IJCRT.ORG ISSN : 2320-2882

INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

Impact of Life Skill Training on Mental health status and Wellbeing of Young people: Does Gender Matter?

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Abstract

The aim of the study is to assess the impact of life skills training and the influence of gender identity on mental health status and wellbeing of young people. A classical experimental research design with control group and random sampling method was used. The study population comprises720 adolescents (both girls and boys in the age group of 16 to 19yrs) from six higher secondary schools of Kerala. The respondents were sequentially assigned into intervention group and control group with 360 each for determining the effect of the intervention comparatively. The data collection was done in three time lines: pre-intervention, post-intervention and follow-up intervention. Standard tools administered to evaluate the mental health status and mental wellbeing was: GHQ-28 (Goldberg, 1997) and WEMWS-14 (Warwick Edinburg Mental Wellbeing Scale, 2007). Researcher conducted life skills training to the intervention group after pre- intervention. The same assessment tools were administered post-intervention (one – three months) and follow -up intervention to evaluate the impact of intervention on mental health status and well being. Repeated Measures Analysis of Variance (RMANOVA) was performed to test whether there is any significant effect due to intervention in the scores. Independent sample t-test was performed to compare the equality of baseline scores of various components.

The result showed that there was highly significant intervention effect between the scores of mental health status and wellbeing. Though, the base line scores of total mental health status are less for males compared to females, the mental wellbeing score is almost the same for males and females. The result of the average post-intervention scores of mental health status and mental wellbeing is better in females compared to male respondents, showing that intervention helped the female respondents more than the male respondents.

Key words: Mental health, mental wellbeing, life skill training, adolescent health, young people

I. INTRODUCTION

Childhood and adolescence are critical time for laying the foundations for good mental health and wellbeing which in turn affect their path through life and healthy functioning of families and society as a whole. How to enhance mental health status and wellbeing of people across the life course from birth to old age is a challenging question. Poor mental health in childhood is associated with increased risk in life and other adverse outcomes in adulthood. Schools and communities, especially families can make the most of its environment conducive to foster the development of children and adolescents and to promote mental health and wellbeing of young people (Kessler et al., 2005: Kieling C. et al., 2011: Murray, et al., 2008). Teaching life skills in the supportive learning environment of the schools can also do this. Life skills are essentially those abilities that help to promote mental health and wellbeing and competence

in young people as they face the realities of life (WHO, 1994). When health problems are related to behavior, as is the case in adolescent age, health promotion can be achieved by enhancing the adolescents' coping resources.

Researchers have determined that at least half of all mental health disorders appear by the age of 14 and about 75 percent of them by the age of 24. In this particular context, the World Health Assembly recognized mental health as a public health priority and adopted the Comprehensive Mental Health Action Plan to build knowledge and innovative programs that successfully address the health and social needs of people affected by mental health problems, even in the most poorly resourced settings. This report provides a synthesis of the most promising innovations in treatment and care; specifically, those which are the most capable for taking to scale in all countries of the world including India (WHA 2013).

The present study is significant, because most young people are presumed to be healthy but, as per World Health Organization an estimated 2.6 million young people aged 10 to 24 years die each year and a much greater number of young people suffer from illnesses 'behaviors' which hinder their ability to grow and develop to their full potential (WHO, 2004). There is good evidence that mental health promotion programs in schools lead to positive mental health, social and educational outcomes among the students (Weare K., Nind M., 2011). Early intervention and life skills training would be beneficial for reducing crime in young people, improving productivity, increase coping skills and resilience to stress and preserving mental health and wellbeing in older age (Cooper et al., 2009). The available literature indicates that life skills training is needed for children and adolescents and should be developed in all culture. World Health Organization has addressed life skill based education since the 90s, and others are now taking notice (WHO 1993a, 1994, 1996, 1997; Bhave Swati, 2005; Vranda, 2015; Guardian & MINDS foundation, 2017; WFMH-Report, 2018).

