



A Study On Mental Health Awareness Among Adolescents In Low Socio-Economic Families Of Chennai

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Abstract: Mental health is a crucial and very important aspect yet frequently overlooked, especially among adolescents from low socio-economic backgrounds. This study explores the level of mental health awareness among adolescents living in Dr. Santhosh Nagar, Chennai, Tamil Nadu. It focuses on their knowledge, attitudes, stigma, and beliefs. With adolescence being an important time for emotional development. The research aims to assess awareness levels, identify misconceptions and understand the influence of social, cultural and political factors. The study is conducted using a descriptive research design and non – random convenience sampling. The study surveyed 60 respondents by a structured questionnaire.

Findings highlight a mixed response. Majority of respondents recognise the importance of social relationships and mental health; significant stigma and misconceptions still persist. Many respondents relate mental health issues with past karma or punishment and conveys hesitation in approaching professionals for help. Also, majority of adolescents are comfortable sharing about issues with peers than professionals or family members.

The research emphasises the immediate need for targeted mental health awareness and culturally sensitive interventions at grassroot levels. The community based – interventions are needed to improve the mental health literacy and reduce stigma. It is necessary to strengthen school – based programmes, increasing availability and accessibility of mental health facilities like hospitals and counselling centres. Tackling stigma through providing education and awareness are very crucial steps towards creating a supportive environment for adolescent's mental health. Overall, the study identifies gaps in knowledge, prevailing misconceptions and provides insights for educators and policy makers.

Index Terms – Mental health, adolescents, low socio-economic backgrounds and stigma.

I. INTRODUCTION

1. A BRIEF GENERAL INTRODUCTION

Adolescence

According to the World Health Organisation (WHO), adolescence is the phase between childhood and adulthood, from 10 to 19 years of age. Physical, emotional and social changes can make adolescents vulnerable to mental health problems. Physical changes include hormonal fluctuations, brain development and physical changes in appearance. Emotional changes like heightened emotional intensity, increased desire

for independence and developmental pressures. Social changes comprise of increased peer pressure and social expectations, family dynamics and changes like domestic violence and economic disparities.

Socio-Economic Status

Socio-economic status (SES) is defined as the place that an individual or a family occupies in distinction to the existing standards of cultural and material ownership, income and involvement in group activities of the community. Since ages, societies stratify its population based on socio-economic conditions such as approach to resources and goods, social standing wealth, prestige and power, housing, environmental conditions and standard of living of a family or an individual. Socioeconomic status (SES) has a profound influence on multiple aspects of an individual's health and well-being, including nutritional status, mortality rates, and overall morbidity. Additionally, SES is a key factor in determining how individuals access and utilize available healthcare services (Lakhumna et al, 2025).

According to National Cancer Institute, people with a lower socioeconomic status usually have less access to financial, educational, social, and health resources than those with a higher socioeconomic status. As a result, they are more likely to be in poor health and have chronic health conditions and disabilities.

Mental Health

As stated by the WHO, mental health is a state of well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. Mental health matters because it directly impacts every aspect of our lives—our emotional well-being, our relationships, our physical health, our productivity, and our ability to cope with life's challenges. When we are mentally healthy, we're generally happier, more at peace with ourselves, and able to find satisfaction in life's everyday experiences. Good mental health can have positive effects on one's physical body, as it encourages healthier lifestyle choices, such as getting enough rest, eating well, and exercising. When we are mentally well, we are generally more patient, understanding, and empathetic in our relationships. When our mind is clear and focused, we're able to complete tasks efficiently, make good decisions, and be creative. Good mental health helps us develop resilience and coping skills to handle all difficulties without becoming overwhelmed.

Adolescents' Mental Health

According to WHO's report, depression, anxiety and behavioural disorders are one of the leading causes of illness and disability among adolescents.

According to American Psychiatric Association, depression is a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world. Some of the symptoms are feeling sad, irritable, empty and/or hopeless, losing interest or pleasure in activities you once enjoyed, a significant change in appetite, sleeping too little or too much and decreased energy or increased tiredness or fatigue.

As stated by National Institute of Mental health, feeling anxious is a normal part of life. But anxiety disorders involve more than occasional worry or fear. For people with these disorders, anxiety does not go away, is felt in many situations, and can get worse over time. There are various types of anxiety disorders, including generalized anxiety disorder, panic disorder, social anxiety disorder and various phobia-related disorders.

According to WHO, the cases of behavioural disorders are more observed in younger adolescents than older adolescents. These include Attention Deficit Hyperactivity Disorder (ADHD) which has symptoms like difficulty paying attention and/or excessive activity and acting without regard to consequences and Conduct disorder which is characterised by destructive or challenging behaviour. Behavioural disorders increase the risk of criminal behaviour and affect education. Addressing mental health issues throughout adolescence is crucial to promoting holistic development because adolescence is a transforming stage of life.

Adolescents in Low Socio-Economic Families

Lower family income led to higher parenting stress, which in turn predicted more adolescent depressive symptoms and anxiety (Yudan Chen Wang et al, 2023). Due to poor economic condition, parents may experience elevated levels of frustration, emotional exhaustion and feelings of inadequacy, which can affect the parenting practices. This may manifest as reduced emotional availability, inconsistent discipline, or increased conflict within parent-child relationship. Adolescents may experience increased emotions of insecurity, emotional dysregulation, and neglect as a result of these family environment disturbances. Over

a period of time, these factors have the potential to undermine adolescents' psychological resilience, thereby increasing their risk of getting mental health issues like depression and anxiety.

According to a study conducted by Thomas Steare et al (2024), adolescents in lower-income countries are not only more likely to live in poverty, but might also be more likely to experience poorer mental health as a result of financial disadvantage which means adolescents from low socio-economic families are more vulnerable to mental health problems. Adolescents from such a background need more help.

Adolescents in low socio-economic families of India face complex challenges on a daily basis which impact their overall development, mental health and well-being. In low socio-economic families, gender plays a significant role where girls face early marriage, less mobility and have less access to secondary education while the boys are forced into labour work at an early age. Despite the challenging times, many adolescents from low socio-economic background show resilience, drawing strength from schools, peer groups and local NGOs.

Adolescents' Mental Health Conditions in India

Mental health awareness in Indian households has grown significantly in recent years, but stigma, false information, and neglect still surround this issue. The severity of mental health difficulties is undermined in many Indian households, too, as they are frequently written off as behavioural problems or adolescent disobedience. The absence of open communication and awareness is one of the main issues. Due to their strong cultural and traditional beliefs, Indian families frequently place a higher priority on scholastic success and meeting social norms than on mental health. Adolescents who battle with mental health issues experience mockery or invalidation, which prevents them from getting treatment. Interventions may be postponed if parents lack the skills or information necessary to recognise the warning symptoms of mental distress like persistent sadness, rapid and unexpected changes in mood and withdrawal from friends and family. Furthermore, stigma in society is a major factor which hinders discussions on mental health. Seeking professional assistance is frequently perceived as an admission of parenting failure or a display of weakness. Adolescents are left to face their difficulties alone because of this stigma, which fosters a culture of silence. In India, mental health awareness among adolescents is gradually increasing, but stigma and lack of understanding remain significant barriers as they create a fear of judgement and social isolation, discouraging adolescents from openly discussing their mental health issues.

The National Mental Health Survey (2015–16) found that about 7.3% of Indian teenagers had mental illnesses, including depression, schizophrenic and psychotic disorders, although the majority go misdiagnosed or untreated. Families frequently postpone care because they view mental health problems as a weakness or a temporary stage. Adolescents' stress, anxiety, and depression frequently increase due to social pressures, competitive exams, and academic strain. Social media gives people a way to express themselves, but it makes problems like body image issues, cyberbullying, Fear of Missing Out (FOMO) and sleep disturbances worse. Early intervention and care are further hampered by the shortage of qualified mental health experts and the unequal distribution of resources, particularly in rural areas.

Campaigns Released by World agencies

Globally, the World Health Organization (WHO) emphasizes adolescent mental health as a priority area because adolescence is a critical period of development and can affect a person throughout his/her life.

Global awareness initiatives, such as World Mental Health Day which is celebrated every year on 10th October. The objective of World Mental Health Day is to raise awareness of mental health issues around the world and to mobilize efforts in support of mental health. The day gives everyone involved in dealing with mental health issues a chance to discuss their efforts and what more needs to be done to ensure that mental health care is accessible to everyone in the world. The theme of World Mental Health Day of the year 2023 was "Mental health is a universal human right". Mental health is a basic human right for all people. Everyone, whoever and wherever they are, has a right to the highest attainable standard of mental health. However, Indian families' cultural customs frequently clash with international norms due to different value systems. For example, Western society has more open conversations about mental health than Indian families, which take a more conservative position. Western society is able to talk freely about mental health because of various factors, including their upbringing, community and personal beliefs. This disparity restricts India's ability to implement global best practices. However, exposure to international mental health initiatives and heightened worldwide connectedness are motivating Indian adolescents to get help from mental health

professionals, access mental health resources and advocate to shape mental health policies. Sustainable Development Goals have been formed to improve the lives of the people and planet. Sustainable Development Goal 3, one of the 17 Sustainable Development Goals, ensures a healthy life and promotes well-being for all ages. This includes physical, mental and emotional well-being.

Campaigns Introduced by the Indian Government

The Atmanirbhar Bharat Abhiyan, which is also known as the Self-reliant India campaign, is the vision of the New India envisioned by our honourable Prime Minister, Shri Narendra Modi. It was launched on 12 May, 2020. It is a stimulus package for revitalising the economy of India post COVID-19 outbreak. Under the Atmanirbhar Bharat Abhiyan, the Indian government has launched initiatives like the Manodarpan for psychosocial support for students' mental health and well-being during the COVID-19 outbreak and beyond. The Manodarpan comes under the Ministry of Education. This initiative includes a helpline number, "8448440632" which provides tele-counselling which is provided to students, interactive online chat platforms for contact, counselling and guidance by mental health professionals, handbook on 21st century skills for school students which contains skill-sets. These skills are required by an individual to cope up and succeed in facing the challenges in real-life and webinars and audio-visual resources including videos, comic and short films. The Manodarpan foresees to facilitate a sustainable psychosocial support system for students, families and teachers. Adequate systems and provisions for resident psychologists who can intervene at the onset of emotional and mental problems, are yet to become commonplace in both governmental and private institutions/schools in the country. The top-notch institutes in the country still have some counsellors, but such mechanisms are almost non-existent in smaller institutes and schools, especially in tier-2 and tier-3 cities. It is difficult to put these initiatives into practice at the grassroots level due to a lack of understanding and infrastructure.

The Legislations Passed By the Indian Government

A number of legislative initiatives have been proposed to guarantee the welfare of adolescents, with an emphasis on fostering supportive settings in families.

The Right to Education Act, 2009 indirectly contributes to mental health awareness by mandating a stress-free and inclusive educational environment. Providing education to all children can lead to increased self-esteem, reduced stress levels and better coping mechanisms, particularly those who are from disadvantaged sections of society who might otherwise face significant mental health challenges due to a lack of educational opportunities. Even with a lot of legislation being passed, mental health is still a taboo topic. It is not discussed in Indian families. Indian families shy away from talking about their mental health. Whenever a spark for a conversation on mental health is seen, it is then, and there brushed under the rug. The dialogue on mental health is further hampered by a shortage of skilled personnel, limited resources, and sociocultural hurdles. With 253 million people between the ages of 10 and 19 years, adolescent mental health is a serious issue in India. Various estimates illustrate the extent of the problem, with recent studies showing a large prevalence of mental health concerns among Indian adolescents.

