North Asian International Research Journal of Social Science & Humanities

ISSN: 2454-9827 Vol. 4, Issue-1 January-2018

IRJIF: 3.015

Index Copernicus Value: 57.07 UGC Journal No: 48727

MENTAL HEALTH OF THE TRIBAL SCHOOL GOING ADOLESCENTS IN COMPARISON TO THEIR NON-TRIBAL COUNTERPARTS

***KANAK PRAMANIK & **DR. ARJUN CHANDRA DAS**

** Research Scholar, Department of Education, University of Kalyani*

***Assistant Professor, Department of Education, K. U*

ABSTRACT

In this article an attempt has been made to understand mental health of the tribal adolescents in comparison to their non-tribal counterparts. A survey based descriptive study under quantitative paradigm was done where self-administered responses of the school going adolescents of the age group of 14 to 17 from the class IX and XI of the Govt. Sponsored schools affiliated by WBBSE and WBCHSE were collected to statistically analyse the hypotheses framed to get the answer of the research question. Out of 757 sample collected through stratified random sampling from 16 different schools of the districts Murshidabad, Malda, Jalpaiguri and Coochbehar 179 sample (23.6% of the total sample) were of tribal adolescents. It was found that tribal who belongs to the lower socio-economic strata in the social hierarchy has poor mental health in comparison to their non-tribal counterparts but the tribal male adolescents in comparison to the nontribal male adolescents and rural tribal in comparison to the rural nontribal are not significantly different in their mental health score. Though the relationship between socioeconomic status and mental health is well established considering the social theories it was interpreted that the prevalence of general social bonding in rural areas and the absence of perceived racial conflict in the study area might have an effect on these outcomes. Love and compassion between communities might reduce the adverse effect of social status on mental health.

Key words: ***mental healt, Social environment, tribal etc.***

INTRODUCTION

Due to rapid globalization, urbanisation and technological advancements there has been a rapid change in the sphere of social aspects. But the status of tribal continues to belong to the lowest economic strata, least developed habitation with inadequate infrastructure. They are made to think that at every sphere be it, their life style,

customs and folklore, they are inferior. There has been a continuous formidable challenges from the dominant culture, language and religion they are living with. This deculturalization of tribal people along with their socio-political discrimination might have unhinged their overall development as a result of which they are found to have significant difference in socioeconomic and socio-cultural aspects from that of their non-tribal counterparts. This is an outcome of years of neglect, discrimination and misunderstanding.

Mental health has become a global burden. It has been estimated that one of every four families is currently suffering from mental health issues. More than 25% people globally will suffer from some form of mental health issue during their entire lifetime (WHO 2001).The overall weighted prevalence of mental morbidity in India was 10.6% for current and 13.7% for lifetime among adults 18+ years (n = 34802). The rate of Mental and behavioural problems due to psychoactive substance use is22.44 (NIMHANS, 2016). In terms of West Bengal, the scenario is no different from overall picture. Prevalence of mental morbidity rate for lifetime is 15.1% (NIMHANS, 2016). There has been an ever increasing rate of suicide, substance abuse, criminal activities, and problems related to adjustments in any given society especially in India. Metal health issues can affect one's normal life and may hinder the process of development. Studies suggest that socio economic condition are largely responsible for the mental health morbidity. Society or the ethnic group that belongs to the lower strata of the socio-economic hierarchy are found to have poor mental health.

SOCIAL STATUS AND MENTAL HEALTH: EVIDENCE AND THEORY

There is no authentic documentation about the mental health status of the tribal, especially of the tribal residing in West Bengal. However, tribal belong to the lower economic strata in the social hierarchy in comparison to their non-tribal counterparts in any given society in India. Therefore tribalas an ethnic group that belong to the lower social classes have been taken into account. Psychiatric disorders have been consistently shown to be more common among people in lower social classes (Murali&Oyebode, 2004). Research has shown a moderate to strong negative correlation between socioeconomic status, measured on a community-level scale, and mental illness (Hudson, 2005). This relationship appears to hold true in adolescent populations as well (Costello, Compton, Keeler, & Angold, 2003; Miech, Caspi, Moffitt, Wright, & Silva, 1999).

There are two theories of the association between social status and mental illness: the social causation theory and the social selection theory (Hudson, 2005). According to the social causation theory mental health is affected by adversity and stress associated with low social status. The relationship between socioeconomic status and mental illness is a function of stressful economic conditions or family fragmentation and lack of support (Hudson, 2005).

On the other hand, the social selection theory asserts that people who are genetically predisposed to mental illness fail to rise out of poverty (Evans, 2016).

