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Assessment of Social and Functional Skills and Its Correlates among Adolescents- A Cross-Sectional Study.

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ABSTRACT

Background: Adolescents is a period where a lot of biological changes occur accompanied by significant stress on young people and those around them, which may influence and affect their relationships with their peers and adults. The diagnosis of most mental disorders requires not only the presence of specific symptoms of psychopathology, but also impairment in daily functioning and that measure of social and adaptive functioning are important to identify such deficits. The study plans to assess the level of social functioning skills and its associated factors among adolescent school children. **Methods:** This cross-sectional study was conducted among 2568 adolescent school children studying in classes VII to XII during the month of April to June 2016 using the 'Child and Adolescent Social and Adaptive Functioning Scale' (CASAFS) tool which is a validated instrument. Approval from the Institutional ethics Committee was obtained. Descriptive statistics and analytical statistics like chi-square test where used. A p-value of < 0.05 was taken as significant. **Results:** A total of 7 schools constituted by 2 government and 5 private schools were sampled with almost equal proportions of males and females. Family Relationship domain had highest mean (SD) score (20.52±2.6) of social functioning skill and School performance Domain having least mean (SD) score (15.9±2.6) of social functioning skill. Being female, higher the parental education and belonging to Muslim community were found to be significantly associated with Good social functioning skill (p<0.001). **Conclusion:** The study highlights the importance of parental education and guidance, the role of family relationship and peers in developing social competency and good adaptive functional skills in adolescent children.

Keywords: Adaptive skill, Adolescents, Mental health, Social skill.

INTRODUCTION

According to the World health organisation, worldwide 10-20% of children and adolescents experience mental disorders. Half of all mental illnesses begin by the age of 14 and three-quarters by mid-twenties.[1] As the health sector moves toward a drive for universal health coverage, adolescents must not be left behind. A combination of biomedical, behavioural and structural interventions during adolescence is necessary to maximize health across the life-course. Adolescents have specific needs but are often among those least well served by health services as currently organized.[2-4]

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Adolescents defined as the period between 10 to 19 years of age is a critical phase of life, where major physical, physiological, psychological, and behavioural changes with changing patterns of social interactions and relationships take place.[5,6] During this period a lot of biological changes occur accompanied by significant stress on young people and those around them, which may influence and affect their relationships with their peers and adults. It is also an age of impulsivity accompanied by vulnerability, influenced by peer groups and media that result in changes in perception and practice, and characterized by decision making skills/abilities along with acquisition of new emotional, cognitive and social skills.[7]

Social functioning is defined as the degree to which an individual fulfils various roles in his or her life. [8] The primary domains of social functioning are work, family relationships, relationships with family or friends, leisure and social activities, household duties, and self-care.[9] Studies have shown that adolescents with elevated depressive symptoms display lower levels of social functioning, including isolation from peers, poor academic performance and poor family relationships. The pattern of deficits in social functioning may differ according to the form of psychological disorder. For instance, depressed adolescents often withdraw from family and friends, refuse to participate in recreational activities, and find it difficult to fulfil work demands at school or

home.[10-12] According to Price et al the diagnosis of most mental disorders requires not only the presence of specific symptoms of psychopathology, but also impairment in daily functioning and that it is important that the type of deficits in social functioning can be identified, to highlight areas in which remedial intervention and skills training are required and that measures of social and adaptive functioning are important in establishing a baseline level for the severity of an individual's presenting problem, against which to assess improvement over time in response to treatment.[9] Thus this study was conducted to assess the level of social functioning skills and its associated factors among adolescent school children in a state in remote North-East India.

MATERIALS AND METHODS

This cross sectional study was conducted among adolescent school children studying in classes VII to XII in High schools and Higher Secondary Schools located in Imphal West District, Manipur in North East, India during April to June 2016.

