CHAPTER ONE

Introduction

Recent years have evinced growing concern about the psychological factors that improve and impair the health status of a person. This has led to the emergence of health psychology which is an interdisciplinary venture involving mind-body interaction. This field emerged in the context of realization that biological mechanisms alone are insufficient to maintain and promote an individual’s health and wellbeing. Hence, mental health has always been the Cinderella of all health concerns in the developing countries.

Mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem. It is how people think, feel, and act as they face life's situations. It affects how people handle stress, relate to one another, and make decisions. Mental health influences the way individuals look at themselves, their lives, and others in their lives. Like physical health, mental health is important at every stage of life.

As an individual progresses over a lifespan, there exists marked development in physical, cognitive, social and emotional growth. Adolescence is a very significant period of transitions that brings about dramatic changes in physical, cognitive, social and emotional areas of life. At this stage a very important change occurs in the realm of identity. The adolescents’ quest for identity is a quest not only for personal sense of self, but for recognition from others and from society that he/she is a unique individual.

Understanding how and why things go wrong in an individual’s development is important, but equally important are the factors that help things to go right.
Mental Health in relation to Quality of Life and Coping Strategies of adolescents

Research suggests that human beings can survive major traumas both in childhood and adolescence. Resilience, the ability to survive, to overcome adversity, and to regain a degree of control is related to the ability to understand, explain and comprehend what has happened (Elliot and Marmarosh, 1995).

Studies in high-income countries have shown that psychosocial health problems during adolescence, in particular depression, anxiety and substance misuse, are relatively common. Worldwide, the leading causes of disability in 10- to 19-year-olds were unipolar major depression, accidents and falls. Depression and anxiety have long been seen as western afflictions, diseases of the affluent. But new studies find that they are just as common in poor countries, with rates up to 20% in a given year. Researchers say that even in places with very poor people, the ailments require urgent attention. Severe depression can be as disabling as physical diseases such as malaria, the researchers say, and can have serious economic effects.

Young people (aged 10–19 years) comprise more than a fifth of India’s population – an estimated 230 million people. Although adolescent health has gained increasing prominence in India’s national health policies, the focus has been on reproductive and sexual health concerns. Despite reports showing that suicide is a leading cause of death in young people in India, mental health has been a low priority in health policy for adolescents. The few published studies from India have reported prevalence of mental disorders from 2.6% to 35.6%.

In many respects, life is what we make it. It is our personal psychological attitude that defines our abstract level of satisfaction or otherwise with our lives. Thus if we are optimistic we will see the good aspects of our environment, while a pessimist will only see the bad - thus the same environment is perceived differently. Thus our psychological aspects of fitness should prove beneficial, in the fulfillment
of those personal goals that lies behind most definitions of Quality of Life. Campbell and Converse (1972) were concerned with developing subjective indicators of the quality of life as aspirations, expectations and life satisfaction.

Mental health is a fundamental indicator of quality of life. It is a positive sense of wellbeing that helps an individual realize his/her own capabilities, can cope with the normal stressors of life, can work productively and fruitfully, and is able to make a contribution to his/her community (World Health Organization, 2004). The primary aim of mental health activity is to enhance people’s wellbeing and functioning by focusing on their strengths and resources, reinforcing resilience and enhancing protective external factors (WHO Europe Declaration, 2006).

An important variant of quality of life is an individual’s ability to cope with problems in life. This issue is of utmost importance to psychologists who work to promote both mental and physical health. Virtually all living beings routinely utilize coping skills in daily life. The nature of stress can be best understood by the way people perceive and ascribe meaning to stress producing situations, the values they attribute to actions and the way they interact with events. Individuals cannot remain in a continuous state of tension. They may adopt a deliberate and conscious strategy or an unconscious one to deal with the stress.

Cowen (1980) has proposed a general model for primary prevention in mental health setting. He states that primary prevention can be accomplished by both “(a) providing people with skills competence and conditions that facilitate effective adaptation and ward off psychological problems before they occur, and (b) developing interventions designed to short circuit negative psychological sequel for those who have experienced risk augmenting life situations or stressful life events”.
The quality of life of the individual is a factor, often recognized, in planning for prevention. Professionals in the field must become more aware of the importance of contentment, happiness and self satisfaction as a prevention vaccine. One must note the importance of recognizing those environmental variables that result in individual happiness, the development of human potential and prevention of pathology.

