Factors Contributing to Psycho-Social Ill-Health in Male Adolescents

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Abstract: Objective: To study the prevalence of psychosocial problems in male adolescents and find out various factors contributing to psycho-social ill health. Methods: 500 adolescents were selected using a pre-tested structured questionnaire to elicit the information about the psychosocial problems including depression, suicidal thoughts and suicidal attempts. Association of academic performance, family problems, psychological problems and substance abuse was also included. Results: More than one third (39.6%) adolescents were having psychological problems. These problems were significantly higher in middle adolescence (14-16 years), large extended families (> 8 members) and lower socioeconomic status. Conclusion: Considering that male adolescents from large families with lesser education and lower income had higher prevalence of psychosocial problems, it is essential for health care planners to design comprehensive family and health education programs for the adolescents. The family support, teacher-student rapport and peer group communication should be strengthened to counteract unsafe behaviours in the adolescents.

Key Words: Adolescents; Psychological; Substance Abuse; Family

Introduction: Adolescents suffer from psychosocial problems at one time or the other during their development. Many of these problems are of transient nature and are often not noticed. Further children may exhibit these problems in one setting and not in other (e.g. home, school). Several key transitional periods (moving from early elementary to middle school, moving from middle school to high school or moving from high school to college) can present new challenges for these adolescents and symptoms of dysfunction may occur. Just 40 years ago, many physicians doubted the existence of significant depressive disorders in children. However, a growing body of evidence has confirmed that children and adolescents not only experience the whole spectrum of mood disorders but also suffer from the significant morbidity and mortality associated with them.

Ahmad et al (2002) reported that the most common psychosocial problem among school going male adolescents problem was educational difficulties found in 17.4% of the study population, followed by substance abuse with a prevalence of 13.3% adding to an overall prevalence rate of 17.9%, but with insignificant urban and rural differences. The prevalence was higher in lower social class IV (30.8%) as compared to social class I (13.8%), II (12.4%) and III (18.7%).

Arun and Chavan (2009) in a study on 2400 students in Chandigarh, found that 45.8% had psychological problems, 45% reported academic decline, 24.4% students found relationship with parents stressful while 15.4% students found peer relationship stressful. About 8.82% of students felt life as a burden, 6% reported suicidal ideas and 0.39% of students reported of having attempted suicide. There was significant correlation between student's perception of life as a burden and class they were studying, mother's working status, psychological problems and problems students experienced in relation to study, peers, future planning and with parents.

Adolescent depression may affect the teen's socialization, family relations and performance at school often with potentially serious long-term consequences. Studies have found that 3-9% of teenagers meet criteria for depression at any one time and at the end of adolescence, as many as 20% of teenagers report a lifetime prevalence of depression (Zuckerbrot et al. 2006). Ferguson et al (1977) found that 35.1% of adolescents had major depression on at least one occasion during the age period of 16-21 years and 3.9% reported ten or more episodes in Christchurch (New Zealand). An increasing number of depressive episodes years were significantly associated with higher rates of adverse mental health outcomes including major depression, anxiety disorder, suicidal ideation and suicide attempt.

Glied and Pine (1996) found the prevalence of depression in boys was 5% whereas that in girls was 9%. Children and adolescents with high degrees of depressive symptoms missed about 1 day more of school in the month preceding the survey and had higher rate of smoking, bingeing and suicidal ideation. Maharaj et al (2008) did a study on secondary school students aged 13-19 years in Trinidad and found prevalence of depression as 25.3% ± 2.37% and revealed statistically significant associations between depression and the categories of age, gender, living arrangements and school type. Similar findings were observed for respondents who admitted to cigarette and alcohol use or being injured by their parent (p<0.05). He saw that females were 1.7 times as likely to be depressed when
compared with males; respondents not living with both parents were 1.5 times as likely to be depressed as those who were liv-
ing with their parents. Adolescents reporting that they were afraid of parents or of being injured by parents were three times as likely to be depressed as who had not had those experiences. Malhotra and Das (2005) found that depression in adolescents is a severe disorder and adolescents appear to be a special group in terms of consequences of poor psychosocial and aca-
demic outcome, increased risk of substance abuse and suicide. Suicidal behaviour amongst adolescent students is a matter of great concern due to the tragic loss of prime years of life it en-
tails. The true magnitude of suicide as a public health problem is not clear in India. In the last two decades, official figures of suicide rate have increased from 7.9 to 10.3 per 100,000 in In-
dia as reported by Vijaykumar et al(2007). The actual number of suicides is understandably more than the reported official figures as non-reporting, under-reporting and misclassification are prevalent due to various socio-cultural stigmas, religious sanctions, legal issues and insufficient registration systems.

