Journal of Cardiovascular Disease Research

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

Original research article

An investigative evaluation of psychosocial problems in adolescent girls in social welfare resident school within tribal zone

[1]Dr. Ragini Muddasani, [2]Dr. Farheen Sultana, [3]Dr. Molanguri Umanshankar

[1,2]Assistant Professor, Department of Psychiatry, Osmania Medical College/Institute of Mental Health, Hyderabad, Telangana, India

[3]Professor, Department of Psychiatry, Gandhi Medical College, Secunderabad, Telangana, India

Corresponding Author:
Dr. Ragini Muddasani

Abstract

Background and objectives: Investigate the frequency of psychosocial issues among teenage females residing in tribal welfare hostels. Analyse the person's sociodemographic characteristics. Research the psychiatric morbidity of this group. Look into the issues with adolescent adjusting.

Methods: 150 adolescent girls who lived in the tribal area for a year had a descriptive study done to assess their psychological and social difficulties at Department of Psychiatry, Osmania Medical College/Institute of Mental Health, Hyderabad, Telangana, India, between December 2021 to November 2022.

Results: Current marital status of the parent's majority are married and living together (80%). Girls adjustment in with hostel, peers of the children majority 55.3% above averagely adjusted. Mother annual income majority (46.0%) being 50,000 mean was 52000.0 with a standard deviation of 42536.995. Relationship between type of family and adolescent adjustment showed chi-square value 2.03 and p value 0.843 statistically not significant.

Conclusion: 16% of tribal welfare hostel teenage females had mental problems. Most of the girls were in eighth grade and 13-15 years old. Psychiatric disorder is more common among adolescents from broken houses, according to current marital data. Single-parent children have trouble adjusting. Psychiatric illness and adjustment concerns affected school performance. This research found a high frequency of psychiatric disease among tribal welfare hostel youth, requiring careful surveillance and sufficient mental health care for treatment and evaluation.

Keywords: Psychiatric illness, adolescent age, social performance

Introduction

Adolescence is the transitional period between childhood and adulthood. According to the World Health Organization (WHO), adolescence is a stage of life between the ages of 10 and 19 that is also distinguished by particular traits. Some of these characteristics include rapid physical growth and development as well as physical, social and psychological maturity. According to Erikson in his book "life cycle crises of psycho-social development", a teen is in the stage of "Identity vs. Confusion" before moving into the stage of "Intimacy vs. Isolation". The three main stages of adolescence are early adolescence (10-13 years), mid-adolescence (14-15 years) and late adolescence (16-19year). According to the Report on Workforce Need in India (2001), various studies during the 20th century focused on the seriousness of the emotional, behavioural, and developmental problems affecting the nation's kids, teenagers, and their families [1, 2, 3]. According to each of these reports, 4-7% of the children and teenagers in the community experienced serious functional impairment and 16-20% experienced some psychosocial disorder. The most prevalent psycho-social problems included conduct disorders, learning disabilities, depression, anxiety, drug abuse, psychosomatic disorders, delinquency, truancy, insomnia, tiredness, antisocial behaviours and low self-esteem. The social, economic, geographic and ethical backgrounds of these kids are all different.

The hostel is home to students who are away from their families to pursue formal education. Hostel kids will, nevertheless, display more empathy, altruistic behaviour, and mental stability, according to study. In a hostel atmosphere, students have the opportunity to socially socialise. It is crucial to identify the tribes in order to better understand the current study, which is focused on women residing in tribal welfare hostels. A sizeable chunk of the vast nation of India is made up of the native inhabitants, the tribal people. They've been residing there among the hills and woods for a very long time. Compared to the bulk of Indians, they have a social structure, cultural practises, and language that are extremely different [3, 4, 5].

The current study was specifically created for teenage tribal females living in hostels who are between

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

the ages of 10 and 19. Later, it was incorporated into the Sarva Shiksha Abhiyan initiative to provide educational opportunities for girls from Scheduled Castes, Scheduled Tribes, Other Backward Classes, minority groups and families living in poverty in Educationally Backward Blocks [5, 6, 7].

