Mental Behavior Analysis of Teenagers

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A thesis report submitted to the Department of Pharmacy, East West University, Bangladesh, in partial fulfillment of the requirements for the degree of M. Pharm in Clinical Pharmacy and Molecular Pharmacology

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DEDICATION

This Research Paper Is Dedicated to
My beloved parents

DECLARATION BY THE RESEARCH CANDIDATE

I, Shajeda Jahan, hereby declare that the dissertation entitled "Mental Behavior Analysis of teenagers", submitted by me to the Department of Pharmacy, East West University, in the partial fulfillment of the requirement for the award of the degree of M. Pharm in Clinical Pharmacy and Molecular Pharmacology (Masters) is a based on my own investigation carried out by me under r the supervision and guidance Farhana Rizwan, Assistant Professor, Dept. of Pharmacy, East West University and it has not formed the basis for the award of any other Degree/Diploma/Fellowship or other similar title to any candidate of any University.

_____

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CERTIFICATE BY THE INVIGILATOR

This is to certify that the thesis "**Mental behavior Analysis of Teenagers**", East West University in partial fulfillment of the requirements of the degree of M. Pharm in Clinical Pharmacy and Molecular Pharmacology was carried out by Shajeda Jahan (ID# 2013-3-79-035) under my guidance and supervision and that no part of the thesis has been submitted for any other degree. I further certify that all the sources of information and laboratory facilities availed of in this connection is duly acknowledged.

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CERTIFICATE BY THE CHAIRPERSON

This is to certify that the thesis "Mental behavior Analysis of Teenagers", East West University in partial fulfillment of the requirements of the degree of M. Pharm in Clinical Pharmacy and Molecular Pharmacology was carried out by Shajeda Jahan (ID# 2013-3-79-035) under the guidance of Assistant Professor Farhana Rizwan, in partial fulfillment of the requirement for the degree of masters of Pharmacy.

_____

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Abstract

Mental disorder is the most frequent disorder in developing countries. Children and adolescents constitute about 45% of the population of Bangladesh. In Bangladesh, the number of mental disorder in children and teenagers has increased day by day. To understand its symptoms, risk factors including family history like parent's relationship hold a great promise for the treatment, early detection and prevention of these disorders. To study the Mental Behavior Analysis of Teenagers to conduct a targeted enquiry into its quantitative magnitude This is a descriptive study were data was collected through interview with a structured questionnaire from the participants (n= 335). The participants were within 13-19 years of age mostly was a school going students. Mean age of the participant was found to be 15 years with standard deviation SD ±1.65. The percentage of different mental disorder like personality disorder, social anxiety disorder, depressive disorder and parental relationship was determined in this study. The percentage was varying by different class. In higher class teenagers had no social anxiety disorder but found a personality disorder & major depressive disorder. In lower class, lower middle class had a high percentage personality disorder, social anxiety disorder, depressive disorder and low affection to their parents. Also found a personality disorder, social anxiety disorder, depressive disorder in tribal's teenagers. So teenagers are at increased risk of having different types of disorder. They are personality disorder, social anxiety disorder, mood disorders and behavioral disorders etc. The percentage of mental disorder lower and tribal teenagers in Bangladesh is pretty higher. Necessary steps should be taken with in coordination of parents, schools authority, communities & government to stop the prevalence of teenager's mental disorders.

Key word: Teenagers, Teenagers classification, mental disorder, personality disorder, Social anxiety disorder, depressive disorder.

1.1 Overview

Mental disorders constitute a major public health problem and contribute to 13% of the global burden of disease measured as disability adjusted life years. Low and middle income countries have higher burden of mental disorders than economically developed countries. Mental disorders have serious negative effect on survival, and when present with chronic diseases as comorbid condition, serious mental disorders may reduce life expectancy by about 20 years. Today mental health and mental illnesses are key public health issues. A large number of people worldwide suffer from mental disorders. According to World Health Organization at least 40 million people in the world suffer from mental disorders such as schizophrenia and dementia (A Fahmid, Wahab MA, Rahman MM, 2009). Bangladesh is a densely populated area where prevalence of mental illness is not less than that of any other country in the world. A study showed that 29% of patients attending general practice were suffering from functional disorder and 6% from both functional and organic disorder. The same study demonstrated that 47% patients were suffering from neurotic disorder, 37% from psychosomatic disorder, 10% from affective disorder, 1.44% from schizophrenia, 2.88% from substance use disorder and 2% organic psychiatric syndrome (Mohit MA, 2001).

According to WHO (1999) all the mental and neurological disorders, depression accounts for the largest proportion of the burden. Almost everywhere, the prevalence of depression is twice as high among women as among men.

Children and adolescents constitute about 45% of the population of Bangladesh. (Faridpur Med. Coll. J. 2012).Various studies from developing countries including India show that a significant percentage (ranging between 7-35%) of child and adolescent population suffers from mental illness. They are reported to seek help in psychiatric service facilities for a variety of psychiatric disorders (Verghese A and Beig A, 1974; Mahat P *et al*., 2006; Chadda RK and Saurabh, 1994; Shrestha DM, 1986). The common

mental disorders affecting other adults also affect many children and adolescents. Such disorders usually affecting adult also distressing in this age group include mood (affective), and neurotic and stress related and somatoform disorders including anxiety and dissociative (conversion) disorders (Srinath S, Girimaji SC, Gururaj G, Seshadri S, *et al*., 2005; Chaudhury S, Prasad PL, Zacharias R, Madhusudan T, Saini R, 2007; Regmi SK, Nepal MK, Khalid A, Sinha UK, Kiljunen R, Pokharel A, Sharma SC, 2000). Another group of disorders are commonly diagnosed among children and adolescents. They include: mental retardation, disorders of psychological development (e.g. specific learning disorders, autistic disorders) and behavioral and emotional disorders with onset usually occurring in childhood and adolescence (e.g. hyperkinetic disorders, enuresis).

Children and adolescents heavily depend on family for their needs. They may not appreciate or may not be able to express psychological distress. They may somatize their symptoms because of other reasons like ignorance, myths and misconceptions regarding mental illness. The costs of childhood & teenagers disorders can be both large and largely hidden (Knapp *et al*., 1999). Early onset of mental disorders disrupts education and early careers (Kessler *et al*., 1995). The consequences in adulthood can be enormous if effective treatment is not provided (Maughan & Rutter, 1998).

1.2 Mental behavior and disorder

Term Behavior used to describe the actions of a person. Behavior is something that can be observed by others. It includes activities such as walking, talking, blinking, trembling, eating, crying etc. Mental Behavior analysis is rooted in the behaviorist tradition and utilizes learning principles to bring about behavior change. The fact that teenager's behavior analysis focuses on behavior as a subject makes it unique. This analysis is based on the ratio of emotional & mental development of the teenagers form part of a complex web of potential challenges to adolescent's healthy emotional and physical development. For all individuals, mental, physical and social health is vital strands of life

that are closely interwoven and deeply interdependent. As understanding of this relationship grows, it becomes ever more apparent that mental health is crucial to the overall wellbeing of individuals, societies and countries.

A mental disorder also called a mental illness is a mental or behavioral pattern or anomaly that causes suffering or an impaired ability to function in daily life. This pattern or anomaly is not developmentally or socially normative. Mental illness or disorders are a combination of how someone thinks, behaves, feels and perceives. That is mental illness is a wide range of mental health conditions — disorders that affect mood, thinking and behavior.

The impact is more than in statistics and factoids, it's in feelings and emotions. It's in our families, with our friends and in our communities. Having a mental disorder should not be any different than experiencing a physical illness. And it doesn't have to be; you can help to make a difference.

A mental illness makes the things you do in life hard, like: work, school and socializing with other people. If you think you (or someone you know) might have a mental disorder, it is best to consult a professional as soon as possible. Early identification and effective intervention is the key to successfully treating the disorder and preventing future disability. A health care professional (doctor, mental health specialist, etc) will connect the symptoms and experiences the patient is having with recognized diagnostic criteria (DSM or ICD) to help formulate a diagnosis.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and provides a common language and standard criteria for the classification of mental disorders. It is most commonly used in North America.

The ICD, part of the International Classification of Diseases produced by the World Health Organization (WHO), is another commonly-used guide, more so in Europe and other parts of the world.

This analysis actually based on teenager's those are in different angles like there socio-economic condition, mental condition, parental condition, treating condition, food habit and entertainment. I do believe that considering that area one can build a teenager with strong mentality, who can build a new sound generation.

1.3 Teenagers or Adolescents

Firstly I would like to explain of teenager, "Teenagers," "teens," "adolescents" or "youth", these are the years that last from puberty to adulthood. Adolescence is a critical period for mental, social, and emotional well- being and development. During adolescence, the brain undergoes through significant developmental changes, establishing neural pathways and behavior patterns that will last into adulthood. Because their brains are still developing, adolescents are particularly receptive to the positive influences of youth development strategies, social and emotional learning, and behavioral modeling. The importance of teenager's mental, social, and emotional health needs of their age group. Mental health and social and emotional wellbeing – combined with sexual and reproductive health, violence and unintentional injury, substance use, and nutrition and obesity.

1.4 Categories of teenager's:

The teenager's categories are defined on the basis of the socio-economic condition. The teenager's categories are as follows:

- Lower class
- Lower Medium class
- Medium class
- Medium high class
- Higher class
- Tribal teenager's as well.

There are Different category people in a society. In this society every people are dependent to each other. Because of society will not be developed without teenagers. Teenagers play an integral role in the family and in the society. So analysis of these categories is important because we can easily find out the actual mental behavior of the teenagers which is important for our society.

Good mental behavior can enhance one's life. Maintaining good mental health is crucial to living a long and healthy life. It was concluded in this research paper that teenager who is inclined to anti-social behaviors, aggressive behaviors. These behaviors are a direct reflection of their mental health.

1.5 Common Mental Disorders of teen-Agers

There are various types of mental disorders and everyone has its own developmental history, its own way of affecting the person and its own treatment. Information about the most common disorders is given below:

- Mood Disorders: Disturbances in usual mood states

- Major Depressive Disorder (Clinical Depression)

- Bipolar Disorder

  - Anxiety Disorders: Disturbances in brain mechanisms designed to protect you from harm

- Specific Phobias
- General Anxiety Disorder
- Social Anxiety Disorder
- Panic Disorder
- Agoraphobia
- Post Traumatic Stress Disorder (PTSD)

  - Psychotic Disorders: Disturbance of thinking perception and behavior

- Schizophrenia
- Delusional Disorder

  - Personality Disorders: Maladaptive personal characteristics

- Eccentric: Paranoid, Schizoid, Schizotypal (Cluster A)
- Dramatic/Emotional: Antisocial, Borderline, Histrionic, Narcissistic (Cluster B)
- Fear-Related: Avoidant, Dependent, Obsessive-Compulsive Personality Disorder (Cluster C)

  - Eating Disorders: Disturbances of weight and feeding behavior

- Anorexia Nervosa
- Bulimia Nervosa

  - Developmental Disorders: Early disturbances in usual brain development

- Autism Spectrum Disorder
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Learning Disorder

  - Behavioral Disorders: Persistent disturbances in expected behaviors

- Oppositional Defiant Disorder
- Conduct Disorder

1.6 Effects of mental illness (Mental health 2001)

Mental illnesses are disorders of brain function. They have many causes and result from complex interactions between a person's genes and their environment. Having a mental illness is not a choice or moral failing. Mental illnesses occur at similar rates around the world, in every culture and in all socio economic groups.

The statistics are staggering 1 in 5 young people suffer from a mental illness, that's 20% of our population but yet only about 4 percent of the total health care budget is spent on our mental health.

- According to recent estimates, approximately 20% of Americans, or about one in five people over the age of 18, suffer from a diagnosable mental disorder in a given year.
- Four of the 10 leading causes of disability—major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder—are mental illnesses.
- About 3% of the population has more than one mental illness at a time.
- About 5% of adults are affected so seriously by mental illness that it interferes with their ability to function in society. These severe and persistent mental

illnesses include schizophrenia, bipolar disorder and other severe forms of depression, panic disorder, and obsessive-compulsive disorder.

- Approximately 20% of doctor's appointments are related to anxiety disorders such as panic attacks.
- Eight million people have depression each year.
- Two million Americans have schizophrenia disorders, and 300,000 new cases are diagnosed each year.

1.7 Risk factors for mental disorder in teenagers:

Risk of depression may be related to a combination of genetic, physical, psychological, and environmental factors. These include:

- Family History of Mental Illness
- Chronic Physical or Mental Disorders (stroke, cancer, hormonal disorder etc)
- Major Life Changes and Stress
- Little or No Social Support (Having few or no supportive relationships)
- Psychological Factors (low self-esteem, perfectionism and sensitivity to loss and rejection)
- Low Socioeconomic Status (low social status, cultural factors, financial problems, stressful environments, social isolation, and greater daily stress)
- Female Gender (Hormonal factors, premenstrual changes, pregnancy, miscarriage, postpartum period, pre-menopause, menopause responsibilities at work and home, single parenthood, and caring for children and aging parents)
- Age
- **Insomnia, Sleep Disorders**

- Medications (including: pain relievers, sedatives Sleeping pills, Cortisone drugs Seizure drugs, certain medications for heart problems, high blood pressure, high cholesterol and asthma).

Risk of social anxiety disorder may be related to following factors:

- Family history: You're more likely to develop social anxiety disorder if your biological parents or siblings have the condition.
- Negative experiences: Children who experience teasing, bullying, rejection, ridicule or humiliation may be more prone to social anxiety disorder. In addition, other negative events in life, such as family conflict or sexual abuse, may be associated with social anxiety disorder.
- Temperament: Children who are shy, timid, withdrawn or restrained when facing new situations or people may be at greater risk.
- New social or work demands: Meeting new people, giving a speech in public or making an important work presentation may trigger social anxiety disorder symptoms for the first time. These symptoms usually have their roots in adolescence, however.
- Having a health condition that draws attention. Facial disfigurement, stuttering, Parkinson's disease and other health conditions can increase feelings of self-consciousness and may trigger social anxiety disorder in some people.

Although the precise cause of personality disorders isn't known, certain factors seem to increase the risk of developing or triggering personality disorders, including:

- Family history of personality disorders or other mental illness
- Low level of education and lower social and economic status
- Verbal, physical or sexual abuse during childhood
- Neglect or an unstable or chaotic family life during childhood

- Being diagnosed with childhood conduct disorder
- Variations in brain chemistry and structure
- Personality disorders usually begin in the teen years or early adulthood

1.8 Classification based on socio-economic condition

1.8.1. Lower Class:

The lower class refers to individuals who are at or near the lower end of the socioeconomic hierarchy.

The lower class is typically defined as service employees, low-level manual laborers and the unemployed. Generally those are employed in lower class occupations are often colloquially referred to as the working poor. Those who do not participate in the labor force and who rely on public assistance, such as food stamps and welfare checks, as their main source of income are commonly identified as members of the underclass or colloquially, the poor. Generally, lower class individuals work easily-filled employment positions that have little prestige or economic compensation. These individuals often lack a high school education.

Madrasa is in this category speacially Quomi madrasass. There are an estimated 6,500 Quomi madrasas in the country, with almost 1.5 million students approximately.

1.8.2. Areas:

There are different types of Madrassa in all Districts in the Bangladesh. Most of the Madrasas are State-sponsored Alia madrasas. Maximum no of Madrasa are situated in Chittagong, Sylhet, Nowakhali, Comilla, & north bangle.

According to some sources there are about 500 of these Madrasahs in Dhaka. About 400 Madrasass are operated under the Faridabade Befaqul Madrasah located at Gendaria in

Dhaka city. Around 70 Madrasass are under the Lalbagh Madrasa, there are several more located at Jatrabari and Madaninagar. These controlling Madrasa each operates like separate boards. Similarly, there are 300 Madrasass under the Ittehadul Madrasah located at Potia in the Chittagong district, at least 90 Madrasass are run under the Dwini Education Board and the Azad Dwini Education Board in Sylhet. There are 50 Madrasass under the Sawtul Hera Madrasass in the greater Mymensingh district; more are controlled by the Tanjimul Madrasass of Kishjoregamj and the Pathalia Madrasass of Jamalpur. However, the largest concentration of Qawmi Madrasass exists in Brahmanbaria. According to the chairperson of the Madrasah Education Board, Qawmi Madrasass number around 2,000 in Bangladesh (Protom Alo 2000).

1.8.3. Socioeconomic condition:

Socioeconomic condition (SEC) is an important predictor of a range of health and illness outcomes. Lower SEC is reliably associated with a number of important social and environmental conditions that contribute to crowding, crime, noise pollution, discrimination, and mental disorders.

Low income and education have shown to be strong predictors of a range of physical and mental health problems. These may be due to environmental conditions in their workplace or in the case of mental illnesses.

A class of people in a society characterized by low income, low level of education, high unemployment and as a result of these, a low social status. In the poor countries most of the people live under poverty. As a whole the life of the lower class people also very miserable. Usually they could not able to buy the extra necessities even there food, clothes and education. Their accommodation system is so poor basically they live in slum or in village straws made house. They are not capable to lead average life. Always

they fall in trouble to earn the food. Their life style is so poor, they can't able to send their children school to take education .Poor people tend to have low levels of education and limited access to land and hold low paying, physically demanding, and socially unattractive occupations, such as casual wage labor. In both urban and rural areas, the poor lack access to modern amenities and services, and they also tend to live in houses of inferior quality. Households headed by women, who are widowed, divorced, or separated, have a considerably higher incidence of poverty relative to the others.

Poverty levels are typically determined based on income and consumption levels. But evidence, and the voices of poor people themselves, has shown that poverty has many more dimensions. Poverty means hunger, lack of medical treatment, and poor access to basic services, such as electricity and water supply. It means being unable to send children to school and often needing them to work instead.

Poverty means a lack of assets—such as land or savings—and thus extreme vulnerability to shocks due to economic downturns, family illness or natural disasters. It means social exclusion, and a constant feeling of insecurity and stress based on an uncertain future.

1.8.4. Mental condition:

Generally behavior problem refers to behavior which may lead to different types of psychological problems. In the lower level, teenagers are usually involve with various kings of behaviors problem incomprehensive to others and they are generally antisocial, destructive broadly maladaptive. Extreme behavior is a common problem for the lower class teenagers, which is difficult to manage when for a long time it is, or is not, appropriate for his or her age. Problem behaviors are common in the lower class teenagers, which occur in about one quarter of all teenagers.

The negative effects of low SEC can interfere with a child's cognitive development. In addition lower-class teenagers consistently show elevated self-reports of anxiety, hopelessness, and hostility. They are sensitive and reactive to external forces in their environment (Grossman & Varnum, 2011; Kraus *et al*., 2009; Stephens, Markus, & Townsend, 2007), and especially those that may threaten themselves and others.

In the madrasass female students have not enough ambivalent idea about their physical and mental well being. Generally they are introvert, feeling shy and they hide their physical & mental problems. Many of them believe early marriage means getting married before puberty. They don't have any idea about the possible danger and complicacys regarding early marriage and pregnancy.

1.8.5. Parental condition:

With regard to hostility and aggression, lower-class mothers tend to report more hostile emotions (e.g., anger) and to suppress their nonhostile emotions (e.g., sadness and anxiety) in response to hypothetical stories of their child's anger.

Most of teenagers are not friendly with their parents. Generally parents are not trying to understand their emotions or unable to fulfill their unnecessary or necessary demand. They do misbehave with or without any reason. Most of the teenagers do not care their parents & they do not bother to their parents as well as society. Due to loss of affection and hush parenting they are involving to un-ethical work.

1.8.6. Treating condition:

Due to low socio economic condition, lower class teenagers do not get behave well to them. Our society generally neglects the teenagers due to their harsh behavior, low socioeconomic condition, low mentality, anti-socialism and low nature of work. Madrasass student generally believe on their misconceptions and religious bigotry by faith.

1.8.7. Education:

In Bangladesh in case of poor people who are always deprived from education. Because these people have not capability to send their children in schools, even they are not getting basic primary schools. Although some non government organizations (NGO) establishes school education such as BRAC school, ASA etc. As well as government took some initiative steps to provide primary education for lower level and grassroots people. For the poverty these people send their child to do the work for earn the money.

The low SEC students suffer from the lack of support from their homes. The home environment contributes substantially to the development of academic skills.

1.8.8. Food habit:

Lower class people mean those peoples live hand to mouth and they live under poverty level. They are really very poor so they can't eat good food.

They start their long day with a meal of panta with salt and green chilli. Muri, cheera, khoi and some other items of a traditional breakfast in most lower class peoples. Sometimes they don't eat at morning. Most of the rickshaw pullers and labours go to the tea stall and eat a piece of bread with a cup of tea in the morning. Sometimes they eat rice with potato vorta, brinjal vorta etc but it is very rear. They never eat like higher or lower class peoples.

Their main lunch menu is rice and dal. They do not eat restaurants food. Sometimes they do not lunch. At dinner they eat usually rice, dal, vegetables, vorta etc. sometimes they also eat fish. In lower class peoples have large number of family members and they have not enough money that's why they do not eat properly.

At the time of occasions they eat some normal pitha. Those food generally they eat its quality is very very low. Their food habits are really bad. It is not good for health but they are undone because they are very poor. They have no money.

1.8.9. Entertainment:

Basically they do not have any entertainment; they do enjoy their time by playing games like marbel, Danda Guli, riding kites and sometime watching TV by standing road site or in a hotel/ open restaurant. Madrasa students usually make some hamd/nath competition among them.

1.8.10 Lower Medium level

The term refers to the group of middle class households or individuals who have not attained the status of the upper middle class associated with the higher realms of the middle class.

1.8.11. Socioeconomic condition:

The people of lower middle class are little bit more educated then the lower level of education, employment and as a result of these, their social status is upper level then low level. In Bangladesh most of the people live under poverty. As a whole the life of the lower middle class people also miserable. Usually they can only able to buy the necessities even there food, clothes and education. There accommodation system is little bit better then the poor people. They live in tin shaded house. Sometimes they are not capable to lead average life. They are able to earn the food and cloths, able to send their child in school to take education. Lower mid level people tend to have mid-levels of education and limited access to land and hold low paying, physically demanding and socially hard level occupations, such as Good wage labor, plumber, Carpenter etc. In both urban and rural areas, the mid level has minimum access to modern amenities and services and they also tend to live in houses of moderate quality.

1.8.12. Parental condition:

Some of teenagers are friendly with their parents. Generally parents are tried to understand their emotions and due to their earning level they are unable to fulfill their necessary demand for this reason they do avoid the situation. In some cases the teenagers try to care their parents but they avoid the parents & society.

1.8.13. Mental condition:

In the lower Medium level, teenagers are also involved with various kings of behaviors problem incomprehensive to others and they are not always antisocial. But due to some social wrong activities or different situation they became antisocial. Due to social negligence the low mid level teenagers shows some behavioral and mental problems and some time they are become dangerous for the society.

1.8.14. Treating condition:

Lower mid class teenagers some time get behave well to them. Our society sometimes avoids the teenagers due to they are not able to behave properly. Other factors are Low socioeconomic condition, low mentality, anti-socialism and level of occupation. As they are not in a level of educated basically they do not know how to cop up with the society.

1.8.15. Education:

Alia madrasa follow a standardised syllabus that includes subjects such as English, Bengali, science, and mathematics. They dispense degrees, up to MA level, and are registered with, and regulated by, the Bangladesh Madrasa Education Board. The students who graduate from Alia madrasas often go on to complete their education at secular institutions – in fact, 32% of Bangladeshi university teachers in the humanities and social sciences are graduates from Alia madrasas. Depending on how you look at it, madrasas are either an insignificant proportion of the education system, or crucial in determining the future of the nation's relationship to its faithful.

1.8.16. Food habit:

At lunch they eat rice, dal, many types of vorta, vegetables etc. sometimes they eat small fishes. They like to eat road side food like shigara, samusa, dal puri, jhalmuri, chanachur etc. but they do not eat enough because they do not have enough money.

1.8.17. Entertainment:

Usually the teenager's enjoy their time by playing games like football, Cricket and other games playing on the road or sometimes in the field. Female teenager's are some indoor games like ludo, golla shoot etc. They are passing their time by watching television. Drama etc. The village teenager's are getting huge enjoyment by watching jatra and pala song etc.

1.8.18 Medium level

The middle class is a class of people in the middle of a social hierarchy. In Weberian socio- terms, the middle class is the broad group of people in contemporary society who fall socio-economically between the working class and upper class. The common measures of what constitutes middle class vary significantly among cultures.

1.8.19. Socioeconomic condition:

The Middle class is generally educated and they are doing mid level jobs. In some cases they are doing business and some official jobs. In Bangladesh most of the people are under this category. Usually they are socially able to buy the necessities even their food, clothes and education. Most of them are living in a rental house due to their occupation or business purpose. They are living an average life. They are able send their children in the college and university to take education. The mid levels are able to deposit after spending or leading their family.

1.8.20. Parental condition:

Most of teenagers are able to mix with their parents. Generally parents are trying to understand their emotions or able to fulfill their necessary demand. They do not misbehave without any reason. Most of the teenagers do care of their parents & they do try to understand their parents as well as society. Due to level of education they are not involved any un-ethical work.

1.8.21. Treating condition:

In this level teenagers are respected by the society due to their education, participating in all aspect of the society. They are able to behave properly. They are getting the opportunities in different level of occupation due to socioeconomic condition, mentality and educational background.

