Section: Community Medicine

Original Research Article

PREVALENCE OF PSYCHOSOCIAL PROBLEMS AMONG SCHOOL-GOING ADOLESCENTS IN RURAL AND URBAN CHENNAI-A CROSS-SECTIONAL STUDY

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Received *: 20/02/2026*
Received in revised form *: 07/04/2026*
Accepted *: 24/04/2026*

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DOI: 10.70034/ijmedph.2026.2.202

Source of Support: Nil,
Conflict of Interest: None declared

Int J Med Pub Health
2026; 16 (2); 1198-1205

ABSTRACT

Background: Adolescence is a critical period marked by rapid emotional, physical, and social changes. Psychosocial problems during this phase can hinder overall development, especially with differing exposures in urban and rural settings. Aim: To determine and compare the prevalence of psychosocial problems among school-going adolescents in urban and rural areas of Chennai.
Materials and Methods: A school-based comparative cross-sectional study was conducted among 374 adolescents aged 11–14 years, selected from two schools (one urban and one rural) in Chennai between January 2025 and April 2025. Psychosocial status was assessed using the validated Pediatric Symptom Checklist–Youth Report (Y-PSC). Data were entered and analyzed using SPSS version 28. Descriptive statistics were used to summarize the data, and inferential statistics were applied to assess associations. The Chi-square test was used for categorical variables and a p-value of <0.05 was considered statistically significant.
Results: Among the 374 school-going adolescents aged 11–14 years included in the study (urban = 187, rural = 187), psychosocial problems were significantly more prevalent among urban adolescents (28.8%) compared to rural adolescents (1.6%). Urban students reported higher levels of loneliness and low self-esteem. However, on univariate logistic regression analysis, place of residence was not found to be a statistically significant predictor of psychosocial problems. Female gender (OR = 1.76; 95% CI: 1.10–2.82; p = 0.019) and third birth order (OR = 2.65; 95% CI: 1.02–6.87; p = 0.045) were identified as significant predictors, whereas other sociodemographic variables were not significantly associated.
Conclusion: Psychosocial problems were more prevalent among urban adolescents at the descriptive level; however, residence was not an independent predictor after adjustment. Female gender and higher birth order were significantly associated with psychosocial problems. These findings emphasise the importance of early identification through school-based screening and targeted interventions to address adolescent mental health concerns effectively.
Keywords: Mental Health, Prevalence, School Health Services, Screening.

INTRODUCTION

Adolescence, covering the age group of 10 to 19 years, is a critical developmental phase marked by rapid physical, emotional, and social changes.[1,2] This period represents a transition from childhood to adulthood and is characterised by increased vulnerability to psychosocial stressors.[3-8] In India, adolescents constitute a substantial proportion of the population, with approximately 243 million individuals accounting for nearly 21.3% of the country's total population.[9] This significant

demographic representation highlights adolescent health as an important public health priority. Early adolescence, particularly between the ages of 11 and 14 years, is a critical transitional phase during which individuals move from childhood into adolescence and experience rapid biological maturation along with emotional and social development.[2] During this period, adolescents are exposed to increasing academic pressures, evolving peer relationships, and changing family environments, all of which may influence their psychosocial well-being.[2]

Adolescent mental health is increasingly recognised as a major public health concern worldwide, with a significant proportion of mental health conditions having their onset during this period [10]. Psychosocial problems in adolescents include a broad spectrum of emotional and behavioural difficulties. Emotional or internalizing problems encompass anxiety, depression, withdrawal, and low self-esteem, whereas behavioural or externalizing problems include hyperactivity, attention difficulties, aggression, substance use, and conduct-related issues.[3,11] These problems may adversely affect academic performance, interpersonal relationships, and overall quality of life. If psychosocial difficulties are not identified and addressed at an early stage, they may persist into adulthood, increasing the risk of chronic mental health disorders, impaired social functioning, and reduced productivity.[12,13]

Rapid urbanisation, evolving family patterns, increasing academic demands, and greater exposure to digital media have significantly influenced the psychosocial environment of adolescents, especially in urban settings.[14,15] Adolescents living in urban areas may experience higher levels of academic stress, reduced parental interaction due to nuclear family structures, and increased screen exposure, all of which can contribute to emotional and behavioural difficulties. Additionally, variations in living conditions, social interactions, parental supervision, and availability of community support between urban and rural areas may affect the prevalence and pattern of psychosocial problems among adolescents.[16] Conversely, adolescents in rural areas may encounter challenges such as limited access to educational opportunities, mental health services, and psychosocial support systems.[17]

