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# Review of Research

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A STUDY ON ADOLESCENT GIRLS OF WORKING MOTHER  
LIVING IN URBAN AND RURAL LOCALITY



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## ABSTRACT:

The present study is on adolescents girls of working mother living in urban and rural locality. Random samples of 100 adolescent girls of working mothers of age ranging between 16-18 years were selected. Of which 50 equal numbers of girls were from urban and rural locality. The tools used for the present investigation were Health Problem Inventory devised by the Investigator (2013) and Health Anxiety Inventory formulated by Lucock and Morley (1996) to find out the health problem and health anxiety among adolescent girls. The data obtained was subjected to statistical analysis using arithmetic mean, standard deviation, Standard 't' test, Karl pearson co-efficient of correlation.

The results of the present study showed that rural adolescent girls of working mothers had more health problems than the urban adolescent girls. But no difference was observed in health

anxiety between adolescent girls of working mothers belonging to urban and rural locality. From the overall findings, it is viewed that there was a relationship between health problems and health anxiety among adolescent girls of working mothers belonging to urban and rural locality.

**KEY WORDS:** adolescent girls, working mother, urban, rural.

**INTRODUCTION:**

Adolescence has been described as a phase of life beginning in biology and ending in society. Indeed, adolescence may be defined as the period within the life span when most of a person's biological, cognitive, psychological, and social characteristics are changing from what is typically considered child-like to what is considered adult-like. Health is the level of functional or metabolic efficiency of a living organism. In humans, it is the general condition of a person's mind and body. Meghachandra et al (1999) opined that during adolescence phase of growth the girls first experience menstruation and related problems which is marked by feelings of anxiety and eagerness to know about this natural phenomenon. However, they do not get the appropriate knowledge due to lack of a proper health education programme in schools. Moreover, the traditional Indian society regards talks on such topics as taboo and discourages open discussion on these issues. This leads to culmination in repression of feelings which can cause intense mental stress and seek health advice from quacks and persons who do not have adequate knowledge on the subject. Such health seeking behaviour by the adolescent girls is undesirable. Moreover, the routine health services do not have provisions for adequate care of adolescent health problems. This further exaggerates the problems manifold.

According to Janet (1990) many adolescent health problems are linked with educational performance, family relationships, poverty, and the general lifestyles that adolescents experience in their communities. Although serious chronic, medical and psychiatric disorders affect about 6 percent of the adolescent population, many more adolescents are at risk for death and for poor health outcomes that are not primarily biomedical in origin. Medical and social science research has revealed two disturbing trends many health problems are affecting adolescents at younger ages and many adolescents are simultaneously involved in several health threatening behaviours.

Schwartz et al (1994) noted that in densely populated urban areas, there is often a lack of facilities and outdoor areas for exercise and recreation. In addition, air quality is often lower in urban environments which can contribute to chronic diseases such as asthma. In the developing world, urban dwellers often live in large slums which lack basic sanitation and utilities such as water and electricity. Lack of basic infrastructure can exacerbate rates of infectious disease and further perpetuate the cycle of poverty. According to Richards and Duckett (1994) for children of working mothers, particularly daughters, tend to be more independent, to enjoy higher self-esteem, and to hold higher educational and occupational aspirations and less stereotyped views of men and women than those whose mothers are not employed. Van Nostrand (1993) estimated that in the developing and developed world, many rural individuals must travel substantial distances for primary medical care, requiring significantly longer travel times to reach care than their urban counterparts.

Sánchez-Carracedo et al (2012), reviewed the main reasons for an integrated approach to the spectrum of eating- and weight related problems, which include anorexia nervosa, bulimia nervosa, anorexic and bulimic behaviours, unhealthy dieting practices, body dissatisfaction, binge-eating disorder, overweight and obesity. Given differences between the fields with regard to current perspectives and objectives, key barriers to an integrated approach to prevention are discussed. In order to show the possibilities of development of this approach, they reviewed the main contributions

made to date in the fields of both obesity and ED (Eating disorder) prevention. In particular, environmental approaches in the prevention of obesity and ED are reviewed, given their potential for preventing a broad spectrum of eating- and weight-related problems.

Storch et al (2006) examined the relationship between peer victimization and child and parent reports of psychosocial adjustment and physical activity in a clinical sample of at-risk-for-overweight and overweight children and adolescents. Peer victimization was positively related to child-reported depression, anxiety, social physique anxiety, and loneliness, and parent-reported internalizing and externalizing symptoms. Peer victimization was negatively related to physical activity. Depressive symptoms and loneliness mediated the relations between peer victimization and physical activity. Recognition of the magnitude of the problem and the means of evaluating for peer victimization is important for clinicians who work with overweight youth. Assessing peer experiences may assist in understanding rates of physical activity and or past non adherence to clinician recommendations.