**CONCEPTS**

1.1 Adolescence

Adolescence is a wonderful time of life, filled with new feelings, a higher level of self-awareness and a sense of almost unlimited horizons to explore. It is a time of paradox. Adolescence can be defined as a transitional stage in human development during which the individual undergoes marked physiological, psychological and social changes in the process of growing from a child into an adult.

The precise onset, duration and termination of adolescence vary with cultural context and individual rate of maturation. Puberty is often the developmental marker used to designate the onset of adolescence. However there is a wide variation in both onset and duration of normal puberty. For girls, puberty usually occurs between the ages of 8 – 18 years; for boys between 9 - 19 years. Because our society uses the system of age grading, which emphasizes chronological age in conferring certain rights, responsibilities and privileges to the individual, it is useful to consider other socially defined markers of entry such as starting junior high school.

Societal attitudes towards adolescents are often inconsistent and contradictory; there is tension between the wish that adolescents would remain children and follow unquestioningly the percepts of their elders and the hope
that they will not repeat the mistakes of past generations and become saviors who lead society into a better future.

Because adolescence brings with it new capacities and new opportunities, there is the possibility of reworking and resolving earlier problems during this developmental phase. The adolescents growing ability to perceive differences among people and their increasing capacity to weigh moral dilemmas presage a new way of relating to others and provide the mechanisms for important steps towards identity consolidation.

People in this stage can integrate what they have learned in the past with the challenges of the present and make plans for the future. Thought at this stage has flexibility. The ability to think abstractly has emotional implications. Earlier a child could ‘love a parent or hate a classmate’ now the adolescent can ‘love freedom or hate exploitation’.

Adolescence is commonly divided into three periods: early adolescence (11 – 14 years); middle adolescence (14 – 17 years) and late adolescence (17 – 20 years). These divisions are arbitrary; growth and development occur along a continuum that varies from person to person. The early years of this developmental period are marked by callousness and egocentricity, but by late adolescence relations and mental life are infused by sensitivity and altruism.

During early adolescence, the intensity and exclusivity of parental attachments begins to change. But children are still dependent on their parents and rely to a great extent on their parent’s value systems and beliefs (Blos, 1967). Early adolescents generally possess relatively limited formal operational thinking, tending to see most situations as either black or white. They tend to distance themselves
from parents by being impulsive and acting in a manner that can be a distorted mirror image of parental values.

What appears on the surface to be a process of distancing is often accompanied by discomfort and conflict and in extreme cases, anguish and dysfunction for both the adolescent and his family. In the process of distancing from the dependency and control of early childhood, adolescents use a variety of defenses and character traits. These defenses may take form of displacements or substitutions and may be played out through imitation of the parental interactions with their own friends; or they may show up in the form of ego disturbances such as acting out, negativism, exaggerated moodiness or episodic acts of aggression.

By *middle adolescence*, most teenagers have had enough experience with reality to begin dispensing with their ‘imaginary’ audience. Their ‘testing’ of this fictional construct allows them to replace it with a more realistic framework. Middle adolescents show a healthy respect for authority figures and seem to have an emotional stake in maintaining the status quo. As a result, they begin to exhibit a relatively superficial awareness of individual relationship patterns among different family members. The adolescent chooses peer group values and interactions in preference to parental standards and associations.

By *late adolescence*, adolescents are capable of greater conceptual complexity, self-criticism and differentiated feelings, motives and forms of self-expression. In terms of moral development, late adolescents begin to recognize the difference between mere conventions and laws or more rooted in matters of conscience. As a result, authority conflicts take the form of appeals to a higher authority or appeals to universal conscience.
Besides disengaging the self from parental egos, adolescents also face the task of reorganizing the superego. This process can be difficult, depending on the success of early ego organization and parental support for children’s individuation and separation. Thus, altered relationships with parents can be seen as springing in part from children’s growing cognitive abilities and their capacities to make moral judgments outside of the parent’s moral milieu.

