
PREDICTORS OF WELL-BEING AMONG COLLEGE GOING ADOLESCENTS

Medhashree

Abstract

The increasing burden of anxiety related mental health problems among Indian adolescents can largely be attributed to ignorance about the indicators of poor mental health. Transition to college during late adolescence presents a unique set of life challenges that need to be recognised and dealt with. However, most contemporary Indian research studies are centred on psychological pathologies and their developmental trajectories and as such exclusive focus on positive mental health and enhancement of well-being is largely missing from the Indian research scene. In the present study, two hundred university students from Hyderabad (India) both men and women, between 17-19 years, were selected and data was collected from the participants using the WHO, MAS, and ISAW questionnaires in a classroom setting to assess the level of well-being and anxiety. The obtained data was analysed by means of descriptive statistics, Pearson's product-moment correlations and Two-way between subjects ANOVA. The two-way ANOVA revealed insignificant differences in the well-being of adolescents based on their institution type (government or corporate institutions). Gender also did not have any statistical significance in determining well-being. Interestingly, other important correlations were identified that can be helpful in screening for anxious adolescents, predicting low well-being and in designing psychosocial interventions for promoting adolescent well-being and positive health.

Introduction

Adolescence is a separate and distinct stage of development that is characterised by rapid growth

and transition (Meehan, Durlak & Bryant, 1993). During this time of transition and uncertainty, many college going adolescents

□ *Medhashree is Consultant Psychologist and Freelance Medical Writer & Editor.*

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experience increased levels of anxiety associated with their identity, self-image, physical appearance, academic performance, social expectations, and relationship roles (Rana et al., 2014; Mathew et al., 2015). Cumulatively, these issues increase an adolescent's chances of engaging in risky behaviours.

It is critical to identify the indicators of poor well-being, such as low self-esteem, trust issues, poor body image, anxiety, and depression, as early as possible in order to minimise the intensity of psychological damage (Dadds et al., 1997; Farrington, 1986; Meeus et al., 2015). Previous studies have suggested that an adolescent's initial involvement in reckless or risky behaviour should be seen as a red flag and as an indicator of emotional distress and underlying mental health problems (Farrington, 1986; King, 1993).

Mental health problems and health-related risk behaviours often have their origin in an adolescent's immediate environment, such as their college, where they spend a significant amount of their waking time (Hafen et al., 2011; Phillips, 2012; VanRyzin, Gravely & Roseth 2007). As such, the role of a safe, stable and robust college

environment in shaping a well-balanced adolescent cannot be underestimated (WHO, 1984). One of the main aims of this research was to find out whether well-being is affected by the type of educational institution one attends.

The tripartite model of well-being, one of the most widely accepted models of well-being, proposes three components of well-being namely subjective, psychological, and social well-being (Diener, 2000). Subjective well-being is the idea of how individuals perceive their life. It is largely influenced by a person's culture, physical environment, social support network, and living situation (Mounts et al., 2006). Maslow (1970, 2013) suggested that subjective well-being is partly dependent on whether fundamental human needs are fulfilled or not.

Emotional well-being has been considered important in quantitative quality of life assessments. Low emotional well-being is associated with mental health concerns namely stress, depression, and anxiety (Mathew, Khakha, Qureshi, Sagar & Khakha, 2015) which in turn ultimately lead to physical illnesses such as digestive problems, sleep disturbances and fatigue (Wolman,

Resnick, Harris & Blum, 1994). Conversely, improved emotional well-being enhances coping ability, self-respect, work performance, productivity, and longevity (Ciarrochi, Parker, Kashdan, 2015).

Social well-being measures people's experiences of their connections with others and the quality of those relationships. It measures support, trust and belonging. The relationship qualities can suggest whether the bonds are strong or weak. Young people with a robust sense of well-being are fully engaged in realizing their true potential, function effectively and are able to contribute to the community despite significant life challenges and the common stresses of life. Additionally, such an adolescent is able to strive for achievement, utilise all their available resources, abilities and talents suggesting that the experience of well-being is holistic in nature and provides a sense of self-fulfilment, connectedness, contentment, happiness, and life purpose. Self-esteem, health locus of control and resilience are good predictors of whether an adolescent has psychological well-being (Suresh et al., 2013).

Dimensions of Well-being

The 'Indian Scale of Adolescent Well-being' (ISAW) has described twelve dimensions of well-being as follows:

- **Autonomy** is defined as the independence to make one's own decisions.
- **Achievement** is defined as the personal commitment to excel.
- **Freedom from anxiety** refers to the stress experienced in response to external events or internal thoughts.
- **Control** refers to the degree of control one exerts over others or the influence others have over the individual.
- **Freedom from depression** is actually defined as the degree to which one feels depressed (rather than free from depression).
- **Lifestyle** is defined as patterns of living and behaving that are exclusive to the individual.
- **Personal competence** looks at whether one feels confident about their capabilities.
- **Personal morale** is defined as sense of purpose, direction and usefulness.

