

Contents lists available at [ScienceDirect](#)

Journal of Adolescence

journal homepage: www.elsevier.com/locate/jado

Mental health and psychosocial functioning in adolescence: An investigation among Indian students from Delhi

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ARTICLE INFO

Article history:

Available online 10 January 2015

Keywords:

Adolescence

Mental health

Anxiety

Depression

Stress

Psychosocial functioning

ABSTRACT

While developmental studies predominantly investigated adolescents' mental illness and psychosocial maladjustment, the present research focused on positive mental health of Indian adolescents within the Mental Health Continuum model. Aims were to estimate their prevalence of mental health and to examine its associations with mental distress and psychosocial functioning, taking into account age and gender. A group of 539 students (age 13–18; 43.2% girls) in the National Capital Territory of Delhi completed Mental Health Continuum Short Form, Depression Anxiety and Stress Scales-21, Strengths and Difficulties Questionnaire. Findings showed that 46.4% participants were flourishing, 51.2% were moderately mentally healthy, and only 2.4% were languishing. A higher number of girls and younger adolescents were flourishing compared to boys and older adolescents. Moreover, flourishing youths reported lower prevalence of depression and adjustment difficulties, and more prosocial behavior. Findings support the need to expand current knowledge on positive mental health for well-being promotion in adolescence.

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Introduction

Adolescence is a crucial period in life marking the transition from childhood to adult age. Around 18% of the world's population are in this life stage ([United Nations Children's Fund \[UNICEF\], 2012](#)), characterized by physical, cognitive, and socio-emotional changes which are often perceived as stressful ([Frydenberg, 1997](#)), and having potential negative consequences in terms of psychosocial adjustment. Deviant behavior, poor scholastic achievement, drug abuse and social maladjustment are among the most frequent problems detected in adolescence, having far-reaching implications for adult development ([Cicchetti & Cohen, 2006](#)).

Many studies have found associations between these problems and youth's mental health ([UNICEF, 2011](#)). There is thus great concern among nations worldwide about the incidence of mental illness in adolescence: It is estimated that around 20% of the world's youngsters have a mental health problem, with anxiety disorders and depression largely contributing to the global burden of disease for people aged 12–18 ([Costello, Egger, & Angold, 2005](#)). According to the International Consortium in Psychiatric Epidemiology ([ICPE, 2000](#)), the median age of the first onset of any anxiety, substance and mood disorders is

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between 15 and 26 across several countries in Europe, North America, and Latin America. High levels of stress are also detected in this life stage, which in turn are associated with psychopathology (Grant et al., 2006). In addition, variability in mental illness severity was found among youths in relation to age and gender. Overall, compared to late adolescence (age 15–19), early adolescence (age 12–14) is characterized by substantive developmental transitions (Petersen, Kennedy, & Sullivan, 1991), such as change from elementary to middle school, different peer expectations, and novel roles and relationships within the family and other life contexts. These transitions account for higher mean levels of stress, anxiety and depression among early than late adolescents. Moreover, irrespective of age, girls generally fare worse than boys (Hale, Raaijmakers, Muris, van Hoof, & Meeus, 2008; Holsen, Kraft, & Vittersø, 2000; Seiffge-Krenke, Aunola, & Nurmi, 2009).

While mental illness clearly represents a world's challenge at the heart of World Health Organization (WHO)'s Mental Health Action Plan 2013–2020, researchers in positive psychology have long called for a shift in focus from the sole investigation and repair of human shortcomings, deficits and pathologies, to the construction and implementation of individual strengths, resources, and ultimately positive mental health (Seligman & Csikszentmihalyi, 2000). Keyes (2002, 2007) has argued that most research has equated mental health with absence of psychopathology, neglecting WHO's positive definition of 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" (2004, p. 12). In line with this definition, Keyes proposed a measure of positive mental health hinging on two longstanding traditions in positive psychology: The hedonic tradition dealing with feelings of happiness, satisfaction and positive emotions; and the eudaimonic tradition focusing on optimal functioning in individual and social life (Deci & Ryan, 2008; Keyes, 1998). Mental health comprises emotional well-being – the affect component of hedonia – as well as psychological and social well-being, reflecting how well individuals perceive themselves as functioning in life according to the eudaimonic tradition. Psychological well-being comprises self-acceptance, personal growth, purpose in life, positive relations with others, autonomy, and environmental mastery (Ryff, 1989), while social well-being consists of social integration, contribution, coherence, actualization, and acceptance (Keyes, 1998).

