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AN ECONOMIC ANALYSIS OF DISORDERS AND MENTAL HEALTH STATUS OF HIGH SCHOOL STUDENTS IN VISAKHAPATNAM DISTRICT

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ABSTRACT

Mental health is about coping and adjusting to the demands of growing up. It does not all happen at one point in time, and appears to result from an interactive process to which we can all contribute, based on the child's environmental, social and cultural context. In this context, the present study attempted to analyse the mental health status of school children in Visakhapatnam District of Andhra Pradesh. The sample of the present study covered 9th and 10th classes belonging to low SES urban and rural schools situated in Visakhapatnam city and Araku Valley of Andhra Pradesh. At the end, the study gave interesting results of differences in mental health status between low SES rural and urban adolescent students of 9th and 10th classes.

KEYWORDS
Severe Depression, Social Dysfunction, Socio Economic Status, Somatic Symptoms and urban adolescents.

INTRODUCTION
Mental, emotional and behavioral disorders may occur during childhood and adolescence. All can have a serious impact on a child's overall health. Some disorders are more common than others, and conditions range from mild to severe. Mental Health is about maintaining a good level of personal and social functioning. For children and young people, this means getting on the others, both peers and adults, participating in educative and other social activities, and having a positive self-esteem. Often, a child has more than one disorder according to U.S. Department of Health and Human Services, 1999. However, it is important to remember that diagnosis is often complex and mental health problems may exist alongside each other. It is also important to guard against the labelling of children and young people as having a mental illness, especially where difficulties may be seen as part of the difficult task of growing up. Emotional disorders refer to the whole range of emotional problems that are experienced by children. The majority of children are miserable on occasions, and the ability to understand and resolve minor setbacks or difficulties is a central part of a child's psychological development in adolescence, young people who are depressed may appear to be overly irritable.

MENTAL, EMOTIONAL AND BEHAVIORAL DISORDERS
Young people can have mental, emotional, and behavioral problems that are real, painful, and costly. These problems, often called "disorders," are sources of stress for children and their families, schools and communities. The number of young people and their families who are affected by mental, emotional, and behavioral disorders is significant. It is estimated that as many as one in five children and adolescents may have a mental health disorder that can be identified and require treatment. Mental health disorders in children and adolescents are caused by biology, environment, or a combination of the two. Examples of biological factors are genetics, chemical imbalances in the body, and damage to the central nervous system, such as a head injury. Many environmental factors also can affect mental health, including exposure to violence, extreme stress, and the loss of an important person. Families and communities, working together, can help children and adolescents with mental disorders. A broad range of services is often necessary to meet the needs of these young people and their families.

BIPOLAR DISORDER
Children and adolescents who demonstrate exaggerated mood swings that range from extreme highs (excitedness or manic phases) to extreme lows (depression) may have bipolar disorder (sometimes called manic depression). Periods of moderate mood occur in between the extreme highs and lows. During manic phases, children or adolescents may talk nonstop, need very little sleep, and show unusually poor judgment. At the low end of the mood swing, children experience severe depression. Bipolar mood swings can recur throughout life. Adults with bipolar disorder (about one in 100) often experienced their first symptoms during their teenage years (National Institutes of Health, 2001).

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER
Young people with attention-deficit/hyperactivity disorder are unable to focus their attention and are often impulsive and easily distracted. Attention-deficit/hyperactivity disorder occurs in up to five of every 100 children. Most children with this disorder have great difficulty remaining still, taking turns and keeping quiet. Symptoms must be evident in at least two settings, such as home and school, in order for attention hyperactivity disorder to be diagnosed.

CONDUCT DISORDER
Young people with conduct disorder usually have little concern for others and repeatedly violate the basic rights of others and the rules of society. Conduct disorder causes children and adolescents to act out their feelings or impulses in destructive ways. The offenses these children and adolescents commit often grow more serious over time. Such offenses may include lying, theft, aggression, truancy, the setting of fires, and vandalism Current research has yielded varying estimates of the number of young people with this disorder, ranging from one to four of every 100 children 9 to 17 years of age (U.S. Department of Health and Human Services, 1999).