Sample size and sampling

Sample size was calculated based on a prevalence of 17.9%of psychosocial problems,[13] among adolescent school children. Using 1.5% precision and at 5% significance level a sample size of 2509 was calculated. Sampling of schools was done using lottery method. From the list of high schools and higher secondary schools located in the schools the schools were sampled sequentially till the required sample size was obtained. All eligible students from selected schools were included in the study. Absentees on the day of visit and refusals to participate were excluded.

Study tool and operational definition

Study tool used was the 'Child and Adolescent Social and Adaptive Functioning Scale' (CASAFS) [9]which is a self-reported inventory consisting of 24 items designed to assess the social functioning of children and adolescents, defined as the degree to which an individual fulfils various roles in his or her life. It comprises of four subscales examining functioning in four key social role areas relevant to children and adolescents, namely (i) school performance, (ii) peer relationships, (iii)family relationships, and (iv) home duties/ self-care. Each dimension was represented by six items which were randomly allocated within the questionnaire. A Likert scale scoring was done for each item ranging from 1 (never), 2 (sometimes), 3 (often) and 4(always). The total scores ranges from 24 to 96. The scores obtained by each respondent were summated and categorised into three groups. Adolescents scoring less than 25th percentile were categorised as having 'Low social functioning skill', those scoring between 25th and 75th percentile as having 'Average social functioning skill' and those scoring above 75th percentile as 'Good social functioning skill'.

Ethical issues

The study was approved by the institutional Ethics committee. Prior permission for the visit was obtained from school authorities. School principals were requested to make announcement in school assembly one day ahead about the visit so that students may obtain permission from parents/guardians.

On the day of visit the purpose of the study was explained and verbal assent were obtained. After collecting the questionnaire an interactive health talk was given covering areas on mental health, adolescent mental health problems, warning signs and ways to prevent mental ill-health. All identifiers were removed from collected data and strict confidentiality was maintained.

Statistical analysis

Collected data was entered into Ms Excel and data cleansing was performed. Data was then transferred into IBM SPSS version 22 software and analysed. Descriptive statistics like mean, median, percentile, standard deviation were generated. Analytical statistic like chi-square test was applied and a P-value of <0.05 was taken as significant.

RESULTS

A total of 7 schools were visited, out of which 2 were Government schools and 5 were private schools. The total number of eligible students was 2863; there were 293 absentees and no refusals, so a total of 2568 students were included in our study. The age of the students ranges from 11 to 19 years. The mean (SD) age was 13.93±1.3 and median age was 14 year. Males and females constitute almost equal proportions. Majority of the students were Meeteis (36.6%) followed by Hindus (31.0%). Most of the respondents (1014, 39.5%) had only 1 sibling [Table 1]. The mean (SD) score of all the domains combined was 71.48±6.3 with Family Relationship domain having highest mean (SD) score (20.52±2.6) of social functioning skill and School performance Domain having least mean (SD) score (15.9±2.6) of social functioning skill. A total of 543 (21.1%) students were categorized as having 'Good social functioning skill' whereas 65.5(25.5%) students had 'Poor social functioning skill'. Females students had a significantly higher social functioning skill as compared to males (P<0.001). Children belonging to Islam by religion showed a significantly higher social functioning skill as compared to those belonging to other religion (p<0.001). The higher the educational status of the mother the better is the social functional skill and this was found to be statistically significant (p<0.001). Similar relationship was observed between educational status of father and social functional skill of the children [Table 3]

Table 1: Showing socio-demographic profile of the respondents (N= 2568).