- **Spiritual quality** is defined as the degree to which one feels connected to a higher power.
- **Social support** is defined as the degree to which one feels a sense of belonging and support.
- **Social contact** is defined as the degree to which one wants to socialise.
- **Interpersonal trust** is defined as the degree to which one is willing to trust others.

Defining Anxiety

Anxiety is an undesired negative emotion or state. Barlow & Wolfe (1981) define anxiety as “a future-oriented mood state in which one is ready to attempt to cope with upcoming negative events.” In lay terms, anxiety is often described as an agony, terror, dread or apprehension. Anxiety is accompanied by unease, somatic problems, and excessive worry and fear over anticipated events which may or may not be real. Anxiety is different from fear since fear is a response to a real threat while anxiety is the anticipation of a future threat. Anxiety is subjective in nature and is known to silently reduce quality of life and well-being significantly. It can cause muscular tension, fatigue, restlessness, and

concentration problems in adolescents.

Rationale

Adolescent Well-being is a rather neglected area of research in India. Consequently, literature linking well-being and institutional factors, gender, and individual characteristics in the Indian setting is scarce. However, as the World Health Organisation rightly proclaims, well-being is not the same as the absence of disease or infirmity. Rather, it has to do with the overall picture of complete mental, physical, social and psychological well-being. The problems (psychological or otherwise) faced by late adolescents in today’s world are numerous. However, even those adolescents who do not have any psychological issues or problems need to be aware of the indicators of psychological health or anxiety in order to enhance the state of their well-being and be able to successfully handle the pressures of growing up in a fast changing world. There is an untapped potential to generate interesting new findings by studying these variables. Hence, this study has been conceptualized.

Review of Literature

This review encompasses the previous studies conducted on

adolescent well-being with special focus on the Indian studies. An extensive literature search with keywords like adolescent, subjective well-being and anxiety has yielded many relevant studies. The articles were collected from Journals such as International Journal of Public Health, International journal of qualitative studies on health and wellbeing, Journal of Adolescence, Journal of youth and adolescence, Indian Journal of Community Medicine, Indian journal of medical sciences etc.

Many anxiety related disorders typically begin during adolescence and persist into adulthood. If left undiagnosed or untreated, it can lead to clinically significant distress and dysfunction in all areas of an adolescent's life. For instance, King (1993) administered panic attack questionnaire and the Manifest Anxiety Scale (revised edition) to students in Australia and America and the findings revealed that adolescents who have significantly higher levels of anxiety suffer from panic attacks more than other adolescents. This hampers their daily functioning greatly.

Rana et al., (2014) reported that an increase in anxiety negatively

affects adolescents by increasing their sense of ambiguity about the future and related negative emotionality in the form of hopelessness. An important implication of this finding is that anxiety is a precursor of hopelessness and loss of hope is directly related to suicidal behaviour in adolescents (Thompson et. al, 2005). In contrast, a recent study by Rana & Nandinee (2016) suggests that adolescents who experience more positive emotions have greater psychological well-being and thus score higher on four of its dimensions such as environmental mastery, positive relationship, personal growth and self -acceptance. Another Indian study, on the contrary, found that individuals who have high levels of suspicion and tension (aspects of anxiety) tend to suffer from psychological distress (Sharma & Yadava, 2006).

Samari & Tahmasebi (2007) reported that a general deficit in competence is a cause of depression in adolescents while social anxiety has been observed to be strongly related to perceived lack of social competence. Spiritual connections act as a social protective factor. Zarzar et al., (2012) examined the relationship

between friend circle and binge drinking and found that late adolescents whose best friends were from church and not school had a lowered risk of binge drinking suggesting that spiritual connections play a protective role in an adolescent's life. However, Saab & Kilnger (2010) found very small difference in the well-being of adolescents based on their school. This may be attributed to the fact that their study was conducted in a developed nation, Canada.

Phillips (2012) found that family structure and adolescent well-being are not related. However, family climate and well-being are related significantly. This implies that regardless of the type of family (nuclear, joint, single parent), the quality of relationships and harmony at home can impact an adolescent's level of well-being. Interestingly, Indian adolescent women who have access to social support and material or tangible resources do not face adverse effects of living away from parents (Peltzer et al., 2014). This finding highlights the importance of finding substitute, secondary support. Conversely, research has focussed on the effects of receiving negative social support during the adolescent years. More recently, Schwartz,

Lansford, Dodge, Pettit & Bates (2015) carried out a longitudinal study on the effects of peer victimisation on adolescents. The findings of multilevel analyses revealed that peer victimisation during middle adolescence leads to internalising problems later on and is also a risk factor for the development of unipolar depression in late adolescence. Ryan & Deci (2000) noted that the extent to which an adolescent's autonomy needs are met is directly related to their sense of well-being. In addition, young people's perception of their classrooms as accepting and encouraging student autonomy is associated with increased engagement throughout the course (Hafen et al., 2011; Ryzin, 2009). It is important to note that during the phase of adolescence, young people strive for greater autonomy and when this urge is constantly unfulfilled, it may lead them on to minor transgressions or acts of delinquency. Acting out (aggressiveness) is common among early and middle adolescent males who have poor quality of friendships. Researchers have interpreted acting out as an attempt to switch from anxiety to instrumental aggression in order to become more visible and gain

autonomy (Granic, 2014; Meeus et al., 2016). Family church attendance and lower negative family interactions act as risk-buffering protective factors for not engaging in violence in adulthood. This implies that pro-social attachments and bonding to society reduces the likelihood of violent behaviour in later life (Schwartz et al., 2015).