Living in a disadvantaged environment can expose individuals to greater uncertainty, conflicts, and threats for which there are often inadequate resources to respond effectively (Adler & Rehkopf, 2008). These experiences can create chronic stress, the effects of which continue to cumulate throughout the life course (Adler & Rehkopf, 2008). Social characteristics vary systematically across communities along dimensions of socioeconomic status, family structure and life cycle, residential stability, and racial-ethnic composition (Kawachi & Berkman, 2003). This inequality of available resources across socio-cultural group continues with income inequality.

There is another concept that the presence of strong social bonds and absence of social conflict in a particular social group may lead to better mental health despite low socio economic condition (Berkman & Kawachi, 2000). Evidence has shown that children in same society with high levels of social cohesion and collective efficacy had lower levels of antisocial behavior than their peers in in same society with lower levels of social cohesion (Odgers et al., 2009).

STATEMENT OF THE PROBLEM

In this article an attempt has been made to understand mental health of the tribal school going adolescents in relation to their non-tribal counterparts in a particular socio economic and socio cultural condition. While the relationship between socioeconomic status and mental illness has been well established, much less research has been done on mental health of the tribal adolescents, especially in the selected area where perceivable events of racial conflict between tribal and non-tribal is found to have less evidence and social bond is stable.

Although, there is no standard way to measure, diagnose, or study the presence of mental health; the default depiction of mental health has been the absence of mental diseases (Keyes, 2005). While diagnosable mental illness is indeed an important issue, the WHO's definition of health clearly states that health is not simply the absence of disease, but rather a complete state of physical, mental, and social well-being (World Health Organization, 1946). Mental health-related quality of life is therefore important from a public health perspective. Mental health is a subjective assessment of one's well-being, encompassing life satisfaction, happiness, anxiety, and depressive symptoms (Keyes, 2005). The ever widening of the gap between rich and poor has important implications for health. The health disparities will continue to grow, including mental health disparities. The study of mental health of the tribalis therefore important in order to address disparities in social bonds.

In this article an attempt has been made to understand the mental health status of the school-going tribal adolescents in relation to their non-tribal counterparts.

RESEARCH QUESTION:

1. What is the status of mental health of tribal adolescents in relation to their non-tribal counterparts?

OBJECTIVES:

1. To assess mental health of the tribal school going adolescents across groups.
2. To compare mental health status of tribal and non-tribal school going adolescents.

HYPOTHESES:

Based on the related study and theory the following hypotheses have been framed to get the answer of the research questions.

H_1: There is a significant difference in mental health status between tribal and non-tribal school going adolescents.

H_2: There is a significant difference in mental health between tribal boys and girls school going adolescents.

H_3: There is a significant difference in mental health between tribal and non-tribal male school-going adolescents.

H_4: There is a significant difference in mental health between tribal and non-tribal female school going adolescents.

H_5: There is a significant difference in mental health between urban and rural tribal school going adolescents.

H_6: There is a significant difference in mental health between rural tribal and non-tribal school-going adolescents.

H_7: There is a significant difference in mental health between urban tribal and non-tribal school going adolescents.

VARIABLES:

1. **Dependent variable**: Mental Health
2. **Independent variables**: Gender (Male and Female), Category (Tribal, Non-Tribal) and Location (Urban and Rural).

ASSESSMENT OF VARIABLE:

a) **Mental Health**:

F-inventory, used for the purpose, was originally prepared by Girindra Sekhar Bose, a revised version of which was standardized by Aratisen (1969) and was found to have high reliability and validity. This revised version of the inventory consisted of 70 items, each with three response alternatives, covering the following psychiatric syndromes and symptoms:

1) Obsession, 2) Anxiety, 3) Hysteria, 4) Anxiety-Hysteria, 5) Paranoia, 6) Schizophrenia, 7) Depression, 8) Manic Depression, 9) Mania, 10) Neurasthenia, 11) Aggression, and Psychiatric Anxiety.

Different weightages were given to items and responses in terms of scores and on the basis of clinical assessment of the gravity of symptoms. Note that the first question of the inventory has not been given any weightage as it is the part of the instruction. A high score on the test indicates greater degree of mental illness. Various forms of reliability coefficients found by AratiSen for subjects in the age group 12- 17 year ranges fron.74 to .88 which may be considered as fairly high. Validity was studied by comparing test results with Bernteuter Personality Inventory (R=.59) and also by comparing the means of scores of normal children with clinically diagnosed patients. (Means for patient is 171.56 which is 2 SD higher than the mean for normal which is 86.9). Although this inventory is way old, it has been used in several studies in recent years with high reliability and validity in assessing mental health status of the respondents of the age group of 14 to 17.

PROCEDURE

STUDY AREA

The study has been conducted in the northern region of west Bengal that consists of 7 districts excluding the hilly region of Darjeeling district. People residing this area are predominantly of middle class and lower middle class society. Schedule caste and schedule tribe along with lower caste Hindu is predominant here. There is no distinct industrial area in this region nor is the corporate sector.

