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Review article

# Building a Sustainable Mental Health Support System for Nigerian Youth: A School-Based Intervention

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## Abstract

Youth-focused interventions to improve the mental health awareness and mental health seeking behaviour among the population have been relatively scarce. This study therefore explored the improvement in mental health literacy, resilience, coping strategies and overall mental wellbeing of undergraduates through a youth-driven multifaceted mental health intervention. A pre and post intervention study between 2023 and 2024 was conducted among the undergraduates of the University of Ilorin. This was followed by a comprehensive training on overall mental health promotion and mental disorders, establishment of a safe space for early intervention of minor mental illnesses, campus radio program and sensitization outreaches and; monitoring. Both baseline and endline data were collected using semi-structured questionnaires and interviews. Secondary data was also collected from the on-campus mental health safe space using the WHO-5 Well Being Index, Brief COPE (Coping Orientation to Problems Experienced Inventory), Social Connectedness Scale, Emotional Regulation and Resilience Measure. The quantitative data were analyzed for frequency of occurrence and inferential statistics. The information from the exit interviews were transcribed and analyzed for themes and contents. A total of 42 students were trained as peer supporters and curators. A total of 919 out of 2282 clients with a mean age of 20.7 ± 2.3 years recorded at the mental health safe space completed at least 4 visits. Majority of the clients (63.6%) were females. Comparison of the baseline and endline survey findings showed significant changes in knowledge and behavioural responses about mental illness as a result of the intervention. The results showed significant improvement in the mental health wellbeing and resilience of the clients. There was significant demonstration of improved coping skills, increased help seeking behaviour and utilization of positive coping strategies by the clients. The peer to peer model of youth mental health intervention showed remarkable positive outcomes over the implementation timeframe. The evaluation demonstrated the potential for sustainability with more efforts and further intervention.

**Keywords:** Mental Health Intervention, Behavioural Responses, Mental Well Being, Peer Support

## Introduction

It is widely accepted that mental health and mental well-being are critical to a happy, satisfactory and meaningful life [1]. The reason being that mental health plays an integral part of health and well-being. According to the WHO [2], mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

Globally, there is increase in the prevalence of mental disorder among children and young people [3]. Additionally, it is estimated that 50% of adults with disorders experienced them prior to age 15 [4]. There is also an increasing awareness of mental illness as a significant cause of morbidity throughout the world. Mental and behavioural disorders are common, affecting more lives. [5].

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From the history, certain medical conditions (e.g. mental illness, physical disabilities, developmental disability) were isolated from mainstream society. Stigma, detracting stereotypes, and negative attitudes toward medical conditions are a major impediment in the provision of healthcare, with research showing that such attitudes can have a direct impact on patients' well-being and the type of health care they receive.

Studies on knowledge, attitudes and perceptions toward mental health disorders have been conducted in various countries. A cross-sectional study among medical undergraduates [6] reported considerable low knowledge and negative attitudes towards mental disorders among young people, especially in the early years of education. Many young people with mental health problems refuse to seek help because of stigma and leave the problem untreated. Previous research suggests that contact interventions with education could improve the stigma of mental illness in young people, thereby encouraging help-seeking in distress [7]. Research on interventions to improve the mental health awareness and improve mental health seeking behaviour among youth has been relatively scarce [8]. To address this, it is important to pay attention to promotion and prevention practice, with schools being well-placed to deliver. This is because of the amount of time young people spend in this environment [9]. Some interventions aimed to increase the mental health literacy of young people through the school setting [8], [10]. However, there is no standardisation of mental health education in schools. Also, there are interventions which train people, including those who can support young people, in mental health early interventions [11]. Despite the limitations of the evidence, it is clear that mental health literacy and coping strategies can be improved through planned interventions using the school setting.

### Pre-Intervention

The baseline survey [12] conducted with the intervention population showed a generally good knowledge, positive attitudes and perceptions toward mental illness in the study but with some stigmatizing tendencies towards persons with mental illness and relatively poor mental health seeking behaviour.

### Intervention

Following the baseline survey, a set of evidence-based interventions were implemented in the project site. These interventions were divided into three components:

#### *Peer Support System (PSS)*

This system is made up of students trained with basic knowledge of mental health and provided non-clinical Mental Health and Psychosocial Support (MHPSS) information and services to students as peer supporters. These were also trained to provide early intervention to students experiencing minor mental health symptoms within departments and hostels of the University community.