Quine et al (2003) studied on health concerns and access to healthcare for younger people. They reported findings on rural-urban similarities and differences. The analysis revealed certain health concerns that were common to both rural and urban adolescents such as diet and body image, sexual health, stress and depression.

Harlow and Matanoski (1991) enumerated association between weight, physical activity, and stress and variation in the length of the menstrual cycle was prospectively examined in college women, aged 17–19 years, who kept menstrual diaries during their freshman year. Women with a history of long cycles were more likely to have a long cycle during the study. Stressors, characterized by situations which create a demand for performance or require adjustments to new demands, also increased the risk of a long cycle. Moderate exercise minimally increased the probability of a long cycle. Changes in weight and being overweight were independently associated with the probability of long cycles. Further investigation of the biologic mechanisms that mediate the stress effect is warranted.

Deliwala et al (2013) opined that urban females are more exposed to stress as compared to rural. The different types of stress and its gravity are related to their jobs, studies, social and economical factors. They are more prone to develop menstrual problems. He evaluated prevalence of menstrual problems in urban females and its relation to different types of stress and its etiological factors, cross sectional descriptive study included females selected randomly from hostel of medical and nursing college, doctors and nurses and office going females. Dysmenorrhoea was more common in adolescent age group while oligomenorrhoea and amenorrhoea were more common in late twenty and menorrhagia was common in females towards menopausal age and premenstrual symptoms was an associated problem. 263 (88%) females had some kind of stress as an etiological factor for menstrual problems. He concluded stress is a very common etiological factor for menstrual problems. McLaughlin (2009) examined the role of emotion dysregulation as a mechanism linking stress to changes in internalizing symptoms among adolescents. Stressful life events appear to disrupt the adaptive processing of emotion among adolescents. Emotion dysregulation represents an intrapersonal mechanism linking stress to poor mental health outcomes.

Khalil et al (2010) described adolescents rarely seek psychiatric help, they even hesitate to disclose their feelings to their parents. However; the adolescents especially the females experience depressive symptoms more frequently than general population. In this study, the authors aimed to estimate the prevalence of depressive disorders in Egyptian adolescent female students. In that fatigue was the most common presenting depressive symptom 81% in addition to other emotional, cognitive and physiological symptoms. Suicidal ideations were the most common suicidal symptoms in depressed adolescent females. Depressive phenomena including unexplained fatigue, decreased

energy, psychomotor changes, lack of concentration, weight changes and suicidal ideations may be the presenting complaints. Fisher et al(1991) determined whether adolescent females with abnormal eating attitudes display lower levels of self-esteem and higher levels of anxiety. Analysis revealed that those with more unhappiness with their weight and higher scores on the eating attitudes test were more likely to have lower self-esteem and higher anxiety and to participate more in health-risk behaviours.

**Methodology:**

**Objectives Of The Study:**

1. To determine the effect of locality and working status of mother on the health problems of adolescents.
2. To find out whether locality and working status of mother has any impact on the health anxiety of adolescents.
3. To examine the relationship between health problems and health anxiety of adolescents.

**SAMPLE**

The sample for the present study was obtained from different colleges from Chennai city. A sample of 100 adolescents girls of age group 16-18 years living in urban and rural areas belonging to working mothers were selected for the present investigation.

**Tools:**

The tools used for the present investigation were Health Problem Inventory devised by the Investigator (2013) and Health Anxiety Inventory formulated by Lucock and Morley (1996) to find out the health problem and health anxiety among adolescent girls. Health Problem Inventory (Investigator, 2013) consists of two sections. The first section dealt with the demographic details and the second section consists of five domains such as body mass index, sleep disorder, menstrual problems, improper dietary habits and physical inactivity to be answered either in Yes or No. To find out the body mass index, the investigator utilized the vertical measuring scale to measure height and weighing scale to measure weight. Health Anxiety Inventory (Lucock and Morley, 1996) was given to each adolescent girl. It is used to assess the anxiety regarding their health. Health anxiety Inventory was framed by Lucock and Morley in the year 1996. It consists of 21 statements categorized under 4 domains such as health worry and preoccupation, fear of illness and death, reassurance seeking behaviour, interference with life. The statements are answered in the form of not at all, sometimes, often and most of the time.

