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Chapter-II

Theoretical Orientation

and

Review of Related Researches

2.1 Introduction

The health of children all over the world in developing society is far from satisfactory. Fast life and living as a consequence of scientific methods and technological development and advancement has generated tension oriented life situation, threats generated by stressful condition of life has an unfavorable impact on the mental health and quality of life of the student in general. According to Aurobindo, the concept of health is essentially related to human existence where life is a goal-oriented programme and multi-dimensional evolutionary process. Human life in its totality includes physical, mental and spiritual dimensions. It has a dynamic and functional nature and so it is related to the socio-cultural set up by means of activities. The wholesome evolutionary programme is a kind of sublimation of activities from gross dilution of physical to mental and to spiritual.

In this chapter historical and recent development, definitions, concept, various perspectives, principles, importance, adolescent’s and genders’ angle of mental health, need and characteristics of mental health were discussed in detail. The review of related literature and research conducted in the specific area of mental health were also discussed. It includes brief
review of the understanding attained through reading various books, articles, articles from journals and past investigated studies.

2.2 **Mental Health: General Overview**

Mental health is a term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. Mental health is the state of psychological well-being that includes both subjective comfort and the capacity to function effectively with others.

The concept of mental health, given its polygenic nature and its imprecise borders, benefits from a historical perspective to be better understood. What today is broadly understood by “mental health” can have its origins tracked back to developments in public health, in clinical psychiatry and in other branches of knowledge.

Although references to mental health as a state can be found in the English language well before the 20th century, technical references to mental health as a field or discipline are not found before 1946. During that year, the International Health Conference, held in New York, decided to establish the World Health Organization (WHO) and a Mental Health Association was founded in London. Before that date, mental health was reffered as mental hygiene, which first appeared in the English literature in 1843, in a book entitled mental hygiene or an examination of the intellect and passions designed to illustrate their influence on health and duration of life. Moreover, in 1849, “healthy mental and physical development of the citizen” had already been included as the first objective of public health in a draft law submitted to the Berlin Society of Physicians and Surgeons.
2.3 History of Mental Health and Recent Development

History and recent development of mental health have been described by WHO and in other academic resources. It gives details on the related issues of the term ‘Mental Health’. In the middle of nineteenth century, William Sweetzer was the first to clearly define the term “mental hygiene”, which can be seen as the precursor to contemporary approaches to work on promoting positive mental health. Isaac Ray, one of thirteen founders of the American Psychiatric Association, further defined mental hygiene as an art to preserve the mind against incidents and influences, which would inhibit or destroy its energy, quality or development.

At the beginning of the 20th century, Clifford Beers founded the National Committee for Mental Hygiene and opened the first outpatient mental health clinic in the United States.

In 1948, the WHO was established and in the same year, the first International Congress on Mental Health took place in London. At the second session of the WHO’s Expert Committee on Mental Health (1950, p. 21), “mental health” and “mental hygiene” were defined as follows: “Mental hygiene refers to all the activities and techniques which encourage and maintain mental health. Mental health is a condition, subject to fluctuations due to biological and social factors, which enables the individual to achieve a satisfactory synthesis of his own potentially conflicting, instinctive drives; to form and maintain harmonious relations with others; and to participate in constructive changes in his social and physical environment”.

Significantly, the Dorland’s Medical Dictionary does not carry an entry on mental health, whereas the Campbell’s Dictionary of Psychiatry gives its two meanings: first, as a synonym of mental hygiene and second, as a state
of psychological wellbeing. The Oxford English Dictionary defines mental hygiene as a set of measures to preserve mental health and later refers to mental health as a state. These lexicographic concepts even so, more and more mental health is employed in the sense of a discipline (e.g., sections/divisions in health ministries or secretaries or departments in universities), with an almost perfect replacement of mental hygiene.

In addition, given this polymetric nature of mental health, its delimitation in relation to psychiatry (understood as the medical specialty concerned with the study, prevention, diagnosis and treatment of mental disorders or diseases) is not always clear. There is a more or less widespread effort to set mental health at least aside from psychiatry and at most as an overarching concept with encompasses psychiatry.

After half a century of the mental health and almost a century of the mental hygiene movements, some developments can be perceived. On a more general level, the WHO’s very concept of health has been recently questioned; formulated half a century ago, it is no longer felt by some as much appropriate to the current situation.

On the whole, mental health continues to be used both to designate a state, a dimension of health – an essential element in the definition of health – and to refer to the movement derived from the mental hygiene movement, corresponding to the application of psychiatry to groups, communities and societies, rather than on an individual basis, as is the case with clinical psychiatry. However, mental health is, quite unfortunately, still viewed by many as a discipline, either as a synonym of psychiatry, or as one of its complementary fields.

A recent trend has been the addition of the qualifier public to either mental health or to psychiatry, as it can be seen in a WHO document entitled
Public mental health, or in a journal named Psiquiatría Pública, published in Spain since 1989. This is very much in line with the concept of mental health as a movement rather than a discipline. In 2001, the WHO dedicated its annual report (The World Health Report - Mental health: new knowledge, new hope) to mental health.

In the message from the WHO Director-General that opens that report, Gro H. Brundtland summarizes the three main knowledge areas covered by the document: a) effectiveness of prevention and treatment, b) service planning and provision and c) policies to break down stigma and discrimination and adequate funds for prevention and treatment. If one allows for the semantic variations between the beginnings of the 20th and the 21st centuries, the same concerns of the origins of the mental hygiene movement, discussed earlier on, can be found in the mental health content of the World Health Report. Perhaps the biggest difference between these two political platforms is the emphasis on the improvement of hospital care in the former (the only form of treatment available by them) and the contemporary emphasis on distancing mental health from psychiatric hospitals and placing it in the community.

However, one must admit that, unfortunately, what was high in Beers’ agenda in 1909. Namely, an improvement in the standards of mental health care and an abolition of the abuses to which people with mental disorders are usually subject, are still a major concern of the most progressive and advanced agenda of people interested in the promotion of mental health around the world.

2.4 The International Congress of Mental Health

The First International Congress of Mental Health was organized in London by the British National Association for Mental Hygiene from 16 to
21 August, 1948. Starting as an International Conference on Mental Hygiene, it ended with a series of recommendations on mental health. Throughout the proceedings of the conference, hygiene and health, qualifying mental, are used interchangeably, sometimes in the same paragraph, without any clear conceptual distinction. However, in the 17 pages of the recommendations of the conference, hygiene is very sparingly used. At the end of the congress, the International Committee on Mental Hygiene was superseded by the World Federation for Mental Health.

In addition to the wording employed in the proceedings of that congress, gradually replacing hygiene by health, some of its recommendations were also influential at other levels. An example is recommendation 6 to the WHO that “as soon as practicable, an advisory expert committee be established, composed of professional human resources in the field of mental health and human relations”.

The conference had been convened under the theme “Mental Health and World Citizenship”. From a conceptual point of view, nevertheless and perhaps reflecting an immediately post-war situation, discussions over world citizenship prevailed over those on mental health. Only one concept of mental health was put forward, by J.C. Flugel, Chairman of the Conference’s Programme Committee: Mental health is regarded as a condition which permits the optimal development, physical, intellectual and emotional, of the individual, so far as this is compatible with that of other individuals. Echoing concerns about the absence, or rather limited number of, participants from places such as Far East, South America and the Soviet Union, the hope was expressed that mental health as understood in Western countries [is not] necessarily at variance with the sense in which it is understood in other countries.
In a more detailed way, some delegates elaborated on what was summarized as the four levels of mental health work: custodial, therapeutic, preventive and positive. It is not difficult to see a considerable overlapping between this proposal and the one already implemented by the mental hygiene movement.

Reading through the proceedings of this congress gives one a feeling of the tensions between a pragmatic approach, developed by the mental hygiene movement (basically defended by delegates from the USA) and a more politically-oriented approach, proposed by other participants, perhaps translating the experiences of some delegates from European countries, which had severely suffered from the war. In the end this latter approach prevailed, with the transformation of the mental hygiene movement into the mental health movement. Perhaps as a reflection of this basically political movement, in 1949 the National Institute of Mental Health started its activities in the USA.

