EXTENT OF ENGAGEMENT IN RISK-TAKING BEHAVIORS OF SENIOR HIGH SCHOOL STUDENTS OF TUGUEGARAO CITY

Teresita T. Lasam, RGC, PhD
Guidance
tlasam@spup.edu.ph

ABSTRACT

This descriptive study assessed and correlated senior students' extent of engagement in risk-taking behaviors and their mental health. Participants were randomly selected senior high school students (N=1145) from selected schools in the city. Results showed that most of the participants were females, 17 years old, first-born children, Catholics and enrolled in public schools. Results also revealed that the participants had a low extent of engagement in risk-taking behaviors either in non-self and self-harm risk-taking behaviors. A marked difference was observed in the participants' extent of engagement in risk-taking behaviors when they were grouped according to sex and age. In support of this result, male participants scored higher in non-self-harm risk behaviors than the females while the female participants scored higher in self-harm risk behaviors than males. Among age groups, participants who are 17 years old showed high extent of engagement in risk-taking behaviors. Along with mental health, participants manifested increasing mental health symptoms derived from stress, starting from moderate anxiety to moderate depression. t-Test results revealed that female participants experienced more stress, anxiety, and depression than males. Test of correlation revealed that risk-taking behaviors significantly relates to mental health.

INTRODUCTION

Adolescents obviously do not always act in ways that serve their own best interests, even as defined by them. Sometimes their perception of their own risks, even of survival to adulthood, is larger than the reality; in other cases, they underestimate the risks of particular actions or behaviors. It is possible, indeed , that some adolescents engage in risky behaviors because of a perception of invulnerability— the current conventional wisdom of adults' views of adolescent behavior. Others, however, take risks because they feel vulnerable to a point approaching hopelessness. In either case, these perceptions can prompt adolescents to make poor decisions that can put them at risk and leave them vulnerable to physical or psychological harm that may have a negative impact on their long-term health and viability. Today, adolescents' life is full of challenges and changes. Interaction of individual characteristics with the environment determines the adjustment and reactive responses. Economic and social changes are important factors that have an influence on adolescences' life. Changes in life have positive or negative effects. Negative changes lead to high-risk behaviors and increase the risk of unsecured behaviors.

Risk-taking behaviors are one of the major threats to adolescents' health and well-being. The negative effects of risk behaviors are currently well known to lead to personal, social, emotional, economic, and psychological problems, and are associated with mortality through accidents, violence, and crime. Risk-taking behavior is very influential and prevalent in adolescents' life.

For the adolescent to have a quality of life, their mental health is very important. Mental health as a state of well-being in which every individual realizes his or her own potential can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community (World Health Organization, 2014). Mental health problems for adolescents can range from emotional, behavioral, and mental disorders. They include depression, anxiety, adjustment, conduct, self-injurious thoughts, and others. Mental health is considered the foundation for well-being and effective functioning of an individual and a community. A community of

mentally healthy individuals is therefore empowered, productive, and resilient. Altogether, individuals' mental health conditions are strongly associated with levels of happiness, stress, and resilience (Ness, 2013), which makes these factors important for understanding adolescents' psychological health. Knowledge of stress and resilience in adolescents is also important for understanding their healthy development and well-being (Ahern 2006; Byrne, Davenport, & Mazanov 2007; Fergus & Zimmerman 2005).
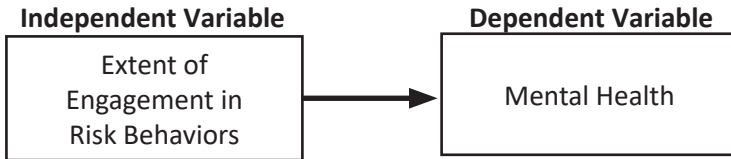
Conceptual framework

Adolescence, the period of life between 13 and 18 years, is typically marked by growing independence from parents, greater reliance on the judgments of peers, and increased exposure to and interest in novel activities. At the same time, the adolescent brain is restructuring, with their actions guided much more by instinctual reactions and less by control and reasoning. Consequently, adolescents are more susceptible to risky behaviors such as alcohol, tobacco, drugs, and early sexual debut and other high-risk behaviors. Risk-taking behavior is further described as either a socially unacceptable volitional behavior with a potentially negative outcome in which precautions are not taken, such as speeding, drinking, and driving, drugs abuse, unprotected sex or a socially unaccepted behavior. One of the biggest casualties of the modern, fast-paced world has been the health of the people, especially their mental health. Mental health is a term used to describe how well the individual is adjusted to the demands and opportunities of life. A person is said to be physically fit when his body is functioning well, and he is free from pains and troubles.