Several studies conducted across different regions of India have reported the prevalence of psychosocial problems among adolescents.[4,5,17] However, most available studies have focused on either urban or rural populations independently, limiting the ability to draw direct comparisons between the two settings. Moreover, variations in the age groups studied, screening tools used, and sociocultural contexts have resulted in wide disparities in reported prevalence rates.[18] Importantly, there is limited comparative data examining urban–rural differences in psychosocial problems among early adolescents, particularly in South India.[6,17] Several standardized screening tools, including the Strengths and Difficulties Questionnaire (SDQ), have been widely used to identify psychosocial problems among children and adolescents in school and community settings.[19] Early adolescence is a critical period for preventive interventions, yet this age group remains relatively under-represented in comparative mental health research.

Such comparative evidence is particularly important in the context of national adolescent health initiatives. In India, the Rashtriya Kishor Swasthya Karyakram (RKSK) emphasises a comprehensive approach to adolescent health, with mental health promotion, early detection of psychosocial problems, and appropriate referral and management as key components of the programme.[21] Standardised behavioural assessment frameworks, such as the Achenbach System of Empirically Based Assessment (ASEBA), provide a foundation for the systematic identification of psychosocial difficulties among children and adolescents.[20] Furthermore, global public health guidance highlights that failure to identify and address psychosocial problems during adolescence may increase the risk of self-harm and suicidal behaviour, underscoring the importance of early preventive strategies.[22] Evidence generated from setting-specific studies can therefore inform the strengthening of school-based screening programmes and support the development of targeted mental health interventions tailored to the needs of adolescents in both urban and rural settings.

Thus, this study was undertaken to address many gaps like growing public health importance of adolescent mental health.[23] The aim of the study is to determine and compare the prevalence of psychosocial problems among school-going adolescents in urban and rural areas of Chennai.

The Primary Objective of this study is to estimate the prevalence of psychosocial problems among school-going adolescents in urban and rural areas of Chennai. And the Secondary Objective is to assess the association between selected sociodemographic factors and psychosocial problems among school-going adolescents from urban and rural settings.

MATERIALS AND METHODS

Study design and setting

A school-based comparative cross-sectional study was conducted among school-going adolescents aged 11–14 years in the urban and rural areas of Chennai. The study was carried out over a period of four months from January 2025 to April 2025.

The study was conducted after obtaining approval from the Institutional Ethics Committee of ACS Medical College and Hospital (Approval No. 1220/2024/IEC/ACS MCH DL, dated 04.07.2024).

Study population

The study population consisted of school-going adolescents aged 11–14 years studying in 6th to 9th standards in selected urban and rural schools of Chennai.

Sample size calculation

The sample size was calculated using the formula:

$n = Z^2pq / d^2$

Where,

n = required sample size

Z = standard normal deviate at 95% confidence level = 1.96

p = prevalence of psychosocial problems = 33.03% (0.3303), based on the study by Nimje AT et al.

$q = 1 - p = 1 - 0.3303 = 0.6697$

d = allowable error = 5% (0.05)

Substituting the values:

$n = (1.96 \times 1.96 \times 0.3303 \times 0.6697) / (0.05 \times 0.05)$

$n = (3.8416 \times 0.2212) / 0.0025$

$n = 0.8496 / 0.0025$

$n = 339.84$

$n \approx 340$

After adding 10% non-response rate:

10% of 340 = 34

Final sample size = 340 + 34

Final sample size = 374

Thus, the total sample size was 374 adolescents, with 187 participants each from urban and rural areas.

Sampling technique

A multistage sampling technique was employed.

In the first stage, schools were selected using simple random sampling. In the urban field practice area, one school was selected from five eligible schools using the lottery method. Similarly, in the rural field practice area, one school was selected from three eligible schools using simple random sampling.

In the second stage, proportionate stratified random sampling was used to select students from each class (6th to 9th standard) based on the total number of students in each grade. The required number of students from each class was calculated proportionately to ensure equal representation.

Table 1: Proportionate stratified random sampling of study participants

Urban area			Rural area		
Class	Number of students	**Proportion sampling** Nos. of students in each grade *187 ---------- Total no students in all grades	Class	Number of students	**Proportion sampling** Nos. of students in each grade *187 ---------- Total no students in all grades
6th Grade	77	50	6th Grade	62	53
7th Grade	62	41	7th Grade	48	41
8th Grade	67	44	8th Grade	49	42
9th Grade	79	52	9th Grade	61	51
Total	**285**	**187**	**Total**	**220**	**187**

Proportionate stratified random sampling was performed independently for urban and rural strata. Similar sample sizes across grades were obtained due to comparable grade-wise proportions and rounding to the nearest whole number.