**Procedure:**

In order to administer the inventories the Head of the Institutions were contacted and prior permission was sought. Students were selected by random sampling method and Inventories were administered individually. Direction was given to orient the students to the questionnaires. After the inventories were filled up, they were scrutinized to check whether all the statements were answered by the adolescent girls

**Results And Discussion:**

The finding of the study on the health problem and health anxiety among adolescent girls is presented and discussed in this chapter under the following section, namely

1. Health problems, locality and working status of mothers
2. Health anxiety, locality and working status of mothers

3. Relationship between health problems and health anxiety

**1. Health problems, locality and working status of mothers:**

This section deals with the effect of locality on the health problems of adolescent girls belonging to working mothers, t' test was carried out and the results are presented in the table given below.

**Table -1**  
**Comparison of health problems among adolescent girls of working mothers living in urban and rural areas**

Health problems	Locality				't' test	Level of significance
	Urban N=50		Rural N=50			
	Mean	SD	Mean	SD		
Body mass index	1.44	0.61	1.80	0.88	2.37	0.05
Sleep disorder	3.04	1.93	5.38	2.56	5.16	0.01
Menstrual problem	1.50	1.52	2.28	1.83	2.32	0.05
Improper dietary habits	3.58	1.57	4.26	1.29	2.37	0.05
Physical inactivity	6.90	2.13	5.94	1.91	2.37	0.05
Overall Health Problems	16.46	4.30	19.66	5.14	3.38	0.01

It is evident from table-1 that there exist significant difference in the domains of health problems such as body mass index, sleep disorder, menstrual problem, improper dietary habits and physical inactivity among adolescent girls of working mothers. The mean values for body mass index ( $\bar{X}=1.44$ ,  $\bar{X}=1.80$ ), sleep disorder ( $\bar{X}=3.04$ ,  $\bar{X}=5.38$ ), menstrual problem ( $\bar{X}=1.50$ ,  $\bar{X}=2.28$ ), improper dietary habits ( $\bar{X}=3.58$ ,  $\bar{X}=4.26$ ) and physical inactivity ( $\bar{X}=6.90$ ,  $\bar{X}=5.94$ ) among urban and rural adolescent girls of working mothers. The calculated 't' value for sleep disorder 5.16 which was greater than the table value 2.58 at 1% level of significance, hence it was significant. With regard to body mass index, menstrual problem, improper dietary habits and physical inactivity the 't' values were 2.37, 2.32, 2.37, 2.37, which were greater than the table value 1.96 at 5% level of significance, hence they were significant.

From the findings of overall health problem, it is noted that there was a significant difference in the health problems among urban and rural adolescent girls of working mothers. It is viewed from the findings that the rural adolescent girls of working mothers had more health problems than the urban adolescent girls. The mean values were 19.66 and 16.46 respectively. The calculated 't' value 3.38 was greater than the table value 2.58 at 1% level of significance, hence it was significant.

It is viewed from the results that adolescent girls in rural areas have high body mass index therefore this has affected their sleep pattern, menstrual problem, improper dietary habits and physical inactivity. It is a fact that poverty plays an important role among the rural dwellers when compared to the urban dwellers. Apart from poverty, mothers who go out for work will not be able to provide proper nutritional care to their adolescent girls. Hence this could be a reason for the poor health status among rural adolescent girls.

Swallemetal (2005) investigated that adolescents who were overweight had significantly worse self-reported health. Only among the youngest adolescents they found a significant deleterious impact of overweight and obesity on depression, self-esteem, and school or social functioning.

**2. Health anxiety, locality and working status of mothers:**

This section deals with the effect of locality on the health anxiety among adolescent girls

belonging to working mothers, 't' test was carried out and the results are presented in the table given below.

**Table -2**  
**Comparison of health anxiety among adolescent girls of working mothers living in urban and rural areas**

Health Anxiety	Locality				't' test	Level of significance
	Urban N=50		Rural N=50			
	Mean	SD	Mean	SD		
Health worry and preoccupation	7.00	3.92	7.96	4.46	1.14	NS
Fear of illness and death	5.42	4.54	5.70	4.89	0.30	NS
Reassurance seeking behavior	2.88	1.79	2.56	2.09	0.82	NS
Interference with life	1.62	2.08	2.86	2.36	2.79	0.01
Overall Health Anxiety	16.92	10.27	19.08	12.38	0.95	NS

Note: NS- Not significant

Table 2 indicates that there exist a significant difference in the domain of health anxiety such as interference with life and no significant difference was observed in the health worry and preoccupation, fear of illness and death and reassurance seeking behaviour among adolescent girls of working mothers living in urban and rural areas. The mean values for interference with life ( $\bar{X}=1.62$ ,  $\bar{X}=2.86$ ) for adolescent girls of working mothers living in urban and rural areas. The calculated 't' value 2.79 which was greater than the table value 2.58 at 1% level of significance, hence it was significant. Whereas the calculated 't' values for health worry and preoccupation, fear of illness and death and reassurance seeking behaviour were 1.14, 0.30 and 0.82 respectively, which were less than the table value 1.96 at 5% level of significance, hence they were not significant.