2.5 The World Health Organization

From its very beginning, the WHO has always had an administrative section specially dedicated to mental health, as an answer to requests from its Member States. The first Report of the WHO’s Director General, in its English version, refers to an administrative section called “Mental Health”. However, the French version of the same report calls it “Hygiène Mentale”. Well until the 1960s we find hygiène as the French translation of health in some WHO publications and in some instances we find also mental hygiene used interchangeably with mental health in the English version of some documents. The volume no. 9 of the WHO’s series Public Health Papers was published in 1961 in English with the title Teaching of Psychiatry and Mental Health, in 1962 in French with the title
L’enseignement de la Psychiatrie et de l’Hygiene Mentale and in 1963 in Spanish with the title Ensenanza de la Psiquiatria y de la Salud Mental.

In the preamble to the WHO Constitutions, it was stated that “health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” a now widely quoted definition (WHO, 2001, p.4). This definition is clearly a holistic one, intended to overcome the old dichotomies of body vs. mind and physical vs. psychic. It is also a pragmatic one, as far as it incorporates into medicine a social dimension, gradually developed in Europe during the 19th century.

It should be noted that mental, in WHO’s definition of health (as well as physical and social) refers to dimensions of a state and not to a specific domain or discipline. Therefore, according to this concept, it is incongruous to refer to physical health, mental health or social health. Should one wish to specify a particular dimension, the most appropriate noun to designate it should be wellbeing and not health (e.g., mental wellbeing or social wellbeing). This negligent use of the word health seems to have been also in operation when mental hygiene (a social movement, or a domain of activity) was replaced by mental health (originally intended to designate a state and later transformed in a particular domain or field of activity).

2.6 Mental Health: Meaning and Definition

The word ‘mental’ means ‘of the mind’. It describes your thoughts, feelings and understanding of yourself and the world around you.

The word ‘health’ generally describes the working order of your body and mind. So when we talk about ‘mental health’ we are referring to the working order of your mind.
An individual possessing mental health can adjust properly to his environment and can make the best effort for his own, his family’s and his society’s progress and betterment. The chief characteristic of mental health, it is evident, is ‘adjustment’. The greater the degree of successful adjustment, the greater will be the mental health of the individual. Lesser mental health will lead to lesser adjustment and greater conflict. The healthy individual can interpret any new situation and adapt it to suit himself, or adapts himself to suit it. He maintains a healthy and positive attitude towards life. He is aware that difficulties visit everyone in life, so that running away from them is cowardness.

There is no perfect definition of mental health. Various psychologist defined mental health in different ways. Some definition are as follows:

Mental health stands for the mind as Carter V. Good in The Dictionary of Education (1959, p. 563) has termed it as “The wholesomeness of the mind” analogous of the wholesomeness of the body implicit in physical health. Accordingly, mental health is concerned with the health of one’s mind and its functioning in the same way as the physical health is concerned with the health of one’s physical organs and their functioning.

Definitions of mental health invariably include some value statement about how an individual should live his or her life; thus, there are almost as many definitions as there are psychological theories. Sigmund Freud’s famous view that health is the capacity “to work and to love” is still widely accepted.

The World Health Organization (2005) defines mental health as “A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community”.
Waltin, J.E.W. (1951, p. 41) describes “Mental health concerns with the development of ‘wholesome’ balanced personality, one who does not comfort himself like a series of compartmentalized self, - honest on Sunday, dishonest on Monday, generous today, crabbed tomorrow, reasonable and logical at times, at other times confused and inconsistent.”

“Mental health means freedom from disability and disturbing symptoms that interfere with mental efficiencies, emotional stability or peace of mind”

“Let us define mental health as the adjustment of human beings to the world and to one another with a maximum at effectiveness and happiness”

P. B. Lewkan (1949, p. 68) describes, “Mentally healthy person is one who is happy, lives peacefully with his neighbors, makes his children healthy citizens and after fulfilling such basic responsibilities is still empowered with sufficient strength to serve the cause of the society in any way.”

“Mental health is an adjustment which is relatively good enough if it reduce the tension created by the conflict of frustration and makes constructive changes in the conditions causing the frustration.” - Kulhen,R.C.

“Mental health means ability to make adequate adjustment to the environment on the plane of reality.” -Ladell

“Mental health means the ability to balance feelings, desires, ambition and ideals in one’s daily life. It means the ability to face and accept the realities of life.”-Kuppu Swamy

K. A. Menninger (1967, p. 46) define, “Mental health as the adjustment of human beings to the world and each other with a maximum of
effectiveness and happiness. It is the ability to maintain even temper, an alert intelligence, socially considerate behaviour and a happy disposition.”

According to WHO Expert Committee (1951), “Mental Health implies the capacity in an individual to form harmonious relations with others and to participate in or contribute constructively to changes in his social and physical environment. It also implies his ability to a harmonious and balanced satisfaction of his own potentially conflicting instinctive drives in that it reaches an integrated synthesis rather than the denial of satisfaction to certain instinctive tendencies as a means of avoiding the thwarting of others.”

Mahesh Bhargava and Reeta Raina noted in their book Prospects of Mental Health, Sortorives (1983, p.61) stated that “mental health is a state of balance between the individual and the surrounding world, a state of harmony between oneself and others, a coexistence between the realities of the self and those of other people as also of the environment”.

Park (1995) defined “Mental health is thus the balanced development of the individual’s personality and emotional attitudes which enable him to live harmoniously with the fellow men”.

Singh (2000) defined, “Mental health as the ability to establish and care for loving relationships with relevant others, to discern and engage in rewarding work, to continually develop one’s understanding of self and relevant others, to discern and engage in rewarding work, to continually develop one’s understanding of self and relevant others, to meaningfully contribute one’s mite towards promotion of well-being of community to which one belongs without losing one’s identity, independence and autonomy and to think and behave with an adequate blend of objectivity
and sensitivity in all kinds of situations which one happens to come across.”

Bhatia (1982) describes, “Mental health is a ability to balance desires, feelings, ambitions and ideals in one’s daily living. It may also be understood as the behavioral characteristics of a person.”

According to Kumar (1992, In Prospects of Mental Health, 2007, p. 2), “Mental health is an index which shows the extent to which the person has been able to meet his environmental demands – social, emotional or physical.”

Schneiders (1964) describes, “Mental health, as such, represents a psychic condition, which is characterized by mental peace, harmony and content. It is identified by the absence of disabling and debilitating symptoms, both mental and somatic in the person.”

In short, mental health is a functional process in which one can adjust himself, balance with others, harmony with environment, fulfill basic responsibilities and come out from conflict to make better personality and health.

On the basis of above definitions of mental health, investigator has decided various components for mental health scale. It is as follows,

1. Security-Insecurity
2. Adjustment
3. Emotional stability
4. Self concept
5. Autonomy

After discussion of various definitions, concept of mental health is cleared.
2.7 Concept of mental health

Good mental health is not merely an absence of illness or disorder but ‘includes a positive sense of wellbeing; individual resources including self-esteem, optimism, a sense of mastery and coherence; the ability to initiate, develop and sustain mutually satisfying personal relationships and the ability to cope with adversities’ (Jenkins et al, 2001, p. xvi). Moreover, it is probably a common misconception to view mental health and mental illness as dichotomous. Rather, they may best be understood as different points on a continuum; a continuum one hastens to add, on which each and every one of us can be found at different points, at different times in our lives, for different reasons.

Most people experience some small or large difficulties or problems at one time or another during the course of their life. This may cause an individual to endure stress and/or distress and possibly some physical or mental dysfunction. Mentally healthy people may not always be happy, every day and all of the time.

Everyone’s life will usually, inevitably, contain some discomfort or sorrow; yet also, paradoxically, very happy events, as well as the ‘usual’ sad life events, can trigger the subsequent appearance of minor physical and/or psychological ‘symptoms’ and/or dysfunction.

Jahoda (1958) has identified categories within which concepts of mental health could be represented. He described these as follows:

• Mental health is indicated by the attitudes of the individual towards themselves.
• Mental health is expressed in the individual’s style and degree of growth, development or self-actualisation.

• Mental health is based on the individual’s relation to reality in terms of autonomy, perception of reality, environmental mastery.

• Mental health is the ability of the individual to integrate developing and differing aspects of themselves over time.

2.8 Various perspectives of Mental Health

This segment presents various perspectives of Mental Health.

