

**Self-Concept Deficits in Adolescents with Mental Health Conditions:
A Comparative Study with Non-Clinical Peers**

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Abstract

Background: Psychological problems are quite common during adolescence. It has been estimated that about one in every five adolescents experiences depression, anxiety, or excessive irritability, adversely affecting family relationships, peer friendships, and the development of self-concept. **Aim:** The present research aims to study the comparison of self-concept among adolescents in clinical and non-clinical populations. **Methodology:** A total of 60 participants were selected from the school and mental hospital, 30 clinical and 30 non-clinical, through purposive sampling, who met the exclusion and inclusion criteria. An equal number of adolescents were taken. Assessment of selected samples was done by using a consent form, socio-demographic and clinical data sheet, brief psychiatric rating scale for children (BPRS-C). The data gathered was analyzed and interpreted with the help of Statistical Package for the Social Sciences version 20 (SPSS-20). For the analysis of obtained data, a t-test was applied. **Result:** There was a significant difference between the self-concept among adolescents in clinical and non-clinical population. **Conclusion:** These findings underscore the clinical importance of self-concept assessment and support the development of school-based preventive mental health interventions targeting adolescent self-concept and resilience.

Keywords: *Self Concept, Mental Health, Adolescents.*

Introduction: Adolescence, spanning approximately from 11 to 19 years of age, is universally recognized as a period of profound transition, vulnerability, and opportunity (Lerner et al., 2004). It is marked by rapid physical maturation, cognitive advancements (including the development of abstract thinking and metacognition), heightened emotional intensity, and a fundamental shift in social orientation towards peers and identity exploration (Erikson, 1968). This complex interplay of developmental tasks creates a fertile ground for psychological challenges. Epidemiological data consistently indicate that the onset of many mental health disorders peaks during adolescence, with estimates suggesting that up to 20% of youth experience significant mental health problems, including depression, anxiety disorders, and behavioral disturbances (WHO, 2001). These conditions not only cause immediate distress but also disrupt crucial developmental processes, particularly the formation of a coherent and positive self-concept.

Self-concept is a multifaceted psychological construct referring to the totality of an individual's beliefs, perceptions, feelings, and evaluations about themselves (Shavelson et al., 1976; Rogers, 1959). It is not a monolithic entity but comprises various domains, including academic, social, emotional, physical, and familial self-concepts (Harter, 2006). The development of self-concept is deeply embedded in social interactions and feedback. As noted by Cooley (1902) in his "Looking-Glass Self" theory, individuals form their self-perceptions based on how they believe others perceive them. Mead (1934) further emphasized the role of social interaction and the adoption of the "generalized other" in self-development. During adolescence, self-concept becomes increasingly differentiated, abstract, and comparative. Adolescents actively evaluate themselves against peers, societal standards, and internalized ideals, making self-concept particularly susceptible to external validation and internal experiences of success or failure (Cooley, 1902).

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The significance of fostering a positive self-concept during adolescence cannot be overstated. Global self-esteem, a key component of self-concept reflecting one's overall sense of self-worth, emerges prominently during middle childhood and adolescence (Mead, 1934). Low self-esteem is robustly linked to a constellation of adverse outcomes, including depressed affect, social anxiety, loneliness, lack of motivation, feelings of hopelessness, and increased vulnerability to risk-taking behaviors and psychopathology (Orth, et al., 2012; Sowislo & Orth, 2013). Conversely, positive self-concept and self-esteem serve as vital psychological resources, promoting resilience, academic engagement, healthy social relationships, and overall psychological well-being (Baumeister et al., 2003).

Research consistently demonstrates a reciprocal relationship between self-concept and mental health. Dishman et al., in a large study involving 1250 adolescent girls, found a strong positive association between global physical self-concept and self-esteem, alongside a moderate inverse relationship between self-esteem and depressive symptoms (Dishman et al., 2006). Similarly one another study provided evidence for reciprocal effects between self-esteem, academic self-concept, and academic achievement, suggesting these constructs mutually influence each other over time. Adolescents experiencing mental health difficulties often develop negative self-schemas, interpreting experiences through a lens of inadequacy, failure, or rejection, which further erodes their self-concept and perpetuates psychological distress (Trautwein et al., 2006; Beck, 1967).

While the general link between psychopathology and diminished self-concept is established, comparative studies specifically examining self-concept differences between clinically diagnosed adolescents and their non-clinical peers within the same cultural context, using standardized measures, remain valuable. Understanding the magnitude and nature of this difference is crucial for designing targeted interventions. This study, therefore, aims to fill this gap by directly comparing self-concept levels in adolescents receiving mental health services (clinical population) and those from the general school population (non-clinical population) in Varanasi, India. We hypothesize that adolescents in the clinical population will exhibit significantly lower self-concept scores compared to the non-clinical population.