From the findings of overall health anxiety, no significant difference is observed in the health anxiety of adolescent girls belonging to urban and rural areas. The calculated 't' value 0.95 was less than the table value 1.96 at 5% level of significance, hence it was not significant.

### 3. Relationship between health problems and health anxiety:

This section deals with the relationship between health problems and health anxiety among adolescent girls.

**Table-3**  
**Relationship between health problems and health anxiety among adolescent girls of working mothers living in rural areas**

Health Problem	Health Anxiety				
	Health worry and preoccupation	Fear of illness and death	Reassurance seeking behavior	Interference with life	Overall Health Anxiety
Body mass index	0.01	0.07	0.03	0.17	0.06
Sleep disorder	0.28(*)	0.21	0.36(**)	0.26	0.30(*)
Menstrual problem	0.36(*)	0.25	0.20	0.31(*)	0.32(*)
Improper dietary habits	0.19	0.21	0.20	0.43(**)	0.27
Physical inactivity	0.60(**)	0.67(**)	0.63(**)	0.72(**)	0.72(**)
Overall Health Problems	0.54(**)	0.50(**)	0.54(**)	0.65(**)	0.61(**)

\* Correlation is significant at the 0.05 level.

\*\* Correlation is significant at the 0.01 level.



It is depicted from the table- 3 that no relationship existed between body mass index and the domains of health anxiety. Whereas there was a relationship between sleep disorder with the domains of health anxiety such as health worry and preoccupation, reassurance seeking behaviour and overall health anxiety. In case of menstrual problem it has relationship with the domains of health anxiety such as health worry and preoccupation, interference with life and overall health anxiety. With regard to improper dietary habits relationship existed with only interference with life. There a relationship between physical inactivity and with the domains of health anxiety.

From the overall findings it is viewed that there is a relationship between health problems and health anxiety among adolescent girls of working mothers living in rural areas.

The finding is substantiated by a study Meghachandraetal (1999)who found out that during adolescence phase of growth the girls first experience menstruation and health related problems which is marked by feelings of anxiety among adolescent girls.

**Table-4**  
**Relationship between health problems and health anxiety among adolescent girls of working mothers living in urban areas**

Health Problem	Health Anxiety				
	Health worry and preoccupation	Fear of illness and death	Reassurance seeking behavior	Interference with life	Overall Health Anxiety
Body mass index	0.08	0.09	0.12	0.07	0.06
Sleep disorder	0.30(*)	0.14	0.05	0.21	0.21
Menstrual problem	0.43(**)	0.44(**)	0.43(**)	0.15	0.46(**)
Improper dietary habits	0.06	0.16	0.05	0.31(*)	0.04
Physical inactivity	0.27	0.19	0.07	0.28(*)	0.26
Overall Health Problems	0.39(**)	0.24	0.16	0.39(**)	0.36(*)

\* Correlation is significant at the 0.05 level.

\*\* Correlation is significant at the 0.01 level.

A perusal of table- 4 indicates that no relationship existed between body mass index and the domains of health anxiety. With regard to sleep disorder relationship exists with the health worry and preoccupation. Whereas there was a relationship between menstrual problem with the domains of health anxiety such as health worry and preoccupation, fear of illness and death, reassurance seeking behaviour and overall health anxiety. There was a relationship between improper improper dietary habits and interference with life and also there exist relationship between physical inactivity and interference with life.

From the overall findings it is viewed that there is a relationship between health problems and health anxiety among adolescent girls of working mothers living in urban areas.

The finding is corroborated by a study, Deliwalaaetal (2013) opined that urban females are more exposed to stress as compared to rural. He concluded that females had some kind of stress as an etiological factor for menstrual problems. Stress is a very common etiological factor for menstrual problems.

**Conclusion:**

The conclusion arrived from the study was that adolescent girls of working mothers belonging to rural locality suffered more from health problems than the adolescent girls of urban locality. But significant difference was observed in health anxiety between adolescent girls of working mothers belonging to urban and rural locality. Whereas with regard to relationship between health problem and health anxiety, it was noticed that a relationship existed between these two variables among adolescent girls of working mothers belonging to urban and rural locality.

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