1.8.22. Mental Condition:

Basically they have good mental and behavioral condition. Parental social condition indicators, childhood intelligence, personality traits, education and occupation were all significance correlates of mental well-being. Their mental condition is better than the low or mid low level because they are more educated and they have free access and for their contribution to the society. Their mentally condition is well developed so that they do not getting un-tolerable hazel form the society.

1.8.23. Education:

In middle class people they provide education their child according to their ability. Because Bangladeshi education system is discriminate system. Most of the parents are not able to send their child expensive school. So in education there has big disparity in our society. Primary education is the foundation on which the nation's edifice of education has to be built and the ground laid for the individual's pursuit of further

learning and fulfillment of life's potentials. Progress in primary education in Bangladesh in the last fifteen years, despite its many deficiencies, is characterized by strengths, which truly can be regarded as points of shining light. A major achievement of the last decade was to attain gender parity in primary school enrollment. Other accomplishments are improvement in gross and net enrollment in primary education and reduction in dropout and improvement in completion of the cycle. Middle class families prefer to send their children in public and private schools, colleges, universities. Some private education organizations are so expensive. Finally, we can see the education system also play the great role in life style in the society.

1.8.24. Food habit:

Middle class peoples mean those have not lot of money like rich people. They started their day with a cup of tea with biscuits. They usually eat ruti or porota with egg fry or vegetables or halua. Some of them eat rice with vorta, dal, vegetable etc. they also eat khicuri.

At lunch they must eat rice with dal, vegetable, fish. They usually eat small fishes or which fishes are cheap like puti fish, koi fish, telapiafish, shing fish, pangas etc. They often eat big fishes like hilsa fish, rui fish, boal fish etc. they also eat some sea fishes. Meat is not their common every day dish. They eat meat once or twice in a weak. They eat chicken curry, mutton curry and beef curry. They also eat egg at lunch. Sometimes they eat biriani, polao etc. they take restaurants food very often.At afternoon or evening they drink tea with biscuits as well as noodles, jhal muri, chop, chanachur, fuska, chotpoti, chips, muglai, dal puri, vel puri, sighara, samusa and other junk food. At the evening they like to eat road side food. Road side food is very popular in middle class peoples.

At dinner they also eat rice, ruti, porota with vegetables, dal, eggs curry, fishes curry etc. they eat meats sometimes. They usually repeat their lunch at diner so most of the day they are not cooking at night. They do not prefer hard drinks usually.

They cook many items on their occasions. They cook usually rice or polao, dal, one small fish dish, one big fish dish, once or two types of meats. They also made many types of pitha like chitoi pitha,vhapa pitha, puli pitha etc. That day they also take some sweets like curd, payes, rosogolla etc. They take restaurants food occasionally. Last of all middle class peoples want to take healthy food in a cheap rate.

1.8.25. Entertainment:

Teenagers are highly interested to pay computer games, facebook chatting, riding cycle and sometimes motor cycle etc. Female teenager's are enjoying by shopping and like to participate in party and gossip with their friends. Sometimes they do like to participate school games.

1.8.26 Medium higher level

The upper middle class is a sociological concept referring to the social group constituted by higher-status members of the middle class. This is in contrast to the term "lower middle class", which is used for the group at the opposite end of the middle class stratum, and to the broader term "middle class". According to sociologist Max Weber the upper middle class consists of well-educated professionals with graduate degrees and comfortable incomes.

1.8.27. Socioeconomic condition:

The higher middle class generally educated and they are doing Higher mid level jobs. In some cases they are doing business and some high official jobs. In Bangladesh many of the people are under this category. Usually they are socially maintaining a class with

their food, clothes and education. Some of them are living in their won house/flat due to their level of earning capacity. They are highly able to achieve their desire educational level. The Higher mid levels are able to leading their family smoothly.

1.8.28. Parental condition:

Generally parents feel their kids emotions or able to fulfill their necessary demand. Teenagers are basically gentle in their behavior due to they are treated form his/her very childhood, taking care to their parents & they do understand the socioeconomic and mental condition of their parents.

1.8.29. Treating condition:

Highly mid level teenagers are also respected by the society due to their education, behavior and socioeconomic condition. They are getting the high opportunities in different level of occupation educational background and quality. They are getting huge opportunity to take part in the society.

1.8.30. Mental Condition:

They are able to behave properly. They have sound mental and behavioral condition. Due to their broad mental they are taking part to development to the society. They are willingly participating to develop the socioeconomic condition to the society due to their healthy mental condition.

1.8.31. Education:

Most of the parents are highly educated and they are sending their child to the reputed or Govt. educational organization for high level of education. A major achievement of the decade accomplishments are improvement in gross and net enrollment in university education and reduction in dropout and improvement in completion of the cycle. High

middle class families prefer to send their children in private universities. Some private education organizations are so expensive.

1.8.32. Food habit:

People from the middle classes generally enjoy healthier diets than their lower class counterparts. Part of the explanation for this is that middle class mothers tend to be less permissive in their food choices, are less concerned with the cost of food products, and are more attuned to issues of health. However, permissiveness, health and cost considerations are insufficient to account for the social class variation in food consumption. (Germov, John, Williams, Lauren, 2008).

Higher middle class peoples mean those have enough of money like rich people. They started their day with a cup of tea with biscuits. They usually eat ruti, porota or bread with omlet or vegetables or halua. Some of them eat rice with vorta, dal, vegetable etc. They also eat khicuri.

At lunch they must eat rice with dal, vegetable, fish. They usually eat small fishes or which fishes are cheap like puti fish, koi fish, telapiafish, shing fish, pangas etc. They often eat big fishes like hilsa fish, rui fish, boal fish etc. they also eat some sea fishes. Meat is not their common every day dish. They eat meat once or twice in a weak. They eat chicken curry, mutton curry and beef curry. They also eat egg at lunch. Sometimes they eat biriani, polao etc. they take restaurants food very often. They usually do not take sweets after lunch.

At dinner they also eat rice, ruti, porota with vegetables, dal, eggs curry, fishes curry etc. they eat meats sometimes. They usually repeat their lunch at diner so most of the day they are not cooking at night. They do not prefer hard drinks usually.

They cook many items on their occasions. They cook usually rice or polao, dal, one small fish dish, one big fish dish, once or two types of meats. They also made many types of

pitha like chitoi pitha,vhapa pitha, puli pitha etc. That day they also take some sweets like curd, payes, rosogolla etc. They take restaurants food occasionally.

1.8.33. Entertainment:

Higher mid level Teenager's are very similar to mid level teenagers. Most of them are riding motor cycle and sometime they are driving car. Female teenager's are enjoying by shopping and like to participate in party and gossip with their friends. Sometimes they do like to participate school games etc. They are also highly interested to pay computer games, facebook chatting,

1.8.34. Higher level

The upper class in modern societies is the social class composed of the wealthiest members of society, who also wield the greatest political power. According to this view, the upper class is generally contained within the wealthiest 1-2% of the population, and is distinguished by immense wealth (in the form of estates) which is passed on from generation to generation.

The term is often used in conjunction with the terms "middle class" and "working class" as part of a tripartite model of social stratification.

1.8.35. Socioeconomic condition:

High socio economic condition is a double-edged sword, buffering against the development of depression but also leading to increased discrimination, which in and of itself causes depression. The higher class people generally highly educated and they are leading the society even they played a vital role of the county. In some cases they are doing huge business, In Usually they are socially maintaining a luxuries life. Thus they are financially rich and they do like to visit around the world for visit or business purpose. They do not bother to spend for education or housing or desire wish. All of

them are living in their won house/flat due to their level of earning capacity. They are highly able to achieve their desire educational level.

1.8.36. Parental condition:

Some of the high class teenagers are closely attached to their parents. But at the broken family the relation between parents and teenagers are poor. They do not give concentration or extra attention to their child.

1.8.37. Treating condition:

High socioeconomic people are more likely to be able to access primary care than those of low socioeconomic people even within a universal health care system. They took all the benefit from the society due to their higher socioeconomic condition.

1.8.38. Mental Condition:

Higher SES is consistently associated with better health. Overall, the protective effects of high parent education are zeroed out by the negative effects of increased discrimination experienced because of that high socioeconomic status. Most of the high level people are broad mentality, but few people are rich and high caliber bur mentally are very poor.

1.8.39. Education:

The high SES student is likely to do more reading, more skill building, and less television watching in the home than the low SES student, even during any vacation like summer or winter (Woolfolk, 2007).

In Bangladeshi upper level people can afford to send their child to a High standard school. The expenses are so high such as Maple leaf school, oxford International school, North South University etc. They are generally going abroad for higher studies.

1.8.40. Food habit:

Higher class peoples mean those peoples have lots of money. They live in their own luxurious house or own luxurious flat and also have brand new car to go here and there. Their house is well decorated. They spent their money in many ways such as shopping, travelling own country as well as abroad and many more. They use many expensive things.

Their food habit is very very different from other peoples. They start their day with a cup of tea or coffee. At the time of their breakfast they usually eat bread and butter, corn flex, boiled egg, milk, many types of fruits juice and vegetables juice, fruits salad etc. Children's like chocolate or vanilla milk shake, bread with chocolate and chocolate corn flex.

Higher class peoples like take food from restaurants. They like to visit many countries so they like to eat foreign food such as Chinese food, Japanese food, Italian food, French food etc. They eat many types of foreign chips, ice-cream, chocolates etc that food is really very expensive. They do not eat road side food because they think that food is for poor peoples. They arrange many foods item at festive occasions like child births, birthdays, successes in examinations and job searches, promotions, weddings etc. Last of all their foods are very healthy but very costly.

1.8.41. Entertainment:

Bangladeshi upper level people usually used to do the high level entertainment. They can able to spend huge amount of money in entertainment. The upper class men had races, tournaments (including knights, and squires), and would put on a show for peasants the lords and the upper class men. The upper level people usually spend time by going vacation in richest places even in abroad. Most of the people spend their vacation with family in tourist attract places such as Switzerland, Paris, London, Bangkok

and more tourism places. Tease level of people usually watch movie at home, sometime they go at cinema hall. They could buy LCD television, VCR, DVD etc musical instrument. Even they could play badminton, billiard in their own home ground.

Upper level people's beliefs, and activities, and abilities of upper-class people covered the Principle of Legitimacy amply; but he could not resist the opportunity to exercise his special faculties in a field he knew of old. This class of people usually goes to the party such as DJ party dance party and other kind of recreational party. Some people take amusement by swim to their own swimming poll. The elite class people also can attend nationally and internationally entertainment function. so someway the richest people are so lucky.

1.8.42. Tribal:

The Bengali term ‘Adibasi’ is a respectable term to denote the communities which were known as tribes or upajatis in our country, Bangladesh. ‘Adibasi’ literally means the original or ancient inhabitants rather than ethnic minorities or groups.

1.8.43. Area:

In Bangladesh there are about 45 different tribal groups spread across the country. In overall majority of the tribal people live in different geographic location of CHT (Chittagong Hill Tracts) greater Rajshahi region. Mymensingh area is another major concentration of tribal people. (Nutrition and Population Services Plan (2008)

1.8.44. Education

There is a lack of information on education of the Tribal population. From 1991 census, it was found that the literacy and school enrolment of tribal people are not satisfactory (World Bank Report, 2008). About 82% of the children aged 5-16 are enrolled in primary

or secondary schools. According to Mullah et al., 2007, the literacy and enrollment rates rate among the tribal people is very low comparatively than the other part of Bangladesh and this literacy rate varies significantly between male and female. Three fifths of all children go to Government primary schools irrespective of the distance from the residences. The average travel time for going to a nearby school, irrespective of communities, is around half an hour. Dropout rates are high with 65% children discontinuing their education before completion of primary schooling and 19% after completion of the same. Financial problem is the main reason for school dropouts. The other reasons include distance of the school from the residence, children are not welcomed at schools, and medium of instruction is not understandable parents' not supportive, insecurity, and lack of interest of the child.

1.8.45. Socio-economic condition:

They have been working as labor and still they are. Most of them have no land, no deposit. So they have no social status. Overall participation in local level organization is low. Bamboo/straw is the most common roofing material of the tribal people and about six in ten households live in structures with walls made of natural material such as bamboo or straw. Members of landless families use to work as wage laborers, collect and sell firewood, hunt crabs and tortoises, trade hand-made bamboo products etc.

They used to live on agriculture and 90 to 95% of them owned agricultural lands. But 70 percent of them are landless now. Even the land which rest in their ownership is also decreasing being acquired legally by the government and illegally by some other dishonest usurpers from the ethnic majority.

1.8.46. Food habit:

Food habit of the tribal people is almost similar to that of the plain land people except that they consume their traditional food and a very few items like nappi (a special type of fish paste), bamboo shoots and dry vegetables.

The items consumed by the indigenous peoples and the Bengalis are mostly similar, except for some special dishes which are found to be consumed by tribal peoples' households only.

1.8.47. Treating condition:

Tribal peoples are the holders of unique cultures, knowledge systems and livelihood strategies. However, many have lost control over their own development path through historical processes. As a result, they are often excluded from political participation and their economies are undermined due to their lack of control over land and resources. Whether these peoples are pastoralists, hunter-gatherers, forest dwellers, peasants, workers in the informal economy or formally employed, most face high levels of discrimination and poverty – together with the lack of proper voice and representation in decision-making. Tribal women face additional gender-based marginalization and discrimination. Overall they are badly treated by the society.

1.8.48. Entertainment:

Overall 43% households (50% tribal and 34% Bengali) listen to radio, and 60% households with 54% indigenous and 68% Bengali watch TV. Of those not owning radio, 16% go to neighbor's houses and 13% to Hat/Bazaar and relatives'/ friends' homes. Of those not owning TV, 29% go to neighbor's homes, 15% to Hat/bazaar, and 13% to relative's/ friend's homes.

1.9. Facts about Adolescent Mental Health

Approximately 20% of adolescents have a diagnosable mental health disorder (Kessler, R.C.;Walter,E.E. *et al*., 2005).

Many mental health disorders first present during adolescence

–Between 20% and 30% of adolescents have one major depressive episode before they reach Adulthood (Rushton J. L. Forcier M. Schectman R. M. 2002)

–For a quarter of individuals with mood disorders like depression, these first emerge during adolescence.

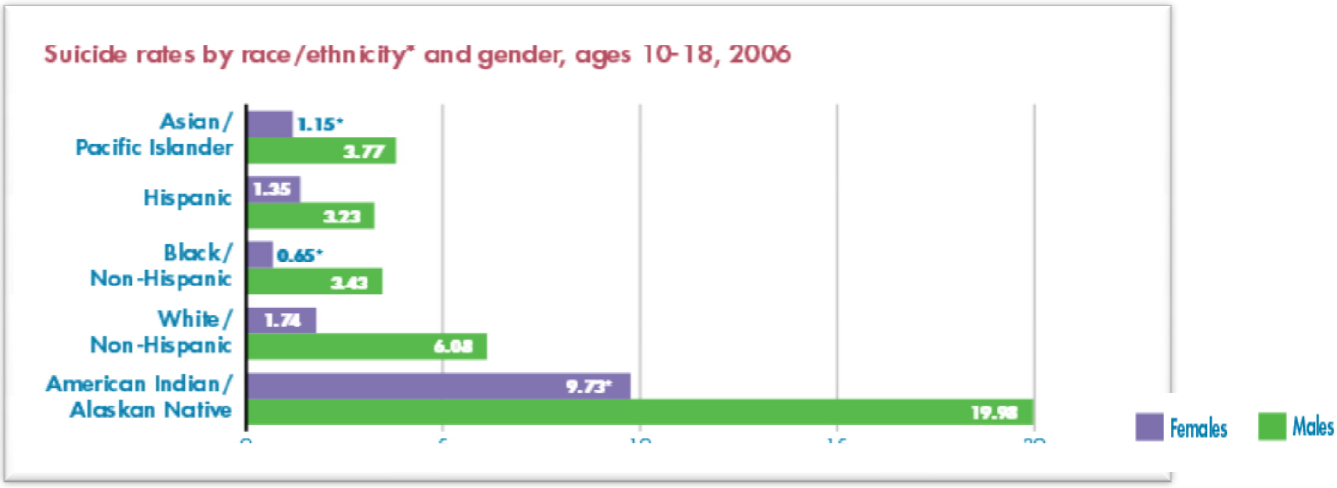
–Between 50% and 75% of adolescents with anxiety disorders and impulse control disorders (such as conduct disorder or attention-deficit/hyperactivity disorder) develop these during adolescence.

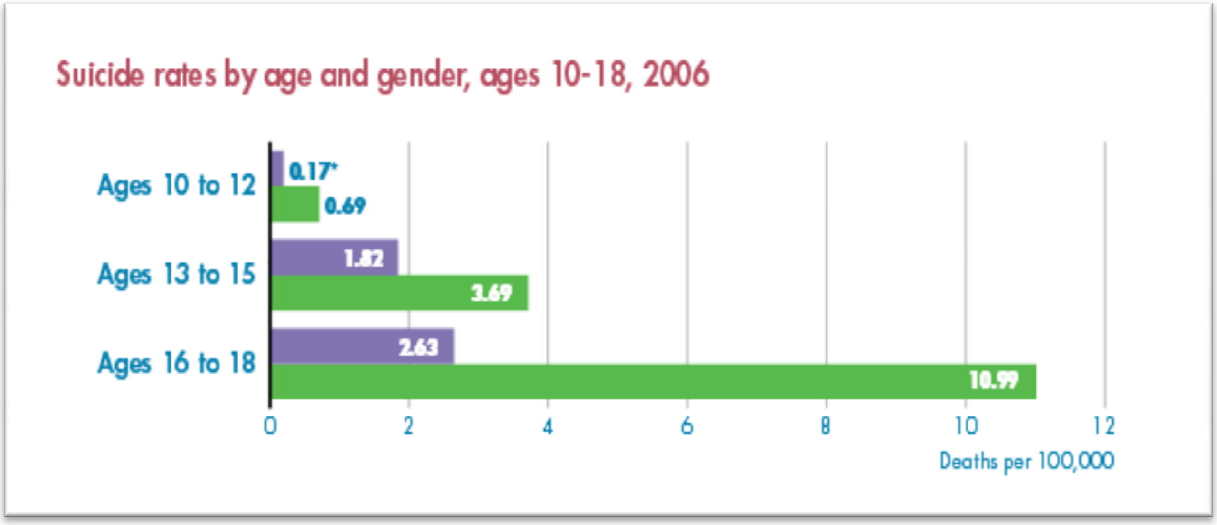
Suicide is the third leading cause of death in adolescents and young adults (World Bank Report, 2008)

–Suicide affects young people from all ages, races, genders, and socioeconomic groups, although some groups seem to have higher rates than others (National Adolescent Health Information Center. 2006)

–Older adolescents (aged 15-19) are at an increased risk for suicide (7.31/100,000).12

–Between 500,000 and one million young people aged 15 to 24 attempt suicide each year. (Children's Mental Health Statistics 2000).





Source: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System(WISQARS).www.cdc.gov/ncipc/wisqars.

Existing mental health problems become increasingly complex and intense as children transition into adolescence (Patel, V.; Flisher, A. J.; Hetrick, S.; McGorry, P. 2007).

Untreated mental health problems among adolescents often result in negative outcomes.

–Mental health problems may lead to poor school performance, school dropout, strained family relationships, involvement with the child welfare or juvenile justice systems, substance abuse, and engaging in risky sexual behaviors (Kapphahn C. Morreale M. Rickert V. Walker L. 2006)

–An estimated 67% to 70% of youth in the juvenile justice system have a diagnosable mental health disorder (Skowyra K. R., Cocozza J. J. 2006)

1.10 Significance of mental behavior analysis

Evidence from the World Health Organization suggests that nearly half of the world's population especially teenagers are affected by mental illness with an impact on their self-esteem, relationships and ability to function in everyday life (Storrie K. Ahern K. Tuckett A. 2010) .An individual's emotional health can also impact on physical health and poor mental health can lead to problems such as substance abuse (Richards K.C. Campania C. Muse-Burke J.L 2010)

Maintaining good mental health is necessary for living a long and healthy life. Good mental health can enhance one's life, while poor mental health can prevent someone from living an enriching life. According to Richards, Campania, & Muse-Burke (2010) "There is growing evidence that is showing emotional abilities are associated with prosocial behaviors such as stress management and physical health" (2010). It was also concluded in their research that people who lack emotional expression are inclined to anti-social behaviors. These behaviors are a direct reflection of their mental health. Self-destructive acts may take place to suppress emotions. Some of these acts include drug and alcohol abuse, physical fights or vandalism (Richards, K.C.; Campania, C. Muse-Burke J.L 2010).In Bangladesh, a very few substantial analysis on mental disorder about teenagers.

Teenager's mental disorder has reached widespread level in developed countries. Over the past two to three decades number of mental disorder has increased in a great ratio. In Bangladesh, the number of mental disorder teenagers has also increased in lower class & tribal teenagers. There is little work done on mental disorder as well as risk factors influence teenagers mental health in Bangladesh. Adolescents are at increased risk of having personality disorder (type A, B, C), mood disorder (bipolar disorder, major depressive disorder), anxiety disorder, psychosocial complications, psychological disorder, eating disorder etc. The number of mental disorder in lower & tribal teenagers of Bangladesh is pretty higher. Necessary steps should be taken with in coordination of parents, schools authority, communities & government to stop the prevalence of mental disorder in teenagers. In Bangladesh, the prevalence of mental disorder in teenagers is increasing day by day. To know the current statistics of the teenagers mental health, symptoms & risk factor behind mental disorder in different ages teenagers in Bangladesh.

1.11 Aim & Objectives:

The purpose of the study is to document, review and critically analyze literature on mental behavior of Teenagers and Tribal.

The specific objectives are as follows:

- To determine the major reasons behind the risk of teenagers mental health
- Analysis the symptoms of different disorders.
- To review existing literature and conduct statistical analyses to establish the prevalence and determinants of mental behavior.

There are a few substantial amounts of research on mental behavior Analysis of teen-agers. Different study showed different types of mental disorder on teen-agers.

2.1 Diagnosis of personality disorders in adolescents: a study among psychologists

Laurenssen performed a study on Diagnosis of personality disorders in adolescents. Mental health care professionals have traditionally been reluctant to diagnose personality disorders (PDs) in adolescents because of their supposed transient nature and because of stigmatizing effects. For example, Westen and colleagues assessed how often clinicians diagnosed PDs in adolescents with personality pathology. Clinicians were first asked to provide their own categorical Axis II disorders of one patient. Second, clinicians received a checklist with all Axis II criteria in random order, and were asked to decide whether each criterion applied to the patient. The authors found that when clinicians were using their own categorical Axis II diagnoses, only 28.4% of the patients were diagnosed with an Axis II disorder and almost all patients had only one PD. When using the checklist, 36.8% of the patients were diagnosed with a cluster A PD, 54.4%with a cluster B PD, and 41.2% with a cluster C PD. Also, approximately 33% of the patients were diagnosed with more than one PD. A possible explanation for the difference is that clinicians at first hesitate to diagnose PDs in adolescents because they believe certain features of PDs are normative and not particularly symptomatic of a personality disturbance per se. Another possible explanation is that Westen's research took place before the publication of evidence-informed guidelines for diagnosing PD in adolescence. New research since then has indicated, for example, that borderline personality disorder (BPD) in adolescents is common and that the diagnosis of BPD can be measured with sufficient reliability and validity. Regarding stability, the diagnosis of BPD remained stable over time only for the most severe subgroup of adolescents; however it is possible that symptoms were reduced during the course of treatment. More generally, PDs can be diagnosed reliably

in adolescents and are highly prevalent; prevalence rates range from 10 to 15% in this age group. Furthermore, PDs in adolescents are extremely invalidating and may cause serious current and future distress in young people and their environment.

Although a majority of psychologists working with adolescents acknowledged the existence of PDs in adolescents (57.8%), only a small minority diagnoses PDs in adolescence (8.7%) and offers a treatment specifically aimed at targeting PD pathology (6.5%). Reasons for not diagnosing PDs in adolescence mainly concerned the belief that adolescent personality problems are transient (41.2%) and that the DSM-IV-TR does not allow diagnosing PDs in adolescence (25.9%) (Laurenssen *et al.* 2013).

2.2 Mental health of children and young people in Great Britain

McGinnity H, Meltzer T, Ford R. G published a book on mental health to the children and young people. The authors found that absence from school Children with mental disorders were much more likely than other children to have had time off school: 17% of those with emotional disorders, 14% of those with conduct disorders and 11% of those with hyperkinetic disorders had been away from school for over 15 days. Among other children, the proportion was just 4%. Children with mental disorders tended to have poorer general health than other children and at least some of these absences will have been health related. However, children with emotional disorders and those with conduct disorders were much more likely than other children to have had unauthorized absences and high proportions in all three disorder groups were thought by their teachers. As many as one in three children with a conduct disorder had been excluded from school and nearly a quarter had been excluded more than once.

Among children with generalized anxiety disorder, 19% lived in a family containing stepchildren compared with 11% among children with no emotional disorder Children with emotional disorders were more likely than other children to have parents who had no educational qualifications (35 per cent compared with 20 per cent) and to live in low

income families. Parents of children with an emotional disorder were more than twice as likely as other parents to have a score on the General Health Questionnaire (GHQ-12) indicative of an emotional disorder (51% compared with 23% other parents). Children with hyperkinetic disorders were more likely than other children to live with single or previously married lone parents (38% compared with 24%) (McGinnity H, Meltzer T, Ford R. G. 2004).