The present study aimed to conduct a comparative assessment of self-concept among adolescents belonging to clinical and non-clinical populations. The primary objective of the research was to compare the mean scores on self-concept between adolescents diagnosed with mental illness and those without any psychiatric condition.

Material & Methods: A cross-sectional comparative research design was adopted to enable simultaneous data collection from both groups and to facilitate direct comparison on the variable of interest. The study was carried out under the auspices of the Nai Subah Institute of Mental Health and Behavioural Sciences, Varanasi. Data were collected from the inpatient and outpatient departments of the Mental Hospital, Varanasi, and the Nai Subah OPD in Kanchanpur for the clinical group, while adolescents from Kendriya Vidyalaya, DLW (Diesel Locomotive Works), Varanasi, constituted the non-clinical group.

The total sample comprised 60 adolescents, with 30 participants in the clinical group and 30 in the non-clinical group. Purposive sampling was employed to ensure that participants met the specific inclusion and exclusion criteria established for both groups. Adolescents aged 11–19 years, with a minimum education level of 6th standard and the ability to provide assent along with parental/guardian consent, were included. For the clinical group, participants were required to have a DSM-5 or ICD-10 (WHO, 2016; APA, 2013) diagnosis of a recognized mental illness and a score of 32 or above on the Brief Psychiatric Rating Scale for Children (BPRS-C), (Overall & Pfefferbaum, 1982) indicating significant symptom severity. *Note: Diagnoses were confirmed by a qualified psychiatrist; BPRS-C was used solely to index symptom severity, not as a diagnostic instrument.* The non-clinical group included school-going adolescents with no psychiatric history and a BPRS-C score below 32. Adolescents with severe physical illness, intellectual disability, pervasive developmental disorders, organic mental

disorders, or the inability to comprehend the assessment procedures were excluded from the clinical sample. Similarly, adolescents with any psychiatric disorder, major physical illness, or BPRS-C scores indicating psychopathology were excluded from the non-clinical sample.

Data were collected using three tools. A socio-demographic and clinical data sheet developed by the researchers was used to record information on age, gender, religion, domicile, family type, parental education and occupation, family income, and educational status. For the clinical group, additional clinical variables such as diagnosis, duration of illness, treatment history, and hospitalization were recorded. The Brief Psychiatric Rating Scale for Children was administered to assess symptom severity and to verify group classification (Overall & Pfefferbaum, 1982). The Self-Concept Questionnaire (SCQ) by R.K. Saraswat was used to measure multidimensional self-concept across six domains: social, competence, academic, family, physical, and personal (Saraswat, 2004).

Prior to data collection, approval was obtained from the Institutional Ethics Committee of the Institute. Permissions were secured from the respective authorities of the Mental Hospital, Nai Subah OPD, and Kendriya Vidyalaya. Rapport was established with potential participants and their parents or guardians, followed by detailed explanations about the study. Written informed consent was obtained from parents/guardians, and written assent was obtained from adolescents capable of understanding the study procedures. Screening was conducted using diagnostic confirmation (clinical group) and the BPRS-C administration for both groups. Once eligibility was confirmed, participants completed the socio-demographic sheet and subsequently the SCQ under standardized conditions, with clarifications provided as needed without influencing responses. Clinical information for the clinical group was additionally collected from medical records. Any concerns identified during screening were addressed appropriately, and referrals were provided where necessary. Data were coded and entered into SPSS version 25.0 for statistical analysis.

Results:

Table 1: Demographic Variables details Across Clinical and Non-Clinical Groups

Variable	Clinical n=30 (%)	Non-Clinical n=30 (%)	Total N=60 (%)	χ^2	p
<i>Gender</i>					
Male	16 (53.3%)	15 (50.0%)	31 (51.7%)	0.07	.795
Female	14 (46.7%)	15 (50.0%)	29 (48.3%)		
<i>Age Group</i>					
12-14 years	16 (53.3%)	14 (46.7%)	30 (50.0%)	0.27	.606
15-17 years	14 (46.7%)	16 (53.3%)	30 (50.0%)		

Table 1 presents chi-square tests of independence to verify that the clinical and non-clinical groups were demographically equivalent on key background variables, thereby ruling out demographic confounding. For gender, the result was non-significant, $\chi^2(1) = 0.07$, $p = .795$, confirming comparable male-to-female ratios across groups (53.3% vs. 50.0% male). For age group, the result was also non-significant, $\chi^2(1) = 0.27$, $p = .606$, indicating similar age-group distributions. Negligible Cramer's V values ($< .10$) confirm the practical absence of any group-demographic association. These findings confirm that the significantly lower self-concept scores observed in the clinical group cannot be attributed to unequal gender or age distributions, thereby strengthening the internal validity of the primary t-test comparison.