An overwhelming sense of personal responsibility and uncontrolled worry about the future leads to generalised anxiety disorder which persists in later life (Meeus et al., 2015). It is more likely for male adolescents who show anxiety earlier to develop aggression or delinquency later on in late adolescence (Farrington, 1986; Froh et al., 2009; Meeus et al., 2015). However, other studies have not found any gender differences in terms of (Bhosale, 2015; Froh, 2009; Rathi & Rastogi, 2007) A cross sectional study in Delhi, India found that stressful life events are significantly related to self-reported psycho-social morbidity. As many as 41% students were screened as borderline to high risk cases with either internalising (anxiety, withdrawal, somatic symptoms) or externalising (aggression, anger,

deviant behaviour) problems (Mathew et al., 2015). This study reveals a need for school based mental health screening and intervention programme in India. Research findings, therefore, indicate the need for early identification of those at risk. Early intervention is more cost effective and successful than clinical treatment (Mathew et al., 2015). School based intervention programs have been effective in reducing the symptoms of existing disorders and preventing the onset of new ones (Dadds et al., 1997; Shoshani & Steinmetz, 2014). Additionally, receiving social support at home, college and neighbourhood is associated with good mental health of adolescents (Schwartz et al., 2015).

Summary of Review

The existing literature on adolescent well-being has reported many factors to be hazardous for adolescent well-being exclusively in the Indian context. For instance, living in a nuclear family has been observed as a risk in many of the studies. Therefore, a need was felt for exploring the effect of institute type, gender and several other factors on well-being of late adolescents in the Indian context.

Research question

The present study attempted to find whether there exists a difference in the well-being of Private and Government College going adolescents.

Objective

To find out any differences in the well-being and anxiety of Private and Government College going adolescents.

Hypothesis

There will be a significant difference in the well-being and anxiety among Private and Government College going adolescents.

Method

Plan and Design

The present study used a between subjects Two-way Analysis of Variance design which involved analysing two factors using IBM SPSS 20 version. Factor one was Type of institution (Privately owned and government owned) and the second factor was Gender (male or female). The dependent variables measured were the well-being and anxiety of adolescents.

Participants

Purposive sampling method was used and a total number of 200 Adolescents (45% male and 53 %

females) were selected. The group private college going adolescents comprised of 45 boys and 55 girls. Government going adolescents consisted of 48 boys and 5 girls. The selected sample's age ranged from 17 to 19 years. The entire data was collected from colleges based on the Type of Institution with an aim to cover a wide range of college characteristics for a representative sample of late adolescents. Informed consent was obtained from both the students and the Heads of the Institutions before the study began. The inclusion criterion for this study was the age of the participants. The participants who were less than 17 years of age and more than 19 were excluded from the study.

Research Tools

Three scales were used in this study: Indian scale of Adolescent well-being, World Health Organization Well-being Index and the Manifest Anxiety Scale. All the scales were translated into Hindi and thus, they were administered both in English and Hindi for the purpose of the present study.

Indian scale of Adolescent well-being consisting of 15 items was used to measure the well-being among college going adolescents. This scale measures twelve

dimensions of well-being viz. autonomy, achievement, freedom from anxiety, control, freedom from depression, lifestyle, personal competence, personal morale, spiritual quality, social contacts, social support, and interpersonal trust. The scores obtained on this scale can range from 15 to 90. The Cronbach's α was found to be .45 for the present study.

World Health Organization-5 Well-being Index consisting of 5 items was used to measure the well-being of late adolescents in this study. This scale has a maximum score of 25. High scores indicate better well-being. Cronbach's α for this scale was found to be 0.82 in a study on adolescents. The WHO-5 Well-being index has been reported to have concurrent validity. The researchers, De Wit et al., (2007) found that it has strong correlations with other standardised scales. This scale has good psychometric properties. The Cronbach's α was found to be .72 for the present study.

The Taylor Manifest Anxiety Scale (TMAS) has 38 items and it was used in this study to measure anxiety inherent in personality of late adolescents (Taylor, 1953). The statements had true or false options

for recording their responses. This scale has a Cronbach's α of .72.

Procedure

The researcher approached various educational institutions in Hyderabad to obtain permission for collecting data from their students. The data was collected from different colleges in Hyderabad. Adolescents from varied socio economic and cultural backgrounds were part of this study. Participants were assured of anonymity and confidentiality before administering the questionnaires.

