



A STUDY OF HEALTH NUTRITION AND SOCIO PSYCHOLOGICAL BEHAVIOR OF ADOLESCENTS

Sharad Somnath Gorade

Research Scholar , JJT University Rajasthan .



ABSTRACT:

Worldwide, 20% of children and adolescents experience a disabling mental illness, almost half of which begin by the age of 14. Puberty also marks a transition in risks for depression and other mental disorders, psychosomatic syndromes, and antisocial behavior. The increase in stress during adolescence due to nutritional and pubertal transition may impact physical health and behavior.

KEYWORDS : socioeconomic status, Adolescence, Health behaviors, Health outcomes.

INTRODUCTION:

Immaturity is for the most part characterized in reference to a time of years. W.H.O has characterized pre-adulthood as a period between the age gatherings of 10-19 years. Immaturity might be evidently characterized as time of physical, mental and social development from adolescence to adulthood i.e. the period stretching out from adolescence to the accomplishment of full regenerative development. It is a scaffold amongst adolescence and adulthood and a time of fast changes in every single formative measurement of developing to sexual development, finding one's genuine self, characterizing identity esteems and discovering one's professional and social headings. It is additionally a period of testing of pushing against ones abilities and restrictions as postured by grown-ups (Clifford 1993). In any case, characterizing the period of puberty differs starting with one social-social setting then onto the next. A youngster going to the school might be viewed as an immature at one place while someone else of a similar age bunch at somewhere else might be hitched and all things considered be characterized as a grown-up. The time of pubescence has moved bit by bit to before years and an extended time of instruction and reliance has served to grow the life of immaturity (Garg 2002). Amid this time of life the worry of fast development winds up apparent and are show both in Physical and mental changes and in sexual development of the person. In the event that there is no acknowledgment of immature part as an individual or a male or a female, there is pick to build up a disobedient dejection, feeling of dismissal, and a terrible disdain or even contempt of oneself or of one or the two guardians that may exchange to all individuals from a specific sex or social gathering or to society all in all with appalling outcomes. Out of this turmoil there may develop panoply of special medical and social problems. Some are related to genetic factors and some to physiological changes within the individual where as others develop from the search for identity and purpose with concomitant rebellion against a real or apparent restraining society not infrequently the causes interrelated and mutual reinforcing such as defiance of parents, drinking alcohol, drugs, pregnancy and venereal diseases (Harkin 1997; O N S 1997). Demographically the adolescent population is rising faster than that of other age groups. Between 1960 and 1980, while the world population increased by 46 per cent, the population of adolescents increased by 66 per cent. Today 84 per cent of the adolescent population live in the developing world, despite the fact that as many as 1/5th of India's population comprises adolescents

aged between 10-19 years. The percentage of adolescent's population in Jammu and Kashmir State is nearly 27 per cent (Garg 2002; Statistical Digest 2003-2004). Several specific biological changes occur during adolescence. Differences between sexes and between individuals of the same sex become more pronounced during this age span. Hormones drive growth spurt begins between age 10 ½ years and 11 years for females with the peak in the rate of growth at around 12. For boys growth spurt begins between 12 ½ and 13 years and peak at around age 14. This spurt or period of maximal growth lasts about 2 years. The first phase of adolescent growth is linear. Average boys grow 8 inches and girls 6 inches at puberty. A typical girl achieves about 95 per cent of her adult height by menarche. Growth rates are closely related to sexual maturation. The second phase of adolescent is lateral. A typical healthy girl will gain 35 pounds during adolescence; a typical boy gains about 45 pounds the timing of change in the body varies between individuals and between sexes. Girls have fewer variations than boys. The total span of time from the onset of puberty to maturity is shorter and there are fewer differences between late and early maturing girls. The first visible change is development of breast between the ages of 7-12 years. In boys the first sign is the increase in the size of testes. This occurs at the age of 11 years, the range may be between 9-15 years. Sex differences become marked with the onset of puberty. Girls become taller by 10 years but after 13 years boys surpass girls and attain greater ultimate height. On an average, by 18 years males become 13 cm taller and 12 kgs heavier than girls.

Increased production of adrenal steroids is believed to be the first indication of approaching puberty and occurs in both sexes at approximately 7 years of age. Progress towards puberty is then faster in girls both in appearance of secondary sex characteristics and in acceleration of growth.

Sex differences in body contours proportions and composition becomes more pronounced during adolescence. As a result of greater production of androgens primarily testosterone males develop wider shoulders and greater muscle mass. Females with higher estrogen secretion develop wider hips and more adipose tissue. Males have longer legs and shorter sitting height in relation to total height than females. These changes in combination with the development of secondary sex characteristics constitute to increasing difference in physical size and appearance between males and females.