Material and Methods

A descriptive study was conducted in 150 females at Department of Psychiatry, Osmania Medical College/Institute of Mental Health, Hyderabad, Telangana, India, between December 2021 to November 2022. The hostel guardian signed a permission document. The municipal authorities gave their consent. The ethics committee approved the institution. Proforma intake Sociodemographic data was collected using a semi-structured proforma. Age, grade, religion, ethnicity, and family type were included. Also considered were the parents' educational, career and marital statuses. Kiddie-SADS Current and Lifetime (K-SADS-PL) Version 1.0 (1996) to evaluate present and previous psychopathology. Cross-cutting symptoms in DSM5 (DSM5 CC SM). Before the KSADS interview, the guardian and child complete the DSM5 CCSM. It screens for affective and psychotic illnesses in 45-75 minutes. The K-SADS-PL scores most elements on a 0-3 scale. Scores of 0 and 1 indicate no information and symptom presence, respectively. Score 2 indicates sub threshold symptoms, whereas score 3 indicates threshold symptoms. Inter-rater reliability is 98% (93-100%).

Adjustment scale for adolescents: Students' school acclimation is assessed using this measure. Sinha & Singh (2013) created the Adjustment Inventory for School Students (AISS) with 60 items, 20 in each of the three categories of adjustment: emotional, social, and educational. For each item, responses are yes or no. High AISS scores suggest poor adjustment, whereas low scores indicate excellent adjustment. Test-retest reliability is 0.93, K-R formula-20 reliability is 0.94, and reliability is 0.95. Each answer received a 0 or 1 score. This product moment coefficient of correlation was 0.51, validating the inventory by comparing hostel superintendent ratings with inventory scores [7, 8].

Inclusion criteria

1. **Age:** Ranging from 11 to 15 years old.
2. Only females.
3. Those who consent to be a part of the research and are willing to contribute.

Exclusion criteria

Adolescents who are unwilling to consent to the research are excluded.

Results

Table 1: Psychiatric Diagnosis According to K-SADS

Shows total 150 members 16% prevalence of psychiatric illness

Psychiatric diagnosis according to K-SADDS	Frequency	Percent
illness	24	16.0
no illness	126	84.0
Total	150	100

Table 2: Place of Residency and Psycho-Social Problems of Adolescence

Chi-square value 0.192 and p-value 0.661

		K. SADS		Total	Chi-square	P- Value
		illness	no illness			
Residency	Urban Rural	0 24	1 125	1 149	.192	.661
Total		24	126	150		

Table 3: Relationship of Age and Psycho-Social Problems of Adolescence

Chi-square value .12.751 and p value .0005 is the result is statistically significant

Age		K. SADS		Total	Chi-square	p-value
		illness	no illness			
	13	4	52	56	12.751	.0005
	14	6	43	49		
	15	8	22	30		
	16	6	9	15		
Total		24	126	150		

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

Table 4: Education Level of Participants

Shows education of the study sample, with majority (39.3%) being 8th class.

Class	Frequency	Percent
8th	60	40.0
9th	52	34.7
10th	38	25.3
Total	150	100.0

Table 5: Religion

Shows religion of the study sample, with majority (51.3%) being Christian.

Religion	Frequency	Percent
Hindu	73	48.7
Christian	77	51.3
Total	150	100.0

Table 6: Relationship of Religion with Psychosocial Problems of Adolescents

Chi-square value 1.426 and p-value 0.232 not significant.

Religion	K.SADS		Total	Chi-squre	p-value
	illness	no illness			
Hindu	9	64	73	1.426	.232
Christian	15	62	77		
Total	24	126	150		

Table 7: Type of Family

Shows family of the study sample, with majority (80.7) being nuclear family.

Family	Frequency	Percent
joint family	29	19.3
Nuclear family	121	80.7
Total	150	100.0

Table 8: Relationship of Type of Family and Psycho-Social Problems of Adolescence

Chi-square value .130 and p value .718 is the result is statistically not significant

Family	K. SADS		Total	Chi square	P value
	Illness	No illness			
Joint family	4	25	29	.130	.718
Nuclear family	20	101	121		
Total	24	126	150		

Table 9: Current Marital Status of Parents

Shows current marital status of the parent's majority are married and living together (80%).

Current marital status of the parents of participants	Frequency	Percent
Married	120	80.0
Separated	9	6.0
One parent died	19	12.7
Both parents died	2	1.3
Total	150	100.0

Table 10: Relationship between Marital Status of Parents and Psychosocial Problems of Adolescence

Chi-square value 77.28 and P value < 0.00 statistically significant.

CMSP	K. SADS		Total	Chi-square	P value
	illness	no illness			
Married	4	116	120		
Separated	4	5	9	77.283	.0000
One parent died	14	5	19		
Both parents died	2	0	2		
Total	24	126	150		

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

Table 11: Relationship between Current Marital Status and Adolescent Adjustment

Chi-square value 119.394 and P value < 0.00 statistically significant.