1.1 Gender Identity and Mental Wellbeing

Youth is a period characterized by a time of indecision, despair, and doubt, especially in instances where they are not mentally conditioned and physically prepared to cope with the changes taking place in and around them, and also it is a delightful period of life and a period marked by stress and conflict in the family. Young people today are caught up in an identity crisis, one which is not easy to define and does not mean breakdown or catastrophe but rather a 'crucial period' when stable reference points in and around the young person must be established (Erickson, 1968). Young people cannot wait, because it is a period which is fleeting! Youth play an important role in building the nation, so there is a pressing need to enhance their mental capital and well being, not only in terms of preventive and promotional measures, and health care services but also in terms of authentic research evidences.

WHO defines mental health as "a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Wellbeing itself is one of the aims of the WHO strategy "Health 2020", which states that mental health promotion involves building peoples' resilience against various stressors in their lives. (WHO, 1996, 2013, Lindert J, von Ehrenstein OS, Grashow R, et al. 2014; Frankenburg W., 1987).

Many young people explore their gender identity during their youth, sometimes resulting in major changes in their reality, their relationships and their stability. Education, advocacy and basic human rights for the thousands of young people considering their identities right now are crucial to help them achieve their long term wellbeing (Report WFMH, 2018, pg 50). Research evidence indicates that, Gender is a critical determinant of mental health and wellbeing of young people. Gender role differentiation increases during adolescence, and discrimination based on gender also intensifies during this critical phase of development (Petroni, Patel, & Patton, 2015). Rigid gender norms can profoundly and negatively affect both girls and boys and can particularly constrain girls' aspirations and opportunities. They can influence girls' ability to travel or attend school, the places they can and cannot go in the community, and the nature and types of social interactions they are permitted to engage in. Boys are more able to move freely about and thus have greater opportunities than girls to participate in society and in income-generating activities (Lundgren et al., 2013). Gender

also determines the differential power and control men and women have over the socio-economic determinants of mental health and lives, their social position, status and treatment in society, and their susceptibility and exposure to specific mental health risks. Both girls and boys are affected by social norms and expectations based on their gender and sexuality (WHO, 2014b).

Gender intensification and the increased pressure on adolescents to conform to culturally sanctioned gender roles have been posited as explanations for gender differences in depression. These pressures come from a variety of sources such as parents, peers, educators and the media. While gender socialization starts at birth, early adolescence (10–14 years) is a critical point, as puberty intensifies social expectations from family members and peers related to gender (Hill & Lynch, 1983). Mental health problems commonly emerge during the adolescent years, influenced both by the biological, emotional and cognitive processes associated with puberty and by the social contexts surrounding adolescents as they mature through this important phase of life (Chisina Kapungu& Suzanne Petroni, 2017).

Some research (Patel, et al., 2013; Patton et al., 2016) reveals that puberty, especially early puberty, can trigger psychological stress for both girls and boys. And the existing literature suggests that complex and important links among the adolescent developmental phase, gender norms and mental health and wellbeing of girls are no more likely than boys to evidence depression in early childhood. But after puberty, girls' risk of depressive disorders increases drastically. Females are about 1.5 to 2 times more likely than males to be diagnosed with depression, both during adolescence and throughout their lives. In this particular context, *researcher* would like to share the results and learning experiences on the current study entitled the Impact of life skills training and the influence of gender identity on mental health status and wellbeing of young people.

2. RESEARCH METHODOLOGY

This study was done with the objectives: (a) To study the impact of LST on mental health status and wellbeing of young people, and (b) To study the influence of gender identity on mental health status and well being of young people.

3.1Population and Sample

This study was done on a sample of regular school going higher secondary school children in Kerala aged between 16 to 19 years, excluding those with any physical or mental illness and those who have had any life skill training. We selected a control group of 360 students and a study group of another 360 students, both with equal proportion of boys and girls. Proportionate random sampling was adopted to select the subjects from schools which are different by their offer of co-education or exclusive (gender selective) admission policy. All of them were subjected to mental health and well-being assessment at the pre-intervention phase. The study group was given life skill training and they were assessed in two follow up periods after three months and six months. The control group was also assessed simultaneously, but they were given life skill training in view of our moral commitment to them, shortly after their final assessment.