#### *Campus Support System (CSS)*

This system provided a safe space where more structured non-clinical MHPSS therapy was provided to students within a friendly, confidential and non-judgmental environment.

#### *Remote Support System (RSS)*

This system consisted of:

1. A 24/7 toll-free line for mental health counselling,

2. Twenty episodes of one-hour live mental health radio program tagged *'Healthy Mind Hour'* where mental health topical issues were discussed by experts drawn from the University departments of Psychology, Psychiatry Nursing, Counseling and Health Promotion; and

3. An introductory mental health 5-Module e-course with the objective of familiarizing students or trainees with issues relating to mental health, mental fitness, self care and recognizing risk factors in mental health.

### Post-Intervention

This endline study targeted the analysis of post-intervention data and evaluates if interventions were adequate and achieved desired objectives. It also established the magnitude of impact of the project interventions. Similarly, the survey evaluated the changes in knowledge, contact experiences and behavioural responses about mental illness as a result of this intervention.

This report therefore presents the estimates of key project indicators that were measured at baseline (2023) and endline (2024), providing a summary assessment of significant changes that occurred in knowledge and practice among the target population. The endline further explored the improvement in mental health literacy, resilience, coping strategies and overall mental wellbeing.

## Methods

### Study Design and Setting

This was a cross-sectional descriptive study carried out within the University of Ilorin located at about 10 miles away from the city centre.

### Study Population and Sample Size

The study population consisted of the undergraduates of

the University of Ilorin admitted in the 15 faculties of the university.

### Study Instruments

A self-administered, semi-structured questionnaire was used for the survey. There were a total of 22 questions and these were divided into six sections. The 5-question structured exit interview guide also contained an introduction of the researcher and full disclosure of the research, ethical considerations as well as request for consent.

### Data Collection

The validated semi-structured questionnaire was administered to the students within the faculties while the exit interview was administered to the students who had accessed the mental health interventions highlighted above. Participants who were unwilling to participate were exempted from the survey. There was a 100% return rate. Also, secondary data was collected using the service provision forms of all clients who had completed at least 4 visits to the mental health safe space on campus.

### Statistical Analysis

Information gathered from the questionnaire was cleaned and coded for data entry. It was then entered and analyzed using IBM SPSS software version 29.0. The quantitative data were analyzed for frequency of occurrence. Both descriptive (means and standard deviations) and inferential (Paired sampled t-test) statistics were used to analyze the data. For the statistical analysis, a p-value less than 0.05 were considered statistically significant. The information from the structured interviews were transcribed verbatim and analyzed for themes and contents.

### Ethical Considerations

Approval was obtained from the University Ethical Review Committee to conduct the interventions. The respondents were anonymous; this was done to ensure confidentiality and verbal informed consent was obtained from each of the respondent. This research did not in any way inflict harm on the respondents and every respondent was treated equally as much as possible. Respondents who refused to participate in the study were not coerced into the study.

## Results

### Findings from Questionaire

#### *Socio-demographic Information*

Age, sex, marital status and educational class level of respondents were some of the key background variables collected from respondents at both baseline and endline. The endline survey identified more females in the age group (between 20-24 years) than the baseline.

**Table 1,** *Socio-demographic data of respondents*

| Socio-demographic variable | Baseline (%) | Endline (%) |
|---|---|---|
| **Age** | | |
| 15 - 19 years | 42.2 | 19.1 |
| 20 - 24 years | 52.4 | 72.3 |
| 25 years and above | 5.3 | 8.5 |
| Mean | 20.4 | 21.3 |
| SD | 2.4 | 2.5 |
| **Sex** | | |
| Male | 46.9 | 29.8 |
| Female | 53.1 | 70.2 |
| **Marital Status** | | |
| Single | 98.9 | 97.9 |
| Married | 0.9 | 2.1 |
| Separated | 0.2 | 0 |
| **Class level** | | |
| 100 level | 40.0 | 2.1 |
| 200 level | 24.0 | 29.8 |
| 300 level | 16.4 | 44.7 |
| 400 level | 15.1 | 23.4 |
| 500 level | 3.8 | 0 |
| 600 level | 0.7 | 0 |

### *Knowledge about Mental illness*

Knowledge score for mental illness was calculated for each respondent using a 20-point knowledge scale. Each correct answer had a score of 4 and an incorrect answer or a no response had a score of 0. The scores were then summed up to give a composite knowledge score for each respondent. The higher the score, the higher the knowledge and vice versa.