Similarly, a person is in good mental health when his or her mind and personality are functioning effectively, and he or she is free from emotional disturbances. In general, he or she enjoys life and any unhappiness he or she has, can be understandably explained. He or she is self-confident, hopeful about himself or herself and his or her opportunities, though he or she may have temporary set-backs and discouragement. He or she is able to meet his problems without much disturbance, and his or her fears and anxieties are normal. He or

she keeps an equable temper and when aroused expresses his or her anger in a socially acceptable way. He or she has emotional maturity, balance, and equilibrium, understands himself or herself, his or her merits and abilities; he or she also knows his or her handicaps and disabilities.

Paradigm of the Study

Independent Variable	Dependent Variable
Extent of Engagement in Risk Behaviors	Mental Health

Figure 1. Paradigm of the study

The paradigm shows the direction of the study. The independent variable presents the participants' extent of engagement in risk-taking behaviors while the dependent variable consists of the mental health status. The study further looked into the relationship between risk behaviors and mental health of the participants.

Statement of the Problem

This research study generally aimed to assess, compare and correlate participants' extent of engagement in risk behaviors and their mental health status. Specifically, it sought answers to the following:

1. What is the profile of the participants when they are grouped according to:
    1.1 Sex;
    1.2 Age;
    1.3 Birth order;
    1.4 Religion, and
    1.5 School?
2. To what extent do the participants engage in the following risk-taking behaviors:
    2.1 Non-self harm risk-taking behaviors, and
    2.2 Self-harm risk-taking behaviors?

3. What is the mental health status of the participants?
4. Is there a significant difference in the participants' extent of engagement in risk-taking behaviors when they are grouped according to profile variables?
5. Is there a significant difference in the participants' mental health status when grouped according to profile variables?
6. Is there a significant relationship between the participants' extent of engagement in risk-taking behaviors and their mental health status?
7. What regression model can be used to predict the participants' mental health using risk behaviors as predictors?

METHODOLOGY

Research Design

The study used the descriptive research design. Descriptive method was employed to determine the participants' extent of engagement in risk behaviors and their mental health status. It likewise described the differences in the extent of engagement in risk behaviors, and mental status when grouped according to profile variables. It further looked into the relationship of the two main variables under study.

Participants of the Study

The participants of the study were 1,145 senior high school students of Tuguegarao City. The number of the participants was determined through random sampling.

Instrumentation

Questionnaires on The Risk Taking and Self Harm Inventory for Adolescent was used. It assesses risk-taking behaviors and self-harm behaviors. It was answered using a 4-point Likert scale, where 1 equals to "never," 2 "once," 3 "more than once," or 4 "many times." The mean ranges from 1.00 to 4.00 with the highest mean indicating many times or high extent of engagement in risk behaviors.

The study also used the DASS 21 – a self-report questionnaire designed to measure the severity of symptoms of depression, anxiety, and stress where the participants are asked to check the box which indicates how much the statement applies to them. The scale to which each item belongs is indicated by the letters D (Depression) A, (Anxiety), and S (Stress). For each of the scales (D, A, and S) the scores for identified items are summated. The final score of each item groups was multiplied by two (X2) to calculate the final score.

Data Gathering Procedure

The researcher, upon the approval of the conduct of the study, prepared letters of permission for the participation of the schools concerned. First, the researcher coordinated with the school principal of Senior High School of St. Paul University Philippines and the president of the University of Cagayan Valley. A letter of permission was also sent to the Schools Division Superintendent of Cagayan and the Research Office of the division. Upon approval of the request, the researcher was endorsed to the principals of Cagayan National High School and the Tuguegarao City Science High School for their approval. Schedules of the conduct of the study were sought; after which, the researcher prepared copies of the questionnaires and administered them after securing the participants' informed consent.