Much attention has not been given to the health of the adolescents because morbidity rates are less to this age group and because problems are seen in pregnancy and in early childhood. Objective is not only reduction in morbidity but also improvement in health and quality of life. As they are less likely to consider health risks realistically, adolescents represent a high-risk population. Other major health problems of adolescents such as cancer and heart diseases are overshadowed by intestinal injuries, homicide and suicide. However, during this period the young people develop habits that have importance for health in later years. Life style patterns related to nutrition, physical fitness, exercise, and cigarette smoking, drug use, safety in sexual conduct emerge during this period. This behavior helps to determine the rate of future chronic illness in cohort of population as it ages. Even though the percentage of those who smoke has declined from 48 percent in 1965 to 27 percent in 1990, yet alcohol consumption is a major contributor to accidents and violence is linked to chronic disability, unwanted pregnancies and sexually transmitted disease. Present health risk in the population is 84 percent of all teenage mothers who did not finish school have higher unemployment rates and have low birth weight infants (Harkin 1997; O N S 1997; foster 1997; Health United States 2000). Adolescent's health problems may be considered to fall into certain categories in relation to origin severity and behaviorism about which parents, physicians, health agencies, schools and society should be aware. One such category is the extensive group of congenital conditions, some genetic and some acquired. Included are metabolic conditions, such as diabetes, certain enzymatic disorders anatomic condition, such as cardiac and alimentary canal malformation, physiologic conditions, such as phenylketoneuria and certain anemia, psychiatric or neurological conditions, such as Huntington's Chorea and schizophrenia and finally certain infections that may be acquired congenitally of which syphilis is a well known example (Park 1990). The emerging sexuality of the adolescents presents both opportunities and problems. Girls mature earlier than boys. Both develop sex roles based on the models and examples

established by their parents, their relationship with their peers and external influences such as magazine, T.V. and most importantly their school experience. The prevalence of teen aged girls who had experienced sexual intercourse increased during 1970 so that in 1976, 55 per cent of those who had never been married had intercourse by the age of 19 (Furstenberg 1987).

Health effects of malnutrition-The consequences of malnutrition could hardly be more serious: around 45% of child deaths in 2011 were due to malnutrition (including fetal growth restriction, suboptimal breast feeding, stunting, wasting, and deficiencies of vitamin A and zinc). In 2013 the growth of around 161 million children aged under 5 was stunted by chronic under nutrition, leading to hampered cognitive and physical development, poor health, and an increased risk of degenerative diseases.³ In the same year 51 million children were wasted (having low weight for height) because of acute under nutrition; severe wasting increases the risk of morbidity, particularly from infectious diseases such as diarrhea, pneumonia, and measles, and is responsible for as many as two million deaths a year.⁴ Meanwhile, deficiencies of vitamin A and zinc cause many deaths (157 000 and 116 000 child deaths, respectively, in 2011),⁵ and iodine and iron deficiencies, along with stunting, contribute to children not achieving their full potential. Iron and calcium deficiencies increase the risks associated with pregnancy, particularly maternal mortality.⁵ At the same time overweight and obesity in children and adults have been increasing rapidly in all regions of the world, and half a billion adults were affected by obesity in 2010. Dietary risk factors, together with inadequate physical activity, were responsible for 10% of the global burden of disease and disability in 2010

Nutritional Needs during Adolescence: -Dietary recommendations during adolescence must take into account the social and attitudinal characteristics of the individual as well as the timing and the rate of growth. Greater independence from family supervision and guidance is associated with increased peer conformity and influences of mass media. Rapid changes in body create alterations in body image and individual reactions to those changes. Emotional instability may cause intermittent stress. Physical activity may be higher among individuals who participate in competitive sports but very low in those with sedentary pursuit's time schedule may lead to the omissions of some meals or to greater frequency of eating may be consumed more often away from home and may commonly be bought in franchised food outlets. Interest of nontraditional eating pattern may increase. Nutrient needs during adolescence are dictated by the rate of growth. Requirement increases at the outset of growth. Spirit reaches their maximum at the time of peak growth and gradually approach adult levels as growth subsides (Srilakshmi 2002).

Energy: Calorie needs increases with the metabolic demands of growth and energy expenditure. Although individual needs vary, girls consume fewer kilocalories than boys. Boys need 2500-2800 kilocalories a day.

Proteins: For most adolescents eating to satisfy appetite offers a reasonably sensitive indicator of energy needs. Protein needs represent 12-14 per cent of energy needs. Protein intake usually exceeds 1 gm/kg body weight. This meets growth needs and for the pubertal changes in both sexes and for the developing muscle mass in boys. The protein needs for both boys and girls are the same up to the age of 10 years.