The change in their relationship to parents may cause adolescents to feel conflict, ambivalence, even despair. Coleman (1980), made a cross sectional study of 800 English boys and girls of ages 11, 13, 15 and 17 and this study documents the changing and sometimes stressful nature of adolescents relationships to their parents. Only at the end of adolescence, at ages 17 and 18 are these unsettled feelings resolved. Coleman found that the rocky path to a new level of independence differs for boys and girls. The boys in Coleman’s group sought freedom from constraint and felt “chained, cribbed, cabined and confined” when with parents. The girls, however, sought autonomy within the family unit. Their desire for independence and identity was more likely to take the form of wanting to have independent thoughts and feelings while remaining part of the family. Asked to complete a sentence, “when a girl is with her parents…”, the girls in Coleman’s group said: “she is not herself. The parents think they know her but they don’t. She becomes like them and cannot find her identity” (Coleman, 1974).

Parents treat males and females somewhat differently from birth onward and they continue to do so when their children reach adolescence. A comparison of parent – child relations for male and female high school students documents these differences (Stinnett, Farris and Walters, 1974). Using questionnaire replies from 499 11th and 12th graders, researchers found twice as many boys as girls reporting
their fathers had been the primary source of discipline when they were children. Twice as many girls as boys reported being praised often during childhood. Girls indicated that they received equal amounts of affection from their mothers and fathers, but boys identified their mothers as the principle source of affection. Nevertheless, both boys and girls identified their mother as the greatest influence in their lives.

Parents may grant their adolescent sons greater freedom, but they seem to be anxious and have fears about letting go of their daughters. A daughters adolescence appears to be a greater cause of tension and dissatisfaction within families than a sons adolescence. Parents worry about their daughters safety and her sexual behavior, especially the possibility of pregnancy. (Hoffman and Manis, 1977).

A study by Verma and Singh (1998) highlights the major perceived causes of behavior problems among adolescents resulting from various aspects of family relationships. The sample consisted of 80 boys and girls in the age group of 16 – 19 years belonging to higher and middle – income groups. The major behavior problems reported in the study were aggression, lying, bullying, stealing, depression and cruelty. The social environment in the home was reported to be the dominant factor having major bearing on adolescent behavior problems. Being a boy or girl was significantly associated with the perception of adolescents about poor parent-child relationship as a cause of behavior problems. Also a maximum number of adolescents belonging to middle income parents considered poor parent-child relationship, parental disharmony, sibling rivalry, economic constraints and gender discrimination as causative factors of behavior problems.
D’Cunha, Tina and Shetgovekar, Suhas (2006) studied the effect of perceived parental behavior on the adjustment and self-concept of adolescents in Goa. A total of 150 adolescents were examined. The results indicated that there is a negative correlation between perceived parenting and adolescents’ adjustment whereas perceived parenting is found to have a positive effect on adolescent’s self-concept. Gender differences with regards to perceived parenting and adjustment as well as self-concept were found to be absent. Significant difference was found on adolescents adjustment depending on the phases of adolescence (early, middle and late) while it was absent with regards to their perceived parental behavior. There was no significant difference in the perceived parental behavior and self-concept of adolescents with regards to the phases of adolescence. No significant difference was found between perceived maternal behavior and perceived paternal behavior. This study ascertains that home influences along with other environmental effects determine the fundamental organization of adolescents’ behavior.

Vora, Kshipra and de Souza, Janet (July 2007), in their study explored gender differences in conflict resolution styles among adolescents. The study also aimed to understand the impact of using a particular resolution style on mental health. 100 undergraduate college students, 50 males and 50 females, in the age range of 17-20 years, selected randomly, were administered the Conflict Resolution Style Scale and the General Health Questionnaire. Results revealed that significant gender differences in the choice of conflict resolution styles did exist. Female Adolescents were more likely to utilize a smoothing style in managing conflict whereas male adolescents were more likely to utilize a confronting approach to conflict resolution. Significant differences on mental health as a function of the type of resolution style used in managing conflicts were also observed. Significant differences on mental
health as a function of gender were not evident. However interaction effect of gender and conflict resolution strategy used was found to be significant. The confronting strategy assured better mental health highlighting the fact that use of assertive behavior and mutual respect are the keys to productive conflict responses.

1.2 Mental Health

The World Health Organization (WHO) defines mental health as a 'state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'.

The concept of mental health takes a ‘Gestalt’ view of a person. It embraces the concepts of personality, character and behavior. An individual’s mental health involves his outlook towards life, perceptions of his achievements and his physical, mental and emotional style of adjustment.