EATING DISORDERS
Children or adolescents who are intensely afraid of gaining weight and do not believe that they are underweight may have eating disorders. Eating disorders can be life threatening. Young people with anorexia nervosa, for example, have difficulty maintaining a minimum healthy body weight. Anorexia affects one in every 100 to 200 adolescent girls and a much smaller number of boys (National Institutes of Health, 1999). Youngsters with bulimia nervosa feel compelled to binge (eat huge amounts of food in one sitting). After a binge, in order to prevent weight gain, they rid their bodies of the food by vomiting, abusing laxatives, taking enemas, or exercising obsessively. Reported rates of bulimia vary from one to three of every 100 young people (National Institutes of Health, 1999).

TREATMENT, SUPPORT SERVICES, AND RESEARCH: SOURCES OF HOPE
Now, more than ever before, there is hope for young people with mental, emotional, and behavioral disorders. Most of the symptoms and distress associated with childhood and adolescent mental, emotional, and behavioural disorders can be alleviated with timely and appropriate treatment and supports. In addition, researchers are working to gain new scientific insights that will lead to better treatments and cures for mental, emotional, and behavioral disorders. Innovative

studies also are exploring new ways of delivering services to prevent and treat these disorders. Research efforts are expected to lead to more effective use of existing treatments, so children and their families can live happier, healthier, and more fulfilling lives.

GENERALISED ANXIETY DISORDER

Generalised anxiety disorder is 'generalised' in the sense that there is often no focus but an ongoing dread; a fear that something bad is going to happen. The child begins to feel 'out of control' and starts to exhibit a number of physical problems such as stomach aches, headaches and problems with sleep. Relationships are affected and schooling may be interrupted.

PHOBIAS

A phobia is a kind of anxiety disorder that involves a strong and excessive desire to avoid an object, person or situation that in itself presents no actual danger. In this sense, phobias are irrational and sometimes difficult to comprehend. They become a problem when they prevent a person from functioning normally and maintaining normal relationships. Phobias are common in children and young people.

SEPARATION ANXIETY

While it is normal for a young child to be upset when left by his or her primary caregiver, this anxiety in older childhood or adolescence may indicate that something is wrong. Separation anxiety can return when a young person experiences change, such as that caused by the illness of a parent, changing school, the divorce or death of a parent, or moving house. Symptoms include excessive crying when a parent leaves, fear that harm may come to the parent or that they may not return problems with sleep and refusal to go to or stay at school. Separation anxiety is distressing for the parent as well as the child.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

ADHD affects about two per cent of children of school age - mainly boys. Young people with ADHD become bored and distracted easily, and may have difficulty playing with other children. They are often disorganised, have difficulty listening for long periods and are easily distracted by other children or external stimuli. They may have difficulty taking turns when playing or in the classroom and engage in risky activities. When frustrated they may express anger in aggressive ways; for example, slamming and kicking doors or shouting. It is not hard to see why ADHD is directly associated with school failure, exclusion and poor future prospects.

AUTISM AND ASPERGER'S SYNDROME

Autism is a lifelong developmental disorder (not a mental illness) that affects a young person's ability to relate to others. The main difficulties experienced by a young person with autism are known as the 'triad of impairments', which include difficulties with communication, social interaction and 'social imagination', which, among other difficulties, affects a young person's ability to read the emotions of others, predict social behaviour; understand the concept of danger and engage in imaginative play. The term 'autism' covers a spectrum of disorders, including Asperger's syndrome. People with Asperger's syndrome may have difficulties in social relationships and communicating, and limitations in social imagination and creative play.

BIPOLAR DISORDER

Bipolar disorder (which used to be known as manic depression) is a serious illness characterised by abnormal shifts in mood. It rarely occurs before late adolescence and can be difficult to diagnose. Manic symptoms include elevated mood, inflated self-esteem, decreased need for sleep, hyperactivity, shortened attention span, and ideas and thoughts that are out of control; feelings of euphoria are disproportionate to events in the young person's life. Depressive periods are associated with deep sadness and unhappiness, a loss of interest, inactivity, irritability and sometimes a preoccupation with death and dying.

DEPRESSION

Depression is characterised by ongoing sadness, irritability and feelings of anxiety, guilt and a sense of worthlessness. It is deeper and more persistent than feeling low. If left untreated, depression can have serious implications for a young person and their family. School performance is likely to be adversely affected as the young person loses motivation and energy and has difficulty concentrating. Young people who are depressed find it hard to establish and maintain friendships and they may turn to alcohol and drugs as a means of coping. Eating habits are often affected, with the young person either over- or under-eating. Sleep patterns are also likely to be affected. Sometimes the child's depression manifests itself as anger, violence or rage. Depression in young people is treatable, especially where there is early diagnosis and treatment and support from family and friends.