2.3 Mental health problems in children and young people

Margaret M, Peter F. reported in a study that the British Child and Adolescent Mental Health Surveys found that 1 in 10 children and young people under the age of 16 had a diagnosable mental disorder. Among the 5 to 10 year olds, 10% of boys and 5% of girls had a mental health problem while among the 11 to 16 year olds the prevalence was 13% for boys and 10% for girls (survey from 1999 to 2004). The most common problems are conduct disorders, attention deficit hyperactivity disorder (ADHD), emotional disorders (anxiety and depression) and autism spectrum disorders. Rates of mental health problems in children and young people in the UK rose over the period from 1974 to 1999, particularly conduct and emotional disorders.9 in the absence of more recent data; it is unknown whether this trend has continued. Mental health problems in children and young people cause distress and can have wide-ranging effects, including impacts on educational attainment and social relationships, as well as affecting life chances and physical health. Mental health problems in children and young people can be long-lasting. It is known that 50% of mental illness in adult life (excluding dementia) starts before age 15 and 75% by age 18. In addition, there are well-identified increased physical health problems associated with mental health. There are strong links between mental health problems in children and young people and social disadvantage, with children and young people in the poorest households three times more likely to have a mental health problem than those growing up in better-off homes. Parental mental

illness is associated with increased rates of mental health problems in children and young people, with an estimated one-third to two-thirds of children and young people whose parents have a mental health problem experiencing difficulties themselves (Margaret M, Peter F. 2012).

2.4 Prevalence of children's behavioral

Achenbach and Howell looked at whether the prevalence of children's behavioral or emotional problems changed significantly over a 13 year period. Problems reported by parents and teachers for a random sample of 7 to 16 years olds assessed in 1989 were compared with those reported by parents for a 1976 sample and by teachers for a 1981/1982. Parent reports were obtained with the child behavior Checklist; teacher reports were obtained with the Teacher's Report form. They found problem scores are higher than in earlier assessments (Achenbach and Howell 1993).

2.5 Prevalence study among child and adolescent patients

The study of Grilo and colleagues Grilo and colleagues (1998) published prevalence study among adolescent patients. Most research on personality disorders in adolescents is derived from the Children in the Community study (CIC; Chen, Cohen, Kasen, & Johnson, 2006; Johnson *et al.,* 2000; Johnson, Chen, & Cohen, 2004; Kasen *et al.,* 2007), which was carried out in the general population. Recent studies have provided convincing evidence that personality disorders are common in adolescents. Furthermore, research shows that adolescents with personality disorders are at a greater risk for having a broad range of problems than adolescents without personality disorders. 257 adolescents aged 14 to 19 years were included in this study. They were referred to de Viersprong from May 2006 to March 2008. One hundred thirty-three of these adolescents (51.8%) were admitted to Psychotherapy for Adolescents, and were followed for two years. Personality disorders can be reliably classified in adolescents; prevalence rates range from 10 to 15% in this age group. These problems include:

suicidal thoughts and attempts ; problems at school (Westen *et al.,* 2003); behavioral problems (Johnson *et al.,* 2005); substance abuse (Serman, Johnson, Geller, Kanost, & Zacharapoulou, 2002); deviant sexual behavior (Lavan & Johnson, 2002), and emergency admissions (Kasen *et al*., 2007), failing at school (Johnson *et al.,* 2005): mood- (Daley et al., 1999); anxiety- , and substance use disorders (Johnson *et al.,* 1999). They are also more likely to have: financial and health problems (Chen, Cohen, Kasen, & Johnson, 2006a); more setbacks in life (Chen *et al.,* 2006b); more familial conflicts (Johnson, Chen, & Cohen, 2004), and interpersonal difficulties and stress (Daley, Rizzo, & Gunderson, 2006).

2.6 The Office of National Statistics (ONS) surveys of 1999 and 2004

The Office of National Statistics (ONS) surveys reported that their prevalence was 5% among children and young people aged between 5 and 16 years. Conduct disorders nearly always have a significant impact on functioning and quality of life. The 1999 ONS survey demonstrated that conduct disorders have a steep social class gradient, with a three- to fourfold increase in prevalence in social classes D and E compared with social class A. The 2004 survey found that almost 40% of looked-after children, those who had been abused and those on child protection or safeguarding registers had a conduct disorder. The prevalence of conduct disorders increases throughout childhood and they are more common in boys than girls. For example, 8% of boys and 5% of girls aged 11 to 16 years have conduct disorders. Conduct disorders commonly coexist with other mental health problems: 46% of boys and 36% of girls have at least 1 coexisting mental health problem. The coexistence of conduct disorders with attention deficit hyperactivity disorder (ADHD) is particularly prevalent and in some groups more than 40% of children and young people with a diagnosis of conduct disorder also have a diagnosis of ADHD.

In 1999 survey, the 3 common groups of disorders were covered:

Emotional disorders such as anxiety, depression and obsessions.

Conduct disorders characterized by awkward, troublesome, aggression and anti-social behavior.

Hyperactivity disorders involving in attention and over activity.

2.7 The prevalence in studies of children and adolescents with ODD

A literature review conducted by Hinshaw and Lee (2003) the prevalence in studies of children and adolescents with ODD ranged from 1% to more than 20%, while the prevalence for CD (Conduct disorders) ranged from less than 1 percent to over 10 percent. The progression of conduct problems appears to remain somewhat stable from early childhood to later childhood (Broidy, *et al.,* 2003; Campbell, 1991; Olweus, 1979). Furthermore, studies have shown that ODD(Oppositional Defiant Disorder) characteristics emerge 2 to 3 years earlier in childhood than do CD symptoms (Lahey *et al.,* 1997; Loeber, *et al.,*1992; Loeber & Farrington, 2000), with the average age of onset for ODD being 6 years compared to 9 years for CD behaviors. Approximately 33 percent of children with ODD subsequently develop conduct disorder, 40 percent of whom will develop antisocial personality disorder in adulthood (Loeber, *et al.,* 2000). Literature reviews by Hanley, Iwata, and McCord (2003) and Beavers, Iwata, & Lerman (2013) collectively identified 435 peer-reviewed articles where functional analysis of problem behavior was reported. Studies listed below represent large scale consecutive controlled case series studies involving functional analysis. These studies demonstrate that functional analysis is highly effective in identifying the controlling variables for problem behavior.

2.8 An estimated one in five adolescents has a diagnosable disorder

A paper published by David M., Megan B., B.A., and Brigitte V., in 2003. An estimated one in five adolescents has a diagnosable disorder. Adolescence is a time when many mental disorders first arise; in fact, more than half of all mental disorders and problems with substance abuse (such as binge drinking and illegal drug use) begin by age 14, and three-quarters of these difficulties begin by age 24. Accurate estimates of the number of adolescents who have diagnosable mental disorders are difficult to come by, for several reasons: many adolescents are reluctant to disclose these disorders and most diagnoses rely on clinical judgment rather than on biological markers (such as a blood test).However, available data suggest that 20% of adolescents have a diagnosable mental disorder. In 2011, more than one in four (29%) high school students in grades 9-12 who participated in a national school-based survey reported feeling sad or hopeless almost every day for two weeks or longer during the past year which is called depression (David M., Megan B., B.A., Brigitte V. 2003).

Another survey that collected information from adolescents between the ages of 12 and 17 found that in 2008, about one in 12 (8%) reported experiencing a major depressive episode during the past year. These estimates have not changed much over the past five to 10 years. A slightly lower percentage of adolescents (3%) met the criteria for conduct disorders. Adolescents with conduct disorders are extremely uncooperative, are persistent in defying societal rules and authority figures, and are often severely angry, aggressive, and destructive. An estimated 10% of adolescents have anxiety disorders, the most common of which are OCD, post-traumatic stress disorder, and phobias (Substance Abuse and Mental Health Services Administration 2009). Results from the National Survey on Drug Use and Health: National Findings (Office of Applied Studies).

The mental health of adolescents: A national profile, 2008. National Adolescent Health Information Center Rockville, MD. Knopf, D. *et al.* 2008).

2.9 The prevalence of clinically significant psychiatric disorder in children

Worldwide, the prevalence of clinically significant psychiatric disorder in children is at least 7%. This rate rises in socially disadvantaged and densely populated urban areas. It also increases by 3%–4% after puberty. Childhood psychopathology presents as:

•disturbed or antisocial behavior (externalizing disorders) — prevalence 3%–5%

•troubled emotions and feelings (internalizing disorders) — prevalence 2%–5%

•a mixture of psychological problems and physical illness (somatoform disorders) — prevalence 1%–3%

•more rarely as childhood psychosis or pervasive developmental (autism spectrum) disorders — prevalence about 0.1%.

Boys are two or three times more likely than girls to be affected by disturbed and antisocial behavior. The ratio is more equal for emotional disturbances. There are more girls than boys affected by depression and anorexia

In 2009, in a survey by the Centers for Disease Control (CDC), 26.1% of students nationwide reported feeling so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing some usual activities. Similar statistics are also reported in mental health studies by the American College Health Association and by independent surveys although there are treatments for depression, many victims do not recognize symptoms. If left untreated, depression can cause appetite loss, sleep disorders, fatigue and anxiety, along with poor academics and higher dropout rates.

Estimates of the number of school aged children with emotional problems vary. Incidence and prevalence are controversial, with estimates ranging from 2-3% to 22% (Costello, l989; Doll, l996; Knitzeret *et al.,* l990; Knopf *et al*., 2008). The numbers increase when those referred at risk are included (Dryfoos, l990, l994; Hodgkinson, l989). One reason is that legal mandates require certain mental health services for students diagnosed with special education needs (Duchnowski, 1994). Another is that school policy makers and practitioners recognize that social, emotional, and physical health problems and other major barriers to learning must be addressed if schools are to function satisfactorily and students are to learn and perform effectively (Flaherty *et al.*, 1996; Tyack, 1992).

2.10 Child and Adolescent Psychiatry and Mental Health

Malhotra and Patra published a review paper in Child and Adolescent Psychiatry and Mental Health. Previous epidemiological studies have found that the prevalence of child and adolescent mental disorders to be 17.7% in Ethiopia, 15% in Bangladesh. 12.7% and 7% in urban and rural Brazilian school sample respectively and 6.9% in PuertoRico.

In India, Sixteen community based studies on 14594 children and adolescents; and seven school based studies on 5687 children and adolescents, reporting prevalence of child and adolescent psychiatric disorder were analyzed. The prevalence rate of child and adolescent psychiatric disorders in the community has been found to be 6.46% (95% confidence interval 6.08% - 6.88%) and in the school it has been found to be 23.33% (95% confidence interval 22.25% - 24.45%).The prevalence was much higher in some other countries like Germany 20.7%, 14.5% and Switzerland 22.5%. this studies done in the schools only to the child and adolescent population within 5–19 years age group (Malhotra and Patra 2014).

A Five-year Strategic Plan for the Tribes of Idaho, Oregon, and Washington Northwest Portland Area Indian Health Board, Portland in 2014. According to this Adolescents (10 to 19 years old) and young adults (20 to 24years old) make up 21% of the U.S. population.

During adolescence, young people experience profound physical, psychological, emotional and social changes. In an attempt to cope with the complex changes and challenges of development, adolescents often take risks to explore who they are and test their limits as individuals. Because adolescents are in developmental transition, they are particularly sensitive to social and environmental influences.

- Environmental factors-including family, friends, schools, neighborhoods, policies, and societal cues-can support or challenge young people's health and wellbeing.
- Behavior patterns established during this period affect their current and future health status.
- , For Native adolescents (ages 10-24) in Oregon, Washington and Idaho:
  - Accidents and unintentional injury are the leading causes of death, with unintentional injury causing over 50% of deaths in this age group
  - Suicide is the second leading cause of death in this age group, accounting for 17% of deaths among NW Native adolescents
  - Homicide is the 3rd leading cause of death, accounting for 11% of adolescent deaths
- Moreover, of high-school aged AI/ANs (American Indians and Alaska Natives):
  - 70.6% have tried smoking cigarettes (national average, 44.7%)
  - 78% have consumed alcohol (national average, 71%)
  - 71.6% have smoked marijuana (national average, 39.9%)
  - 21.2% are overweight and 17.5% are obese (both higher than national averages of 15.2% and 13.0% respectively)
  - 22.3% have been bullied at school (national average, 20.1%)
  - 21.8% seriously considered attempting suicide and 14.7% attempted suicide at least once in the last year (national averages respectively, 15.8% and 7.8%).
- There is little evidence for a genetic basis for behavior problems. Genetic contributions to childhood aggression appear to be relatively small (Jacobson, Pres

cott, & Kendler, 2002) and psychobiological influences are at best inconclusive (Hinshaw & Lee, 2003). Instead, a large emphasis is placed on the multifaceted and transactional causal factors for disruptive behaviors (Coie & Dodge, 1998; Hinshaw & Lee, 2003). The literature concerning underlying factors for disruptive behaviors converges on environmental factors. Most importantly, high levels of parental psychopathology, poverty, poor family functioning, dysfunctional parent-child interactions, and childabuse are thought to play a role in the severity of disruptive behaviors in children (Coie & Dodge, 1998). Associated variables with disruptive behaviors include, but are not limited to, cognitive deficits (Moffit & Lynam, 1994), difficulties in social-cognitive information processing (Crick & Dodge, 1994), and peer rejection (Coie & Dodge, 1998).

3.1 Topic of the study:

Mental Behavior Analysis of Teen-agers

3.2 Type of Study:

This is a cross sectional (descriptive study), where data was collected through interviews with a structured questionnaire as well as recorded data of each patient. The study protocol was reviewed and approved by the supervisor.

3.3 Place of study:

The present study was carried out in the

- Baitul Fojol Islamia Alim Madrasa, Mohammadpur, Dhaka
- Ati Bazar darul ulum islamia madrasa,Ati bazaar, Dhaka
- Dhaka college, Dhaka
- Lalmatia college, Dhaka
- St. joseph, mohammadpur,Dhaka
- Mastermind, pachlaish Chittagong.
- Mohammadpur Girls High School, Dhaka
- Lalmatia Girls High School, Dhaka
- I.E.S Uttora sector-5, Dhaka
- Mohammadpur model School & College
- Badsha faisal Institute, mohammaded, Dhaka
- Mohammadpur Govt High School, mohammaded, Dhaka
- Mohammadpur preparotory school, mohammaded, Dhaka
- Gonovobon govt high school , mohammaded, Dhaka
- Faizur rahman ideal institute, mohammaded, Dhaka
- Naogaon, Rajshahi.

3.4 Study Population:

Around of 335 teenagers were included in the study.

3.5 Data collection method:

This paper consisted of multiple choice questions and open answer questions. A total of 335 teenagers were included in the study and interviewed as per the questionnaire.

3.6 Statistical analysis used:

Standard deviation, mean, frequency and percentage (%) were applied to select observations and results were calculated with Microsoft® Excel 2013 & statistical package for the social Sciences SPSS v.18.

Result

During the study period 335 Participant were interviewed. The age of the teenagers ranged from 13 to 19 years. Where male participants were 61.19% & female were 38.81%.

Table 4.1: Participant of different age

Age	Number of participants	Percentage (%)
13	40	11.9
14	77	23.0
15	75	22.4
16	59	17.6
17	38	11.3
18	32	9.6
19	14	4.2
Mean	15.39	
Std. Deviation(SD)	±1.65	
Minimum	13	
Maximum	19	

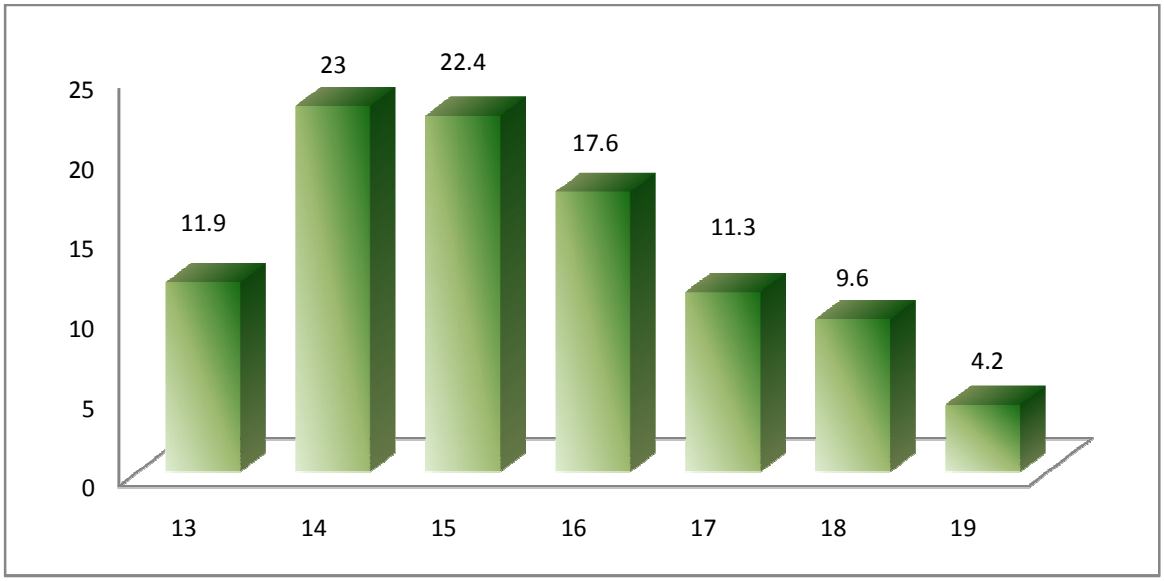


Fig: Age distribution

More than 63% of participants were in the age group of 14 to 16 years.

Table 4.2: Gender distribution:

	Number of participants	Percentage (%)
Male	205	61.19
Female	130	38.81

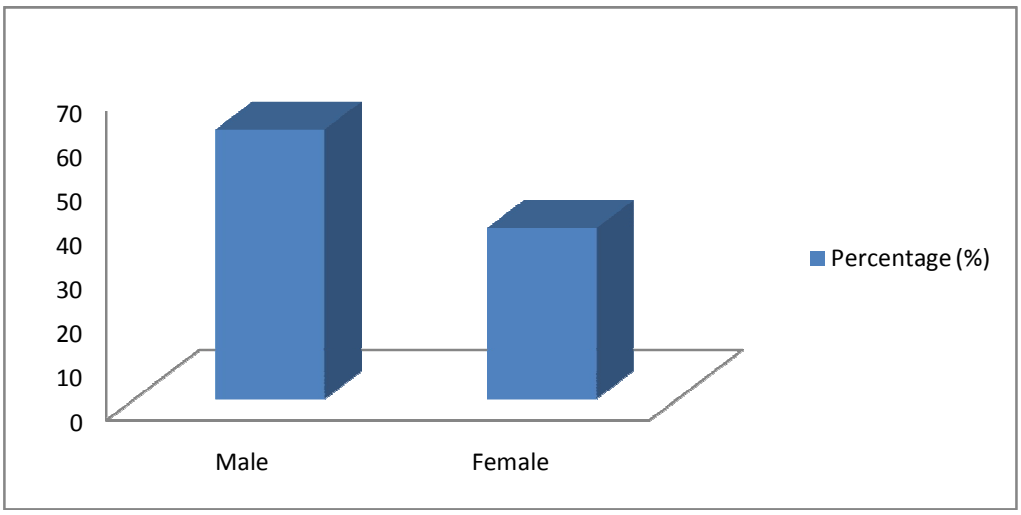


Figure: Gender distribution

In this study majority of the participants are male. The percentage of male (61.2%) teenagers was higher than the female (38.8%) teenagers.

Table 4.3: Symptoms of personality disorder in lower class

Symptoms		Yes	No
Difficulties in making friends	Frequency	18	12
	Percent (%)	60	40
Feeling lonely	Frequency	16	14
	Percent (%)	53.3	46.7
Trust people	Frequency	22	8
	Percent (%)	73.3	26.67
Impulsive	Frequency	18	12
	Percent (%)	60	40
Dependent	Frequency	20	10
	Percent (%)	66.67	33.33
Perfectionist	Frequency	11	19
	Percent (%)	36.7	63.3

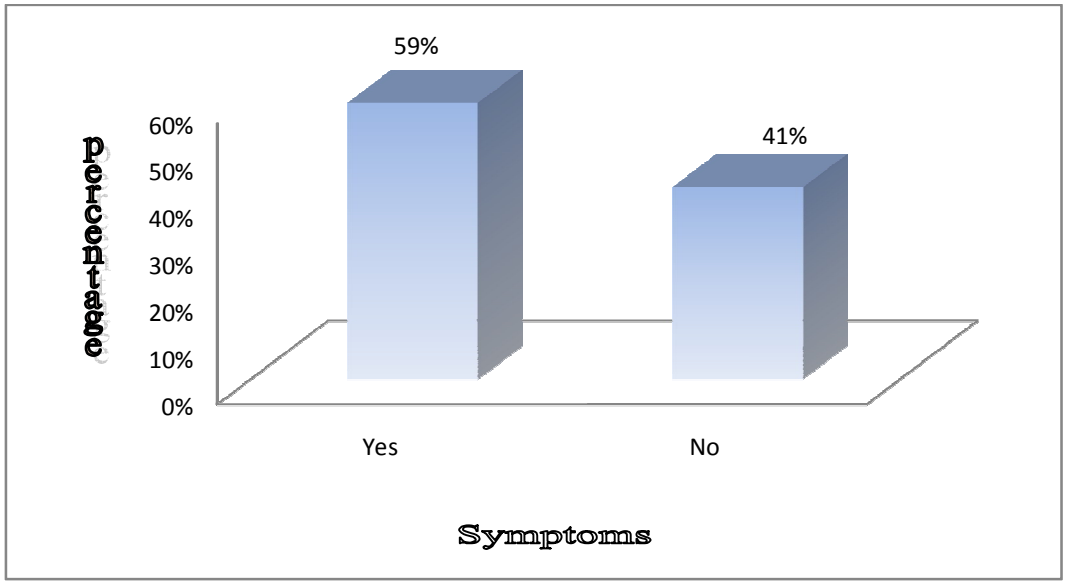


Figure: The Percentage (%) of personality disorder in lower class

Symptoms of personality disorder, lower class teenagers (60%) are facing difficulty making friends,53.3% describe as a loner, 73.3% trust other people, 60% are normally an impulsive sort of person, 66.67% are depend on other people, 36.7% are perfectionist.

Lower class teenagers have 60% personality disorder.

Table 4.4: Symptoms of Social anxiety disorder in lower class

Symptoms		Not at all	A little bit	Somewhat	Very much	Extremely
Afraid people of authority	Frequency	6	10	7	4	3
	Percent (%)	20	33.3	23.3	13.3	10
Blushing in front of people	Frequency	5	8	3	10	4
	Percent (%)	16.7	26.7	10	33.3	13.3
Scaring of parties and social event	Frequency	4	9	8	6	3
	Percent (%)	13.3	30	26.7	20	10
Avoid talking to strangers	Frequency	2	7	8	9	4
	Percent (%)	6.7	23.3	26.7	30	13.3
Scaring of criticizes	Frequency	5	5	6	12	2
	Percent (%)	16.7	16.7	20	40	6.7
Avoid doing/ speaking people for fear of embarrassment	Frequency	3	7	6	10	4
	Percent (%)	10	23.3	20	33.3	13.3

Sweating in front of people	Frequency	7	9	4	7	3
	Percent (%)	23.3	30	13.3	23.3	10
Avoid to go parties	Frequency	6	7	6	9	2
	Percent (%)	20	23.3	20	30	6.7
Avoid activities when center of attention	Frequency	3	5	7	10	5
	Percent (%)	10	16.7	23.3	33.3	16.7
Scared to talk strangers	Frequency	9	7	10	3	1
	Percent (%)	30	23.3	33.3	10	3.3
Avoid to give speeches	Frequency	7	4	10	6	3
	Percent (%)	23.3	13.3	33.3	20	10
Do anything to avoid being criticized	Frequency	3	5	14	4	4
	Percent (%)	10	16.7	46.7	13.3	13.3
Heart palpitations bothered by surrounding people	Frequency	11	6	7	3	3
	Percent (%)	36.7	20	23.3	10	10
Afraid of doing things when people are watching	Frequency	12	6	3	8	1
	Percent (%)	40	20	10	26.7	3.3
Worst fear of being embarrassed & looking stupid	Frequency	4	8	6	10	2
	Percent (%)	13.3	26.7	20	33.3	6.7
Avoid speaking anyone to authority	Frequency	9	6	14	1	0
	Percent (%)	30	20	46.7	3.3	0

Percentage of Social anxiety disorder

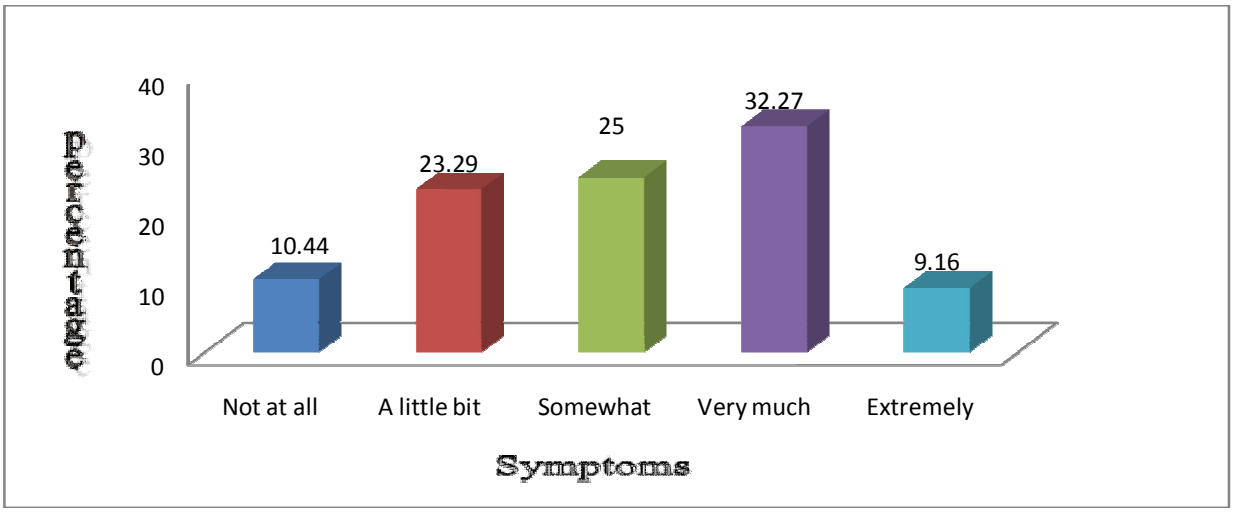


Figure: Percentage of Social anxiety disorder

From our study, the total percentage of symptoms of social anxiety disorder of lower class teenagers 32.27% are very much, 25 % are somewhat, 23.13 % are a little bit,

9.16% are extremely & 8.03% are not at all. We found that most of the lower class teenagers have high social anxiety disorder.