On a similar note, Lok Sabha passed the Juvenile Justice (Care and Protection of Children) Act, 2015 on 7 May 2015, despite strong opposition from several members of the Parliament. On 22 December 2015, the Rajya Sabha also passed it. The Juvenile Justice (Care and Protection of Children) Act, 2015 came into force from 15 January 2016. The Juvenile Justice (Care and Protection of Children) Act, 2015 replaced the Indian Juvenile Delinquency Law, Juvenile Justice (Care and Protection of Children) Act, 2000. The Juvenile Justice (Care and Protection of Children) Act, 2015 allows for juveniles in conflict with law in the age group of 16-18 years of age involved in heinous offences to be tried as adults. This aims to balance child's welfare with societal safety. Adolescents are less culpable as a group and has a greater chance to reform so this legislation gives them an opportunity to reform themselves. The Juvenile Justice (Care and Protection of Children) Act, 2015 made it necessary for all Child Care Institutions, whether run by the State Government or by voluntary or non-governmental organisations are to be mandatorily registered under the Act within 6 months from the date of commencement of the Act. By this Act, children who are in need of care will be protected in a better way and will be guarded from a traumatic childhood. The Juvenile Justice (Care and Protection of Children) Act, 2015 established a universally accessible adoption law for India which superseded not replaced Hindu Adoption and Maintenance Act, 1956 (applicable to Hindus, Buddhists, Jains, and Sikhs) and the Guardians and Wards Act, 1890 (applicable to Muslims). This can reduce emotional toll on children, especially those who have experienced neglect or abandonment, as they are more likely to find stable homes sooner. The

Juvenile Justice (Care and Protection of Children) Act, 2015 has further been amended by the Juvenile Justice (Care and Protection of Children) Amendment Act, 2021 which have come into force from 1 September 2022. It provides that instead of the court, the District Magistrate (including Additional District Magistrate) will issue such orders.

A historic piece of legislation, the Mental Healthcare Act, 2017 was passed on 7 April, 2017 and came into force from 29 May, 2018. This Act superseded the previously existing Mental Health Act 1987, which was passed on 22 May, 1987. The act effectively decriminalized attempted suicide which was punishable under Section 309 of the Indian Penal Code. It has outlined some measures such as protection of individual rights, promoting awareness and integrating mental health into mainstream health care. By fostering an inclusive, rights-based framework, the Mental Healthcare Act aims to create a more understanding and stigma-free environment for those who are affected by mental health issues.

Current Statistics

These concerns are not just worldwide but also very severe.

According to the World Health Organisation (WHO), depression and anxiety are among the leading causes of illness and disability among adolescents, and suicide is among the leading causes of death in people aged 15–19 years. According to the data published by the National Crime Records Bureau (NCRB), In 2022, 1,70,924 suicides were reported in India. Tamil Nadu's suicide rate was 25.9 per 1,00,000 population in 2022. The rate of suicide has seen a dramatic rise since the first published Accidental Deaths & Suicides in India (ADSI) report in 1966.

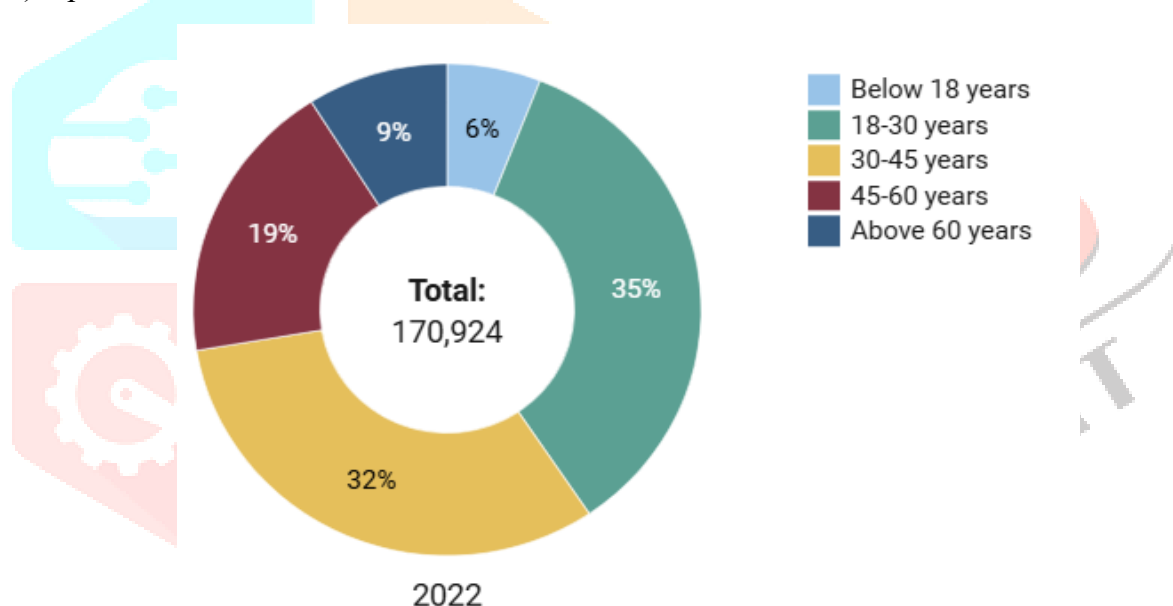


Figure 1 This chart illustrates that 6% of total suicides were reported for the age of below 18 years. Young adults aged 18-30 years accounted for 35% of all suicides in 2022, the biggest share of all the age groups.

Half of all mental health disorders in adulthood starts by age 18, but most cases are undetected and untreated. The vast majority of those who are impacted do not obtain proper care, as seen by the 90% treatment gap for mental health illnesses in India. It is due to the widespread social stigma associated with mental health issues, lack of awareness about mental illnesses and their treatment options, limited access to qualified mental health professionals, particularly in rural areas, and inadequate infrastructure for mental health services, leading to people not seeking help when needed. According to an article titled “The burden of mental disorders across the states of India: The Global Burden of Disease Study 1990–2017”, in 2017, 197.3 million people had mental disorders in India, including 45.7 million with depressive disorders and 44.9 million with anxiety disorders where the Indian population was 1354.2 million in 2017.

District Mental Health Program (DMHP)

In the year of 1951 five-year plans were introduced in India for social welfare, economic stability, modernisation and poverty reduction. In 1996, Ninth Five-year plan was introduced where National Mental Health Program (NMHP) was a part of it. Under NHMP the District Mental Health Program (DMHP) was

launched in Tamil Nadu. DMHP is being implemented in 16 districts, the highest number in the country. DMHP was first launched in 1997 in Trichy district and was extended to Madurai and Ramnathapuram in 2001. Subsequently, the programme was extended to 13 other districts. In these districts, there is a ten-bedded psychiatric ward with adequate human resources (psychiatrists, psychologists and psychiatric social workers) along with a mobile psychiatric clinic. To develop a larger public health-based District Mental Health Programme in Tamil Nadu, Tamil Nadu's government collaborated with the Centre for Public Health, NIMHANS, Bangalore. The objectives of this activity were to undertake an assessment of the state – district mental health care programme from a public health perspective, to identify current scenario and to develop a road map for future activities with a focus on District Mental Health Programme. In today's time, the District Mental Health Program (DMHP) covers all 38 Districts in Tamil Nadu that is the whole state of Tamil Nadu. The services are offered based on the Bio-Psycho-Social Approach taking into consideration the biological, psychological and sociological determinants of Mental Health of individuals. The services include creating awareness about Mental Health, workshop for the specific population like Students, Working women, training of school teachers on life skills.

Non-Governmental Organisations (NGOs)

In Tamil Nadu, the Centre for Mental Health and Inclusive Development exists which is co-founded by The Banyan and Rural India Supporting Trust (RIST), envisions “to build inclusive living options and mental health friendly communities as a response to the prolonged segregation of individuals in psychosocial distress in an institutional setting, by adopting justice-oriented approaches and as a result, values of participation, equity, dialogue, inclusivity, choice, social mixing and interdependence are promoted”. They have collaborated with various organisations in different states like in Kerala with Unmad and Mariyasadanam and in Madhya Pradesh with Gramin Adivasi Samaj Vikas Sansthan (GASVS).

The Schizophrenia Research Foundation (SCARF) was founded in 1984 by a group of mental health professionals and philanthropists headed by Padma Bhushan Late Dr M Sarada Menon in Chennai. It offers a multidisciplinary, comprehensive range of psychiatric care and rehabilitation services. They provide both outpatient and inpatient services. They raise awareness about schizophrenia and dementia.

2. STATEMENT OF THE PROBLEM

Even though there are so many conversations happening about Mental health but in some families, it is still stigmatised and stereotyped. It is important to address mental health issues because so many people especially adolescents attempt suicide or die by suicide and this number is increasing year after year which is alarming. While the need for public mental health interventions has been promoted for adolescents globally, evaluation measures and methods lack behind in development (WHO, 2021). This calls for the need to know their mental health awareness level so that we know what we are dealing with. This clarity will lead to proper planning.

3. NEED / SIGNIFICANCE / IMPORTANCE OF THE STUDY

According to reports of UNICEF, India has the highest number of adolescents that is 253 million. Adolescence is a critical stage of a human development where mental health problems often emerge yet awareness and understanding often remain low. Mental health profoundly impacts an adolescent's academic performance and social life. Cognitive functions such as memory, concentration, and problem-solving are often compromised by mental health disorders like anxiety and depression. Mental health struggles can manifest as behavioural issues such as aggression, hyperactivity, or withdrawal. Promoting positive adolescent mental health requires a multi-faceted approach at the individual, institutional, and societal levels. In order to raise mental health awareness among adolescents we need to know the mental health awareness levels of adolescents. The research will ensure we have a better plan of action like relevant mental health policies, proper utilisation of mental health resources in the community and proper addressal of mental health issues.

II. REVIEW OF LITERATURE

1. **Prerna Martin *et al* (2024, p. 533-556) published an article titled “A qualitative study of mental health problems among children living in New Delhi slums”.** This is the first qualitative study to assess local perceptions of the mental health needs of children living in New Delhi slums. The purpose of this study was to understand local conceptualizations of mental health problems among children

living in New Delhi slums, with the ultimate goal of identifying and adapting culturally appropriate evidence-based interventions to address these problems. The findings suggest that children living in these impoverished neighbourhoods have many adverse experiences that lead to internalizing and externalizing symptoms consistent with depression, anxiety, and conduct problems. The results suggest that in New Delhi slums, many of the described proximal causes of mental health problems are chronic stressors (e.g., poverty, sex discrimination), academic pressure, and social pressures (e.g., public shaming by the community).