Social Psychologist Marie Jahoda (1958) made an exhaustive study of positive mental health concepts. She identified six major approaches indicating that a person is mentally healthy: (a) the persons attitudes towards himself are characterized by self acceptance, self-esteem and accuracy of self-perception, (b) he actualizes his potentials through personal growth, (c) his inner drives are focused and his personality integrated, (d) he has a dependable sense of inner identity and values so that he is not overly dependent on the influence of others, (e) he is able to see reality – the world and the other people – with accuracy because his subjective needs do not distort his perceptions, (f) he is able to take what life gives him; master his environment; and enjoy love, work and play.
Mental health problems often have no clear physical symptoms and victims may suffer in silence. Some of these issues include anxiety disorders, panic disorder, schizophrenia, borderline personality disorder, obsessive compulsive disorder (OCD), mysophobia (also known as germaphobia), claustrophobia and post-traumatic stress disorder. While anxiety disorder treatments, schizophrenia treatment, OCD treatment, borderline personality disorder treatment and treatment for post-traumatic stress disorder, including cognitive behavioral therapy are available, people need to recognize that they have a problem that requires help first.

Pandey and Pandey (1995) related mental health to decision making skills and opined that only a person having sound mental health can make a good and quick decision. They also considered mental health to be an important gradient of personality.

Maslow (1970) regarded mental health as a consequence of complete gratification of psychobiological demands. A mentally healthy person has a positive self concept and is motivated to strive for self actualization. He is integrated, that is, there is a balance of psychic forces in the individual. There is a lack of suspicion, disregard of all internal defenses and unbounded confidence in loving relations, mutual care and responsibility. He has a unifying outlook on life and has a reasonable capacity to resist stress.

Adolescence is a time of heightened psychological risk in general, but more specifically for girls. Biology, culture, psychology and trauma leave many girls vulnerable to periods of crises and negative life experiences, including juvenile justice involvement (Budnick and Shield, 1998).

Renouf and Harter (2000) reported that girls have higher rates of depression than boys throughout adolescence and are more likely to attempt suicide. Low self –
esteem, negative body image and substance abuse are also common problems for adolescent girls.

A study conducted by Marsetteller, Recgmoch and Elin, (2003) on college girls, revealed that 60% of the girls met criteria for anxiety disorder (in contrast to 32% among boys), 59% girls had a mood disorder (versus 22% among boys).

Suicide attempts and self mutilation are particular problems of college girls. Seclusion, parent’s insensitivity, loss of privacy that add to the negative feelings and loss of control in girls are the characteristic behaviors of these suicide attempters. There is also evidence that females are more likely than males to engage in ruminative coping responses, and that this gender difference may account in part for the preponderance of female depression that emerges during the teen years (Garmenzy, 1991).

Mental health has, thus, been described in terms such as creativity, spontaneity in interpersonal relations, integrated personality, and correct perception of oneself and of one’s environment. It is a process of adjustment which involves compromises, adaptation, growth and continuity and ability of the individual to make personal and social adjustment.

1.3 Quality of Life

Quality of life (QOL) is the degree of well-being felt by an individual or group of people. In many respects, life is what we make it. It is our personal psychological attitude that defines our abstract level satisfaction or otherwise with our lives. Thus if we are an optimist we will see the good aspects of our environment, while a pessimist will only see the bad - thus the same environment is perceived differently.
The World Health Organization defines Quality of Life as “an individual’s perception of his/her position in life, in the context of culture and value systems in which he/she lives, and in his relation to his/her goals and expectations, standards and concerns”. According to Christopher Peterson of the Oxford University Press (2006) “quality of life is an overarching label that includes all of the emotions, experiences, appraisals, expectations and accomplishments that figure into a good life”.

Quality of Life is similar to the concept of wellbeing or subjective wellbeing. It is an ongoing perception that the present time of one’s life, or even, one’s life as a whole, is fulfilling, meaningful and pleasant. Positive thinking of love, courage and optimism, self esteem and purpose in life will add meaning to living. Positive emotions, feeling and a positive mental attitude can improve the quality of people’s lives and heal their bodies of illness and stress.

Quality of life has been synonymously used as life satisfaction. Researchers Pavot & Diener (1993) theorized that life satisfaction depends on a comparison of life circumstances to one’s standards. Various standards or indicators could measure these circumstances. Furthermore, Borthwick-Duffy (1992) stated that quality of life could relate to objective indicators and subjective indicators. Borthwick-Duffy defined objective indicators as life conditions and subjective indicators as life satisfaction.

