

Behavioural problems among school children in selected schools of Dharwad district

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Received: 23.12.2018; Revised: 17.04.2019; Accepted: 27.04.2019

■ **ABSTRACT** : The study on behavioral problems among school children aged 8-12 years was conducted in the Dharwad district. For the study, two taluks from Dharwad district namely, Dharwad and Navalagund were randomly selected and from these taluks two each villages were selected. From these four villages, 85 children from first village, 120 from second village, 49 from third village and 54 from fourth village were randomly drawn. Hence, the final sample comprised of 277 children. CBCL-Teacher Report Form developed by Achenbach *et al.* (2001) was used to identify the problem behaviour in children. The results revealed that 51.6 per cent of children were in clinical range and 31.8 per cent in borderline. Only 16.6 per cent were in the normal range. The prevalence of Internalizing problems showed that nearly 52 per cent children were in the clinical range followed by 24.5 per cent in borderline. Similarly for the externalizing problems, 33.9 per cent children were in the borderline and 31.0 per cent in the clinical range. But, 35 per cent were in the normal category. About 49.1 per cent children had somatic complaints, 44.8 per cent had thought problems, 43.3 per cent withdrawn, 41.9 per cent social problems, 39.0 per cent anxious/depressed, 27.4 per cent aggressive, 23.1 per cent with rule breaking and 12.6 per cent had attention problems. Hence, there is need to reduce their problematic behaviour through mental health improvement and positive parenting programmes.

■ **KEY WORDS**: Problem behaviour, Prevalence, Externalizing problems, Internalizing problems

■ **HOW TO CITE THIS PAPER** : Mokashi, M. V. and Khadi, P. B. (2019). Behavioural problems among school children in selected schools of Dharwad district. *Asian J. Home Sci.*, 14 (1) : 80-87, DOI: 10.15740/HAS/AJHS/14.1/80-87. Copyright © 2019: Hind Agri-Horticultural Society.

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The child's problems are often multi-factorial and the way in which they are expressed may be influenced by a range of factors including developmental stage, temperament, coping and adaptive abilities of family, nature and the duration of stress. In general, chronic stressors are more difficult to deal with than isolated stressful events.

Children do not always display their reactions to events immediately, although they may emerge later.

Anticipatory guidance can be helpful to parents and children wherein parents can attempt to prepare children in advance of any potentially traumatic events *viz.*, elective surgery or separation. Children should be allowed to express their true fears and anxieties about impending events.

It's normal for younger children to have fears (for example, of ghosts or monsters or dogs), as they become aware there are dangers in the wider world around them

and they learn to distinguish between reality and fiction. Many children develop patterns of behaviour to comfort themselves if they feel anxious, such as thumb sucking or wanting to do the same things at the same time every day. As they get towards puberty, children can become more defiant as they start to be independent and separate psychologically from parents and their care givers. When the teen years begin, many young people become moody, angry or tearful and battles with parents can become a daily occurrence. Children can also be naughty, defiant and impulsive from time to time, which is perfectly normal. However, some children have extremely difficult and challenging behaviours that are outside the norm for their age. Behaviour is the manner in which one may act or conduct oneself.

Normal behaviour in children depends on the child's age, personality, physical and emotional development. A child's behaviour may be a problem if it doesn't match the expectations of the family or if it is disruptive. Normal or "good" behaviour is usually determined by whether it's socially, culturally and developmentally appropriate. Children suffer from behavioural problems at one time or the other during their development. Many of these problems are of transient nature and are often not even noticed. However, at times, the severity and their overall effect on the development of the child may be distressing. At times there are some problems which persist and in due course interfere or become obstacles for the normal development of children which may lead to developmental deviations. In the western countries, parents tends to seek advice for even minor problems like thumb sucking, while in developing countries, behaviour problems of children have not accorded its due importance.