OBSESSIVE-COMPULSIVE DISORDER (OCD)

People with OCD are disturbed by recurring thoughts (obsessions) or a need to engage in repetitive and ritualised behaviours (compulsions). OCD may take the form of excessive hand washing, repeated checking, touching, hoarding and collecting, counting, and/or a need for symmetry and order. Carrying out compulsive acts offers only temporary relief, however, and the child may become consumed by fears about dirt and contamination by germs, death, illness, a lack of order, or the belief that something bad may happen if they do not perform these acts. OCD can cause major difficulties for a child and the adults in their world.

SCHIZOPHRENIA

Schizophrenia is a serious, complex and often disabling mental health problem. Although it is rare in young people, some children exhibit signs at an early age. The symptoms of schizophrenia take the same form in young people as in adults. These include unnatural suspicions and fear of other people (paranoia); difficulty distinguishing what is real from fantasy, which may include hearing voices (hallucinations); and false beliefs, e.g. that they have been visited by aliens (delusions). Young people with schizophrenia perceive the world differently from others; they are withdrawn, have thought disorders and are sometimes devoid of emotion.

SELF-HARM

Self-harm (also referred to as self-injury) often involves cutting with blades, glass or any object with a sharp edge. Injury may also be inflicted by rubbing, burning, scratching and swallowing objects, pinching or picking at the skin. Overdosing and misusing drugs may also be regarded as forms of self-harm. Self-harm is most often an expression of deep-rooted emotional problems that a young person has difficulty expressing in less harmful ways. It can be seen as a form of communication and has been described as an 'inner scream'. Paradoxically, self-harm is often a means of coping with difficult feelings and, some argue, lessens the desire to attempt suicide. In this sense, it represents restraint, and may therefore be seen as a survival strategy. Nevertheless, self-harm is distressing for families, teachers and friends who see the results and feel helpless.

SUICIDE

Suicide is the third main cause of death in young people after illness and accidents. Attempted suicide is often referred to as Para suicide. Girls attempt suicide more often than boys, though young men's attempts are more likely to be fatal. Suicide is linked with depression, loss, failure and abuse, when often a young person cannot see another way out of their despair. Fortunately, statistics show that the suicide rate in young people is beginning to decrease, though it is

certain that many young people consider suicide as an option at some point. Young people who attempt suicide often give indications to those around them that something is seriously wrong and go ahead with extreme step.

SLEEP PROBLEMS
It is not uncommon for children and young people to experience difficulties with sleeping, which may take the form of nightmares, night terrors or sleepwalking. As with all sleep problems, such difficulties do not necessarily indicate an underlying problem, and sleep disturbance can be caused by a television programme or a scary story. Sleep problems can have biological causes and may result from poor drinking and eating habits. However, if a problem continues, especially in an older child or teenager, there may be an underlying emotional cause.

METHODOLOGY
The present study aims to examine the differences between low SES urban and rural school Adolescent Students of Visakhapatnam district, regarding to their Mental Health problems. The sample of the present study consists of 193 students (101 students, i.e., 52.33% of them belonging to low SES urban high school adolescents and 92 i.e., 47.66% studying 9th and 10th classes) belonging to low SES urban and rural schools situated in Visakhapatnam city and Araku Valley of Andhra Pradesh. The age range of the sample is from 13 to 16 years. I felt that there is a need to conduct study of Mental Health Status of Low SES Urban and Rural Schools adolescent students. We are selected some individual variables to study Mental Health among Low SES urban and low SES rural Telugu medium school adolescents to know the comparison of different individual variables.

CULTURALLY RELEVANT BELL ADJUSTMENT INVENTORY (CRBAI)

Culturally Relevant Bell Adjustment Inventory (CRBAI) is an adaptation of the student form of Bell Adjustment inventory (1962). Norms are provided for each of the five adjustment dimensions and for each of the 25 factorially derived sub factors. As followed by Bell (1963), percentile norms method was used to develop norms and I obtained scores based on their percentile ranks are categorised as Excellent, Good, Average, Poor and Unsatisfactory. Apart from measuring these dimensions DCRBAI also measures a total of 25 sub factors derived by factor analysis.