Data Analysis

Frequency and percentage distribution were used for the descriptive analysis of the profile variables (sex, age, birth order, religion, and school).

The participants' extent of engagement in risk behaviors, level of resilience and mental health were based on the means and mean scores.

On the test of differences, Multi Analysis of Variance (MANOVA) was used to determine the differences in the participants' profile variables on their extent of engagement on risk behaviors and mental health status.

Pearson r was utilized to determine the significant relationship between the extent of engagement in risk behaviors and mental health of the participants under study. Test of difference and relationship were interpreted based on $p < 0.05$ in each analysis.

A four-point Likert scale was used to determine the participants' extent of engagement in risk-taking behaviors.

Mean	Interpretation
3.25 -4.00	Very High Engagement
2.50 -3.24	High Engagement
1.75 -2.49	Moderate Engagement
1.00 -1.74	Low Engagement

To determine the participants' mental health status, the following scale was used.

Level	Scores		
	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34+

RESULTS AND DISCUSSION

Participants' Profile

Table 1
Participants' Distribution by Profile Variables

Profile	Specifics	Frequency	Percentage
Sex	Male	465	40.60
	Female	680	59.40

(table continues)

Table 1 *(continued)*

Age	15 and below	35	3.10
	16	392	34.20
	17	602	52.60
	18	98	8.60
	19	14	1.20
	20 and above	4	0.40
Birth Order	First Born	366	32.0
	Middle Born	355	31.0
	Youngest	355	31.0
	Only child	69	6.0
Religion	Roman Catholic	986	86.1
	Born Again Christians	95	8.3
	Jehovah Witness	11	1.0
	Iglesia ni Cristo	22	1.9
	Mormons	25	2.2
	No religion	6	.5
School	St. Paul University Philippines	183	16.00
	Cagayan National High School	594	51.9
	University of Cagayan Valley	228	19.9
	Tuguegarao Science High School	140	12.2

Majority of the participants are female, within the age of 17 years old having the highest percentage (52.6%). Most of the participants are first born (366 or 32.0%), followed by middle born and youngest (both at 355 or 31.0%), and lastly, the only child are 69 (6.0%). Majority (86%) are Roman Catholic and are enrolled in public high school institutions.

Extent of Engagement in Risk-Taking Behaviors (Non-Self and Self-Harm Risk Behaviors)

Table 2
Participants' Extent of Engagement in Risk-taking Behaviors

Risk Behaviors	Mean Score	SD	Descriptive Interpretation
Non-Self Harm Risk Behaviors	1.36	0.384	Low Engagement
Self Harm Risk Behaviors	1.34	0.427	Low Engagement
Overall	**1.35**	**0.348**	**Low Engagement**

As seen in the means of the two categories of risk-taking behaviors, there is low extent of engagement in both the non-self-harm risk-taking behaviors and self-harm risk-taking behaviors. A general mean of 1.35 was observed which implies a low extent of engagement in both the non-self-harm and self-harm risk-taking behaviors by the participants.

Non-self harm risk-taking behaviors are risk-taking behaviors which include putting oneself in a risky situation such as cheating, shoplifting even knowing that one might be caught, using illegal drugs, smoking, drinking alcohol to the point of being drunk, being promiscuous or having engaged in sexual intercourse and have taken contraceptives to prevent pregnancy. On the other hand, self-harm includes risk behaviors in which an engagement is characterized by intentionality, destructiveness, and conventionality of thoughts and acts of self-harm; it also includes non-suicidal self-injurious behaviors which incorporate intentionally hurting, punishing, cutting burning a part of the body, and with conscious thoughts to end one's life or to kill oneself (Vrouva, Fonagy, Fearon, Roddouw, & Gullone 2000).