The mean knowledge score for mental illness was 18.9 ± 2.3 which is indicative of an overall good knowledge about mental illness.

**Table 2,** *Knowledge on the causes of Mental Illness*

| Causes of Mental Illness | Baseline (%) | Endline (%) |
|---|---|---|
| Heredity | 61.8 | 83.0 |
| Head injury | 75.3 | 95.7 |
| Substance use | 89.8 | 100.0 |
| Stress | 84.0 | 95.7 |
| Traumatic events or shock | 91.6 | 100.0 |

**Table 3**. *Knowledge about Mental Illness*

| Variable | Baseline (%) | Endline (%) |
|---|---|---|
| **Knowledge score for mental illness** | | |
| 0 – 7 (Poor) | 2.2 | 0 |
| 8 - 14 (Fair) | 28.4 | 6.4 |
| 15 – 22 (Good) | 69.3 | 93.6 |

### *Attitude towards Mental Illness*

The attitudinal score was calculated for each respondent using a 15-point attitudinal scale. Each positive attitudinal response had a score of 3 while a negative attitudinal response or a no response had a score of 0. The scores were then summed up to give a composite attitudinal score for each respondent. The higher the score, the more positive the attitude; conversely, the lower the score, the more negative the attitude. The mean attitudinal score of respondents was 9.0 ± 3.6 which is indicative of an overall positive attitude towards mental illness.

**Table 4.** *Attitude towards Mental Illness*

| Variables | Baseline | | Endline | |
|---|---|---|---|---|
| | Agree | Disagree | Agree | Disagree |
| People with mental illness might attack someone | 54.4% | 6.9% | 72.3 | 27.7 |
| Mental illness is contagious | 10.0% | 25.8% | 29.8 | 70.2 |
| People with mental illnesses can help others | 16.0% | 17.1% | 36.2 | 63.8 |
| Only people who are weak and overly sensitive let themselves be affected by mental illnesses | 12.2% | 50.4% | 14.9 | 85.1 |
| Students with mental illnesses should not be in regular classes | 26.2% | 22.4% | 19.1 | 80.9 |

### *Perception about Mental Illness*

The perception score was calculated for each respondent using a 10-point scale. Each positive perception response had a score of 2 while a negative attitudinal response or a no response had a score of 0. The scores were then summed up to give a composite perception score for each respondent. The higher the score, the more positive the perception; conversely, the lower the score, the more negative the perception. A score of 0 to 5 was categorized as a negative perception while a score of 6 to10 was categorized as a positive perception score. The mean perception score at endline was 8.5 ± 2.1 (Baseline = 6.6 ± 1.7) which is indicative of an overall positive perception about mental illness. Table 5 illustrates the perception of respondents about mental illness.

**Table 5.** *Respondents' Perception about Mental Illness*

| Variables | Baseline | | Endline | |
|---|---|---|---|---|
| | Agree | Disagree | Agree | Disagree |
| People with mental health are to be blamed for their conditions | 3.3% | 89.6% | 4.3% | 95.7% |
| People with mental illnesses are dangerous | 35.3% | 37.1% | 19.1% | 80.9% |

| | | | | |
|---|---|---|---|---|
| People with mental illness usually need medication | 74.7% | 15.8% | 42.6% | 57.4% |
| People with mental illness are often of lower intelligence | 10.4% | 78.7% | 6.4% | 93.6% |
| People with mental illness cannot be successful in life | 4.9% | 86.4% | 2.1% | 97.9% |
| **Perception Score**<br>0 - 5 (negative)<br>6 - 10 (positive) | 24.7%<br>75.3% | | 4.3%<br>95.7% | |

### *Mental Health Wellness and Self Care*

Tables 6 illustrate the full details of the mental wellness and social connectedness of the respondents.