Behaviour problem is a deviation from the accepted pattern of behaviour on the part of an individual in society (Verma's, 1964). The term 'behaviour problem' is used to designate the deviation in behaviour from the one expected or approved by the group. Behavioural problems that precede or are concomitant with most common mental disorders in childhood and adolescence have been the focus of interest of Developmental Psychopathology (Cicchetti, 1984 and Sroufer and Rutter, 1984). Within the theoretical framework of Developmental Psychopathology, children who face difficulties in their relations with peers can be grouped into two broad categories: those with "externalizing problems" - little control (under control) over their emotions, thoughts and

behaviours and those with "internalizing problems" - excessive control (over control) of these processes (Achenbach and Edelbrock, 1978 and Achenbach *et al.*, 1991). In the first category, the effects of low control, expressed by aggressive, impulsive, antisocial and challenging behaviours, has an immediate impact on others. In the second category, the excessive control, expressed in forms of social withdrawal, inhibition, depression or various forms of anxiety, brings immediate consequences for the child himself/herself, limiting social experiences and thus, creating obstacles for the social and psychological adjustment in childhood (Aunola and Nurmi, 2005). Due to the negative consequences for the individual mental health and given the emotional and social cost for the families and society in general, the correlates and predictors of internalizing and externalizing behaviours, in childhood and adolescence, have been the focus of great attention for researchers, in different cultures. Hence, the present study was an attempt to study the prevalence of behavioral problems among children aged 8 to 12 years in selected government schools of Dharwad district.

■ RESEARCH METHODS

A differential research design was used to compare the behavioural problems among children. The population of the study consisted of children of late childhood period between the ages of 8 to 12 years from government schools of Dharwad district.

Two taluks from Dharwad district namely Dharwad and Navalgund were selected purposively for the study. It was reported from the Census data that, 119 villages were there in Dharwad taluk and 60 villages in Navalgund taluk. The village which is having a government school with primary and upper primary section was selected. From the selected taluks, two villages each were selected. The sample comprised of the children studying in the 4th to 7th standards of the Government schools of selected villages *i.e.* 85 children from first village, 120 from second, 49 from third and 54 from fourth village. The students and teachers of each class were administered with the questionnaire separately. During the scrutinizing process, 31 children were excluded because of their long term absenteeism and irregularity in the activities. Total sample comprised of 277 children. The child behaviour checklist (CBCL)-Teacher Report Form developed by Achenbach and Rescorla (2001) was administered for identifying

problem behaviour in children. The behavioural problems were categorized into internalizing, externalizing and total behavioural problems. The tool also assess the components of behavioural problems *viz.*, Anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule breaking behaviour and aggressive behaviour with 113 items. Each item was scored and categorized into normal, borderline and clinical range. Frequency and percentages were used to assess the behaviour of the children. Chi-square analysis was used to know the association between the problem behaviour of children and by villages.

■ RESEARCH FINDINGS AND DISCUSSION

The problems were categorized into internalizing, externalizing and total behavioural problems. The results on prevalence of internalizing problems, revealed that majority of the children were in the clinical range (52 %) followed by borderline (24.5 %) and normal (23.5 %). With regard to comparison of children by villages, majority of the children from three villages were in the clinical range followed by borderline. In one village, majority of the children fell under normal category (40.0%); followed by 31.8 per cent in the clinical range and 28.2 per cent in the borderline. This increase in the prevalence rate of internalizing problems may be due to negative parenting style and practices used by their parents and also the child's socio-economic status and temperamental may develop some internalizing problems in them. Studies show that negative parental control increases internalizing problems in children who are over-controlled or high on fearfulness (Van Leeuwen *et al.*,

2004). These results are in line with Ginige *et al.* (2014) findings who reported that nearly 8.8 per cent of 7 to 11 year old children had significant internalizing problems. Alfons *et al.* (1997) also reported that internalizing problems increased with the age of the children. Children with internalizing symptoms were prone to sadness, low attention regulation and low impulsivity. Eisenberg *et al.* (2001) revealed that relations between internalizing problems and emotionality were more frequent in the school going children.

Similarly for externalizing problems, 35 per cent of children were in the normal range whereas 33.9 per cent were in the borderline and 31.0 per cent were in the clinical range. With regard to comparison of children by villages, majority of the children from two villages fell under clinical range followed by borderline and normal, while majority of the children from one village were normal (53.6 %) followed by borderline (30.0%) and clinical range (16.4 %). Similarly, in another village, majority of the children fell under borderline (42.3%) followed by normal (34.6 %) and clinical (23.1%). The chi-square analysis showed no significant association between the externalizing problems and children of all villages ($X^2=1.37$). Poor parenting (Gardner, 2000 and Hodgins *et al.*, 2001), maternal rejection (Raine *et al.*, 1994), or social adversity (Arsenault *et al.*, 2002) and poor cognitive ability (Deitz *et al.*, 1997 and Huesmann *et al.*, 1987) have been reported to directly predispose the externalizing and antisocial behaviour problems among children. Better parental care, or effective parenting or better social service, can help to reduce the externalizing risk factors. Denham *et al.* (2000) reported that proactive parenting (*i.e.*, supportive presence, clear

