

Mental health status of tribal school going adolescents: a study from rural community of Ranchi, Jharkhand

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Abstract

Aim: To assess the mental health status of school going tribal adolescents from rural community.

Objective: To find out the mental health status (emotional, hyperactivity, relationships, and conduct problems and pro-social behaviors) among school going tribal adolescents.

Methodology: The present study is a cross sectional descriptive study design. Schools were selected purposively from rural areas of Ranchi district, Jharkhand. Socio demographic data sheet and Strengths and Difficulties Questionnaire (SDQ) were administered to the respondents. Random sampling technique was used for selection of tribal students.

Results: A total of 780 male students participated in the study. In the survey study it was found that 5.12% of the tribal students were having emotional symptoms, 9.61% of the tribal students were having conduct problems, 4.23% of the students were having hyperactivity and 1.41% of the tribal students were having significant peer problems.

Conclusion: Mental health status of tribal adolescents often gets neglected and misunderstood. A better understanding of the prevalence of mental health issues among the tribal adolescents can help family, school and mental health system to take appropriate steps to remedy, prevent mental health problems and promote better mental and emotional health

Key words: Mental Health Status, Tribal Adolescents and Rural Community

Introduction

Adolescence is often described as a period of stress and strain. Peer influence, fulfilling expectations from family, dealing with the stimulations from the external world and creating a niche and identity for oneself in this fast paced, dynamic and demanding society can throw up challenges that an adolescent may not be equipped to handle. The biological changes coupled with pressure to perform, conform and succeed could influence the adolescent's state of mind and being. As the onset of psychiatric illness has their origin in their early childhood and risk for psychiatric disorders in adulthood is increased by childhood difficulty and adversities in their life⁽¹⁾. Additionally, psychiatric disorders are the most common causes of burden and disability in young persons aged 10–24 years in whom they account for 45% of these, and are strongly associated with risk behavior and substantial psychosocial impairment⁽²⁻³⁾.

The prevalence rates of adolescents' emotional and behavioral problems are high internationally, only a small percentage of adolescents eventually make use of mental health services. Further, in an Indian study done by Reddy⁽⁵⁾ to assess a community of Indian adolescents studying in urban schools using the Strengths and Difficulties Questionnaire (SDQ) for behavioral difficulties and mental health disorders. They found that thirty participants (8.7%) had an abnormal SDQ score and 53 (15.3%) had a borderline abnormal SDQ score. Recently in a meta-analysis of epidemiological studies on child and adolescent psychiatric disorders from India, reported a prevalence

rate of be 6.46% (95% confidence interval 6.08% - 6.88%) in the community, and 23.33% (95% confidence interval 22.25% - 24.45% in the school⁽⁶⁾.

Tribal communities in general and primitive tribal groups in particular are highly disease prone. Also, they do not have required access to basic health facilities. They are most exploited, neglected, and highly vulnerable to diseases with high degree of malnutrition, morbidity and mortality⁽⁷⁾. As a result their problems are associated with poverty, illiteracy, ignorance of causes of diseases, hostile environment, poor sanitation, lack of safe drinking water and supernatural beliefs, prevalence of alcohol and tobacco use, make tribal population vulnerable to various diseases especially in rural areas. There is scarcity of reliable information on mental health status among tribal population of Jharkhand, especially the school going adolescents. Therefore, an early detection and adequate intervention are crucial to reduce overall burden and disability associated with psychiatric disorder. Therefore, attention to adolescent risk-behaviors in addition to mental health is critical in facilitating prevention and early intervention.

Aim

To assess the mental health status of school going tribal adolescents from rural community.

Objectives

To assess the mental health status (emotional, hyperactivity, relationship, and conduct problems and

pro-social behaviors) among tribal school adolescent from rural community.

Methodology

The present study is a cross sectional survey design study. Four schools were taken from rural areas of Ranchi district, Jharkhand. The subjects were selected from school going adolescent of tribal community. Purposive sampling technique was used in selection of school. Male in the age range of 13 to 17 years going to school, belonging to tribal community and those who gave consent for the study were randomly selected for the present study included in the study. Respondents were informed about the confidentiality. The tool was translated in Hindi and was validated by the field experts.

Tools

- **Semi structured Socio demographic data sheet:** Semi-structured pro forma that contained details of demographical information (age, education, religion, tribe etc.).
- **Strengths and Difficulties Questionnaire [SDQ]:** SDQ is a brief behavioral screening standardized questionnaire for measuring emotional and behavioral disorders in children and adolescents ranging from 11 to 17 years of age⁽⁸⁾. Giannakopoulos & Tzavara⁽⁴⁾ conducted a study on the factor structure of the Strengths and Difficulties Questionnaire (SDQ) in Greek adolescents.