**Table 6.** *Mental Wellness and Social Connectedness*

| Variable | Baseline (%) | Endline (%) |
|---|---|---|
| **Sleeping Habit** | | |
| 8 hours | 14.9 | 4.3 |
| Below 8 hours | 79.6 | 70.2 |
| Above 8 hours | 4.2 | 25.5 |
| **Eating Habit** | | |
| At least 3 meals per day | 43.1 | 34.0 |
| Skip meals | 46.0 | 53.2 |
| Not always hungry | 9.8 | 10.6 |
| **Doing well in studies** | | |
| Yes | 34.4 | 53.2 |
| Need to improve | 63.3 | 46.8 |
| **Social connectedness** | | |
| Have friends | 84.0 | 87.2 |
| Lone ranger | 13.6 | 12.8 |

## Findings from Service Delivery Data

Findings from the secondary data showed clients' age ranged from 16 to 36 years with a mean age of 20.7 ± 2.3 years with the majority of the clients in the age group 20 to 24 years (61.2%). Majority of the clients (63.6%) were females. A total of 919 out of 2282 completed 4 visits at the mental health safe space provided (details in methodology).

### *Mental Well Being Analysis using the WHO - 5 Index*

Improvement in the mental health wellbeing was collated at first and fourth contacts for 910 clients in the reporting period. The level of mental health wellbeing improvement was determined using the Paired Sample T-test. The results showed significant improvement in the mental health wellbeing of the clients: First contact *(mean = 15.14, SD = 5.15)* to Fourth contact *(mean = 22.85, SD = 2.44), t = 39.86, p<.001(two-tailed).* The mean increase in the test scores was 7.708 with a 95% confidence interval ranging from 7.32 to 8.08.

### *Measurement of Mental Health Seeking Behaviour and Utilization of Coping Strategies*

Using the Brief COPE (Coping Orientation to Problems Experienced Inventory) scoring scale [13], the analysis below depicts demonstration of improved coping skills, increased help seeking behaviour and utilization of positive coping strategies for the clients. Overall level of improvement in coping skills and utilization strategies was determined using the Paired Sample T-test of the Brief- COPE assessment data collated at first and fourth contacts for 918 clients. The results showed significant improvement in the positive coping skills strategies of the clients: First contact *(mean = 66.66, SD = 12.13)* to Fourth contact *(mean = 88.24, SD = 5.74), t = 50.42, p<.001(two-tailed).* The mean increase in the test scores was 21.58 with a 95% confidence interval ranging from 20.74 to 22.42. The analysis showed a significant difference in the coping skills and strategies.

*Problem-Focused Coping*

The mean score for the problem-focused coping strategy utilized by the clients was 22.55 ± 5.35 on the scale of 8

to 32 indicative of psychological strength, grit, a practical approach to problem solving. The analysis showed that clients utilized coping strategies that are aimed at changing the stressful situation.

*Emotion-Focused Coping*

The mean score for the emotion-focused coping strategy utilized by the clients was 29.86 ± 6.49 on the scale of 12 to 48 which indicated that clients utilized coping strategies aimed at regulating their emotions in association with the stressful situation.

*Avoidant Coping*

The mean score for the emotion-focused coping strategy utilized by the clients was 15.66 ± 4.32 on the scale of 8 to 32 which indicated that clients utilized physical or cognitive efforts to disengage from their stressor. Low scores are typically indicative of adaptive avoidant coping.

### *Early Intervention for Depression (using the Social Connectedness Scale)*

The Social Connectedness scale [14] assessed the degree to which youth feel connected to others in their social environment. The mean score for clients with depression using the Social Connectedness Scale was 32.81 ± 11.77 on the scale of 8 to 48 which indicated that clients were more connectedness to others.

### *Early Intervention for Anxiety (Emotional Regulation)*

The mean score for clients with anxiety using the emotional regulation scale were 22.06 ± 4.76 for cognitive reappraisal (range = 6 to 30) and 13.39 ± 3.46 for expressive suppression (range = 4 to 20). This indicated that clients demonstrated positive attitude towards anxiety regulation.

### *Early Intervention for Stress (Resilience Measure)*

Overall level of mental resilience improvement was determined using the Paired Sample T-test. The data on the improvement in the mental resilience was collated at first and fourth contacts for 919 clients. The results showed significant improvement in the mental resilience of the clients: First contact *(mean = 38.74, SD = 7.51)* to Fourth contact *(mean = 46.58, SD = 10.81), t = 18.24, p<.001(two-tailed).* The mean increase in the test scores was 7.84 with a 95% confidence interval.