Variable	Categories	Frequency (%)
Gender	Male	1332 (51.9)
	Female	1236 (48.1)
Religion	Hinduism	818 (31.9)
	Islam	229 (8.9)
	Christianity	539 (21.0)
	Meeteism	939 (36.6)
	Others(Sikhs, Buddhists etc)	43 (1.7)
Mother's educational status	Illiterate	249 (9.7)
	Primary & middle school	466 (18.1)
	High school/10th passed	684 (26.6)
	12th passed	634 (24.7)
	Graduate & above	466 (18.1)
	Don't know/unknown	69 (2.7)
Father's educational status	Illiterate	95 (3.7)
	Primary & middle school	312 (12.1)
	High school/10th passed	520(20.2)
	12th passed	646(25.2)
	Graduate & above	891(34.7)
	Don't know/unknown	104(4.0)
No. of siblings	Only child	123(4.8)
	1	1014 (39.5)
	2	758 (29.5)
	3 & above	673 (26.2)
Birth order	Only child	123 (4.8)
	First born	926 (36.1)
	Second	771 (30.0)
	Third & above	748 (29.1)

Table 2: Assessment of the students by different domains (N= 2568).

Items	Scales				
	Never	Sometimes	Does not apply to me	Often	Always
Peer relationship domain					
I go out to places with my friends	185(7.2)	1691(65.8)	-	423(16.5)	269(10.5)
I have friends of the opposite sex	540(21.0)	1158(45.1)	-	444(17.3)	426(16.6)
I go to parties or school dances	833(32.4)	1341(52.2)	-	280(10.9)	114(4.4)
I have at least one or two special friends.	124(4.8)	318(12.4)	-	412(16.0)	1714(66.7)
I spend most of my spare time alone.	739(28.8)	1328(51.7)	-	331(12.9)	170(6.6)
I have difficulty making friends	1181(46.0)	969(37.7)	-	251(9.8)	167(6.5)
School performance domain					
I get good marks in Maths /Arithmetic.	116(4.5)	1734(67.5)	-	546(21.3)	172(6.7)
I get good marks in Science	51(2.0)	1343(52.3)	-	870(33.9)	304(11.8)
I get good marks in Social Science and/ or History	89(3.5)	1261(49.1)	-	822(32.0)	396(15.4)
I get good marks in reading / writing /English	37(1.4)	780(30.4)	-	1078(42.0)	673(26.2)
I have trouble with my School work	380(14.8)	1575(61.3)	-	440(17.1)	173(6.7)
I am successful at my school work	69(2.7)	1075(41.9)	-	1032(40.2)	392(15.3)
Family relationship domain					
I have a good relationship with my mother	20(0.8)	146(5.7)	16(0.6)	402(15.7)	1984(77.3)
I have a good relationship with my father	52(2.0)	236(9.2)	68(2.6)	432(16.8)	1780(69.3)
I get on well with brother(s) / sister(s) (if you have any)	68(2.6)	407(15.8)	87(3.4)	638(24.8)	1368(53.3)
I get on well with my relatives	40(1.6)	414(16.1)	-	696(27.1)	1418(55.2)
I have fights with my parent(s)	1604(62.5	866(33.7)	-	65(2.5)	33(1.3)
I have an adult who I can talk to if I have a problem	193(7.5)	674(26.2)	-	541(21.1)	1160(45.2)
Home duties/ self-care domain					
I help around the house	41(1.6)	937(36.5)	-	758(29.5)	832(32.4)
I keep my room and belongings tidy	64(2.5)	381(14.8)	-	705(27.5)	1418(55.2)
I keep my clothes clean and tidy	15(0.6)	222(8.6)	-	536(20.9)	1795(69.9)
I shower and keep myself clean	13(0.5)	131(5.1)	-	490(19.1)	1934(75.3)
I help with the cooking at home	276(10.7)	1399(54.5)	-	536(20.9)	357(13.9)
I help with the clearing up after meals.	141(5.5)	876(34.1)	-	574(22.4)	977(38.0)

Table 3: Comparison of Social functioning skill by selected variables.