Table 4.5: Symptoms of Social anxiety disorder in lower class

symptoms		Not at all	Several days	More than half of the days	Nearly everyday
little interest or pleasure in doing things	Frequency	15	5	6	4
	Percent (%)	50	16.7	20	13.3
Feeling depressed or hopeless	Frequency	5	8	10	7
	Percent (%)	16.7	26.7	33.3	23.3
Trouble in falling asleep or over sleeping	Frequency	6	7	13	4
	Percent (%)	20	23.3	43.3	13.3
Poor appetite or over eating	Frequency	4	7	12	7
Feeling bad about failure family down	Frequency	11	8	8	3
	Percent (%)	36.7	26.7	26.7	10
Hard to concentrate in studying or playing	Frequency	1	8	16	5
	Percent (%)	3.3	26.7	53.3	16.7
Suicidal tendency	Frequency	10	6	6	8
	Percent (%)	33.3	20	20	26.7

Percentage of Depressive disorder

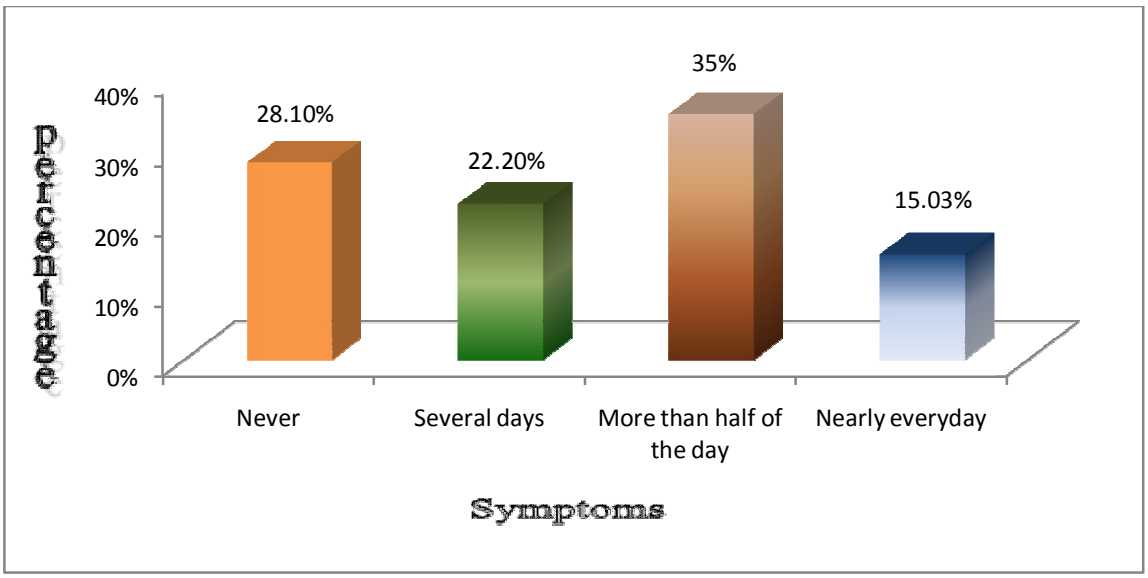


Fig: The Percentage (%) of Depressive disorder

In lower class teenagers, the maximum percentage of teen agers was found who more than half of the days were depressed (35%). never depressed teenagers were (28.10%).15% teenagers were found who depressed nearly every day & 22.2% were found who were depressed in several days.

Table 4.6: Percentage of having parents in lower class

		Yes	No
Having parents	Frequency	13	17
	Percent (%)	43.3	57.7

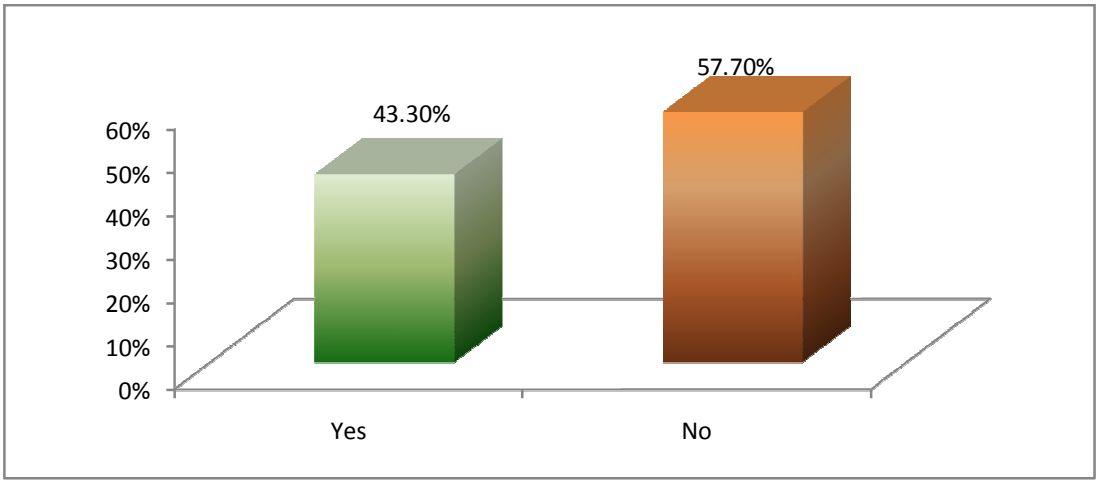


Figure: Percentage of having parents

In our study, lower class teenagers having 43.3% parents.

Table 4.7: Parent's relationship with their children

		Never	Sometimes	Often	Very Often
Children share everything	Frequency	15	7	2	6
	Percent (%)	50	23.3	6.7	20
Children are feeling extremely happy or wound up & excited	Frequency	3	5	5	17
	Percent (%)	10	16.7	16.7	56.7
Children not giving concentration on study	Frequency	4	8	17	1
	Percent (%)	13.3	26.7	56.7	3.3
Children fear of making friends	Frequency	5	6	11	8
	Percent (%)	16.7	20	36.7	26.7
Children are feeling irritation or chunky	Frequency	6	4	8	12
	Percent (%)	20	13.3	26.7	40
Aggressive behavior of children	Frequency	3	4	13	10
	Percent (%)	10	13.3	43.3	33.3
Children talk dirty	Frequency	0	2	25	3
	Percent (%)	0	6.7	83.3	10
Feeling shy & an introvert	Frequency	2	6	14	8
	Percent (%)	6.7	20	46.7	26.7
child are confusing of sudden change in the body	Frequency	6	7	15	2
	Percent (%)	20	23.3	50	6.7

Get angry if anything is not according children will	Frequency	6	11	9	4
	Percent (%)	20	36.7	30	13.3
Disobedient behavior	Frequency	1	23	4	2
	Percent (%)	3.3	76.7	13.3	6.7
Taking thing without permission	Frequency	4	5	9	12
	Percent (%)	13.3	16.7	30	40
Arguing nature of children	Frequency	4	5	12	9
	Percent (%)	13.3	16.7	40	30
Feeling of inferiority	Frequency	1	11	10	8
	Percent (%)	3.3	36.7	33.3	26.7

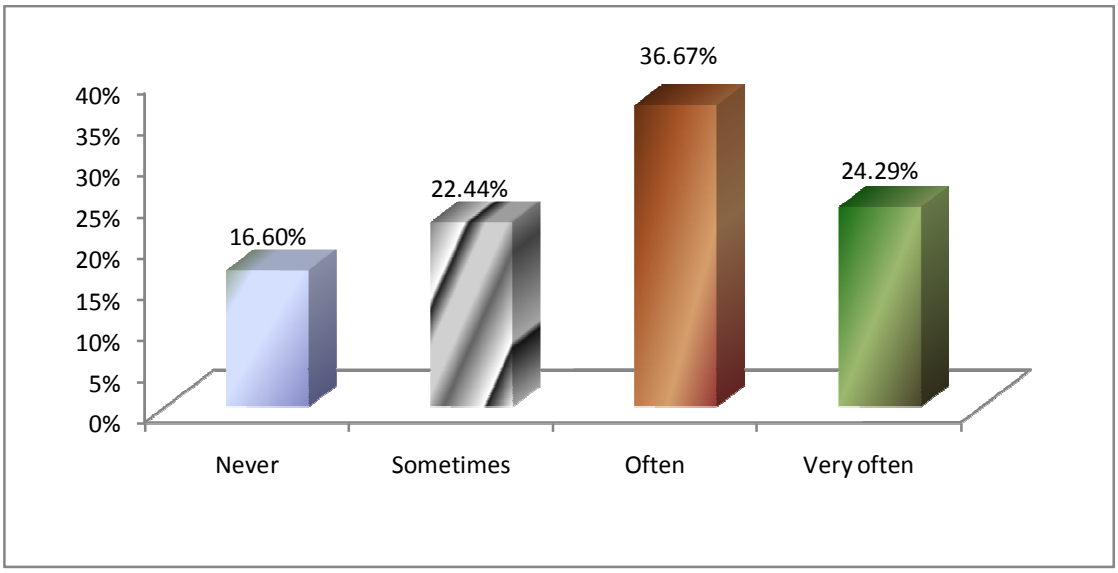


Figure: percentage of parent relationship with their children

According to the symptoms lower class teenagers are low parents relationship. In lower class 16.6% teenagers is close to their parent's. 22.44% are sometimes 24.3% are very often, 36.67% teenagers are often distance with their parent due to low affection & harsh parenting.

Table 4.8: Symptoms of personality disorder in lower medium class

Symptoms		Yes	No
Difficulties in making friends	Frequency	32	23
	Percent	58.2	41.8
Feeling lonely	Frequency	48	7
	Percent	87.3	12.7
Trust people	Frequency	38	17
	Percent	69.1	30.9
Impulsive nature	Frequency	14	41
	Percent	25.5	74.5
Dependent	Frequency	20	35
	Percent	36.4	63.6
Perfectionist	Frequency	16	39
	Percent	29.1	70.9

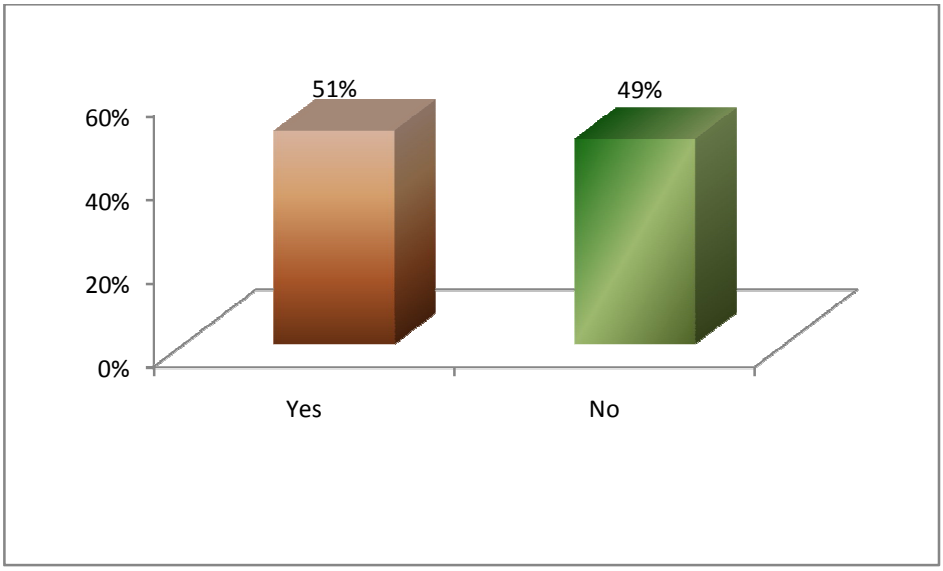


Fig: The Percentage (%) of personality disorder lower medium class

In lower medium class teenagers have 51% personality disorder.

Table 4.9: Social anxiety disorder in lower medium class

Symptoms		Not at all	A little bit	Somewhat	Very much	Extremely
Afraid people of authority	Frequency	16	19	13	5	2
	Percent	29.1	34.5	23.6	9.1	3.6
Blushing in front of people	Frequency	13	10	8	17	7
	Percent	23.6	18.2	14.5	30.9	12.7
Scaring of parties and social event	Frequency	5	32	10	6	2
	Percent	9.1	58.2	18.2	10.9	3.6
Avoid talking to strangers	Frequency	18	17	10	4	6
	Percent	32.7	30.9	18.2	7.3	10.9
Scaring of criticizes	Frequency	8	4	37	5	1
	Percent	14.5	7.3	67.3	9.1	1.8
Avoid doing/ speaking people for fear of embarrassment	Frequency	10	19	11	6	9
	Percent	18.2	34.5	20	10.9	16.4
Sweating in front of people	Frequency	29	10	6	7	3
	Percent	52.7	18.2	10.9	12.7	5.5
Avoid to go parties	Frequency	4	28	11	8	4
	Percent	7.3	50.9	20	14.5	7.3
Avoid activities when center of attention	Frequency	15	11	19	6	4
	Percent	27.3	20	34.5	10.9	7.3
Scared to talk strangers	Frequency	27	10	11	7	0
Avoid to give speeches	Percent	10.9	29.1	34.5	14.5	10.9
	Frequency	6	15	13	5	16
Do anything to avoid being criticized	Percent	10.9	27.3	23.6	9.1	29.1
	Frequency	17	20	6	6	6
Heart palpitations bothered by surrounding people	Percent	30.9	36.4	10.9	10.9	10.9
	Frequency	7	14	19	11	4
Afraid of doing things when people are watching	Percent	12.7	25.5	34.5	20	7.3
	Frequency	12	9	8	20	6
Worst fear of being embarrassed & looking stupid	Percent	21.8	16.4	14.5	36.4	10.9
	Frequency	12	22	18	2	1
Avoid speaking anyone to authority	Percent	21.8	40	32.7	3.6	1.8

Social anxiety disorder

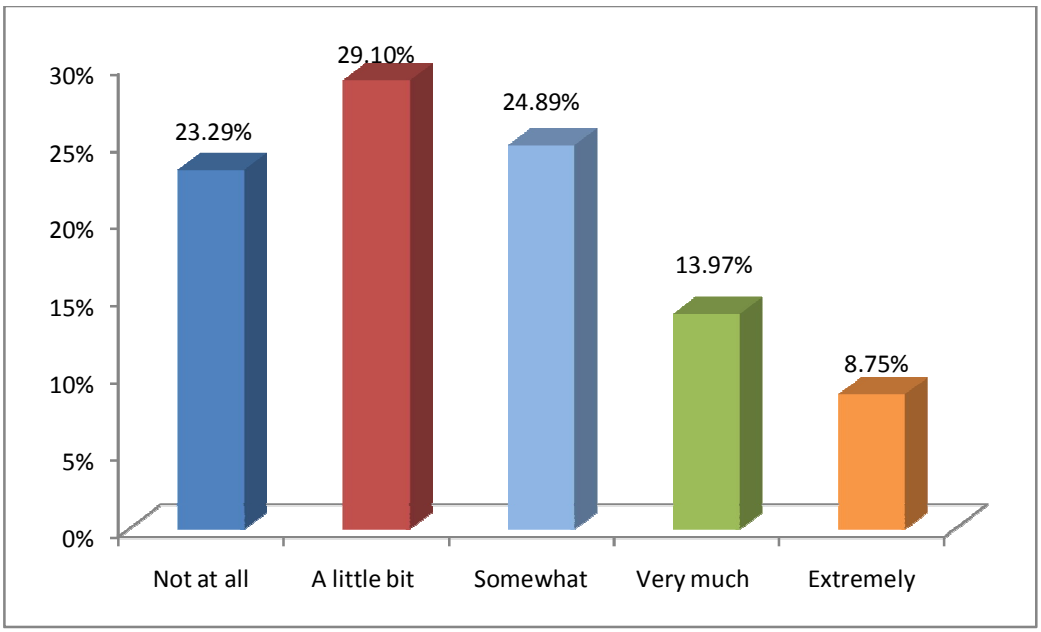


Figure: The Percentage (%) of social anxiety disorder lower medium class

From our study, the percentage of social anxiety disorder lower medium class teenagers between a little bit (29%) and somewhat (25%) was almost equal.

23% teenagers have no social anxiety disorder. Only 8.7% teenagers have extreme social anxiety disorder.

Table 4.10: Symptoms of Depressive disorder in lower medium class teenagers

Symptoms		Not at all	Several days	More than half of the days	Nearly everyday
little interest or pleasure in doing things	Frequency	24	16	14	1
	Percent	43.6	29.1	25.5	1.8
Feeling depressed or hopeless	Frequency	12	26	12	5
	Percent	21.8	47.3	21.8	9.1
Trouble in falling asleep or over sleeping	Frequency	11	24	15	5
	Percent	20	43.6	27.3	9.1
Poor appetite or over eating	Frequency	3	25	19	8
	Percent	5.5	45.5	34.5	14.5

Feeling bad about failure family down	Frequency	22	24	7	2
	Percent	40	43.6	12.7	3.6
Hard to concentrate in studying or playing	Frequency	6	33	12	4
	Percent	10.9	60	21.8	7.3
Suicidal tendency	Frequency	12	27	10	6
	Percent	21.8	49.1	18.2	10.9

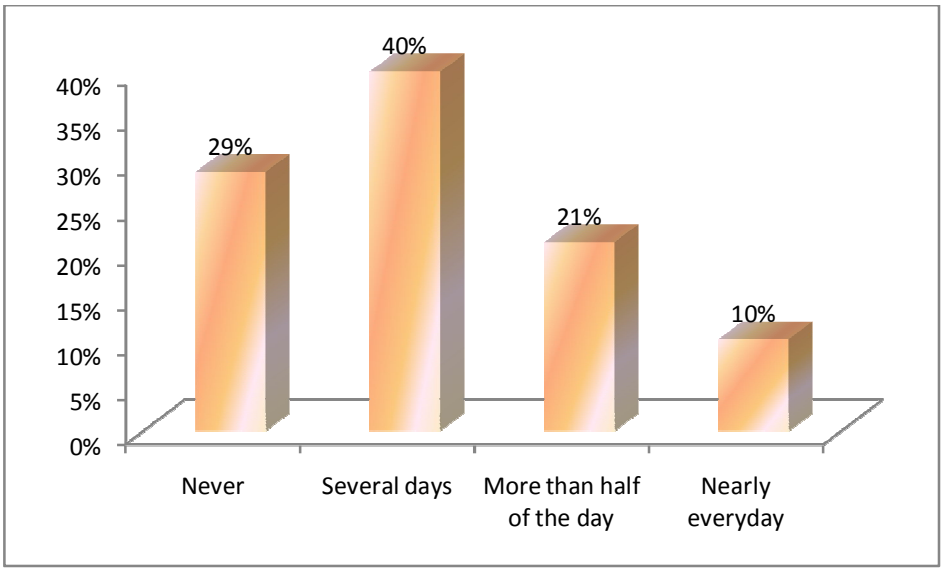


Figure: Percentage of depressive disorder in lower medium class teenagers

In lower middle class the maximum percentage of teen agers was found who were depressed in several days (40%). 10% teenagers are depressed nearly every day. 21% teenagers are depressed more than half of the days & 29% teenagers are never depressed.

Table 4.11: frequency of having parents

		Yes	No
Having parents	Frequency	55	0
	Percentage (%)	100	0

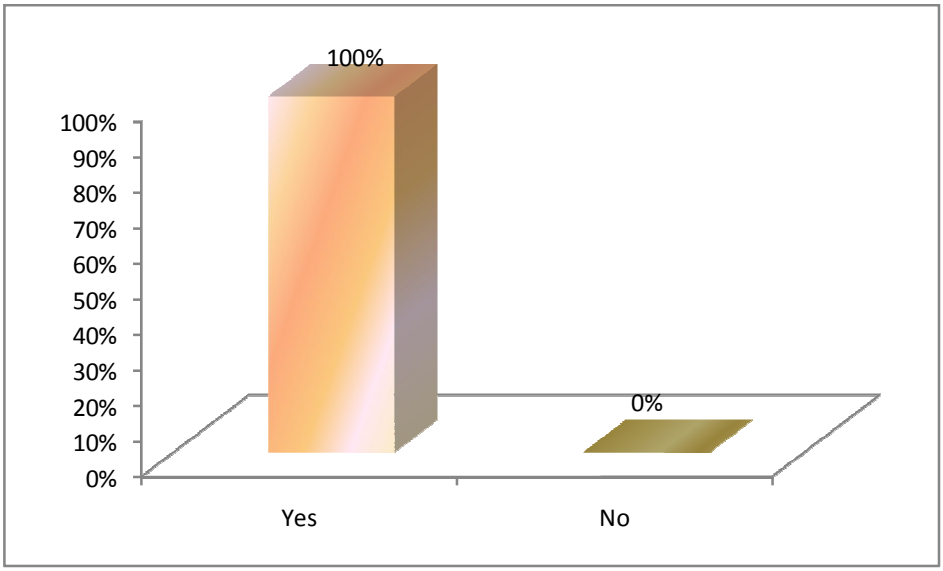


Figure: Graphical representation of percentage of having parents

The percentage of having parents in lower medium class teenagers is 100%

Table 4.12: Parent's relationship in lower medium class

		Never	Sometimes	Often	Very Often
Children share everything	Frequency	7	38	3	7
	Percent (%)	12.7	69.1	5.5	12.7
Children are feeling extremely happy or wound up & excited	Frequency	31	13	2	9
	Percent (%)	56.4	23.6	3.6	16.4
Children not giving concentration on study	Frequency	6	11	32	6
	Percent (%)	10.9	20	58.2	10.9
Children fear of making friends	Frequency	12	28	8	7
	Percent (%)	21.8	50.9	14.5	12.7
Children are feeling irritation or chunky	Frequency	17	20	8	10
	Percent (%)	30.9	36.4	14.5	18.2
Aggressive behavior of children	Frequency	8	21	17	9
	Percent (%)	14.5	38.2	30.9	16.4
Children talk dirty	Frequency	40	4	1	10
	Percent (%)	72.7	7.3	1.8	18.2
Feeling shy & an introvert	Frequency	8	33	13	1

	Percent (%)	14.5	60	23.6	1.8
child are confusing of sudden change in the body	Frequency	11	40	2	2
	Percent (%)	20	72.7	3.6	3.6
Get angry if anything is not according children will	Frequency	6	17	23	9
	Percent (%)	10.9	30.9	41.8	16.4
Disobedient behavior	Frequency	5	10	7	33
	Percent (%)	9.1	18.2	12.7	60
Taking thing without permission	Frequency	9	35	6	5
	Percent (%)	16.4	63.6	10.9	9.1
Arguing nature of children	Frequency	18	17	13	7
	Percent (%)	32.7	30.9	23.6	12.7
Feeling of inferiority	Frequency	17	12	19	7
	Percent (%)	30.9	21.8	34.5	12.7

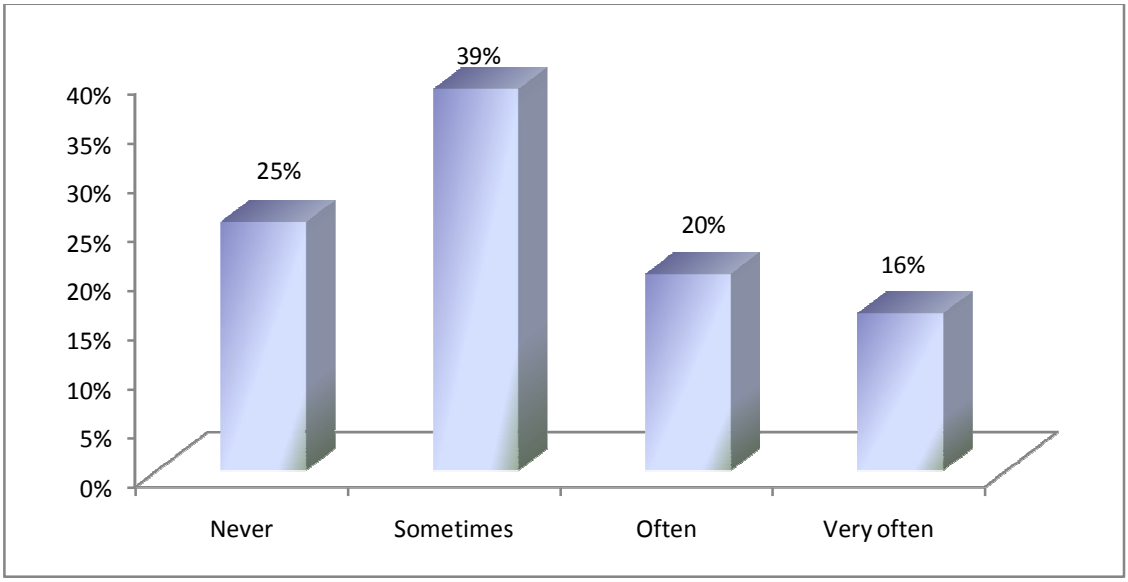


Figure: percentage of parent's relationship in lower medium class teenagers

According to the symptoms lower medium class teenagers are low parents relationship. In lower medium class 25% teenagers is close to their parent's. 39% teenagers are often, 16% teenagers are very often, 39% teenagers are sometimes distance with their parent due to low affection & harsh parenting.