Quality of life is not defined in terms of functional ability, medical or psychological symptoms, or objective life circumstances since these constructs ignore the empirically validated assumption that Quality of life is cognitively mediated (Brief et. al., 1993; Diener and Larsen, 1993; Lazarus, 1991; Michalos, 1991) and therefore, a person’s satisfaction with his or her life (eg. Subjective
WellBeing) can be, and often is, independent of these ‘objective’ factors (Arns and Linney, 1995; Mehnert et. al., 1990; Mirin and Namerow, 1991; Moreland et. al., 1994). In keeping with Diener (1984), the quality of life theory views Quality of life as an inherently subjective, personal phenomenon; these factors may or may not influence life satisfaction or subjective well being, depending on how they are perceived and evaluated; thus, their impact, if any, is cognitively mediated (Michalos, 1991).

The Quality of life theory assumes that a finite number of areas of human aspiration and fulfillment may be identified which will be applicable to both clinical and nonclinical populations; numerous subjective wellbeing researchers have found support for this assumption (Andrews and Withey, 1976; Campbell et. al, 1976; Veenhoven, 1984). It is assumed that people tend to want the same things, although the particular areas valued by an individual as well as their subjective importance to that individual’s overall life satisfaction will vary. Thus, an area of life such as work may be highly valued by one individual but judged irrelevant to overall satisfaction by another.

Quality of life and life satisfaction are considered to be related to attaining a healthy and productive lifestyle (Corrigan, et. al. 2001). People with an upbeat, optimistic explanatory style enjoy good health (Peterson and Bossio, 1991). They lead healthier and longer lives, have shorter hospital stays, faster recovery from coronary artery bypass surgery, and greater longevity when battling AIDS (Scheier, Matthews, Owens, and Magovern, 1989).

Madnawat A., Bharadwas V. and Kachhawa P. (2007) investigated the effect of life skills and gender on psycho-physical well being and coping response among adolescents and found that life skills and gender creates a significant and interactive
effect on physical wellbeing, value and creativity, life management and coping, except that there was no significant main effect of life skills and gender on psychological well being and total physical well being.

Quality of life indicates the amount of satisfaction one is deriving from one’s own overall life. The word ‘quality’ suggests an assessment of value relative to some standard. The assessment is most commonly expressed in terms of levels of satisfaction or dissatisfaction. The word ‘life’ suggests a reference to the total human experience and is not restricted to any specific domain of life.

Nature is passive, humans are not. That message means that the value of our lives is a fluid quantity. It depends upon many dynamic aspects, relating not only to our own attitudes but to those of our society and our physical or environmental context. As a species we have far more say in our own Quality of Life than other creatures, indeed since we base much of our perceived social fitness on abstract ideas of worth we are in a position to change this fitness globally, almost overnight. What is required to maximize Quality of Life is largely awareness.

Why a Quality of Life Perspective?

Examining adolescent health and its determinants within a quality of life perspective achieves various aims that go beyond most other approaches. A quality of life approach

• Considers a broad range of determinants, including both psychological and societal aspects, thus identifying determinants of adolescent health which may not have been considered to date.

• Draws attention to determinants of health at a range of levels; specifically, personal factors such as attitudes and beliefs; community factors such as family, peers,
employment, and schools; and structural factors such as income distribution, and educational and employment opportunities. Usually, research into the health of adolescents is limited to only one or two of these levels without considering level interrelationships.

- Allows for consideration of multiple perspectives, in this case the views of adolescents, their parents, service providers, and government analysts among others, concerned with adolescent health. Consideration of the views of adolescents and those close to them helps put a human face on the determinants of health and healthy behavior during adolescence.
- Can be linked to health promotion and rehabilitation perspectives suggesting means of promoting positive health and healthy behaviors among adolescents.

1.4 Coping

Over the course of adolescence, changes occur on almost all fronts of an adolescent’s life. They change physically and acquire adult shape and reproductive capacity and these physical changes are often the most common source of worry among adolescents (Berzonsky, 1982). The developmental stage also includes cognitive as well as social changes. Great anxieties exist over relationships with members of the opposite sex and rejection by their peers (Coleman, 1974). Kuhlen (1952) points out that adolescence is the period of sexual, social, ideological and vocational adjustment and for striving independence from parents. For some, adolescence is a stormy time of life. Hall (1916) characterized adolescence as a period of storm and stress – a stormy decade of emotional turmoil. It is important to note, however, that it is not a stressful time for all. These differences stem from
differences in individual temperaments and circumstances and in part from cultural and environmental conditions.