2. **G. Balamurugan *et al* (2024, e61035) issued an article titled “Mental Health Issues Among School Children and Adolescents in India: A Systematic Review”** which highlights that childhood and adolescence are critical developmental stages for mental health, and the environment in which they grow has an impact on their well-being and growth. There is high prevalence of depression, behavioural and emotional problems, anxiety, psychological distress, internet addiction, and other mental health issues in school children and adolescents. There is an urgent need to strengthen and reinforce school based mental health screening programs with an integrated approach to recognize mental health symptoms and raise awareness about mental health issues among teachers, parents, and stakeholders in school and community settings. There is a need for healthcare professionals to collaborate with parents and teachers for training to provide prompt intervention and family-focused strategies to deal with problems more effectively. There is also the need for advocacy for the welfare of school children and adolescents and the provision of skilled counsellors who can collaborate with mental health professionals
3. **Soham Rej and Neeti Sasi (2023, p.334) issued an article called “World Mental Health Day 2023: Increasing awareness of mental health in India & exciting opportunities for the future”** which revealed that Awareness of mental health issues is increasing in India as more and more people are suffering from mental illness. By 2030, depression alone will likely to be the second- and third-leading contributors to disease burden in low income and middle-income countries, respectively. Despite this dire need, the Indian government spends only about 0.06 per cent of its total health expenditure on mental health. Lack of mental health awareness continues to be a major issue in rural areas and disadvantaged strata of the society.
4. **Md. Abu Bakar Siddique *et al* (2022, e11084) issued an article titled “Mental health knowledge and awareness among university students in Bangladesh”.** Despite of having awareness of mental health issues, the mental health knowledge of Bangladeshi university students is poor. Their low level of knowledge of mental illness prevents them from properly recognizing these problems and offering support. Female and students who are financially self-sufficient have more knowledge, whereas students over the age of 22 have more awareness. Both knowledge and awareness about mental health were influenced by the good mental health status of the respondents. Interestingly, a vital number of participants still believe in superstitious acts such as black magic or religious rituals rather than modern psychiatric treatment.
5. **Anna Kågstrom *et al* (2022, 115031) published an article titled “Development and validation of a Universal Mental Health Literacy (MHL) scale for Adolescents (UMHL-A)”** which talks about young adolescents being the most vulnerable to mental health problems, with 50% of mental health disorders beginning by 14 years of age. According to WHO, While the need for public mental health interventions has been promoted for adolescents globally, evaluation measures and methods lack behind in development. So, UMHL-A Scale was developed to assess MHL in universal populations of children between ages 10 and 14 across all four components within Kutcher’s framework for MHL. The 17- items scale showed sufficient face, content, construct, and convergent validity on a target sample of 10-14 years old Czech adolescents. The study is limited by its lack of focus on cross-cultural and predictive validity. The scale was developed within a Czech educational context.
6. **Franziska Reiss *et al* (2019, e0213700) published an article titled “Socioeconomic status, stressful life situations and mental health problems in children and adolescents: Results of the German BELLA cohort-study”** brings into light the impact of a stressful life situation on mental health problems in children and adolescents depends on the SES. Children from families with low SES are at higher risk of suffering from different stressful life situations. Furthermore, a stressful life situation is associated with mental health problems in children and adolescents. In terms of opportunities for intervention and prevention, the aspect of parental education turned out as the most critical issue. Children with less educated parents obviously need more support in dealing with stressful life situations (e.g., parental illness or accident or severe financial crises) than their peers in a comparable situation but with higher-educated parents.

7. **Kalpna Srivastava *et al* (2016, p.133) published an article titled “Mental health awareness: The Indian scenario”** which concluded that the time has come to adapt a new strategy with renewed vigor to improve mental health, since most previous approaches have failed over the past sixty years or more in less developed nations. Mental health awareness can become both the means and the way of ending this apathy. Together, evidence-based progressive government policies, active media coverage, a thriving educational system, a responsive industry, aggressive use of newer technology, and innovative crowdsourcing could help erase the stigma associated with mental diseases.
8. **Kirti Gaur and Usha Ram (2016, p.104) published an article titled “Mental Health Problems Among Youth in India and its Correlates”** which brings into light that an estimated 11-31 million youth suffer from reported mental health problems in India. The gap in the treatment is a function of both the poor health system and non-detection or under detection of Common Mental Disorders (CMDs). Looking at the huge number of persons showing symptoms of mental health disorder, there is a need to improve the early detection of the disease by integrating the routine screening of mental health care with primary care. There are various policies and programmes in place in India, the only need is to strengthen the existing policies and programmes for better implementation. Addressing young people’s needs is crucial if they are to fulfil their potential and contribute fully to the development of their communities.
9. **Wulf Rössler (2016, p-1250) published an article titled “The stigma of mental disorders”** which revealed that in ancient Greece, a “stigma” was a brand to mark slaves or criminals. For millennia, society did not treat persons suffering from depression, autism, schizophrenia and other mental illnesses much better than slaves or criminals: they were imprisoned, tortured or killed. Stigma can be described on three conceptual levels: cognitive, emotional and behavioural, which allows us to separate mere stereotypes from prejudice and discrimination. Stereotypes are not necessarily wrong or negative, as they can help us make quick judgements about persons who share specific characteristics. Stereotypes thereby allow us to deal with or adapt to a specific situation without needing more information about the persons involved. To make a fair and rational judgement about individuals, however, would require more information than simply calling up stereotypes. In cases of mental illness, stereotypes can therefore become dysfunctional because they typically activate generalized rather than customized response patterns. Many approaches are used to decrease stigma and discrimination, but only a combination of different measures will have the most success in the long term.
10. **Matt O’Connor and Leanne Casey (2015, p.511-516) published an article titled “The Mental Health Literacy Scale (MHLS): A New Scale-Based Measure of Mental Health Literacy”** where a new scale-based measure of Mental Health Literacy (MHL), the Mental Health Literacy Scale (MHLS) was developed to provide a methodologically robust and time-efficient means to assess an individual’s level of MHL. It is a 35-item questionnaire that can be used to assess knowledge of a range of areas in mental health and attitudes toward mental health and help-seeking. Use of this scale will enable efficient identification of individuals who have low levels of MHL and may benefit from further education or support. The MHLS will also allow the detection of changes within an individual in order to assess the impact of programs to improve MHL. It has good psychometric properties and is easily administered and scored. Use of the MHLS will aid efficient evaluation of programs that aim to improve MHL and ensure they are adequately addressing all attributes of MHL.
11. **Rakesh K Chadda and Swati Kedia Gupta (2012, p.66-71) published an article titled “Economic Disparity and Mental Health”** which placed in the spotlight the risk factors that make the lower socio-economic group more vulnerable to psychiatric disorders, which are poor coping styles, ongoing life events, exposure to stress, and a weak social support system. Two-levels of researches have been conducted to understand the association between poverty and mental illnesses- individual level and area level. Individual-level researches have consistently demonstrated that poverty is significantly associated with high levels of common mental health disorders such as anxiety and depression. Area level analysis have found that in poorer areas, there are high rates of hospital admissions, higher out-patient mental health services and suicide. In low- and middle-income countries, women bear the brunt of adversities associated with poverty including less access to education, emotional and physical abuse, sexual trafficking, unwanted pregnancies and fewer job opportunities, hence increasing their vulnerabilities for mental disorders. Relationship between social class and mental illness is one of the earliest and the most firmly established association in psychiatric epidemiology. Socially disadvantaged people have higher rates of psychiatric disorders than their

advantaged counterparts as measured by treatment statistics, non-specific distress in the community and epidemiological surveys of psychiatric disorders.

12. **Patrick W Corrigan and Amy C Watson (2002, p.16) issued an article titled “Understanding the impact of stigma on people with mental illness”** which brings to limelight that on one hand, people with mental illness struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people. Although research has gone far to understand the impact of the disease, it has only recently begun to explain stigma in mental illness. Stigma seems to be less evident in Asian and African countries, though it is unclear whether this finding represents a cultural sphere that does not promote stigma or a dearth of research in these societies. Education provides information so that the public can make more informed decisions about mental illness.

The literature under review mentions some of the different magnitudes of awareness and challenges in mental health in various regions and populations. Previous studies have pointed out the problems experienced by marginalized groups, such as children residing in slums in New Delhi, university students in Bangladesh, and Indian youth. It was revealed that poverty, academic stress, gender discrimination, and social stigma are presented as key factors of mental health concerns such as depression, anxiety, and conduct disorder. However, the awareness of mental health issues is growing, and knowledge and treatment gaps remain, especially in rural and economically poor regions. In India, nowadays, mental health awareness is improving. However, unfortunately, the government's expenses on mental health awareness are less. The rural regions still continue to lack education and resources. In Bangladesh, university students demonstrate poor knowledge about mental health despite some awareness, with many continuing to depend on superstition rather than psychiatric care.

Previous literature studies have revealed that there needs to be a culturally responsive intervention to assess mental health literacy. For example, the Universal Mental Health Literacy (UMHL-A) scale is meant to measure mental health literacy among adolescents from various populations. However, its effectiveness is constrained as it fails to address cross-cultural validation. Scales such as the Mental Health Literacy Scale (MHLS) are constructed initially to target those with low knowledge levels and to improve mental health education and assistance.

Another key topic is the stigma of mental illness, which is still a critical impediment to treatment and social integration. Previous studies also indicated that the stigma of mental illness may hinder the opportunities for such people to obtain employment, accommodation, and medical care, which worsens the plight of the mentally ill. The only way to overcome this is to address this stigma through awareness, education and community outreach if mental health conditions are to be improved. Additionally, importance of early intervention is also emphasised which is the strongest overall predictor of mental health outcomes.

A study brought into limelight the significant moderating effect of parental education: children whose parents had higher educational attainment exhibited fewer mental health issues when exposed to stressful life events, suggesting a buffering effect.

the need for improved mental health awareness, with a special focus on mental health care in primary services and anti-stigma interventions to provide appropriate support and opportunities to the affected people. Reinforcing the current policies, employing the use of technology, and supporting people with mental health issues are important in addressing these enduring issues. Integrating mental health services within the educational framework is essential to enhance awareness, reduce stigma, and provide timely interventions for the youth.

III. RESEARCH METHODOLOGY

Title of the Study: Mental Health Awareness Among Adolescents in Low Socio-Economic Families of Chennai

General and Specific Objectives:

- To study the socio-demographic condition of the respondents.
- To assess the mental health awareness level of the respondents.
- To identify the stigma, superstition and stereotype associated with mental health
- To understand the available resources for mental health in the community

Field of Study: Dr Santhosh Nagar is located in Egmore, Chennai, Tamil Nadu. It was constructed by The Tamil Nadu Slum Clearance Board (TNSCB). Now it is a multi-storey building which accommodates around 560 families from economically weaker sections from our society. Each house has a bedroom, kitchen and toilet. The building has two-wheeler parking with lift which makes the building accessible by persons with disability and elderly.

Pilot Visit: Dr Santhosh Nagar is home to economically weaker sections of society. As we needed the adolescents from low socio-economic families, Dr Santhosh Nagar seemed like a perfect place to collect responses from. Madras School of Social Work has signed Memorandum of Understanding (MOU) with Dr Santhosh Nagar. Nevertheless, we asked for permission from Ms Sushma, Secretary of Dr Santhosh Nagar

Research Design: Descriptive Research design is employed in this research. Descriptive Research design is a type of research design which aims to determine the characteristics, behaviours, attitude and perceptions of a particular group of people. This research attempts to find the levels of mental health awareness among adolescents of Chennai's low socio-economic families and the factors influencing the level of mental health awareness.

Selection of Sample: The adolescents who belong to low socio-economic families of Chennai. Using non-random convenience sampling, the samples were selected from the universe.

Tools of Data Collection: Tool that is used to gather data in this research is the questionnaire. The questionnaire consists of 49 questions.

Sources of Data: There are two sources of Data. Primary Data and Secondary data. Primary data is the first-hand data which is generated at the time of the research data collection process. Secondary data is the already available data that is books, articles and journals. Primary data and secondary data have been collected for the research.

Pre- testing: Pre-test is the step that is undergone to test the efficacy of the tool. Pre-test was done with 5 respondents based on the suggestions one question was tweaked in order to give clarity to the respondents.

Data Collection: The data was collected in the month of April. Around 10-15 minutes was spent per respondent. It was quite difficult to take responses from adolescents as after coming back from school they have to rush to their tuition. In a few cases, parents were quite hesitant to let their children answer the questions.

Definition of Terms: According to World Health Organisation (WHO), mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community.

Analysis: Analysis of data is done using Statistical Package for the Social Sciences (SPSS).

