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Impact of Personality on Mental Health of Adolescents among Selected Government and Aided Schools

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Abstract
Adolescents in the age group 10-19 years are in transient phase of life requiring nutrition, education, counseling and guidance to ensure their development into healthy adults. (WHO 2014) The main objective of the study was to assess the impact of personality on mental health of adolescent students. Survey method of research approach was used for the present study. The population selected for the present study comprised of adolescents studying in Government/Aided Hindi medium intermediate schools and a total of six schools were selected. Sampling technique selected for the present study was Non- Probability convenient sampling and total sample size was 300 adolescents. The tools used for data collection were Mental Health Battery (MHB) by Singh and Gupta (1978) and Eysenck's Personality Questionnaire by Eysenck (1975). The major findings of the study revealed that approximately 41.33% adolescents had good mental health; 35.66% had average mental health, and 8.0% adolescents had poor mental health. The finding also revealed that mental health of adolescents was positively and significantly related to extroversion dimension of personality which means that extrovert had better mental health.
Keywords: *Personality, Mental Health, Adolescents, & Schools.*

Back Ground of the Study

Adolescence marks the developmental transition from childhood to adulthood, a time when many important social, economic, biological, and demographic events set the stage for adult life. The nature and quality of young people's future lives, as well as a country's future social and economic development, depend largely on how well adolescents navigate this transition. In India, myriad social, economic, and health factors may undermine the ability of adolescents to lead full and productive lives. This is of particular concern given the sheer number of young people in India—an estimated 31% (358 mn) of national population is aged between 10-24 years and almost 22% comprise of 10- 19 year olds (242 mn) (Office of the Registrar General and Census Commissioner of India 2006). It is well

recognized that India's ability to achieve the Millennium Development Goals and to achieve its population stabilization goals will depend on the investment made in its young people. (UNICEF 2013)

Suicide is estimated to be a major cause of mortality during adolescence for males and females, particularly at ages 15–19. It is the leading cause of death for 15-19 year old males and females in the South-East Asia Region.

Poor mental health can have import effect on the wider health and development of adolescents and is associated with several health and social outcomes such as higher alcohol, tobacco and illicit substances use, adolescent pregnancy, school dropout and delinquent behaviours. There is a growing consensus that healthy development during childhood and adolescence contributes to good mental health and can prevent mental health problems. (WHO 2013)

Need for the Study

Parents, practitioners, and policymakers are recognizing the importance of young people's mental health. Youth with better mental health are physically healthier, demonstrate more socially positive behaviors and engage in fewer risky behaviors. Most mental health problems diagnosed in adulthood begin in adolescence. Half of lifetime diagnosable mental health disorders start by age 14. This number increases to three fourths by age 24. The ability to manage mental health problems, including substance use issues and learning disorders can affect adult functioning in areas such as social relationships and participation in the workforce. (David K nopf M Jane Park & Tina Paul Mulye 2008)

Nurses play an important role to improve physical and mental health of adolescents. In order to take care of the adolescents the nurse need to know the normal adolescent development; to differentiate age-expected behavior and maladaptive behavior. The nurse needs to maintain a good relationship and needs to make an initial contact directly with the adolescent. While caring for the adolescents, the parents also should be involved as part of the team. Parents cannot help the adolescent's treatment if they do not understand and accept it. Until and unless the parents are receptive, the nurse cannot proceed with the therapy. The nurse must continue with the adolescent until the parents are receptive. Parents should be told the normal adolescent behavior they can expect.

The nurse needs to educate the adolescents as well as the parents. One of the best ways to educate the parents about the adolescent is through parents' group. The nurse can provide information in the group and through mutual experiences and searching for solutions in a supportive environment can be extremely helpful to the parents. The parents can be educated to be self reliant.

Problem Statement

"A descriptive study to assess the impact of personality on mental health of adolescents among selected Government and Aided schools"

Objectives

1. To study the mental health of adolescents
2. To study the different dimensions of personality in the adolescents.
3. To find out the association of mental health of adolescents with their personality

Methodology

The present study was conducted in Government managed / Aided Hindi medium intermediate schools using survey method of research. Non-Probability convenient sampling technique was selected. Total six schools were selected and 50 students were taken from each school. The total sample size was 300. The tools used for data collection were Mental Health Battery (MHB) by Singh and Gupta (1978) for assessment of mental health of adolescents, and Eysenck's Personality Questionnaire by Eysenck (1975) for assessing the different dimensions of personality.

Authoritative permission was taken from the Manager/Principal of the concerned intermediate schools. Purpose and nature of the study was explained to the students and were also oriented regarding the various tools which will be used by the investigators. Students were assured regarding confidentiality of the provided data. The investigator himself collected the data from different schools.