## Findings from Interviews

### *Impact of Participation on Peer Supporters and Curators*

The Peer Supporters and Curators shared various stories and experiences in the peer support system. The following were the selected stories shared:

A peer supporter shared that she had a customer who buys 'fura' from her on a regular basis but she did not hear from him for a while, so she called him: *The guy was surprised that she called to check on him because according to him no one cares about him, not even his family members (he is from a family where the mother had 4 children from 4 different men and according to him, all his siblings' fathers are responsible for their welfare except his own father). He reportedly said that the isolation and lack of concern from his family has really affected his mental health and academics. The peer supporter was able to provide some basic mental health counselling to him and she is still following up with him.*

Another peer supporter narrated *"I met a guy just because I like him, we started talking and that was when I noticed he needed help. He was probably having anxiety, because he is always running away from people and conversations and the moment I try to push it he gets angry. I talked to him about it telling him to attempt the e-course, which he reluctantly did. I tried bringing him to the clinic but he insisted that only me should talk to him and address him which I did with the counselling skill I have acquired and there were changes and then all of a sudden, he blocked me. I'm still trying to find another way to reach him. I believe he is deliberately avoiding me because he is owing me some money".*

Another peer supporter reported *"My experience as a peer supporter has been eye opening and insightful, meeting various people each day and communicating with fellow colleagues made me realise that a lot of people just needs someone to listen to them and I am really grateful for this platform. One of my many experiences that I can't forget was meeting this guy during one of our sensitization outreaches and I was opportuned to talk to him. During the conversation he made me understand what he was going through and how the pressure of life and being a student has not been easy on him, he also told me about how he gets depressed most times because where he wants to be and where he is, is not the same as a guy, and how he feels he ought to be doing more but it always not going as planned... Seeing guys of his age doing some things and where they are and where he is makes him feel that life is mostly unfair... Though I did give him some counselling and made him see things from a new angle and ever since we have been in communication. Although I already knew being a guy is not easy and the responsibility and expectations are high but it was an experience of a whole new level seeing a guy who is willing to open up about his challenges and how it is affecting him mentally...not all guys are willing to open up and they generalized all problems as lack of money"*

A female peer supporter shared her experience about a course mate *'who is always smiling and looked happy but she found out from her friends that she was exhibiting suicidal behaviour, she was cutting herself. She reached out to her and thankfully she was willing to come to the clinic. She will continue to follow up on the client. She also noted that the overall experience has been amazing and eye opening, she was thankful for the opportunity provided through the peer support system to be a better person and also able to impact others'.*

A male peer supporter shared this story - *"there was this lady I was introduced to due to her ill mental state, she happens to be my class mate. For professional purpose I won't reveal her name... She was totally disconnected from social life, feeling so sad for more than a month, couldn't concentrate in class to learn and according to her it was as if life was at pause and nothing is happening in the world...Seeing her in that condition I then realized many people complain about having issues in life without seeing what others are facing, I appreciated God for his mercy in my life while I offered peer counselling aid to the client. This lady does not have financial issue neither academic problem nor any form of harassment. I offered peer counselling aid to stabilize and sensitize her and later she was referred to the WFI Body and Mind Clinic for professional handling where she could access real treatment. To God be the glory the lady is now fine and whenever we see each other, her smile is a motivation for me, to do more by helping other victims out there get out of the ill mental situation. God bless WFI CAMPUS PROJECT for the opportunity given to we peer supporters in Unilorin, we will continue to serve the purpose.*

### *Impact of Early Intervention for Mental Illness from Clients*

The following exerts were the impact of the mental health counselling and services received as shared by the clients from the on-campus Mind and Body Clinic (mental health safe space)

*'The program has impacted on my psychological, emotional and physical well -being. I learned coping mechanisms, on how to manage stress on campus and in life as a whole'.*

*'It has helped me to be more aware of the need for mental health awareness even when you do not necessarily have a mental disorder''.*

*'I feel relieved in the aspect of depression, not feeling among my peers and also feeling insecure. With the help of the counselling, I have been able to overcome feelings of being insecure and depression. I am now proud of myself both publicly and privately'.*

*'I was taught a lot of things to improve my mental health and how to familiarize myself with people and all other things'.*

