11 | Health Practices Among Adolescents

Latha

Health related researches have generally concentrated on adult health status and many psychosocial factors related to such a state. Same set of concerns can be applied while addressing the young one's health issues. Children and adolescents are those sets of population where morbidity and mortality are the lowest; yet, this collective group is a target of premordial prevention intervention as well as promotional activities. Currently in India, the incidence and prevalence of various psycho—social and medical risk factors for major non-communicable diseases warrants the need to explore and examine various health related habits and processes among young people. In India, adolescents (10 – 19 years) constitute 21.8% of the population, *i.e.*, 207 million. The first Adolescent Friendly Health Services Centre (AFHSC) in India was operationalised in 2001, at Safderjung Hospital, New Delhi. It has partnership with NGOs, schools and colleges in promoting health among young ones. According to the study conducted by the National Children and Youth Fitness Study, many children do not engage in physical activity that promotes long term health; less than 36% of the elementary and secondary schools offer physical education classes, even if they are offered, many give up when they reach higher classes.

A simple survey (Archana, 2004) on a sample of 50 adolescent boys and girls (16–18 years) revealed that only 2% of

the sample were involved in some form of exercise. Watching TV (32%) and playing computer games (14%) were major recreational activities. Boys were involved in outdoor games (40%).

Health educator's efforts to promote the knowledge among adolescents about health risks or health behaviours have been partially successful. The failure is encountered in transforming the awareness or attitude into goal-directed actions. School environment is chosen as an ideal, though largely under used (in India) setting, for tackling the health promotive issues. Participation of parents, teachers, peers and community is well understood, good educational materials are provided; yet the skills related training is yet to take its roots in these educational programmes.

Many of health behaviours and lifestyle patterns are established in early childhood and adolescence, which continue throughout life. The pattern of eating, dietary intake, sports, recreational activities, exercise behaviors, and also many emotional and cognitive patterns are set during the age of 7 to 17 years. Psychological resources which either mediate or moderate health status such as self-esteem, optimism – pessimism, negative positive affectivity, hostility, social support strengths, *etc* have their source in early life experiences. Family environment, parental bond, support or supervision and peer group influences have a role to play in the onset of many life style habits, such as quantity of food intake, smoking, stress tolerances *etc*. Many of these behaviours are highly inter-connected (Chen, Mathews, Boyce, 2002; Yarcheski, Mahon and Yarcheski, 1997). Reports based on a survey conducted at Mumbai (Kaila, 2003) emphasized the need for structured guidance and counseling services at schools to promote the mental health.

Higher rate of Academic Stress, Anxiety, Low Self-Esteem and Anger Experiences in younger group warrants the need for

building positive resource, taking into consideration the developmental approach rather than the problem-focused clinical orientation to solve the issues.

The need for motivation is repeatedly emphasized in all the types of educational and life-skills oriented training interventions. Motivation for adherence to certain skills or actions is modelled through parental, peer group and societal influences (mass media *etc*). At the micro-level, the individual's level of Goal-Directedness is strongly related to the Time-Perspective. Practicing specific skills, whether it is academic related, personal hobbies or health related behaviours is related to the time-perspective and intensity of goal-directedness.

Time-Perspective, defined as each individual's categorization of human experiences into temporal phase of past, present or future, provides the structure from which people select and pursue short-term and long term-goals. People differ in influences- for some, the event of past influences their present behaviour, for others the event of present and its salient features decides the behaviour. However, there are some for whom the conception of future, where the consequences of present and past actions are realized, is most important.

In planning of many of our action, where we have to build assets like finances, skills, career, health etc, the future perspective is essential. Future oriented individuals are higher on self – motivation, and goal-directed behaviours. Time-Perspective tends to change our life span (Hamilton et al, 2003). Generally young children are more present-oriented and thus are unable to initiate and maintain goal-oriented behaviours. Health related practice among young people not only depends on parental or educational training but it does depends on the individuals' motivation, which is generally influenced by their time orientation. Till date, very little attention is paid to relate the past and future orientation to the inclination in practicing Health related behaviours.

A survey was conducted with the objectives of evaluating the health practices of school children and estimate the relation between their future goal-orientation and health habits.

METHOD

Sample

A sample of children studying in senior secondary school *i.e.*, 8th to 12th standard, from 5 different schools were selected in Mumbai City (N= 550).