Mental Health Status of the Participants as Measured in Terms of Depression, Anxiety, and Stress Levels

Table 3
Participants Distribution by Level of Depression, Anxiety, and Stress

Variables	Status	f	Percentage
Level of Depression	Normal	363	31.7
	Mild	230	20.1
	Moderate	374	32.7
	Severe	92	8.0
	Extremely Severe	86	7.5
	Mean Score = 16.17	**SD = 7.55**	**Moderate Depression**
Level of Anxiety	Normal	121	10.6
	Mild	57	5.0
	Moderate	374	32.7
	Severe	216	18.9
	Extremely Severe	376	32.8
	Total	1144	99.9
	Missing	1	.1
	Mean Score = 16.17	**SD = 7.55**	**Severe Anxiety**
Level of Stress	Normal	641	56.0
	Mild	233	20.3
	Moderate	168	14.7
	Severe	70	6.1
	Extremely Severe	30	2.6
	Total	1142	99.7
	Missing	3	.3
	Mean Score = 14.80	**SD = 7.385**	**Normal Stress**

As regards level of depression, about 52% of the participants had

mild to moderate levels. The general mean indicates a moderate level of depression among the participants. Moderate level of depression is characterized by depressed mood or irritability for most of the day and a lack of interest or pleasure in most activities within a two-week period but does not meet the minimum requirement of 5 of the 7 depressive symptoms of "couldn't experience any positive feeling at all, difficult to work out the initiatives to do things, felt that they had nothing to look forward to, felt down-hearted and blue, unable to become enthusiastic about anything, felt they weren't worth much as a person and felt that life was meaningless, and suicidal thoughts."

As to the level of anxiety, 52% of the participants had severe to extremely severe anxiety, and around 38% had mild to moderate anxiety, and 10.6% had normal anxiety. Taken as a whole, a mean of 16.17 suggests the participants articulated a severe level of anxiety. Livestrong.com described severe anxiety as a condition in which the ability to focus and solve problems is impaired, which can lead to further anxiety when the symptoms cause other symptoms to develop. People with severe anxiety may not even be able to recognize or take care of their own needs and attempts of others to redirect their attention are likely to be unsuccessful. As confirmed by the participants they possibly have experienced severe anxiety symptoms of "difficulty in breathing, dryness of mouth, trembling, worried about situations in which they might panic and make a fool of themselves, felt close to panic, were aware of the actions of their heart in the absence of physical exertion, and felt scared without any reason that could have interfered or even impaired their ability to focus and solve problems.

In terms of level of stress, the majority of the participants had normal stress. However, almost 35% had mild to moderate stress level, and just about 8.7 % had severe stress to extremely severe stress level. As seen in the table, nearly half of the participants acknowledged that they experienced stress symptoms from mild to extremely severe feelings of difficulty to wind down, tendency to overreact to situations, using a lot of nervous energy, getting agitated, difficulty to relax, intolerant of anything that keeps one from getting things done, and feeling irritable"-which may interfere with their daily life and activities, decision making, and problem solving. The other

half of the participants also claimed that they experienced stress at a normal level. On the whole, a general mean of 14.80 indicates that the participants had normal stress levels. This could mean that some were able to cope well with their experiences of stress which could have eventually dissipated as the day passes and continue to respond positively to a the challenges of their everyday life interactions.

Significant Difference in Participants' Extent of Engagement in Risk-Taking Behaviors According to Profile Variables

Table 4
MANOVA Results on the Extent of Engagement in Risk-taking Behaviors by Profile Variables

Variables	Wilks' Lambda	f	Df	Error df	P value	Decision
Sex	.900	83.73	2.0	1142	.000	Reject Ho
Age	.994	3.265	2.0	1142	.039	Reject Ho
Birth order	.997	.816	4.0	2282	.514	Do not Reject Ho
Religion	.997	1.485	2.0	1142	.232	Do not Reject Ho
School	.981	10.81	2.0	1142	.000	Reject Ho

Note. Significant at 0.05 level of significance

There is a significant difference in the extent of engagement in risk-taking behaviors of participants when grouped according to sex, age, and school. However, no significant difference was observed in terms of birth order and religion. The data in Table 5 further support the significant difference in the participants' risk-taking behaviors.