Data collection procedure: All the subjects who fulfill the inclusion criteria were included in the study. They were explained about the purpose and the procedures of the data collection. Respondents were informed about the confidentiality and they would be given choice to withdraw from the study at any stage. Sufficient

opportunity was given to the participants to contact the investigator for any clarification if needed.

Statistical plan: An appropriate statistical measure was used for data analysis with the help of SPSS 19.

Ethical issues: The respondents were assured of confidentiality; informed consent was taken from the respondents. The participants were clearly explained the purpose of the study and subjects were selected on voluntary basis.

Results

Table 1: Demographic characteristics of the sample

Variables	MEAN± SD	N=780
Age	17.44±1.11	
Education	Class 8 th	130(16.6%)
	Class 9 th	110(14.10%)
	Class 10 th	120(15.38%)
	10+2	420(56.41%)
Religion	Hindu	135(17.30%)
	Christian	225(28.84%)
	Sarna	420(53.8%)
Tribe	Munda	440(56.41%)
	Santhal	220(28.20%)
	Oraon	120(15.3%)

In the survey 780 male tribal adolescents participated in the study. The above table shows that mean age of the tribal students was 17.44±1.11 years, majority of the students were from class 10+2 (56.41%), followed by class 10th (15.38%), class 8th (16.6%) and class 9th (14.10%). Majority of the tribal students were Sarna by religion (53.8%) followed by Christians (28.84%) and Hindu religion (17.30%). Majority of the tribal students belong to Munda tribe (56.41%) followed by Santhal and Oraon.

Table 2: Mental health status of tribal adolescents

	Average unlikely to be clinically significant (Normal)	Slightly raised may reflect clinically significant problems (Borderline)	Score is high substantial risk of clinically significant problems (Abnormal)
Emotional symptoms	630(80.76%)	110(14.10%)	40(5.12%)
Conduct problems	616(78.97%)	89(11.41%)	75(9.61%)
Hyperactivity	647(82.94%)	100(12.82%)	33(4.23%)
Peer problem	715(91.66%)	54(6.92%)	11(1.41%)
	Close to average clinically significant problems unlikely (Normal)	Score is slightly low may reflect Clinically significant problems (Borderline)	Score is low there is substantial risk of clinically significant problem (Abnormal)
Pro-social behavior	720(92.30%)	49(6.128%)	11(1.41%)

The above table shows the mental health status of tribal adolescents and it was found that overall 5.12% of the tribal adolescent students were having emotional symptoms, 9.61% of the tribal students were having conduct problems, 4.23% of the students were having hyperactivity and 1.41% of the tribal adolescent students were having significant problems in peer problems score. In the Pro-social behavior score only 1.41% of the students were having problems, while 14.10% of the tribal adolescents were found to be in borderline (Slightly raised may reflect clinically significant problems) in emotional symptoms, 11.41% were found to be borderline in conduct problems, 12.82% were found to be borderline in hyperactivity and 6.92% were found in borderline in peer problems.

Discussion

International Institute of Population Sciences⁽⁹⁾ reported that among the scheduled tribes or Adivasis (tribal) of India, mortality, morbidity and malnutrition rates remain particularly high when compared to the Indian population at large. Dispensation of health care services to this population, however, by the government and private sector alike, is disproportionately lacking⁽¹⁰⁾. The objective of this study was to screen possible psychiatric disorders, using the Strengths and Difficulties Questionnaire (SDQ), in tribal adolescents of Ranchi district, Jharkhand, India. In the present study it was found that 5.12% of the tribal students were having emotional symptoms, 9.61% of the tribal students were having conduct problems, 4.23% of the students were having hyperactivity and 1.41% of the tribal students were having significant problems in peer problems. Venu Gopal and Ashok⁽¹¹⁾ investigated the prevalence of emotional and behavioral problems among tribal and non-tribal adolescents and high prevalence of anxiety/depressed, somatic, withdrawn/depressed, thought problems and attention problems in the tribal adolescents.

Among Indian studies, Sarkhel⁽¹²⁾ reported prevalence of conduct disorder (CD) 4.58%, Deivasigamani⁽¹³⁾ has reported the prevalence of CD to be 11.13%, Sarkar et al.⁽¹⁴⁾ reported the prevalence rate of antisocial behavior to be 7.1% In an Indian study the prevalence of ADHD among primary school children was found to be 11.32%⁽¹⁵⁾ According to World health organization, world-wide, approximately 20% of children and adolescents suffer from a disabling mental illness⁽¹⁶⁾. It has been reported that in adolescents the most common mental health problems are anxiety disorders, depression and other mood disorders, and behavioral and cognitive disorders and half of all lifetime cases of mental disorders start by age 14⁽¹⁾. There was a certain limitation in the study; firstly gender comparison was not done only male students were taken. Using purposive sampling technique for selection of school was another limitation of the study.