Tools

The Health Related Practices were assessed using a structured questionnaire which contains statement about various health related practices such as hygiene, eating behaviour, exercise, recreation, *etc.* The students were to respond on a four-point frequency scale, how often they engage in those practices in daily life. The questionnaire yielded not only the frequency of health promotive or enhancing practices but also health-compromising behaviours. Higher score indicated good health practice in daily life.

The Time–Orientation of the subjects were assessed using four items, which focused on their ability to be goal-oriented, planning for future and ability to maintain hobbies and interests. Higher score indicated better time – orientation and goal – orinentedness. The reliability coefficient estimated using Chronbach alpha, resulted in a value of 0.70, which indicates higher internal consistency of the tool. Only content validity of the questionnaire was established by having the experts' opinion on the scale with regard to validity of each and every item on the scale.

Procedure

The data was collected from the students in the school after obtaining permission from the school authorities. Two psychologists administered the questionnaire to the students and

collected the data. Completely filled up forms which were obtained from two locations were taken up for the analysis. A total sample of 550 school children participated in the study.

RESULTS AND DISCUSSION

The descriptive and inferential statistics were used to analyze the data. The total sample of the study was analyzed for the distribution on various socio demographic features. Table 1. gives the frequency and percentage of distribution gender wise, and educational status of parents.

TABLE 1

Demographic Profile of the Sample

Variable	Group	Frequency	Percent
Gender	Male	302	54.9
	Female	248	45.1
Parents' Education	Father Graduate	489	89.1
	Father Non- Graduate	61	10.9
	Mother Graduate	451	82.6
	Mother Non-Graduate	99	17.4

Boys are more represented in this sample. The sample here is from much lower class level and includes students up to tenth class. Due to academic preoccupation, the secondary school level students could not be represented.

From the analysis of sample, it is evident that 89.1 % of fathers of students were educated up to graduate level and 82.6% of mothers were educated up to graduate's level.

The mean score on the health practices was 91.66, and the maximum possible score is 132. The group had an average level of positive health behaviours. The practices of these behaviours are classified into different dimensions. The personal care and maintenance of hygiene is predominant habit. These are nurtured

from early childhood and thus are found to be strong. The energy consuming and creative pursuits are minimal compared to sedentary and health compromising habits.

TABLE 2
Mean and SD on Health Practice Schedule on different dimensions

Dimensions	Mean	SD
Personal care and hygience	21.60	3.82
Energy consuming action	9.81	1.61
Creative activities	8.91	2.81
Sedentary activities	12.96	2.24
Compromising behaviours	12.22	1.82
Health promotive habits	99.66	8.87

TABLE 3
Significance of mean difference between boys and girls on Health Practices

Dimensions	Males		Females		
	Mean	SD	Mean	SD	't' value
Health Practice	91.34	9.42	92.04	8.01	0.92
Personal Hygiene	21.77	3.95	21.39	3.64	1.15
Sedentary Habits	12.85	2.22	13.10	2.26	1.30
Compromising Habits	12.02	1.96	12.46	1.62	2.88**
Creative Habits	8.30	2.18	9.64	1.95	7.48**
Energy Activities	10.16	1.41	9.38	1.72	5.80**

** —p> 0.01 level

The boys and girls in this sample did not differ in overall health related habits. Irrespective of the habit being positive or negative the boys are similar to girls in the practices. Girls were more involved in fine arts activities (9.64 ± 1.95) than the boys (8.30 ± 2.18) (t value = 7.48, p > 0.01). On the other hand, the boys often practiced energy consuming outdoor activities (10.16 ± 1.41) than the girls (9.38 ± 1.72) (t value 5.80, p > 0.01). Thus, the tendency for emotionally expressive artistic behaviour is seen in girls and typically, age related and gender related sports preferences is observed among boys.

TABLE 4
Mean scores on Health Habits in relation to future perspective

Group	Mean	SD	't' value	'p' value
Career orientation (n=449)	91.71	8.89	0.31	0.75
Non-career oriented (n=99)	91.39	8.48		
Training oriented (n=174)	93.59	8.69	3.52	0.00
Non-training oriented(n=376)	90.77	8.73		
Under Medication (n=78)	90.18	9.91	1.61	0.10
Non-medication (n=463)	91.90	8.52		
Hobbies (n =464)	91.42	8.53	1.18	0.23
No-hobbies (n=83)	92.66	10.20		
Future orientation (n=366)	91.34	8.65	1.20	0.22
Non-future orientation (n=183)	92.30	9.14		
Planned (n=424)	92.25	8.58	2.93	0.00
Unplanned (n=123)	89.62	9.25		
Study activities (n=404)	92.56	8.25	3.93	0.00
Non-study activities(n=145)	89.25	9.80		