Limitations

- The study may not include enough adolescents to generalise the finding to the entire low socio-economic adolescents population in Chennai
- Participants may come from specific schools or colleges or neighbourhoods which might not represent the diversity of Chennai's low socio-economic families
- Mental health is often stigmatised in Indian society and adolescents might hesitate to answer truthfully.
- The finding may not be applicable to adolescents from different socioeconomic backgrounds.

Scope of the Study: If we know the current level then interventions can be done to empower and equip adolescents with the knowledge and skills which lead to effective early identification, help-seeking behaviour, and early interventions in order to remove the potentially life-long results of poor mental health. We can plan the programmes accordingly to increase mental health awareness levels of the adolescents. This will help in effective execution of the prepared programmes. This will lead to proper implementation of the programmes.

IV. ANALYSIS AND INTERPRETATION

Table-1 Age of the Respondents

S.No.	Age	Frequency	Percentage
1	11	2	3.33%
2	12	3	5.00%
3	13	6	10.00%
4	14	8	13.33%
5	15	5	8.33%
6	16	10	16.67%
7	17	10	16.67%
8	18	9	15.00%
9	19	7	11.67%
	Total	60	100

The most frequent ages are 16 years (10 respondents 16.67%) and 17 years (10 respondents, 16.67%). Other notable ages include 18 years (9 respondents, 15.00%), 14 years (8 respondents, 13.33%), 19 years (7 respondents, 11.67%), 13 years (6 respondents, 10.00%), 12 years (3 respondents, 5.00%) and 11 years (2 respondents, 3.33%).

Table-2 Gender of the Respondents

S.No.	Gender	Frequency	Percentage
1	Female	31	51.67%
2	Male	29	48.33%
	Total	60	100

According to the data collected, there is a slightly higher representation of females (31 respondents, 51.67%) compared to males (29 respondents, 48.33%).

Table-3 No. of Siblings of the Respondents

S.No.	No. of Siblings	Frequency	Percentage
1	Nil	4	6.67%
2	1	31	51.67%
3	2	17	28.33%
4	3	4	6.67%
5	4 or more	4	6.67%
	Total	60	100

According to the data collected, the majority of respondents (31 respondents, 51.67%) have one sibling. A notable number of respondents (17 respondents, 28.33%) have 2 siblings. A slightly lesser number of respondents (4 respondents, 6.67%) have 3 siblings. Likewise, the same number of respondents (4 respondents, 6.67%) have 4 or more siblings. And equal number of respondents (4 respondents, 6.67%) have no siblings.

Table-4 Religion of the Respondents			
S.No.	Marital Status	Frequency	Percentage
1	Hinduism	41	68.33%
2	Christianity	18	30.00%
3	Islam	0	0
4	Sikhism	0	0
5	Buddhism	0	0
6	Jainism	0	0
7	Atheist / No religion	1	1.67%
	Total	60	100

According to the data collected, the majority of respondents (41 respondents, 68.33%) follow Hinduism. A notable number of respondents (18 respondents, 30.00%) follow Christianity. Only 1 respondent (1.67%) identifies as an atheist/ have no religion.

Table-5 Marital Status of the Respondents			
S.No.	Marital Status	Frequency	Percentage
1	Unmarried	60	100
2	Married	0	0
3	Separated	0	0
4	Divorced	0	0
5	Widow	0	0
	Total	60	100

According to the data collected, all the respondents are unmarried.

Table-6 Current Involvement of the Respondents			
S.No.	Current involvement	Frequency	Percentage
1	School	45	75.00%
2	College	10	16.67%
3	Job	4	6.67%
4	None of these	1	1.67%
	Total	60	100

According to the data collected, the majority of respondents (45 respondents, 75.00%) are currently involved in school. A notable number of respondents (10 respondents, 16.67%) are in college. A few respondents (4 respondents, 6.67%) are currently working. Only one respondent (1.67%) is involved in nothing.

Table-7 Family Structure of the Respondents			
S.No.	Family Structure	Frequency	Percentage
1	Nuclear	43	71.67%
2	Joint	14	23.33%
3	Single-parent	3	5.00%
	Total	60	100

According to the data collected, the majority of respondents (43 respondents, 71.67%) have a nuclear family. A notable number of respondents (14 respondents, 23.33%) have joint families. A few respondents (3 respondents, 5.00%) have a single – parent household.

Table-8 Highest Educational Qualification of Respondents' mother

S.No.	Highest Educational Qualification of Respondents' Mother	Frequency	Percentage
1	No formal education	16	26.67%
2	Primary education	28	46.67%
3	Secondary education (high school)	13	21.67%
4	Vocational/Technical education	0	0
5	Bachelor's degree	3	5.00%
6	Master's degree	0	0
7	Doctoral degree (Ph.D.)	0	0
	Total	60	100

According to the data collected, the majority of respondents' mother (28 respondents, 46.67%) only had primary education. A notable number of respondents' mother (16 respondents, 26.67%) had no formal education. A slightly lesser number of respondents' mother (13 respondents, 21.67%) studied high school. A few respondents' mother (3 respondents' mother, 5.00%) completed their bachelor's degree.

Table-9 Highest Educational Qualification of Respondents' Father

S.No.	Highest Educational Qualification of Respondents' Father	Frequency	Percentage
1	No formal education	9	15.00%
2	Primary education	30	50.00%
3	Secondary education (high school)	16	26.67%
4	Vocational/Technical education	1	1.67%
5	Bachelor's degree	4	6.67%
6	Master's degree	0	0
7	Doctoral degree (Ph.D.)	0	0
	Total	60	100

According to the data collected, the majority of respondents' father (30 respondents, 50.00%) only had primary education. A notable number of respondents' father (16 respondents, 26.67%) studied till secondary education (high school). A slightly lesser number of respondents' father (9 respondents' father 15.00 %) had no formal education. A few respondents' father (4 respondents' father 6.67%) attained bachelor's degree. Only one respondent's father (1.67%) had vocational/technical education.

Table-10 Respondents' Mothers' Occupation

S.No.	Respondents' Mothers' Occupation	Frequency	Percentage
1	Homemaker	35	58.33%
2	Private sector employee	6	10.00%
3	Self-employed	12	20%
4	Daily wage worker	4	6.67%
5	Not applicable / Deceased	3	5%
6	Government Employee	0	0

7	Retired	0	0
8	Unemployed	0	0
	Total	60	100

According to the data collected, the majority of respondents' mothers (35 respondents' mother, 58.33%) are homemaker. A notable number of respondents' mothers (12 respondents' mother, 20%) are self-employed. A slightly lesser number of respondents' mothers (6 respondents' mother, 10.00%) work in private sector. A few respondents' mothers (4 respondents' mother, 6.67%) work as daily wage worker. For 3 respondents' mothers (5.00%) it is not applicable/deceased.

Table-11 Respondents' Fathers' Occupation

S.No.	Respondents' Fathers' Occupation	Frequency	Percentage
1	Homemaker	0	0
2	Private sector employee	6	10.00%
3	Self-employed	21	35%
4	Daily wage worker	18	30%
5	Not applicable / Deceased	9	15.00%
6	Government Employee	4	6.66%
7	Retired	1	1.67%
8	Unemployed	1	1.67%
	Total	60	100

According to the data collected, the majority of respondents' fathers (21 respondents' father, 35%) are self-employed. A notable number of respondents' fathers (18 respondents' father, 30.00%) work as daily wage worker. A slightly lesser number of respondents' fathers (9 respondents' father 15.00 %) are not applicable / deceased. A few respondents' fathers (6 respondents' father, 10.00%) work in private sector. 4 respondents' fathers (6.66%) are government employees. 1 respondent's father (1.67%) is retired and 1 respondent's father (1.67%) is unemployed.

Table-12 Annual Income of the Respondents' Families

S.No.	Annual Income of the Respondents' Families	Frequency	Percentage
1	Less than 1 lakh	1	1.67%
2	1 lakh- 2 lakhs	31	51.69%
3	2 lakhs- 3 lakhs	28	46.68%
	Total	60	100

According to the data collected, the majority of respondents' family's (31 respondents, 51.69%) annual income is between 1 lakh and 2 lakhs. A notable number of respondents' family's (28 respondents, 46.68%) annual income is between 2 lakh and 3 lakhs. Only one respondent's family's (1.67%) annual income is less than 1 lakh.

Table-13 General Mindset or Values of Respondents' Families Regarding Social Issues

S.No.	General Mindset or Values of Respondents' Families Regarding Social Issues	Frequency	Percentage
1	Very conservative	26	43.33%
2	Somewhat conservative	19	31.67%

3	Neutral	4	6.67%
4	Somewhat open-minded	0	0
5	Very open-minded	11	18.33%
	Total	60	100

According to the data collected, the majority of respondents' families (26 respondents, 43.33%) lean towards the very conservative end regarding social issues. A notable number of respondents' families (19 respondents, 31.67%) lean towards the somewhat conservative end regarding social issues. A slightly lesser number of respondents' families (11 respondents, 18.33%) are very open-minded regarding social issues. A few respondents' families (4 respondents, 6.67%) have neutral mindset with respect to social issues.

Table-14 General Mindset or Values of Respondents' Families Regarding Cultural Issues

S.No.	General Mindset or Values of Respondents' Families Regarding Cultural Issues	Frequency	Percentage
1	Very conservative	25	41.67%
2	Somewhat conservative	19	31.67%
3	Neutral	8	13.33%
4	Somewhat open-minded	1	1.67%
5	Very open-minded	7	11.67%
	Total	60	100

According to the data collected, the majority of respondents' families (25 respondents, 41.67%) lean towards the very conservative end regarding cultural issues. A notable number of respondents' families (19 respondents, 31.67%) lean towards the somewhat conservative end regarding cultural issues. A slightly lesser number of respondents' families (8 respondents, 13.33%) are neutral regarding cultural issues. A few respondents' families (7 respondents, 11.67%) are very open-minded with respect to cultural issues. Only 1 respondent's family (1.67%) is somewhat open-minded with respect to cultural issues.

Table-15 General Mindset or Values of Respondents' Families Regarding Political Issues

S.No.	General Mindset or Values of Respondents' Families Regarding Political Issues	Frequency	Percentage
1	Very conservative	12	20.00%
2	Somewhat conservative	15	25.00%
3	Neutral	9	15.00%
4	Somewhat open-minded	9	15.00%
5	Very open-minded	15	25.00%
	Total	60	100

According to the data collected, the majority of respondents' families (15 respondents, 25.00%) lean towards the somewhat conservative end regarding political issues. Likewise, an equal number of respondents' families (15 respondents, 25.00%) are very open-minded regarding political issues. A notable number of respondents' families (12 respondents, 20.00%) are very conservative regarding political issues. A slightly lesser number of respondents' families (9 respondents, 15.00%) are neutral regarding political issues. Likewise, an equal number of respondents' families (9 respondents, 15.00%) are somewhat open-minded regarding political issues.

Table-16 Leadership Structure in Respondents' Families

S.No.	Leadership Structure in Respondent's Families	Frequency	Percentage
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1	Primarily led by a female family member i.e. Matriarchal	18	30.00%
2	Primarily led by a male family member i.e. Patriarchal	25	41.67%
3	Shared equally between male and female family members	15	25.00%
4	No clear leadership role	2	3.33%
	Total	60	100

According to the data collected, the majority of respondents' families (25 respondents, 41.67%) are patriarchal. A notable number of respondents' families (18 respondents, 30.00%) are matriarchal. A slightly lesser number of respondents' families (15 respondents, 25.00%) described leadership is shared equally between male and female family members. A very few respondents' families (2 respondents, 3.33%) reported no clear leadership role.

Table-17 Type of School/College Respondent is Studying/Studied			
S.No.	Type of School/College Respondent is Studying/Studied	Frequency	Percentage
1	Co-education	51	85.00%
2	Single sex	9	15.00%
	Total	60	100

According to the data collected, the majority of respondents (51 respondents, 85.00%) have studied/are studying in co-education school or college, and a smaller percentage (9 respondents, 15.00%) have studied/are studying in single sex school or college.