Major Findings

The first objective of the study was to study the mental health of adolescents and to study this objective the data was presented in terms of frequency and percentage which is given in Table 1:

Table 1 Frequency and Percentage Distribution of Mental Health Scores of Adolescents

Class Interval of Mental Health Scores	Frequency	%
121-130	2	0.66
111-120	3	1.00
101-110	6	2.00
91-100	23	7.66
81-90	46	15.33
71-80	78	26.0
61-70	64	21.33
51-60	43	14.33
41-50	16	5.33
31-40	8	2.66
21-30	6	2.00
11-20	5	1.66
Total	**300**	**100.00**

Mean= 69.73; Median= 79.97; Mode = 71.69; SD= 21.29

Table 1 shows that 34 out of 300 adolescents (11.33%) have mental health scores 91 & above having excellent mental health; 124 out of 300 adolescents (41.33%) have mental health scores between 70 to 89 having good mental health; 107 out of 300 adolescents (35.66%) have mental health scores between 50 to 69 having average mental health; 24 out of 300 adolescents (8.0%) have mental health scores between 30 to 49 having poor mental health, and 11 out of 300 adolescents (3.66%) have mental health scores below 29 having very poor mental health.

The second objective of the study was to study the different dimensions of personality in the adolescents and to study this objective the data is presented in terms of frequency and percentage which is explained as:

(i) Psychoticism

The distribution of psychoticism scores of adolescents is given in Table 2.

Table 2 Frequency and Percentage Distribution of Psychoticism scores of Adolescents

Class Interval of Psychoticism Scores	Frequency	%
16-18	74	24.66
13-15	106	35.33
10-12	82	27.33
7-9	27	9.00
4-6	8	2.66
1-3	2	0.66
Total	**300**	**100.00**

Mean= 12.86; Median= 13.10; Mode= 13.16; SD= 1.34

Table 2 shows that majority of the adolescents 106 (35.33%) have scores between 13-15 which falls in 97 to 99 (P_{97}-P_{99}) percentile which means that only 1-3 % individuals are more prone to develop psychoticism compared to these adolescents. It also reveals that 74 (24.66%) of adolescents are having scores between 16-18 which falls in 100 (P_{100}) percentile which means that these individuals are at highest risk of developing mental abnormalities. Very few, 37 (12.33%) of the adolescents have scores below 9 which falls in below 85 percentile (P_{85}) which means that these adolescents are at 85 % risk of developing mental abnormalities.

(ii) Neuroticism

The distribution of neuroticism scores of adolescents is given in table 3.

Table 3 Frequency and Percentage Distribution of Neuroticism Scores of Adolescents

Class Interval of Neuroticism Scores	Frequency	%
16-18	13	4.33
13-15	77	25.66
10-12	104	34.66
7-9	55	18.33
4-6	29	9.66
1-3	22	7.33
Total	**300**	**100.00**

Mean= 12.17; Median= 13.15; Mode= 12.35; SD= 3.94

Table 3 shows that 104 adolescents (34.66%) have scores between 10-12 which falls in 92 to 96 (P_{92}-P_{96}) percentile which means that only 4-8 % individuals are more prone to develop nueroticism features compared to these adolescents. It also reveals that 90 (30.00%) of adolescents are having scores between 13-18 which falls in 97 to 100 (P_{97}- P_{100}) percentile which means that these individuals are at higher risk of developing nueroticism features and only 3 % of adolescents are more at risk to develop neuroticism compared to these individuals. Majority 106 (35.33 %) of the adolescents have scores below 9 which falls in below 85 percentile (P_{85}) which means that these adolescents are at 85 % risk of developing nueroticism features.

(iii) Extroversion

The distribution of extroversion scores of adolescents is given in table 4.

Table 4 Frequency and Percentage Distribution of Extroversion Scores of Adolescents

Class Interval of Extroversion Scores	Frequency	%
16-18	20	6.66
13-15	124	41.33
10-12	72	24
7-9	70	23.33
4-6	10	3.33
1-3	4	1.33
Total	**300**	**100.00**

Mean= 13.62; Median= 12.16; Mode= 15.66; SD= 3.033

Table 4 shows that majority 124 adolescents (41.33%) have scores between 13-15 which falls in 97 to 99 (P_{97}-P_{99}) percentile which means that only 1- 3 % individuals are having more extroverted features compared to these adolescents. It also reveals that 72 (24%) of adolescents are having scores between 10-12 which falls in 92 to 96 (P_{92}- P_{96}) percentile

which means that these individuals are having extrovert features and only 4 – 8 % of adolescents are more extroverted compared to these individuals. Few 84 (28 %) of the adolescents have scores below 9 which falls in below 85 percentile (P_{85}) which means that these adolescents are having 85 of extroverted features.