2.8.1 Mental wellbeing

Mental health can be seen as a continuum, where an individual’s mental health may have many different possible values. Mental wellness is generally viewed as a positive attribute, such that a person can reach enhanced levels of mental health, even if they do not have any diagnosable mental health condition. This definition of mental health highlights emotional well-being, the capacity to live a full and creative life and the flexibility to deal with life’s inevitable challenges. Many therapeutic systems and self-help books offer methods and philosophies espousing strategies and techniques vaunted as effective for further improving the mental wellness of otherwise healthy people. Positive psychology is increasingly prominent in mental health.

A holistic model of mental health generally includes concepts based upon anthropological, educational, psychological, religious and sociological perspectives, as well as theoretical perspectives from personality, social, clinical, health and developmental psychology.
An example of a wellness model includes one developed by Myers, Sweeney and Witmer. It includes five life tasks-essence or spirituality, work and leisure, friendship, love and self-direction-and twelve sub tasks-sense of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity, sense of humor, nutrition, exercise, self care, stress management, gender identity and cultural identity are identified as characteristics of healthy functioning and a major component of wellness. The components provide a means of responding to the circumstances of life in a manner that promotes healthy functioning.

2.8.2 Lack of a mental disorder

Mental health can also be defined as an absence of a major mental health condition (for example, one of the diagnoses in the Diagnostic and Statistical Manual of Mental Disorders) though recent evidence stemming from positive psychology suggests mental health is more than the mere absence of a mental disorder or illness. Therefore the impact of social, cultural, physical and education can all affect someone’s mental health.

2.8.3 Cultural and religious considerations

Mental health can be socially constructed and socially defined; that is, different professions, communities, societies and cultures have very different ways of conceptualizing its nature and causes, determining what is mentally healthy and deciding what interventions are appropriate. Thus, different professionals will have different cultural and religious backgrounds and experiences, which may impact the methodology applied during treatment.
Research has shown that there is stigma attached to mental illness. In the United Kingdom, the Royal College of Psychiatrists organised the campaign Changing Minds (1998-2003) to help reduce stigma.

Many mental health professionals are beginning to, or already understand, the importance of competency in religious diversity and spirituality. The American Psychological Association explicitly states that religion must be respected. Education in spiritual and religious matters is also required by the American Psychiatric Association.

2.8.4 Mental health across culture

The World Health Organization believes that there is no single definition for mental health due to differences in culture. What could be mentally healthy (or acceptable behavior) in one culture may present something too eccentric in another. For example, cannibalistic behavior in some tribes living in remote areas is highly regarded as a religious practice however, in the majority of urbanized world this could be seen as barbaric or insane.

2.8.5 Disruption in mental health

Abnormalities in mental health could lead to a number of problems with various representations. Some people with mental illnesses have aggressive behaviors while others are withdrawn and lack social interest. Each type of disorder has its own signs and symptoms therefore; diagnosis as well as treatment varies depending on the nature of the mental health problem.

There are several factors that disrupt mental health including: environment or upbringing, biological make-up of a person, pre-programmed instructions in the genes, medical disorders, hurtful experiences such as loss and mistreatment. While one factor could be dominant than the other,
all of these are contributors to the development of the majority of mental health disorders. In some cases, a single factor may be sufficient to trigger the disorder but the majority of disorders require an accumulation of experience that constantly challenge the well-being of a person.

2.9 Importance of Mental Health

Importance of Mental Health is described here at two levels:

1. Importance of mental health in general sense and
2. Importance of Mental Health for the Adolescents

2.9.1 Importance of Mental Health in general sense

Good mental health is a necessity if you want to live a complete and full life. Because so many people ignore their mental health concerns until the last minute, many diagnosis go on undetected until it is too late. This trend should not be continuing. Shootings and suicides run rampant every year because of an undiagnosed person with a mental or psychological disorder is untreated.

Hackner, T. (2007) defines the importance of Mental Health in the following aspects:

- Self-image

Good mental health means appreciating your achievements and accepting your shortcomings. A mental illness can cause an inferiority complex, a negative body image and intense feelings of self-hate, anger, disgust and uselessness which could mutate into extreme depression, psycho-social disorders, or eating disorders.
- **Education**

Students with mental problems socially isolate themselves and develop anxiety disorders and concentration problems. Good mental health ensures an all-round educational experience that enhances social and intellectual skills that lead to self-confidence and better grades.

- **Relationships**

Mental health largely contributes to the functioning of human relationships. Mental illness can hamper even basic interactions with family, friends and colleagues. Most people suffering from mental illness find it difficult to nurture relationships, have problems with commitment or intimacy and frequently encounter sexual health issues.

- **Sleep**

An inability to handle stress or anxiety can cause sleeplessness. Even if you manage to fall asleep, you may wake up a dozen times during the night with thoughts of what went wrong the day before or how bad tomorrow is going to be. You may develop severe sleeping disorders which leave you exhausted and less productive.

- **Eating**

People with mental disorders are more horizontal to indulging in comfort eating or emotional binge. Finding comfort in food is something we all do from time to time. But with a mental illness, it becomes difficult to control yourself. Overeating can lead to obesity, which puts you at a risk for heart disease and diabetes, in addition to creating an unhealthy body-image.
- **Physical health**

Your mental state directly affects your body. For example, stress can lead to hypertension or stomach ulcers. People who are mentally healthy are at a lower risk for many health complications.

- **Mental Health Improves the Quality of Life**

When we are free of depression, anxiety, excessive stress and worry, addictions and other psychological problems, we are more able to live our lives to the fullest. Peace of mind is a natural condition and is available to everyone.

- **Mental health strengthens and supports our ability to:**

  - have healthy relationships
  - make good life choices
  - maintain physical health and well-being
  - handle the natural ups and downs of life
  - discover and grow toward our potential

- **Mental Health Reduces Medical Costs**

Many research studies have shown that when people receive appropriate mental health care, their use of medical services declines. For example, one study of people with anxiety disorders showed that after psychological treatment, the number of medical visits decreased by 90%, laboratory costs decreased by 50% and overall treatment costs dropped by 35%.

Other studies have shown that people with untreated mental health problems visit a medical doctor twice as often as people who receive mental health care.
2.9.2 Importance of Mental Health for the Adolescents

Mental health is not simply the absence of mental illness but it is also the ability to cope with the challenges in life. Mental health is as important as physical health to everybody. Youths usually experiment with attitudes, appearances and behaviors. Most of their experiments are harmless, but some experiments may have terrible results. Children and youths experience creates mental health problem such as stress, anxiety, harassment, family problems, depression, learning disability, etc. Serious mental health problems, such as self-injurious behaviors and suicide are increasing among youth.

A good mental health is essential for leading a good life. Youth cannot succeed in academic and personal life effectively if they are struggling with a mental health problem such as depression or unsteady feeling due to academic, social or family pressures.

Failure to detect youth’s mental health problem may result in negative consequences such as increased risk for academic failure, social isolation, unsafe sexual behavior, drug and alcohol abuse, suicide attempt, unemployment and poor health. A recent report says that the rising rates of mental and emotional problems among U.S. children and youngsters signal a crisis for the country.

Mental health services are very necessary because depression, anxiety, attention deficit, conduct disorders, suicidal thinking and other serious psychological problems are striking more and more in children and youths. Even if detected mental health problem earlier, unfortunately many children and youth do not receive the help they need. Some reports say that most children and youth who need a mental health evaluation do not
receive services and that the rates of use of mental health services are also low.

Mental health services are important for student’s and youth’s success. Prevention programs help in early identification of mental health problems in youth. These programs provide education on mental health issues, violence prevention, social skills training, harassment prevention, suicide prevention, conflict resolution and screening for emotional and behavioral problems. The Family Guide Web sites are designed for parents and other adults to emphasize the importance of family, promote mental health and help to prevent underage use of alcohol, tobacco and illegal drugs.

Good mental health is very important for youth’s success. In order to emphasize the importance of mental health in youth, the following steps can be taken: Create awareness programme for child and youth mental health issues; provide a comprehensive guide for effective and meaningful youth meetings for organizations and professionals and conduct programs to generate awareness about youth’s mental health in each communities. Awareness about the importance of mental health issues among youth is equally important to other physical issues, such as heart disease, AIDS, cancer, etc. Local and state health officials must draw more attention to the importance of mental health treatment of affected children and youths.