	CMSP				Total	Chi square	P value
	Married	Separated	One parent died	Both parents died			
Extremely unsatisfactory adjustment	1	1	3	2	7	119.394	0..000
Unsatisfactory adjustment	2	2	7	0	11		
Below average adjustment	4	3	5	0	12		
Average/moderate adjustment	21	2	4	0	27		
Above average adjustment	82	1	0	0	83		
High adjustment	10	0	0	0	10		
Total	120	9	19	2	150		

Table 12: Father Education

Shows father education majority are illiterates and primary education.

Education of father	Frequency	Percent
Illiterate	55	36.7
Primary education	55	36.7
Secondary education	32	21.3
Post-Graduation	8	5.3
Total	150	100.0

Table 13: Father Annual Income

Shows the father annual income majority (30%) being above 50,000 mean was 73400.00 with a standard deviation of 32724.803.

Fathers Annual income	Frequency	Percent	Mean (std deviation)
30000	1	.7	73400.00
50000	45	30.0	(32724.803)
60000	18	12.0	
70000	31	20.7	
80000	27	18.0	
90000	8	5.3	
100000	15	10.0	
200000	4	2.7	
300000	1	.7	
Total	150	100.0	

Table 14: Mother Annual Income

Mother annual income majority (46.0%) being 50,000 mean was 52000.0 with a standard deviation of 42536.995.

Annual income of mother	Frequency	Percent	Mean (Std deviation)
20000	1	.7	52000.00
30000	25	16.7	42536.995
40000	30	20.0	
50000	69	46.0	
60000	12	8.0	
70000	6	4.0	
80000	3	2.0	
100000	1	.7	
200000	2	1.3	
500000	1	.7	
Total	150	100.0	

Table 15: Relationship between Father Annual Income and Psycho-Social Problems in Adolescents

Chi-square-4.0098 and p-value 0.045236 statistically significant.

Income	Psychiatric illness	No psychiatric illness
Below 80000	23	98
Above 80000	1	27
Total	24	125

Table 16: Relationship between Mother Occupation and Psycho-Social Problems of Adolescence

Chi-square 3.754 and p-value 0.289 are statistically not significant

Mother Occupation	K. SADS		Total	Chi-square	P value
	illness	no illness			
house wife	4	9	13	3.754	0.289
Farmer	8	61	69		

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

daily wage	11	47	58	.	
government employee	1	9	10		
Total	24	126	150		

Table 17: School Performance of Adolescents

Shows academic performance of the children majority 44.0% are grade B.

School performance	Frequency	Percent
grade A	65	43.3
grade B	66	44.0
grade C	19	12.7
Total	150	100.0

Table 18: Relationship between School Performance and Psycho-Social Problems

Chi-square value 28.889 and P value .00 statistically significant

School Performance and Psychosocial Problems	K.SADS		Total	Chi-square	P value
	illness	No illness			
Grade A	5	60	65	28.889	.0000
Grade B	8	58	66		
Grade C	11	8	19		
Total	24	126	150		

Table 19: Father Physical, Medical and Psychiatric Illness

Shows the father with history of physical, medical and psychiatric illness among those majority are psychiatric illness

History of medical, surgical and psychiatric illness to father	Frequency	Percent
Physical	4	2.7
Medical	10	6.7
Psychiatric illness	11	7.3
no illness	125	83.3
Total	150	100.0

Table 20: Mother Physical, Medical and Psychiatric Illness

Shows the mother with history of physical, medical and psychiatric illness among those majority are medical illness.

Medical/surgical/psychiatric illness in mother	Frequency	Percent
physical	4	2.7
medical	13	8.7
psychiatric	7	4.7
no illness	126	84.0
Total	150	100.0

Table 21: Relationship between Father Illness and Participant Illness

Chi-square value 41.485 and P value .00 statistically significant.

Father illness and Participant Illness	KSADS		Total		
	illness	no illness		Chi-square	P value
Surgical	0	4	4	41.485	.0000
Medical	3	7	10		
Psychiatric illness	9	2	11		
no illness	12	113	125		
Total	24	126	150		

Table 22: Relationship between Mother Illness and Participant Illness

Chi-square value 30.601 and P value .00 statistically significant

Mothers illness and illness of participants	KSADS		Total	Chi-square	p-value
	illness	no illness			
surgical	1	3	4	30.691	.0000
medical	4	9	13		
psychiatric illness	6	1	7		
no illness	13	113	126		
Total	24	126	150		

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

Table 23: Adolescent Adjustment

Adjustment in with hostel, peers of the children majority 55.3% above averagely adjusted.