POPULATION AND SAMPLE:

The sample consisted of 757 school going adolescents of classes IX and XI of the age group of 15+ and 17+ respectively. They were drawn from 16 randomly selected higher secondary schools affiliated by both West

Bengal Council of Higher Secondary Education and West Bengal Board of Secondary Education from the districts of Murshidabad, Malda, Jalpaiguri and Coochbehar. The children were all day scholar, attending schools for about 6 hours a day. Out of 757 samples 179 consisting 23.6% of the total sample are tribal and 578 consisting of 76.4% are non-tribal. The sample consists 388 female and 369 male adolescents.

Frequency table					
NON-TRIBAL	GIRLS	RURAL	N	Valid	149
		URBAN	N	Valid	147
	BOYS	RURAL	N	Valid	136
		URBAN	N	Valid	146
TRIBAL	GIRLS	RURAL	N	Valid	44
		URBAN	N	Valid	48
	BOYS	RURAL	N	Valid	50
		URBAN	N	Valid	37

METHODOLOGY:

This is a quantitative study. Self-administered responses were quantified following the manual of the selected tools. The statistical measures have been calculated through SPSS version 23 software as per the need of the study.

DESCRIPTIVE STATISTICS

Descriptive Statistics of Mental Health Score						
Category	Gender	Location	N	Mean	Std. Error	Std. Deviation
NON-TRIBAL	GIRLS	RURAL	149	129.48	3.486	42.557
		URBAN	147	111.77	3.143	38.108
	BOYS	RURAL	136	108.72	2.747	32.034
		URBAN	146	107.21	3.215	38.847
TRIBAL	GIRLS	RURAL	44	130.52	5.069	33.623
		URBAN	48	141.48	5.570	38.588
	BOYS	RURAL	50	110.50	5.049	35.702
		URBAN	37	122.92	6.042	36.752

RESULTS OF THE STUDY:

$\boldsymbol{RQ_1}$: 1. What is the status of mental health of tribal adolescents in relation to their non-tribal counterparts?

Obj_1: To compare mental health between tribal and non-tribal school going adolescents across groups.

Hypothesis:

H_1: There is a significant difference in mental health status between tribal and non-tribal school going adolescents.

H_2: There is a significant difference in mental health between tribal boys and girls school going adolescents.

H_3: There is a significant difference in mental health between tribal and non-tribal male school-going adolescents.

H_4: There is a significant difference in mental health between tribal and non-tribal female school going adolescents.

H_5: There is a significant difference in mental health between urban and rural tribal school going adolescents.

H_6: There is a significant difference in mental health between rural tribal and non-tribal school-going adolescents.

H_7: There is a significant difference in mental health between urban tribal and non-tribal school going adolescents.

STATISTICAL PROCEDURE:

To find out the answer of the Research Question 1 the following statistical procedure has been adopted. To find out mean difference between tribal andnon-tribal adolescents frequency of the non-tribal group has been equalized with the help of SPSS ver23.

MAJOR FINDINGS:

Groups are equal or near to equal with unequal variances. Under this circumstances the 't'-test as illustrated by Edward (1971) was used for group comparison. The result is given in the following table.

Group Statistics												
	Groups		N	Mean	Std. Deviation	Std. Error Mean	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference
H_1	TRIBAL		179	126.30	37.807	2.826	.027	.869	3.138	356	.002	12.777
	NON-TRIBAL		179	113.52	39.208	2.931						
H_2	TRIBAL	BOYS	87	115.78	36.466	3.910	.038	.845	-3.749	177	.000	-20.458
		GIRLS	92	136.24	36.517	3.807						
H_3	BOYS	TRIBAL	87	115.78	36.466	3.910	.003	.959	.903	181	.368	4.969
		NON-TRIBAL	96	110.81	37.802	3.858						
H_4	GIRLS	TRIBAL	92	136.24	36.517	3.807	.089	.765	3.352	173	.001	19.589
		NON-TRIBAL	83	116.65	40.780	4.476						
H_5	TRIBAL	URBAN	85	133.40	38.700	4.198	.182	.670	2.423	177	.016	13.528
		RURAL	94	119.87	35.988	3.712						
H_6	RURAL	TRIBAL	94	119.87	35.988	3.712	.001	.981	1.554	170	.122	8.795
		NON-TRIBAL	78	111.08	38.065	4.310						
H_7	URBAN	TRIBAL	85	133.40	38.700	4.198	.015	.902	3.095	184	.002	17.994
		NON-TRIBAL	101	115.41	40.155	3.996						

The content of the table depicts that there is a significant difference in mean of mental health score between tribal and non-tribal school going adolescents at 0.05 level. Tribal adolescents have a poor mental health (mean Diff 12.78) than that of their non-tribal counterparts. Tribal girls have significantly (at .01 level) higher mean than that of tribal boys (Mean diff 20.45). but where mean difference of tribal and non-tribal boys is not significant, tribal girls are found to have significantly (at .01 level) higher mean (Mean Diff 19.58) than their non-tribal counterparts. On the other hand where mean difference in mental health score between tribal and non-tribal is not significant in rural areas, it is fond significant at 0.05 level in urban areas with mean difference 18.