The youth’s mental health will more effectively improve their life standard. This also positively impacts their academic and personal life achievements. The families, society and youths benefit only when mental health problems in youths are identified and prevented earlier.
2.10 Characteristics of Mentally Healthy Person

Marie Jahoda, in 1958 devised a list of characteristics which are present in the majority of people who are regarded as normal, known as ideal mental health, these were:

- Efficient self perception
- Realistic self esteem and acceptance
- Voluntary control of behaviour
- True perception of the world
- Sustaining relationships and giving affection
- Self direction and productivity

Mental Health like physical health is also a condition. And this condition can be recognized by its characteristic features. Roughly speaking a mentally healthy individual would exhibit the following symptoms.

1. Self – Evaluation: A mentally healthy individual evaluating himself properly is aware of his limitations. He easily accepts his faults and makes efforts to rid himself of them. He introspects so that he may analyze his problems, prejudices, difficulties etc. and reduce them to a minimum.

2. Adjustability: It has been pointed out earlier also that one special characteristic of a mentally healthy individual is that he adjusts to a new situation with least delay and disturbance. He makes the fullest possible use of existing opportunities and adjusts to every new situation. He is aware of the fact that change is the principle of life. He is ever prepared for change and always finds some suitable mode of adjustment.

3. Maturity: Intellectual and emotional maturity is another peculiar sign of mental healthy individual. The mature mind is constantly engaged in
increasing his fund of knowledge, behaves responsibly, expresses his thoughts and feelings with clarity and is prepared to sympathize with others feeling and viewpoints. The healthy individual behaves like a balanced, cultured and sensible adult in all matters.

4. Regular Life Habits: Regular life habits are an important element in maintaining mental health. Forming proper habits in matters of food, clothing and the normal routines of daily life leads to their becoming systematic and regulated which is in the long run. A healthy person performs most of the common function of life with quick assurance and show of neutrality, without any other argument. Their life is a model of regularity, balance and measured calculation.

5. Absence of Extremism: Aristotle believed that the lacks excess in any and every directions and the principle that excess of anything is bad is golden ruled as far as mental health is concerned.

6. Satisfaction from Chief Occupation: For mental health it is essential that everyone should find satisfaction from his chief occupation, his vocation. Money is the result of work if one works only for it, that much time is obviously a waste. If a work interests an individual, it will yield more money, but at the same time, a proper illustration of time will bring an increase in his pleasure and happiness. In fact, if one works for interest and maintains it even in the events of a loss in trade or at least the pain of loss is considerably lessened.

Here are some of the ideas that have been put forward by Taylor, J. (1977) as characteristics of mentally healthy person:

- The ability to enjoy life - The ability to enjoy life is essential to good mental health. James Taylor wrote, “The secret of life is enjoying the
passing of time. Any fool can do it. There isn’t anything to it.” The practice of mindfulness meditation is one way to cultivate the ability to enjoy the present. Of course, one should need to plan for the future at times and also need to learn from the past. Too often we make ourselves miserable in the present by worrying about the future. Our life metaphors are important factors that allow us to enjoy life.

• **Resilience** - The ability to bounce back from adversity has been referred to as “resilience”. It has been known that some people handle stress better than others. Why do some adults raised in alcoholic families do well, while others have repeated problems in life? The characteristic of “resilience” is shared by those who handle well with stress.

• **Balance** - Balance in life seems to result in greater mental health. We all need to balance time spent socially with time spent alone, for example. Those who spend all of their time alone may get labeled as “loners” and they may lose many of their social skills. Extreme social isolation may even result in a split with reality. Those who ignore the need for some solitary times also risk such a split. Balancing these two needs seems to be the key – although we all balance these differently. Other areas where balance seems to be important include the balance between work and play, the balance between sleep and wakefulness, the balance between rest and exercise and even the balance between time spent indoors and time spent outdoors.

• **Flexibility** - We all know people who hold very rigid opinions, no amount of discussion can change their views. Such people often set themselves up for added stress by the rigid expectations that they hold. Working on making our expectations more flexible can improve our mental health. Emotional flexibility may be just as important as cognitive
flexibility. Mentally healthy people experience a range of emotions and allow themselves to express these feelings. Some people shut off certain feelings, finding them to be unacceptable. This emotional rigidity may result in other mental health problems.

**Self-actualization** - What have we made of the gifts that we have been given? We all know people who have surpassed their potential and others who seem to have squandered their gifts. We first need to recognize our gifts, of course and the process of recognition is part of the path toward self-actualization. Mentally healthy persons are persons who are in the process of actualizing their potential. In order to do this we must first feel secure.

A mentally healthy person shows homogenous organisation of desirable attributes, healthy values and righteous self-concept and a scientific perception of the world as a whole. Mental health presents a humanistic approach towards self and others. It is an important factor that influences an individual’s various activities, behaviour, happiness and performance.

Mental health includes how you feel about yourself and how you adjust to life events. However, the National Mental Health Association (2008) cites ten characteristics of people who are mentally healthy.

1. They feel good about themselves.
2. They do not become overwhelmed by emotions, such as fear, anger, love, jealousy, guilt, or anxiety.
3. They have lasting and satisfying personal relationships.
4. They feel comfortable with other people.
5. They can laugh at themselves and with others.
6. They have respect for themselves and for others even if there are differences.
7. They are able to accept life’s disappointments.
8. They can meet life’s demands and handle their problems when they arise.
9. They make their own decisions.
10. They shape their environment whenever possible and adjust to it when necessary.

- Mentally healthy people share some common characteristics:

- They are happy with themselves and their lives.
- They do not worry excessively about the future, but they do plan ahead.
- They do not spend time wondering what other people think or say about them.
- They are open and friendly and do not have any difficulty to meet new people.
- They are able to work at a job successfully and support themselves.
- They are able to get enough sleep.
- They are usually able to give a correct reading if asked to tell someone else’s mood or feelings.

- How does the mentally healthy person feel about himself:

- He/she feels good about himself
- He/she accepts self – although not self satisfied
- He/she can look into self and examine self
- He/she sees “self ”in a realistic manner
- He/she is aware of his/her capabilities and limitations
- He/she does not over or underestimate him/herself
- He/she has self respect
- He/she possesses self esteem
- He/she self confident and self reliance
- He/she is able to adapt and adjust
- He/she works towards self realization
- Set goals that are realistic.

2.11 Gender and Mental Health

Many developmental studies have examined the effect of age and gender as well as their interaction on the epidemiology of mental health and have consistently revealed that problems are less common in early adolescence than in late adolescence (Fleming and Offord, 1990, pp.571-80) and females experience higher rates of such problems than males (Sprock and Yoder, 1997).

i. Male’s Mental Health

The social expectations placed on men not to express their emotions and to be dependent on women for many aspects of their domestic life may contribute to high levels of distress among men when faced with situations such as bereavement. The social and religious expectation on men to bear the sole responsibility for providing financially for their families may also add to stress levels for males.

ii. Female’s Mental Health

Both genders are burdened by the tremendous personal and financial work that mental unhealthiness exacts, females suffer in higher numbers from certain conditions. Women are affected twice as often as men by most forms of depression and anxiety disorders, for instance and nine times as often by eating disorders.
In addition to these epidemiologic disparities, there are disparities between men and women in the ways mental health problems occur. All mental health disorders, including those such as schizophrenia and bipolar disorder that affect males and females equally, occur at different ages for women and men, exhibit different types and patterns of symptoms and require different treatment responses.

The implication of these epidemiologic and clinical differences are important too for planning research programs and developing policy related to prevention, treatment and mental health services.

2.12 Adolescent and Mental Health

This segment presents details of the Need of mental health for the Adolescents.

Mental health is an essential component of young peoples’ overall health and wellbeing. It affects how young people think, feel and act; their ability to learn and engage in relationships; their self-esteem and ability to evaluate situations, options and make choices. A person’s mental health influences their ability to handle stress, relate to other people and make decisions.

Many people experience mental health problems at some time during their lives. At least one in five children and adolescents may express a mental health problem in any year. However, in any given year, it is estimated that fewer than one in five of such children receives needed treatment.