Adolescent adjustment	Frequency	Percent
extremely unsatisfactory	7	4.7
unsatisfactory adjustment	11	7.3
below average	12	8.0
average/moderate	27	18.0
above average adjustment	83	55.3
high adjustment	10	6.7
Total	150	100.0

Table 24: Relationship of School Performance and Adolescent Adjustment

Chi-square value 48.124 and P value .00 statistically significant.

A.D	S.P			Total			
	A	B	C		Chi-squre	p-value	
EU	2	2	3	7	48.124		.000
U	1	3	7	11			
BA	3	6	3	12			
MA	10	12	5	27			
AA	44	39	0	83			
HA	5	4	1	10			
Total	65	66	19	150			

Table 25: Relation Ship of Adolescent Adjustment and Annual Income of Father

Chi-square value 57.69 and P value .036 statistically significant

F.A.I	A.D						Total	Chi square	P value
	EU	U	BA	MA	AA	HA			
30000	1	0	0	0	0	0	1	57.69	.036
50000	4	3	3	9	21	5	45		
60000	1	1	1	4	11	0	18		
70000	1	3	5	6	15	1	31		
80000	0	3	3	3	17	1	27		
90000	0	0	0	1	7	0	8		
100000	0	1	0	4	9	1	15		
200000	0	0	0	0	3	1	4		
300000	0	0	0	0	0	1	1		
Total	7	11	12	27	83	10	150		

Table 26: Relationship of Adolescent Adjustment and Annual Income of Mother

Chi-square value 61.43 and P value .048 statistically significant

M.A.I	A.D						Total	Chi-squre
	EU	U	BA	MA	AA	HA		P value
20000	1	0	0	0	0	0	1	61.843 .000
30000	3	2	2	5	12	1	25	
40000	0	3	3	6	13	5	30	
50000	3	5	4	13	41	3	69	
60000	0	1	1	2	8	0	12	
70000	0	0	1	0	5	0	6	
80000	0	0	0	0	3	0	3	
100000	0	0	0	0	1	0	1	
200000	0	0	1	1	0	0	2	
500000	0	0	0	0	0	1	1	
Total	7	11	12	27	83	10	150	

Table 27: Relationship of Age and Adolescent Adjustment

Chi-square value 23.332 and P value .077 statistically not significant.

Age			A.	D			Total	Chi-squre	P value
	EU	U	BA	MA	AA	HA			
13	1	3	5	9	34	4	56	23.332	0.077
14	1	3	3	9	31	2	49		
15	4	3	1	5	16	1	30		
16	1	2	3	4	2	3	15		
Total	7	11	12	27	83	10	150		

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

Table 28: Relationship of Marital Status of Parents and Adolescent Academic Performance

Chi-square value 35.70 and P value .00 statistically significant

CMSP	S.P			Total
	A	B	C	
M	58	56	6	120
S	1	5	3	9
OP	5	5	9	19
Both parents died	1	0	1	2
Total	65	66	19	150

Table 29: Relationship between Type of Family and Adolescent Adjustment

Chi-square value 2.03 and P value 0.843 statistically not significant

Type of family	A.D						Total	Chisquare	p-value
	EU	U	BA	MA	AA	HA			
J	2	1	2	5	18	1	29	2.043	.843
N	5	10	10	22	65	9	121		
Total	7	11	12	27	83	10	150		

Discussion

24 adolescent girls (16%) were found to have psychiatric morbidity in this study's cohort of school-age children and adolescents living in a tribal welfare hostel. This result is comparable to one from a study by Madhu *et al*. (2018), in which 16.41% of adolescents had psychiatric illness. In several early research, the prevalence rate for psychiatric morbidity was estimated to be between 14 and 20 percent. 17.7% in Ethiopia, 15% in Bangladesh, 16.8 in Faridpur, India, and 17% in Nepal, however in some other research, the frequency was significantly higher at 45%. Western studies were conducted in nations including Germany (20.7%), Switzerland (22.5%), and 14.5%. When adolescents experience physical harm, emotional stress, or significant changes in their environment, they are more likely to develop a psychological disorder, especially if they lack robust support networks [8, 9, 10].