Table 1 : Percentage distribution of children by level of internalizing and externalizing behavioural problems

Villages	Normal	Borderline	Clinical	X ²
Village 1	6 (9.1)	14 (21.2)	46 (69.7)	1.45 ^{NS}
Village 2	44 (40.0)	31 (28.2)	35 (31.8)	
Village 3	8 (15.4)	16 (30.8)	28 (53.8)	
Village 4	7 (14.3)	7 (14.3)	35 (71.4)	
Total	65 (23.5)	68 (24.5)	144 (52.0)	
Village 1	11 (16.7)	26 (39.4)	29 (43.9)	1.37 ^{NS}
Village 2	59 (53.6)	33 (30.0)	18 (16.4)	
Village 3	18 (34.6)	22 (42.3)	12 (23.1)	
Village 4	9 (18.4)	13 (26.5)	27 (55.1)	
Total	97 (35.0)	94 (33.9)	86 (31.0)	

NS=Non-significant

instruction and limit setting) predicted fewer behaviour problems over time, after controlling for initial problems in the school going children.

Regarding total behavioural problems, majority of the children were in the clinical range (51.6%) followed by borderline (31.8 %) and normal (16.6 %). With regard to comparison of children by villages, majority of the children from three villages were in the clinical range followed by borderline and normal. In one village, majority of them were in the borderline (40.0 %) followed by clinical range (37.3 %) and normal (22.7 %). However, the chi-square analysis showed no significant association between villages and behavioural problems ($X^2=2.92$). Parental stress, poor attachment with children, negative parenting style used by the mothers and fathers in rearing their children, child's poor adjustment with the academics, and also child's emotional and mental health problems may be reason for this high prevalence. The results are in line with Bhargava *et al.* (1988) who surveyed 10,000 primary school children using questionnaire and reported that 6199 children had behaviour problems. According to Gupta *et al.* (2001) 45.6 per cent of the children were estimated to have behavioural problems, of which 36.5 per cent had significant problems. Gearing *et al.* (2013) reported that approximately 53 per cent of the 11-18 year old adolescents were identified as experiencing mental health problems and 43 per cent and 46 per cent had high internalizing and externalizing scores, respectively.

The perusal of Table 2 shows that for anxious/depressed syndrome, 39.0 per cent of the children were in the clinical range followed by 37.2 per cent in normal and 23.8 per cent in borderline. On comparison between villages, 60.6 per cent of children from one village were in the clinical range and only 18.2 per cent of children in the normal range. Similarly, in one village 52.7 per cent were normal and only 19.1 per cent were in clinical range. But in another village, 46.2 per cent, 30.8 per cent and 23.1 per cent of children fell under normal, clinical and

borderline. In other village, majority of the children fell under clinical range (63.3 %) whereas equal percentage of children fell under borderline (18.4 %) and normal range (18.4 %). However, the chi-square analysis showed no significant association between anxious/depressed syndromes with villages. Michael *et al.* (2007) reported that anxiety disorders with lifetime prevalence rates ranging between 13.6 per cent and 28.8 per cent in Western countries. He also reported that comorbidity among individuals with an anxiety disorder is high *i.e.* three out of four people with a lifetime anxiety disorder experience and at least one other mental disorder in their lifetime.

With regard to withdrawn/depressed syndrome, 43.3 per cent fell under clinical range followed by 35.7 per cent in borderline and 20.9 per cent in normal range. In two villages, majority of the children were in the clinical, borderline and normal range. Whereas, in one village, 41.8 per cent, 32.7 per cent and 25.5 per cent of children fell under borderline, clinical range and normal range, respectively and in another village, equal percentages of children (42.3 %) were in the clinical and borderline whereas only 15.4 per cent were normal. However, the chi-square analysis showed no significant association between withdrawn / depressed syndrome with villages. The results are supported by the prevalence study of Fleming *et al.* (1989) who reported that 0.6 per cent pre-adolescents and 1.8 per cent of adolescents had severity of the depressive syndrome with high diagnostic certainty.