Coping is considered an essential mechanism to enhance an adolescent’s competency in this developmental phase. Coping is defined as an individual’s constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person’s resources (Lazarus, 1966). There are three key features of this definition. First, it is process oriented; indicating that it focuses on what the person actually thinks and does in a specific stressful encounter and how this changes as the encounter unfolds. Second, coping is viewed as contextual, that is, influenced by the individual’s appraisal of the actual demands in the encounter and resources for managing them. The emphasis on the context indicates that particular individual and situation variables together shape coping efforts. Third, there is no assumption made about what constitutes good or bad coping; it is simply a person’s efforts to manage demands, whether or not the efforts are successful.

The psychological definition of coping is the process of managing taxing circumstances, expending effort to solve personal and interpersonal problems, and seeking to master, minimize, reduce or tolerate stress or conflict.

Coping strategies refer to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. In coping with stress, people tend to use one of the three main coping strategies: either appraisal focused, problem focused, or emotion focused coping. (Weiten, Lloyd, 2006). Appraisal-focused strategies occur when the person modifies the way they think. For example, employing denial, or distancing oneself from the problem. People may alter the way they think about a problem by altering
their goals and values, such as by seeing the humor in a situation. People using problem focused strategies try to deal with the cause of their problem. They do this by finding out information on the disease, learning new skills to manage their disease and rearranging their lives around the disease. Emotion focused strategies involve releasing pent-up emotions, distracting one-self, managing hostile feelings, meditating, using systematic relaxation procedures.

Men often prefer problem focused coping, whereas women can often tend towards an emotion focused response. Problem focused coping mechanisms may allow an individual greater perceived control over their problem, while emotion focused coping may more often lead to a reduction in perceived control. Certain individuals therefore feel that problem focused mechanisms represent a more effective means of coping. (Nicholls & Polman, 2006).

One group of coping skills are coping mechanisms, defined as the skills used to reduce stress. In psychological terms, these are consciously used skills and defense mechanisms are their unconscious counterpart. Overuse of coping mechanisms (such as avoiding problems or working obsessively) and defense mechanisms (such as denial and projection) may exacerbate one's problem rather than remedy it.

Although there are many ways to classify coping responses (Moos and Billings, 1982) most approaches distinguish between strategies that are active in nature and oriented toward confronting the problem, and strategies that entail an effort to reduce tension by avoiding dealing with the problem.

Caplan, Naidu and Tripathi (1984) examined how patterns of coping and defense, as well as their main effects, influence well-being of adolescents. The analysis indicated that coping was generally and positively correlated with positive
affects (such as satisfaction) whereas defense was primarily and positively correlated with somatic complaints and negative affects.

Coping behaviors were studied in relation to appraisal of academic and personal stressors as controllable-uncontrollable and challenging-threatening in 258 college students by Mehta (1989). Students appraised the academic stressor as more controllable and challenging, and the personal stressor as more uncontrollable and challenging. Both, problem-focused and emotion-focused forms of coping were used by students in dealing with the two stressors, and there were more similarities than differences in the styles of coping across situations. Gender differences were observed in relation to distress and coping styles, but not in relation to appraisal. The coping strategies used by the poorly adjusted group were escape-avoidance, external attributions of blame wish-fulfilling strategies.

Parent-child relationship affect the relative ease with which young individuals face, adjust and cope with stressful episodes of their lives. Becker (1964) found that over-protected children have low tolerance, less patience and insecurity and so found it difficult to face challenges of life successfully. The failure of adolescents to learn the needed competencies and coping behavior or their learning of maladaptive ones, can be seen as stemming from faulty learning. Lacking such competencies, the individual is likely to feel inadequate and insecure in the highly competitive and hostile world.

Tandon (1986) in his study hypothesized that those who cope with life stress without impairing their health would be characterized by a more positive philosophy of life and perception of meaning even when suffering. The group which reported fewer symptoms was designated the superior health group and those who reported more symptoms the inferior health group. It was found that the superior health
subjects had a positive self image, thought well of others, perceived a positive meaning in suffering and believed more that prayers helped. The inferior health group perceived God as being capricious and unjust, believed more in external locus of control, and was harassed by negative thoughts.