(99.3%) of the participants in this study came from rural areas. According to a study, rural areas have a higher frequency of psychiatric problems than urban areas. This can be as a result of the tribal welfare hostel's rural location. The mean age of the 24 adolescent females in this study who were diagnosed with psychiatric disease was 14.3 years, the chi-square value was 12.751, and the p value was 0.0005. This result is statistically significant. About 18 (or 75%) of the girls were between the ages of 13 and 15 years. This demonstrates that the 13-15 age range has a higher prevalence of psychosocial disorder. Similar results were found in the study by Banstola *et al*. Stress may have contributed to the rise in the prevalence of psychiatric disorder in this age group. Hormonal and biological changes [11, 12].

However there is variation in association of psychiatric illness and age group for example it was more common in age groups. 14-15 and 16-19 years. Indian and American studies respectively. In a study by Bista *et al*., 2016 found that 14-15 years age group students were most commonly Vaibhav *et al*., in his study showed majority of the adolescents i.e., (39 percent) belonged to 16-19 years of age group (late adolescents) and the least number of (27.6 percent) were in the 14-15 years of age group (mid adolescents). Multiple issues, for instance, increasing transitional social role/responsibilities, peer relations and health-50 related problems look to have contributed in the development of psychosocial dysfunction between 13-and 15-years adolescent students. In this study among adolescent girls, majority 40% were in 8th class, 34.7% were in 9th class whereas 25% were in 10th class. This study was similar to another study by Bista *et al*., where 36.3% adolescents were in 9th class Singh *et al*., in his study shows majority i.e. 48.64% patients were secondary school educated while around 29.84% patients had studied beyond 10th standard [12, 13]. Madhu *et al*., 2018 in his study among students of 8th and 9th class 16.41% of the prevalence of psychiatric morbidity among school students of class 8 and 9. In this study majority of adolescents belong to Christian religion 77(51.3%). followed by Hindus 73 (48.7%). Among Hindus 9 adolescents had psychiatric illness and 15 Christians had psychiatric illness, however there was no statistical significance (p-value 0.232) in relation to psychiatric illness and religion there is variability in relation to religion and psychiatric illness in different studies. Nanda *et al*., 2001 Christian adolescence were more likely to develop mental health problems. By contrast a study from Nepal revealed that adolescents from Hindu religion had more psychosocial dysfunctions. This variation in representation of religion could be due to distribution of religion in the population studied. However the effect of religion on psychiatric illness among adolescents need to be explored. Type of family vs. psychiatric illness In this study majority of adolescents belong to nuclear family 121(80.7%) and 29 (19.3%) were from joint family. When compared for presence of psychiatric illness in nuclear family and joint family there was no statistically significant association between (p-value=0.718) [13, 14]. However this finding is different from Bista *et al*., 2016 found adolescents from nuclear family were 3.60 times more likely to have psychosocial dysfunction than those from a non-nuclear family. Students living with single parents were