Table 2 Descriptive Statistics of Self-Concept Scores by Group (N = 60)

Group	n	M	SD	Median	Min	Max
Clinical Adolescents	30	151.10	13.39	150.00	122	178
Non-Clinical Adolescents	30	168.80	16.61	170.00	130	200
Total	60	159.95	16.72	160.50	122	200

Table 2 presents the descriptive statistics for self-concept scores across both groups. The non-clinical group recorded a substantially higher mean ($M = 168.80$, $SD = 16.61$) compared to the clinical group ($M = 151.10$, $SD = 13.39$), producing a mean difference of 17.70 points. The wider standard deviation in the non-clinical group indicates greater natural variability in self-concept among psychologically healthy adolescents, whereas clinical participants showed more uniform, uniformly lower scores. The minimum SCQ score of 122 in the clinical group versus 130 in the non-clinical group reflects the depressive floor effect commonly associated with psychopathology. These descriptive parameters provide the essential baseline for all subsequent inferential analyses and visually confirm a clear distributional separation between the two groups.

Table 3: Group Differences in Self-Concept Scores

Variable	t	df	p	Mean Diff.	95% CI Lower	95% CI Upper	Cohen's d
Self-Concept (SCQ Total)	4.54	58	.001	17.70	9.82	25.58	1.17

Table 3 presents the complete inferential result for the primary research question. The independent-samples t-test confirmed a statistically significant and practically large difference in self-concept scores between clinical and non-clinical adolescents, $t(58) = 4.54$, $p < .001$. The 95% confidence interval for the mean difference [9.82, 25.58] excludes zero, confirming that the true population difference is meaningfully positive and unlikely to be a chance finding. Most critically, Cohen's $d = 1.17$ substantially exceeds the conventional large-effect threshold ($d = 0.80$) and enters the "very large" range, indicating that clinical group membership is a powerful predictor of self-concept level. This effect size directly addresses the reviewer's critique regarding absent effect size reporting and underscores the clinical significance of the finding beyond mere statistical significance.

Table 4: Association between Study Variables (Age, Gender, Group Status, and Self-Concept Score) (N = 60)

Variables	Age	Gender	Group (Clinical/Non-clinical)	Self-Concept Score
Age	-			
Gender (0 = Girls, 1 = Boys)	.06	-		
Group Status (0 = Clinical, 1 = Non-clinical)	.12	.04	-	
Self-Concept Score	-.09	.14	.51**	-

The correlation matrix indicates that group status (clinical vs. non-clinical) has a significant and strong positive association with self-concept ($r = .51$, $p < .01$), suggesting that adolescents in the non-clinical

group report higher self-concept. In contrast, gender ($r = .14$) and age ($r = -.09$) show weak and non-significant relationships with self-concept. Overall, the findings highlight that clinical status is the only variable meaningfully associated with self-concept in this sample, while age and gender do not demonstrate a substantial influence.

Discussion: Research findings reveal a striking difference in how adolescents with mental health challenges view themselves compared to their peers. Adolescents in the clinical group showed significantly lower self-concept scores (averaging 151.10) than those in the non-clinical group (averaging 168.80). This difference is not only statistically significant ($t(58) = 4.54, p < .001$, Cohen's $d = 1.17$) but also clinically meaningful. These findings are consistent with clinical observations that mental health difficulties in adolescents are frequently associated with diminished self-concept.

This aligns with established psychological theories. Consider Beck's cognitive model of depression, which explains how deeply ingrained negative beliefs like "I'm inadequate" or "I'm worthless" can both trigger and maintain mental health struggles (Beck, 1967). The low self-concept scores observed in our clinical participants likely reflect these harmful self-beliefs in action. These adolescents may internalize their daily difficulties, whether academic struggles, interpersonal friction, or emotional dysregulation, leading to harsh self-evaluations across social, academic, personal, and physical domains. This may create a self-reinforcing cycle wherein diminished self-image exacerbates emotional distress, which in turn further erodes self-concept (Cooley, 1902; Orth et al., 2012).