Gilligan, Lyon and Hanmer (2000) have reported that many adolescent girls will not seek mental health treatment or other support for themselves, instead relying upon internalization, avoidance and self harm as coping strategies. Studies by Poe Yamagata and Butt (2004) indicate that juvenile justice personnel and mental health professionals working with young women must be cautious not to re-traumatize girls who have been abused or victimized, while encouraging them to learn appropriate coping strategies and constructively explore and resolve their feelings.

CONCEPTUALIZATION OF THE DIMENSIONS USED IN THE STUDY

- **Mental Health**

  1. Emotional stability: An experiencing of subjective stable feelings which have positive or negative values for the individual.

  2. Adjustment: An individual’s achievement of overall harmonious balance between the demands of various aspects of the environment such as home, health, social, emotional and school on the one hand and cognition on the other.

  3. Autonomy: A stage of independence and self-determination in thinking. It has emotional, cognitive and behavioral components to it.

  4. Security-Insecurity: A high or low sense of safety, confidence, freedom from fear, apprehension or anxiety particularly with respect to fulfilling the
persons present and future needs.

5. Self-Concept: The sum total of a person’s attitudes and knowledge towards himself and evaluation of his achievements.

6. Intelligence: A general mental ability which helps the person in thinking rationally and in behaving purposefully in his environment.

**Quality of Life**

1. Physical Domain: This domain explores the experiences of pain and discomfort, energy and fatigue, sleep and rest, mobility, activities of daily living, dependence on medication and treatments and work capacity and how each contribute to the quality of life.

2. Psychological domain: This domain explores the experience of positive feelings, thinking, esteem, body image and appearance, negative feelings and spirituality in relation to an individual’s quality of life.

3. Social relationships: This domain assesses the experience of personal relationships, social support and sexual intimacy in relation to quality of life.

4. Environment: This domain explores safety and security, home environment, financial resources, health and social care services, opportunities for acquiring new information and skills, participation in leisure activities, physical environment and transport in relation to quality of life.

**Coping**

- Problem Focused Coping

1. Focus on solving the problem: A problem-focussed strategy which tackles the problem systematically by learning about it and takes into account different
points of view.


3. Seek to belong: Indicates caring and concern for ones relationships with others in general and more specifically concern with what others think.

4. Focus on the positive: Indicates a positive and cheerful outlook in the current situation. This includes seeing the ‘bright side’ of circumstances and seeing oneself as fortunate.

5. Seek relaxing diversions: Describes leisure activities such as reading and painting.

6. Physical recreation: Relates to playing sports and keeping fit.

- Reference to Others

7. Seek social story: Indicates and inclination to share the problem with others and enlist the support in its management.

8. Social action: letting others know what is of concern and enlisting support by writing petitions or organizing an activity such as a meeting or a rally.

9. Seek spiritual support: Reflects prayer and belief in the assistance of a spiritual leader or God.

10. Seek professional help: Denotes the use of a professional adviser, such as a teacher or a counselor.

- Non Productive Coping

11. Worry: Indicates a concern about the future in general terms or more specifically concern with happiness in the future.

12. Invest in close friends: Engaging in a particular intimate relationship.

13. Wishful thinking: Coping skills based on hope and anticipation of a positive
outcome.

14. Not coping: Reflect the individuals inability to deal with the problem and the development of psychosomatic symptoms.

15. Tension reduction: Reflect an attempt to make oneself feel better by releasing tension.

16. Ignore the problem: Reflect a conscious blocking out of the problem.

17. Self-blame: Indicates that individuals see themselves as responsible for the concern or the worry.

18. Keep to self: Reflect the individual’s withdrawal from others and a desire to keep others from knowing about concerns.

1.5 MENTAL HEALTH IN GOA

Goa, a tiny state on India’s western coastline, has been found to have a high prevalence of depression and stress-related problems, affecting 5–10% of young adults and 15–25% of people who visit primary health centers.

The state launched a pilot project in October 2005 that takes an innovative approach to addressing depressive and anxiety disorders which are a major cause of mental health disability worldwide.

Recent studies by NGO Sangath in Goa found that depression and anxiety disorders are common, particularly in young adults in the prime of their lives. Sangath’s studies found that one in five adults attending primary health centers and one in four mothers attending antenatal clinics in Goa suffer from depression.