Thirdly, only self reported version of SDQ scale was administered, parents or teacher version was not used.

Conclusion

There is a prevalence of emotional and behavioral problems in tribal adolescent population. In every country and culture children and adolescents are suffering with mental health problems. There is lack of appropriate mental health services in the rural areas and tribal population is unable to access the appropriate service and treatment. There is need to develop psychosocial care programmes for adolescent to promote of positive social, physical, psychological and emotional wellbeing appropriate to their cultural context.

Reference

1. Kessler RC, Berglund PMBA, Demler O, et al. Life time prevalence and age-of-onset distributions of DSM-IV disorders in the National Co morbidity Study Replication. *Arch Gen Psychiatry*,2005;62(6):593-602.
2. Gore FM, Bloem PJ, Patton GC, Ferguson J, Joseph V, Coffey C, Sawyer SM, Mathers CD. Global burden of disease in young people aged 10–24 years: a systematic analysis. *The Lancet*. 2011 Jun 24;377(9783):2093-102.
3. Kieling C, Baker-Henningham H, Belfer M, Conti G, Ertem I, Omigbodun O, Rohde LA, Srinath S, Ulkuer N, Rahman A. Child and adolescent mental health worldwide: evidence for action. *Lancet*. 2011 Oct 22;378(9801):1515-25. doi:10.1016/S0140-6736(11)60827-1. Epub 2011 Oct 16. Review. PubMed PMID: 22008427.
4. Giannakopoulos G, Tzavara C, Dimitrakaki C, Kolaitis G, Rotsika V, Tountas Y. The factor structure of the Strengths and Difficulties Questionnaire (SDQ) in Greek adolescents. *Annals of General Psychiatry*. 2009;8:20. doi:10.1186/1744-859X-8-20.
5. Reddy KR BK, Biswas A, Rao H. Assessment of Mental Health of Indian Adolescents studying in urban schools. *Malaysian Journal of Pediatrics and Child Health Online Early*. MJPC-2011.1.05-17.
6. Malhotra S, Patra BN. Prevalence of child and adolescent psychiatric disorders in India: a systematic review and meta-analysis. *Child and Adolescent Psychiatry and Mental Health*. 2014; 8:22. doi:10.1186/1753-2000-8-22.
7. Balgir RS. Dimensions of rural tribal health, nutritional status of Kondh tribe and tribal welfare in Orissa: a biotechnological approach. *Proceedings of the UGC Sponsored National Conference on Human Health and Nutrition: A Biotechnological Approach (Lead Lecture)*, 12-13th December 2004. Thane. pp. 47-57.
8. Goodman R. The Strengths and Difficulties Questionnaire: a research note. *J Child Psychol Psychiatry*. 1997;38:581–586. doi: 10.1111/j.1469-7610.1997.tb01545.x.
9. International Institute of Population Sciences. *National Family Health Survey 2, 1998-99*. Online. Accessed 30 June 2007.[www.nfhsindia.org/india2.html].
10. Ministry of Health and Family Welfare. 2002. *National Health Policy*.
11. Venu Gopal D.V. and Ashok A. Prevalence of Emotional and Behavioral Problems among Tribal and Non-tribal Adolescents. *Journal of the Indian Academy of Applied Psychology*, 2012;38(1):63-67.

12. Sarkhel S, Sinha VK, Arora M, Desarkar P. Prevalence of conduct disorder in schoolchildren of Kanke. *Indian J Psychiatry*, 2006;48(3):159-64.
13. Deivasigamani TR. Psychiatric morbidity in primary school children: An epidemiological study. *Indian J Psychiatry*, 1990;32:235-40.
14. Sarkar AB, Kapur M, Kaliaperumal VG. The prevalence and pattern of psychological disturbance in school going middle childhood children. *NIMHANS J*, 1995;13:33-41.
15. Venkata JA, Panicker AS. Prevalence of Attention Deficit Hyperactivity Disorder In Primary School Children. *Indian J Psychiatry*, 2013;55:338-42.
16. WHO. Child Mental Health Atlas. Geneva, Switzerland: WHO, 2005. Available on-line at: http://www.who.int/mental_health/resources/Child_ado_atlas.pdf.

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