Results and Discussion

The obtained quantitative data were analysed by using inferential statistics like correlation, two-way ANOVA, graphs and tables through the SPSS statistics 20.0 software. The Pearson's correlation was used to find the relationship between the three psychological tests used i.e. Indian Scale of Adolescence well-being, WHO Well-being Index, and Manifest anxiety scale (MAS), age, type of institution, and various dimensions of well-being. The two way ANOVA was used so as to analyse the difference between group 1 (participants belonging to government institutions) and group 2 (participants belonging to private institutions) in their well-being.

Table-1: The Correlation between Age, Institution Type, Well-being and its Respective Dimensions

<i>Late adolescence</i>	<i>Institute type</i>	<i>Age</i>	<i>ISAW</i>	<i>WHO</i>	<i>MAS</i>	<i>ISAW1</i>	<i>ISAW2</i>	<i>ISAW3</i>	<i>ISAW4</i>
Institute Type	1	.00	-.03	-.11	.16*	.00	-.15*	.13	.08
Age		1	.04	-.03	-.04	.07	.11	-.01	.02
Well being (Indian Scale of Adolescence Well being)-ISAW			1	.38**	-.10	.66**	.46**	.26**	.26 **
Well being (WHO Well being Index)-WHO Well being				1	-.30**	.37**	.24**	.23**	-.07
Anxiety (Manifest Anxiety Scale)-MAS					1	-.16*	-.13	-.03	.18**
Control –ISAW(1,4)						1	.29**	.06	.10
Freedom from anxiety-ISAW 2							1	-.12	-.01
Spiritual quality-ISAW 3								1	-.08
Freedom from depression-ISAW 5									1
Social support-ISAW 6									
Interpersonal trust-ISAW(7,8)									
Personal morale-ISAW 9									
Autonomy –ISAW 10									
Personal CompetenceISAW 11									
Achievement-ISAW 12									
Lifestyle –ISAW(13,15)									
Social contact-ISAW14									

<i>Late adolescence</i>		ISAW5	ISAW6	ISAW7	ISAW8	ISAW9	ISAW10	ISAW11	ISAW12
Gender		-.00	-.03	-.04	-.10	-.07	.04	-.01	-.05
Age		-.03	-.02	-.02	-.00	.02	-.00	.05	.00
Well being (Indian Scale of Adolescence Well being)-ISAW		.51**	.31**	.52**	.37**	.58**	.32**	.29**	.11
Well being (WHO Well being Index)-WHO		.27**	.02	.19**	.21**	.24**	.04	.07	-.07
Anxiety (Manifest Anxiety Scale)-MAS		-.18*	.00	-.20**	-.13	-.19**	.20**	-.02	.15*
Control –ISAW(1,4)		.37**	.07	.32**	.10	.33**	.12	.18**	-.02
Freedom from anxiety-ISAW 2		.15*	.13	.23**	.09	.26**	.05	.10	.04
Spiritual quality-ISAW 3		.14*	.14*	-.05	.02	.03	.04	-.09	-.04
Freedom from depression-ISAW 5		-.05	.06	.05	-.14*	.02	.01	-.03	.11
Social support-ISAW 6		1	.04	.22	.25	.44	.17	.19	-.10
Interpersonal trust-ISAW(7,8)			1	-.05	-.04	-.11	-.04	.00	-.08
Personal morale-ISAW 9				1	.23**	.48**	-.00	.12	.02
Autonomy –ISAW 10					1	.26**	.07	.10	-.03
Personal CompetenceISAW 11						1	.10	.13*	-.00
Achievement-ISAW 12							1	-.01	.01
Lifestyle –ISAW(13,15)								1	-.01
Social contact-ISAW14									1

Note. $N=200$, * $p<.05$, ** $p<.01$

The inter correlation coefficient (r) between 'Indian Scale of Adolescence' well-being scale and its twelve dimensions (Control, Freedom from anxiety, Spiritual quality, Freedom from depression, Social support, Interpersonal trust, Personal morale, Autonomy, Personal Competence, Achievement, Lifestyle, Social contact), WHO Well -being Index, and Manifest anxiety scale (MAS) and Institute type and age is presented in Table 1.

Institute type had a significant positive correlation with Manifest anxiety scale, $r = .16, p < .05$. This indicated that Institute type had an influence on Manifest Anxiety. There was a significant negative correlation between Institute type and Indian Scale of Adolescence well-being, $r = -.15, p < .05$. However, age was not found to have a significant correlation with any domain. This indicates that the age of the participants did not influence their well-being since all of them belonged to late adolescent category.

It was observed that ISAW scale has a positive correlation with WHO well-being scale, $r = .38, p < 0.01$, but has no significant correlation with MAS. This shows that the two well-being scales have

strong correlation. If the score on one of the scales is high, it is very likely to be high on the second scale as well. It was found that WHO well-being scale has a negative correlation with Manifest anxiety scale, $r = -.30, p < 0.01$, partial correlation with the ISAW domain control, $r = .38, < 0.01$, a positive correlation with freedom from anxiety, $r = .24, p < 0.01$, a positive correlation with spiritual quality, $r = .23, p < 0.01$, a positive correlation with social support, $r = .27, p < 0.01$, a positive correlation with personal morale, $r = .19, p < 0.01$, a positive correlation with autonomy $r = .21, p < 0.01$, and a positive correlation with personal competence $r = .24, p < 0.01$.