Table 4.13: Symptoms of personality disorder in medium class teenagers

Symptoms		Yes	No
Difficulties in making friends	Frequency	31	61
	Percent (%)	33.7	66.3
Feeling lonely	Frequency	19	73
	Percent (%)	20.7	79.3
Trust people	Frequency	57	35
	Percent (%)	62	38
Impulsive nature	Frequency	29	63
	Percent (%)	31.5	68.5
Dependent	Frequency	34	58
	Percent (%)	37	63
Perfectionist	Frequency	32	60
	Percent (%)	34.8	65.2

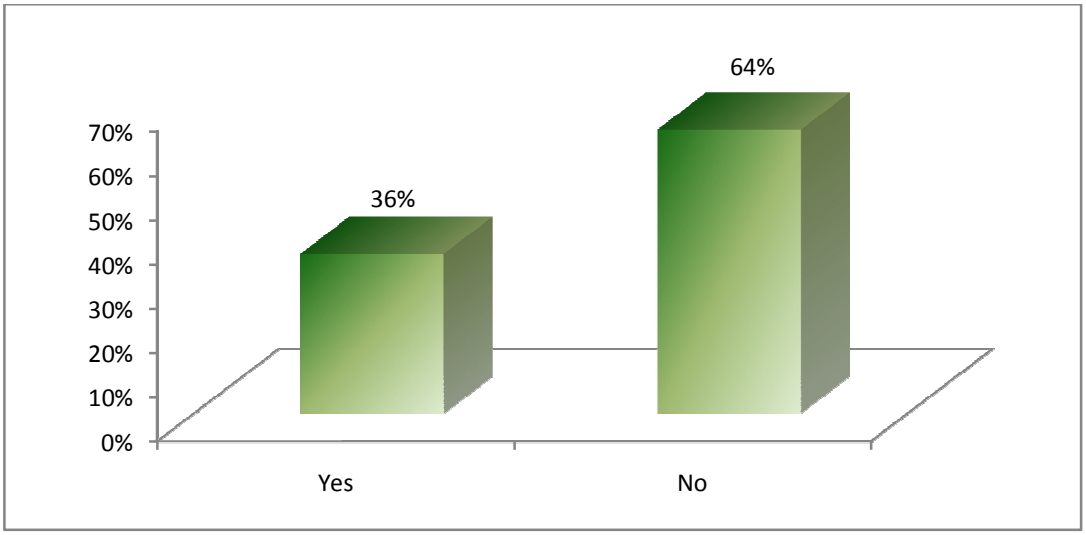


Figure: The Percentage (%) symptoms of personality disorder in Medium class

The symptoms of personality disorder, medium class teenagers 33.7% are facing difficulty making friends,20.7% describe as a loner, 62% trust other people, 31.5% are normally an impulsive sort of person, 37% are depend on other people,34.8% are perfectionist.

36% middle class teenagers have personality disorder. 64% teenagers have no personality disorder.

Table 4.14: Symptoms of Social anxiety disorder in medium class

Symptoms		Not at all	A little bit	Somewhat	Very much	Extremely
Afraid people of authority	Frequency	40	44	8	0	0
	Percent (%)	43.5	47.8	8.7	0	0
Blushing in front of people	Frequency	41	31	13	7	0
	Percent (%)	44.6	33.7	14.1	7.6	0
Scaring of parties and social event	Frequency	66	16	7	3	0
	Percent (%)	71.7	17.4	7.6	3.3	0
Avoid talking to strangers	Frequency	29	24	27	11	1
	Percent (%)	31.5	26.1	29.3	12	1.1
Scaring of criticizes	Frequency	17	36	28	9	2
	Percent (%)	18.5	39.1	30.4	9.8	2.2
Avoid doing/ speaking people for fear of embarrassment	Frequency	34	24	10	19	5
	Percent (%)	37	26.1	10.9	20.7	5.4
Sweating in front of people	Frequency	51	27	8	4	2
	Percent (%)	55.4	29.3	8.7	4.3	2.2
Avoid to go parties	Frequency	56	12	14	8	2
	Percent (%)	60.9	13	15.2	8.7	2.2
Avoid activities when center of attention	Frequency	38	26	14	7	7
	Percent (%)	41.3	28.3	15.2	7.6	7.6
Scared to talk strangers	Frequency	23	36	21	11	1
	Percent (%)	25	39.1	22.8	12	1.1
Avoid to give speeches	Frequency	22	28	22	14	6
	Percent (%)	23.9	30.4	23.9	15.2	6.5
Do anything to avoid being criticized	Frequency	18	36	20	15	3
	Percent (%)	19.6	39.1	21.7	16.3	3.3
Heart palpitations bothered by surrounding people	Frequency	39	29	16	7	1
	Percent (%)	42.4	31.5	17.4	7.6	1.1
Afraid of doing things when people are watching	Frequency	41	24	11	9	7
	Percent (%)	44.6	26.1	12	9.8	7.6
Worst fear of being embarrassed & looking stupid	Frequency	14	23	17	32	6
	Percent (%)	15.2	25	18.5	34.8	6.5
Avoid speaking anyone to authority	Frequency	33	29	24	6	0
	Percent (%)	35.9	31.5	26.1	6.5	0

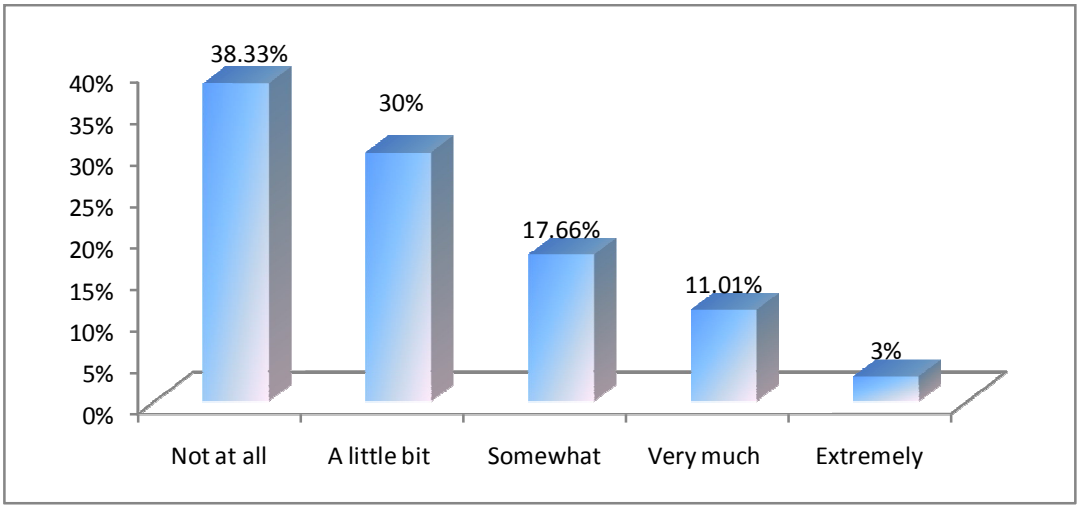


Figure: The Percentage (%) of social anxiety disorder

We found that most of the medium class teenagers have no social anxiety disorder. 38.33% have no social anxiety disorder. From our study, 17.66% teenagers are somewhat, 11% are very much & 30% teenagers have a little bit social anxiety disorder. Only 3% teenagers have extreme social anxiety disorder.

Table 4.15: Symptoms of Depressive disorder in medium class

Symptoms		Not at all	Several days	More than half of the days	Nearly everyday
little interest or pleasure in doing things	Frequency	14	42	23	13
	Percent (%)	15.2	45.7	25	14.1
Feeling depressed or hopeless	Frequency	49	18	21	4
	Percent (%)	53.3	19.6	22.8	4.3
Trouble in falling asleep or over sleeping	Frequency	52	29	10	1
	Percent (%)	56.5	31.5	10.9	1.1
Poor appetite or over eating	Frequency	56	23	6	7
	Percent (%)	60.9	25	6.5	7.6
Feeling bad about failure family down	Frequency	52	17	14	9
	Percent (%)	56.5	18.5	15.2	9.8
Hard to concentrate in studying or playing	Frequency	34	33	12	13
	Percent (%)	37	35.9	13	14.1
Suicidal tendency	Frequency	71	13	3	5
	Percent (%)	77.2	14.1	3.3	5.4

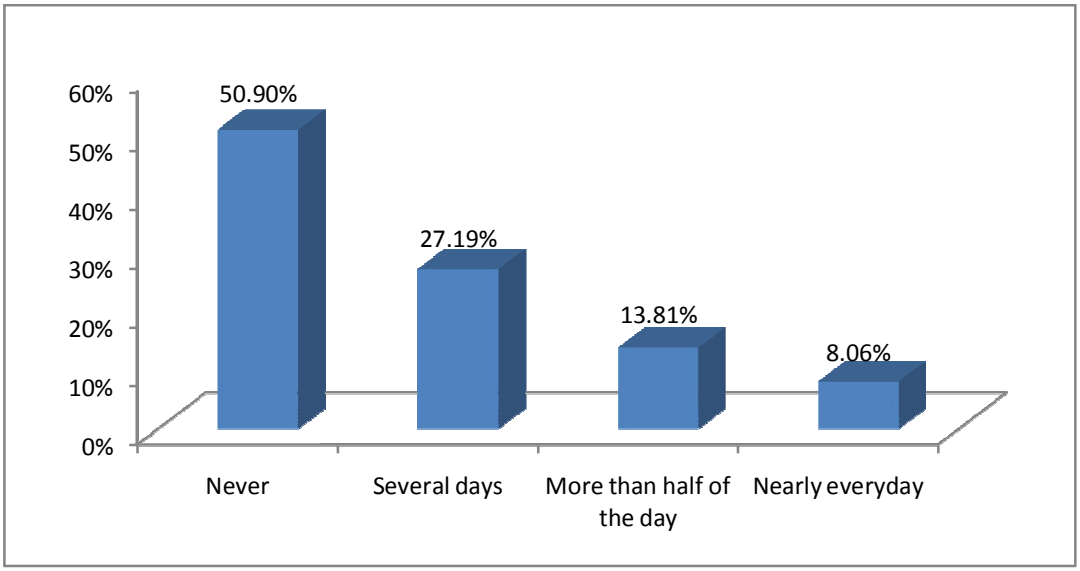


Figure: The Percentage (%) of Depressive disorder

In middle class the maximum percentage of teen agers was found who never depressed (51%). Only 8% teenagers are depressed nearly every day. 27.2% teenagers are depressed several days & 13.81% are depressed more than half of the days.

Table 4.16: Percentage of having parents in medium class

		Yes	No
Having parents	Frequency	83	9
	Percent (%)	90.2	9.8

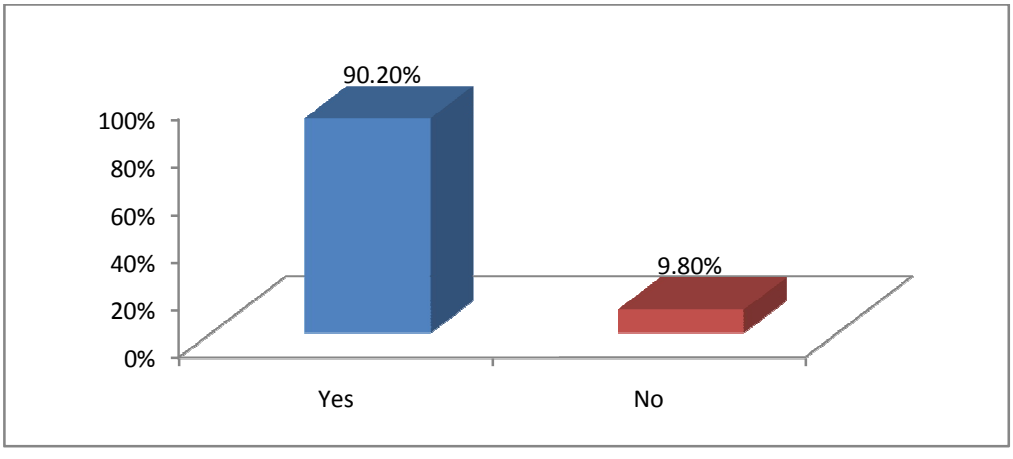


Figure: Graphical representation of percentage of having parents

We found in medium class teenagers 9.8% have single parents.

Table 4.17: Parent's relationship with their children in medium class

		Never	Sometimes	Often	Very Often
Children share everything	Frequency	27	46	11	8
	Percent (%)	29.3	50	12	8.7
Children are feeling extremely happy or wound up & excited	Frequency	10	44	24	14
	Percent (%)	10.9	47.8	26.1	15.2
Children not giving concentration on study	Frequency	23	49	18	2
	Percent (%)	25	53.3	19.6	2.2
Children fear of making friends	Frequency	66	17	7	2
	Percent (%)	71.7	18.5	7.6	2.2
Children are feeling irritation or chunky	Frequency	29	42	16	5
	Percent (%)	31.5	45.7	17.4	5.4
Aggressive behavior of children	Frequency	39	39	9	5
	Percent (%)	42.4	42.4	9.8	5.4
Children talk dirty	Frequency	60	20	7	5
	Percent (%)	65.2	21.7	7.6	5.4
Feeling shy & an introvert	Frequency	38	33	15	6
	Percent (%)	41.3	35.9	16.3	6.5
child are confusing of sudden change in the body	Frequency	36	42	10	4
	Percent (%)	39.1	45.7	10.9	4.3
Get angry if anything is not according children will	Frequency	22	39	13	18
	Percent (%)	23.9	42.4	14.1	19.6
Disobedient behavior	Frequency	42	33	13	4
	Percent (%)	45.7	35.9	14.1	4.3
Taking thing without permission	Frequency	49	28	11	4
	Percent (%)	53.3	30.4	12	4.3
Arguing nature of children	Frequency	39	39	6	8
	Percent (%)	42.4	42.4	6.5	8.7
Feeling of inferiority	Frequency	36	33	17	6
	Percent (%)	39.1	35.9	18.5	6.5

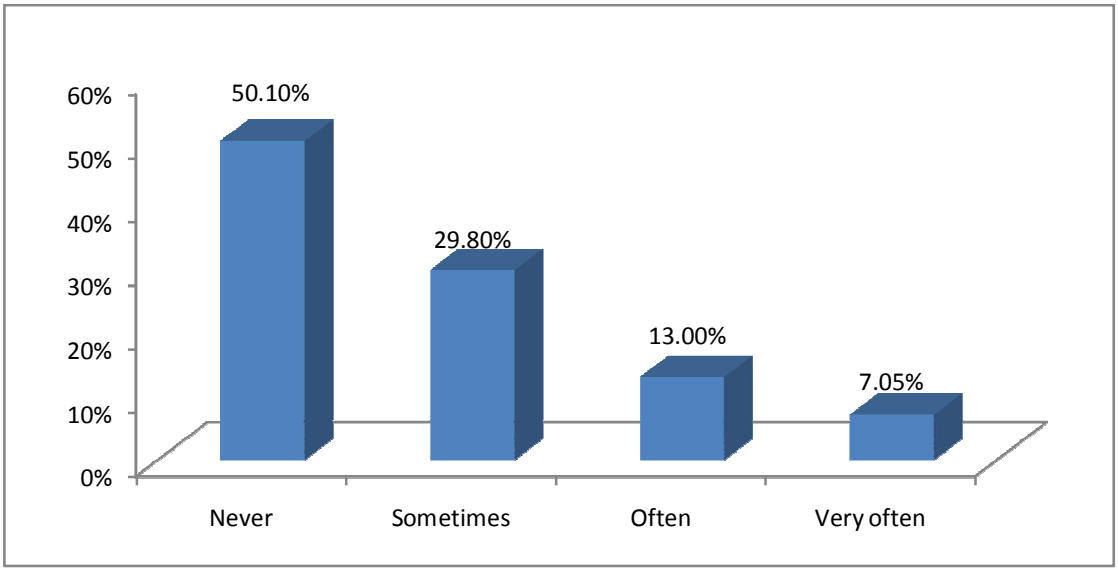


Figure: Percentage of parent's relationship with their children

According to the symptoms 50.10% medium class teenagers are close relationship with their parents. 25% teenagers are sometimes close to their parent's. 13% teenagers are often, 7.05% teenagers are very often distance with their parent due to low affection & harsh parenting.

Table 4.18: Symptoms of personality disorder in higher medium class

Symptoms		Yes	No
Difficulties in making friends	Frequency	13	31
	Percent (%)	29.5	70.5
Feeling lonely	Frequency	2	42
	Percent (%)	4.5	95.5
Trust people	Frequency	41	3
	Percent (%)	93.2	6.8
Impulsive nature	Frequency	10	34
	Percent (%)	22.7	77.3
Dependent	Frequency	13	31
	Percent (%)	29.5	70.5
Perfectionist	Frequency	31	13
	Percent (%)	70.5	29.5

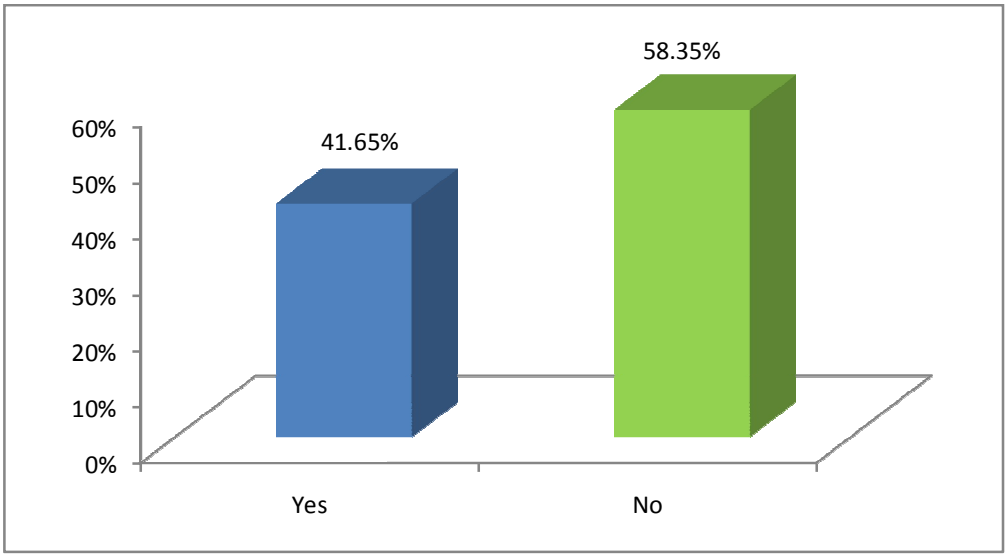


Figure: The Percentage (%) of personality disorder

The symptoms of personality disorder, higher medium class teenagers 29% are facing difficulty making friends, 4.5% describe as a loner, 93.2% trust other people, 22% are normally an impulsive sort of person, 29% are depend on other people, 70% are perfectionist.

The percentage of having personality disorder in higher medium class teenagers is 41.65%.

Table 4.19: Symptoms of Social anxiety disorder in higher medium class

Symptoms		Not at all	A little bit	Somewhat	Very much	Extremely
Afraid people of authority	Frequency	23	12	9	0	0
	Percent (%)	52.3	27.3	20.5	0	0
Blushing in front of people	Frequency	20	15	7	0	2
	Percent (%)	45.5	34.1	15.9	0	4.5
Scaring of parties and social event	Frequency	40	0	1	3	0
	Percent (%)	90.9	0	2.3	6.8	0
Avoid talking to strangers	Frequency	9	15	11	4	5
	Percent (%)	20.5	34.1	25	9.1	11.4
Scaring of criticizes	Frequency	17	14	8	3	2
	Percent (%)	38.6	31.8	18.2	6.8	4.5
Avoid doing/ speaking people for fear of	Frequency	21	7	6	4	6
	Percent (%)	47.7	15.9	13.6	9.1	13.6

embarrassment						
Sweating in front of people	Frequency	35	3	3	1	2
	Percent (%)	79.5	6.8	6.8	2.3	4.5
Avoid to go parties	Frequency	27	4	6	5	2
	Percent (%)	61.4	9.1	13.6	11.4	4.5
Avoid activities when center of attention	Frequency	23	17	2	2	0
	Percent (%)	52.3	38.6	4.5	4.5	0
Scared to talk strangers	Frequency	12	11	16	3	2
	Percent (%)	27.3	25	36.4	6.8	4.5
Avoid to give speeches	Frequency	21	11	5	1	6
	Percent (%)	47.7	25	11.4	2.3	13.6
Do anything to avoid being criticized	Frequency	9	11	14	4	6
	Percent (%)	20.5	25	31.8	9.1	13.6
Heart palpitations bothered by surrounding people	Frequency	23	10	10	0	1
	Percent (%)	52.3	22.7	22.7	0	2.3
Afraid of doing things when people are watching	Frequency	6	25	9	3	1
	Percent (%)	13.6	56.8	20.5	6.8	2.3
Worst fear of being embarrassed & looking stupid	Frequency	6	15	12	9	2
	Percent (%)	13.6	34.1	27.3	20.5	4.5
Avoid speaking anyone to authority	Frequency	23	9	8	3	1
	Percent (%)	52.3	20.5	18.2	6.8	2.3

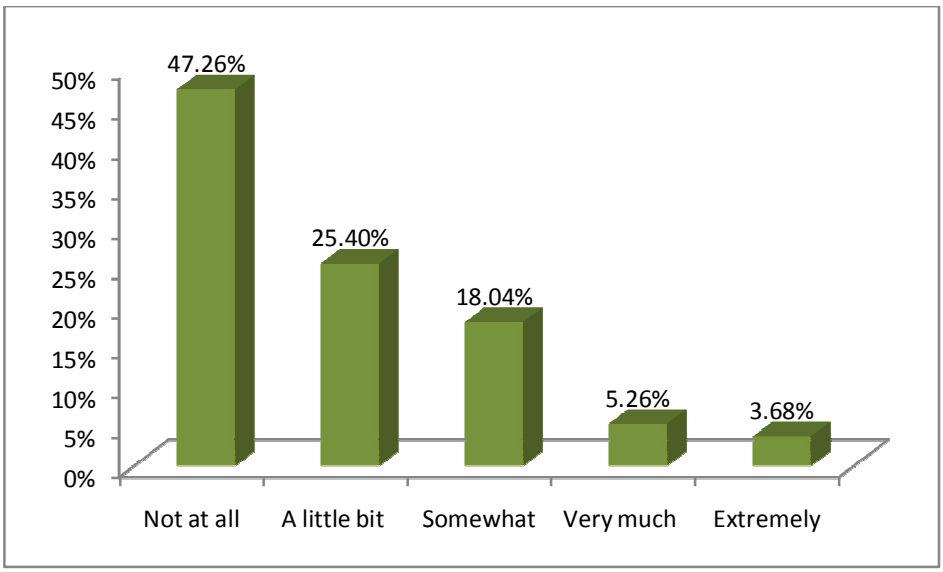


Figure: The Percentage (%) of social anxiety disorder

We found that most of the higher medium class teenagers have no social anxiety disorder (47.26%).

From our study, 18% teenagers are somewhat, 5.26% are very much & 25.4% teenagers have a little bit social anxiety disorder. Only 3.68% teenagers have extremely social anxiety disorder.