Although adolescents comprise a fifth of the population of India, there is little research on their mental health. Patel et.al., conducted an epidemiological study in
the state of Goa, India to describe the current prevalence of mental disorders and its correlates among adolescents aged between 12 and 16 years. The most common diagnoses were anxiety disorders (1.0%), depressive disorder (0.5%), behavioral disorder (0.4%) and attention-deficit hyperactivity disorder (0.2%). Adolescents from urban areas and girls who faced gender discrimination had higher prevalence. The final multivariate model found an independent association of mental disorders with an outgoing ‘non-traditional’ lifestyle (frequent partying, going to the cinema, shopping for fun and having a boyfriend or girlfriend), difficulties with studies, lack of safety in the neighborhood, a history of physical or verbal abuse and tobacco use. Having one’s family as the primary source of social support was associated with lower prevalence of mental disorders. The current prevalence of mental disorders in adolescents in this study was very low compared with studies in other countries. Strong family support was a critical factor associated with low prevalence of mental disorders, while factors indicative of adoption of a non-traditional lifestyle were associated with an increased prevalence.

In the context of rapid social change being witnessed in India, researchers suggest that there is a need to research the aspects which may play a role in preventing mental disorders in early adolescence while also building resilience into adulthood.

In an article ‘Sadness in Paradise: Mental Health in Goa’ by Gawas and Sawal it was highlighted that research in Goa, and elsewhere in India, now provides us with the evidence to demonstrate that, far from being a luxury or peripheral item, mental health is in fact a major public health issue. What is clear is that despite its apparently privileged position in terms of its economy, environment and overall health infrastructure, mental illness is at least as much of a problem (if not more so)
in Goa as elsewhere. In addition to the illnesses typically attributed to mental disorders such as schizophrenia and manic-depressive disorder (also called Bipolar Disorder), mental health problems include a wide variety of other, much commoner conditions such as depression, suicidal behaviour, marital conflict, problem drinking, learning difficulties and child abuse.

While it may appear there are many mental health care providers in the State, the reality is that the vast majority of persons with mental disorders will never come into contact with them. Instead, persons with depression or alcohol problems prefer to consult generalists: family physicians, primary care doctors and other non-mental health professionals remain the most important source of health care for those with mental health problems, largely because they are more accessible and do not have any stigma attached to consulting them. However, the vast majority of these general doctors and health workers have limited knowledge of how to diagnose and treat these common mental health problems. Many people with mental health problems seek help from religious and spiritual leaders. The growing popularity of priests with healing powers, the rise of charismatic Christianity with the message of healing through faith and the regular pilgrimages to places of healing for sick person are evidence of these trends. Similarly, Hindus with emotional problems are likely to turn to priests, ghaddis and dishtikonns rather than psychologists and counselors. Informal counselors such as members of Marriage Encounter provide informal and personal support and help to individuals and families in distress.

However, it is said that Goa’s experience of social and human development is a unique model. Goa has been able to achieve exceptionally high physical quality of life. Its achievements are commendable in areas like health, education, and even demographic transition.

The present study aims at assessing the mental health, quality of life and coping strategies used by adolescents who are experiencing a wonderful time of life, filled with new feelings, a higher level of self-awareness and a sense of almost unlimited horizons to explore. The study is based in Goa which is a state experiencing rapid social change but is at the same time said to possess a unique family, social and human development model.

1.6 IMPORTANCE OF THE PRESENT STUDY

1. Mental health plays a significant role in the development of an integrated, self-reliant and determined individual. This study will highlight the positive predictors of mental health.

2. Our psychological health should prove beneficial in the fulfillment of an individual’s goals and attainment of a positive self. This study analyses the importance of an individual’s quality of life experience.

3. Understanding every persons need to strive for a balanced life, this study would provide an insight to an adolescents coping strategies in times of stress and conflict.

4. The research findings would provide a base to derive a suitable intervention strategy for the sample group.
1.7 APPLICATIONS OF THE STUDY

1. The results of the study would help focus on and improve the serious consequences of neglect of mental health among adolescents in Goa.

2. Various community based mental health programs could be conducted inorder to reach out to people and initiate an attitudinal change.

3. Research findings will help formulate assertiveness and coping skill training programs to psychologically empower adolescents.

4. Findings on mental health status, quality of life and coping strategies based on gender would help in listing and developing a healthy combination of those male and female traits essential for healthy adjustment.

5. The study would provide relevant information to help in formulating various intervention programs for adolescents.