*'A positive impact and it helped a lot, to manage stress and academic challenges and it improved my personal life'.*

*'I was able to have someone to speak with and it made me have a different reality on what is on my head, a change in my view'.*

*'While appreciating the number of time I got counselled, I must admit it actually took me a while but it has a positive impact on my mental health now'.*

*'It has been good, and I have seen improvement and I can recommend the body and mind clinic to anyone'.*

*'My communication skills are getting better and I now open up to people, I share my opinions and express my feelings'.*

*'It helped me through my 100 level, because I was dealing with some issues whereby I couldn't make friends and I was always alone but later got along'.*

*'Being able to come out of my shell and not keeping things to myself or thinking too much'.*

*'The counselling was good and I have been holding dearly to the advice given to me by the curator. Though I used to think that I'm inferior to others, but I still try to put in my best, so I will say the counselling is good.'*

*'I'm now able to cope and balance my schedule to avoid being stressed.'*

*'Their impact cannot be over emphasized because they came to my aid when I was about to give up'.*

*'It has reduced my stress and anxiety. I have been able to cope with stress'.*

*'It has helped reduced low self-esteemed, because of my age most of my class mate don't talk to me and feel alone but now it has reduced, I now have friends to talk to'.*

*'I can relate with my peers, they give me more attention so I feel more achievable about my career.'*

## 4. Discussion

The study aimed to test the effectiveness and efficiency of peer, campus and remote support systems in delivering quality, timely and friendly Mental Health and Psychosocial Support (MHPSS) information and services to students.

Findings from this study has shown that targeted trainings of peer mental health counselors, provision of safe space for early interventions for minor mental illnesses, campus mental health outreaches and media campaigns have the capacity to increase knowledge and improve behavioural practices for mental health. This is consistent with an earlier study [12] on recommendations for mental health

promotion to include support systems focusing on peer influence and confidential counselling for strengthening within institutions of higher learning.

The influence of trained youth curators and peer supporters for the provision of non-clinical mental health information, counselling and services confirmed the previous report [15] that mental health services are shifting away from traditional models of health care and into locations such as schools, to improve access to care and increase the availability and diversity of non-specialist mental health workers. Also in support of the study's utilization of students as peer mental health providers was also contributory to the overall mental health improvements as seen in the findings. This is consistent with the submission which stated that the conceptualisation of mental health is expanding from the focus on clinically defined disorders to a broader dimensional approach to mental health approaches that are well suited for the school environment [16]. The interventions implemented in the study were evidence-based. Mental health interventions are the programs that promote mental health (such as improving self-esteem and promotion of self care), those that prevent mental illness developing (such as improving coping strategies, utilization of health seeking behaviour and promotes social connectedness), and those that treat diagnosed illnesses (through referral). The safe space environment provides opportunities to promote resilience (e.g., enhancing positive peer support and networks) and reduce exposure to risk factors (e.g., academic stressors[17].

The study demonstrates that the peer to peer model of mental health counseling has the capacity to improve the mental health awareness, literacy and healthy seeking behaviour of young people as evident from the endline data. Similarly, the provision of youth-focused safe space for early intervention for minor mental illnesses in the design of the intervention improved the overall mental well-being of the target population. This is consistent with a similar intervention, in which supportive interactions are fostered among different actors with a positive effect in decreasing affective symptoms and in increasing personal wellbeing among children and adolescents [18].

Analysis of the qualitative data indicates that the benefits of capacity building, sensitization outreaches and the distribution of IEC materials were significantly associated with achievement of the outcome measures reported in this survey.

## Conclusion

The study has demonstrated the importance and proven significance for youth mental health interventions. All the components of the intervention were holistically relevant to the achievement of the study outcomes. Training of students in mental health counselling and service delivery to their peers played a crucial role in the success of the study. The mental health safe space provided a haven of confidentiality for clients' free expression of their feelings with their peers. Also, the introduction of the mental health e-course, public enlightenment through the social and traditional media was instrumental to the recorded improvement in the mental health literacy of the students. Furthermore, the modes of delivery and the nature of these interventions appealed to the targets hence, the laudable positive influence demonstrated. This could be facilitated by expanding the scope of mental health promotion to more schools and also with further consideration for digital health as social media form a central part in daily life of an average youth.

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