GENERAL HEALTH QUESTIONNAIRE

The GHQ is a 28 item self-administered questionnaire used for the detection of psychiatric distress related to general medical illness. It requires respondents to indicate if their current "state" differs from his or her usual state, thereby assessing change in characteristics and not lifelong personality characteristics. The tool has been used successfully in community settings and non-psychiatric clinical settings in many countries; the GHQ 28 is one of four versions of the GHQ. The original version of the GHQ has 60 items and the three shorter versions have 30, 28, and 12 items. The GHQ-28 yields four subscales including, somatic, anxiety, social dysfunction, and depression. Each subscale contains 7 items in the GHQ 28 and it was designed from the results of a principal component analysis based on the original GHQ.

PROCEDURE

First, permission was obtained from the District Education Officer (D.E.O) to collect data from Government schools and also obtained permission from the school principals/ head master. Along with the associates who were trained to administer the Biographical information sheet, CRBAI and GHQ administered the version of these forms in their class rooms during the school hours. Students were assured of the confidentiality of their answers, while administering the checklist, first the students were asked to fill in the demographic data sheet. All the instructions were clearly explained by the administrators. The administrators read aloud the items while the students are asked to read it silently and complete them. No time limit was set for completing the checklist but usually it took 30 to 40 minutes to complete the form.

DATA ANALYSIS
The results of the anlysed data are presented in the following tables. The mean scores and standard deviation are calculated by applying t-test for the dimensions of CRBAI sub scale.

TABLE 1: MEAN DIFFERENCE BETWEEN LOW SES URBAN SCHOOL ADOLESCENTS AND LOW SES RURAL SCHOOL ADOLESCENTS ON GENERAL HEALTH QUESTIONNAIRE SCALE

G.H.Q Sub -Scale	Mean/S.D	Low SES Urban School (N=101)	Low SES Rural School (N=92)	t-value
Somatic Symptoms	Mean	1.030	1.717	-3.339**
	S.D	1.195	1.613	
Anxiety and Insomnia	Mean	1.337	1.707	-1.534
	S.D	1.545	1.782	
Social Dysfunction	Mean	1.238	1.620	-1.545**
	S.D	1.686	1.741	
Severe Depression	Mean	1.426	1.783	-2.026**
	S.D	1.043	1.365	

Note: *Significant at 5%;**Significant at 1%level

Table 1 has explained that mean scores of rural high school adolescents are more on the dimensions of somatic symptoms, social dysfunction and severe depression symptoms when compared to low SES urban school adolescents, are highly significant at 1% level. This shows that significant difference was observed between low rural and urban adolescent students.

TABLE 2: MEAN DIFFERENCE OF MALE ADOLESCENTS BETWEEN LOW SES URBAN AND RURAL SCHOOL STUDENTS ON THE GHQ SCALE

G.H.Q Sub -Scale	Mean/S.D	Low SES Urban School (N=50)	Low SES Rural School (N=37)	t-value
Somatic Symptoms	Mean	1.26	1.818	-1.614
	S.D	1.3063	1.7454	
Anxiety and Insomnia	Mean	1.680	1.486	.553
	S.D	1.731	1.520	
Social Dysfunction	Mean	1.360	1.513	-.491
	S.D	.221	.176	
Severe Depression	Mean	1.540	1.432	.463
	S.D	.151	.175	

Note: *Significant at 5%;**Significant at 1%level

Table 2 has revealed that mean difference of male adolescents between low SES urban and rural school students on the GHQ Scale. On all the dimensions of somatic symptoms, anxiety and Insomnia social dysfunction and severe depression symptoms the t-value showed insignificant difference between low rural and urban male adolescent students.

TABLE 3: MEAN DIFFERENCE OF FEMALE ADOLESCENTS BETWEEN LOW SES URBAN AND RURAL SCHOOL STUDENTS ON THE GHQ SCALE

G.H.Q Sub -Scale	Mean/S.D	Low SES Urban School (N=50)	Low SES Rural School (N=37)	t-value
Somatic Symptoms	Mean	.8039	1.654	-3.369**
	S.D	1.039	1.530	
Anxiety and Insomnia	Mean	1.000	1.854	-2.707**
	S.D	1.265	1.939	
Social Dysfunction	Mean	1.117	1.690	-1.562
	S.D	1.807	1.970	
Severe Depression	Mean	1.313	2.018	-2.859**
	S.D	1.009	1.497	

Note: *Significant at 5%;**Significant at 1%level

Table 3 reveals that mean score of low SES rural school adolescent females on the dimensions of somatic symptoms, Anxiety and Insomnia and Severe Depression are higher than that of the mean scores of the low SES urban adolescent females on GHQ scale and they are significant at 1% level. The t-value for the dimension of Social Dysfunction is insignificant between female adolescents of low SES urban and rural schools. It means rural school adolescent females have higher symptoms of Somatic, anxiety and Insomnia, Social dysfunction and severe depression than urban school adolescent female students.