According to the Mental Health Continuum model (Keyes, 2005, 2007), mental health – like mental illness – is a syndrome of symptoms. Keyes uses the term *diagnosis* to identify mental health categories, in order to parallel the Diagnostic and Statistical Manual of Mental Disorders (DSM–III–R; American Psychiatric Association, 1987) approach to appraising mental illness. Consequently, a diagnosis of mental health is made when an individual exhibits high levels on at least one symptom of hedonia and on just over half of the symptoms of eudaimonia. Under this condition, individuals are diagnosed as flourishing in life. When individuals report low levels on at least one symptom of hedonia and on just over half of the symptoms of eudaimonia, they are diagnosed as languishing. A diagnosis of moderate mental health is done when individuals are neither flourishing nor languishing. Accordingly, studies targeting adults in countries such as Italy, South Africa and the Netherlands showed that the majority of participants were categorized as non-flourishing, namely languishing or moderately mentally healthy (between 63% and 80%; Keyes et al., 2008; Petrillo, Capone, Caso, & Keyes, 2014; Westerhof & Keyes, 2010). In addition, initial evidence was gathered showing that mental health varies based on sociodemographic variables, such as education, employment status, age, and gender. Higher education and having a job positively correlated with mental health in US and South African samples (Keyes, 2002; Khumalo, Temane, & Wissing, 2012). Regarding gender, men in the US sample reported better mental health than women (Keyes, 2002), but this finding has not yet been replicated in other studies. Data concerning age suggest that, within the range of 25–74 years, mental health is higher among adults between 65 and 74 (Keyes, 2002). However, longitudinal data revealed that mental health is dynamic over time, with single adult individuals moving up or downward the mental health continuum as age advances (Keyes, Satvinder, Dhingra, & Simoes, 2010).

Confirmatory factor analysis substantiated the tripartite structure of mental health across countries, and further corroborated that mental health and mental illness are not opposite ends of a continuum (Joshanloo, Wissing, Khumalo, & Lamers, 2013; Keyes et al., 2008; Lamers, Westerhof, Bohlmeijer, Klooster, & Keyes, 2011; Petrillo et al., 2014; Westerhof & Keyes, 2010). Findings highlighted independent effects of mental health on a number of indicators of psychosocial functioning. In particular, languishing was shown to have similar negative effects as depression. For instance, both were associated with low perceived emotional health, limitations in activities of daily living, and days lost or cutback from work (Keyes, 2002). By contrast, flourishing was associated with better psychosocial functioning. Recently, longitudinal data also showed that changes in level of positive mental health were predictive of future risk of mental illness, with gains in mental health decreasing the odds of mental illness incidence (Keyes et al., 2010). In addition, absence of positive mental health was shown to increase the probability of all-cause mortality for men and women at all ages after adjustment for known causes of death (Keyes & Simoes, 2012).

In spite of the promising results obtained among adults about the positive consequences associated with mental health, to date few studies have targeted adolescence. In one US research (Keyes, 2006), flourishing youths aged 12–18 amounted to 37.9%, languishing to 6.2%, and moderately mentally healthy to 55.9%. Similarly, South African adolescents aged 15–17 were shown to be flourishing with a prevalence of 42%, to be languishing with 5%, and to be moderately mentally healthy with 53% (van Schalkwyk & Wissing, 2010). In addition, the US findings detected a decline in mental health from early to late adolescence. Specifically, nearly 10% more youths in the age group 12–14 were flourishing compared to youths in the range 15–18; by contrast, nearly 10% more older adolescents were moderately mentally healthy than younger adolescents. Notably, however, US findings supported results obtained with adult samples revealing that, irrespective of age, flourishing youths functioned better than those with moderate mental health, who in turn functioned better than languishing youths. In particular, the flourishing reported the fewest depressive symptoms and the fewest conduct problems such as having been

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