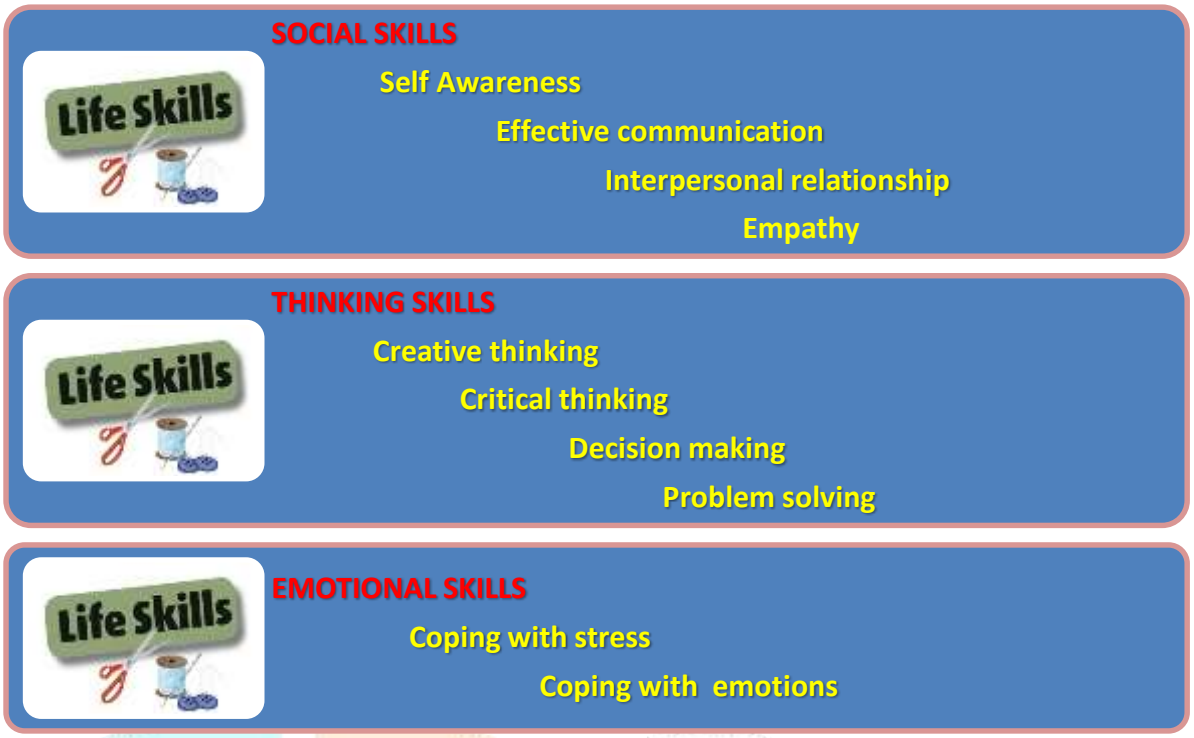
3.2 Data collection method

For this study primary data has been collected and it obtained from July 2017 to January 2019 in three different timelines of pre, post and follow-up intervention.

3.3Tools used for data collection

The following tools were used for data collection in three timelines (pre, post and follow-up intervention) are: demographic proforma and standardized statistical tools of General Health Questionnaire (GHQ-28) and Warwick Edinburg Mental Wellbeing Scale (WEMWS-14).

Figure 1 Ten Core Life Skills (WHO, 2004)



3. ETHICAL AND LEGAL SANCTIONS

This study was approved by the University Ethics Committee of Assam Don Bosco University. Permission granted from the Regional Deputy Director (Dept. of Higher Secondary Education Kerala) and the principals of the concerned schools for conducting the study among the students. Informed written consent was obtained from the participants and their parents prior to the study.

5. RESULTS AND FINDINGS

The result and findings of the study are summarized based on the objectives are given below.

The following tables and figures has given the result and findings of the statistical analysis of the effect of life skills training on mental health status and wellbeing in three time lines of pre, post and follow - up intervention.