Table 4.20: Symptoms of Depressive disorder in higher medium class

Symptoms		Not at all	Several days	More than half of the days	Nearly everyday
little interest or pleasure in doing things	Frequency	2	13	13	16
	Percent (%)	4.5	29.5	29.5	36.4
Feeling depressed or hopeless	Frequency	31	11	2	0
	Percent (%)	70.5	25	4.5	0
Trouble in falling asleep or over sleeping	Frequency	21	16	3	4
	Percent (%)	47.7	36.4	6.8	9.1
Poor appetite or over eating	Frequency	28	12	2	2
	Percent (%)	63.6	27.3	4.5	4.5
Feeling bad about failure family down	Frequency	25	10	6	3
	Percent (%)	56.8	22.7	13.6	6.8
Hard to concentrate in studying or playing	Frequency	22	10	6	6
	Percent (%)	50	22.7	13.6	13.6
Suicidal tendency	Frequency	31	7	3	3
	Percent (%)	70.5	15.9	6.8	6.8

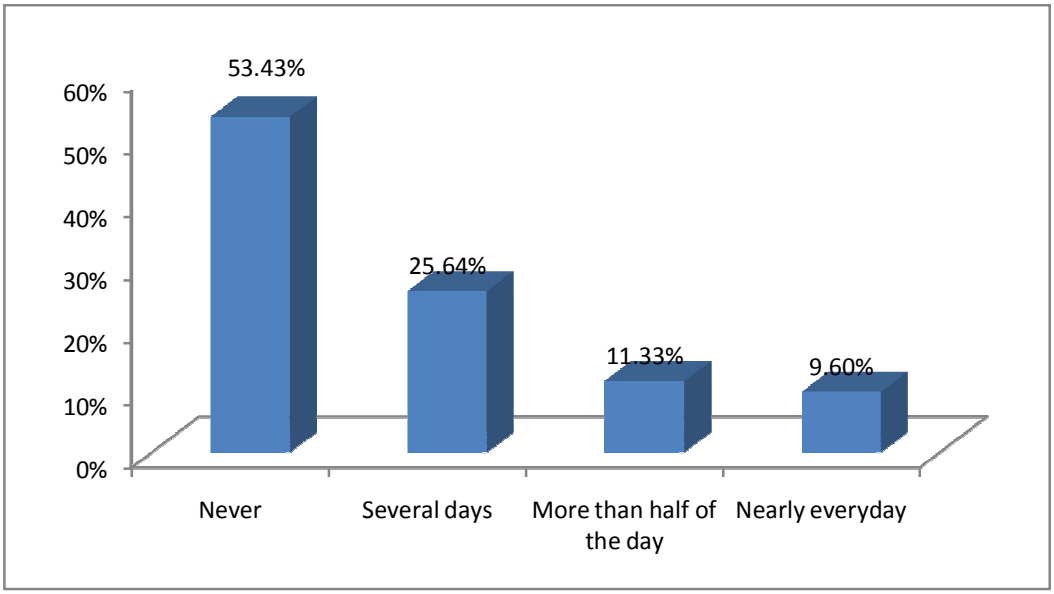


Figure: The Percentage (%) of Depressive disorder

The maximum percentage in higher medium class teen agers was found who never depressed & the percentage is 53.4%. Only 9.6% teenagers are depressed nearly every day. 25.6% teenagers are depressed several days & 11.33% are depressed more than half of the days.

Table 4.21: having parents in higher medium class

		Yes	No
Having parents	Frequency	39	5
	Percent (%)	88.6	11.4

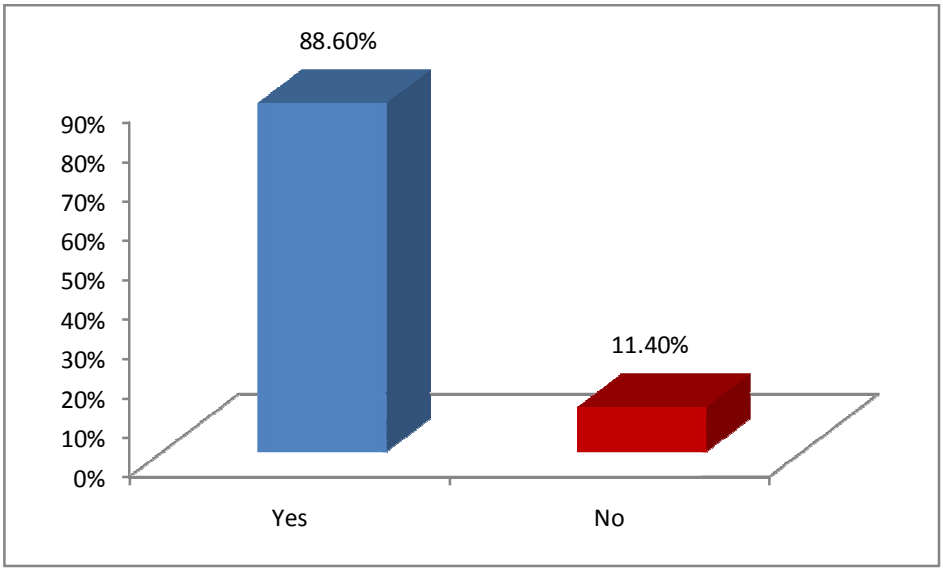


Figure: Graphical representation of percentage of having parents

The percentage of having parents in higher medium class teenagers are 88.6%.

Table 4.22: Parent's relationship in higher medium class

		Never	Sometimes	Often	Very Often
Children share everything	Frequency	10	30	4	0
	Percent (%)	22.7	68.2	9.1	0
Children are feeling extremely happy or wound up & excited	Frequency	2	12	11	19
	Percent (%)	4.5	27.3	25	43.2
Children not giving concentration on study	Frequency	12	16	12	4
	Percent (%)	27.3	36.4	27.3	9.1
Children fear of making friends	Frequency	29	11	1	3
	Percent (%)	65.9	25	2.3	6.8
Children are feeling irritation or chunky	Frequency	13	23	6	2
	Percent (%)	29.5	52.3	13.6	4.5
Aggressive behavior of children	Frequency	27	11	5	1
	Percent (%)	61.4	25	11.4	2.3
Children talk dirty	Frequency	30	13	1	0
	Percent (%)	68.2	29.5	2.3	0
Feeling shy & an introvert	Frequency	17	18	9	0
	Percent (%)	38.6	40.9	20.5	0
child are confusing of sudden change in the body	Frequency	14	15	13	2
	Percent (%)	31.8	34.1	29.5	4.5
Get angry if anything is not according children will	Frequency	5	22	8	9

	Percent (%)	11.4	50	18.2	20.5
Disobedient behavior	Frequency	27	12	3	2
	Percent (%)	61.4	27.3	6.8	4.5
Taking thing without permission	Frequency	16	15	8	5
	Percent (%)	36.4	34.1	18.2	11.4
Arguing nature of children	Frequency	27	15	2	0
	Percent (%)	61.4	34.1	4.5	0
Feeling of inferiority	Frequency	26	12	4	2
	Percent (%)	59.1	27.3	9.1	4.5

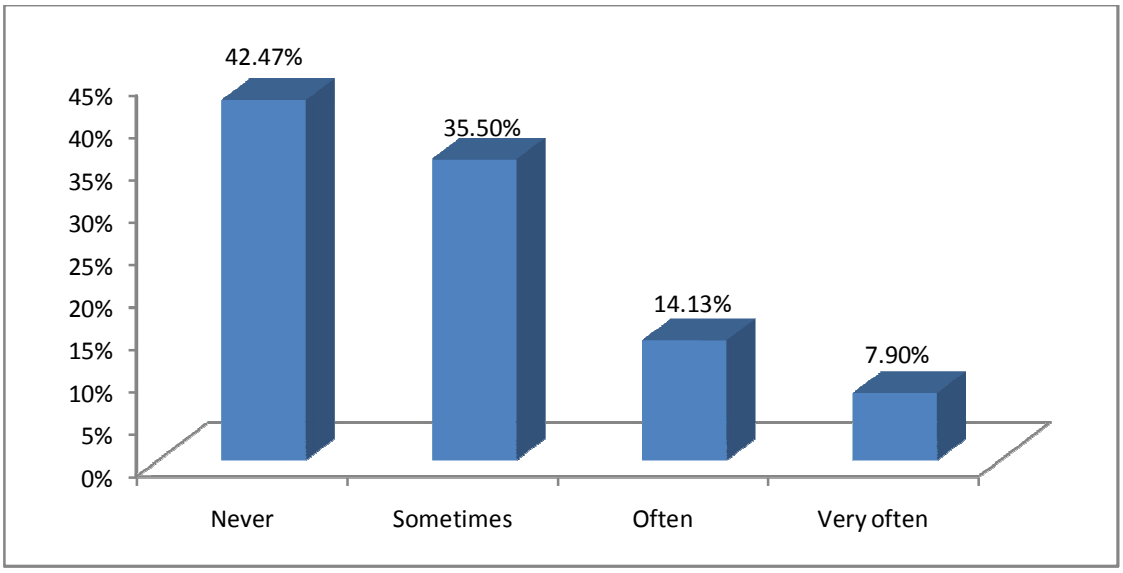


Figure: Percentage of parent's relationship with their children

According to the symptoms 42.47% medium class teenagers are closely bond with their parents. 35.5% teenagers are sometimes close to their parent's. 14% teenagers are often & only 7.9% teenagers are very often distance with their parent due to low affection & harsh parenting.

Table 4.23: Symptoms of personality disorder in higher class teenagers

Symptoms		Yes	No
Difficulties in making friends	Frequency	11	43
	Percent (%)	20.4	79.6
Feeling lonely	Frequency	12	42
	Percent (%)	22.2	77.8
Trust people	Frequency	19	35
	Percent (%)	35.2	64.8
Impulsive nature	Frequency	29	25
	Percent (%)	53.7	46.3
Dependent	Frequency	17	37
	Percent (%)	31.5	68.5
Perfectionist	Frequency	35	19
	Percent (%)	64.8	35.2

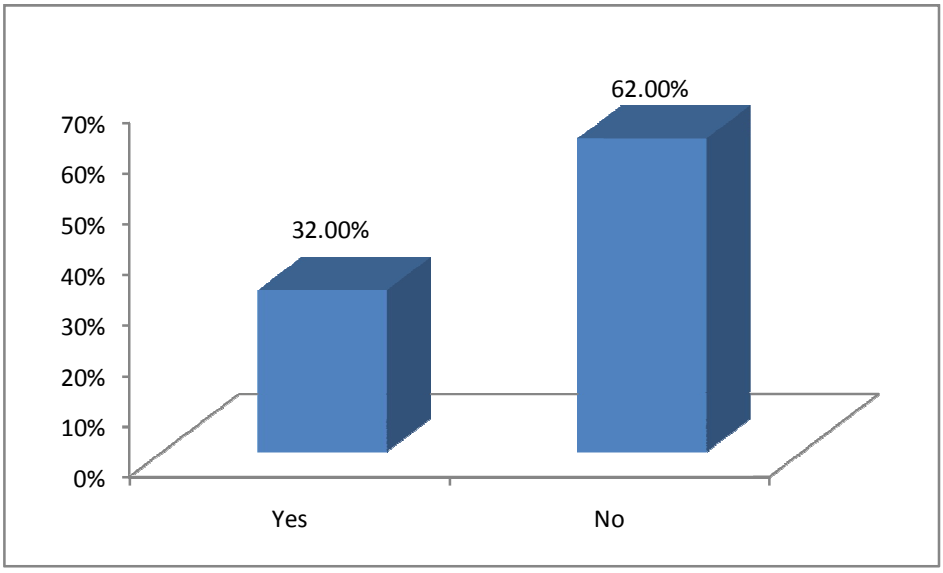


Figure: The Percentage (%) of personality disorder

The symptoms of personality disorder, higher class teenagers 20% are facing difficulty making friends,22% describe as a loner,35% trust other people,53.7% are normally an impulsive sort of person,31.5% are depend on other people,65% are perfectionist.

In our study 38%, higher class teenagers have found personality disorder.

Table 4.24: Symptoms of Social anxiety disorder in higher class teenagers

Symptoms		Not at all	A little bit	Somewhat	Very much	Extremely
Afraid people of authority	Frequency	34	12	4	4	0
	Percent (%)	63	22.2	7.4	7.4	0
Blushing in front of people	Frequency	21	20	9	3	1
	Percent (%)	38.9	37	16.7	5.6	1.9
Scaring of parties and social event	Frequency	33	9	9	2	1
	Percent (%)	61.1	16.7	16.7	3.7	1.9
Avoid talking to strangers	Frequency	21	13	8	12	0
	Percent (%)	38.9	24.1	14.8	22.2	0
Scaring of criticizes	Frequency	28	17	5	3	1
	Percent (%)	51.9	31.5	9.3	5.6	1.9
Avoid doing/ speaking people for fear of embarrassment	Frequency	31	11	7	4	1
	Percent (%)	57.4	20.4	13	7.4	1.9
Sweating in front of people	Frequency	25	15	8	3	3
	Percent (%)	46.3	27.8	14.8	5.6	5.6
Avoid to go parties	Frequency	23	9	3	8	11
	Percent (%)	42.6	16.7	5.6	14.8	20.4
Avoid activities when center of attention	Frequency	26	11	4	7	6
	Percent (%)	48.1	20.4	7.4	13	11.1
Scared to talk strangers	Frequency	23	18	6	7	0
	Percent (%)	42.6	33.3	11.1	13	0
Avoid to give speeches	Frequency	23	18	7	6	0
	Percent (%)	42.6	33.3	13	11.1	0
Do anything to avoid being criticized	Frequency	14	15	11	9	5
	Percent (%)	25.9	27.8	20.4	16.7	9.3
Heart palpitations bothered by surrounding people	Frequency	31	14	5	3	1
	Percent (%)	57.4	25.9	9.3	5.6	1.9
Afraid of doing things when people are watching	Frequency	26	19	3	5	1
	Percent (%)	48.1	35.2	5.6	9.3	1.9
Worst fear of being embarrassed & looking stupid	Frequency	21	16	4	11	2
	Percent (%)	38.9	29.6	7.4	20.4	3.7
Avoid speaking anyone to authority	Frequency	34	11	7	2	0
	Percent (%)	63	20.4	13	3.7	0

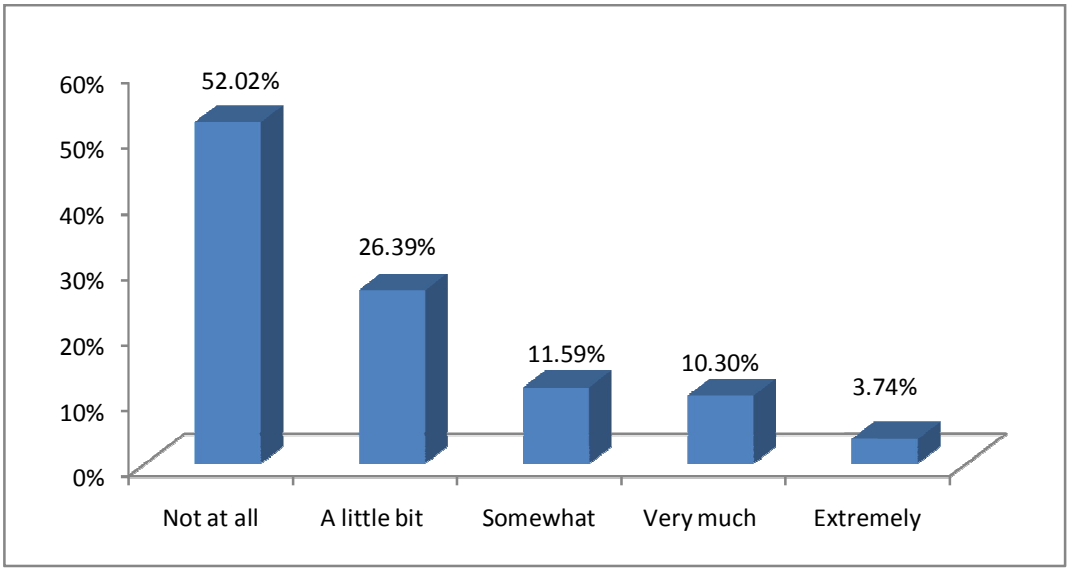


Fig: The Percentage (%) of social anxiety disorder

We found that most of the higher class teenagers have no social anxiety disorder (52.02%). From our study, 11.5% teenagers are somewhat, 10.3% are very much & 26.4% teenagers have a little bit social anxiety disorder. Only 3.7% teenagers have found extremely social anxiety disorder.

Table 4.25: Symptoms of Depressive disorder in higher class teenagers

Symptoms		Not at all	Several days	More than half of the days	Nearly everyday
little interest or pleasure in doing things	Frequency	2	13	13	16
	Percent (%)	4.5	29.5	29.5	36.4
Feeling depressed or hopeless	Frequency	31	11	2	0
	Percent (%)	70.5	25	4.5	0
Trouble in falling asleep or over sleeping	Frequency	21	16	3	4
	Percent (%)	47.7	36.4	6.8	9.1
Poor appetite or over eating	Frequency	28	12	2	2
	Percent (%)	63.6	27.3	4.5	4.5
Feeling bad about failure family down	Frequency	25	10	6	3
	Percent (%)	56.8	22.7	13.6	6.8
Hard to concentrate in studying or playing	Frequency	22	10	6	6
	Percent (%)	50	22.7	13.6	13.6
Suicidal tendency	Frequency	31	7	3	3
	Percent (%)	70.5	15.9	6.8	6.8

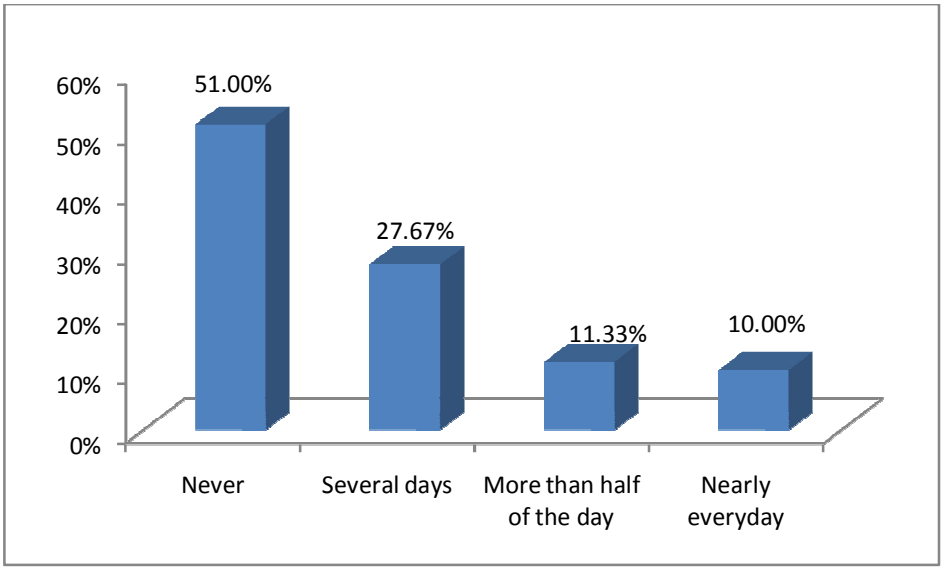


FIG: The Percentage (%) of Depressive disorder.

The maximum percentage in higher class teen agers was found who never depressed (51 %.) Only 10% teenagers are depressed nearly every day. 27.67% teenagers are depressed several days & 11.33% are depressed more than half of the days.

Table 4.26: Percentage of having parents in higher class teenagers

		yes	no
Do you Have both of your parents	Frequency	45	9
	Percent (%)	83.3	16.7

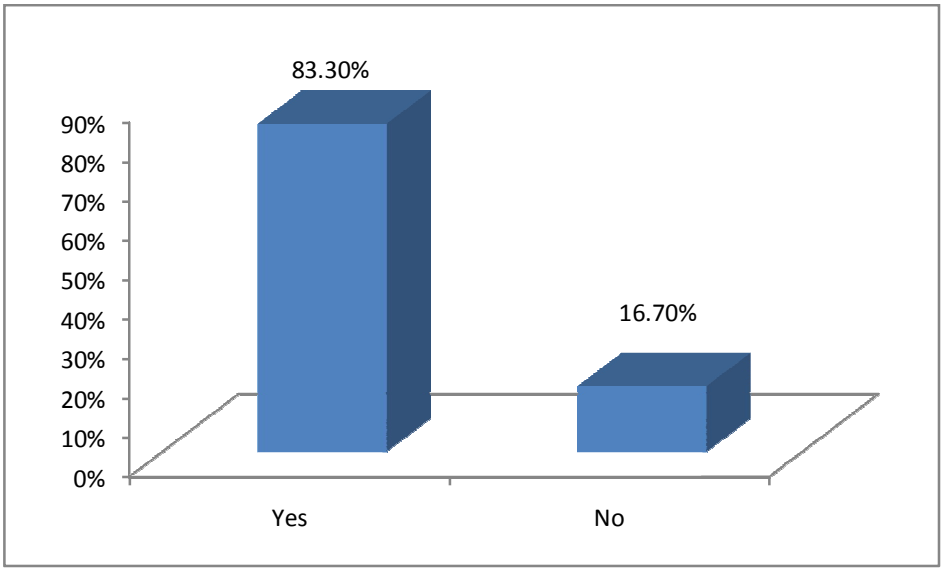


Figure: Graphical representation of percentage of having parents

In higher class teenagers the percentage of having parents is 83.3% & 16.7% teenagers have single parents.

Table 4.27: Parent's relationship in higher class teenagers

		Never	Sometimes	Often	Very Often
Children share everything	Frequency	19	26	7	2
	Percent (%)	35.2	48.1	13	3.7
Children are feeling extremely happy or wound up & excited	Frequency	10	24	16	4
	Percent (%)	18.5	44.4	29.6	7.4
Children not giving concentration on study	Frequency	14	28	10	2
	Percent (%)	25.9	51.9	18.5	3.7
Children fear of making friends	Frequency	35	14	4	1
	Percent (%)	64.8	25.9	7.4	1.9
Children are feeling irritation or chunky	Frequency	20	19	9	6
	Percent (%)	37	35.2	16.7	11.1
Aggressive behavior of children	Frequency	22	19	10	3
	Percent (%)	40.7	35.2	18.5	5.6
Children talk dirty	Frequency	22	22	6	4
	Percent (%)	40.7	40.7	11.1	7.4
Feeling shy & an introvert	Frequency	33	10	8	3
	Percent (%)	61.1	18.5	14.8	5.6
Confusing of sudden body change	Frequency	28	18	6	2
	Percent (%)	51.9	33.3	11.1	3.7

Get angry if anything is not according children will	Frequency	8	27	13	6
	Percent (%)	14.8	50	24.1	11.1
Disobedient behavior	Frequency	29	13	8	4
	Percent (%)	53.7	24.1	14.8	7.4
Taking thing without permission	Frequency	29	11	9	5
	Percent (%)	53.7	20.4	16.7	9.3
Arguing nature of children	Frequency	28	12	10	4
	Percent (%)	51.9	22.2	18.5	7.4
Feeling of inferiority	Frequency	30	17	6	1
	Percent (%)	55.6	31.5	11.1	1.9

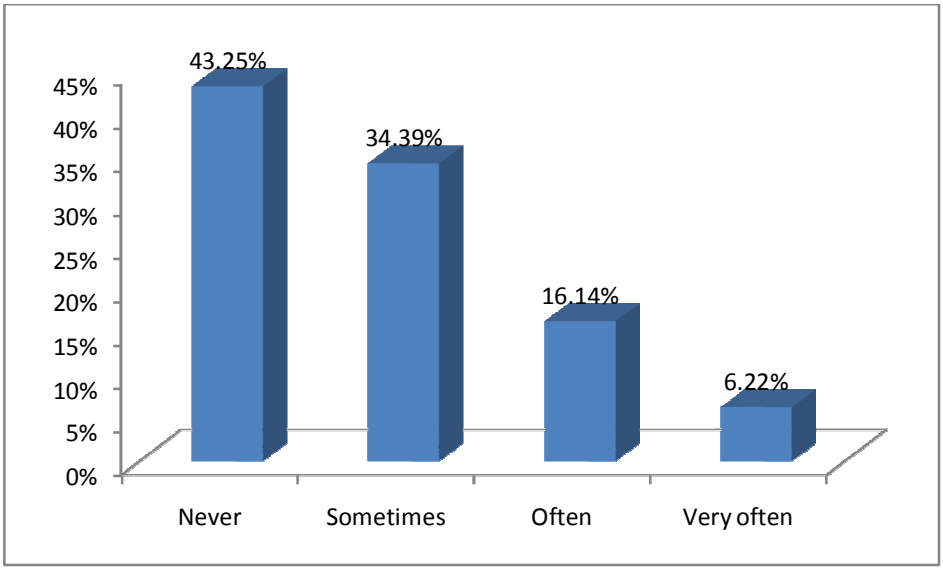


Figure: Percentage of parent's relationship

According to the symptoms 42.47% higher class teenagers are closely bound with their parents. 34.39% teenagers are sometimes close to their parent's. 16% teenagers are often & only 6.2% teenagers are very often distance with their parent due to low affection & harsh parenting.