Knowing that on an average these children have good health related regimen, these practices were examined in relation to different dimensions of future orientation. Comparisons of the dichotomized orientations and their mean scores on health practices showed that a bout 83 % of the students had expressed having made a clear choice of career and the mean scores of this group on health habits was 91.71 and those who had no specific choices (18%) were found to score 91.39. Thus, making a decision on career did not differentiate the practice levels. Many children in this group were too young to understand and make a decision about their careers. The interest in health educational course was endorsed by 31% of the sample and their scores on health behaviour was 93.59, the remaining 68% who had no interest in health education scored 90.77. The difference of 3 points in favour of former group reflect a significant relation between attitude to learn and practice. The children having a favourable orientation to learn about health were more skilled practitioners of behaviours and *vice versa*. It was evident that some children had some personal illness (Asthma, Cough cold, Allergies, deficiencies). Thus, some children were on medication (14%). Those who were not taking medicines were found to be higher on health related practices. (91.90), but the differences in these two groups are not statistically significant.

Another dimension on which these children were assessed is planning activity. The group who had a definite plan of maintaining hobbies, interests, activities (76%) were found to have a mean score of 92.25 on health related behaviors than those (34%) who had no definite planned activities or maintained them. The lower scores of the latter group 89.62 was significantly (t = 2.93, p< 0. 001) indicative of a generalized non-planned goal-orientation. This was also evident in the study activities plan. Those who had a clear plan of study activities (73.4%) are those who scored high on health related actions *i.e.*, mean score = 92.56. Whereas children who lacked a clear plan of study activities scored significantly lower (Mean = 89.25) on health behaviour (t = 3.93; p > .001).

The overall findings of the study cover a group of children in the range of 12–16 years. These children exhibit fairly good health related habits, characterized by involvement in personal care and hygiene, involvement in fine arts as hobbies and creative habits and involvement in energy consuming outdoor physical activities. Some children also exhibited sedentary habits, indulgence in rich food, and specific risk behaviors like smoking, indiscriminate dieting.

The study highlights the role of behavioural discipline and activities among adolescents as a continuum weaving through different aspects of life. Studies, hobbies, eating pattern, recreational pattern are inter linked and to a large extent is sustained by the motivational level and goal-directedness of the adolescent. The psychosocial focus and health practice focus are linked. The parental educational attainment did not significantly contributed to children's health habits. Generally positive health habits are found to be stronger in the young adolescents. Among the older adolescents compromising and risk behaviors were found to be stronger. Thus biological, emotional independence leads to independence for varied activities including many life style patterns. The findings imply that health habits that are established in young age are related to time orientation and self-motivation. Developing and training modules for children must incorporate time-oriented inputs and enhance self-motivation to establish positive behaviours. The achievement orientation as a personality predisposition can be a marker for acquiring many life skills, including skills of health achievement.

Adolescents are aware of both health enhancing as well as health compromising habits and they do involve in such practices. The self-motivation, goal-directed behaviour, which encompasses future orientation, is found to underlie many of adolescents' life activities such as hobbies study skills, career plans and also their health related habits. Gender status significantly influences the choice and practice of health behaviours.

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The Role of Family Environment in Happiness Disposition

12

Mousami Thappa

There is nothing absolute about the concept of happiness. It is probably impossible to objectively define happiness as we know and understand it, as internal experiences are subjective by nature. Happiness is person's cognitive and affective evaluation of his or her life in terms of well-being and contentment. It depends on how they evaluate their life, *i.e.*, either in positive way or in negative way. (Lyubomirsky & Tucker, 1998). Happiness is the whole aim and end of human existence. In most of the studies, it was found that people rank the pursuit of happiness as one of the most cherished goal in life. (Diener & Oishi, 2000; Suh, Smith & Shao, 1995; Freedman, 1978; Triandis, Bontempo, Leung, & Hui, 1990; Lyubomrisky, 2000).

Human happiness, the greatest aim of science and ultimate goal of all mankind is influenced by the family, which is the starting point in the life of an individual. Man is not born human nor is he born social, but he becomes so both through association and communication. The family is the first and foremost agency in the "Cultural conditioning", by providing for him "his earliest behaviour pattern and standard of conduct". The infant at birth is primarily on a biological level. Its first contact by which it begins to become a social, psychological beings is in the family. The happiness of an individual is determined by their family