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

3.46 times more likely to encounter psychosocial dysfunction than those living with both parents. Patil *et al*., 2013 also found increase risk of psychiatric disorders in adolescents of nuclear family (38). The findings of the researches done by Dudley revealed that adolescents who spend time with their grandparents, are generally emotionally and socially better and have fewer behavioural problems. Dhyani *et al*. found in their study that educational adjustment components from biological nuclear families were found non-significant. Wising *et al*. study's findings revealed that a conflicting family environment is associated with adolescents' insecurity and psychological distress, as well as aggressive behaviour and conduct disorders, which affect their adjustment in different areas of life. The majority of parents in nuclear families may not have been able to spend quality time with their kids, depriving the teenagers of appropriate parenting and counseling. The unconditional love that grandparents give to their grandchildren in joint families helps with their self-esteem/efficacy and aids in proper psychosocial development both directly and indirectly, according to Singh B *et al*. Higher representation of nuclear families in this study could also point towards change in joint family system to nuclear family in India. In this study majority (80%) of adolescent's parents were married and living together. In 12.67% single parent was dead, 6% of adolescent's parents were separated. In 1.33% both parents were dead; In order to raise a child who is psychologically and sociologically well-adjusted, parents play a critical role. A child's social and emotional development is threatened by the profound psychological trauma of losing a parent when they are young. Having single-parent households or parents who passed away as a result of psychosocial dysfunction [14, 15]. In this study, those adolescent students living with single parents had a greater risk of having psychosocial dysfunction than those living with both parents and the difference is statistically significant chi square value 77.28 and P value < 0.05. A child's social and emotional development is threatened by the profound psychological trauma of losing a parent when they are young. When a child has only one parent, they feel vulnerable, isolated, and their behavior is immature. Depression and anxiety disorders related to separation may result from parental loss. Raza *et al*., 2008 found significant psychosocial problems among adolescents with single parent when compared to both parents alive. Adolescents whose both parents are alive have better ability to form friendly relationship and had better social adjustment and are less likely to be depressed, compared to those who had their parent died. Banstola *et al*., 2018 found disrupted marital status of parents to be associated with increased psychosocial dysfunction [16, 17]. It is undeniable that a parent's divorce has a negative emotional impact on young children right away. Children seemed to be the most prone to developing emotional and psychological issues, according to one study. In this study on comparing the marital status of parents with adolescent adjustment it found that majority of adolescents no parents or single parents had significant adjustment problems when compared to those with both parents alive (Chi square value 119.394' p-value=.00) the result is statistically significant. Single parent (by death) children face complex problems related to home and family. Miss's research showed that parental loss could affect the health of adolescents. Tallush *et al*., in there study increased risk of psychiatric disorders in children of divorced parents. Furthermore, it makes physiological sense why experiencing parental loss as a young child can result in stress and psychopathological issues in the future. In addition, poor adolescent rearing techniques may contribute to psychosocial dysfunction in children raised by a single parent under difficult financial circumstances. The majority of them reported experiencing verbal or physical abuse at home, felt that their home environments were not as positive, and that stress at school was more likely to result in adjustment issues. The family environment and parental marital discord were also found by Pathak *et al*. (2011) to be statistically significant with adolescent psychosocial problems in India. Similar findings were made by Kouros, Merrilee and Cummings, who discovered a link between child emotional problems and parental marital conflict. Child abuse is a factor in psychosocial issues. Adolescents who have experienced neglect also exhibit a higher 54 rate of antisocial and violent behavior. Additionally, Oakajee *et al*. discovered a strong correlation between family trauma and physical abuse of children and adolescents' mental health issues. An increased risk of psychological, social, and behavioral impairment has been linked to early exposure to abusive and neglectful situations. About father's education in this study majority are illiterate's (36.7%) or having primary education (36.7%) there was no statistical significance in developing psychosocial dysfunction on level of literacy. This is in contrast to a study done by Bista *et al*., which shows positive effect of parental education, such as proper counseling, may be attributed [18, 19]. This could be explained by the fact that the study sample in this study was staying in the hostel. In this study most of the adolescent's fathers were farmers and majority 121 (80.67%) of them had annual income of less than 80,000 Rupees. On comparing the psychosocial dysfunction with annual income there was statistical significance in psychosocial dysfunction and father's annual income. The chi-square statistic is 4.0098. The p-value is .045236. The result is significant. This is similar to other study by Ahmed *et al*., reported the higher prevalence of psychosocial problems in lower social class. Chandrasekharappa *et al*., 2016 found increased incidence of psychosocial dysfunction in adolescents with low parental income. Apollo Hospital Report poor economic condition is a risk factor for the 55 psychosocial problem. Banstola *et al*., 2018 found increased incidence of psychosocial problems in low socioeconomic status. In another study it is found that students who did not have enough pocket money were more likely of having psychosocial dysfunction than those having enough pocket money. Rahi *et*