Manifest anxiety scale was found to have a positive correlation with the ISAW domain control, $r = .18, p < .01$. The greater the participants had a need for control, the more anxiety they had. MAS also had a positive correlation with autonomy, $r = .20, p < .01$ and achievement $r = .15, p < .05$. This indicates that the greater an adolescent's score on autonomy and achievement, the more anxiety they have. There was a significant negative correlation found between MAS and ISAW domain control, $r = -.16, p < .05$, this indicates that

adolescents who had high amount of anxiety had poor control. There was also a significant negative correlation found between MAS and freedom from depression, $r = -16, p < .05$. This indicated that the amount of anxiety a participant experienced was related to depression, the freer an adolescent was from depression, the more likely it was that they were suffering from anxiety. This may be because anxiety and depression are opposite polarities on the same continuum. Negative correlations were also seen between MAS and interpersonal trust, $r = -20, p < .05$ and negative correlations were also seen between personal morale and MAS, $r = -19, p < .05$. This indicates that those adolescents who had high interpersonal trust and personal morale were less likely to have manifest anxiety.

The ISAW domain control had a positive correlation with Freedom from anxiety, $r = .29, p < 0.1$, freedom from depression, $r = .37, p < .01$, interpersonal trust, $r = .32, p < .01$, Personal morale, $r = .33, p < .01$ and Personal Competence, $r = .18, p < .01$. This suggests that those individuals who were free from anxiety and depression, had interpersonal trust, personal competence and personal

competence were high on well-being.

The ISAW domain freedom from anxiety had a positive correlation with freedom from depression, $r = .15, p < .05$, interpersonal trust, $r = .23, p < .01$ and personal morale, $r = .26, p < .01$. This indicates that adolescents who were free from anxiety had high interpersonal trust and personal morale and were also free from depression to some extent. The ISAW domain spiritual quality had a positive correlation with freedom from depression, $r = .14, p < .05$ and social support, $r = .14, p < .05$. This means that spiritual quality is related to being free from depression and having good social support.

The ISAW domain freedom from depression had a negative correlation with interpersonal trust, $r = -.14, p < .05$. This result is unexpected but it may suggest that those adolescents who were free from depression had low interpersonal trust because they depended on themselves more than others.

The ISAW domain personal morale had a positive correlation with interpersonal trust $r = .23, p < .01$ and personal morale $r = .48, p < .01$. This indicates that

Table-2: Two-way ANOVA Table

Measures	Government		Corporate		Results of 2x2 ANOVA		
	Male	Female	Male	Female	F-ratio for Institute Type	F-ratio for Gender	F-ratio for Type x Gender
	(n=48)	(n=51)	(n=45)	(n=55)			
	M(SD)	M(SD)	M(SD)	M(SD)			
ISAW	4.12 (.55)	4.03 (.51)	4.08 (.54)	4.00 (.65)	1.59	1.01	<1
WHO	16.47 (4.71)	16.55 (4.32)	15.80 (4.41)	15.12 (5.67)	2.34	0.18	0.29
MAS	16.79 (6.26)	17.91 (5.33)	15.86 (4.90)	18.34 (5.25)	5.40*	0.10	0.77
Control	4.69 (1.04)	4.66 (.98)	4.81 (1.05)	4.58 (1.19)	0.01	0.44	0.40
Freedom from Anxiety	4.56 (1.21)	4.32 (1.39)	3.97 (1.45)	4.03 (.42)	5.01	0.20	0.56
Spiritual quality	3.56 (.18)	3.21 (1.63)	4.22 (1.86)	3.54 (1.64)	4.02	4.30	0.43
Freedom from Depression	3.54 (1.64)	3.51 (1.62)	3.51 (1.62)	3.83 (1.77)	1.49	0.38	<1
Social support	4.81 (1.42)	4.78 (1.17)	4.88 (1.68)	4.69 (1.24)	<1	0.32	0.19
Interpersonal trust	3.99 (1.15)	3.09 (1.23)	5.78 (1.23)	3.13 (1.35)	0.23	19	0.47
Personal morale	3.75 (1.46)	4.34 (1.28)	3.64 (1.70)	4.16 (1.46)	0.47	7.07**	0.03
P_ competence	4.39 (1.31)	4.46 (1.47)	3.55 (1.68)	4.58 (1.37)	3.01**	6.93	5.36**
Achievement	3.47 (1.52)	3.78 (1.43)	3.57 (1.78)	3.96 (1.55)	0.37	2.42	0.02
Lifestyle	3.90 (1.01)	3.90 (1.24)	4.0 (1.35)	3.78 (1.15)	<1	0.42	0.40
Social contact	3.54 (1.85)	3.44 (1.78)	3.31 (2.04)	3.29 (1.88)	0.50	0.05	0.02

Note: N=200, * $p < .05$, ** $p < .01$

adolescents who have high personal morale also have high interpersonal trust. The ISAW domain autonomy had a positive correlation with personal morale, $r = .26$, $p < .01$, suggesting that as autonomy increases, personal morale also increases.