INTERPRETATION:

The result is quite interesting in case of male andrural tribal adolescents. It seems that the relation between low social environment and mental healthis not always in conformity with the previous study. Considering the social cohesion theory and the general characteristics of the cohabitation of the tribal and non-tribalwithout any perceivable social conflict it can be said thatdespite the prevalence of disparity in the sociocultural context, mental health does not get affected due to the social bonding present in the society. It seems that social cohesion has an effect on metal health in rural areas. However girls is found to have poor mental health across location.

CONCLUSION:

From the above study it is found that economic disparity does have an effect on mental health but the difference gets reduced in some cases. Social bonding might have an effect on the mental health status of the tribal adolescents. Social cohesion is stronger in rural areas and that might have reflected in the result. Being supportive to the lower class and strengthening the bond between tribal and non-tribal people might reduce the mental health disparity among adolescents.

REFERENCES

1. Adler, N. E., Boyce, T., Chesney, M. A., Cohen, S., Folkman, S., Kahn, R. L., &Syme, S. L. (1994).
2. Socioeconomic status and health: the challenge of the gradient. American psychologist, 49(1), 15.
3. Adler, N. E., &Rehkopf, D. H. (2008). US disparities in health: descriptions, causes, and mechanisms. Annu. Rev. Public Health, 29, 235-252.
4. Berkman, L., &Kawachi, I. (2000). Social epidemiology. New York, New York: Oxford University Press, Inc.
5. Berkman, L. F., Glass, T., Brissette, I., &Seeman, T. E. (2000). From social integration to health: Durkheim in the new millennium. Social science & medicine, 51(6), 843-857.
6. Brown, G. W., & Harris, T. (2012). Social origins of depression: A study of psychiatric disorder in women: Routledge.
7. Darling, N. (2007). Ecologycal System Theory: The Person in the Center of the Circle. *Research in Human Development, 4(3-4)*, 203-217. doi: 10.1080/15427600701663023
8. Edward, A. (1971). *Experimental Design in Psychological Research* (Third Edition ed.). New Delhi: Amerind Publishing Co Pvt. Ltd.
9. Evans, M. S. (2016). *EXAMINING THE RELATIONSHIP BETWEEN SOCIO-ECONOMIC STATUS AND MENTAL*. University of Iowa. Iowa Research Online. Retrieved 12 10, 2017, from file:///C:/Users/USER/Desktop/Examining%20the%20relationship%20between%20socioeconomic%20status%20and%20menta.pdf
10. F. S. Chapin. (1942). A Revision of Chapin's Social Status Scale. *American Sociological Review, 7*, 362-369.
11. Kawachi, I., &Berkman, L. F. (2001). Social ties and mental health. Journal of Urban health, 78(3), 458-467.
12. Kawachi, I., &Berkman, L. F. (2003). Neighborhoods and health: Oxford University Press. Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., . . . Walters, E. E.(2003). Screening for serious mental illness in the general population. Archives of general psychiatry, 60(2), 184-189.

13. Keyes, C. L. (2005). Mental illness and/or mental health? Investigating axioms of the complete state model of health. Journal of consulting and clinical psychology, 73(3), 539.
14. Kuppuswamy, B. (1962). *Manual of Social-economic Status Scale (Urban).* Delhi: Manasayan.
15. Nijhawan, H. K. (1972). *Anxiety in School Children.* New Delhi: Wiley Easteern Private Limited.
16. NIMHANS. (2016). *National Mental Health Survey of India, 2015-16: Prevalence, Pattern and Outcomes.* Bengaluru: Ministry of Health and Family Welfare.
17. Pareek, U., & Trivedi, G. (1964). *Manual of Socio-economic Status Scale.* Delhi: Manasayan.
18. Sarkar, A. (1981, October). Relationship of mental health and some family characteristics of middle class school going adolescents. *Indian Education Review, 16*, 1-8.
19. Sarkar, A. (1981, October). Relationship of mental health and some family characteristics of middle class school going adolescents. *Indian Education Review, 16*, 1-8.
20. World Health Organization. (1946). Preamble to the Constitution of the World Health Organization. Paper presented at the International Health Conference, New York.
21. World Health Organization. (2004). Promoting mental health: Concepts, emerging evidence, practice: Summary report.