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

al., 2005 have observed that prevalence of psychopathological disorders was highest in children of low socio-economic status, living in overcrowded dwellings and children of illiterate parents and in lower socioeconomic status. This could lead to parents using unfavorable tactics to get along with their kids, which would lead to a bad parent-child relationship. The unfavorable relationship may deprive kids of favorable psychological conditions that are good for their cognitive growth. In contrast, parents in high SES families have a lot more time, energy and education-related knowledge, and they also tend to be more warm and affectionate toward their children in order to foster a good parent-child relationship. Previous studies have also found a link between mental health issues in kids and poor family economic conditions. In this study most of the mothers of adolescents were working women majority of them were daily wage labor and farmers 127 (84.67%) housewives were 13 (8.67%) there is no association between the psychosocial problems and employment status of mothers. (Chi square = 3.754; p-value = .289) Similar finding was found by Subbu *et al*. psychosocial problem of the respondents, there was no significant difference between the psychosocial problem of school children of working and non-working mothers. The 56 findings that revealed no discernible difference in the psychological adjustment of adolescent children of working and non-working women support this conclusion. This study's conclusion is in conflict with another finding that showed parental involvement was significantly linked to a lower likelihood of poor mental health. (89) Children of working mothers also have high levels of emotional maturity, according to another study. In this study the academic performance of majority of adolescents were grade A and B about 43% and 44% respectively. Only 12.7% of adolescents had grade C performance on comparing the academic performance with psychiatric illness majority of grade C performers had psychiatric illness when compared with grade A and grade B and this difference is statistically significant. (Chi square value is 28.889; p-value =.00). But little is known about the connection between psychological suffering and passing all of their courses among Norwegian students (Kohlhagen and Alamode, 2009). However, a review article that incorporated 11 studies from three different nations found a definite link between poor emotional well-being and sluggish academic progress. According to a different study, students' comprehension of and capacity for coping with emotional difficulties depend, at least in part, on their ability to handle academic pressure. Anxiety appeared to be unrelated to both study persistence and 57 college achievement, according to a meta-analytic study conducted among community college students in the United States, and stress can have both a positive and a negative effect on students' academic performance (Fong *et al*., 2017). In this study about 25 (16.67%) fathers of adolescents had medical, surgical and psychiatric illness. Of which 11 (7.33%) had psychiatric illness. Among mothers of adolescents 22 (14.67%) had medical, surgical, and psychiatric illness, of which 7 (4.67%) had psychiatric illness. Those adolescents whose fathers had psychiatric illness majority of them had psychiatric illness and the association is statistically significant (Chi square=41.485; pvalue=.00) those adolescents with mothers having psychiatric illness majority of them had psychiatric illness and association is statistically significant (chi square=30.691; p value =.00) These findings are similar to other study by Beardslee.et.al., which showed increased prevalence of psychiatric illness among adolescents whose parents had psychiatric illness. This could be due to various reasons like increased incidence of psychiatric illness due to genetic predisposition, psychiatric illness may impair parenting abilities and care towards children, also psychiatric illness may predisposes the parents to substance abuse, lack of job, marital discord. Poor parental attention may not provide psychologically and emotionally healthy environment causing maladaptive behavior in children. Another study shows disadvantage in growing with affectively ill parent over long period of time. One study shows problems of internalizing, externalizing, and 58 general difficulties in functioning in children of affectively ill patients. Parental mental illness is associated with increased risk of disruptive, and antisocial behavior. In this study majority of the adolescents had above average adjustment 83 (55%): and about 38% of adolescents had average and below average adjustments; where as only 6.7% of adolescents had high adjustments, with peers and others. On comparing adolescent adjustment with academic performance those students with below average, unsatisfactory, and extremely unsatisfactory adjustment had poor academic performance than those adolescents who had average, above average, and high adjustment and the difference is statistically significant. (Chi square value 48.124;p-value=.00). Majority of those adolescents with lower annual income of father had extremely unsatisfactory, unsatisfactory, or below average adjustment when compared to those with higher annual income the difference is statistically significant (Chi square value= 57.469; p-value=.036) the result is statistically significant. Similarly those adolescents with lower annual income of mother had extremely unsatisfactory, unsatisfactory, or below average adjustment when compared to those with higher annual income the difference is statistically significant (Chi square value= 61.843; p-value=.048) the result is statistically significant. Adjustment in adolescents is influenced by various personal, family, societal factors. In the case of tribal students, this could be due to adolescents being forced to stay in hostels where ethnically, culturally and linguistically strange people appointed as teachers. Also academic difficulties in learning new concepts may lead to poor adjustment. In this study on comparing adolescents age with adjustment there was no statistically significant difference between age and adjustment (chi square 23.332; pvalue=.077). This finding is similar to other studies like. However other

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

study has shown lower adjustments in lower ages. According to the study by Henshall *et al*. (2007), there was poor adjustment as age increased, with lower ages scoring poorly and higher ages more favorably. This inability to adjust as one gets older may be a result of the growing academic demands, parental expectations for their children's performance, and the complexity of each stage's social obligations and role to be played. Table 28 In this study on comparing the marital status of parents with academic performance of adolescents it is seen that, those adolescents whose parents were separated, or one parent died, or both parents dead showed poor academic performance when compared to those adolescents whose parents are living together, the difference is statistically significant Chi square value=35.70; p-value is 0.00; the 60 result is significant. Parental separation only impacted children who exhibited low school performances. It is significant to our study. This finding is consistent with results of previous studies that revealed a decrease in educational performance or an increase in academic, psychological, and behavioural problems after parental separation [19, 20].

Their poor academic results may be attributed to circumstances that existed before the parental split, such as parental conflict or a lack of parental interest in the kids' education. In this study on comparing adjustment with family type it was found that overall there is no significant effect of family type on adjustment (chi square 2.043; p value =.843). In this study about 61.5% of adolescent girls were adjusted well above average this finding is similar to Rehman *et al*., where about 65% of girls from nuclear family were well adjusted. Children's earlier school experiences, their connections with peers and the instructor, as well as certain facets of the classroom environment, all have an impact on how well they adjust. Adjustment to the environment of the school and to the daily schedule are two significant aspects of adjustment.