When young people’s mental health problems go untreated, it can affect their development, school performance and relationships. The state of their mental health affects how they view themselves and others, how they
evaluate and react to situations and what choices they make and actions they take. Because mental health problems can affect a young person’s judgment, in the rare case, emotional disturbances and mental disorders can be a risk factor for violence.

2.12.1 Need for mental health in adolescent

Major depressive period and health problem occurs among adolescents and young adults. Adolescence is a developmental phase during which several of the mental health disorders of adulthood appear. The diagnostic studies conducted during this phase offer a good opportunity to gain a thorough understanding of the development of various mental disorders. The study of mental health and disorders in adolescents has been a part of the research since long.

By this age mental illness such depression, anxiety, substance abuse, eating disorders and behavioural disorders suicidality, adjustment disorder and, later on, the anxiety disorders are likely to develop. This is highly a risk level age for such mental illness.

The foundation for good mental health is laid in the early years and society as a whole benefits from investing in children and families. Good mental health in childhood is a prerequisite for optimal psychological development, productive social relationships, effective learning and ability to care for oneself, good physical health and effective economic participation as adults. There is growing evidence on the long-term value of promoting the positive mental health of children and young people, for example through the shaping of early childhood experience, through positive parenting and through effective educational services and school programmes. Schools and the community can play an important role in reaching youth and determining their level of mental health. Effective
mental health promotion in educational and community settings in turn strengthens the core objectives of education and the youth sector.

2.12.2 Characteristics of Adolescence changes

Adolescence is characterised by rapid change in the following areas:

**Physical** – puberty (physical growth, development of secondary sexual characteristics and reproductive capability)

**Psychological** – development of autonomy, independent identity, value system, cognitive – moving from concrete to abstract thought

**Emotional** – moodiness; shifting from self-centeredness to empathy in relationships, social – peer group influences, formation of intimate relationships

2.12.3 Risk Factors

Mental health problems in children and adolescents can be caused by biological factors, environmental factors or their combination.

Biological causes may include genetics, chemical imbalances in the body and damage to the central nervous system. The relationship of genes to mental health is complex. Researchers have not yet isolated all of the genes that might contribute to vulnerability for specific mental disorders, or determined how environmental factors might trigger that vulnerability.

Family violence is an example of an environmental factor that can increase the possibility of developing a serious behavioral disorder. For example, a young person’s exposure to childhood harassment such as child abuse and neglect that increased risk for misbehaviour, adult criminality and violent criminal behavior.
2.12.4  *Adolescent Health Status*

Young people have specific health problems and developmental needs that differ from those of children or adults. The causes of ill-health in adolescents are mostly psycho-social rather biological.

- Young people often engage in health risk behaviours that reflect the adolescent developmental processes of experimentation and exploration
- Young people often lack awareness of the harm associated with risk behaviours and the skills to protect themselves
- Young people lack knowledge about how and where to seek help for their health concerns
- Young peoples’ health status is also strongly influenced by family, social and cultural factors as well as environmental hazards to which they may be exposed e.g.
  i. socio-economic status
  ii. cultural background
  iii. family breakdown
  iv. physical / sexual abuse and neglect
  v. homelessness

The leading causes of death and illness in the age group 12 – 24 years are:
Accidents and injuries – both unintentional and self-inflicted Mental health problems – depression and suicide Behavioural problems – including substance abuse

2.12.5  *Key Features of Adolescent Health Problems*

- The majority of adolescent health problems are psycho-social – a consequence of health risk behaviours, developmental difficulties and exposure to social and environmental risk factors.
• Many health problems co-occur in adolescents with the occurrence of one health problem raising the risk for a subsequent problem.
• Many health risk behaviors and lifestyles are established in adolescence and continue into adulthood leading to chronic health problems – e.g. tobacco use; dietary habits; alcohol use etc.

2.13 Foundation base for development of the Scale (Stages of Adolescence)

- The Developmental Perspective of Adolescence

Determining the developmental stage of the adolescent provides a guide to the adolescent’s physical and psycho-social concerns, the young person’s cognitive abilities and capacity for understanding choices, making decisions and appropriate communication strategies and interventions.

There are three main stages of adolescent development – early, middle and late adolescence. However, psycho-social development can be highly variable in terms of progression from one stage to the next.

Age in itself does not define maturity in different areas of adolescent development – in any particular adolescent, physical, cognitive and psychological changes may be ‘out of sync’

Example: An early developing, mature-looking girl may be psychologically immature and emotionally vulnerable.
## Development Stages

<table>
<thead>
<tr>
<th>Early (10 – 14 years)</th>
<th>Middle (15 – 17 years)</th>
<th>Late (&gt; 17 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CENTRAL QUESTION</strong></td>
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</table>

### MAJOR DEVELOPMENTAL ISSUES

- coming to terms with puberty
- struggle for autonomy commences
- same sex peer relationships
- all important
- mood swings
- new intellectual powers
- new sexual drives
- experimentation and risk-taking
- relationships have self-centred
- quality need for peer group acceptance
- emergence of sexual identity
- independence from parents
- realistic body image
- acceptance of sexual identity
- clear educational and vocational
- goals, own value system
- developing mutually caring and responsible relationships

### MAIN CONCERNS

- anxieties about body shape and changes
- comparison with peers
- influence of peers
- tensions between family and individual over assertions of autonomy
- balancing demands of family and peers
- prone to fad behaviour and risk taking strong need for privacy
- maintaining ethnic identity while striving to fit in with dominant culture
- self-responsibility
- achieving economic independence
- developing intimate relationships

### COGNITIVE DEVELOPMENT

- still fairly concrete thinkers
- less able to understand delicacy
- daydreaming
- common difficulty identifying how their immediate behaviour impacts on the future
- able to think more rationally
- concerned about individual freedom and rights
- able to accept more responsibility for consequences of own behaviour
- begins to take on greater responsibility within family as part of cultural identity
- longer attention span
- ability to think more abstractly
- more able to synthesise information and apply it to themselves
- able to think into the future and anticipate consequences of their actions
The Scale in the research is developed with reference to the following two adolescent development stages. The Scale takes into consideration of Middle (15-17 years); and Late (> 17 years) of adolescent age stages of development. Hence the preparation of content and structure of Scale is developed according to –

1. Central Questions regarding these two stages
2. Issues related to these two stages
3. Main Concerns of these two stages.

**Developmental Stages of Adolescent:**

<table>
<thead>
<tr>
<th></th>
<th>Middle (15 – 17 years)</th>
<th>Late (&gt; 17 years)</th>
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</thead>
<tbody>
<tr>
<td><strong>CENTRAL QUESTION</strong></td>
<td>&quot;Who am I?&quot;</td>
<td>&quot;Where am I going?&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;Where do I belong?&quot;</td>
<td></td>
</tr>
<tr>
<td><strong>Issues Related to the Stages of Adolescent</strong></td>
<td>• new intellectual powers</td>
<td>• independence from parents</td>
</tr>
<tr>
<td></td>
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</table>
After the theoretical discussion regarding mental health, the investigator has decided to review related researches.

2.14 Need of review of related literature

Review of the work done in the field of mental health is necessary and it helps the investigator to get insight into the scale and prepare a design to attack the problem on hand. It gives ideas how to select or prepare appropriate scale and sample designs. It also helps the investigator to get a closer view of the present work and understand the real nature of the scale. The review of related researches is necessary to know how the researches are undertaken in the same field and which techniques are adopted by the investigators to carry out the research.

Review of the work done is necessary to show the available evidence to develop the scale effectively and thus the risk of duplication can also be avoided. Again it is necessary to provide ideas, theories, explanations in formulating the scale. It also suggests appropriate research methods for the scale, to locate comparative data useful in the interpretation of results and contribute to the general scholarship of the investigator. The review of the work done is useful from the point of view of handling the present study properly.

2.15 Review of related researches

Investigator reviewed different past researches related to this study. Related researches are classified in two types which are given below.

1. Researches done in India at Ph.D. level
2. Researches done in foreign countries
2.15.1 *Researches done in India at Ph.D. level*

The review of past researches done in India are as follows:

**Study – 1**

**Title**: Personality and mental health concomitant of religiousness in the Tibetan students in the adolescent age group.