Kar (1996) studied 149 suicide attempters and found that male to female ratio was around 1:3 in adolescents and most of the attempters were from rural areas. The attempters reported childhood trauma, had addiction, wrote suicide notes and took alcohol before the attempt. Most attempters belonged to extended families, and most of them had expressed suicidal ideas before the actual act. Most of the attempters had a middle socioeco-
nomic status (SES) amongst which the majority (86.8%) were of lower-middle socio-economic status.

Sharma et al (2008) found 15.8% adolescents having thought of attempting suicide while 5.1% had actually attempted sui-
cide, both being more in females than in males. Statistically significant associations were observed with the age of the stu-
dent, living status of parents, working status of mother and whether the student was working part-time.

Materials and Methods

A cross-sectional study was conducted in schools and colleges located in rural and urban field practice areas of Department of Paediatrics, Sri Guru Ram Das Hospital, Amritsar. A total of 500 male adolescent students from age 12-18 years were selec-
ted by systematic random sampling so that 250 males were from rural areas and 250 were from urban areas. The families of ad-
olescents were divided into 3 groups based on total number of family members (< 4 family members, 4-8 family members and >8 family members). Socio-economic status was evaluated on the basis of Kuppuswamy’s socioeconomic index which is an impor-
tant tool in hospital and community based research in In-
dia. The study tool consisted of self developed, semi structured proforma containing questions regarding adolescents’ socio
demographic background and adolescents’ school, family, psychosocial and personality problems and history of substance abuse. The data was collected and analyzed using SPSS-17. Multivariate analysis of association was also done between school, family, psychosocial, substance abuse and sexual activ-
ity among themselves using chi square test. For all statistical tests, a p-value of >0.05 was considered non significant, a p-
value of <0.05 was considered significant and a p-value of <0.001 was considered highly significant.

Results:

Table 1 shows that about 39.6% adolescents experienced loneliness and depression. Out of them, majority (66.7%) had occa-
sional depression but 33.3% were persistently depressed. Fam-
ily was the most common contributory factor (59.6%) cited by adolescents with depression. 20.4% adolescents had suicidal thoughts but out of them, only 13.8% had actually attempted it in comparison to 86.2% males who made no suicidal attempts.

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>198</td>
</tr>
<tr>
<td>No</td>
<td>302</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent</td>
<td>66</td>
</tr>
<tr>
<td>Occasional</td>
<td>132</td>
</tr>
<tr>
<td>Family</td>
<td>118</td>
</tr>
<tr>
<td>Teachers</td>
<td>32</td>
</tr>
<tr>
<td>Friends</td>
<td>39</td>
</tr>
<tr>
<td>Unknown</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 2 shows that more than one third (39.6%) adolescents were having psychological problems. These problems were sig-
ificantly higher in middle adolescence (14-16 years), large extended families (> 8 members) and lower socioeconomic status. Residence had no significant relation to psychological problems in the adolescents. Maximum (62%) number of psychological problems were in adolescents in age group 14-16 years in com-
parison to 16-18 years (18.0%) and this was statistically highly significant (p<0.001).Psychological problems were found in 39.2% urban adolescents and 40% rural adolescents and this was not significant statistically (p<0.05). Maximum psychological problems were in adolescents with family size >8 members (60.0%) as compared to family size ≤4 members (12.6%) which was statistically highly significant (p<0.001).

Table 3 shows that psychological problems were higher in adolescents with academic stress (p<0.05), Family dispute (p<0.001), domestic violence (p<0.001) and having no close friends (p<0.001). Substance abuse was also related to psychological problems (p<0.05).
Table 3: Association of Psychological Problems with Other Adolescent Problems

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sub group</th>
<th>Number of adolescents with psychosocial problems (n=198)</th>
<th>Percentage</th>
<th>Statistical analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic problems</td>
<td>Yes (n=319)</td>
<td>140</td>
<td>43.8</td>
<td>S</td>
</tr>
<tr>
<td></td>
<td>No (n=181)</td>
<td>58</td>
<td>32.0</td>
<td></td>
</tr>
<tr>
<td>Family dispute</td>
<td>Yes (n=165)</td>
<td>95</td>
<td>57.5</td>
<td>HS</td>
</tr>
<tr>
<td></td>
<td>No (n=335)</td>
<td>103</td>
<td>30.7</td>
<td></td>
</tr>
<tr>
<td>Domestic violence</td>
<td>Yes (n=145)</td>
<td>98</td>
<td>67.5</td>
<td>HS</td>
</tr>
<tr>
<td></td>
<td>No (n=555)</td>
<td>100</td>
<td>28.1</td>
<td></td>
</tr>
<tr>
<td>Close friends</td>
<td>Yes (n=309)</td>
<td>83</td>
<td>26.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No (n=191)</td>
<td>115</td>
<td>60.2</td>
<td></td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Yes (n=94)</td>
<td>50</td>
<td>53.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No (n=406)</td>
<td>148</td>
<td>36.4</td>
<td>S</td>
</tr>
</tbody>
</table>