The third objective of the study was to find out the association of mental health of adolescents with their personality

Table-5 Correlation Matrix of Mental Health of Adolescents' and Different Dimensions of Personality

Variables	Mental Health	Psychoticism	Neuroticism	Extroversion
Mental health	1	-0.081	0.055	0.101**
Psychoticism		1	0.072*	0.049
Neuroticism			1	0.043
Extroversion				1

** p<0.01; *p<0.05

Table 5 indicates that there was positive and significant relationship of mental health of adolescents with intelligence (r=0.164; p<0.01).

The co-efficient of correlation of mental health of adolescents with psychoticism dimension of personality came out to be negative and insignificant (r=-0.081; p>0.05). The co-efficient of correlation of mental health of adolescents with neuroticism dimension of personality turned out to be positive and insignificant (r=0.055; p>0.05). The co-efficient of correlation of mental health of adolescents with extroversion dimension of personality came out to be positive and significant (r=0.101; p<0.01).

Discussion

Mental health of adolescents was positively and significantly related to extroversion dimension of personality which means that extrovert had better mental health. Similar studies have been conducted and results have revealed that extrovert teachers enjoy better mental health as compared to introvert teachers. (Srivastava, 1983) Extraversion was associated with decreased likelihood of use of mental health services. (Goodwin et al., 2002; Kendler, 2006) Extraversion had no direct effect on depression or anxiety. (Suurmeijer et al., 2005) Extroversion is a positive correlate of happiness and better mental health. (Furnham and Cheng, 1999) Extroversion tendencies enhance the mental health where as introversion tendencies deteriorate mental health. (Sangeeta, 2006) A lower extraversion score was associated with worse perceived health. (Benjamin, 2006)

Similar studies have been conducted and results have also revealed that Neuroticism were significantly associated with increased likelihood of allergy (Goodwin et al., 2006) Symptoms of depression and anxiety, an abnormal illness behavior and unhealthy mental health (Jylha and Isometsa, 2006; Savastano et al., 1996; Abbott et al., 2008; Nordin, 2009) low sensory threshold was positively related to neuroticism, physical problems, anxiety and mental health. (Ahadi and Basharpoor, 2010)

Conclusion

The findings of the study thus in this era with specific reference to adolescents will help the parents in becoming more aware of the importance of their concern, approval, encouragement and affective relationship in achieving mental health of their wards which play very important role in their day-to-day life.

References

1. Ahadi, B. and Basharpoor, S.(2010) Relationship between Sensory Processing Sensitivity, Personalty Dimensions and Mental Health Journal of Applied Sciences, 10 (7) , 570-574.
2. Eysenck, H.J. (1975) Manual of the Eysenck Personality Questionnaire.

London: Hodder and Stoughton.
3. Furnham, A and Cheng, H. (1999) Personality as Predictor of Mental Health and Happiness in the East and West. Personality and Individual Differences, 27(3), 395-402. General Psychiatry, 63(10), 1113-1120.
4. Goodwin, R.D., Castro, M. and Kovacs, M.(2006) Major Depression and Allergy: Does Neuroticism Explain the Relationship? American Psychosomatic Society, 68, 94-98.
5. Kendler, K.S. (2006) Personality and Major Depression. Archives of General Psychiatry, 63(10), 1113-1120.
6. Knopf, D., Park, M. J., & Paul Mulye, T. (2008). The Mental Health of Adolescents: A National Profile, 2008. San Francisco, CA: National Adolescent Health Information Center, University of California, San Francisco.
7. Sangeeta, T. (2006) Introversion and Mental Health among School Students. Psycho-Linguistic Association of India, 3(2), 121-125.
8. Singh, A.K. and Gupta, A.S. (1978) Mental Health Battery. Lucknow: Ankur Psychological Agency.
9. Srivastava, A.K. (1983) Construction and standardization of a Mental Health Inventory: A Pilot Study. Perspective in Psychological Research, 35-37.
10. Sujay, R. 2009. Premarital Sexual Behaviour Among Unmarried College students of Gujarat, India. Health and Population Innovation Fellowship Programme Working Paper, No. 9. New Delhi: Population Council. UNICEF. 2012.
11. Suurmeijer, P.B.M., Stevens, S.J., Van. Sonderen, F.L.P, Krol, B. and Sanderman, R. (2005) The Relationship between Personality and Mental Health of Patients with Early Rheumatoid Arthritis. Social Indicators Research, 73, 179.
12. World Health Organization (2013). The World Health Statistics Report, 2013 – A wealth of information on Global public health. World Health Organization, 2013, Geneva.