Research article

The impact of parenting & social disparities in psychological distress among adolescents

Bharat Mishra[1]* David Banji[2], Kamal Saju[3], Johnson V. Babu[3], Delphina V Joseph[3], G.V Nagaraju[4]

1. Rameshwaram Institute of Technology & Management, Lucknow, Uttar Pradesh, India
2. Department of Pharmacy Practice, Jazan University, Jazan, Saudi Arebia
3. Nirmala College of Pharmacy. Muvattupuzha, Ernakulam, Kerala, India
4. Jaipur National University, Rajasthan, India

ABSTRACT

Psychological distress among adolescents in India remains a meager research domain owing to the lack of proper resources & research tools. The states like Kerala and others, where the significant number of children are not staying regularly with their parents, provided, the stay has been arranged with their relatives or school hostels have seen the unorganized and undervalued parenting brings the social disparity and psychological perturbation. The study have focused on identifying the prevalence of mental distress among the adolescents (11-17 years of age) & the Influence of parenting, social disparities on them, 2) Compare the prevalence rate of these disorders among different economic classes and area of their living. Cluster sampling surveys were conducted in ten schools in Ernakulum, Kerala. Five hundred adolescents with equal distribution from urban & rural areas were surveyed. Strengths & Difficulties Questionnaire was used to evaluate the psychological status & the original 3-band classification was used to categorize adolescents into abnormal (17-40), borderline (14-16) & normal (0-13). Modified Kuppuswamy socioeconomic scale was used to classify the subjects into five economic classes. Parenting & Social Disparities tool was employed to correlate the Influence of parenting & social disparities with the mental distress among adolescents. The participants had high SDQ scores are 59.80%. Boys showed more prevalence than females. The urban area had more prevalence than in a rural area. The lower economic class had the high value of prevalence & the upper-middle class had the lowest prevalence. The parenting score of adolescents from urban & rural areas always had a negative correlation with SDQ scores irrespective of their economic class. Compromised parenting & social disparities found in serious conditions in Kerala, India, and lead to mental distress in adolescents. The outcome of the study indicates the inattentive and deprioritized parenting.

INTRODUCTION

The psychiatric disorder may be a behavioural or mental pattern that causes significant distress. Such features may be persistent, relapsing and remitting, or occur as a single episode.[1] Mental health is a clinically significant annoyance in an individual's cognitive and emotional behaviour that represents a dysfunction in the biological or psychological processes.[2] Mental disorders are seriously affecting the occupational, social or other vital activities.[3]A great number of disorders concerning to the psychological states have been identified as Depressive disorders, obsessive compulsive disorder, Neurodevelopmental Disorders, Affective disorder, Addictive disorders, Neurocognitive disorders Personality disorders.[4] Psychological disorders have presented

Multi-dimensional causes, including interactions between, genetics, social factors, environmental factors, biological factors [5].

The psychological disorders are defined by the existence of various symptoms as abnormality of thoughts, perceptions, frequent swings in emotions, behavioural changes, and altered relationships.[6] Psychotherapy can improve their emotional states, anxiety, or depression.[7,8] There are some reserved methods, as the Brain-stimulation in which includes transcranial magnetic stimulation, electroconvulsive therapy, vagus nerve stimulation, etc. to manage the disease.[9]

Cultural differences in parenting may bring to differences in the relationship between parenting and child outcomes.[10]

Journal of medical pharmaceutical and allied sciences, Volume 10 - Issue 5, 1595, September - October 2021, Page – 3707-3712

3707

Socioeconomic status (SES) have a serious and direct relation with the health care system, environmental exposure and health conditions. The serious threats have exist as chronic stress associated with lower SES may also increase morbidity and mortality.[11] Social status and the social development plays a crucial role in children's personalities, There is a big role of parents where they can create an healthy environment around them to encourages the growth of healthy and stable psychological state.[12]

Mental health problems associated with cultural, social and parenting in children and their causes, and prevalence are not significantly studied or researched in India. Parenting and social environment are the two primary pillars that adds to a healthy mental state and a strong emotional state. Hence such studies are necessary to assess the well-being of children mental health by evaluating the environment provided to them and the parenting. If such cases are left unidentified and untreated, that will negatively affect the child's future life and may even inherit to the next generation. This can even affect the growth of a developing country like India, where manpower is the major resource. This study has an intention to bring the real situation on the surface and bring some awareness for the parents and schools.

AIM OF THE STUDY

The principal aim of the study was to study the prevalence of psychological disorders in adolescents motivated by parenting and social disparities and to compare differences between rural and urban areas & different economic classes in Ernakulam District, Kerala among the age group of 11 to 17years.

ETHICS APPROVAL

The study protocol was approved by the Institutional Human Ethical Committee (No. 015/IHEC/10/2019/NCP) of Nirmala College of Pharmacy, Muvattupuzha. The study did not involve any biochemical sampling or experiment during the data collection. Prior permission from parents and educational institutions have obtained (a school from each cluster) before the conduct of the survey. The participants were well-taught about the purpose of the study, provided they could decline to answer any questions if felt inappropriate. The data collected, have been used for research purposes only with strict confidentiality.

MATERIAL AND METHODS

Study design and Study settings

The sampling of the study was done by using cluster random sampling. The two-stage cluster design has been used among, 11-17-year-old children living in Ernakulam district, Kerala. The clusters were randomly chosen from the district. A total of 10 clusters in which 5 represents the urban and 5 represents the rural area. The study was conducted between 2018 September and 2019 march using the schooling time.

Subject recruitment & Study participants

The study have included children of 11-17 years old from 10 clusters (5 each in urban and rural).The total sample size was five hundred with equal distribution from urban & rural areas by using X^2 tests - Goodness-of-fit tests: Contingency tables with a 95% confidence level, 5% margin of error. With a p-value of 0.95, the sample size of study 500 was found significant. Two different grades with at least thirty students were selected. The first twenty-five students based on their class numbers were selected and surveyed.

Survey questionnaire & Data collection

An expert panel have approved the survey questionnaire used for data procurement under the Ethical Clearance Committee of the institution. The original version of the questionnaire was prepared in English (U.S.& U.K.) and vernacular language (Malayalam), which has provided a better understanding to each subject for ease of completion. A pilot study was conducted with a few randomly selected children to assure that they could understand the questions and produce the required answers correctly. The questionnaire included three tools Strengths and Difficulties Questionnaire (SDQ), Modified Kuppuswamy scale, Parenting & social disparities tool (PSDT).

SDQ, to identify psychological disturbances among children and adolescents were used to assess the mental health status of the subjects. The original 3-band classification was used to categorize adolescents into abnormal (17-40), borderline (14-16) & normal (0-13). The exact SDQ employed was S11-17 - SDQ for self-completion by 11-17-year-old. The S11-17 is a known SDQ that contains twenty-five questions. The questions are framed in such a way that it accounts for emotional problems, conduct issues, peer problems, pro-social aspects & hyperactivity. The results obtained from SDQ are comprehensive, consistent, reproducible & globally accepted.

Modified Kuppuswamy socioeconomic scale was used to categorize the subjects into the five economic classes, upper class (26-29), upper-middle-class (16-25), lower middle class (11-15), upper lower class (5-10), lower-class (<5). PSDT, which was developed and certified by a licensed psychiatrist, employed in Nirmala Medical Centre, Muvattupuzha, Ernakulam, Kerala, India was requested to correlate the impact of parenting & social disparities with the psychological distress faced by the adolescents and frame the appropriate questions. PSDT comprises the practical wisdom and medical knowledge of a senior licensed psychiatrist. The questions encompass the parent- adolescents relationship, family environment, social skills, community relations, and associated psychosocial factors.

Statistical analysis: All the analysis & statistical calculations was done by using SPSS V. 24. The data obtained during

Journal of medical pharmaceutical and allied sciences, Volume 10 - Issue 5, 1595, September - October 2021, Page – 3707-3712

3708

the study were statistically analysed using the univariate analysis to find out the significant contributors of SDQ scores. Correlation analysis was used to establish the relationship between PSDT score and the SDQ score. Chi-square test was performed to check out the p values of SDQ scores in the urban, rural & five economic classes individually.

RESULTS

A total of 500 subjects have participated in the study. The general division (all-inclusive with male & female) and the gender-wise status according to SDQ, is summarized in table 1.

Table 1 Mental status of the subjects obtained from SDQ

	Frequency	Prevalence Rate
General		
Abnormal	299	
Borderline	111	59.80%
Normal	90	
Total	500	
Male mental status		
Abnormal	185	
Borderline	63	67.27%
Normal	27	
Total	275	
Female		
Abnormal	114	
Borderline	48	50.66%
Normal	63	
Total	225	

*Values of Prevalence Rate are presented in percentage (total abnormal population, excluding the number of borderline population)

As per the scale utilized in the study, it is observed from the table that only 99 subjects have found in normal band, 111 subjects were seen in the border category, and 299 subjects were found in the abnormal band. The overall prevalence rate have found as 59.8%, which was assessed using the number of abnormal population and excluding the number of borderline population. Among the 275 males included in the study, 185 of them were seen to be in the band of abnormal, 63 in the border range, and 27 were normal. The overall prevalence in general for males is 67.27%. The males have shown a prevalence rate of 67.27%, which is higher compare to general prevalence rate of 59.80%. It indicates that the males in this age are more prone to psychological stresses and disorders than females of the same category. Out of 225 females included in the study, 114 of them were seen to be in the band of abnormal, 48 in the border range, and 63 were normal. The overall prevalence in general for females is 50.66%. The females show a prevalence rate of 50.66%, which is lower than the general prevalence rate of 59.80%. It means the females in this age are comparatively less prone to psychological stresses and disorders than males of the same category.

The table number 02 is describing the prevalence rate of psychological distress in urban and rural areas. In the urban area, the overall prevalence rate is 60.40%, with an individual contribution of

67.93% and 51.78% by males and females, respectively. In the rural area, there was a general prevalence of 59.20%, with an individual contribution of 67.15% and 49.55% by males and females. It is observed that there is a marginal increase in the overall prevalence rate in the urban area compared to the rural area. In both the domains, the males were showing a higher prevalence rate than the overall prevalence rate of females. In comparison, urban males and females have shown higher prevalence rates than those of rural males and females.

Table 2 Mental status of children based on area.

Domain	Urban			Rural		
	General	Male	Female	General	Male	Female
Normal	42	13	29	48	14	34
Borderline	57	32	25	54	31	23
Abnormal	151	93	58	148	92	53
Total	250	138	112	250	137	113
Prevalence Rate	**60.40%**	**67.39%**	**51.78%**	**59.20%**	**67.15%**	**49.55%**

*Values of Prevalence Rate are presented in percentage

Table 3 Prevalence rates of mental status among urban, rural and different economic classes

Domain	General Prevalence	Male	Female	P-value
General	59.80	67.27***	50.66***	0.001
Urban Area	60.40	67.39**	51.78**	0.002
Rural Area	59.20	67.15***	49.55***	0.001
Upper Class	62.82	67.39**	56.25**	0.038
Upper Middle Class	43.93	45.16**	42.85**	0.195
Upper lower Class	59.09	64.28	55.26	0.693
Lower middle Class	62.50	71.62***	44.73***	0.001
Lower Class	63.63	76.00*	51.02*	0.01

*Values show statistical significance. The p-values less than 0.05 (confidence interval 95%) are considered to be significant.

Table 4 Correlation between parenting score and SDQ score

	Domain			SDQ Score
Parenting Score	Gender	General	Pearson Correlation	-0.594
			Sig. (2-tailed)	0.000
			N	500
		Male	Pearson Correlation	-0.491
			Sig. (2-tailed)	0.000
			N	275
		Female	Pearson Correlation	-0.659
			Sig. (2-tailed)	0.000
			N	225
	Area	Urban	Pearson Correlation	-0.612
			Sig. (2-tailed)	0.000
			N	250
		Rural	Pearson Correlation	-0.575
			Sig. (2-tailed)	0.000
			N	250
	Economic Class	Upper Class	Pearson Correlation	-0.768
			Sig. (2-tailed)	0.000
			N	156
		Upper Middle Class	Pearson Correlation	-0.435
			Sig. (2-tailed)	0.000
			N	66
		Upper Lower Class	Pearson Correlation	-0.662
			Sig. (2-tailed)	0.000
			N	66
		Lower Middle Class	Pearson Correlation	-0.555
			Sig. (2-tailed)	0.000
			N	113
		Lower Class	Pearson Correlation	-0.416
			Sig. (2-tailed)	0.000
			N	99

Journal of medical pharmaceutical and allied sciences, Volume 10 - Issue 5, 1595, September - October 2021, Page – 3707-3712

3709

The individual, males and females, and the general prevalence rates of mental status among different economic classes have represented in table number 3. From the table number 3, it is been observed that in the upper class, there was an overall prevalence of mental status is 62.82 % with an individual prevalence of 67.39 % and 56.25 % for males and females, respectively. The similar trend observed in all other economic classes that prevalence rate of mental status is significantly higher in males compare to female children. In the case of the lower-middle-class subjects, the males had a prevalence with even a higher significance rate of 62.50%, while females with 44.73% and an overall prevalence of 62.50%.

Among the five economic classes specified by the Kuppuswamy's socioeconomic scale, the lower class was exhibiting the highest prevalence, whereas the upper-middle class has the least prevalence. The descending order based on the prevalence rate is as follows, lower-class > upper class > lower middle class > upper lower class > upper-middle class. In all the economic classes, the males are having an individual prevalence rate higher than that of females, the individual prevalence rate of males is higher than that of the overall prevalence rate, and that of females is lesser than the overall prevalence rate.

All the correlations were significant with the p-value <0.05. So, there was a negative correlation between Parenting score and SDQ score for males and females. As the Parenting score increased, the SDQ score decreased. (Table 4).

DISCUSSION

Mental health is an indivisible part of public health. It is not merely the absence of mental disorders or symptoms but also a resource supporting overall well-being and productivity. [13, 14]Cognitive and emotional flexibility are the basis for social skills and resilience in stressful situations, which was considered good mental health. [15, 16]

It has been observed that the overall mental status of student participants, the prevalence rate is significantly high. The data represents the serious condition among adolescents. It may be due to many reasons like improper parenting, child abuse, parental mental health, and lifestyle.[17]Improper parenting can cause psychological and behavioural problems in children. There are other studies, supporting the findings of this study. [18]

The gender-wise data analysis has shown that the predominance of the prevalence of abnormal mental status is higher with male over female subjects. In a country like India, the social setup and beliefs of the society exert significant pressure on young males. The parental expectations and the prevailed practices, such as a long dissociation and inconstant staying with parents, school hostels in early ages, staying with their relatives etc., makes the young males

to suffer and suffocate. It is observed that the children needs constant motivation with love and outmost care to achieve their desired performances and respect among class and friends, but when they fail to achieve their goals, they get psychologically disturbed and depressed.[19]It is further aggravated if their economic status is compromised. The difference between the spread of mental disease among male and female is far narrower than it is suspected. The beliefs that the men are more endurable and resilient compared to women add the mental pressure too. However, contrary to the belief, the evidence available for male vulnerability is suicide statistics. Men are around thrice more likely to kill themselves than women.[20,21]It is quite evident that there is no marked difference in the prevalence rate between males and females. Our study has shown a 50.6% prevalence rate among females. Nearly half of the females who participated in the study had mental health problems. Currently, in a country like India, the females had to own household responsibilities apart from contributing financially to the family. They are experiencing enormous mental pressure to manage their family, and the responsibilities expected from them. Many times, they learned to manage, but sometimes they may not be adapted to some situations, and they experience mental exhaustion. Culturally, females have been facing the gender bias, majority of them have restricted roles, primarily as caregivers to their children and the elderly and the female child used to face the similar prejudice. Women are twice more likely than men to develop specific psychological state conditions like depression, eating disorders, and panic disorders. [22]

All these problems for the young males and females, are probably the outcomes of the improper parenting during the childhood. However, there are different family conditions, as the case of the divorced mother. Single parenting, therefore, brings many miseries and unavoidable compromises in life. Women, who abuses are more likely to invite a traumatic event or a stressful condition and are more inevitable to have been sexually, physically, or mentally abused than other women, and these situation can make a negative impact on their children. [23]While observing the area wise status the disease prevalence of adolescents in the urban area is high than in rural areas. People living in urban are more likely to develop a mental disorder than those in rural areas. [24]The analysis of economic status and diseases prevalence states that Crime, abandoned housing, abandoned resources, high school dropouts and involvement in indecent activities have been fund in abundance. It is observed that the lower class have shown higher prevalence of disease than that of the upper class. However, the mental health associated with the economic instability and family distortions can be compensate by social welfare and other policy measures as family support programs, government relief programs and accessible and responsive primary

support services for the children and their families, at risk and prevent mental health deterioration. Finally, when we look at to correlation of various factors it produced a negative correlation between parenting score and SDQ score. We observed a decrease in parenting scores as the SDQ scores increased, which shows that the person has a mental illness. The primary factor that affects child mental health includes improper parenting. Family factors, including the togetherness of mother and father which provides quality care and support, can make a massive difference to children's early life. Parenting is considered as a critical risk factor in psychopathology. Low levels of sensitive parenting and greater use of harsh discipline have been causally linked to the development of behavioural problems among children. [25]Another dimension is including the abused children, whose mental health is at considerable risk. Abuse may be physical, sexual, psychological, and verbal. [26]Abuse can cause feelings of low esteem, lack of confidence, depression, isolation, and anger; all these feelings that greatly impair a child's chance to live a happy life.

There are following recommendations for future researchers: It is needed to develop some authenticated system to interview the young kids below 11 years of age as it is needed to find the psychological status and reasons by which the corrective measures can be taken from the beginning. It is also recommended to get the scores of the schooling system and correlation with a family environment.

CONCLUSION

The data from the current study have revealed that one in two adolescents are at risk of mental health problems. Compromised parenting & social factors lead to a negative impact on the mental health of adolescents. The gender-wise data have shown that the abnormal mental status is higher with male over female subjects. There are common practices in the state, such as a long separation with the parents and siblings and compulsory stay in school hostels or with distant relatives in early ages etc., makes the adolescents to suffer and suffocate. The area of living and economic status has also shown the change in prevalence of disease towards higher side for urban living and lower economic status. One of the major conclusion drawn from the study is that an immediate corrective step to be taken in order to preserve the healthy childhood, is that the appropriate dimensions of parenting, family environments, primary schooling system; which needs serious and effective amendments, social environment, values up-gradation, modification in traditional values, logical religious, social and spiritual beliefs. Furthermore, active discussions, organized counselling is required with the parents and teachers, among educationists and lawmakers, among counsellors and families, counsellors, and adolescents to save our young generations

from being mentally unstable and to protect from the emerging of mentally unstable society.

ACKNOWLEDGMENT

AUTHOR CONTRIBUTIONS

ABBREVIATIONS

BPAD- Bipolar Affective disorder

ECT- Electroconvulsive therapy

OCD- obsessive-compulsive disorder

PSDT- Parenting & social disparities tool

SES- Socioeconomic status

SDQ - Strengths and Difficulties Questionnaire

REFERENCES

1. Kristalyn Salters-Pedneault, 2018. National institutes of health mental disorders. December 03.

2. World Health Organization (WHO), 2012. Mental Health Gap Action Programme (mhGAP): Scaling up care for mental, neurological and substance use disorders.

3. Caspi, A, Moffitt, TE, Cannon, M, McClay, J, Murray, R, Harrington, H, Taylor, A, Arseneault, L, Williams, B, Braithwaite, A, Poulton, R, Craig, IW, 2005. Moderation of the effect of adolescent-onset cannabis use on adult psychosis by a functional polymorphism in the Catechol-O-methyltransferase gene: longitudinal evidence of a gene-environment interaction, Biol, Psychiatry; 57: 1117–1127.

4. Bergin, Allen E, Richards, PJ, 2000. Handbook of Psychotherapy and Religious Diversity, American Psychological Association (APA).

5. Nancy E, Hill Kevin R, 2004. Relationships between Parenting Environment and Children's Mental Health among African American and European American Mothers and Children Bush First published.

6. Nomura Y, Wickramaratne PJ, Warner V, Mufson L, Weissman MM, 2002. Family discord, parental depression, and psychopathology in offspring: ten-year follow-up, Journal of the American Academy of Child & Adolescent Psychiatry 1;41 (4):402-9.

7. Pitzner JK, Drummond PD, 1997. The reliability and validity of empirically scaled measures of psychological/verbal control and physical/sexual abuse: relationship between current negative mood and a history of abuse independent of other negative life events, Journal of psychosomatic research 1;43 (2):125-42.

8. Gruebner O, Rapp MA, Adli M, Kluge U, Galea S, Heinz A, 2017. Cities and mental health. Deutsches Ärzteblatt International; 114(8):121.

9. Angela oswalt morelli, msw, 2020. Teens and Peer Relationships. Grace point Children development

board. Weblog, Theory adolescence 12-24 / article /41168-teens- and- peer- relationships.

10. Costa PT, Widiger TA, 2002. Introduction: personality disorders and the five-factor model of personality, in Personality Disorders and the Five-Factor Model of Personality, 2nd ed, Edited by Costa PT, Widiger TA, Washington, DC, American Psychological Association, pp 3–14.

11. Kupfer DJ, First MB, Reiger DA (eds), 2002. A Research Agenda for DSM-V, Washington, DC, American Psychiatric Press.

12. Lavikainen, J, Lahtinen, E, Lehtinen, V, 2000. Public health approach on mental health in Europe.

13. Keyes CL, Lopez SJ, 2009. Toward a science of mental health, Oxford handbook of positive psychology 89-95.

14. Allen J, Balfour R, Bell R, Marmot M, 2014. Social determinants of mental health, International review of psychiatry 1; 26(4):392-407.

15. Ryan R, O'Farrelly C, Ramchandani P, 2017. Parenting and child mental health, London journal of primary care, 2; 9(6):86-9.

16. Wisdom JP, Clarke GN, Green CA, 2006. What teens want: barriers to seeking care for depression, Administration and Policy in Mental Health and Mental Health Services Research 1;33 (2):133.

17. Frances barlett, 2020. A silent crisis, Heretohelp Visions Journal Weblog.

18. Vlassoff C., 2007. Gender differences in determinants and consequences of health and illness. Journal of health, population, and nutrition. 25(1):47.

19. Afifi M, 2007. Gender differences in mental health, Singapore medical journal 48(5):385.

20. Malhotra S, Shah R, 2015. Women and mental health in India: An overview, Indian journal of psychiatry; 57 (Suppl 2):S205.

Journal of medical pharmaceutical and allied sciences, Volume 10 - Issue 5, 1595, September - October 2021, Page – 3707-3712

3712