Table-18 Accommodation of the Respondent			
S.No.	Accommodation of the Respondent	Frequency	Percentage
1	Living with parents	60	100%
2	Living without parents in a house	0	0
3	Living in a hostel	0	0
	Total	60	100

According to the data collected, all the respondents (100%) are living with their parents.

Table-19 Respondent's Comfort Zone			
S.No.	Respondent's Comfort Zone	Frequency	Percentage
1	Mother	13	21.67%
2	Father	2	3.33%
3	Sibling	14	23.33%
4	Close friend	24	40.00%
5	Girlfriend	1	1.67%
6	None	5	8.33%
7	Oneself	1	1.67%
	Total	60	100

According to the data collected, the majority of respondents (24 respondents, 40.00%) are most comfortable sharing personal matters with close friend. A notable number of respondents (14 respondents, 23.33%) are most comfortable sharing personal matters with sibling. A slightly lesser number of respondents (13 respondents, 21.67%) are most comfortable sharing personal matters with mother. A few respondents (5

respondents, 8.33%) are not comfortable sharing personal matters with anyone. 2 respondents (3.33%) are most comfortable sharing personal matters with father. 1 respondent (1.67%) is comfortable sharing personal matters with girlfriend. Likewise, only 1 respondent (1.67%) is comfortable sharing personal matters with themselves.

Table-20 Social Relationship is Important for Mental Health			
S.No.	Social Relationship is Important for Mental Health	Frequency	Percentage
1	Yes	38	63.33%
2	No	18	30.00%
3	I don't know	4	6.67%
	Total	60	100

According to the data collected, the majority of respondents (38 respondents, 63.33%) agree with the statement indicating they believe social relationships are important for mental well-being. A notable portion of respondents (18 respondents, 30.00%) disagree. A very few respondents (4 respondents, 6.67%) chose they don't know.

Table-21 The Way People Feel over Time Reflects their Mental Health			
S.No.	The Way People Feel over Time, Reflects their Mental Health	Frequency	Percentage
1	Yes	26	43.33%
2	No	28	46.67%
3	I don't know	6	10.00%
	Total	60	100

According to the data collected, the majority of respondents (28 respondents, 46.67%) disagree with the statement suggesting they do not believe that feelings overtime is necessarily reflective of mental health. However, a substantial portion (26 respondents, 43.33%) agreed with the statement. A few respondents (6 respondents, 10.00%) chose they don't know

Table-22 The Way People Think about Things Influences their Mental Health			
S.No.	The Way People Think about Things Influences their Mental Health	Frequency	Percentage
1	Yes	25	41.67%
2	No	28	46.67%
3	I don't know	7	11.67%
	Total	60	100

According to the data collected, the majority of respondents (28 respondents, 46.67%) disagree with the statement suggesting they do not believe that thought patterns influence mental health. A substantial portion (25 respondents, 41.67%) agreed with the statement. A few respondents (7 respondents, 11.67%) chose they don't know.

Table-23 People's Interactions with Others Influence How They Feel			
S.No.	People's Interactions with Others Influence How they Feel	Frequency	Percentage
1	Yes	38	63.33%
2	No	19	31.67%
3	I don't know	3	5.00%
	Total	60	100

According to the data collected, the majority of respondents (38 respondents, 63.33%) agree with the statement indicating they believe that social interactions impact their emotions. A notable portion (19 respondents, 31.67%) disagree. A few respondents (3 respondents, 5.00%) chose they don't know.

Table-24 The Way People Think Influences How they Feel

S.No.	The Way People Think Influences How they Feel	Frequency	Percentage
1	Yes	39	65.00%
2	No	17	28.33%
3	I don't know	4	6.67%
	Total	60	100

According to the data collected, the majority of respondents (39 respondents, 65.00%) agree with the statement indicating they believe that their thoughts influence their feelings. A notable portion (17 respondents, 28.33%) disagree. A few respondents (4 respondents, 6.67%) chose they don't know.

Table-25 Mental Illnesses are Caused by a Variety of Factors

S.No.	Mental Illnesses are Caused by a Variety of Factors	Frequency	Percentage
1	Yes	38	63.33%
2	No	9	15.00%
3	I don't know	13	21.67%
	Total	60	100

According to the data collected, the majority of respondents (38 respondents, 63.33%) agree with the statement indicating they believe that mental illness have multiple contributing causes. A notable portion (13 respondents, 21.67%) responded I don't know suggesting uncertainty about the factors of mental illness. A few respondents (9 respondents, 15.00%) chose no implying they believe mental illness have singular cause.

Table-26 Mental Health Influences the Way People Behave

S.No.	Mental Health Influences the Way People Behave	Frequency	Percentage
1	Yes	33	55.00%
2	No	16	26.67%
3	I don't know	11	18.33%
	Total	60	100

According to the data collected, the majority of respondents (33 respondents, 55.00%) agree with the statement indicating they believe that mental health influences the way people behave. A notable portion (16 respondents, 26.67%) disagree. A few respondents (11 respondents, 18.33%) chose they don't know.

Table-27 People's Emotions are Affected by Mental Disorders

S.No.	People's Emotions are Affected by Mental Disorders	Frequency	Percentage
1	Yes	32	53.33%
2	No	18	30.00%
3	I don't know	10	16.67%
	Total	60	100

According to the data collected, the majority of respondents (32 respondents, 53.33%) agree with the statement indicating they believe that people's emotions are affected by mental disorders. A notable portion (18 respondents, 30.00%) disagree. A few respondents (10 respondents, 16.67%) chose they don't know.

Table-28 Depression is Identified as One of the Most Common Mental Illnesses Among Young People

S.No.	Depression is Identified as One of the Most Common Mental Illnesses Among Young People	Frequency	Percentage
1	Yes	40	66.67%
2	No	13	21.67%
3	I don't know	7	11.67%
	Total	60	100

According to the data collected, the majority of respondents (40 respondents, 66.67%) agree with the statement indicating they believe that depression is identified as one of the most common mental illnesses among young people. A notable portion (13 respondents, 21.67%) disagree. A few respondents (7 respondents, 11.67%) chose they don't know.

Table-29 A Person's Upbringing has an Impact On their Mental Health

S.No.	A Person's Upbringing has an Impact On their Mental Health	Frequency	Percentage
1	Yes	21	35.00%
2	No	25	41.67%
3	I don't know	14	23.33%
	Total	60	100

According to the data collected, the majority of respondents (25 respondents, 41.67%) disagree with the statement suggesting they do not believe that a person's upbringing has an impact on their mental health. A substantial portion (21 respondents, 35.00%) agreed with the statement. A few respondents (14 respondents, 23.33%) chose they don't know.

Table-30 I would Treat a Person with Mental Health Problems Differently

S.No.	I would Treat a Person with Mental Health Problems Differently	Frequency	Percentage
1	Strongly agree	4	6.67%
2	Agree	12	20.00%
3	Neutral	11	18.33%
4	Disagree	32	53.33%
5	I don't know	1	1.67%
	Total	60	100

According to the data collected, the majority of respondents (32 respondents, 53.33%) disagree with this statement indicating they would not treat someone with mental health problems differently. A notable number of respondents (12 respondents, 20%) chose agree. A few respondents (11 respondents, 18.33%) chose neutral, suggesting an uncertain stance. A slightly lesser number of respondents (4 respondents, 6.67%) chose strongly agree. Only one respondent (1.67%) selected I don't know.

Table-31 I would Advise Someone I Care about to Get Professional Assistance, if they had Mental Health Issues

S.No.	I would Advise Someone I Care about to Get Professional Assistance, if they had Mental Health Issues	Frequency	Percentage
1	Strongly agree	5	8.33%

2	Agree	21	35.00%
3	Neutral	10	16.67%
4	Disagree	23	38.33%
5	I don't know	1	1.67%
	Total	60	100

According to the data collected, the majority of respondents (23 respondents, 38.33%) disagree with this statement indicating they would not advise someone they care about to get professional assistance, if they had mental health issues. A notable number of respondents (21 respondents, 35%) chose agree. A few respondents (10 respondents, 16.67%) chose neutral, suggesting an uncertain stance. A slightly lesser number of respondents (5 respondents, 8.33%) chose strongly agree. Only one respondent (1.67%) selected I don't know.

Table-32 If Someone developed a Mental Health Issue, I would be Open to Keeping Up Our Friendship			
S.No.	If Someone developed a Mental Health Issue, I would be Open to Keeping Up Our Friendship	Frequency	Percentage
1	Strongly agree	23	38.33%
2	Agree	25	41.67%
3	Neutral	2	3.33%
4	Disagree	8	13.33%
5	I don't know	2	3.33%
	Total	60	100

According to the data collected, the majority of respondents (25 respondents, 41.67%) agree with this statement indicating they would be open to keeping up their friendship if their friend developed a mental health issue. A notable number of respondents (23 respondents, 38.33%) chose strongly agree. A few respondents (8 respondents, 13.33%) chose disagree. An equal number of respondents (2 respondents, 3.33%) chose neutral and I don't know.

Table-33 Mental Health Problems should be Kept Private			
S.No.	Mental Health Problems should be Kept Private	Frequency	Percentage
1	Strongly agree	3	5.00%
2	Agree	21	35.00%
3	Neutral	7	11.67%
4	Disagree	25	41.67%
5	I don't know	4	6.67%
	Total	60	100

According to the data collected, the majority of respondents (25 respondents, 41.67%) disagree with this statement, indicating that mental health problems should not be kept private. A notable number of respondents (21 respondents, 35%) chose agree. A few respondents (7 respondents, 11.67%) chose neutral, suggesting an uncertain stance. A slightly lesser number of respondents (4 respondents, 6.67%) chose I don't know. Only 3 respondents (5%) selected I strongly agree.

Table-34 Turning to Superstitions or Rituals to Help You Cope During Stressful Time			
S.No.	Turning to Superstitions or Rituals to Help You Cope During Stressful Time	Frequency	Percentage
1	Yes, I always turn to them for help	15	25.00%
2	Sometimes, if I feel very stressed	16	26.67%
3	No, I never use superstitions to cope	19	31.67%
4	I'm not sure	10	16.67%
	Total	60	100

According to the data collected, the majority of respondents (19 respondents, 31.67%) never use superstitions to cope during stressful time. A notable number of respondents (16 respondents, 26.67%) sometimes turn to superstitions or rituals. A slightly lesser number of respondents (15 respondents, 25%) always turn to superstitions or rituals for help. A few respondents (10 respondents, 16.67%) are not sure.

Table-35 Not Following a Superstition Led to Something Bad Happening to You			
S.No.	Not Following a Superstition Led to Something Bad Happening to You	Frequency	Percentage
1	Yes, I believe something bad happened because I didn't follow it	12	20.00%
2	Sometimes, but I'm not sure if it was related to the superstition	10	16.67%
3	No, I've never noticed anything bad happening	4	6.67%
4	I don't believe in that idea at all.	34	56.67%
	Total	60	100

According to the data collected, the majority of respondents (34 respondents, 56.67%) don't believe that not following a superstition led to something bad happening to them. A notable number of respondents (12 respondents, 20%) believe something bad happened because they didn't follow the superstition. A slightly lesser number of respondents (10 respondents, 16.67%) sometimes believe something bad happened because they didn't follow the superstition but they aren't sure if it was related to the superstition. A few respondents (4 respondents, 6.67%) don't believe something bad happened because they didn't follow the superstition.