Table 5

Mean Distribution on the Extent of Non-Self-Harm and Self-Harm Risk Behaviors and their Overall Extent of Risk-taking Behavior Engagement when Grouped by Profile Variables

Grouping Variables		Risks Behaviors	Mean	SD
Gender	Male	Non – Self Harm Risk	1.456	.4473
	Female	Behaviors	1.277	.3069
	Male	Self Harm Risk	1.3340	.39667
	Female	Behaviors	1.3550	.44734
Age	17 years old & above	Non – Self Harm Risk	1.389	.3921
	14-16 years	Behaviors	1.332	.3732
	17 years old & above	Self Harm Risk	1.3332	.41584
	14-16 years	Behaviors	1.3858	.43992
School	Public School	Non – Self Harm Risk	.32	.3561
	Private School	Behaviors	1.42	.4056
	Public School	Self Harm Risk	1.32	.42444
	Private School	Behaviors	1.38	.42915

As shown, among gender groups, males had a higher tendency to manifest non-self harm risk behavior than females. In contrast, females were more prone to exhibit self-harm risk behavior than males.

Among age groups, the older participants (17 years old and above) had higher propensity to manifest non-self harm risk behavior than their younger counterparts (14-16 years old). On the contrary, the younger ones had a higher predisposition for self-harm behaviors than the older participants.

When grouped according to school, the participants enrolled in the public school had a higher tendency for non-self harm risk behaviors than those enrolled in the private school. On the other hand, those enrolled in private schools had a higher inclination to self-harm behaviors than those enrolled in the public school.

Comparison of the Participants' Mental Health Status by Profile Variables

Table 6
MANOVA Results of Mental Health Status (Depression, Anxiety, and Stress Levels) by Profile Variables

Variables	Wilks' Lambda	F	df	Error df	p-value	Decision
Sex	.993	4.112	2.0	1142	.017	Reject Ho
Age	.997	1.631	2.0	1142	.196	Do not reject Ho
Birth order	.996	1.155	4.0	2282	.329	Do not reject Ho
Religion	.995	2.984	2.0	1142	.051	Do not reject Ho
School	.999	.431	2.0	1142	.650	Do not reject Ho

A significant difference was observed on the mental health of the participants across sex but was not observed when they are grouped according to age, birth order, religion, and school.

Table 7
Mean and Standard Deviations of Significant Mental Health Status by Sex

Mental Health Constructs	Sex	Mean score	SD	DI
Depression	Male	15.41	7.898	Moderate
	Female	16.99	7.272	Moderate
Anxiety	Male	15.41	7.898	Severe
	Female	16.69	7.272	Extremely severe
Stress	Male	14.51	7.542	Normal
	Female	15.00	7.274	Mild

As shown by Table 7, both males and females had a moderate level of depression. Moreover, a severe level of anxiety is observed

among males while females exhibited an extremely severe level. With regards to their stress level, males were within normal level while females had mild stress level. In general, the means reveal that female participants have a higher level of depression, anxiety, and stress than the males.

It can be construed that both the male and female participants have experienced escalated psychological distress as evidenced by their manifested levels of mental health status with female participants experiencing significantly escalated psychological distress from mild stress to extremely severe anxiety to moderate levels of depression.

The mental health status of the students assessed showed a worrying picture with the female students reporting a higher prevalence of depression than males. Data from the 2008 to 2010 SAMHSA National Survey on Drug Use and Health also revealed that each year, an average of 1.4 million adolescent girls aged between 12 to 17 years suffer from a major depressive episode, which is three times higher than the risk of their male counterparts.

The prevalence of major depression among females may be a secondary outcome of a sex difference in early anxiety. The fact that generalized anxiety disorder and panic disorder often precede depressive episodes in early adolescence suggests that early anxiety may lead to later depression, especially in girls (Parker & Hadzi-Pavlovic, 2001).

Relationship of Risk Behaviors and Mental Health

Table 8

Correlation Between Risk Behaviors (Non-Self-Harm and Self-Harm Risk Behaviors) and Mental Health (Depression, Anxiety, and Stress)

Risk Behaviors	Mental Health					
	Depression		Anxiety		Stress	
	r	p-value	r	p-value	r	p-value
Non self harm	.178 **	.000	.178**	.000	.140**	.000

(table continues)

Table 8 *(continued)*

Self Harm	.344**	.000	.344**	.000	.290**	.000
Total Risk Behaviors	**.309****	**.000**	**.309****	**.000**	**.255****	**.000**

Note.   Correlation is significant at 0.01 level (2 tailed)

The results indicate that there is a significant relationship between risk behaviors and mental health (stress, anxiety, and depression) with the occurrence of risk behaviors in adolescents. The present study suggests that the occurrence of risky behaviors positively and significantly influence mental health (stress, anxiety, and depression) of the participants.