From table 2 it is evident that no significant difference in the level of well-being was found between the two groups, $F(1, 196) = 1.59$, $p > .05$, on ISAW scale. The Mean and Standard Deviation scores for the level of well-being on this dimension are $M = 4.07$, $SD = .53$ for government students and $M = 4.04$, $SD = .64$ for corporate students. It indicates that there is no significant difference among the well-being of the two groups. The mean scores for male students was $M = 4.10$, $SD = .54$ and for female students $M = 4.02$, $SD = .58$ but neither the type of institute nor gender influenced well-being.

From the results, it is also evident that no significant difference in the level of well-being was found between the two groups viz. government and corporate, $F(1, 196) = 2.34$, $p > .05$, on WHO scale. The Mean and Standard Deviation scores for the level of well-being on this dimension are $M = 16.52$, $SD = 4.52$ for

government students and $M = 15.43$, $SD = 5.13$ for corporate students. The mean scores $M = 16.15$, $SD = 4.59$ for male students was higher than that for female students $M = 15.82$, $SD = 5.09$. It indicates that there is no significant difference among the well-being of the two groups and gender did not have a significant effect either.

On the MAS domain, the private college students had higher scores ($M = 18.15$, $SD = 5.27$) than the government students ($M = 18.15$, $SD = 5.27$). Institute type was found to have a significant effect on manifest anxiety, $F(1, 196) =$, $p < .05$. However, Gender did not seem to have a significant effect. This indicates that regardless of the gender, corporate students had more anxiety than the government going students.

On the dimension of personal morale, the female students had higher scores ($M = 4.25$, $SD = 1.37$) than the govt. students ($M = 3.69$, $SD = 1.57$). Gender had a significant effect but type of institution did not. $F(1, 196) = 7.07$, $p < 0.01$

On the autonomy domain, The main effect of Institute was found to be significant, $F(1, 196) = 3.01$, $p < 0.01$ and the interaction effect of Gender X Institute was also found to be significant, $F(1, 196) =$

5.36, $p < 0.01$. This means that the Institute plays an important part in how much autonomy an adolescent enjoys. The corporate female students had higher scores ($M=4.58$, $SD=1.37$) than the government female students ($M=4.46$, $SD=1.47$) and all other male students ($M=4.39$, $SD=1.31$) and ($M=3.55$, $SD=1.68$). This indicates that girl students enjoy more autonomy in corporate institutions than in government ones and they also tend to fare well than boys in this domain.

General Discussion and Conclusion

The present study assessed the well-being and anxiety among college going adolescents of both genders (male and female). Results were analysed using Pearson (r) and Two-way ANOVA.

The main objective of the study was to measure the well-being of late adolescents. The dimensions studied under well-being include Control, Freedom from anxiety, Spiritual quality, Freedom from depression, Social support, Interpersonal trust, Personal morale, Autonomy, Personal Competence, Achievement, Lifestyle and Social contact. An exploration of these well-being dimensions revealed that

adolescents with high amount of anxiety had poor sense of control over their life. Also, those who had low interpersonal trust and reduced personal morale, low freedom from depression and poor personal competence were found to be experiencing lower levels of well-being in their life as compared to others.

The second objective of the study was to measure the level of anxiety prevalent among the adolescent participants. The results seem to show a positive correlation between the scores of ISAW and WHO scores. This suggests that those who score high on well-being on one of these scales are also likely to score better on the other scale. This demonstrates the strength of inter-scale validity. As expected, the relationship between anxiety and well-being was indicated by a negative relationship between the two variables. The Scores on ISAW and MAS, and between WHO and MAS were significantly negatively correlated. This means that as anxiety increases, well-being decreases. Thus, there exists a negative correlation between anxiety and well-being.

It was also found that freedom from depression and having a good social support system are positively

related. This finding is supported by previous study which highlights that social support is vital for good mental health by elaborating how loneliness is related to adolescents' anxiety and depression (Mounts et al., 2006).

Interestingly, although India is a developing economy and gender inequalities are widely prevalent, the results of the present study revealed that gender does not directly determine well-being. Instead, individual characteristics play a key role in preventing anxiety and enhancing well-being. This finding may be especially reflective of middle class, urban, educated adolescents in India. The finding is consistent with recent researches that have concluded that gender differences do not have a mediating role in subjective well-being and somatic symptoms (Froh et al., 2009). Similarly, Rathi & Rastogi (2007) found no significant gender differences on any sub scales of Well-Being Manifestation Measure Scale (WBMMS). No significant gender differences were observed in frequency of psychosocial problems experienced by Indian adolescents (Bhosale, 2015).