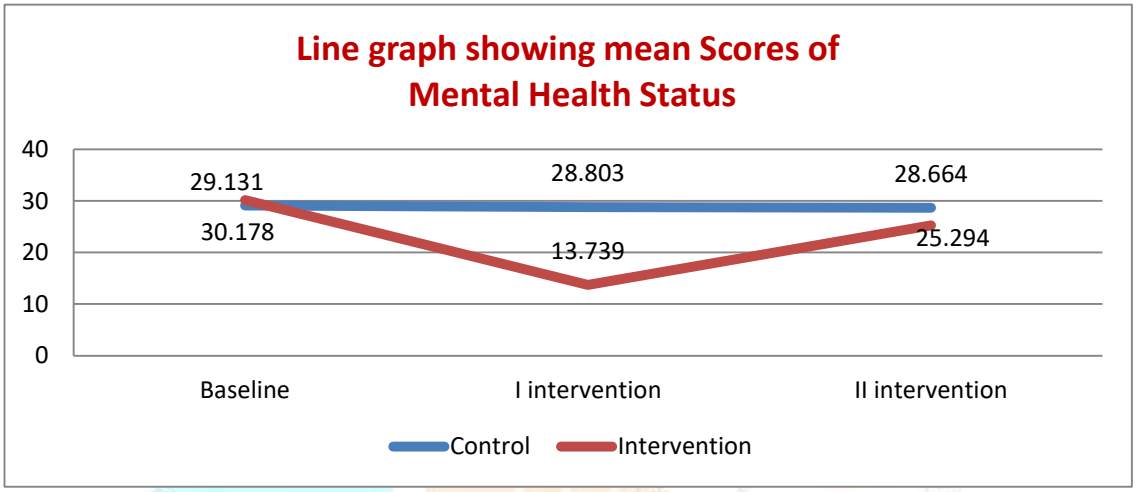
Table1 Results of RMANOVA for Mental Health status Scores

Group	Mean (Standard Deviation)			F statistic and p value		
	Baseline /Pre-int.	Post-intervention	Follow-up intervention	Time	Group	Time*group interaction
Control	29.131 (10.752)	28.803 (10.461)	28.664 (10.298)	F=1438.067 Df=(2, 1436) P=0.000	F=56.891 DF=(1, 718) P=0.000	F=1358.828 DF=(2,1436) P=0.000
Intervention	30.178 (11.739)	13.739(9.126)	25.294 (11.052)			

**Higher scores represent lower level of Mental Health Status.*

The above table describes the extent of change in the Mental Health Status Scores among the respondents across the time period of pre- intervention (baseline), post-intervention and follow-up intervention, between the intervention group and control group. Since p-value (p=0.000) is less than 0.05 (normal value) for Mental Health Status score over different time periods, there is significant difference in the overall mean score of Mental Health Status between the two groups due to intervention indicating that the intervention is effective.

Figure 2 Line graph of the Mean Scores of Mental Health Status



The above line graph shows that, the differences in the average scores are more for intervention group whereas for control group they are not, indicates that intervention is effective.

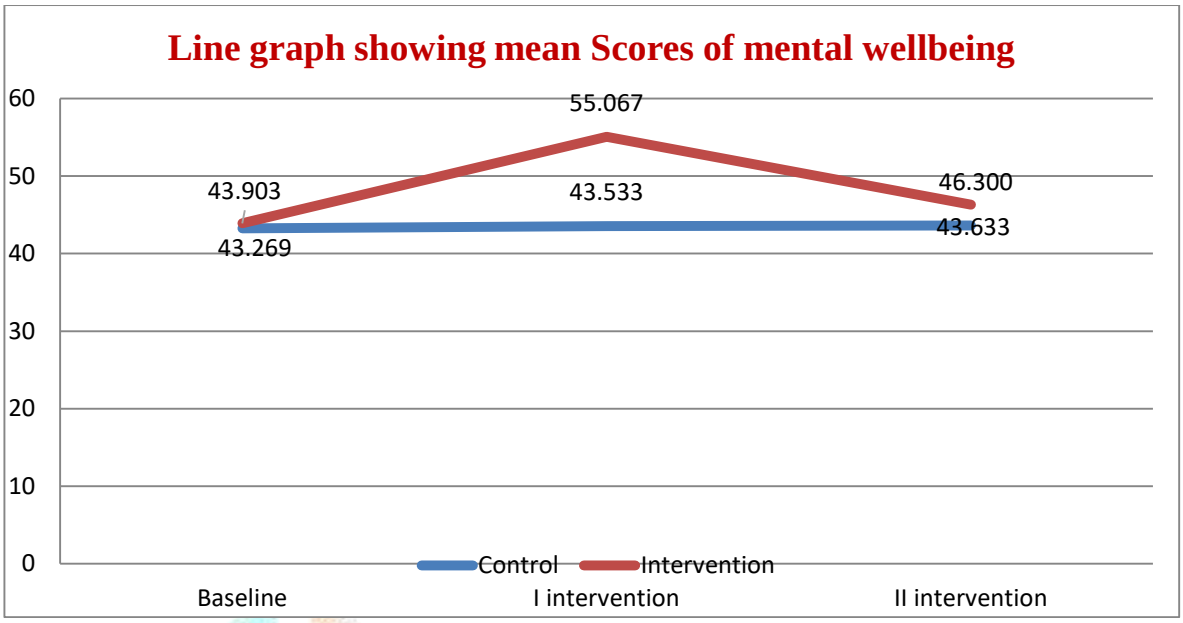
Table 2 Results of RMANOVA for Mental Wellbeing Scores