Table-36 Feeling if something goes wrong after you followed a superstition			
S.No.	Feeling if something goes wrong after you followed a superstition	Frequency	Percentage
1	I feel disappointed and anxious	14	23.33%
2	I feel confused but don't let it affect me.	5	8.33%
3	I don't think about it much.	33	55.00%
4	I feel relieved and at peace because I tried.	8	13.33%
	Total	60	100

According to the data collected, the majority of respondents (33 respondents, 55%) don't think about something going wrong after they followed a superstition. A notable portion of respondents (14 respondents, 23.33%) feel disappointed and anxious when something goes wrong after they followed a superstition. A slightly lesser number of respondents (8 respondents, 13.33%) feel relieved and at peace because they tried following a superstition. A few respondents (5 respondents, 8.33%) feel confused if something goes wrong after they followed a superstition but they don't let it affect themselves.

Table-37 Mental Illness is Caused by Evil Spirits or Black Magic			
S.No.	Mental Illness is Caused by Evil Spirits or Black Magic	Frequency	Percentage
1	Strongly agree	0	0
2	Agree	8	13.33%
3	Neutral	8	13.33%
4	Disagree	22	36.67%
5	Strongly disagree	22	36.67%
6	I don't know	0	0
	Total	60	100

According to the data collected, the majority of respondents (22 respondents, 36.67%) disagree with this statement, indicating that mental illness is not caused by evil spirits or black magic and an equal number of respondents (22 respondents, 36.67%) strongly disagree with this statement. On the contrast, an equal number of respondents (8 respondents, 13.33%) strongly agree and agree that mental illness is caused by evil spirits or black magic.

Table-38 Mental Health Problems are a Punishment for Past Sins or Karma			
S.No.	Mental Health Problems are a Punishment for Past Sins or Karma	Frequency	Percentage
1	Strongly agree	7	11.67%
2	Agree	25	41.67%
3	Neutral	8	13.33%
4	Disagree	9	15.00%
5	Strongly disagree	11	18.33%
6	I don't know	0	0
	Total	60	100

According to the data collected, the majority of respondents (25 respondents, 41.67%) agree with this statement, indicating that Mental health problems are a punishment for past sins or karma. A notable portion of respondents (11 respondents, 18.33%) strongly disagree with the statement. A few respondents (9 respondents, 15.00%) disagree. A slightly lesser number of respondents (8 respondents, 13.33%) chose a neutral stance. Only 7 respondents (11.67%) selected strongly agree.

Table-39 People with Mental Illness should Visit Religious or Spiritual Healers Instead of Doctors			
S.No.	People with Mental Illness should Visit Religious or Spiritual Healers Instead of Doctors	Frequency	Percentage
1	Strongly agree	1	1.67%
2	Agree	22	36.67%
3	Neutral	10	16.67%
4	Disagree	17	28.33%
5	Strongly disagree	10	16.67%
	Total	60	100

According to the data collected, the majority of respondents (22 respondents, 36.67%) agree indicating that people with mental illness should visit religious or spiritual healers instead of doctors. A notable portion of respondents (17 respondents 28.33%) disagree with the statement. A few respondents (10 respondents 16.67%) chose neutral stance. Likewise, an equal number of respondents (10 respondents 16.67%) strongly disagree. A slightly lesser number of respondents (8 respondents, 13.33%) chose a neutral stance. Only 1 respondent (1.67%) selected strongly agree.

Table-40 Individuals with Mental Health Issues Pose a Threat			
S.No.	Individuals with Mental Health Issues Pose a Threat	Frequency	Percentage
1	Strongly agree	1	1.67%
2	Agree	20	33.33%
3	Neutral	10	16.67%
4	Disagree	26	43.33%
5	Strongly disagree	3	5.00%
	Total	60	100

According to the data collected, the majority of respondents (26 respondents, 43.33%) disagree indicating that individuals with mental health issues do not pose a threat. A notable portion of respondents (20 respondents, 33.33%) agree with the statement. A few respondents (10 respondents 16.67%) chose neutral stance. A slightly lesser number of respondents (3 respondents, 5.00%) strongly disagree. Only 1 respondent (1.67%) selected strongly agree.

Table-41 Compared to Physical Illness, Mental Illness is Less Severe			
S.No.	Compared to Physical Illness, Mental Illness is Less Severe	Frequency	Percentage
1	Strongly agree	3	5.00%
2	Agree	17	28.33%
3	Neutral	7	11.67%
4	Disagree	29	48.33%
5	Strongly disagree	4	6.67%
	Total	60	100

According to the data collected, the majority of respondents (29 respondents, 48.33%) disagree indicating that mental illness is more severe than physical illness. A notable portion of respondents (17 respondents, 28.33%) agree indicating that physical illness is more severe than mental illness. A few respondents (7 respondents, 11.67%) chose neutral stance. A slightly lesser number of respondents (4 respondents, 6.67%) strongly disagree. Only 3 respondents (5%) selected strongly agree.

Table-42 Mentally Ill People are Merely Looking for Attention			
S.No.	Mentally Ill People are Merely Looking for Attention	Frequency	Percentage
1	Strongly agree	3	5.00%
2	Agree	21	35.00%
3	Neutral	14	23.33%
4	Disagree	19	31.67%
5	Strongly disagree	3	5.00%
	Total	60	100

According to the data collected, the majority of respondents (21 respondents, 35.00%) agree indicating that mentally ill people are merely looking for attention. A notable portion of respondents (19 respondents, 31.67%) disagree indicating that mentally ill people are not merely looking for attention. A few respondents (14 respondents, 23.33%) chose neutral stance. A slightly lesser number of respondents (3 respondents, 5.00%) strongly agree. Likewise, an equal number of respondents (3 respondents, 5.00%) strongly disagree.

Table-43 Counselling or Therapy is Just for "Crazy" People			
S.No.	Counselling or Therapy is Just for "Crazy" People	Frequency	Percentage
1	Strongly agree	3	5.00%
2	Agree	9	15.00%
3	Neutral	9	15.00%
4	Disagree	25	41.67%
5	Strongly disagree	14	23.33%
	Total	60	100

According to the data collected, the majority of respondents (25 respondents, 41.67%) disagree indicating that counselling or therapy is for everyone. A notable portion of respondents (14 respondents, 23.33%) strongly disagree. A few respondents (9 respondents, 15.00%) agree indicating that counselling or therapy is just for "crazy" people. Likewise, an equal number of respondents (9 respondents, 15.00%) chose neutral stance. A slightly lesser number of respondents (3 respondents, 5.00%) strongly agree.

Table-44 It is Possible to Cure Mental Illness Simply by Thinking Positively			
S.No.	It is Possible to Cure Mental Illness Simply by Thinking Positively	Frequency	Percentage
1	Strongly agree	14	23.33%
2	Agree	18	30.00%
3	Neutral	9	15.00%
4	Disagree	15	25.00%
5	Strongly disagree	4	6.67%
	Total	60	100

According to the data collected, the majority of respondents (18 respondents, 30.00%) agree indicating that it is possible to cure mental illness simply by thinking positively. A notable portion of respondents (14 respondents, 23.33%) strongly agree with the statement. A few respondents (15 respondents, 25.00%) disagree indicating that it is not possible to cure mental illness simply by thinking positively. A slightly lesser number of respondents (9 respondents, 15.00%) chose neutral stance. Only 4 respondent (6.67%) selected strongly disagree.

Table-45 Most Commonly Available Mental Health Services in Your Community			
S.No.	Most Commonly Available Mental Health Services in Your Community	Frequency	Percentage
1	Psychiatrist	4	6.67%
2	Counselling and Therapy Services	0	0
3	Crisis Hotlines	0	0
4	Emergency Services	0	0
5	I don't know	37	61.66%
6	None of the Above	19	31.67%
	Total	60	100

According to the data collected, the majority of respondents (37 respondents, 66.66%) don't know the most commonly available mental health services in their community. A notable portion of respondents (19 respondents, 31.67%) chose none of the above indicating lack of commonly available mental health services in their community. A few respondents (4 respondents, 6.67%) chose psychiatrist as the most commonly available mental health services in their community.

Table-46 Level of Accessibility of Mental Health Services in Your Community

S.No.	Level of Accessibility of Mental Health Services in Your Community	Frequency	Percentage
1	Very Accessible – Easy to Find and Use	1	1.67%
2	Somewhat Accessible – Available but with Barriers	4	6.67%
3	Not Easily Accessible – Limited Availability	23	38.33%
4	Not Accessible at All	32	53.33%
	Total	60	100

According to the data collected, the majority of respondents (32 respondents, 53.33%) are unable to access mental health services in their community. A notable portion of respondents (23 respondents, 38.33%) are unable to easily access mental health services in their community. A few respondents (4 respondents, 6.67%) are somewhat able to access the mental health services in their community. Only 1 respondent (1.67%) is able access the mental health services in their community easily.

Table-47 Biggest Barrier to Accessing Mental Health Resources in Your Community

S.No.	Biggest Barrier to Accessing Mental Health Resources in Your Community	Frequency	Percentage
1	High cost of services	14	23.33%
2	Lack of awareness about available resources	29	48.33%
3	Long wait times for appointments	7	11.67%
4	Stigma around seeking mental health help	10	16.67%
	Total	60	100

According to the data collected, the majority of respondents (29 respondents, 48.33%) feel lack of awareness about available resources as a barrier in accessing mental health resources in their community. A notable number of respondents (14 respondents, 23.33%) feel high cost of services as barrier in accessing mental health resources in their community. A few respondents (10 respondents 16.67%) feel stigma around seeking mental health help, as barrier in accessing mental health resources in their community. A slightly lesser number of respondents (7 respondents, 11.67%) feel long wait times for appointments as barrier in accessing mental health resources in their community.

Table-48 The Most Underserved Group by Mental Health Resources in Your Community

S.No.	The Most Underserved Group by Mental Health Resources in Your Community	Frequency	Percentage
1	Children	27	45.00%
2	Adolescents	12	20.00%
3	Young adults	5	8.33%
4	Middle aged	8	13.33%
5	Elderly	8	13.33%
6	Minority groups	0	0
	Total	60	100

According to the data collected, the majority of respondents (27 respondents, 45.00%) believe children are the most underserved group by mental health resources in their community. A notable number of respondents (12 respondents, 20.00%) believe adolescents as the most underserved group. A few respondents (8 respondents, 13.33%) believe middle aged as the most underserved group. Likewise, an equal number of respondents (8 respondents, 13.33%) believe elderly as the most underserved group. A slightly lesser number of respondents (5 respondents 8.33%) perceive young adults as the most underserved group.