In line with the present study, Saab & Kilnger (2010) found very modest differences in health

outcomes across schools. They reported that school factors accounted for only 2%–4% of the total variance in Self-rated Health (SRH), Emotional Wellbeing (EWB), and Subjective Health Complaints (SHC). Individual level factors were found to play a more important role than school effect in adolescent's well-being.

However, contradictory results were found by Aggarwala & Berk (2015) who conducted a review of existing literature on mental health of adolescents in India in the last 10 years and reported that studying in a government educational institution acts as a risk factor for adolescent mental health. One reason for this contradictory result could be that there have been versatile changes in the climate and infrastructure of educational institutions in our country in the past decade or so. The improved conditions may lead to narrowing of the divide between the government and the corporate institutions in terms of the benefits they offer to the students.

Conclusion

The study was designed as an attempt to measure the well-being and anxiety of participants and to explore the effect of age, gender and type of educational institution of late adolescents. It was

hypothesized that there will be a difference between the participants with respect to well-being and anxiety. Results of the study portrayed that well-being is positively correlated with interpersonal trust and personal competence. Negative correlations were seen between MAS and interpersonal trust and personal morale suggesting that adolescents who had high interpersonal trust and personal morale were less likely to have manifest anxiety symptoms. It was also found that spirituality contributes to freedom from depression and having a good social support system. There was a significant negative correlation found between MAS and ISAW domain control indicating that adolescents who had high amount of anxiety had poor sense of control. This demands attention for appropriate interventions in terms of enhancing well-being dimensions such as personal morale, spiritual quality, interpersonal trust, sense of control and personal competence among adolescents. The limitations and implications of the results are discussed, and future directions are suggested.

Implications of the study

Prior to the present study, several factors which are associated

with Well-being had been minimally studied in adolescent samples in India. This study therefore advances our understanding by showing new evidence that there is almost no difference in well-being between genders (except personal morale) and across Types of institutions that adolescents study in (except on the dimension of autonomy). This implies that the most important factors for adolescent well-being are related to the personal characteristics of the adolescents regardless of the gender or educational institute. These findings can be useful for screening for at-risk or vulnerable adolescents who score high on anxiety and enhancing their psychological well-being.

The positive psychology movement has identified a number of factors that promote Well-being and the present study elucidates which dimensions to look for and strengthen in order to enhance adolescent well-being. However, we need to recognize that research with Indian adolescents in regard to their Well-being is in initial phase and more research work still needs to be undertaken. None the less, the findings can be helpful in designing psycho social interventions for the promotion of health and well-being of late adolescents.

Limitations and Future Directions

Although a balance of gender in the sample was accomplished and it was ensured that the participants were from all socio economic groups, the present study has two important limitations. The sample size was small. The sample size could have been increased to generalize the findings to larger population and could have considered other geographic areas.

The two student groups came from varied institution contexts. Some were from Girls- only colleges while others were from Co-ed institutions. It is possible that there were other differences that were not measured. Future studies should include boys -only colleges as well. The results of this study had a few limitations which should be considered in future research studies. The study would have been much better if more colleges could be included from other parts of India. Students who are enrolled in distance mode of education, part time studies, evening colleges or not enrolled in any type of institutions can also be included in future studies to assess the well-being among the marginalised adolescents. Since, their well-being is likely to be lower than those who are enrolled in formal institutions.

References

1. Barlow, D.H., & Wolfe, B.E. (1981). *Behavioral approaches to anxiety disorders: A report on the NIMH-SUNY, Albany, research conference. Journal of Consulting and Clinical Psychology, 49*(3), 448.
2. Ciarrochi, J., Parker, P., Kashdan, T. B., Heaven, P.C., & Barkus, E. (2015). *Hope and emotional well-being: A six-year study to distinguish antecedents, correlates, and consequences. The Journal of Positive Psychology, 10*(6), 520-532.
3. Dadds, M.R., Spence, S.H., Holland, D.E., Barrett, P.M., & Laurens, K.R. (1997). *Prevention and early intervention for anxiety disorders: a controlled trial. Journal of consulting and clinical psychology, 65*(4), 627.
4. Diener, E. (2000). *Subjective well-being. Psychological Bulletin, 95*, 542-575.
5. Farrington, D. (1986). *Age and crime. Crime and Justice- A review of research, 7*, 189-250.
6. Froh, J. J., Yurkewicz, C., & Kashdan, T. B. (2009). *Gratitude and subjective well-being in early adolescence: Examining gender differences. Journal of adolescence, 32*(3), 633-650.
7. Granic, I. (2014). *The role of anxiety in the development, maintenance, and treatment of childhood aggression. Development and psychopathology, 26*(4pt2), 1515-1530.
8. Hafen, C.A., Allen, J.P., Mikami, A. Y., Gregory, A., Hamre, B., & Pianta, R.C. (2012). *The pivotal role of adolescent autonomy in secondary school classrooms. Journal of Youth and Adolescence, 41*(3), 245-255.
9. King, N.J., Gullone, E., Tonge, B.J., & Ollendick, T.H. (1993). *Self-reports of panic attacks and manifest anxiety in adolescents. Behaviour Research and Therapy, 31*(1), 111-116.
10. Maslow, A.H. (2013). *Toward a psychology of being. Simon and Schuster.*
11. Mathew, N., Khakha, D.C., Qureshi, A., Sagar, R., & Khakha, C.C. (2015). *Stress and coping among adolescents in*