Table 4.28: Symptom of Personality disorder in tribal teenagers

Symptoms		Yes	No
Difficulties in making friends	Frequency	45	15
	Percent (%)	75	25
Feeling lonely	Frequency	35	25
	Percent (%)	58.3	41.7
Trust people	Frequency	50	10
	Percent (%)	83.3	16.7
Impulsive nature	Frequency	33	27
	Percent (%)	55	45
Dependent	Frequency	32	28
	Percent (%)	53.3	46.7
Perfectionist	Frequency	27	33
	Percent (%)	45	55

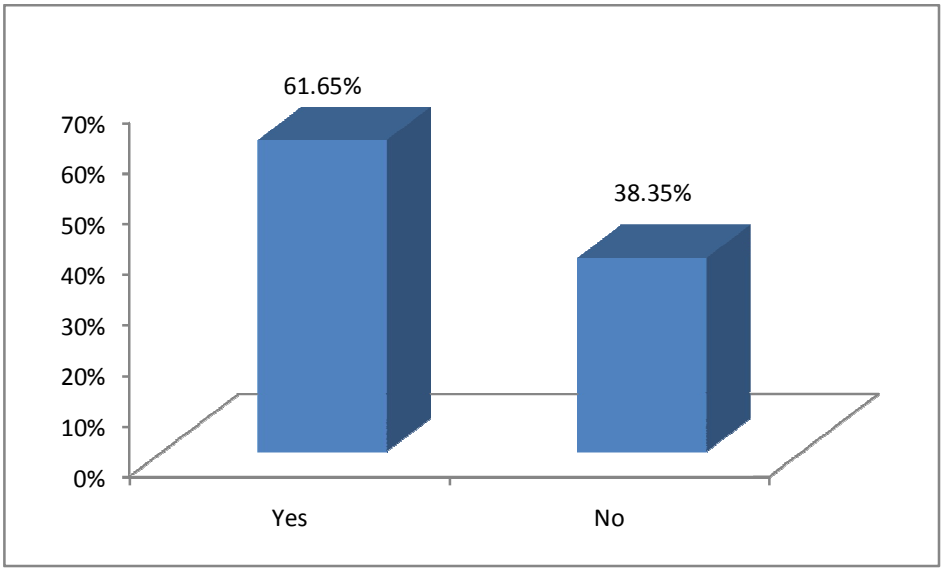


Fig: The Percentage (%) of personality disorder

The symptoms of personality disorder, tribal teenagers 75% are facing difficulty making friends,58,3% describe as a loner, 83.3% trust other people,55% are normally an impulsive sort of person, 53.3% are depend on other people, 45% are perfectionist.

Tribal teenagers' have 61.65% personality disorder.

Table 4.29: Symptoms of social anxiety disorder in tribal teenagers

Symptoms		Not at all	A little bit	Somewhat	Very much	Extremely
Afraid people of authority	Frequency	12	16	7	19	0
	Percent (%)	20	26.7	11.7	31.7	0
Blushing in front of people	Frequency	9	17	14	11	9
	Percent (%)	15	28.3	23.3	18.3	15
Scaring of parties and social event	Frequency	5	17	14	20	4
	Percent (%)	8.3	28.3	23.3	33.3	6.7
Avoid talking to strangers	Frequency	9	23	13	12	3
	Percent (%)	15	38.3	21.7	20	5
Scaring of criticizes	Frequency	9	19	8	13	11
	Percent (%)	15	31.7	13.3	21.7	18.3
Avoid doing/ speaking people for fear of embarrassment	Frequency	11	18	7	17	7
	Percent (%)	18.3	30	11.7	28.3	11.7
Sweating in front of people	Frequency	9	15	12	21	3
	Percent (%)	15	25	20	35	5
Avoid to go parties	Frequency	7	19	5	23	6
	Percent (%)	11.7	31.7	8.3	38.3	10
Avoid activities when center of attention	Frequency	9	19	10	15	7
	Percent (%)	15	31.7	16.7	25	11.7
Scared to talk strangers	Frequency	11	16	12	18	3
	Percent (%)	18.3	26.7	20	30	5
Avoid to give speeches	Frequency	13	22	6	12	7
	Percent (%)	21.7	36.7	10	20	11.7
Do anything to avoid being criticized	Frequency	13	19	9	13	6
	Percent (%)	21.7	31.7	15	21.7	10
Heart palpitations bothered by surrounding people	Frequency	11	16	13	19	1
	Percent (%)	18.3	26.7	21.7	31.7	1.7
Afraid of doing things when people are watching	Frequency	10	22	4	19	5
	Percent (%)	16.7	36.7	6.7	31.7	8.3
Worst fear of being embarrassed & looking stupid	Frequency	4	23	5	20	8
	Percent (%)	6.7	38.3	8.3	33.3	13.3
Avoid speaking anyone to authority	Frequency	8	17	5	29	1
	Percent (%)	13.3	28.3	8.3	48.3	1.7

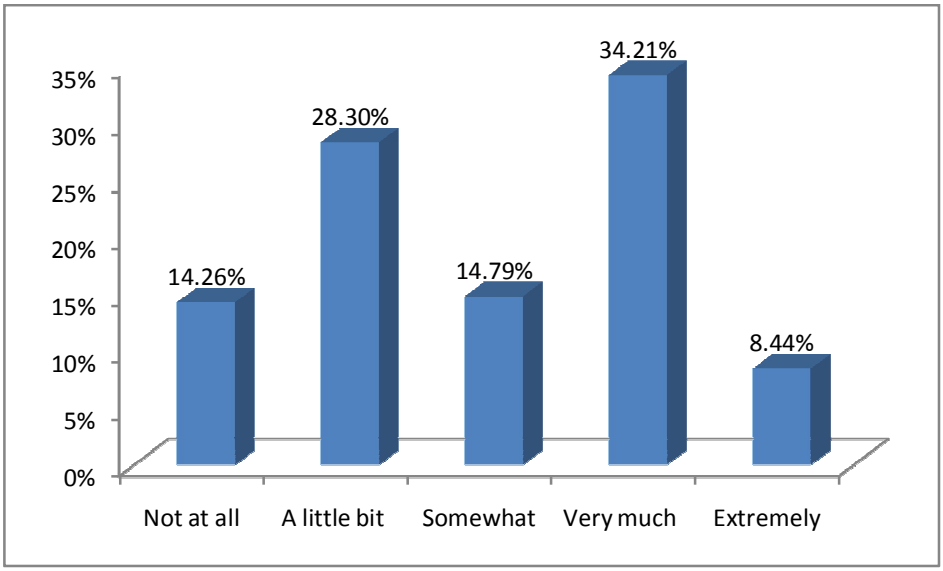


Figure: The Percentage (%) of social anxiety disorder

We found that most of the tribal teenagers have high social anxiety disorder.

From our study, 34.21% tribal teenagers have social anxiety disorder very much, 14.7 % are somewhat, 28.13 % are a little bit, 8.4% have extremely social anxiety disorder. & 14.26% have no social anxiety disorder.

Table 4.30: Symptoms of Depressive disorder in tribal teenagers

Symptoms		Not at all	Several days	More than half of the days	Nearly everyday
little interest or pleasure in doing things	Frequency	14	6	38	2
	Percent (%)	23.3	10	63.3	3.3
Feeling depressed or hopeless	Frequency	10	13	25	12
	Percent (%)	16.7	21.7	41.7	20
Trouble in falling asleep or over sleeping	Frequency	10	11	24	15
	Percent (%)	16.7	18.3	40	25
Poor appetite or over eating	Frequency	8	13	21	18
	Percent (%)	13.3	21.7	35	30
Feeling bad about failure family down	Frequency	11	16	19	14
	Percent (%)	18.3	26.7	31.7	23.3
Hard to concentrate in studying or playing	Frequency	2	10	22	11
	Percent (%)	3.33	16.67	36.67	25.6
Suicidal tendency	Frequency	8	16	24	12
	Percent (%)	13.3	26.7	40	20

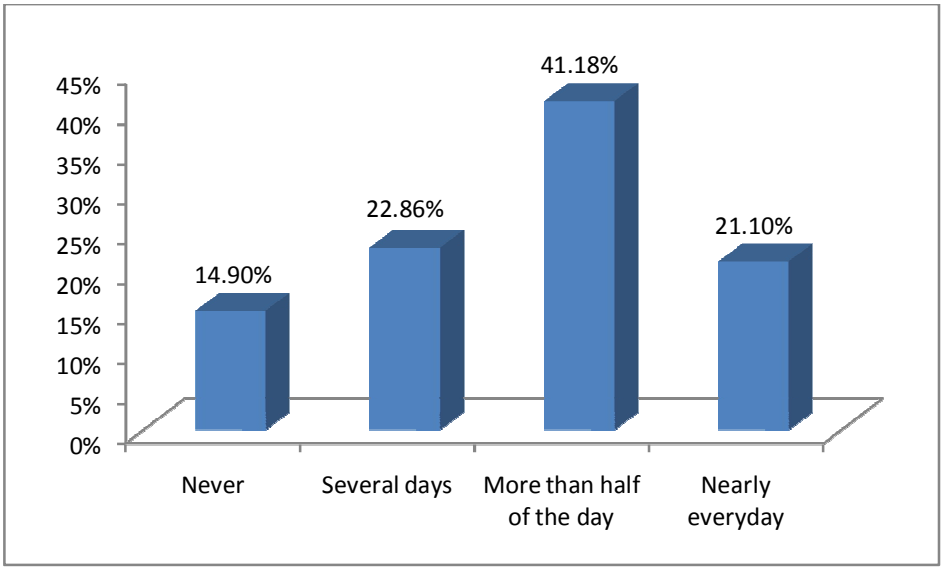


Figure: The Percentage (%) of Depressive disorder

We found most of the tribal teenagers have major depressive disorder. 41.18% teenagers are depressed more than half of the days. 21.1% are depressed nearly every day, 22.86% are depressed several days. We found only 15% tribal teenagers have no depression.

Table 4.31: Percentage of having parents in tribal teenagers

		yes	No
Having parents	Frequency	39	21
	Percent (%)	65	35

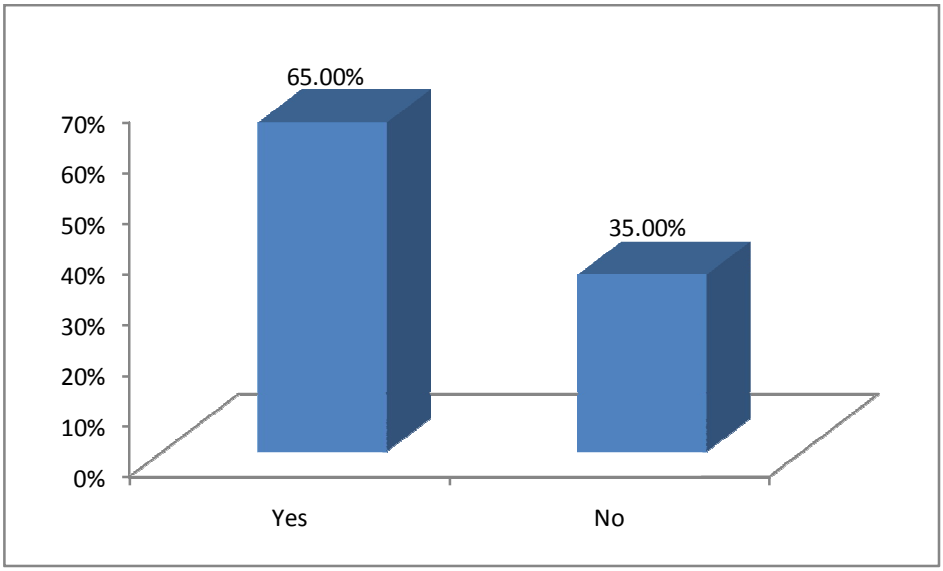


Figure: Graphical representation of percentage of having parents

In tribal teenagers the percentage of having parents is 65% & 35% teenagers have single parents.

Table 4.32: Parents relationship with their children

		Never	Sometimes	Often	Very Often
Children share everything	Frequency	5	18	26	11
	Percent (%)	8.3	30	43.3	18.3
Children are feeling extremely happy or wound up & excited	Frequency	10	25	13	12
	Percent (%)	16.7	41.7	21.7	20
Children not giving concentration on study	Frequency	7	25	17	11
	Percent (%)	8.6	43.1	29.3	19
Children fear of making friends	Frequency	2	0	44	14
	Percent (%)	3.3	0	73.3	23.3
Children are feeling irritation or chunky	Frequency	10	13	20	17
	Percent (%)	16.7	21.7	33.3	28.3
Aggressive behavior of children	Frequency	10	17	27	6
	Percent (%)	16.7	28.3	45	10
Children talk dirty	Frequency	4	9	26	21
	Percent (%)	6.7	15	43.3	35
Feeling shy & an introvert	Frequency	13	20	16	11
	Percent (%)	21.7	33.3	26.7	18.3
child are confusing of sudden change in the body	Frequency	11	6	18	25

	Percent (%)	18.3	10	30	41.7
Get angry if anything is not according children will	Frequency	12	22	21	5
	Percent (%)	20	36.7	35	8.3
Disobedient behavior	Frequency	5	21	17	17
	Percent (%)	8.3	35	28.3	28.3
Taking thing without permission	Frequency	3	11	27	19
	Percent (%)	5	18.3	45	31.7
Arguing nature of children	Frequency	9	13	27	11
	Percent (%)	15	21.7	45	18.3
Feeling of inferiority	Frequency	11	21	12	16
	Percent (%)	18.3	35	20	26.7

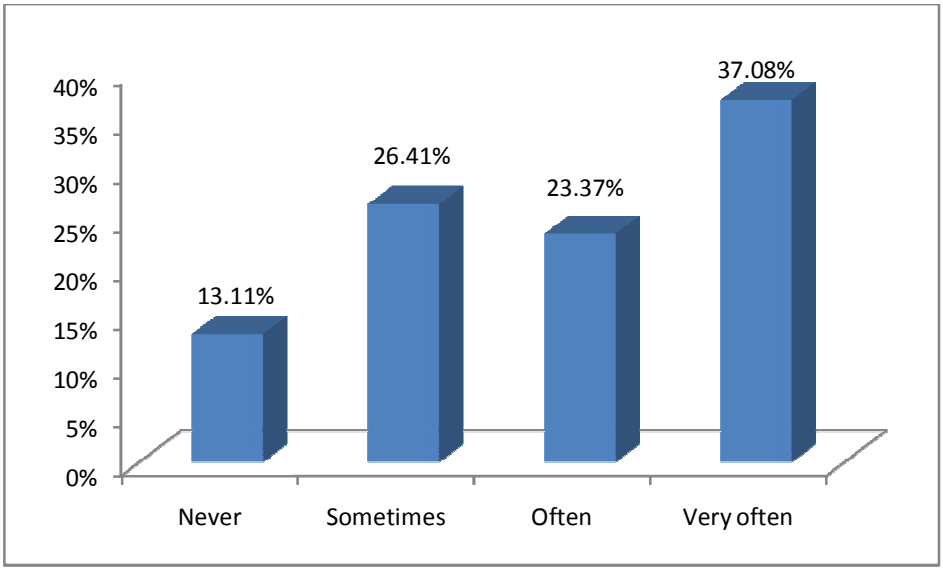


Figure: Percentage of parent's relationship

According to the symptoms 13.1% tribal teenagers are closely bound with their parents. 26.4% teenagers are sometimes close to their parent's. 23.3% teenagers are often but 37.08% teenagers are very often distance with their parent due to low affection & harsh parenting.

Total percentage of having Personality disorder in different class's teenagers

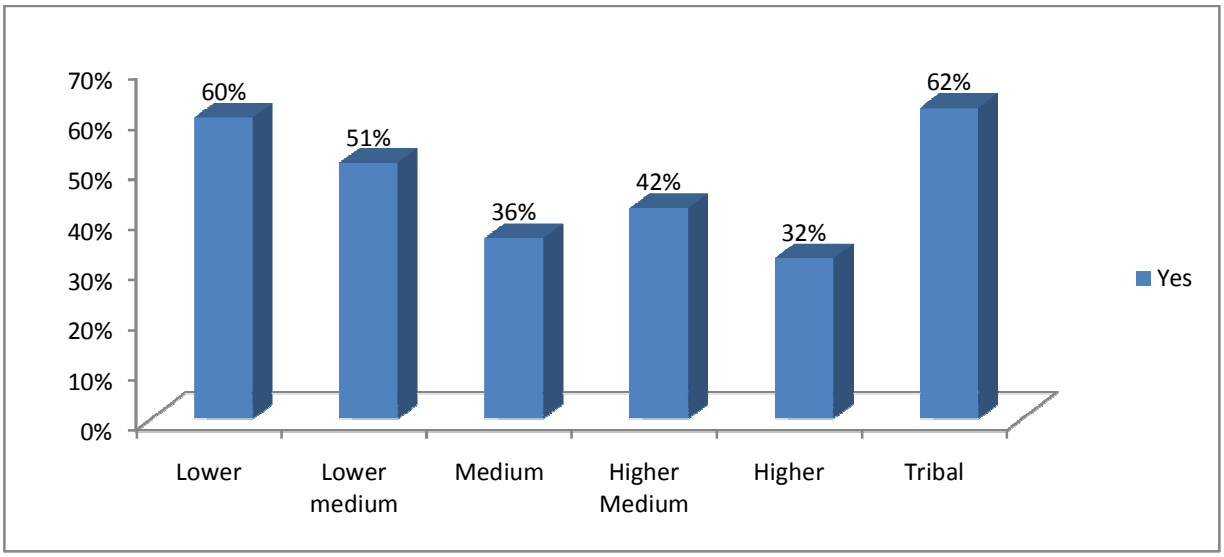


Fig: Percentage of personality disorder in different class's teenagers

In our study lower (60%), lower medium (51%) & tribal (62%) teenagers have high percentage of personality disorder from others.

Percentage of having social anxiety disorder in different class's teenagers

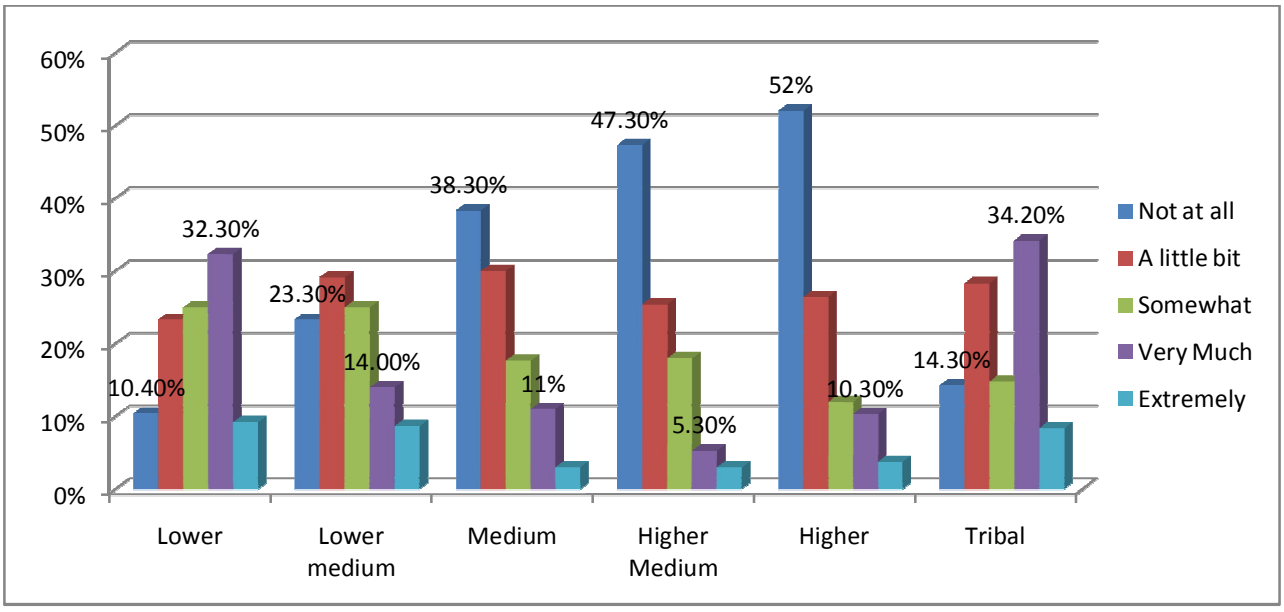


Fig: Percentage of social anxiety disorder in different class's teenagers

From our study lower class (32.3%) & tribal (34.2%) teenagers have high social anxiety disorder. Medium (38.3%), higher medium (47.3%), higher (52%) teenagers have less social anxiety disorder.

Percentage of depressive disorder in different class's teenagers

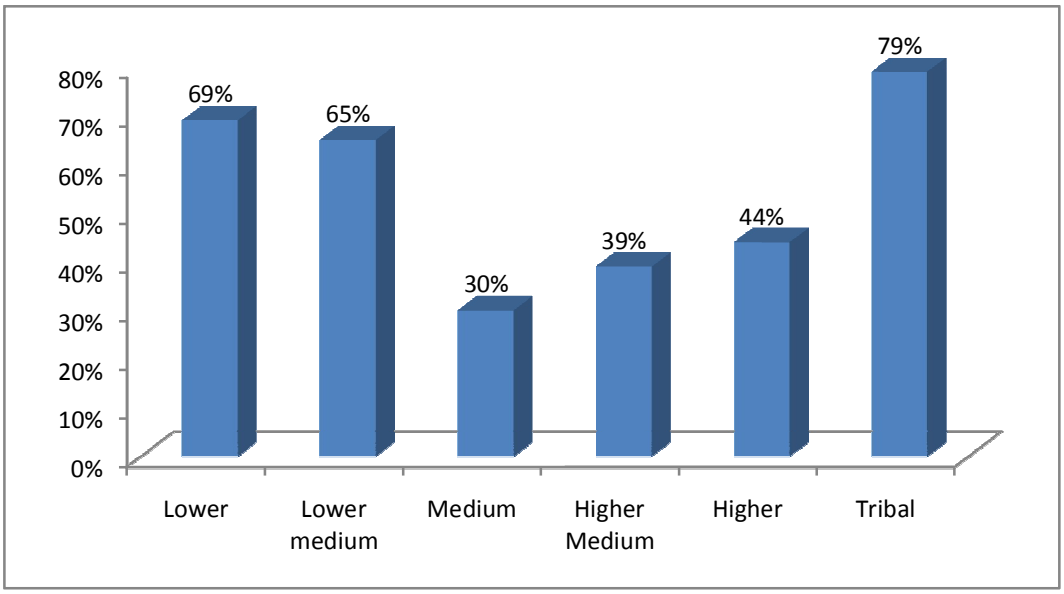


Fig: Percentage of depressive disorder in different class's teenagers

From our study we found lower class (69%), lower medium class (65%) & tribal (79%) teenagers have high depressive disorder. Medium (30%), higher medium (39%) & higher (44%) teenagers have less depressive disorder.

Parent's relationship with their children:

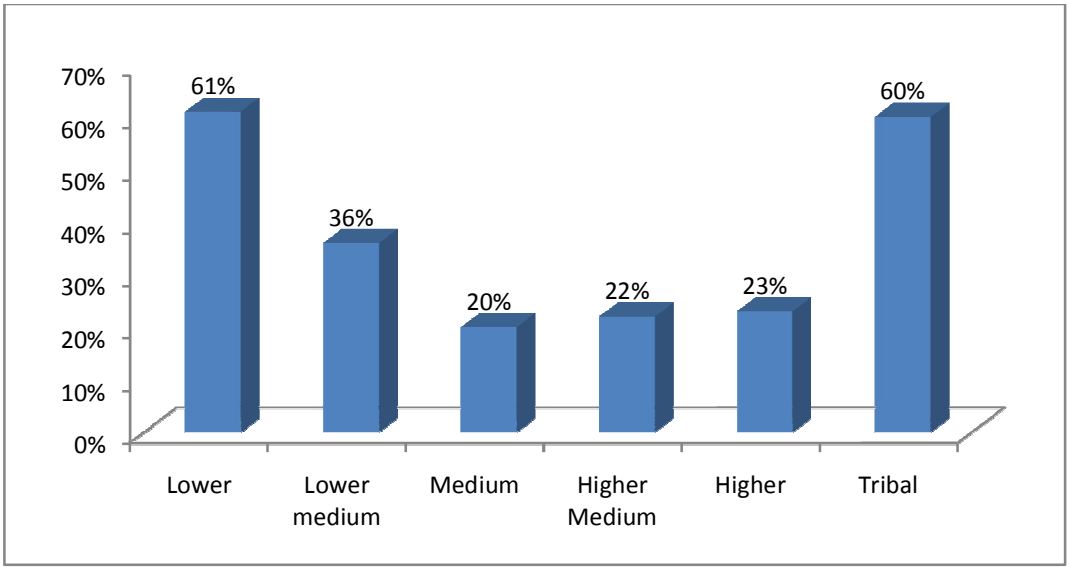


Figure: Percentage of parent's relationship with their children

In overall we found that lower class teenagers (61%) & tribal teenagers (60%) are not close to their parents due to low affection & harsh parenting.

For all individuals, mental, physical and social health is vital strands of life that are closely interwoven and deeply interdependent. As understanding of this relationship grows, it becomes ever more apparent that mental health is crucial to the overall wellbeing of individuals, societies and countries. Unfortunately, in most parts of the world, mental health and mental disorders are not regarded as the same importance as physical health. Instead, they have been largely ignored or neglected. Partly as a result, the world is suffering from an increasing burden of mental disorders, and a widening "treatment gap".

In the broad range of investigations that focus on the teenagers participation in the society, in the socio-economic aspects, their normal behavior and family bonding. Teenager's mental and physical strength develop the society and environment. More than half of all chronic mental illnesses start by age 14. Three-fourths of all chronic mental illnesses start by age 24.

In developing countries, most individuals with severe mental disorders are left to cope as best they can with their private burdens such as depression, dementia, Schizophrenia and substance dependence. Globally, many are victimized for their illness and become the targets of stigma and discrimination. Low and middle income countries have higher burden of mental disorders than economically developed countries. Early intervention leads to a higher chance of recovery, but stigma delays treatment.

Teenager's Health presents the warning signs of mental disorders; describes the types of mental disorders and their prevalence and trends; discusses the consequences and symptoms of different mental disorders.

We found only a limited number of published papers on the mental disorders in Bangladesh little has been studied on teenager's mental condition. In this study we have observed the symptoms of mental disorder in teenagers. We performed our study on 335 participants from different class of teenagers. We divided the teenagers in 5 classes & they are: Lower class, Lower Medium class, Medium class, Medium high class and higher class tribal. Among the participants the highest age of study group was 19 & lowest is 13.