**Researcher**: A. Gupta

**University**: Punjab Uni.

**Year**: 1980

**Objectives**: The major objectives of the study were:

1. To study the religiosity of the Tibetan adolescents studying in higher secondary schools.
2. To study the relationship between personality, religiosity and mental health of the Tibetan adolescents of the age group 16+ to 18 years.
3. To establish relationship between religious attitude and mental health of the Tibetan adolescents.

**Sample**:

The sample consisted of 313 adolescents (251 boys and 62 girls) studying in higher secondary Tibetan schools in different parts of the Himalayas, namely Dharamsala, Dalhousie, Kulu, Mandi, Mussoorie and Darjeeling.

**Tool**:

The tools for the collection of data were sixteen personality factor questionnaire by Cattell, the Cornell Medical Index and Religiosity questionnaire, locally constructed by the investigator.
Methodology:

The study was a descriptive exploratory survey research. Statistical techniques of differential analysis, simple and multiple correlations and factor analysis were used for the analysis of the data.

Findings: The major findings of the study were:

(1) In general, Tibetan adolescents were found to be religious, mentally healthy and possessing positive personality characteristics in being warm-hearted, average in intelligence, emotionally stable, assertive, conscientious, imaginative, experimenting, self-sufficient, controlled and tense.

(2) The high religious groups in respect of \( R_1 \) (faith in God) differed from the low religious groups in being more shrewd and in showing a tendency towards PF (conservatism).

(3) The high religious groups tended to be more conservative.

(4) The high religious groups in respect of \( R_3 \) (faith in religion) differed from the low religious groups in personality characteristics such as intelligence, suspiciousness and relaxation.

(5) The high religious groups were associated with the measures of mental health, which were inadequacy, depression, anxiety, sensitiveness, anger and tension.

(6) Males were more religious than females.

(7) Females were more self-opinionated and imaginative than men.

(8) Only some factors of personality such as intelligence and ego-strength were found to be positively correlated with religiousity.

(9) The subdimensions of religiosity and the measures of mental health were significantly correlated.
(10) Varimax group factors III, VIII and IX with the specific constellation of some factors of personality and dimensions of religiosity were identified as factors of personality and religiosity.

(11) Varimax group factor I identified as factor of mental health and religiosity confirmed that certain measures of mental health were concomitants of religiosity.

Study – 2

Title: Deterioration in interest as a function of insecure mental health during and after the period of certain academic specialization.

Researcher: R. N. Bhan

University: Kur. Uni.

Year: 1972

Objectives: The major objectives of the study were:

(1) To verify if deterioration in interest is a function of insecure mental health among students studying in M.A./M.Sc. or students who had passed M.A./M.Sc.

(2) To find out the factors related to insecurity among students studying for M.A./M.Sc. or who have passed M.A./M.Sc.

(3) To find out how far rejection, isolation and anxiety were the basic factors related to insecurity

(4) To compare the case histories of secure person with those of insecure persons.

Sample:

The sample was drawn from students studying for M.A. or M.Sc. and from the persons who settled down in life after passing M.A./M.Sc. in all 1,300 persons formed the sample of the study. This included 800 in-course and
500 after-course persons. These persons were divided into two groups – secure persons and insecure persons.

**Tools and methodology:**

Investigator used Maslow’s security-insecurity inventory. The Ray-Chawdhury interest survey, the Rorschach psycho-diagnostic test and the Non-directive interview schedule. Along with these data, university or college records of the sample were also studied. The data so collected were analyzed with the help of t-test.

**Findings:**

1. Interest in outdoor and physical activities deteriorated in the case of in-course group due to insecurity of mental health.

2. Interest in such fields as literary activities, welfare and humanitarian activities, outdoor and physical activities, gregarious and social activities deteriorated in the case of after-course group due to insecurity of mental health.

3. Interest fields which were not found to deteriorate in the case of in-course group due to insecurity of mental health were scientific interest, literary interest, gregarious interest and domestic interest.

4. Interest fields which were not found to deteriorate in the case of after-course group due to insecurity of mental health were scientific interest and domestic interest.

5. Security-insecurity was a stable characteristic of personality and was caused by long-standing factors which affected from early childhood.
Study – 3

Title: Mental health as a correlate of intelligence, education, academic achievement and socio-economic status.

Researcher: H. P. MAGOTRA

University: Jammu Uni.

Year: 1982

Objectives: The major objectives of the study were:

1. To isolate the factors associated with mental health and to prepare a questionnaire on them.
2. To make a comparative study of scores of boys and girls on the factors selected and the inventory on mental health.
3. To determine the degree of relationship between the factors selected (independent variables) and mental health (dependent variable) of the students selected for the study.
4. To study the effect of gender, levels of education and socio-economic status on mental health.
5. To find out the constituents which dominated the mental health of boys and girls.

Tools:

For the collection of data the tools used were General Intelligence test (Joshi), cultural level questionnaire, socio-economic status questionnaire, health condition questionnaire and mental health inventory.

Findings:

1. Girls scored higher in the intelligence test and in the socio-economic questionnaire than boys.
(2) Girls appeared to possess better mental health, were capable of facing the realities around them and were in a position to tide over the mental disequilibrium.

(3) The mental health of boys and girls appeared to be considerably influenced by the two factors, namely intelligence and physical health.

(4) The mental life of boys was dominated by the feelings of depression and neurotic behaviour. On the other hand, girls were found to be suffering from a sense of insecurity and anxiety.

Study – 4

Title: Relationship between mental health and some family characteristics of middle class school-going adolescents.

Researcher: A. K. SARKER

University: Kur. Uni.

Year: 1979

Objectives: The major objectives of the study were:

(1) To study the structure of the family today.
(2) To find out the relationship between children’s mental health and their family characteristics, namely family structure and family tension.

Sample:

The sample consisted of randomly selected 400 school-going children (212 boys and 188 girls) of age group 13 to 17 years. Mental health inventory was administered on the 400 children.
Methodology:

After administration of mental health inventory, healthy and unhealthy groups were formed. These groups were interviewed through the Children’s interview schedule and a biodata sheet. Estimates of family structure and family tension were found from the Children’s interview schedule, while the biodata sheet was used for having an idea about the nature of the sample studied. The data were analysed statistically and the groups were compared for the variable study through the t-test.

Findings: The major findings were:

(1) The mentally unhealthy group of children had higher family tension than the healthy group.
(2) The children from families with syncretic division of functions had better mental health.
(3) The family structure was not related to the mental health of the children.

Study – 5

Title: A psycho-social study of the mental health of players and non-players.

Researcher: C. D. Agashe

University: Ravishankar Uni.

Year: 1991

Objectives:

(1) To study the relationship between mental health, neuroticism, extraversion and intelligence.
To study the extent of the main effects of personality dimensions, gender, SES and participation in games and sports on the mental health of players and non-players.

Sample:

The sample of the study comprised 600 young adults drawn equally from the two gender groups (male/female) and players from colleges located at Raipur and Bilaspur in Madhya Pradesh.

Tool and methodology:

The tools used included Mehrotra’s group test of intelligence, Eysenck’s Personality inventory, Strupp and Hadley’s Mental Health inventory and Agashe and Helode’s SES scale. The data were analysed through mean, SD, t-test, product moment correlation and ANOVA.

Findings:

1. Correlational analysis revealed that IQ was not significantly related to any variable.
2. Psychoticism and neuroticism were significantly negatively related to mental health.
3. Extraversion was positively related to mental health.
4. SES was very weakly related to mental health.
5. Players were healthier than non-players. Participation in physical exercise contributed to positive mental health. However, the degree of this contribution was moderated by the personality of the individual.
Study – 6

Title : Influence of home and school environment on the mental health status of children.
Researcher : E. Manjuvani
University : Sri Venkateswara Uni.
Year : 1990
Objective :

To establish home and school environmental influences on mental health status.

Sample :

A sample of 514 students from class – 8 to 10 (271 boys and 243 girls) from Tirupati high school, Andhra Pradesh, India participated in the study. A multistage random sampling was used in selecting the 514 subjects for the present study.

Tools and methodology :

The tools used included three inventories dealing with home environment, school environment and mental health. Two series of step-wise multiple regression analysis was used to analyse the data.

Findings :

The following are some of the major findings drawn within the score investigated and the analysis of data.