TABLE 4: MEAN DIFFERENCE BETWEEN LOW SES URBAN AND RURAL SCHOOL ADOLESCENTS OF 9TH CLASS ON THE GHQ SCALE

G.H.Q Sub -Scale	Mean/S.D	Low SES Urban School (N=36)	Low SES Rural School (N=48)	t-value
Somatic Symptoms	Mean	1.194	1.854	-2.070*
	S.D	1.283	1.637	
Anxiety and Insomnia	Mean	1.638	2.041	-1.013
	S.D	1.726	1.901	
Social Dysfunction	Mean	1.417	1.896	-1.259
	S.D	1.610	1.870	
Severe Depression	Mean	1.472	2.062	-1.951
	S.D	1.298	1.521	

Note: *Significant at 5%;**Significant at 1%level

The analysis in Table 4 reveals that the mean scores of 9th class adolescent students of the rural school are higher than that of low SES urban school. It indicates that the dimension of Somatic Symptom on the GHQ scale is significant at 5% level and reveals that low SES rural school adolescents of 9th class have more problems than low SES urban school adolescents. No significant difference was found on the dimensions of anxiety and Insomnia, Social Dysfunction and severe depression.

TABLE 5: MEAN DIFFERENCE BETWEEN LOW SES URBAN AND RURAL SCHOOL ADOLESCENTS OF 10TH CLASS ON THE GHQ SCALE

G.H.Q Sub -Scale	Mean/S.D	Low SES Urban School (N=65)	Low SES Rural School (N=44)	t-value
Somatic Symptoms	Mean	.938	1.568	-2.260*
	S.D	1.144	1.590	
Anxiety and Insomnia	Mean	1.169	1.341	-.579
	S.D	1.420	1.584	
Social Dysfunction	Mean	1.138	1.318	-.566
	S.D	1.731	1.551	
Severe Depression	Mean	1.400	1.477	-.387
	S.D	.880	1.109	

Note: *Significant at 5%;**Significant at 1%level

The analysis in Table 5 reveals that the mean scores of 10th class adolescent students of the rural schools are higher than that of low SES urban schools. On the dimension of Somatic Symptoms the mean score of low SES rural adolescent students is higher than that of low SES urban school adolescents, and it is significant at 5% level. It shows that low SES rural school adolescents have higher somatic problems than the low SES urban school adolescents. No significant difference was found on the dimensions of anxiety /Insomnia, Social Dysfunction and severe depression. An examination shows that the 10th class adolescent students of low SES rural school have higher somatic symptoms than low SES urban adolescent students.

TABLE 6: MEAN DIFFERENCE BETWEEN LOW SES URBAN AND RURAL SCHOOL ADOLESCENT STUDENTS LIVING IN NUCLEAR FAMILY ON GHQ SCALE

G.H.Q Sub -Scale	Mean/S.D	Low SES Urban School (N=90)	Low SES Rural School (N=75)	t-value
Somatic Symptoms	Mean	.989	1.560	-2.620**
	S.D	1.175	1.553	
Anxiety and Insomnia	Mean	1.267	1.56	-1.178
	S.D	1.527	1.646	
Social Dysfunction	Mean	1.222	1.587	-1.322
	S.D	1.573	1.771	
Severe Depression	Mean	1.422	1.733	-1.715
	S.D	1.080	1.222	

Note: *Significant at 5%;**Significant at 1%level

The analysis in Table 6 reveals that adolescent students of low SES urban and rural schools living in nuclear family have highly significant Psychological variance on the dimension of Somatic Symptoms on the GHQ scale at 1% level. No significant difference was found on the dimensions of anxiety and Insomnia, severe depression and Social dysfunction. An examination of the analysis shows that adolescent students of rural school living in nuclear family have higher Somatic Symptoms than adolescent students studying in urban school.