Discussion:

Table 1 shows that in our study of 500 male adolescents, 198 (39.6%) male adolescents had experienced loneliness and depression and out of these depressed males, 66 (33.3%) had persistent depression and 132 (66.7%) had occasional depression. The most important contributor to adolescent depression was family seen in 118 (59.6%) males followed by friends (19.7%) and teachers (16.1%). Depression may have an etiological role in a range of adverse mental health outcomes in future and our study supports the results found in another survey conducted by Maharaj et al (2008) and Ferguson et al (1977) in Trinidad and New Zealand respectively establishing the importance of developing effective methods for identifying, managing and treating depressive episodes in adolescence.

Table 1 also shows that a total of 398 (79.6%) adolescents reported no suicidal ideation whereas 102 (20.4%) expressed suicidal ideation but out of them, only 14 males had actually attempted suicide in our study. The same finding was also seen in the Indian studies by Sharma et al (2008), Logaraj et al (2005) and Lalwani et al (2004) who observed a similar range for the prevalence of suicidal ideations. In western literature, Bearman et al (2004) mentions that it is expected that suicidal ideation is about three times more prevalent compared to actual suicide attempts. This was confirmed by the findings from the present study. It has been mentioned that suicide is rare before puberty but the rate begins to rise sharply after the age of 14 years. Teenagers in the late stage of adolescence are likely to be experiencing more stress and emotional turmoil as they face the threshold of adulthood. In this period, rising expectations and responsibilities may create pressures for many of them leading to suicidal ideation in the adolescents.

Table 2 shows the socio demographic risk factors of adolescents with psychological problems. In our study, 62% of male adolescents were having psychological problems in middle age group of 14-16 years in comparison to early (31.7%) and late (18%) age groups. Ahmad et al (2002) also found the rising trend of psychological problems with age. The 14-16 years age group faces the transition stress of moving from junior high school to college leading to adjustment problems. Both rural (40%) and urban (39.6%) adolescents were having psychological problems in almost equal numbers and no significant difference was observed. Maximum psychological problems were in adolescents with extended families (60%) of size more than 8 members as compared to nuclear families (12.6%) having less than 4 members as also found by Kar (1996) in Cuttack. About 68.4% of male adolescents of low socioeconomic status were having psychological problems in comparison to 23.7% of adolescents belonging to upper socioeconomic status. Ahmad et al (2002) also had a similar observation in his study in Aligarh showing 30.8% adolescents of lower social class IV having psychological problems as compared to 13.8% adolescents in upper social class I. This could be because of the fact that negative factors like malnutrition, illiteracy, ignorance and negligence which may exaggerate psychological problems are more prevalent in lower socioeconomic status.

Table 3 shows the association of psychological problems with other adolescent problems. On multivariate analysis, psychological problems were higher in adolescents with academic problems (43.8% v 32%), family dispute (57.5% v 30.7%), domestic violence (67.5% v 28.1%) and in teenagers with substance abuse (53.1% v 36.4%) and no close friends (60.2% v 26.8%). Adolescents in schools who have academic decline lose confidence, become discouraged and decrease their effort to study further. Grade failure cause children to be older than their same grade peers which will eventually affect their self confidence negatively leading to serious consequences if left untreated and similar findings were shared by Havas et al (2009) in Netherland. Children need a stable environment to assist them in learning and circumstances like family dispute, domestic violence, single parent and divorce affect adolescents performance at school as reported by Kernic et al (2002) in USA. Arguments between parents and children increase considerably during adolescence and it is the peer group that provides emotional support to the adolescents. Having few or no close friends make adolescents feel anxious and depressed thus causing increased number of psychological problems. These adolescents are more likely to get engaged in health impairing behaviours like smoking, drinking and substance abuse as was also found by Ahmad et al (2002) in Aligarh.

Discussion:

Accepting and supportive family relationships during adolescence may have long-term associations with psychosocial functioning into adulthood. Considering that male adolescents from large families with lesser education and lower income had higher prevalence of psychosocial problems, it is essential for health care planners to design comprehensive family and health education programs for the adolescents.

References:


