The Effect of Life Stressors on Mental Health of Adolescents

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Abstract

Purpose: To study the influence of life stressors on the mental health of adolescents.

Methods: The total of 205 adolescents from South Goa, in the age range of 10 to 19 years, confirming to World Health Organization (1997) standards as to the period of adolescence were the respondents to the questionnaires. In the attempt to study the extent of stress experienced by adolescents, the following psychological tests were used: Life Stressors and Social Resources Inventory (LISRES-Youth) by Rudolf H. Moos and Mental Health Inventory (MHI-38) by Veit and Ware, Jr.

Results: Significant negative correlations were found between mental health and physical health, home and money, stressors due to parents, extended family, school, friends, boy/girlfriends and negative life events.

Conclusions: All the sub-scales of the LISRES-Y are negatively correlated with the total MHI, indicating that in terms of the present sample, greater the psychological well-being, the less stress they experienced.

Keywords: Adolescents, Life stressors, Mental health, Negative life events

Introduction

The transition from childhood to adulthood is a biological and physiological phenomenon, and the in-between stage is known as adolescence in all societies. Adolescence is about growing up, about moving from the immaturity of childhood into the maturity of adulthood, of preparation for the future.¹⁹ The word adolescence is derived from the Latin verb “adolescence”, which means “to grow up” or “to grow to maturity”.¹³ It is the period of life between the boundaries of puberty and maturity, the period during which maturity is being attained, this is the stage when the road is paved for adulthood and the adolescent’s identity is found to be developed and crystallized. The study of this transition stage and the stressors, which modulate and modify the growth into adulthood, become important not just for the individual concerned but also for the community and society as a whole.

The concept of ‘adolescence’ varies over time and in different cultures as it is socially constructed rather than being biologically determined. Current literature also varies in the age ranges used to define adolescence. According to some definitions, adolescence may begin as early as seven years and extend to 18 through 22 years of age.¹⁷ Other definitions describe it as lasting from age 12 to 18 years, or from completion of primary school to graduation from high school. Adolescence can also be distinguished between early and late, wherein the most pubertal changes occur in the former. Current opinion suggests adolescent issues should be considered for girls from age 10 and boys from age 11.⁸ However, the period of dependence appears to be getting longer with a variety of adult behaviors such as leaving home, marriage and economic independence occurring at later ages.¹⁸ The age range of adolescence can vary with cultural and historical circumstances. In western
Review of Literature on Life Stressors and Its Relation to Mental Health among Adolescents

Biddle and Asare assessed the association between sedentary behavior and mental health in children and adolescents by performing a brief review. Physical activity interventions have been shown to have a small beneficial effect for reduced anxiety, but the evidence base is limited. In the short term, physical activity can lead to improvements in self-esteem. Reviews on physical activity and cognitive functioning have provided evidence that routine physical activity can be associated with improved cognitive performance and academic achievement, but these associations are usually small and inconsistent. Primary studies showed consistent negative associations between mental health and sedentary behavior. Association between physical activity and mental health in young people is evident, but research designs are often weak and effects are small to moderate. Evidence shows small but consistent associations between sedentary screen time and poorer mental health.

Studying risky family social environments and the mental and physical health of offspring, Repetti et al. opined that risky families are characterized by conflict and aggression and by relationships that are cold, unsupportive, and neglectful. These family characteristics create vulnerabilities and/or interact with genetically based vulnerabilities in offspring that produce disruptions in psychosocial functioning (specifically emotion processing and social competence), disruptions in stress-responsive biological regulatory systems, including sympathetic-adrenomedullary and hypothalamic-pituitary-adrenocortical functioning, and poor health behaviors, especially substance abuse. This integrated biobehavioral profile leads to consequent accumulating risk for mental health disorders, major chronic diseases, and early mortality.

Bernstein and Borchardt conducted a critical review of anxiety disorders of childhood and adolescence. The review examined the anxiety disorders of childhood and adolescence (separation anxiety disorder, overanxious disorder, and avoidant disorder), including prevalence rates, demographic profiles, comparisons of clinical presentations in different developmental age groups, and comorbidity patterns. Fears and simple phobias, obsessive-compulsive disorder, post-traumatic stress disorder, and panic disorder in children and adolescents were also evaluated.

Comparing worldwide data to the prevalence of anxiety and depression in Australian adolescents, Boyd et al. analyzed data from two Australian studies. The combined sample comprised 1299 adolescents, randomly selected from metropolitan and country schools in Melbourne. The data were examined in order to ascertain the percentages of adolescents who scored above the clinical cut-off on two self-report instruments – the Revised Children’s Manifest Anxiety Scale (C. R. Reynolds & B. O. Richmond, 1985) and the Reynolds Adolescent Depression Scale (W. M. Reynolds, 1986). The results of these analyses were then compared with previously reported prevalence rates from studies worldwide. This comparison revealed striking differences in the prevalence of anxiety and depression across different countries and cultures.

Tomb and Hunter studied the prevention of anxiety in children and adolescents in a school setting. Although anxiety disorders represent the primary reason children and adolescents are referred for mental health services, children showing symptoms of these disorders are not easily recognized. School-based practitioners are in a unique position to help minimize the risk and prevent the development of anxiety disorders. The research examined the importance of early intervention and the applicability of the three-tiered prevention model to treat anxiety disorders. The three-tiered approach to preventive intervention distinguishes between universal, selected, and targeted levels of prevention.

Essau et al. studied the frequency, comorbidity, and psychosocial impairment of anxiety disorders in German adolescents. The frequency, comorbidity, and psychosocial impairment of anxiety disorders among German adolescents was estimated from a survey of 1035 students aged 12–17.
years. Anxiety disorders and other psychiatric disorders were coded based on criteria from the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, using the computerized Munich version of the Composite International Diagnostic Interview. Anxiety disorders occurred frequently in the sample of adolescents, with a rate of 18.6%. When considering the sub-types of anxiety disorders, phobia was the most common. Post-traumatic stress disorder and obsessive-compulsive disorder occurred less frequently with rates below 2%. Panic disorder and generalized anxiety disorder were the least common, with rates well below 1%. Anxiety disorders were significantly higher in girls than in boys, and the rates increased with age. Comorbidity occurs quite frequently, both within the anxiety disorders and also with other psychiatric disorders. The most common pattern of comorbidity was that of anxiety and depressive disorders. Although a high number of anxiety cases were psychosocially impaired, at least during the worst episode of their disorders, only a few of them sought treatment for their problems.

Weeks et al. studied the correlates and consequences of early appearing social anxiety in young children. The study explored the correlates of social anxiety in an unselected sample of young children. Participants were n=178 elementary school children in grade two (aged 7–8 years). Children were individually administered the Social Anxiety Scale for Children-Revised (SASC-R), as well as measures of socio-emotional adjustment. Teachers completed measures of children’s socio-emotional problems and school adjustment. Results indicated that social anxiety was positively associated with self-reported loneliness, school avoidance, and internalizing coping, and negatively related to school liking. However, social anxiety was mostly unrelated to teacher-rated outcomes.

Moretti and Peled studied adolescent-parent attachment. Parents continue to play a key role in influencing their adolescent’s development. Adolescent-parent attachment has profound effects on cognitive, social and emotional functioning. Secure attachment was associated with less engagement in high risk behaviors, fewer mental health problems, and enhanced social skills and coping strategies.

Investigating whether insecure attachment was a predictor of subsequent depressive symptoms among adolescents 12–14 years of age, when controlled for depressive levels the preceding year, various demographic and psychosocial factors, and stressful life events. Sund and Wichstrom assessed a representative sample of 2360 young adolescents at two time points one year apart. Measures included depressive symptoms measured by the Mood and Feelings Questionnaire (MFQ), attachment to parents and friends measured by the Inventory of Parent and Peer Attachment, stressful events, and various socio-demographic factors. The proportions of high scorers (MFQ >33) increased threefold from T1 to T2 (3.4% to 10.9%). Results of multivariate logistic regression analyses showed that the following variables at T1 were predictive of depressive symptoms at T2: severe depressive symptoms (odds ratio [OR]=5.30), gender (OR=4.08), attachment to parents (OR=1.36), and stressful life events (OR=1.12). No interactions between attachment and severe depressive symptoms and gender and stressful life events, respectively, were found. Insecure attachment to parents may contribute to the development of severe depressive symptoms among young adolescents.

Also studying insecure attachment as a predictor of depressive and anxious symptomology, Jinyao et al. examined whether anxious and avoidant attachment, both of which are operationalized as insecure attachment, predict depressive and anxious symptoms following the occurrence of hassles. A sample of 662 Chinese university students was recruited from Hunan, China. At the initial assessment, participants completed self-report measures assessing insecure attachment (i.e., anxious and avoidant attachment), hassles, anxious symptoms, and depressive symptoms. Additionally, hassles and symptoms of anxiety and depression were assessed once a month for the subsequent six months. The results of hierarchical linear modeling analyses indicated a significant interaction between anxious attachment and hassles in predicting follow-up depressive symptoms. Specifically, participants with high levels of anxious, but not avoidant, attachment reported high levels of depressive symptoms when experiencing high, as opposed to low, levels of hassles. At the same time, while both anxious and avoidant attachment predicted higher levels of anxious symptoms over time, a cross-level, significant interaction did not emerge. Insecure attachment styles serve as a vulnerability factor in the development of depressive and anxious symptoms in Chinese young adults. Consequently, fostering the development of secure attachment in prevention and intervention programs may, ultimately, prevent the onset and maintenance of depressive and anxious disorders.

Fowler et al. examined the role that attachment insecurity plays in mediating the relationship between prior exposure to trauma and current expression of depression severity. Exposure to traumatic events is a nonspecific risk factor for psychiatric symptoms including depression. Past-trauma and attachment anxiety and avoidance were assessed at baseline in a large cohort (N=705) of adults admitted to a specialized adult psychiatric hospital with typical lengths of stay ranging from 6 to 8 weeks. Depression severity was assessed at day 14 of treatment using the Beck Depression Inventory-II. Interpersonal trauma (e.g., assaults, abuse) was correlated with depression severity, whereas exposure to interpersonal trauma (e.g., natural disasters, accidents) was not. Adult attachment partially mediated the relationship between past interpersonal trauma and depression severity at day 14 among psychiatric inpatients.
Questioning whether life satisfaction predicts victimization experiences in adolescence, Martin et al.\textsuperscript{14} assessed 417 students in Grades 6–8 completed the Multidimensional Students’ Life Satisfaction Scale (MSLSS: Huebner, 1994) and the Children’s Social Experience Questionnaire – Self Report (SEQ-SR: Crick & Grootpeter, 1996) on two occasions (Time one and Time two), one year apart. The results revealed that ‘Time one’ life satisfaction scores did not add to the prediction of ‘Time two’ overt victimization scores but did add to the prediction of ‘Time two’ relational victimization scores and prosocial experiences. Additionally, ‘Time one’ overt victimization, relational victimization, and prosocial experiences did not significantly add to the prediction of ‘Time two’ general life satisfaction. However, the predictive equations for ‘Time one’ relational victimization and prosocial experiences approached significance, suggesting the possibility of bidirectional effects between life satisfaction and relational victimization and prosocial peer experiences. Lower levels of life satisfaction appeared to be a newly identified risk factor for two qualitatively distinct types of adverse peer relationships.

In a longitudinal study that tested the prediction that adolescents’ judgments of life satisfaction moderate the influence of stressful life events on the subsequent development of psychopathological behavior, Suldo and Huebner,\textsuperscript{26} using a sample of 816 middle and high school students, demonstrated support for the moderational model for externalizing behavior outcomes, but not internalizing behavior problems. Specifically, adolescents with positive life satisfaction (vs. those who were dissatisfied with their lives) were less likely to develop later externalizing behaviors in the face of stressful life events. The study also revealed that adolescent life satisfaction reports show moderate stability across a one-year time frame and independently predict subsequent externalizing behavior even while controlling for prior levels of externalizing behavior.

**Setting of the Study**

This research was undertaken among adolescents in South Goa. The state of Goa being small has only two districts, North and South. The present study was carried out only in the southern district. The district is further divided into five talukas, which are further divided into villages, each village is then divided into waddos. The five talukas are Canacona, Mormugao, Quepem, Salcete, Sanguem and has a total of 163 villages.

**Sample Design**

In order to measure and then understand the effect of life stressors on mental health of adolescents, a sample of adolescents from South Goa district in the State of Goa were interviewed.

The population for this research included individuals in the age range of 10 to 19 years thus, confirming to World Health Organization (1997) standards as to the period of adolescence.

The criteria for inclusion were that of any individual who was within the age range of 10 to 19 years and who had a working knowledge of English as the standardized questionnaires used in the research were in English.

A questionnaire survey was adopted for this research. A total of 400 questionnaires were distributed to adolescents from the five talukas, of South Goa district in the State of Goa with each taluka receiving 100 questionnaires. However, only 350 questionnaires were received back. After a through scrutiny, to make sure that all questions were responded, it was found that a total of only 205 completed questionnaires were useful for the present research. The questionnaires that were not complete in any respect were discarded.

| Demographic Variables | n  | Percentage |
|-----------------------|----|------------|
| Age range             |    |            |
| 10-11                 | 12 | 5.9        |
| 12-13                 | 38 | 18.5       |
| 14-15                 | 49 | 23.9       |
| 16-17                 | 52 | 25.4       |
| 18-19                 | 54 | 26.3       |
| Total                 | 205| 100        |
| Gender                |    |            |
| Male                  | 99 | 48.3       |
| Female                | 106| 51.7       |
| Total                 | 205| 100        |

**Data Collection Procedure**

A questionnaire survey was adopted for this research. For the collection of data, a stratified sampling technique was used. In the first phase a list of all the talukas and the villages of each taluka was obtained. Based on the number of villages, from each taluka 50% of the villages were selected to obtain data. The researchers choose a representative sample of villages from each taluka.

The researchers employed a combination of stratified sampling technique and the snowballing technique. Research participants were initially contacted personally through local contacts, a suitable time and place were agreed upon to administer the questionnaires and then the researchers administered the questionnaires.

The next step involved contacting higher secondary schools and colleges in the area and after obtaining permission for the respective authorities, the questionnaires were administered.

The third step involved asking the respondents to give the
questionnaires to other adolescents known to them, like adolescents who were not employed, or not pursuing any academic course. The questionnaires were then given to those respondents who in turn gave it to adolescents known to them. The researchers then collected the questionnaires from the respondents.

Following precautions were taken while collecting the data:

- Several visits were undertaken to various schools, colleges before the administration of the questionnaires.
- The teachers were approached so as to take their prior permission for the conduct of the study, so that they did not find it a sudden intrusion in their schedule for the day.
- Considerable time was spent in talking to the adolescents before giving them the questionnaires. This ensured that they clearly understood what they were supposed to do and were also motivated enough to respond to it in the manner intended.
- The adolescents were not told about the exact nature of the scale, in order to prevent any biased responses.
- The adolescents were reassured that their responses would be used as data for the purposes of research and would be kept strictly confidential.
- The researcher’s presence in the classroom during the entire process of administration the scale ensured that the students were not influenced by either their teachers or friends while filling up the scale. This was helpful in dealing with queries regarding any aspect of the scale, which came up while responding to the questionnaires.
- The time limit was not specified. This ensured that the adolescents did not feel pressurized to complete the scale in a hurry, without reflecting on the issues contained therein.

Despite all this effort, when the questionnaires were finally scrutinized, there were instances of some of the questions been left unanswered. Their reluctance to answer all the questions despite the researchers best efforts maybe because of inherent fear or inhibitions among the adolescents.

**Tools Used**

In the attempt to study the extent of stress experienced by adolescents the following psychological tests were used:

- Personal data questionnaire.
- Life Stressors and Social Resources Inventory (LISRES-Youth) by Rudolf H. Moos.
- The Mental Health Inventory (MHI-38) by C. T. Veit and J. E. Ware, Jr.

**Results and Discussion**

**Hₐ₁:** There will be a significant negative correlation between the scores of the sub-scales of LISRES-Y and the scores on the MHI.

| MHI – Total Score | PH       | HM       | PAR      | SIB      | FAM      | SCH      | FR       | BG       | NLE      |
|-------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| MHI – Total Score | 1        | -.210**  | -.225**  | -.216**  | -.102    | -.280**  | -.196**  | -.243**  | -.188**  | -.361**  |
| PH                | -.210**  | 1        | .158*    | .150*    | .111     | .097     | .018     | .056     | .099     | .216**   |
| HM                | -.225**  | .158*    | 1        | .176*    | .219**   | .101     | .092     | .081     | .033     | .168*    |
| PAR               | -.216**  | .150*    | .176*    | 1        | .323**   | .385**   | .391**   | .399**   | .041     | .274**   |
| SIB               | -.102    | .111     | .219**   | .323**   | 1        | .188**   | .252**   | .249**   | .181**   | .192**   |
| FAM               | -.280**  | .097     | .101     | .385**   | .188**   | 1        | .518**   | .544**   | .280**   | .283**   |
| SCH               | -.196**  | .018     | .092     | .391**   | .252**   | .518**   | 1        | .698**   | .147*    | .232**   |
| FR                | -.243**  | .056     | .081     | .399**   | .249**   | .544**   | .698**   | 1        | .305**   | .243**   |
| BG                | -.188**  | .099     | .033     | .041     | .181**   | .280**   | .147*    | .305**   | 1        | .359**   |
| NLE               | -.361**  | .216**   | .168*    | .274**   | .192**   | .283**   | .232**   | .243**   | .359**   | 1        |

**Correlation is significant at the 0.01 level (2-tailed)**

**Correlation is significant at the 0.05 level (2-tailed)**

Key: MHI – Mental health inventory, PH – Physical health, HM – Home and money, PAR – Parents stressor, SIB – Siblings stressor, FAM – Extended family stressor, SCH – School stressor, FR – Friends stressor, BG – Boyfriend/girlfriend stressor, NLE – Negative life events
Table 2 indicates the correlation coefficients between the sub-scales of LISRES-Y and the scores on the MHI. A high score on the MHI indicates greater psychological well-being and for the LISRES-Y, a low score indicates lesser the stressor.

All the sub-scales of the LISRES-Y are negatively correlated with the total MHI, indicating that in terms of the present sample, the greater their psychological well-being, the less stress they experienced.

Physical health is the key factor for the overall feeling of well-being and satisfaction with life. Mental and physical health is fundamentally linked, there are multiple associations between mental health and chronic physical conditions that significantly impact quality of life. The World Health Organization (WHO) defines: health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Constitution of the World Health Organization). The WHO states that “there is no health without mental health.”

Poor physical health can lead to an increased risk of developing mental health problems and can negatively impact physical health leading to an increased risk of some conditions. A physically healthy person is mentally stable and this is indicated with a correlation coefficient of .210**, statistically significant at the 0.01 level. Majority of the sample 97.6% or 200 of the 205 respondents in the personal data sheet answered that they did not suffer from any major illness. Hence it can be assumed that the majority of the adolescents in this sample did not have any physical health issues and led a healthy life, leading to better mental satisfaction or a sense of greater psychological well-being.

Physical activity has potentially beneficial effects for reducing depression, but the evidence base is limited. Physical activity may play an important role in the management of mild-to-moderate mental health diseases, especially depression and anxiety. In general, acute anxiety responds better to exercise than chronic anxiety. Studies of older adults and adolescents with depression or anxiety have been limited, but physical activity appears beneficial to these populations as well. Physical activity can lead to improvements in self-esteem, at least in the short term. Reviews on physical activity and cognitive functioning have provided evidence that routine physical activity can be associated with improved cognitive performance and academic achievement, but these associations are usually small and inconsistent. Association between physical activity and mental health in young people is evident, but research designs are often weak and effects are small to moderate.

Home and money: Problems with the physical condition of home and neighborhood, such as a lack of cleanliness and comfort can affect the overall well-being of an individual. Children’s development is also affected by their parent’s resources, housing conditions and so on. Children living in less affluent areas have lower levels of wellbeing than those in affluent areas. However, the relative risk is small, as individual child and family factors may be more influential than poverty. The above table indicates a negative correlation between mental health and home and money, with a correlation coefficient of .225**. This value is statistically significant which means that the respondents were happy with the quality of their homes and the area in which they were living, so this did not cause them to experience any stress.

Parents stressor: As children grow older and enter adolescence they make close relationships outside the family, with friends of their own age. Relationships within the family also change. Parents become less important, as their life outside the family develops. Disagreements emerge as young people develop views of their own that may not be shared by their parents. This is the period when adolescents begin to feel that their parents are a source of stress. According to Table 2, the correlation coefficient between mental health and stress due to parents was .216**, significant at 0.01 level of significance. This indicates that, the adolescents did not feel that their parents were a source of stress to them. 189 or 92.2% of the total sample were living with their parents and only 16 or 7.8% of the total sample are not living with their parents. When questioned, 85 adolescents or 41.5% of the adolescents sampled described their relationship with their parents as extremely close while 88 or 42.9% described their relationship as close. 11.7% described their relationship as cordial and only five or 2.4% shared that they were not on talking terms with their parents. This data only corroborates the data that was obtained from Table 2.

Siblings stressor: According to Table 2, the correlation coefficient between mental health and stress due to siblings was .102. This indicates that, the adolescents did not feel that their parents were a source of stress to them.

Extended family: According to Table 2, the correlation coefficient between mental health and stress due to extended family was .280**, significant at 0.01 level of significance. This indicates that the adolescents did not feel that their parents were a source of stress to them.

School stressors: Table 2, indicates the correlation coefficient between mental health and stress due to school as .196**, significant at 0.01 level of significance. Though school is an important aspect of an adolescent’s life, it can be a major source of stress. The results reveal significant negative stress, between mental health and school as a stressor.

Friends stressors: Table 2, indicates the correlation coefficient between mental health and stress due to friends as .243** significant at 0.01 level of significance. Adolescents spend a lot of time in each other’s company, or
on the mobile or internet chatting to each other. Although this can be irritating to parents, it is an important way of becoming more independent. These friendships are part of learning how to get on with other people, and gaining a sense of identity that is distinct from that of the family. Clothes and appearance are a way of expressing solidarity with friends, although teenage children are still more likely to get their values from the family.

Boyfriend/girlfriend stressor: Table 2 indicates the correlation coefficient between mental health and stress due to a boyfriend/girlfriend as .188** significant at 0.01 level of significance.

Negative life events: Table 2 indicates the correlation coefficient between mental health and stress due to a boyfriend/girlfriend as .361** significant at 0.01 level of significance.

This research of mental health of adolescents and the role of life stressors in ensuring appropriate mental health has brought to light certain factors which affect adolescent mental health in a manner in which it was never thought of earlier, though there is abundant literature on adolescent mental health. This research being focused on very specific areas has brought out definitive results which are spelt out in this study.

Suggested Intervention Strategies

Child and adolescent mental health includes a sense of identity and self-worth; based on a sound family and peer relationship and the ability to be productive. The capacity to learn and to use developmental challenges and cultural resources to maximize development are other attributes contributing to good mental health. Good mental health in childhood is a prerequisite for optimal psychological development, productive social relationships, effective learning, an ability to care for self, good physical health and effective economic participation on reaching adulthood.

Tailoring interventions towards not only the individual adolescent but also the parents, family, school, peers, the local community and thru digital platforms may produce significant changes in the adolescent’s mental health. These interventions could be the following:

Parent-Focused Interventions

This could include different forms of parenting interventions, including parent education, parent training and parenting support. Parenting programs can be implemented as an early intervention to prevent the onset of problems and also to ameliorate the severity of existing problems especially in high risk children and youth. Parenting programs for parents of adolescents should largely aim to minimize the risk factors of coercive family interaction and poor parenting which have a role in causing and/or maintaining external behavior problems and delinquency. Parenting programs should also aim to enhance parent-child communication and connectedness and improve parental supervision and monitoring. Parental supervision, in particular, appears to be of crucial importance in preventing a range of adolescent risk behaviors. Parenting programs may also address additional family risk factors such as parental stress and depression and marital conflict.

Family Focused Interventions

Family based interventions are on the assumption that family functioning may cause, maintain or worsen adolescent disorder or risk behaviors such as substance misuse. If family relationships are appropriately modified, these approaches can be effective in reducing the problem behaviors. Family factors such as poor communication, parental criticism, ineffective discipline, emotional disengagement can negatively impact the adolescent and increase the risk of substance abuse. Consequently, family focused interventions that target negative patterns of interaction have been found to be the most effective approaches to adolescent substance abuse when compared with individual support interventions or skills training. Improving family functioning by working with them within their own social context decreased anti-social behaviors. By involving family members in the intervention there is a shift in the focus of problem from within the adolescent to within the family; this may have particular therapeutic benefits for the adolescent. However, the inclusion of the family in the interventions for young people may not be appropriate for all families. It is important to consider factors such as the young person’s age and level of maturity, as well as the current level of parental/familial involvement. In addition, and probably the most important factor, is the nature and supportiveness of the relationship between adolescent and their family.

School-Based Interventions

An approach focusing on mental health promotion rather than on mental illness prevention is effective in promoting adolescent and youth mental health. School-based mental health interventions specifically focusing on low and middle-income children suggest that the majority of the school-based life skills and resilience programs indicated positive effects on students’ self-esteem, motivation, and self-efficacy. A range of procedures should be adopted in schools that will bring “at risk” students systematically to the attention of mental health staff.

Mental health and education policy makers might also need to consider new methods, such as virtual counselling, Internet programs and online clinics as mechanisms to allow high school students to reach mental health services. Given the shortage of counsellors, there is a need to think
clearly about new models for individual health care of students in schools.

Community-Based Interventions

It is pertinent to note that the community in which the adolescent lives has a substantial impact on the adolescents’ mental frame. Therefore community-based interventions targeting adolescents and youth could result in positive effect on behavioral changes, self-confidence, self-esteem, levels of knowledge, and physical activity. To engage the community, there will be need to design such activities where the community would naturally consider itself as a part and participant of such activity. Therefore, such activities need to have a wider based and scope like, competitions, exhibitions of local talents, community cleaning of common areas, environment protection activities, including cooking and so on would naturally involve a community.

Digital Platforms for Mental Health Interventions

In this cyber age, it is but natural for every individual especially the adolescents to be constantly engaged in the use of digital platforms, be it the social media or work based activity or entertainment. These digital platforms have huge impact on adolescents therefore, proactively creating such applications aimed at developing positive mental attitude as an end result will impact adolescents.

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