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- selected schools in the capital city of India. *The Indian Journal of Pediatrics*, 82(9), 809-816
12. Meehan, M.P., Durlak, J.A., & Bryant, F.B. (1993). *The relationship of social support to perceived control and subjective mental health in adolescents*. *Journal of Community Psychology*, 21(1), 49-55.
 13. Meeus, W., Van de Schoot, R., Hawk, S.T., Hale III, W.W., & Branje, S. (2016). *Direct aggression and generalized anxiety in adolescence: heterogeneity in development and intra-individual change*. *Journal of youth and adolescence*, 45(2), 361-375.
 14. Mounts, N.S., Valentiner, D.P., Anderson, K.L., & Boswell, M.K. (2006). *Shyness, sociability, and parental support for the college transition: Relation to adolescents' adjustment*. *Journal of Youth and Adolescence*, 35(1), 68-77.
 15. Peltzer, K., Pengpid, S., & Mohan, K. (2014). *Prevalence of health behaviors and their associated factors among a sample of university students in India*. *International journal of adolescent medicine and health*, 26(4), 531-540.
 16. Phillips, T.M. (2012). *The influence of family structure vs. family climate on adolescent well-being*. *Child and Adolescent Social Work Journal*, 29(2), 103-110.
 17. Phillips, T. M. (2012). *The influence of family structure vs. family climate on adolescent well-being*. *Child and Adolescent Social Work Journal*, 29(2), 103-110.
 18. Rana, S., & Nandinee, D. (2016). *Profile of Adolescents' Positive Emotions: An Indicator of their Psychological Well-being*. *Psychological Studies*, 1-8.
 19. Rana, S., Lall, G., Mishra, A., Nandinee, D., & Vincent, K. (2014). *Hopelessness during emerging adulthood: Contributions of anxiety*. *International Journal of Health & Allied Sciences*, 3(4), 273.
 20. Rathi, N., & Rastogi, R. (2007). *Meaning in life and psychological well-being in pre-adolescents and adolescents*. *Journal of the Indian Academy of Applied Psychology*, 33(1), 31-38.
 21. Ryan, R. M., & Deci, E.L. (2000). *Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being*. *American psychologist*, 55(1), 68.
 22. Saab, H., & Klinger, D. (2010). *School differences in adolescent health and wellbeing: Findings from the Canadian Health Behaviour in School-aged Children Study*. *Social science & medicine*, 70(6), 850-858.
 23. Samari, A.A., & Tahmasebi, A. (2007). *The Study of Correlation between Emotional Intelligence and Academic Achievement among University Students*. *The Quarterly Journal of Fundamentals of Mental Health*, Fall-Winter (9) 121-128.
 24. Schwartz, D., Lansford, J.E., Dodge, K.A., Pettit, G. S., & Bates, J.E. (2015). *Peer victimization during middle childhood as a lead indicator of internalizing problems and diagnostic outcomes in late adolescence*. *Journal of Clinical Child & Adolescent Psychology*, 44(3), 393-404.
 25. Sharma NR, Sahrma A, Yadava A. *Study of general mental health in relation to personality*. *J Indian Health Psychol* 2006;1:67-75. Back to cited text no. 28.
 26. Shoshani, A., & Steinmetz, S. (2014). *Positive psychology at school: A school-based intervention to promote adolescents' mental health and well-being*. *Journal of Happiness Studies*, 15(6), 1289.
 27. Suresh, A., Jayachander, M., & Joshi, S. (2013). *Psychological Determinants of Well-Being Among Adolescents*. *Asia Pacific Journal of Research Vol: 1 Issue XI*.
 28. Thompson EA, Mazza JJ, Herting JR, Randell BP, Eggert LL. *The mediating roles of anxiety depression, and hopelessness on adolescent suicidal behaviors*. *Suicide Life Threat Behav* 2005;35:14-34
 29. Van Ryzin, M.J., Gravely, A.A., & Roseth, C.J. (2009). *Autonomy, belongingness, and engagement in school as contributors to adolescent psychological well-being*. *Journal of youth and adolescence*, 38(1), 1-12.

30. **Wolman, C., Resnick, M.D., Harris, L.J., & Blum, R.W.** (1994). Emotional well-being among adolescents with and without chronic conditions. *Journal of Adolescent Health, 15*(3), 199-204.
31. **World Health Organization (WHO).** (1984). *Health promotion: A discussion document on the concept and principles.* Copenhagen, Denmark: WHO Regional Office for Europe.
32. **Zarzar, P.M., Jorge, K.O., Oksanen, T., Vale, M.P., Ferreira, E.F., & Kawachi, I.** (2012). Association between binge drinking, type of friends and gender: A cross-sectional study among Brazilian adolescents. *BMC public health, 12*(1), 1.