According to Glied and Pine (2002), the mental health status of adolescents relates in various ways. Mental or psychological distress as well as emotional problems may be among the reasons that young people are attracted to risky behaviors, and these problems, in turn, may intensify the risky behaviors. Various mental health problems are also among the possible negative outcomes of some risky behaviors. In a prospective epidemiological study in the United States of diagnosed depression among boys and girls by age, data showed that depression rates begin to increase in the early puberty years and increase across the span of puberty, particularly among girls (Glied and Pine, 2002); thus, rates of increase in depression are higher for girls than for boys. The same is true for rates of overanxious disorder, although this disorder is actually more prevalent at ages 10 to 13. In contrast, conduct problems are more prevalent among boys. These disorders are predictive of a range of risk-taking behaviors. Major depression is predictive of suicide and suicide attempts and possibly substance abuse as well.

Poor mental health can have important effects on the general health and development of adolescents and an association with several health and social outcomes such as higher alcohol, tobacco and illicit substances use, adolescent pregnancy, school dropout, and delinquent behaviors. There is a growing consensus that healthy development during childhood and adolescence contributes to good mental health and can prevent mental health problems.

Because the consequences of mental health problems for adolescents can be severe, understanding trajectories of the development of depression in males and females during adolescence and the factors that influence these trajectories are critical to efforts that aim to prevent the emergence of depression and its debilitating effects on well-being. There is a well-established gender difference in the rates of depressive symptoms and across most of the lifespan, with females showing more depression than males, beginning at some point in adolescence (Nolen-Hoeksema, Larson, & Grayson, 1999; Piccinelli & Wilkinson, 2001).

Regression Model Analysis

The following tables provide an account of the models that were attempted to be estimated in the study. Using the Stepwise method of the Multiple Linear Regression, SPSS was able to generate a model for each mental health indicators, namely, depression, anxiety, and stress.

Table 9
Model Summary for the Three Mental Health Constructs

Model 1	R	R square	Adjusted R	Std. Error of the estimate
Depression	.344a	.118	.117	7.098
Anxiety	.344a	.118	.117	7.098
Stress	.290a	.084	.083	7.071

Note. Predictors: (constant) RBS
Dependent variable: Depression, Anxiety, and Stress

The values for R is 0.344. The result further indicates a significant relationship between RSB and the different mental health indicators. The values of R Square show that RSB accounts for 11.8% of the variation in DEP, 11.8% of the variation in ANX, as well as 8.4% of the variation in STR. These values imply that there are other variables which also have an influence on the three mental health indicators which cannot be explained by the model.

Table 10
ANOVA of Depression, Anxiety Stress and Risk Behaviors

Model	Sum of squares	Df	Mean squares	F	Significance
Depression					
Regression	7718.814	1	7718.814	153.208	.000b
Residual	57585.654	1143	50.381		
Total	**65304.468**	**1144**			
Anxiety					
Regression	7718.814	1	7718.814	153.208	.000b
Residual	57585.654	1143	50.381		
Total	**65304.468**	**1144**			
Stress					
Regression	5234.268	1	5234068	104.666	.000b
Residual	57149.910	1143	50.381		
Total	**62384.178**	**1144**			

Note.   Dependent variable: Depression, Anxiety, Stress
          Predictors: (constant) Risk Behaviors

As shown, the F values for the models are significant. These means that the correlations between RSB and DEP; RSB and ANX; RSB and STR are significant. They also mean that the regression models predict the mental health of the participants significantly well.

Table 11
Coefficients of the Models

Model	Unstandardized Coefficients		t	p-value
	B	Std error		
Constant	7.986	.694	11.514	.000
DEP/ RBS	6.077	.491	12.376	.000
Constant	7.986	.694	11.514	.000
ANX/ RBS	6.077	.491	12.376	.000
Constant	8.066	.691	11.674	.000
STR/ RBS	5.004	.489	10.232	.000

The coefficients of 6.077 for the RBS variable means that the participants' depression is predicted to increase by 6.077 for every increase in their RBS. The same coefficient value holds true for the RBS variable in predicting the increase of the participants' ANX. In terms of the level of STR, it increases by 5.004 for every unit of increase in RBS. The t-test confirms these in the Coefficients table where the t-statistics for the predictor variable are significant, p values of .000 are less than 0.005.