Lipids: No allowances have been established for fat intake. The range from minimum to maximum intakes during adolescent was 27-47 per cent for males and 24-51 per cent for females.

Carbohydrates: Since carbohydrates can be made in the body from same amino acids and from glycerol of fat. No recommended allowances have been established.

Vitamins: The need for thiamin, riboflavin and niacin increased directly with increased calorie intake. Folic acid and B12 are essential for Deoxyribonucleic Acid (DNA) and Ribonucleic Acid (RNA) synthesis and needed in higher amounts when tissue synthesis is occurring rapidly.

Minerals: Calcium and iron are particularly needed during adolescence. Bone growth demands calcium. About 150 mg of calcium must be retained each day to allow for the increase in bone mass. Iron needed for hemoglobin synthesis is necessitated by considerable expansion of blood volume and for the myoglobin needed for muscle growth.

Health Problems in Adolescence -Obesity: Obesity in the adolescent is more complex than at other ages in the life span. The healthy individual approximately doubles body weight during adolescence. The body weight tends to have a temporary increase in the body fat measurement in early puberty and then becomes leaner.

Anemia: There does seem to be a trend towards a decrease in the age at menarche over the decade both in the rural and urban situation not only in the upper strata but also among the poor strata of urban and rural communities and making adolescent girl to susceptible to anemia.

Infections: **Social** contact of the adolescent with the peers and strangers is notably increased. This exposure to potentially infected individuals and environment makes them more prone to contact infections. The stress of physical growth also increases their susceptibility to infections.

Goiter: Thyroid enlargement is not unusual during puberty especially in girls. Etiology is uncertain. The thyroid is firm in consistency and may be asymmetric and nodular. On histological examination shows the follicle size is variable, Colloid is dense and epithelium is flattened.

Acne Vulgarism: Complexion problems acne often is a source of embarrassment for the teenager. Acne occurs on the face-chest and back due to inflammation of the sebaceous glands. Its cause is believed to be related to the change in hormonal secretion. The most effective treatment is skin care involving cleanness.

REVIEW OF LITERATURE

Nair, M.K.C. (2013) In the Health Examination Survey in the United States of youth between 12 and 17 years of age only 4 per cent of whites and 10 per cent of black rated their own health as fair to poor. The large majority of rating ranged from good to excellent. Youth in the lowest income group were more under weight and those in upper income group were overweight .

Adolescence is the most important period in human development about which poets, writers and historians have made occasional references and have held in high esteem the sacrifices made by the adolescences. It is the transaction period and turning point in the life of the individual (**Seifert Kelvin, (2015)**

Chandrasekhar, C.R.(2006) A famous psychoanalyst, who developed very comprehensive theory of human development, defined 'adolescence as a period of rapid changes physical, physiological, psychological and social. According to Adams (1973) "Adolescence can be defined as a holding period in which education maturing and waiting are the major tasks to be faced."

OBJECTIVES OF THE STUDY

Keeping in mind the above points a survey was conducted with the following objectives.

1. To assess the knowledge regarding nutrition and nutritional needs in maintaining good health
2. To gain an insight into adolescent's eating behavior and practices.
3. To identify the socio demographic profile of the adolescent girls in the Children's Home

4. To assess the adolescent girls' awareness on developmental changes in adolescence
5. To assess the self-esteem of the adolescent girls in the Children's Homes

SIGNIFICANCE OF THE STUDY

The situations of the adolescent girls and boys in Children's in Government school of Nasik district are not much exposed to the society, social planners and NGOs. Researcher believe that this research study will bring out the situation of the adolescent girls and boys in the children's home to the notice of the social planners, social workers, policy makers who are dedicated to bring up and highlight the psychosocial well being of these neglected population of our society.

REFERENCES

1. Chandrasekhar, C.R. (2006).Adolescent Mind- Problems and their prevention. Bangalore: Navakarnataka Publications.
2. Joshi, Kavita, (2004). Sexuality in India: Teenager and Teacher. New Delhi: Kalpaz publications
3. Nair, M.K.C. (2002). Adolescence and family life education. Bangalore: Prism Books Pp. 2 – 63.
4. Mullick, Premlata (1995). Text Book of Home science .New Delhi: Kalyani Publishers, pp. 570 – 572.
5. Seifert Kelvin, (2015). Child & Adolescent development", 5th Edition. University of New Heaven :
6. Singal Sushila, and Rao, U.N.B. (2004).Adolescent concerns through own eyes. New Delhi: Kanishka Publisher. p.220.