We studied the percentage of the symptoms of personality disorder, social anxiety disorder, depressive disorder, & the family bonding of the teenagers which depend on harsh parenting & low affection.

From this study it has found that lower classes of teenagers facing higher personality disorder, higher social anxiety disorder & higher depressive disorder comparative to others. Lower classes of teenagers having all these problems due to their socio economic condition of the family, family bonding, lower educational qualification, and negligence from the society. Higher class teenagers also facing some disorders due to their low affection of parents. Tribal teenagers are facing different types of disorder.

National survey conducted between 2003 and 2005 illustrated the high burden of mental disorders in Bangladesh. As there is no similar nationally representative mental health survey carried out in recent time (Hossain *et al.,* 2014).

Family relationship is important risk factor for mental disorder. Today, some 450 million people suffer from a mental or behavioral disorder, yet only a small minority of them receives even the most basic treatment. In developing countries, most individuals with

severe mental disorders are left to cope as best they can with their private burdens such as depression, dementia, schizophrenia, and substance dependence. Mental disorders constitute a major public health problem and contribute to 13% of the global burden of disease measured as disability adjusted life years. Mental disorders have serious negative effect on survival, and when present with chronic diseases as comorbid condition, serious mental disorders may reduce life expectancy by about 20 years. Mental disorders are generally not perceived as a health problem and are not priority in the health care delivery. Epidemiological and health system data related to mental disorders are scarce and are not readily available in Bangladesh although a few published articles provide some estimates of different mental disorders (Hossain *et al.,* 2014).

Age is an important factor for occurrence and management of mental disorder in teenagers. Child behavior checklist (Achenbach and Edelbrock) were completed interviews by parents of 7 to 16 years old in 1976, 1989 and 1999. Problem scores increased from 1976 to 1986 and decreased in 1999 but emained higher than in 1976. For the 114 problem items that were common to the 1976, 1989 and 1999 assessments. This survey focused on the prevalence of mental disorders among people aged 5-16 (The 1999 survey had the same minimum age but a maximum age of 15 rather 16. Young adults aged 17 and above were included in the national adult psychiatric surveys in 1993 and 2000.

In our present study the interviewed 335 participant age between 13-19 years. Study among 335 participants 205 (61.2%) were male & 130 (38%) were female. More than 63% of participants were in the age group of 14 to 16 years.

The British Child and Adolescent Mental Health Surveys in 1999 and 2004 found that 1 in 10 children and young people under the age of 16 had a diagnosable mental disorder.

Among the 5 to 10 year olds, 10% of boys and 5% of girls had a mental health problem while among the 11 to 16 year olds the prevalence was 13% for boys and 10% for girls.

In another study the prevalence increased in adolescence with rates of 1.2% in those with no disorder, rising to 9.4% in those with an anxiety disorder and 18.8% in those with depression. In a 2007 survey of young adults, 6.2% of 16–24 year olds had attempted suicide and 8.9% had self-harmed in their lifetime.

Fahmida, Wahab & Rahman performed a research study in 2009 which is Pattern of psychiatric morbidity among the patients admitted in a private psychiatric clinic. Among 304 patients 184 (60.53%) were males and 120 (36.47%) were females. More than 50% of patients were in the age group of 18 to 37 years. Most common psychiatric disorders were schizophrenia and other psychotic disorders (39.4%), mood disorder (18.75%), borderline personality disorder (3.6%), conduct disorder (2.3%), somatoform disorder (1.6%), anxiety disorder (0.7%).

Study conducted in Outpatient department of National Institute of Mental Health (NIMH), Dhaka revealed that 37.4% of patients were suffering from schizophrenia and schizophrenia like psychotic disorders, 16.14% from anxiety disorders, 11.19% from Major Depressive disorder, 8.95% from Bipolar mood disorder, 7.66 % from substance related disorder, 6.60% from somatoform disorder, 4.12% from mental retardation and 7.88% from other disorders.

In our study among 335 participants 205 (61.2%) were male & 130 (38%) were female. More than 63% of participants were in the age group of 14 to 16 years. The common disorder found in teenagers is personality disorder, social anxiety disorder & major depressive disorder. We found lower class (60%), lower medium (51%) & tribal teenagers (62%) have high percentage of personality disorder. lower class (32.3%) & tribal (34.2%) teenagers have high social anxiety disorder. Medium (38.3%), higher

medium (47.3%), higher (52%) teenagers have less social anxiety disorder. lower class (69%), lower medium class (65%) & tribal (79%) teenagers have high depressive disorder.

In 1988, there were 424 hospitalizations in IHS or contract health care facilities (discharges also include deaths) for adolescents age 10 to 19 which involved a suicide attempt. 70% (298) were females, with the majority (55%) of female suicide discharges among 15 to 17 year olds. Ingestion of pills was the most common method of attempt (94%) (351). Likewise, nearly half (47%) of all suicide discharges for males were for 15 to 17 year olds.

Another survey of young adults 2% of 16–24 year olds had attempted suicide and 8.9% had self-harmed in their lifetime. Suicide is the leading cause of death in young people. The suicide rate among 10–19 year olds is 2.20 per 100,000; it is higher in males (3.14 compared with 1.30 for females) and in older adolescents (4.04 among 15–19 year olds compared with 0.34 among 10–14 year olds). Recent research has shown a significant all in the rates among young men in the period 2001–2010.

In our study one of the symptoms of major depressive disorder is suicide attempt. We found lower class 26.7% teenager are thought that he/she better off dead or hurt him/her nearly every day. 20% Tribal teenagers are thought that he/she better off dead or hurt him/her nearly every day. 10.9% lower medium class teenagers are thought that he/she better off dead or hurt him/her nearly every day. 5.4% medium class teenagers are thought that he/she better off dead or hurt him/her nearly every day. 6.8% higher medium higher class teenagers are thought that he/she better off dead or hurt him/her nearly every day.

Beiser and Attneave (29) reported that anxiety was the fourth most common mental health problem for youth seen through IHS mental health programs in 1974, nearly equal to the frequency of depression. 8% of all boys and girls between the ages of 15 and 19 were identified as suffering from anxiety. May's (202) survey revealed that in 1981 and 1982, about 18% of all males and nearly 10% of all females seen for anxiety in the IHS Albuquerque Area Office mental health program were between 10 and 19 years of age. Studies of boarding school and college students conducted by the National Center for American Indian and Alaska Native Mental Health Research also included measures of anxiety symptoms. These studies suggest remarkably high levels of different forms of anxiety among Indian adolescents.

In 2011, more than one in four (29%) high school students in grades 9-12 who participated in a national school-based survey reported feeling sad or hopeless almost every day for two weeks or longer during the past year—a red flag for possible clinical depression.

Another survey that collected information from adolescents between the ages of 12 and 17 found that in 2008, about one in 12 (8%) reported experiencing a major depressive episode during the past year. These estimates have not changed much over the past five to 10 years. An estimated 10% of adolescents reported symptoms of an anxiety disorder. About 5% of adolescents report symptoms of an eating disorder. About 9% of adolescents reported symptoms of an Attention deficit hyperactive disorder (ADHD).

In our study lower class (60%), lower medium (51%) & tribal teenagers (62%) have high percentage of personality disorder. lower class (32.3%) & tribal (34.2%) teenagers have high social anxiety disorder. Medium (38.3%), higher medium (47.3%), higher (52%) teenagers have less social anxiety disorder. lower class (69%), lower medium class (65%) & tribal (79%) teenagers have high depressive disorder.

A large, national survey of adolescent mental health reported that about 8% of teens ages 13–18 have an anxiety disorder, with symptoms.

From our study lower class (32.3%) & tribal (34.2%) teenagers have high social anxiety disorder. Medium (38.3%), higher medium (47.3%), higher (52%) teenagers have less social anxiety disorder.

In this study we found that most of the lower class teenagers have high personality disorder (60%). They also have high social anxiety disorder. 32.27% (very much), 25 % (somewhat) 23.13 %(a little bit) 9.16% (extremely) teenagers have a depression. Only 8.03% lower class teenagers have no social anxiety disorder. In lower class teenagers, the maximum teen agers were depressed more than half of the days (35%).15% teenagers were depressed nearly every day & 22.2% were depressed in several days. 28% teenagers have no depression. According to the symptoms lower class teenagers are low parents relationship. 57% teenagers are living with a single parent. In lower class 16.6% teenagers is close to their parent's. 22.44% are sometimes 24.3% are very often, 36.67% teenagers are often distance with their parent due to low affection & harsh parenting.

In this study we found that lower medium class teenagers have 51% personality disorder. They also have high social anxiety disorder. 32.27% (very much), 25 % (somewhat) 23.13 %(a little bit) 9.16% (extremely). Only 8.03% lower class teenagers have no social anxiety disorder. In lower class teenagers, the maximum teen agers were depressed more than half of the days (35%).15% teenagers were depressed nearly every day & 22.2% were depressed in several days. 28% teenagers have no depression. According to the symptoms lower class teenagers are low parents relationship. 57%

teenagers are living with a single parent. In lower class 16.6% teenagers is close to their parent's. 22.44% are sometimes 24.3% are very often, 36.67% teenagers are often distance with their parent due to low affection & harsh parenting.

In this study we found that medium class teenagers have 51% personality disorder. They also have high social anxiety disorder. 32.27% (very much), 25 % (somewhat) 23.13 %(a little bit) 9.16% (extremely). Only 8.03% lower class teenagers have no social anxiety disorder. In lower class teenagers, the maximum teen agers were depressed more than half of the days (35%).15% teenagers were depressed nearly every day & 22.2% were depressed in several days. 28% teenagers have no depression. According to the symptoms lower class teenagers are low parents relationship. 57% teenagers are living with a single parent. In lower class 16.6% teenagers is close to their parent's. 22.44% are sometimes 24.3% are very often, 36.67% teenagers are often distance with their parent due to low affection & harsh parenting.

In this study we found that higher medium class teenagers have 51% personality disorder. They also have high social anxiety disorder. 32.27% (very much), 25 % (somewhat) 23.13 %(a little bit) 9.16% (extremely). Only 8.03% lower class teenagers have no social anxiety disorder. In lower class teenagers, the maximum teen agers were depressed more than half of the days (35%).15% teenagers were depressed nearly every day & 22.2% were depressed in several days. 28% teenagers have no depression. According to the symptoms lower class teenagers are low parents relationship. 57% teenagers are living with a single parent. In lower class 16.6% teenagers is close to their parent's. 22.44% are sometimes 24.3% are very often, 36.67% teenagers are often distance with their parent due to low affection & harsh parenting.

In this study we found that higher class teenagers have 51% personality disorder. They also have high social anxiety disorder. 32.27% (very much), 25 % (somewhat) 23.13 %(a little bit) 9.16% (extremely). Only 8.03% lower class teenagers have no social anxiety

disorder. In higher class teenagers, the maximum teenagers were depressed more than half of the days (35%). 15% teenagers were depressed nearly every day & 22.2% were depressed in several days. 28% teenagers have no depression. According to the symptoms lower class teenagers are low parents relationship. 57% teenagers are living with a single parent. In lower class 16.6% teenagers is close to their parent's. 22.44% are sometimes 24.3% are very often, 36.67% teenagers are often distance with their parent due to low affection & harsh parenting.

In this study we found that tribal teenagers have 61% personality disorder. They also have high social anxiety disorder. 32.27% (very much), 25 % (somewhat) 23.13 %(a little bit) 9.16% (extremely). Only 8.03% lower class teenagers have no social anxiety disorder. In lower class teenagers, the maximum teen agers were depressed more than half of the days (35%).15% teenagers were depressed nearly every day & 22.2% were depressed in several days. 28% teenagers have no depression. According to the symptoms tribal teenagers have low parents relationship. 57% teenagers are living with a single parent. In lower class 16.6% teenagers is close to their parent's. 22.44% are sometimes 24.3% are very often, 36.67% teenagers are often distance with their parent due to low affection & harsh parenting.

Allik, J. (2005). Personality dimensions across cultures. *Journal of Personality Disorders, 19*, pp. 212–232 [Online]. Available at http://psych.ut.ee/~jyri/en/Allik_JPD2005.pdf [Accessed 25 July, 2015]

Berrios, G. E., (1993). "*European views on personality disorders*: a conceptual history". Comprehensive Psychiatry. [Online], 34 (1), pp. 14–30. Available at http://www.ncbi.nlm.nih.gov/pubmed/8425387[Accessed 25 July, 2015]

Chadda R.K., Saurabh. (1994). Pattern of Psychiatric Morbidity in Children Attending a General Psychiatric Unit. The Indian Journal of Pediatrics [Online], 61, pp.281-285. Available at http://link.springer.com/article/10.1007/BF02752225[Accessed 25 July, 2015]

Chaudhury S., Prasad PL., Zacharias R., Madhusudan T., Saini R. (2007). Psychiatric Morbidity Pattern in a Child Guidance Clinic [Online]. 63, pp.144-146. Available at

http://www.nepjol.info/index.php/JNPS/article/viewFile/2604/2992[Accessed 25 July, 2015]

Collishaw S., Maughan B., Goodman R., Pickles A: Time trends in adolescent mental health. J Child Psychology and Psychiatry 2004, 45(8), pp. 1350-1362 [Online]. Available at:http://onlinelibrary.wiley.com/doi/10.1111/j.1469-7610.2004.00335.x/epdf[Accessed 25 July, 2015]

Costello., (1989) DEVELOPMENTS IN CHILD PSYCHIATRIC EPIDEMIOLOGY. Journal of the American Academy of Child & Adolescent Psychiatry [Online], 28(6), pp.836–841. Available at http://www.jaacap.com/article/S0890-8567%2809%2960204-5/pdf[Accessed 25 July, 2015]

Elian F., Praveetha P., Helen S., Journal of Adolescent Health 56 (2015), Mental Health Difficulties in Early Adolescence: A Comparison of Two Cross-Sectional Studies in England from 2009 to 2014 [Online] Available at: http://www.jahonline.org/article/S1054-139X%2815%2900064-6/pdf[Accessed 25 July, 2015]

Fahmid A., Wahab M.A., Rahman M.M, (2009). BANGLADESH JOURNAL OF MEDICAL SCIENCE 8, pp.1-2. Pattern of psychiatric morbidity among the patients admitted in a private psychiatric clinic. Available at: http://www.banglajol.info/index.php/BJMS/article/view/3186[Accessed 25 July, 2015]

Giasuddin N.A., Diba S.F. (2012).Pattern of Child and Adolescent Patients Attending Psychiatric Outpatient Department of the Mental Hospital in Bangladesh. [Online] Faridpur Med. Coll. J. 7(2), pp. 67-70. Available at: http://www.banglajol.info/index.php/FMCJ/article/viewFile/13501/9713[Accessed 25 July, 2015]

Goodman R., Ford T., Meltzer H. Mental health problems of children in the community: 18 month follow up. BMJ 2002, 324(7352), pp. 1496-1497. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC116447/[Accessed 25 July, 2015]

Green H., McGinnity A., Meltzer H., Ford T., Goodman R., Mental health of children and young people in Great Britain, 2004. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan, 2005 [Online]. Available at: http://www.esds.ac.uk/doc/5269/mrdoc/pdf/5269technicalreport.pdf[Accessed 25 July, 2015]

Hoagwood K., Horwitz S., Stiffman A., *et al.* (2000). Journal of Child and Family Studies. 9(3), pp. 315–331. Concordance between Parent Reports of Children's Mental Health

Services and Service Records: The Services Assessment for Children and Adolescents (SACA) [Online]. Available at http://scholar.harvard.edu/files/jweisz/files/2000a.pdf[Accessed 25 July, 2015]

Hossain *et al.,* (2014). Mental disorders in Bangladesh: a systematic review. BMC Psychiatry, 14, pp.216. [Online] Available at http://www.biomedcentral.com/1471-244X/14/216/[Accessed 25 July, 2015]

Indrajit B., Brijesh S., Prasanta K. C., Bedanta R., Archana S. (2014), Pharmacotherapy of Bipolar Affective Disorder: A Hospital based Study from Sub Himalayan Valley of Nepal [Online] 2014. 8(6): HC22-HC27. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4129323/[Accessed 25 July, 2015]

John F., Clarkin, Kenneth L., (2003). A Psychodynamic Treatment for Severe Personality Disorders: Issues in Treatment Development. [Online] Available at: http://levylab.psych.psu.edu/publications/2003/a-psychodynamic-treatment-for-severe-personality-disorders-issues-in-treatment-development[Accessed 25 July, 2015]

Kernberg O., Yeomans F., (2013).Borderline personality disorder, bipolar disorder, depression, attention deficit/hyperactivity disorder and narcissistic personality disorder: Practical differential diagnosis. 77(1) Available at: http://www.bpdresourcecenter.org/wp-content/uploads/2014/04/Kernberg-Yeomans-20131.pdf[Accessed 25 July, 2015]

Kessler R.C. et al., (1995). Social consequences of psychiatric disorders, I: Educational attainment. American Journal of Psychiatry, 152(7), pp. 1026–1032. [Accessed 25 July, 2015]

Knapp MRJ, Jennifer Beecham *et al.,* (2004) Routine outcome monitoring in clinical practice: service and non-service costs of psychiatric patients attending a community mental health centre in Italy. European psychiatry, 19(8), pp. 469-477. [Online] Available

at: http://eprints.lse.ac.uk/325/1/clinical-practice%28Italy%29_euro-psychiatry_19-8.pdf[Accessed 25 July, 2015]

Laurenssen *et al.,* (2013). Child and Adolescent Psychiatry and Mental Health 2013, 7:3; Available at: http://www.capmh.com/content/7/1/3[Accessed 25 July, 2015]

Mahat P et al., (2006). Emotional and Behavioral Problems among Nepalese School Children and Adolescents: Prevalence and Risk factors. Souvenir of Second International conference of SAARC Psychiatric Federation. pp. 39-45. Available at: http://imsear.li.mahidol.ac.th/bitstream/123456789/147070/1/jnps2010v30i2p79.pdf [Accessed 25 July, 2015]

Margaret M., Peter F., (2013). Mental health problems in children and young people Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays. [Online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255237/2901304_CMO_complete_low_res_accessible.pdf[Accessed 25 July, 2015]

Maughan B., Rutter M., (1998). Continuities and discontinuities in antisocial behaviour from childhood to adult life. In: Ollendick TH, Prinz RJ (eds.), Advances in Clinical Child Psychology. New York, Plenum [Online]. Available at: http://link.springer.com/chapter/10.1007/978-1-4757-9038-2_1[Accessed 25 July, 2015]

McGinnity H, Meltzer T, Ford R. G., (2004) national statistics Department of Health and the Scottish Executive Mental health of children and young people in Great Britain.4:21-23 Available at: http://www.hscic.gov.uk/catalogue/PUB06116/ment-heal-chil-youn-peop-gb-2004-rep2.pdf [Accessed 25 July, 2015]

McWilliams, Nancy (29 July 2011). Psychoanalytic Diagnosis, Second Edition: Understanding Personality Structure in the Clinical Process. Guilford Press. p. 196. Retrieved in 2011. [Accessed 25 July, 2015]

Millon T., (2004). Personality Disorders in Modern Life, p. 4. John Wiley & Sons, Inc., Hoboken, New Jersey. Available at: http://turkpsikiyatri.org/arsiv/personality.disorders.millon.pdf [Accessed 25 July, 2015]

Mohit M.A., (2001). Diagnosis of Patients Attending Out Patient Department (OPD) of NIMH. Bang J Psychiatry, 15 (1) pp. 5-12.

Mulrow C.D., Williams J.W, Chiquette E., Aguilar C., Badgett R., Ramirez G., Stamm K. (1999). Treatment of depression—newer pharmacotherapies summary. [Online] Available at: http://www.ncbi.nlm.nih.gov/books/NBK11912/[Accessed 25 July, 2015]

Mulye T.P., Park M.J., Nelson C.D*., et al.* (2009). Trends in adolescent and young adult health in the United States. Journal of Adolescent Health. 45(1), pp. 8-24 [Online] Available at: http://download.journals.elsevierhealth.com/pdfs/journals/1054139X/PIIS1054139X09001244.pdf [Accessed 25 July, 2015]

National Adolescent Health Information Center (2006). Fact Sheet on Suicide: Adolescents & Young Adults. San Francisco, CA: University of California, San Francisco. [Online]. Available at: http://www.nahic.ucsf.edu/ downloads/Suicide.pdf [Accessed 25 July, 2015]

National Institute of Mental Health (2009). Treatment of children with mental illness: Frequently asked questions about the treatment of mental illness in children. Retrieved November 9, 2012 [Online] Available at: http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-

illness-fact-sheet/nimh-treatmentchildren-mental-illness-faq.pdf[Accessed 25 July, 2015]

Office for National Statistics: The mental health of children and adolescents in Great Britain. London: Office for National Statistics, 1999 [Online] [Accessed 25 July, 2015]

Patel V., Flisher A. J., Hetrick S., McGorry P., (2007). Mental Health of Young People: A Global Public-health Challenge. Lancet 369(9569), pp. 1302-13. Available at: www.clinique-transculturelle.org/pdf/lancet_2007_1.pdf [Accessed 25 July, 2015]

Psych Central. "*Paranoid Personality Disorder Symptoms"*. Psych Central. Retrieved on June 20, 2014, Available at: http://psychcentral.com/disorders/paranoid-personality-disorder-symptoms. [Accessed 25 July, 2015]

Saß H. 2001. "*Personality Disorders*," pp. 11301-11308. International encyclopedia of the social & behavioral sciences. Available at: http://www.addictionhope.com/mood-disorder/personality [Accessed 25 July, 2015]

Shrestha D.M., (1986) Neuropsychiatric problems in children attending a general psychiatric clinic in Nepal. J Nepal Paediatr Soc 5: pp. 97-101. Available at: http://medind.nic.in/maa/t07/i2/maat07i2p144.pdf[Accessed 25 July, 2015]

Srinath S., Girimaji S.C., Gururaj G., Seshadri S., Subbakrishna D.K., Bhola P., Kumar N. Epidemiological study of child and adolescent psychiatric disorders in urban and rural areas of Bangalore, India. Indian J Med Res.2005; 122, pp. 67-79. Available at: http://www.ncbi.nlm.nih.gov/pubmed/16106093 [Accessed 25 July, 2015]

Storrie K., Ahern K., Tuckett A. (2010). "*A systematic review: Students with mental health problems—a growing problem*". International Journal of Nursing Practice, 16 (1), pp. 1–16. Available at: www.ncbi.nlm.nih.gov/pubmed/20158541 [Accessed 25 July, 2015]

Thomas A. W., Simonsen E., Krueger R., Verheul R. (2005):PERSONALITY DISORDER RESEARCH AGENDA FOR THE DSM–V. J Pers Disord. 19(3), pp. 315–338. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2242427/[Accessed 25 July, 2015]

Theodore Millon (1987). On the Genesis and Prevalence of the Borderline Personality Disorder: A Social Learning Thesis. Journal of Personality Disorders: 1 (4), pp. 354-372. Available at: http://guilfordjournals.com/doi/abs/10.1521/pedi.1987.1.4.354?journalCode=pedi [Accessed 25 July, 2015]

Randle, K. (2008). Masochism and where it comes from. Psych Central. Retrieved on June 20, 2014, Available at: http://psychcentral.com/ask-the-therapist/2008/08/11/masochism-and-where-it-comes-from/[Accessed 25 July, 2015]

Regmi S.K., Nepal M.K., Khalid A., Sinha U.K., Kiljunen R., Pokharel A., Sharma S.C. A study of children and adolescents attending the child guidance clinic of a general hospital. Nepalese Journal of Psychiatry 2000; 1, pp. 90-7[Online]. Available at: http://medind.nic.in/maa/t07/i2/maat07i2p144.pdf [Accessed 25 July, 2015]

U.S. Department of Health and Human Services. Mental health: A report of the surgeon general. 2000. Retrieved July 8, 2001, available at http://www.surgeongeneral .gov/Library/MentalHealth/home.html[Accessed 25 July, 2015]

United states Department of Health and Human Services. Rockvelle MD. United States Department of Health and Human Services. Substance Abuse and Mental Health Service Administration. Centre for Mental Health Services. National Institutes of Health. National Institute of Mental Health.1999 [Online] Available at: http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf[Accessed 25 July, 2015]

Verghese A and Beig A. Psychiatric disturbance in children-an epidemiological study. Indian J Med Res.1974; 10:62. Available at: www.nepjol.info/index.php/JNPS/article/viewFile/2604/2992 [Accessed 25 July, 2015]

Widiger, Thomas (2012). The Oxford Handbook of Personality Disorders. Oxford University Press. ISBN 978-0199735013. Available at: [Accessed 25 July, 2015]

WHO (2010) ICD-10: Specific Personality Disorders Available at: http://www.who.int/classifications/icd/en/bluebook.pdf [Accessed 25 July, 2015]

WHO: Mental health: a state of wellbeing. Geneva: World Health Organization; 2011. Available at: www.who.int/features/factfiles/mental_health/en/[Accessed 25 July, 2015]

WHO: The World Health Report 2000-Health system: improving performance, Geneva. World Health organization 2000. Available at: http://www.who.int/whr/2000/en/whr00_en.pdf [Accessed 25 July, 2015]

Zahner G. E., Daskalakis C (1997). Factors associated with mental health, general health, and school-based service use for child psychopathology. Am J Public Health. [Online] 87(9): 1440–1448. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1380967[Accessed 25 July, 2015]