CONCLUSION

The study concluded that adolescent male and female senior high school students engaged themselves in risk behaviors on one occasion of their lives in which non-self-harm risk behaviors are more common among the male participants and self-harm risk behaviors are more prevalent among the female participants. The 17 years old particularly are indicating a vulnerable age. Students attending private schools are more likely to engage in negative risk behaviors than their counterpart in the public schools. It indicates that studying in a private school does not spare them from engaging in negative risk behaviors. The participants experienced escalating mental health problems at different levels from normal stress to severe anxiety to moderate depression, with the females experiencing more mental health symptoms. Furthermore, risk behaviors and mental health are related in which risk behavior is a significant risk factor for mental health or may also be the reason for various risk behaviors seen in adolescents.

RECOMMENDATIONS

Based on the findings and conclusion drawn, the following recommendations are offered:

School administrators may consider strengthening their school-based wellness program by including mental health and psychological resilience activities.

Guidance counselors may intensify awareness campaigns on mental health issues by conducting growth sessions and symposiums.

Teachers may allocate some of their time to observe students with specific needs and behaviors so they can refer these students for guidance, counselling, and specialized help.

Discipline chairs may strengthen the rules and policies concerning students engaging in risky behaviors.

Parents may establish a strong connection with their children by monitoring their activities and being very observant about changes that occur in their children's behavior.

Students may enhance their problem-solving and decision-making skills by actively participating in different mental health awareness programs.

References

Ahern, N. R. (2006). Adolescent resilience: An evolutionary concept analysis. *Journal of Pediatric Nursing, 21*(3), 175-185.

Byrne, D. G., Davenport, S. C., & Mazanov, J. (2007). Profiles of adolescent stress: The development of the adolescent stress questionnaire (ASQ). *Journal of Adolescence, 30*(3), 393-416.

Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/

Fergus, S., & Zimmerman, M. A. (2005). Adolescent resilience: A framework for understanding healthy development in the face of risk. *Annual Review of Public Health, 26*, 399-419.

Glied S., & Pine D. S. (2002) Consequences and correlates of adolescent depression. *Arch Pediatr Adolesc Med., 156*(10), 1009–1014. doi:10.1001/archpedi.156.10.1009

Gullone, E., Moore, S., Moss, S., & Boyd, C. (2000). The adolescent risk-taking questionnaire: Development and psychometric evaluation. *Journal of Adolescent Research, 15*, 231–250. https://doi.org/10.1521/pedi.15.4.300.19186

Ness, M. (2013). Happiness, daily stress and resilience in adolescents. Norwegian University of Science and Technology. Retrieved from https://brage.bibsys.no/ xmlui/bitstream/ handle/ 11250/268005/728834_FULLTEXT01.pdf?sequence=1

Nolen-Hoeksema, S., Larson, J., & Grayson, C. (1999). Explaining the gender difference in depressive symptoms. *Journal of Personality and Social Psychology, 77*(5), 1061-1072. http://dx.doi.org/10.1037/0022-3514.77.5.1061

Norton, P.J. (2007).Depression anxiety and stress scales (DASS-21): Psychometric analysis across four racial groups. *Anxiety Stress Coping, 20*(3), 253-265.

Parker, G., & Hadzi-Pavlovic, D. (2001). A Question of Style: Refining the Dimensions of Personality Disorder Style. *Journal of Personality Disorders, 15*(4), 300-318.

Piccinelli, M., & Wilkinson, G. (2001). Gender differences in depression: Critical review. https://doi.org/10.1192/bjp.177.6.486

Vrouva, I., Fonagy, P., Fearon, P. R. M., & Roussow, T. (2010). The risk-taking and self-harm inventory for adolescents: Development and psychometric evaluation. Psychological Assessment, 22(4), 852-865. Retrieved from http://dx.doi.org/10.1037/a0020583

World Health Organization. (2014). Mental health: A state of well-being.World Health Organization website. Retrieved from http://www.who.int/features/factfiles/mental_health/en/