work as a team to deal with the problem in a more effective way.Further evaluations of program are needed to determine the long-term impact on various multi-component aspects of mental health.

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