In case of somatic complaints, majority of the children (49.1 %) were in the clinical range followed by 34.3 per cent in normal range. Only, 16.6 per cent were in the borderline. On comparison of children by villages, majority of children from three villages were in the clinical range followed by normal and borderline. Whereas, in one village, majority of them fell under normal category (50.0 %) followed by clinical range (34.5 %) and

Table 2: Percentage distribution of children by level of total behavioral problems

Villages	Normal	Borderline	Clinical	X^2
Village 1	7 (10.6)	17 (25.8)	42 (63.6)	2.92 ^{NS}
Village 2	25 (22.7)	44 (40.0)	41 (37.3)	
Village 3	7 (13.5)	18 (34.6)	27 (51.9)	
Village 4	7 (14.3)	9 (18.4)	33 (67.3)	
Total	46 (16.6)	88 (31.8)	143 (51.6)	

NS= non-significant

Table 3: Percentage distribution of children by level of components of behavioural problems					
Components	Villages	Normal	Borderline	Clinical	X ²
Anxious / Depressed	Village 1	12 (18.2)	14 (21.2)	40 (60.6)	1.04 ^{NS}
	Village 2	58 (52.7)	31 (28.2)	21 (19.1)	
	Village 3	24 (46.2)	12 (23.1)	16 (30.8)	
	Village 4	9 (18.4)	9 (18.4)	31 (63.3)	
	Total	103 (37.2)	66 (23.8)	108 (39.0)	
Withdrawn / Depressed	Village 1	12 (18.2)	16 (24.2)	38 (57.6)	44.06 ^{NS}
	Village 2	28 (25.5)	46 (41.8)	36 (32.7)	
	Village 3	8 (15.4)	22 (42.3)	22 (42.3)	
	Village 4	10 (20.4)	15 (30.6)	24 (49.0)	
	Total	58 (20.9)	99 (35.7)	120 (43.3)	
Somatic complains	Village 1	11 (16.7)	10 (15.2)	45 (68.2)	86.32 ^{NS}
	Village 2	55 (50.0)	17 (15.5)	38 (34.5)	
	Village 3	14 (26.9)	13 (25.0)	25 (48.1)	
	Village 4	15 (30.6)	6 (12.2)	28 (57.1)	
	Total	95 (34.3)	46 (16.6)	136 (49.1)	
Social problems	Village 1	6 (9.1)	12 (18.2)	48 (72.7)	99.92 ^{NS}
	Village 2	44 (40.0)	45 (40.9)	21 (19.1)	
	Village 3	15 (28.8)	14 (26.9)	23 (44.2)	
	Village 4	9 (18.4)	16 (32.7)	24 (49.0)	
	Total	74 (26.7)	87 (31.4)	116 (41.9)	
Thought problems	Village 1	2 (3.0)	17 (25.8)	47 (71.2)	1.12 ^{NS}
	Village 2	13 (11.8)	72 (65.5)	25 (22.7)	
	Village 3	5 (9.6)	26 (50.0)	21 (40.4)	
	Village 4	1 (2.0)	17 (34.7)	31 (63.3)	
	Total	21 (7.6)	132 (47.7)	124 (44.8)	
Attention problems	Village 1	31 (47.0)	18 (27.3)	17 (25.8)	80.06 ^{NS}
	Village 2	91 (82.7)	12 (10.9)	7 (6.4)	
	Village 3	45 (86.5)	5 (9.6)	2 (3.8)	
	Village 4	27 (55.1)	13 (26.5)	9 (18.4)	
	Total	194 (70.0)	48 (17.3)	35 (12.6)	
Rule breaking behaviour	Village 1	25 (37.9)	21 (31.8)	20 (30.3)	85.14 ^{NS}
	Village 2	58 (52.7)	33 (30.0)	19 (17.3)	
	Village 3	26 (50.0)	19 (36.5)	7 (13.5)	
	Village 4	17 (34.7)	14 (28.6)	18 (36.7)	
	Total	126 (45.4)	87 (31.4)	64 (23.1)	
Aggressive behaviour	Village 1	24 (36.4)	14 (21.2)	28 (42.4)	1.04 ^{NS}
	Village 2	67 (60.9)	24 (21.8)	19 (17.3)	
	Village 3	24 (46.2)	19 (36.5)	9 (17.3)	
	Village 4	16 (32.7)	13 (26.5)	20 (40.8)	
	Total	131 (47.3)	70 (25.3)	76 (27.4)	

NS= Non-significant

borderline (15.5 %). However, the chi-square analyses showed no significant association between somatic complaints with villages. Children dealing with emotional and behavioural issues will complain of these somatic/physical illness symptoms. The child who is undergoing emotional turmoil may exhibit higher number of somatic problems. It appears likely that there are differences in the psychobiological processes underlying these associations in boys and girls. Somatic complaints were strongly associated with emotional disorders in girls and with disruptive behaviour disorders in boys (Egger *et al.*, 1999). Beidel *et al.* (1991) reported that broader range of somatic complaints were associated with children's expression of anxiety and depression.