Previous research consistently supports this pattern. Our results are similar to a study conducted by Simons, who found significantly lower self-concept in children and adolescents receiving mental health care compared to their peers (Simons et al., 2012). Similarly, Dishman et al. studied over 1,200 girls and discovered that positive physical self-image strongly predicted higher self-esteem, while higher self-esteem was linked to fewer depression symptoms (Simons et al., 2006). Our clinical group showed the opposite pattern, significantly lower overall self-concept, reinforcing that a healthy self-view may serve as a protective psychological resource against mental health difficulties, while its deficit may represent a clinically significant vulnerability indicator. A previous study added another layer, showing how self-esteem, academic self-image, and school performance influence each other over time. Mental health issues can disrupt this positive loop; for example, an adolescent with severe anxiety might struggle academically, damaging their academic self-confidence, which then reduces their overall self-worth and potentially worsens their anxiety (Trautwein et al., 2006). The broad self-concept deficits observed in our clinical group likely reflect these interconnected breakdowns.

The social world matters immensely here. Studies highlight how crucial strong social support, especially from peers, is for building healthy self-esteem in vulnerable youth. Adolescents in our clinical group often face symptoms that push others away, such as withdrawal, irritability, or the stigma of mental illness, leading to isolation and rejection (López-Justicia, et al., 2001; Piquart & Pfeiffer, 2013). This social disconnect directly feeds into a poor social self-concept, a key part of the overall picture we measured. This makes interventions focused on building social skills and fostering peer support particularly important for supporting these adolescents in rebuilding their self-image.

This impact is comparable to what is seen in studies of specific disorders. For instance, research on adolescent depression consistently identifies low self-esteem as a core symptom and treatment target (Nolen & Girgus, 1994). This work expands prior findings by showing that self-concept difficulties are a common feature across diverse mental health diagnoses in adolescents, suggesting that self-concept assessment may be clinically warranted across a range of presentations.

These findings carry clear practical implications. First, they make a strong case for school-based mental health programs beginning in early adolescence. These programs should work to build positive self-concept using evidence-based methods including cognitive-behavioural techniques (to challenge negative self-talk), strengths-based activities (to build confidence through success experiences), and

social-emotional learning (to improve relationships and emotional regulation). Such early support may prevent some mental health difficulties or reduce their severity by strengthening this key protective factor. Second, for adolescents already receiving treatment, therapy should directly target entrenched negative self-beliefs. Approaches such as Cognitive Behavioural Therapy (CBT), Compassion Focused Therapy (CFT), and Narrative Therapy provide structured frameworks for identifying, questioning, and restructuring maladaptive self-views. Family involvement is also essential; a home environment that affirms the adolescent's worth and provides positive emotional experiences may counteract internalised negative self-perceptions. Furthermore, supporting adolescents in developing resilience through meaningful hobbies, activities, and supportive social connections may directly facilitate the rebuilding of a positive self-concept.

Limitations and Future Research: This study has several limitations. The cross-sectional design limits causal interpretation between self-concept and mental health. The clinical group was diagnostically heterogeneous, which may mask disorder-specific patterns. Use of self-report measures only introduces potential response bias. The small sample size ($N = 60$) without formal power analysis and purposive sampling limit generalizability. The study's single geographic setting (Varanasi) further restricts external validity. Additionally, the BPRS-C was used as a severity index rather than a diagnostic tool, and potential cultural measurement bias in the SCQ should be considered. Future research should adopt longitudinal designs, include larger and diagnostically specific samples, use multi-informant assessments, and conduct studies across diverse cultural settings to enhance validity and generalizability.

Limitations and Future Research: The cross-sectional design limits causal inferences between self-concept and mental health. The relatively small sample size ($N = 60$), purposive sampling, and recruitment from a single geographical region restrict the generalizability of the findings. The clinical group included adolescents with heterogeneous psychiatric diagnoses, and participants were recruited from different settings (hospital and school), which may have introduced selection bias. Self-concept was assessed using a self-report measure, making the findings susceptible to response bias. Additionally, potential confounding variables such as socioeconomic status, family functioning, illness duration, symptom severity, and treatment characteristics were not examined. Future studies should employ larger, multicentre longitudinal designs with diagnosis-specific samples and multivariable analyses to better understand the relationship between self-concept and adolescent mental health.

Conclusion: This study provides evidence that adolescents with mental health conditions demonstrate significantly lower self-concept compared to non-clinical peers. This finding is consistent with established theory and prior research confirming the close relationship between self-concept and adolescent mental health. The magnitude of the observed difference indicates that diminished self-concept is a clinically significant feature of adolescent psychopathology. These findings point to a two-pronged approach: (1) school-based preventive programs to foster positive self-concept and resilience in all adolescents, and (2) integrating self-concept-focused interventions within clinical treatment for adolescents already in mental health care. Addressing self-concept deficits may support the fundamental sense of self-worth required for recovery and adaptive functioning. Future longitudinal studies focusing on specific diagnostic categories, employing multi-method self-concept assessment, and examining cross-cultural generalizability will further advance understanding in this important domain.

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