In the final stage, students were selected using simple random sampling from the class attendance registers until the required sample size of 187 students from each area was achieved.

Inclusion criteria

- School-going adolescents aged 11–14 years
- Students studying in 6th to 9th standards
- Students present on the day of data collection
- Students whose parents provided written informed consent and who provided assent

Exclusion criteria

- Adolescents with known diagnosed psychiatric illness
- Adolescents with neurological disorders or chronic medical illness
- Students absent during data collection
- Students unwilling to participate

Study tool and data collection

Data collection was carried out in two phases initially socio-demographic data collection with insightful psychosocial questions followed by Pediatric Symptom Checklist-Youth Report(YPSC).[24,25]

Phase I: Socio-demographic data collection with insightful psychosocial questions.

Socio-demographic details including age, gender, area of residence, type of family, birth order, parental education, and parental occupation were collected using a pre-tested structured questionnaire. Information was obtained from school records and student interviews.

Phase II: Assessment of psychosocial problems

Psychosocial status was assessed using the Pediatric Symptom Checklist – Youth Report (Y-PSC), a validated self-administered screening tool used to identify psychosocial problems in adolescents.

The Y-PSC consists of 35 items rated on a three-point Likert scale:

- Never = 0
- Sometimes = 1
- Often = 2

The total score ranges from 0 to 70.

For the present study, two items related to suicidality were excluded considering the early adolescent age group and to avoid potential psychological distress. The scoring system and cut-off values were applied uniformly to all participants.

Adolescents with a total Y-PSC score ≥30 were classified as having psychosocial problems.

Data were collected in the classroom setting under supervision, ensuring privacy and confidentiality.

Statistical Analysis

Data were entered into Microsoft Excel and analysed using the **Statistical Package for the Social Sciences (SPSS), version 28**. Descriptive statistics such as

frequencies and percentages were used to summarise categorical variables. The Chi-square test or Fisher's exact test was applied to assess associations between psychosocial problems and selected socio-demographic variables. Univariate logistic regression analysis was performed to examine the relationship between individual independent variables and psychosocial problems. The strength of association was expressed using odds ratios (ORs) along with 95% confidence intervals (CIs). A p-value of less than 0.05 was considered statistically significant.

RESULTS

A total of 374 school-going adolescents, belonging to 6th to 9th grade aged 11 to 14 years from both urban and rural study settings were included in the study.

Table 2: Sociodemographic characteristics of study participants (n=374)

Sociodemographic Variable	Urban n = 187(%)	Rural n = 187(%)
Age Group		
11–12 years	49 (26.2%)	94 (50.2%)
13–14 years	138 (73.7%)	93 (49.7%)
Gender		
Male	90 (48.1%)	146 (78.1%)
Female	97 (51.9%)	41 (21.9%)
Education of Head of Family		
Degree (>12th standard)	8 (4.3%)	0 (0%)
Higher Secondary	157 (84.0%)	117 (62.6%)
Middle School	22 (11.8%)	70 (37.4%)
Occupation of Head of Family		
Driver	60 (32.1%)	3 (1.6%)
Carpenter	15 (8.0%)	58 (31.0%)
Painter	22 (11.8%)	55 (29.4%)
Delivery Person	19 (10.2%)	52 (27.8%)
Housekeeping	60 (32.1%)	19 (10.2%)
Plumber	11 (5.9%)	0 (0%)
Type of Family		
Nuclear	172 (92.0%)	164 (87.7%)
Joint	15 (8.0%)	23 (12.3%)
Birth Order		
First-born	107 (57.1%)	171 (91.4%)
Second-born	80 (42.8%)	13 (7.0%)
Third-born	0 (0%)	3 (1.6%)
Distance from School		
1 km	125 (66.8%)	173 (92.5%)
2 km	62 (33.2%)	7 (3.7%)
3 km	0 (0%)	7 (3.7%)

As shown in the Table2/fig 2, Among the 374 adolescents studied, urban participants were predominantly aged 13–14 years, while rural adolescents showed a relatively balanced age distribution. The urban sample had an almost equal gender distribution, whereas males predominated in the rural group. Higher secondary education of the head of the family was the most common educational status in both urban and rural areas. Most adolescents belonged to nuclear families, and first-born children constituted a higher proportion, particularly in rural settings.

Following the collection of sociodemographic details, validated psychosocial insight questions were administered to the participants as shown in Table 3/Fig3, after which the Pediatric Symptom Checklist–Youth Report (Y-PSC) was applied.

Table 3: Psychosocial insights among study participants

Psychosocial Insight	URBAN ADOLESCENTS(n=187) YES n(%) NO n(%)	RURAL ADOLESCENTS(n=187) YES n(%) NO n(%)
Do you have friends	184(98.4) 3(1.6)	187(100) 0
Have trouble speaking with parents	25 (13.4) 162(86.6)	25(13.4) 162(86.6)
Feeling happy about yourself	137(73.3) 50(26.7)	155(82.9) 32(17.1)
Feeling lonely any time	74(39.6) 113(60.4)	40(21.4) 147(78.6)

Table 3/Fig3 showed that most urban and rural adolescents reported having friends and positive self-perception, with difficulty in communicating with parents reported by a small minority in both groups. Feelings of loneliness were more commonly reported among urban adolescents than rural adolescents.

Following this psychosocial insight questions, the Pediatric Symptom Checklist–Youth Report (Y-PSC) was administered to all study participants.

Table 4: Prevalence of psychosocial problems among study participants by place of residence (Y-PSC score ≥30)

Place of residence	Psychosocial problems present n (%)	Psychosocial problems absent n (%)	Total n (%)
Urban (n = 187)	54 (28.8%)	133 (71.2%)	187 (100)
Rural (n = 187)	3 (1.6%)	184 (98.4%)	187 (100)
Total	**57 (15.2%)**	**317 (84.8%)**	**374 (100)**

Overall, 57 (15.2%) adolescents had Y-PSC scores ≥30, indicating psychosocial problems, comprising 54 (28.8%) urban and 3 (1.6%) rural participants, while 317 (84.8%) had scores below 30 as shown in the Table 4/Fig 4.

Table 5: Psychosocial problems of study participants categorized into three principle domains based on Youth-Paediatric Symptom Checklist

Psychosocial domain	Urban adolescents n (%)	Rural adolescents n (%)
Attention problems	107 (57.2%)	40 (21.6%)
Internalizing problems	87 (46.65%)	49 (26.2%)
Externalizing problems	90 (48.05%)	51 (27.15%)

With reference to Table 5 /Fig 5, Based on the Paediatric Symptom Checklist -Youth report (Y-PSC), psychosocial problems of the study participants were categorized into three domains: externalizing, internalizing, and attention-related issues.[25] Non-categorized items were not assessed. The data revealed that urban adolescents exhibited higher levels of problems across all three categories compared to their rural counterparts.

The most frequently reported symptoms included fidgety and frequent involvement in fights with peers. Consequently, an analysis was conducted to examine the association between these symptoms and various sociodemographic factors such as gender, birth order, type of family, and the educational status of the household head (as shown in Table 6/Fig 6) in both urban and rural populations.

Table 6: Association between frequently reported Y-PSC behavioural items and selected Socio-demographic variables among adolescents

Socio demographic variables	Y-PSC Behavioural items (Score)											
	Fidgety - Behaviour						Fight - Behaviour					
	Urban			Rural			Urban			Rural		
	0	**1**	**2**	**0**	**1**	**2**	**0**	**1**	**2**	**0**	**1**	**2**
Gender												
Male [n (%)]	34 (37.77)	42 (46.66)	14 (15.55)	116 (79.45)	30 (20.54)	0 (0.0)	42 (46.66)	25 (25.55)	23 (27.77)	119 (81.50)	26 (17.80)	1 (0.68)
Female [n(%)]	57 (58.76)	29 (29.89)	11 (11.34)	33 (80.48)	8 (19.51)	0 (0.0)	74 (76.30)	15 (15.50)	8 (8.20)	28 (68.30)	13 (31.71)	0 (0.0)
Chi square	8.303			0.021			18.349			3.957		
p-value	**0.016***			0.884			**0.000***			0.138		
Birth order												
1st [n (%)]	57 (53.27)	39 (36.44)	11 (10.28)	138 (80.70)	33 (19.29)	0 (0.0)	131 (76.6)	39 (22.8)	1 (0.6)	71 (68.9)	19 (18.4)	13 (12.6)
2nd [n (%)]	33 (41.25)	32 (40.0)	15 (18.75)	11 (84.61)	2 (15.39)	0 (0.0)	16 (100.0)	0 (0.0)	0 (0.0)	41 (50.6)	22 (27.16)	18 (22.22)
3rd [n (%)]	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.33)	0 (0.0)	2 (66.67)	0 (0.0)	0 (0.0)	0 (0.0)	1 (33.3)	2 (66.7)	0 (0.0)
Chi square	3.888			124.195			4.761			9.94		
p-value	0.143			**0.000***			0.092			**0.041***		
Education of Head												
Middle school [n (%)]	12 (54.54)	8 (36.6)	2 (9.09)	56 (80.0)	14 (20.0)	0 (0.0)	12 (63.2)	4 (21.1)	3 (15.8)	56 (77.8)	16 (22.2)	0 (0.0)
Higher Secondary [n (%)]	75 (47.7)	62 (39.49)	20 (12.73)	93 (79.48)	24 (20.52)	0 (0.0)	96 (60.0)	36 (22.5)	28 (17.5)	92 (79.8)	23 (20.17)	0 (0.0)
Degree [n (%)]	4 (50)	4 (50)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	5 (62.5)	3 (37.5)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Chi square	1.664			0.007			2.23			0.132		
p-value	0.797			0.933			0.694			0.716		
Type of family												

Nuclear [n (%)]	138 (80.2)	34 (19.8)	0 (0.0)	80 (48.72)	64 (38.97)	20 (12.18)	127 (74.1)	34 (19.7)	11 (6.04)	101 (61.5)	37 (22.56)	26 (15.85)
Joint [n (%)]	11 (73.3)	4 (26.7)	0 (0.0)	11 (47.74)	10 (43.41)	2 (8.68)	12 (80)	3 (20)	0 (0)	12 (52.2)	6 (26.1)	5 (21.7)
Chi square	0.406			0.315			1.03			0.826		
p-value	0.524			0.854			0.597			0.662		

Individual Y-PSC items, including behavioural symptoms such as fidgetiness and involvement in fights, were analysed using the standard 0–1–2 item scoring (Never/Sometimes/Often).

Note: Data are presented as numbers (percentages). Percentages represent row-wise distribution within each socio-demographic variable group. Fisher's exact test was applied where expected cell counts were <5. * indicates $p < 0.05$, which is considered statistically significant.

As shown in Table 6/Fig 6, Birth order demonstrated a significant association with behavioural symptoms such as fidgetiness and fighting ($p < 0.05$) among rural school going adolescents. Gender also had a significant association with psychosocial behaviour in urban areas. In contrast, no statistically significant relationship was observed between psychosocial symptoms and either family type or the educational status of the household head.

Variables showing statistical significance in the analysis (gender and birth order) and area of residence, given its epidemiological importance, were entered into a univariate logistic regression model to identify independent predictors of psychosocial problems.

Table 7: Logistic Regression Analysis of Predictors of Psychosocial Problems among School-going Adolescents (n = 374)

Outcome variable: Presence of psychosocial problems (Y-PSC positive)

Variable	Category	Odds Ratio (OR)	95% CI	p-value
Gender	Male	1 (Ref)		
	Female	**1.76**	1.10 – 2.82	**0.019***
Birth order	1st	1 (Ref)		
	2nd	1.28	0.79 – 2.07	0.316
	3rd	**2.65**	1.02 – 6.87	**0.045***
Place of residence	Urban	1 (Reference)		
	Rural	1.21	0.78 – 1.88	0.392

Note: A p-value <0.05 was considered statistically significant.

In Table 7/Fig 7 Logistic regression analysis was performed, to identify predictors of psychosocial problems among school-going adolescents. The presence of psychosocial problems (Y-PSC positive) was considered the outcome variable. The results are presented as odds ratios (OR) with corresponding 95% confidence intervals.

Gender was found to be significantly associated with psychosocial problems. Female adolescents had higher odds of psychosocial problems compared to males (OR = 1.76; 95% CI: 1.10–2.82; p = 0.019).

Birth order also showed a significant association in the third birth order category. Adolescents who were third born had significantly higher odds of psychosocial problems compared with first-born children (OR = 2.65; 95% CI: 1.02–6.87; p = 0.045). However, second-born adolescents did not show a statistically significant association (OR = 1.28; 95% CI: 0.79–2.07; p = 0.316).

Place of residence did not demonstrate a statistically significant relationship with psychosocial problems. Adolescents residing in rural areas had slightly higher odds compared with those in urban areas; however, this association was not statistically significant (OR = 1.21; 95% CI: 0.78–1.88; p = 0.392).

Overall, the findings indicate that female gender and third birth order were significantly associated with psychosocial problems among adolescents, while place of residence did not show a significant association.

DISCUSSION

The present study examined the prevalence and determinants of psychosocial problems among school-going adolescents, with a comparison between urban and rural settings. A substantially higher proportion of adolescents in urban areas (28.8%) screened positive for psychosocial problems compared to those in rural areas (1.6%). This indicates a greater apparent burden in urban environments. Comparable findings have been reported in a study conducted among high school students in Dehradun, where psychosocial problems were more prevalent among urban adolescents than their rural counterparts.[23] The higher prevalence observed in urban settings may be attributed to increased academic demands, heightened parental expectations, nuclear family structures, greater exposure to digital media, and reduced opportunities for social and emotional support. These factors may contribute to stress, behavioural concerns, and emotional disturbances among adolescents.

In contrast, the relatively low prevalence observed among rural adolescents in the present study differs from findings reported by Vijaya et al., who

documented higher levels of psychosocial problems in rural populations.[5] This variation may be explained by differences in sociocultural environments, family cohesion, and supervision patterns. Additionally, underreporting of psychosocial issues due to stigma, limited awareness, and restricted access to mental health resources in rural areas may have contributed to the lower observed prevalence.

Despite the higher prevalence in urban areas, place of residence was not found to be an independent predictor of psychosocial problems in the logistic regression analysis. This suggests that the observed urban–rural difference may be influenced by other underlying sociodemographic or environmental factors rather than residence alone. Such findings highlight the importance of considering confounding variables when interpreting crude prevalence differences.

With respect to gender, the present study identified female adolescents as having significantly higher odds of psychosocial problems. This finding suggests that girls may be more vulnerable to internalizing disorders such as anxiety, depression, and low self-esteem. Biological factors, gender-specific social expectations, and differences in emotional processing may contribute to this increased susceptibility. While some studies, including that of Ahmad et al,[7] have reported higher behavioural problems among males, the present findings underscore the importance of recognising psychosocial distress among female adolescents, which may often be less visible but equally significant.

Birth order was also found to be associated with psychosocial problems, with third-born adolescents showing higher odds compared to first-born children. This may be explained by factors such as reduced parental attention, resource dilution, and differences in intra-family dynamics in larger families. Previous studies have similarly highlighted the role of family structure and environment in shaping adolescent mental health outcomes.[17,18]

Overall, the findings of the present study suggest that while urban adolescents appear to have a higher burden of psychosocial problems at the descriptive level, individual-level factors such as gender and family characteristics play a more significant role when adjusted for confounders.

Public Health Implications

The findings of this study have important implications for adolescent mental health programmes. Under the Rashtriya Kishor Swasthya Karyakram (RKSK), school-based interventions including mental health screening, life skills education, and peer support mechanisms are key strategies for early identification and management of psychosocial problems.[21] Strengthening these services, particularly in schools with higher observed burden, can facilitate timely detection and intervention.

Integration with national mental health services such as the District Mental Health Programme can further improve access to care, counselling, referral services, and specialist care.[22] In addition, training teachers to recognise early signs of emotional and behavioural problems, along with increasing parental awareness, may help bridge the gap between identification and care. A coordinated, multi-level approach is essential to effectively address psychosocial problems among adolescents.

Limitations

The present study has certain limitations. It relied on self-reported data, which may be subject to reporting bias, particularly underreporting in rural areas due to stigma and limited awareness. The study included only school-going adolescents from a single district, which may limit the generalizability of the findings. Furthermore, the cross-sectional design restricts the ability to establish causal relationships between the identified factors and psychosocial outcomes.

CONCLUSION

The study demonstrated a higher prevalence of psychosocial problems among urban adolescents compared to rural adolescents. However, after adjustment for confounding variables, place of residence was not found to be an independent predictor. Female gender and higher birth order emerged as significant factors associated with psychosocial problems. These findings highlight the need for early identification through regular school-based screening and targeted interventions. Strengthening adolescent mental health services, particularly within school settings, is essential to reduce long-term psychosocial consequences and promote overall well-being.

Financial Support and Sponsorship: Nil.

Conflicts of Interest: There are no conflicts of interest.

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