V. FINDINGS

1. It is found that respondents of age 16 and 17 are the highest in number (16.67% each).
2. It is found that there is a slightly higher representation of females (51.67%) compared to males (48.33%).
3. It is found that more than half of the respondents have one sibling (51.67%) and only 6.67% have no siblings, 3 siblings, or 4 or more siblings which is the least.
4. It is found that all of the respondents (100%) are unmarried.
5. It is found that a majority of the respondents are currently in school (75%) and only 1.67% are not involved in school, college, or job, which is the least.
6. It is found that more than two-thirds of the respondents (71.67%) are from nuclear families and only 5% are from single-parent families, which is the least.
7. It is found that most of the respondents' mothers have primary education (46.67%) and only 5% have completed a bachelor's degree, which is the least.
8. It is found that half of the respondents' fathers have primary education (50%) and only 1.67% have vocational/technical education, which is the least.
9. It is found that half of the respondents' family income lies between Rs 1–2 lakhs per annum (50%), and only 3.3% reported an income of less than Rs 1 lakh, which is the least.
10. It is found that 43.33% of the respondents' families are very conservative regarding social issues, and only 6.67% are neutral, which is the least.
11. It is found that most respondents' mothers are homemakers (58.33%), with fewer working in the private sector (10%) or being self-employed (20%). Only 6.67% of mothers are daily wage workers, and 5% were reported as deceased or not applicable.
12. It is found that a majority of respondents' fathers are self-employed (35%), while fewer work in the private sector (10%) or government sector (6.67%). A significant portion of fathers work as daily wage labourers (30%), and 15% were reported as deceased or not applicable. Only a small percentage of fathers are unemployed (1.67%) or retired (1.67%).
13. It is found that 41.67% of the respondents' families are very conservative regarding cultural issues, and only 1.67% are somewhat open-minded, which is the least.
14. It is found that 25% of the respondents' families are very open-minded regarding political issues, and 15% are neutral or somewhat open-minded, which is the least.
15. It is found that 41.67% of the respondents reported living in patriarchal families, and only 3.33% reported no clear leadership role, which is the least.
16. It is found that most respondents are studying in co-educational institutions (85%) and only 15% in single-sex institutions.
17. It is found that all respondents (100%) are currently living with their parents.
18. It is found that 40% of respondents feel most comfortable sharing personal matters with close friends, and only 1.67% with a girlfriend or oneself, which is the least.
19. It is found that 63.33% of respondents agree that social relationships are important for mental health, while only 6.67% are unsure, which is the least.
20. It is found that 46.67% of respondents do not believe that the way people feel over time reflects their mental health, while only 10% are unsure, which is the least.
21. It is found that 46.67% of respondents do not believe that the way people think about things influences mental health, while only 11.67% are unsure, which is the least.
22. It is found that 63.33% of respondents believe that people's interactions influence how they feel, while only 5% are unsure, which is the least.
23. It is found that 65% of respondents agree that the way people think influences how they feel, and only 6.67% are unsure, which is the least.
24. It is found that 63.33% of respondents agree that mental illnesses are caused by a variety of factors, while only 15% disagree, which is the least.
25. It is found that 55% of respondents believe that mental health influences behaviour, while only 18.33% are unsure, which is the least.
26. It is found that 53.33% of respondents believe that emotions are affected by mental disorders, and only 16.67% are unsure, which is the least.
27. It is found that 66.67% of respondents agree that depression is a common mental illness among young people, while only 11.67% are unsure, which is the least.
28. It is found that 41.67% of respondents disagree that upbringing impacts mental health, while only 23.33% are unsure, which is the least.

29. It is found that 53.33% of respondents disagree with treating someone with mental illness differently, and only 1.67% are unsure, which is the least.
30. It is found that 43.33% of respondents agree they would advise someone to get professional help, and only 1.67% are unsure, which is the least.
31. It is found that 41.67% of respondents agree they would maintain friendship with someone with mental illness, while only 3.33% are unsure, which is the least.
32. It is found that 41.67% of respondents disagree with the idea that mental health problems should be kept private, and only 6.67% are unsure, which is the least.
33. It is found that 31.67% of respondents never use superstitions to cope with stress, and only 16.67% are unsure, which is the least.
34. It is found that 56.67% of respondents do not believe that not following a superstition leads to bad outcomes, and only 6.67% reported never noticing any such effect, which is the least.
35. It is found that 55% of respondents don't think much when something goes wrong after following a superstition, while only 8.33% feel confused, which is the least.
36. It is found that 36.67% of respondents disagree and 36.67% strongly disagree that mental illness is caused by evil spirits or black magic, and only 13.33% agree, which is the least.
37. It is found that 41.67% of respondents agree that mental illness is a punishment for past sins or karma, and only 11.67% strongly agree, which is the least.
38. It is found that 36.67% of respondents agree that people with mental illness should visit spiritual healers instead of doctors, and only 1.67% strongly agree, which is the least.
39. It is found that 43.33% of respondents disagree that people with mental illness are a threat, and only 1.67% strongly agree, which is the least.
40. It is found that 48.33% of respondents disagree that mental illness is less severe than physical illness, and only 5% strongly disagree, which is the least.
41. It is found that 35% of respondents agree that mentally ill people are seeking attention, while only 5% strongly disagree, which is the least.
42. It is found that 41.67% of respondents disagree that therapy is only for 'crazy' people, and only 5% strongly agree, which is the least.
43. It is found that 30% of respondents agree and 23.33% strongly agree that mental illness can be cured by thinking positively, while only 6.67% strongly disagree, which is the least.
44. It is found that 61.66% of respondents do not know about mental health services in their community, and only 6.67% identified a psychiatrist, which is the least.
45. It is found that 53.33% of respondents say mental health resources are not accessible at all, and only 1.67% say they are very accessible, which is the least.
46. It is found that 48.33% of respondents feel that lack of awareness is the biggest barrier to accessing mental health resources, and only 11.67% cited long wait times, which is the least.
47. It is found that 45% of respondents believe children are most underserved by mental health services, and only 8.33% chose young adults, which is the least

VI. SUGGESTIONS

- **Integrate Mental Health into School and College Curricula**
Schools and colleges should formally include mental health education within their academic frameworks. Regular workshops, awareness drives, and dedicated mental health days can help students recognize common issues, normalize conversations, and reduce the stigma surrounding help-seeking.
- **Encourage Open Conversations Within Families**
Since many adolescents find it easier to confide in friends rather than parents, families—especially in middle-class and conservative settings—need to cultivate safer spaces for open discussions. Parenting workshops, family counselling, and school-family initiatives can bridge generational communication gaps.
- **Develop Peer Support and Mentorship Programs**
Peers often serve as the first point of emotional contact. Schools can train selected students to act as peer mentors who recognize emotional distress and guide their classmates to trusted adults or professionals, helping to foster a compassionate school culture.
- **Ensure Better Access to Mental Health Services**

With most respondents unaware of local services, institutions should prioritize establishing accessible, youth-friendly counselling services. Community clinics, telehealth support, and in-school mental health professionals can play a pivotal role in early intervention.

- **Tackle Cultural and Gender-Based Barriers**

Conservative and patriarchal family structures hinder open conversations. Community programs should promote inclusive, stigma-free environments by involving local leaders, educators, and role models who can challenge outdated norms and normalize mental health discourse.

- **Launch Targeted Social Media Awareness Campaigns**

Given adolescents' strong online presence, social media is a powerful platform for change. Creative campaigns sharing relatable stories, expert insights, and self-care tips can foster awareness and reduce misinformation around mental health.

- **Normalise Help-Seeking Behaviour**

To combat the stigma of therapy, it's vital to portray professional support as a strength, not a weakness. Sharing real-life stories, testimonials from familiar faces, and emphasizing confidentiality can encourage more adolescents to reach out.

- **Make Mental Health Education Culturally Sensitive**

Since some misconceptions link mental illness to karma, punishment, or black magic, it's crucial to deliver mental health content in a culturally respectful yet fact-based manner. Engaging spiritual leaders and local influencers can help shift perceptions.

- **Promote Critical Thinking and Emotional Literacy in Early Education**

Introducing emotional vocabulary, mindfulness, and discussions about mental health from a young age helps build a foundation for emotionally intelligent and resilient individuals. Schools can integrate these ideas into early learning frameworks.

- **Focus on Parental Mental Health Awareness**

Mothers, often primary caregivers, play a vital role in emotional support. Educating them through community groups or outreach programs can empower them to identify signs of distress and support their children more effectively.

- **Provide Mental Health Support for Underserved Groups**

Children and young adolescents were reported as the most underserved demographic. Tailored interventions, age-appropriate materials, and early access to care should be prioritized in school and community programs.

- **Debunk Superstition-Based Coping Mechanisms**

Many adolescents rely on superstitions or spiritual explanations for emotional challenges. Awareness campaigns should respectfully challenge these beliefs, presenting science-backed explanations and practical coping tools instead.

VII. CONCLUSION

In our research, we noted that although the respondents do understand the importance of mental health and the different factors affecting it, like social relationships, mood, and thinking patterns, there still seem to be considerable barriers to help-seeking. One of the major insights we found is the generally conservative family culture, particularly in social and cultural concerns. Most of the participants are from patriarchal families, where cultural values of their families still continue to influence the way emotions are talked about. Such cultural values may severely limit teenagers from openly expressing their mental health issues, especially in households where male figures are the dominant authority. This highlights the need to take into account the family setting while tackling mental health awareness and the necessity for culturally appropriate interventions that promote free emotional expression.

Interestingly, whereas most respondents live with their parents and study at co-educational schools, most tend to feel stronger emotional bonds toward close friends or siblings than their fathers. This tells us that the male parental source might not be viewed as a strong response as a caring and approachable source of comfort for emotional concern. Our study findings also highlight the importance of enhancing communication between fathers and their teenage children, promoting a more open and supportive conversation regarding mental health, which could be instrumental in improving the stigma of mental health conversations within families.

Our study shows that more than half of the respondents accepted that discussing feelings improves their mental health. However, some of them still showed a level of reluctance or uncertainty, indicating the

continued existence of mental health stigma. Our study also suggests that many teenagers, especially those from more traditional family backgrounds, felt very uncomfortable or even embarrassed about sharing their emotional difficulties. This reflects a wider societal problem of mental illness stigma, which still hinders people from freely expressing themselves or seeking help. The hesitation to seek help is also reflected in the results. Although most respondents appreciate the importance of professional assistance, many are still uncomfortable with bringing their mental health issues to adults, reflecting the differences between generations in how mental health is understood and treated.

Encouragingly, many respondents recognize that mental health is shaped by social relationships and how individuals think or feel in the long term. This is an essential realization in the battle against mental health stigma, as it represents a developing consciousness that mental health is not just an individual concern but also a result of external factors. In addition, most of the respondents show a willingness to help loved ones receive professional assistance and are willing to continue friendships with individuals who struggle with mental illness, indicating that social support systems are perceived as worthwhile assets to mental health.

Apart from the observed attitudes about mental health, we also observed that the respondents' family backgrounds also play a role in the formation of their perceptions and experiences. Most of the mothers are homemakers, while most fathers work for themselves or as daily wage workers, reflecting the socio-economic issues some of the respondents face. These differences, such as economic insecurity and gendered roles, have an impact towards restricted mental health resource availability and do not provide space for mental health discussion at home. The dominance of homemakers and daily wage labourers or self-employed individuals can also indicate a low level of awareness and support for mental health problems, further increasing stigma and limiting help-seeking.

A general trend was also observed in this study. We observed that many respondents understood the significance of mental health. However, their willingness to discuss openly or seek professional advice is always hindered due to their socio-economic limitations and traditional family systems. These observations highlight the need for targeted interventions that not only increase awareness of mental health but also work towards overcoming the socio-economic and cultural limitations and promote access to services.

In addition, the majority of respondents exhibit increasing knowledge that depression is one of the most common mental illnesses in youth and that mental illnesses can be due to a multitude of factors. Such a wide-based understanding is a significant advance in mental health education. Yet, even with such awareness, there is still a lack of mental health literacy. A significant percentage of the respondents still retain myths, including believing that mental illness is due to karma, superstitions, or that it can be healed by just being positive. Such myths could stem from cultural beliefs and misinformation and serve to enhance the stigma associated with mental illness.

To conclude, we observed a positive shift in how adolescents perceive and approach mental health, but we also recognized that several challenges persist. Stigma, limited awareness of available resources, and long-standing misconceptions continue to hinder progress in supporting adolescent mental well-being. These findings highlight the urgent need for comprehensive mental health education that reaches not only children and adolescents but also their families. We must focus on dispelling harmful myths, fostering open and empathetic communication, and improving access to professional mental health support. Most importantly, we believe that creating a more supportive and understanding family environment, particularly by enhancing communication with male parental figures, is essential to encouraging adolescents to seek help and engage in meaningful conversations about their mental health.