TABLE 7: MEAN DIFFERENCE BETWEEN LOW SES URBAN AND RURAL SCHOOL ADOLESCENT STUDENTS LIVING IN JOINT FAMILY ON GHQ SCALE

G.H.Q Sub -Scale	Mean/S.D	Low SES Urban School (N=10)	Low SES Rural School (N=17)	t-value
Somatic Symptoms	Mean	1.300	2.411	-1.808
	S.D	1.418	1.734	
Anxiety and Insomnia	Mean	1.800	2.353	-.727
	S.D	1.686	2.234	
Social Dysfunction	Mean	1.300	1.764	-.893
	S.D	1.059	1.640	
Severe Depression	Mean	1.400	2.000	-1.172
	S.D	.699	1.903	

Note: *Significant at 5%;**Significant at 1%level

Table 7 presents the mean difference between low SES urban and rural school adolescent students living in joint family on GHQ scale. It reveals that no significant difference was found between the adolescent students living in joint family of low SES urban and rural schools on all sub scales of GHQ scale

TABLE 8: MEAN DIFFERENCE BETWEEN MALE AND FEMALE OF LOW SES URBAN ADOLESCENT STUDENTS ON GHQ SCALE

G.H.Q scale Dimensions	Mean/S.D	Male (N=50)	Female (N=51)	t-value
Somatic Symptoms	Mean	1.260	0.804	1.939
	S.D	1.306	1.040	
Anxiety and Insomnia	Mean	1.680	1.000	2.250*
	S.D	1.731	1.265	
Social Dysfunction	Mean	1.360	1.118	0.772
	S.D	1.562	1.807	
Severe Depression	Mean	1.540	1.314	1.091
	S.D	1.073	1.010	

Note: *Significant at 5%;**Significant at 1%level

Table 8 reveals that no significant mean difference was found between males and females on the subscales of Somatic Symptoms, Social dysfunction and severe depression of GHQ scale. However, the dimension of anxiety/insomnia is significant at 5% level which indicates that male adolescents are experiencing more Anxiety/Insomnia symptoms than female adolescents studying in urban school in Visakhapatnam.

TABLE 9: MEAN DIFFERENCE BETWEEN 9TH AND 10TH CLASS STUDENTS OF THE LOW SES URBAN SCHOOLS ON GHQ SCALE

G.H.Q scale	Mean/S.D	9th Class (N=36)	10th Class (N=65)	t-value
Somatic Symptoms	Mean	1.194	0.939	0.997
	S.D	1.283	1.144	
Anxiety and Insomnia	Mean	1.639	1.169	.392
	S.D	1.726	1.420	
Social Dysfunction	Mean	1.417	1.139	.809
	S.D	1.610	1.731	
Severe Depression	Mean	1.472	1.400	.298
	S.D	1.298	0.880	

Note: *Significant at 5%;**Significant at 1%level

The analysis in Table 9 reveal that no significant mean difference was found between 9th and 10th class adolescent students of the low SES urban school on all dimensions of somatic symptoms, anxiety and insomnia, social dysfunction and severe depression on the GHQ questionnaire. The high mean scores of 9th class students than 10th class students on all these dimensions has explained that the 9th class students have significant problems than 10th class students.

CONCLUSION

Families with low socioeconomic status often lack the financial, social, and educational supports that characterize families with high socioeconomic status. Poor families also may have inadequate or limited access to community resources that promote and support children's development and school readiness. Parents may have inadequate skills for such activities as reading to and with their children, and they may lack information about childhood immunisations and nutrition. Morbidity was significantly higher in children hailing from nuclear families and among children who had either failed or those who had scored highest in the class.

Rural school adolescents belonging to low SES have more Somatic symptoms, social dysfunctions and severe depression when compared to low SES urban school adolescents. Low SES rural school adolescent females have significantly higher adjustment problems like Home, Health, Emotional, Hostility and Submissiveness problems than the low SES urban school adolescent females. Further, low SES rural school adolescent females have higher and significant symptoms of somatic symptoms, anxiety and severe depression than low SES urban school adolescent female students. It has been observed that low SES Rural adolescents of 9th class have significantly higher somatic symptoms than the Low SES Urban school adolescents. Mental health problems of school children need to be addressed by the school health services.

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