Regarding social problems, majority of the children fell under clinical range (41.9 %) followed by borderline (31.4 %) and normal (26.7 %). On comparison between villages, majority of children from three villages fell under clinical range followed by borderline and normal. While, majority of children from one village fell under borderline (40.9 %) and normal range (40.0 %) whereas only 19.1 per cent were in the clinical range. However, the chi-square analyses showed no significant association between social problems and village. Some of the factors like temperament, behavioural inhibition fear of negative evaluation and socially anxious modeling by parents may cause these social problems in the children. Many life events, including illness or death of someone close and bullying, are scary or unpleasant for children.

For thought problems, 44.8 per cent, 47.7 per cent and 7.6 per cent of the children were in the clinical, borderline and normal category, respectively. With regard to villages, higher number of children from two villages fell under clinical, borderline and normal category whereas, children from other two villages fell under borderline, clinical and normal category. The chi-square analysis showed no significant association between thought problems with villages.

Regarding attention problems, majority of the children were in the normal range (70.0 %) followed by borderline (17.3 %) and clinical (12.6 %). The chi-square analysis showed no significant association between attention problems and villages. Szatmari *et al.* (1989) reported that there were no significant differences in the prevalence of attention deficit problems by age or urban-rural status. Epidemiologic studies also revealed prevalence rates ranging from 4 per cent to 12 per cent

in the general population of 6 to 12 year olds.

Regarding, rule breaking behaviour, majority of the children fell under normal (45.4 %) range followed by borderline (31.4 %) and clinical (23.1%). With regard to villages, majority of the children from three villages fell under normal, borderline and clinical range whereas children from one village fell under clinical, normal and borderline category. The chi-square analysis showed no significant association between rule breaking behaviour and villages. Children who are in clinical range of rule breaking behaviour may be having higher rate of emotional and attention problems. Child who is having lack of adjustment with their teachers / parents and not able to cope up with their academics may exhibit clinical range of rule breaking behaviour problems.

For aggressive behaviour, majority of the children (47.3 %) were in the normal range whereas 27.4 per cent in clinical and 25.3 per cent in borderline. With regard to villages, more number of children from two villages fell under clinical range followed by normal and borderline whereas majority of children from the other two villages fell under normal range. The chi-square analysis showed no significant association between aggressive behaviour and children from different villages. Some of the studies reported that children having mood disorders, conduct problems, poor attachment with their parents and in classroom or any cognitive problems may exhibit aggressive behaviour in the classroom or in the home settings. Gearing *et al.* (2013) reported that high externalizing scores were observed among 46 per cent (n=32) of youths, with above borderline aggressive behaviour and rule-breaking sub scores in about one-third of the sample, 29 per cent (n=20) and 32 per cent (n=22), respectively. The largest percentages of subscale scores above the cutoff were found for conduct problems (49%, n=34) and social problems (46%, n=32). High prevalence rates were reported across several DSM-IV-related areas, most notably for the DSM-oriented scales of conduct problems (49%, n=34), affective disorders (33%, n=23), anxiety disorders (23%, n=16), and attention-deficit hyperactivity disorder (ADHD) (19%, n=13).

Conclusion:

Majority of the children were found to be in the clinical range of internalizing, externalizing and total behavioural problems. Regarding the components of

behavioural problems such as anxious / depressed, withdrawn / depressed, somatic complaints, social problems, thought problems, attention problems, rule breaking behaviour and aggressive behaviour, majority of them were found to be in the clinical range and borderline. Interventions can help the children to cope with attention deficit and other social problems and also some of the rule breaking and aggressive behaviour. Positive parenting programmes structured for their parents may help to reduce the problem behaviour in the children. Parents may also learn to efficiently use the suitable parenting styles and other measures to control the behavioural problems among their children. This may help the child to gain confidence and may improve their mental health.

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