Group	Mean (Standard Deviation)			F statistic and p value		
	Baseline /Pre-int.	Post-intervention	Follow-up intervention	Time	Group	Time*group interaction
Control	43.269 (7.453)	43.533 (7.128)	43.633 (6.927)	F=1435.309 Df=(2, 1436) P=0.000	F=90.403 DF=(1, 718) P=0.000	F=1354.173 DF=(2,1436) P=0.000
Intervention	43.903 (7.975)	55.067 (5.990)	46.300 (7.503)			

**Higher scores represent higher level of mental wellbeing*

Table 2 describes the extent of changes in the mental wellbeing scores among the respondents across three time lines between intervention group and control group**.** The results tabulated shows that there is significant difference between the two groups because the p values are less than 0.05 for the intervention 'group'. There was highly significant interaction effect between the scores of Mental wellbeing over different time periods and between the two groups, with the value of p=0.000 for the data obtained, showing that intervention is effective.

Figure 3 Line graph of Mean Scores of Mental Wellbeing



The above line chart shows that, the differences in the average scores are more for intervention group whereas for control group they are not.

Statistical Analysis of the effect of gender on mental health status and wellbeing

The pair-wise comparison of the average scores of different components on gender using t-test for control group and intervention groups and the results are given in Table 3

Table 3 Pair-wise comparison of the average scores of different components on gender

Component	Gender	Control Group			Intervention Group		
		Baseline / pre-int.	Post-intervention	Follow-up	Baseline	Post-intervention	Follow-up
Mental Health Status	Male	27.539	27.317	27.172	28.394	12.872	23.572
	Female	30.722	30.289	30.156	31.961	14.606	27.017
Mental Wellbeing	Male	42.944	43.256	43.344	43.956	55.089	45.883
	Female	43.583	43.811	43.922	43.850	55.044	46.717

The result shows that the base line scores of mental health status are less for males compared to females and the mental wellbeing score is almost the same for males and females. But the effect of intervention is very significant in female respondents than the male respondents at post intervention phase, the scores of female respondents is better in both mental health status and wellbeing than the male respondents.

6. CONCLUSION

This study shows that, life skills training have positive impact on mental health status and wellbeing and significantly influenced by the gender identity of young people. The average score of mental health status is in its maximum at the baseline (pr-intervention) level, then reduced to minimum at the post – intervention level but increased again in the follow – up intervention level (i.e. lower score represents better mental health status). But in the case of mental wellbeing score, it is reflected that, the average score is in its minimum at the baseline, then increased to maximum at post- intervention but decreased again in the follow-up intervention level (higher score represents better wellbeing). The scores of two questionnaires (GHQ - 28 and WWEMWS -14) are inversely related /or negatively correlated at 0.01 level of significance, giving the desired result.

Considering the gender identity, it is noticed that mental health status of male respondents is better than that of the female respondents in baseline scores. But the effect of intervention is very significant in female respondents than the male respondents at post intervention phase, the scores of female respondents is better in both mental health status and wellbeing. It is observed that intervention helped the female respondents more than the male respondents. All the scores are highly significant in post- intervention period; this emphasizes the need for continuous / periodic intervention. The intervention being proved to be effective, leads to the conclusion that life skills training has positive impact on mental health status and well being of young people and further that gender identity has a significant influence on mental health status and wellbeing of young people.

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