(1) The home environment as measured by HEI was found to be a major significant contributing variable in predicting all the three mental health
components, namely, assets (MHC-A), liabilities (MHC-Lo) and mental health index. It was found that better the quality of home environment better the mental health status.

(2) The school environment as measured by SEI was found to be a significant contributor to the variance in both liabilities (MHC-Lo) and mental health index.

(3) The availability of resources, opportunity given to explore them and how they are actually utilized by the child are found to be significant determining factors in explaining the mental health status.

**Study – 7**

**Title :** A study of health awareness of women.

**Researcher :** Dhanalaxmi Dash

**Year :** 2006

**Objectives :**

(1) To quantify and assess the health awareness of women of Orissa and compare it among women categories with relation to their place of resident, education, age and socio-economic background.

(2) To find their awareness with relation to different dimensions of health.

**Sample :**

The present study has been carried out with a sample population of 444 women randomly selected from five districts (Cuttack, Puri, Dhenakal, Jaipur and Sundergarh) of Orissa.
Tools:

In the absence of suitable tool, the health awareness questionnaire was developed for collection of required data in the present study. After referring current literature and consulting expert in the field, five dimensions, viz., nutrition and nutritional disorders, communicable diseases, maternal health care and family planning, child health care and access to health services, were included in the instrument. In each dimension both factual and conceptual knowledge items developed in a multiple-choice format were kept. The reliability coefficient for the instrument was 0.68 which reflected near high reliability of the instrument. The developed instrument had 35 items under five dimensions.

Procedure for data collection:

The instrument first developed in English was translated into regional language (Oriya) for the convenience of the target group (women of Orissa). The questionnaires were given to the sample population and were asked to read the questions and give their responses freely. The sample women were encouraged to write their opinion/suggestions if any at the end of each questionnaire. While collecting the marked questionnaires, informal discussions were made to ascertain their views, if any.

Findings:

(1) Analysis of various data on health awareness showed that there was significant difference in the score among different women categories in each locality (rural/urban).

(2) Average mean percent score on each of the five dimensions showed that urban as well as rural women were more aware about access to health
services (score being more than 60.06 percent) followed by communicable
diseases (score 51.10 percent) than other dimensions.

(3) Mean percent score on different dimensions of health showed that rural
women had moderate awareness on access to health services but they were
poor in other dimensions.

(4) Place of residence: Both urban and rural women had less than 50
percent in mean awareness score. This showed that they had low awareness
score on health issues. There was significant difference between these two
groups in their scores and urban women were more aware than rural
women.

(5) Age: Looking into age, similarly both low and high age group women
had scores less than 50 percent and there was significant difference in their
scores.

(6) Education: Illiterate and literate women had an average awareness
score of 28.2 and 58.0 percent respectively and the difference in their
scores was statistically significant at 1 percent level. This reflected that
illiterate woman were poor in health awareness whereas literate women
were moderately aware of the issues.

(7) Socio-economic background: Looking into the socio-economic
background and health care awareness, it was noted that high socio-
economic background women had moderate level awareness whereas other
two (low and middle socio-economic background) categories had poor
awareness.
Study – 8

Title : An investigation into the mental health and physical health differences between retirees and working persons.

Researcher : Saroj Kothari

Year : 2006

Objectives : The main aim of the study was to investigate the mental health and physical health differences between retirees and working persons.

Hypotheses :

(1) There will be no significant difference between the mean score of mental health questionnaire of retirees and working persons.

(2) There will be no significant difference between mean score of physical health questionnaire of retirees and working persons.

Sample :

The sample comprised of 25 Retirees (after opting for VRS) and 25 Workers who were working in manufacturing companies. The educational qualification of the participants ranged from Graduation to post graduation and the average age of the sample was 45 years.

Test Materials Used :

The Occupational stress indicator (OSI, 1988) developed by Carl Cooper, Stephen Sloan and Stephen Williams were used. OSI adopts a dynamic approach to measuring the symptoms of occupational stress and helps to meet the needs of the business users. The indicator was developed with the primary purpose of identifying the level of stress that by its very nature
helped management to take the corrective action and utilize their employees full potential. OSI is a comprehensive scale, which measured various aspects related to the employees stress. For the purpose of this study only the subscale measuring mental and physical health was selected.

(a) Mental Health Questionnaire (Adopted from OSI, 1988) – Part A of this questionnaire focuses on feelings and behaviour and how these are affected by the pressure you perceive in your job.

(b) Physical Health Questionnaire (Adopted from OSI, 1988) – part B is concerned more specifically with the frequency of occurrence of manifestly physical problems.

Method of data collection:

Each respondent of the sample was contacted individually. The respondents were informed about the purpose of the study and after their consent, the questionnaire was given to them. To minimize response bias and help in interpretation of the questions, the respondents were requested to fill the response in the presence of the researcher.

Findings:

The working persons had significantly better mental health than retirees. The cause behind it is that the retirement, which ends this important work role, means that the retiree is likely to suffer psychologically from no longer being able to view himself as a productive, contributing member of society.
Study – 9

**Title**: To study the difference of mental health between handicapped male and female and between urban and rural handicapped in six areas of mental health.

**Researcher**: Suman M. Vaishnav and Rajesh Patel

**Objectives:**

1. To study the difference of mental health between male handicapped and female handicapped in six areas.
2. To study the difference of mental health between rural handicapped and urban handicapped in six areas.
3. To study the difference of mental health between female urban handicapped and male rural handicapped in six areas.
4. To study the difference of mental health between male urban handicapped and male rural handicapped in six areas.
5. To study the difference of mental health between male rural handicapped and female rural handicapped in six areas.
6. To study the difference of mental health between male urban handicapped and female urban handicapped in six areas.
7. To study the difference of mental health between male rural handicapped and female urban handicapped in six areas.
8. To study the difference of mental health between male urban handicapped and female rural handicapped in six areas.
9. To study the overall difference of mental health in six areas between above written groups.
Hypotheses:

(1) There will be no significant difference in mental health between male and female handicapped in six areas.
(2) There will be no significant difference in mental health between urban and rural handicapped in six areas.
(3) There will be no significant difference in mental health between male urban handicapped and male rural handicapped in six areas.
(4) There will be no significant difference in mental health between female urban handicapped and female rural handicapped in six areas.
(5) There will be no significant difference in mental health between male rural handicapped and female rural handicapped in six areas.
(6) There will be no significant difference in mental health between male urban handicapped and female urban handicapped in six areas.
(7) There will be no significant difference in mental health between male rural handicapped and female urban handicapped in six areas.
(8) There will be no significant difference in mental health between male urban handicapped and female rural handicapped in six areas.
(9) There will be no significant difference in mental health in six areas in above written groups.

Sample:

A sample of 120 students was taken from Bhavnagar city with the help of incidental sampling. The data was collected from PNR society and other coaching classes of Bhavnagar.

Tools:
Mental health inventory (MHI) by Jagdish & Srivastava was used to collect data.
Research Design:
2x2 factorial design was used for the analysis of scores.

Findings and Conclusion:

(1) There was a significant difference between male and female handicapped.
(2) No significant difference between urban and rural handicapped.
(3) A significant difference was found between male urban and male rural handicapped.
(4) There was no significant difference between female urban and female rural handicapped.
(5) There was no significant difference between male rural and female rural handicapped.
(6) There has not been significant difference between male urban and female urban handicapped.
(7) A significant difference between male rural and female urban handicapped was found.
(8) A significant difference was found between male urban and female rural handicapped.

Study – 10

Title: Influence of meditation techniques and Jacobson’s Progressive Muscular Relaxation on Measures of Mental Health.

Researcher: S.S. Nathawat and Prena Kumar

Year: 1999

Tools: Standardized questionnaires and projective measures were administered to the participants of all the five groups, firstly on the starting
day and secondly on the eleventh day (i.e. after the course), brief description of the tests is as follow:

1. Overall Evaluation of Life Situation (OEOLS) – it was developed by Dupuy (1978). (range of score is 3-21).
2. Satisfaction with Life Scale (LS) – It was developed by Diener (1983). (Score ranges from 5-35).
3. Positive Affect and Negative Affect Scale (PA & NA) – the test was developed by Bradburn (1969).