Variable		Social functioning skill			P- value
		Low N (%)	Average N (%)	Good N (%)	
Gender	Male	399 (30.0)	703 (52.8)	230 (17.3)	0.001
	Female	256 (20.7)	667 (54.0)	313 (25.3)	
Age (yr)	<14	263 (24.9)	576 (54.5)	217 (20.5)	0.596
	≥14	392 (25.9)	794 (52.5)	326 (21.6)	
	Hindu	176 (21.5)	440 (53.8)	202 (24.7)	0.001
	Islam	40 (17.5)	127 (55.5)	62 (27.1)	

Religion	Christian	190 (35.3)	287 (53.2)	62 (11.5)	
	Meitei	236 (25.1)	494 (52.6)	209 (22.3)	
	Others	13 (30.2)	22 (51.2)	8 (18.6)	
Mother's education	Illiterate	88 (35.3)	121 (48.6)	40 (16.1)	0.001
	Primary & middle	117 (25.1)	270 (57.9)	79 (17.0)	
	10th passed	162 (23.7)	386 (56.4)	136 (19.9)	
	12th passed	157 (24.8)	327 (51.6)	150 (23.7)	
	Graduate& above	104 (22.3)	234 (50.2)	128 (27.5)	
Father's education	Illiterate	39 (41.1)	48 (50.5)	8 (8.4)	0.001
	Primary & middle	97 (31.1)	166 (53.2)	49 (15.7)	
	10th passed	120 (23.1)	293 (56.3)	107 (20.6)	
	12th passed	165 (25.5)	352 (54.5)	129 (20.0)	
	Graduate& above	201 (22.6)	461 (51.7)	229 (25.7)	

DISCUSSION

The study which is a first of its kind in the state with a relatively large sample size was able to measure the adaptive social functioning of the adolescents and highlighted some of the factors associated with it.

In the peer relationship domain a sizable portion of adolescents (66.7%) said that they always have at least one or two special friends but around 6.6% of the adolescents spend most of their spare time alone and 6.5% had difficulty making friends; such adolescents maybe at risk for experiencing loneliness and other mental health symptoms. Other studies also revealed that loneliness prevalence was lower among adolescents who have close supportive relationships.[14-16] As noted in other studies, individuals having good friendship in adolescence had better mental health as compared to those who do not.[17,18] Only around 15.3% of the adolescents feel that they are always successful with their school work. Adolescence is the time period where maximum emotional and psychosocial support is needed from family members to cope with academic stress. In this study although almost a third of the adolescents (77.6%) said they 'always' have good relationship with their mother and 69.3 % said they 'always' have good relationship with their father; only 45.2% felt that they 'always' have an adult who they can talk to if they have a problem. Although strong family ties and bondage plays an important role in our society due to increasing challenges of jobs and other responsibilities parents may not be able to spend quality time with their children.[19] Parental support and understanding is important for adolescent to prevent risk of mental health problems.[20]

The study shows that females have better social functioning skills as compared to males; as females are more likely to take part in home duties like cooking, cleaning and are better at self-care. Adolescent students belonging to Muslim community have better social functioning skills as compared to other communities. This could be due to the larger family size, better understanding and bonding among family members in Muslim communities. The higher the parental education the better the social functioning skill and this was found to be significantly related for mothers' educational level as well as the fathers'. Studies elsewhere also highlighted the importance of parental education and monitoring in the psychosocial development of their wards.[20-22] Social relationships and work are important elements and social relationships have been found to mediate stress and be positively associated with quality of life.[23-24]

The strength of the study was that the study was conducted with a relatively large sample size and the schools were selected using random method which included both government and private schools. Almost equal proportions of boys and girls were sampled in the study and the study tool used was a validated instrument. Hence, the study's findings may be valid and representative of school going adolescent boys and girls in the district. The limitations of the study were that only adolescents attending schools were included. The characteristics of adolescents who were school dropouts or who do not attend schools could not be assessed. It is recommended that such measures are used to identify children with social and adaptive functioning deficits at an early stage in life, for prevention of further social decline and the onset of disorders with timely intervention strategies.

CONCLUSION

The findings of the study highlights the importance of parental education and guidance, the role of family relationship and peers in developing social competency and good adaptive functional skills in adolescent children.

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