Conclusion

We observed that 16% of adolescent girls living in tribal welfare hostels had psychiatric illnesses as a whole. The females were mostly in the eighth standard and ranged in age from 13 to. Current marital statistics appear to be important among all factors affecting the individuals' psychiatric disease, with psychiatric illness occurring more frequently in children from broken households. In children from single parent households, adjustment was also noticeably hampered. In those with psychiatric illness and adjustment issues, school performance was worse. The results of this study show that there is a significant prevalence of psychiatric illness among young people living in tribal welfare hostels, which warrants close observation and the provision of adequate mental health services for both diagnosis and treatment.

Funding support: Nil.

Conflict of interest: None.

References

1. Progress for children: A report card on adolescents. Socio-demographic profile of adolescents. UNICEF; c2012. p. 10.
2. Report of the AACAP Task Force on Work Force Needs; c2001 June. p. 1. [http://www.aacap.org/training/WFN.PDF
3. Census of India. Provisional population totals Paper-1. Series 22. 2001
4. Iftikhar A, Ajmal A. A qualitative study investigating the impact of hostel life. Int. J Emerge Mint Health. 2015;17(2):511-5.
5. Mishra AN. Students and Hostel Life. New Delhi: Mittal Publications; c1994.
6. Kosgei F, Ayyub N, Hassan AS, Kosgei Z. The factors predicting student's satisfaction with university hostels, case study, university. Saints Malaysia. Asian Culture and History. 2010;2(2):148-158.
7. Marmot BH. A comparative study on the effect of residential area on the emotional intelligence of the std. 10 female students staying in hostel and in residence (home). Indian Stream Research Journal; c2012. p. 2.
8. Thakur, Devendra, Thakur. Tribal Life and Forest, New Delhi Deep and Deep Publication; c1994.
9. Majumdar DN. Races and Cultures of India", New Delhi, Asia Publishing House; c1973.
10. Annual Report of Ministry of Tribal Affairs, New Delhi, Ministry of Tribal Affairs Begay; c2011. p. 66.
11. Revised Guidelines for Implementation of Kasturba Gandhi Balika Vidyalaya (KGBVs) Archived 2012-04-19 at the Way back Machine
12. Twenge GM, Nolen-Hoeksema S. Age, gender, race, economic status and birth cohort differences in children's depression inventory: a meta-analysis. J Abnormal Psychol. 2002;111(4):578-88.
13. El-Bohdan S, Van Dom Burgh L, Schaefer B, El-Boo, *et al*. Peer status in relation to psychotic experiences and psychosocial problems in adolescents: a longitudinal school-based study. Eur Child Adolescent Psychiatry; c2017, (13). Doi: 10.1007/s00787-017-1063-2.

ISSN:0975 -3583,0976-2833 VOL14, ISSUE 06, 2023

14. Bista B, Thapa P, Sapkota D, Singh SB, Pokharel PK. Psychosocial Problems among Adolescent Students: An Exploratory Study in the Central Region of Nepal. Front Public Heal. 2016 Aug;4:1-7.
15. Roberts RE, Clifford Attkisson C, Rosenblatt A. Prevalence of psychopathology among children and adolescents. Am J Psychiatry. 1998;155(6):715-25.
16. Bans Tola RS. Psychosocial Problem among School-going Adolescents in Pokhara, Western Nepal. Jana Priya J Interduce Stud. 2018 Dec;6:121-33.
17. Malhotra S, Patra BN. Prevalence of child and adolescent psychiatric disorders in India: A systematic review and meta-analysis. Child Adolescent Psychiatry Mint Health. 2014;8(1):1-9.
18. Jain V, Singh M, Muzammil K, Singh JV. Prevalence of psychosocial problems among adolescents in rural areas of district Muzaffarnagar, Uttar Pradesh. Indian J Community Heal. 2014;26(3):243-8.
19. Srinath S, Giriraj SC, Gururaj G, Seshadri S, Balakrishna DK, Bhola P, *et al*. Epidemiological study of child & adolescent psychiatric disorders in urban & rural areas of Bangalore, India. Indian J Med Res; c2005. p. 122
20. Aradhya GH. Psychosocial morbidities in school going adolescent girls: A study from a South Indian city. J Clin Diagnostic Res. 2013;7(4):684-6.