Findings:

No significant difference was found in pre-test and post-test scores of the control group. The results indicated that Vipassana, TM, Yoga and JPMR were effective in reducing psychological dysfunction as well as enhancing positive mental health.

2.15.2 Researches done in foreign countries

The review of past researches done in foreign countries are as follows:

Study – 1

Topic : The development and evaluation of a mental health promotion programme for post-primary schools in Ireland.

Researcher : Mary Byrne, Margaret Barry, Anne Sheridan

Introduction :

Historically, health and personal development has been delivered on an ad hoc basis in Irish schools. However, from September 2005 Social, Personal and Health Education (SPHE) will be a mandatory curriculum subject for 15 to 18 year olds. There is a shortage of high-quality resources on positive
mental health available for teachers to implement SPHE with this age group and the Mind Out project sought to meet this need.

Aim of the project:

The aims of the programme materials that have been developed are to:

(1) Identify a range of coping strategies available to young people in stressful situations;

(2) Identify rational thinking skills for use in controlling negative emotions;

(3) Raise awareness of feelings and how to deal with them positively;

(4) Raise awareness of sources of support, both informal and formal, for young people in distress;

(5) Explore attitudes towards mental health issues and towards seeking help.

The aims of the associated evaluation study were to:

(1) Establish the feasibility of adapting international models of best practice in curriculum materials for mental health promotion to the Irish school setting;

(2) Assess the impact of the programme on pupils’ knowledge, attitudes and skills in relation to mental health;

(3) Investigate whether the programme’s effects are greater than those of a standard health education programme;

(4) Explore the effects of different levels of teacher fidelity to the process of programme delivery;
(5) Assess the attitudes of teachers towards the content and structure of the programme and its effect on their pupils, the pupil-teacher relationship and the wider school environment;

(6) Ascertain the attitudes of pupils towards the programme;

(7) Explore the usefulness of an activity-based workshop as an evaluation tool with young people.

Method and design:

The evaluation research study employed a randomized controlled experimental design. Programme evaluation assessments took place before and after implementation and at a 12 month follow-up, using the written questionnaire described below. Comparisons were made between: a. intervention groups receiving the Mind Out programme and control groups receiving no health education programme; b. intervention groups receiving the Mind Out programme and control groups receiving a standard health education programme.

A total of 59 schools from within the study region agreed to participate in the study as either intervention or control schools. Data were analysed at the cluster (classroom) level, using multilevel modeling techniques (Byrne et al, in press).

Findings:

Approximately 650 pupils were taught the module by 33 teachers in 22 schools during the academic year 2001–2002. The mean age of participating students at baseline was 16.17 years. 56% were female and 57% came from non-manual social class backgrounds. Over 1 200 control students from a further 37 schools also participated in the evaluation study.
Study – 2

**Topic**: Open to a mentally healthy life: Working with adolescents in Zaragoza, Spain.

**Researcher**: Francisco Galan Calvo, Margarita Lamban Campillo, Margalida Gost Ballester, David Paumard Olivan, M Pilar Moreno Palacios, Miriam Gracia Laguna.

**Year**: 2004

**Introduction**:
This programme was created from formative sessions with young volunteers at the Rey Ardid Foundation. During these sessions, an information gap about subjects related to mental health in young people was noticed.

**Aim of the programme**:

The main aims of the programme are as follows.

1. To make young people responsible for their mental health and motivate them to adopt the most appropriate attitudes to improve their mental health.
2. To involve young people, their families and teachers and professionals belonging to medical and social organizations in order to promote mental health within schools.
3. To support the young people’s educational process from both medical and social perspectives.
4. To promote values such as solidarity and acceptance of difference.

All these aims work in an interrelated manner, with each goal supporting the rest. In this sense, the development of one single aim directly promotes...
the attainment of all the others. In consequence every goal in the programme is intended to be promoted in a joint and combined way.

**Method and design:**

This programme for promoting awareness of mental health issues was produced by a group of volunteers belonging to the Rey Ardid Foundation, a nongovernmental organization. The volunteers were from the fields of social work, medicine, nursery provision, teaching and psychology. The variety of people involved gave a range of experiences and perspectives to the group, while still working to attain the common goal of creating an active attitude towards the difficult situation of accepting a mental illness.

When the project is initiated within a school, students of 14 and 15 years old form four groups of 25 students each. The students are from the same class, so a previous relationship exists among them. All students taking part in the project are evaluated twice, at the beginning and end of the project. This evaluation is made through a questionnaire which asks for students’ opinions of mental illness in the three areas of cause, description and treatment. Altogether 600 questionnaires have been completed so far.

**Findings:**

This project has been carried out every year between 1998 and 2004, in four secondary schools in Zaragoza. In total, 28 groups comprising 640 teenagers have taken part. In addition, 126 educational activities have been organized and arranged by 50 volunteers and three professionals from the Rey Ardid Foundation, together with 10 teachers.

The results obtained from the questionnaires reveal a certain ignorance of the students on mental health issues. Despite the familiarity of the students with the topics of the project and the good command they have of technical
vocabulary, students often use pejorative idioms such as: “No way”, “Don’t even dream about it”, “You are paranoid” or “You are delirious”. The results obtained also show a relationship between those affected by a mental illness and the characteristic problems of adolescence as potential causes of the mental illness.

Study – 3

**Topic:** A study investigating mental health literacy in Pakistan.

**Researcher:** Professor Dr. Kausar Suhail

**Year:** 2005

**Aims:**
This study was conducted to assess public mental health beliefs in Pakistan.

**Method:**
In a large-scale survey, conducted in three cities of Punjab along with their neighbouring suburbs, a total number of 1750 people from all walks of life were read a vignette describing symptoms of either psychosis or major depression. Survey participants were requested to provide diagnosis, causes, prognosis and possible treatments for the disorders.

**Findings:**

The findings showed that mental unhealthiness was four times more likely to be diagnosed than psychosis (18.75% vs. 4.94%). A logistic regression analysis with forward selection for the predictors showed that the type of disorder, education status and area of residence contributed significantly to one’s ability to diagnose. More people believed that GPs (23.76%), psychologists (23.92%) and psychiatrists (20.73%) were the right people to consult for these problems. There were also some who considered hakims and homeopaths (4.22%), magical (13.11%) and religious healers (13.54%) as the appropriate people to contact. Those recognizing mental disorders
were more likely to identify the underlying causes, prognosis and appropriate treatment of the problems.

**Conclusions:** The current findings suggest a need to initiate large mental health movements in Pakistan to increase the mental health awareness of people, especially targeting uneducated and rural populations.

### 2.16 Salient features of the study

The investigator has closely reviewed and studied previous research in the related area and found that the researches included various themes and perspectives like personality and mental health; effect of insecure mental health on interest during and post academic life. Some other research was focused on variables like intelligence, education, academic achievement and socio-economic. Other research was focused on effect of the characteristic of family and school environment on adolescent mental health. One research focused on difference between the mental health of players and non-players, while one research was focused on health awareness of women and mental health of handicapped male and female. The other research focused to study difference of mental and physical health between retired and working people. A research focused on how meditation effects on mental health. While some researches was on developing programme of mental health and literacy.

The present study is different in many ways. The present investigation is based on the variables like gender, area, standard, achievement, stream and cast (category). Moreover, the investigation includes correlated study of the effect of SES, Emotional Intelligence, Security-Insecurity and anxiety on the mental health. The age group of the investigation is adolescent of students of higher secondary school. The investigator has developed a new standardized scale to assess of mental health. The scale developed during
the investigation has been standardized by establishing the norms, reliability and validity. This investigation was administrated in various higher secondary school of Gujarat state.

The investigation is significant to assess mental health of adolescent. Hence, the scale contributes many opportunities to provide remedies to sustain and improve mental health status of adolescent who are the future citizens.

2.17 Conclusion

After study of related literature there are many observation noted. Mental health is an important study as it deals with human being and society. It is observed that studies on mental health is seen with various perspective like social, psychological, cultural, educational etc. and thus the subject of mental health proves its potential correlation with different aspects of life. It is observed that the need of developing more reliable and valid tool is required. Hence looking at the need of mental health scale for higher secondary school students, the present investigation was carried out. The present mental health scale would be constructed to measure mental health status of higher secondary school students of Gujarat state. The plane and procedure of present study is discussed in chapter – III.