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IX. BIBLIOGRAPHY

1. Perna Martin, Emily E Haroz, Catherine Lee, Paul Bolton, Kiran Martin, Rosemary Meza, Elizabeth McCarthy and Shannon Dorsey (2024). Mental health problems among children living in New Delhi slums. Sage journal. <https://doi.org/10.1177/13634615231202098>
2. G. Balamurugan, Sanjay Sevak, Kusum Gurung and M. Vijayrani (2024). Mental Health Issues Among School Children and Adolescents in India: A Systematic Review. Cureus. 10.7759/cureus.61035
3. Soham Rej and Neeti Sasi (2023). World Mental Health Day 2023: Increasing awareness of mental health in India & exciting opportunities for the future. The Indian Journal of Medical Research. http://dx.doi.org/10.4103/ijmr.ijmr_1940_23
4. Md. Abu Bakar Siddique, Musaddiqur Rahman Ovi, Tanvir Ahammed, Muhammad Abdul Baker Chowdhury and Md Jamal Uddin (2022). Mental health knowledge and awareness among university students in Bangladesh. Heliyon. <https://doi.org/10.1016/j.heliyon.2022.e11084>
5. Anna Kågstrom, Ondřej Pešout, Matěj Kučera, Laura Juríková and Petr Winkler (2022). Development and validation of a Universal Mental Health Literacy (MHL) scale for Adolescents (UMHL-A). Psychiatry Research. <https://doi.org/10.1016/j.psychres.2022.115031>
6. Franziska Reiss, Ann-Katrin Meyrose, Christiane Otto, Thomas Lampert, Fionna Klasen and Ulrike Ravens-Sieberer (2019). Socioeconomic status, stressful life situations and mental health problems in children and adolescents: Results of the German BELLA cohort-study. Plos journal. 10.1371/journal.pone.0213700
7. Kalpana Srivastava, Pookala Shivaram Bhat and Kaushik Chatterjee (2016). Mental health awareness: The Indian scenario. Industrial Psychiatry Journal. http://dx.doi.org/10.4103/ipj.ipj_45_17
8. Kirti Gaur and Usha Ram (2016). Mental Health Problems Among Youth in India and its Correlates. International Journal of Human Rights in Healthcare. <http://dx.doi.org/10.1108/IJHRH-08-2015-0024>
9. Wulf Rössler (2016) The stigma of mental disorders. Embo reports. <https://doi.org/10.15252/embr.201643041>
10. Matt O'Connor and Leanne Casey (2015). The Mental Health Literacy Scale (MHLS): A New Scale-Based Measure of Mental Health Literacy. Psychiatry Research. <https://doi.org/10.1016/j.psychres.2015.05.064>
11. Rakesh K Chadda and Swati Kedia Gupta (2012). Economic Disparity and Mental Health. Annals of the National Academy of Medical Sciences.
12. Patrick W Corrigan and Amy C Watson (2002). Understanding the impact of stigma on people with mental illness. World Psychiatry. PMC1489832.
13. Lakhumna, Rachita, Pore, Prasad D, Wadhwa, Saurabh K (2025). Socio-economic Status Scales in India & Globally: A Review. Preventive Medicine: Research & Reviews. 10.4103/PMRR.PMRR_133_24
14. Yudan Chen Wang and Amanda M. McLeroy (2023). Poverty, parenting stress, and adolescent mental health: The protective role of school connectedness reexamined. Children and Youth Services Review. <https://doi.org/10.1016/j.childyouth.2023.107127>
15. Thomas Steare, Sara Evans-Lacko Mesele Araya, Santiago Cueto, Hai-Anh H Dang, Revathi Ellanki, Emily Garman, Gemma Lewis Kelly Rose-Clark and Praveetha Patalay (2024). Economic inequalities in adolescents' internalising symptoms: longitudinal evidence from eight countries. The Lancet Psychiatry. [https://doi.org/10.1016/S2215-0366\(24\)00255-4](https://doi.org/10.1016/S2215-0366(24)00255-4)

X. APPENDIX

SECTION A SOCIO-DEMOGRAPHIC DETAILS

1. What is your initials?
2. What is your age?
3. What is your gender?
 - ☐ Female
 - ☐ Male
 - ☐ Transgender
 - ☐ Non-binary
 - ☐ Other (Specify)
4. How many siblings do you have?
 - ☐ Nil
 - ☐ 1
 - ☐ 2
 - ☐ 3
 - ☐ 4 or more than 4
5. What is your religion?
 - ☐ Hinduism
 - ☐ Islam
 - ☐ Christianity
 - ☐ Sikhism
 - ☐ Buddhism
 - ☐ Jainism
 - ☐ Atheist / No religion
 - ☐ Other (please specify): _____
6. What is your marital status
 - ☐ Unmarried
 - ☐ Married
 - ☐ Separated
 - ☐ Divorced
 - ☐ Widow
7. What are you currently involved in
 - ☐ School
 - ☐ College
 - ☐ Job
 - ☐ None of these
8. What kind of family are you in?
 - ☐ Nuclear
 - ☐ Joint
 - ☐ Single-parent
9. What is the highest educational qualification of your mother?
 - ☐ No formal education
 - ☐ Primary education
 - ☐ Secondary education (high school)
 - ☐ Vocational/Technical education
 - ☐ Bachelor's degree
 - ☐ Master's degree
 - ☐ Doctoral degree (Ph.D.)
 - ☐ Others (specify)
10. What is the highest educational qualification of your father?
 - ☐ No formal education
 - ☐ Primary education
 - ☐ Secondary education (high school)
 - ☐ Vocational/Technical education
 - ☐ Bachelor's degree

- ☐ Master's degree
 - ☐ Doctoral degree (Ph.D.)
 - ☐ Others (specify)
11. What is your mother's occupation?
- ☐ Homemaker
 - ☐ Government employee
 - ☐ Private sector employee
 - ☐ Self-employed (e.g., small business, freelance work)
 - ☐ Daily wage worker
 - ☐ Retired
 - ☐ Unemployed
 - ☐ Other (please specify): _____
 - ☐ Not applicable / Deceased
12. What is your father's occupation?
- ☐ Homemaker
 - ☐ Government employee
 - ☐ Private sector employee
 - ☐ Self-employed (e.g., small business, freelance work)
 - ☐ Daily wage worker
 - ☐ Retired
 - ☐ Unemployed
 - ☐ Other (please specify): _____
 - ☐ Not applicable / Deceased
13. What is the annual income of your family?
14. How would you describe the general mindset or values of your family regarding social issues?
- ☐ Very conservative
 - ☐ Somewhat conservative
 - ☐ Neutral
 - ☐ Somewhat open-minded
 - ☐ Very open-minded
15. How would you describe the general mindset or values of your family regarding cultural issues?
- ☐ Very conservative
 - ☐ Somewhat conservative
 - ☐ Neutral
 - ☐ Somewhat open-minded
 - ☐ Very open-minded
16. How would you describe the general mindset or values of your family regarding political issues?
- ☐ Very conservative
 - ☐ Somewhat conservative
 - ☐ Neutral
 - ☐ Somewhat open-minded
 - ☐ Very open-minded
17. How would you describe the primary authority or leadership structure in your household?
- ☐ Primarily led by a female family member i.e. Matriarchal
 - ☐ Primarily led by a male family member i.e. Patriarchal
 - ☐ Shared equally between male and female family members
 - ☐ No clear leadership role
18. What is the type of school/college you are/were in?
- ☐ Co-education
 - ☐ Single sex
19. Where are you staying now?
- ☐ Living in a hostel
 - ☐ Living without parents in a house
 - ☐ Living with parents
20. Who do you feel most comfortable sharing personal matters with?
- ☐ Mother

- ☐ Father
- ☐ Close friend
- ☐ Sibling
- ☐ Other

SECTION B QUESTIONS TO ASSESS AWARENESS LEVELS

21. Social relationship is important for mental health
- ☐ Yes
 - ☐ No
 - ☐ I don't know
22. The way people feel over time reflects their mental health
- ☐ Yes
 - ☐ No
 - ☐ I don't know
23. The way people think about things influences their mental health
- ☐ Yes
 - ☐ No
 - ☐ I don't know
24. People's interactions with others influence how they feel
- ☐ Yes
 - ☐ No
 - ☐ I don't know
25. The way people think influences how they feel
- ☐ Yes
 - ☐ No
 - ☐ I don't know
26. Mental illnesses are caused by a variety of factors
- ☐ Yes
 - ☐ No
 - ☐ I don't know
27. Mental health influences the way people behave
- ☐ Yes
 - ☐ No
 - ☐ I don't know
28. People's emotions are affected by mental disorders
- ☐ Yes
 - ☐ No
 - ☐ I don't know
29. Depression is identified as one of the most common mental illnesses among young people
- ☐ Yes
 - ☐ No
 - ☐ I don't know
30. A person's upbringing has an impact on their mental health
- ☐ Yes
 - ☐ No
 - ☐ I don't know

SECTION C

STIGMA

31. I would treat a person with mental health problems differently.
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Neutral
 - ☐ Disagree
 - ☐ I don't know
32. I would advise someone I care about to get professional assistance, if they had mental health issues
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Neutral
 - ☐ Disagree
 - ☐ I don't know
33. If someone developed a mental health issue, I would be open to keeping up our friendship
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Neutral
 - ☐ Disagree
 - ☐ I don't know
34. Mental health problems should be kept private
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Neutral
 - ☐ Disagree
 - ☐ I don't know

SUPERSTITON

35. Mental illness is caused by evil spirits or black magic
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Neutral
 - ☐ Disagree
 - ☐ Strongly disagree
36. Mental health problems are a punishment for past sins or karma.
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Neutral
 - ☐ Disagree
 - ☐ Strongly disagree
37. People with mental illness should visit religious or spiritual healers instead of doctors
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Neutral
 - ☐ Disagree
 - ☐ Strongly disagree
38. When you're feeling stressed, do you turn to superstitions or rituals to help you cope?
- ☐ Yes, I always turn to them for help.
 - ☐ Sometimes, if I feel very stressed.
 - ☐ No, I never use superstitions to cope.
 - ☐ I'm not sure.
39. Have you ever felt that not following a superstition led to something bad happening to you?
- ☐ Yes, I believe something bad happened because I didn't follow it.
 - ☐ Sometimes, but I'm not sure if it was related to the superstition.

- No, I've never noticed anything bad happening.
 - I don't believe in that idea at all.
40. How do you feel if something goes wrong after you followed a superstition?
- I feel disappointed and anxious.
 - I feel relieved and at peace because I tried.
 - I don't think about it much.
 - I feel confused but don't let it affect me.

STEREOTYPE

41. Individuals with mental health issues pose a threat.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
42. Compared to physical illness, mental illness is given less importance.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
43. Mentally ill people are merely looking for attention.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
44. Counselling or therapy is just for "crazy" people.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
45. It is possible to cure mental illness simply by thinking positively.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree

SECTION D AVAILABLE MENTAL HEALTH RESOURCES

46. What type of mental health services are most commonly available in your community?
- Counselling and therapy services
 - Psychiatrist
 - Crisis hotlines
 - Emergency services
 - None of the above
 - Don't know
 - Others
47. How accessible are mental health resources in your community?
- Very accessible – easy to find and use
 - Somewhat accessible – available but with barriers
 - Not easily accessible – limited availability
 - Not accessible at all

48. What is the biggest barrier to accessing mental health resources?

- High cost of services
- Lack of awareness about available resources
- Stigma around seeking mental health help
- Long wait times for appointments

49. Which group in your community is most underserved by mental health resources?

- Children
- Adolescents
- Young adults
- Middle aged
- Elderly
- Minority groups
- Others

