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MANIFESTATION OF BEHAVIOUR OWING VARIATIONS IN THE AGE OF MIDDLE SCHOOL CHILDREN

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ABSTRACT:

Manifestation of Behaviour problem among Middle school children found to be increasing. Therefore, attempt has been made to investigate the level of Behavioural problem; using extensive survey technique. In the present study 377 females and 435 male students studying in 5th to 7th grade served as a subject. Each individual student was observed once child behaviour checklist which was measure of internalization, externalization, withdrawn, somatic complaints, Anxiety, Social Problem, Thought Problem, Attention Problem, Aggression, Conduct Disorder and Maladjustment. Further for the purpose of data analysis the sample was divided in 3 age groups i.e., A-1 60-90 months; A-2 91 -115 months; A-3 116- months. Deficiency in Behavioural Problem was found to be highest in A-1 and A-3. As for different aspects of Behaviour Problems was concerned considerable variations was observed for Anxiety, Aggression, conduct disorder and Mal adjustment. By and large prevalence of normal behaviour was high as compared to deficient and severally deficient behaviour in children across the age groups.

KEYWORDS:

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INTRODUCTION

CONCEPT OF BEHAVIOUR

Child development refers to the understanding of all facets of human growth and change from conception to adolescence. It's a part of a larger discipline known as developmental psychology, which encompasses the study of all changes that human beings experience throughout their life span. In fact, no branch of psychology is broader in scope than the study of development, for every facet of the individual – physical, mental, social, and emotional changes over a period of time.

The above definitions of theoretical concepts concluded that behaviour is the result of active interplay between environment & the individual. Indian traditional texts explain behaviour is a reflection of *gunas* (the primary qualities of nature), the *sattva, rajas & Tamas*. They exist naturally in human beings, in various degrees of concentration and combination. Depending upon their relative strengths and combinations, they determine nature of beings, its action, behaviour and attitude (Jayaram, 2000).

Biological - "drives" or "needs" such as the need for food, water, shelter influence our behaviour, even in advanced industrial societies. There is a biological hunger, but the way we quench that hunger is socially shaped (biology and psychology overlap - on balance, "drives" and "needs" are more the province of psychology than biology). Other biological influences are mutations, sexual behaviour, visual and vocal apparatuses/perceptual apparatuses, physical deformities, genetics - the list is endless. In short, biology clearly affects behaviour. Psychological influences - if all influences on human behaviour were biological or social, then every person would react exactly the same to every biological or social influence.

The child's personality is the product of an inter play between influences in the environment and hereditary. Though the hereditary information received from parents that signals the body to grow and affects all our characteristics and skills, the complex forces of the physical and social world that children encounter in their homes, neighbour-hood, schools, and communities. Here, the term environment refers to the quality of child – rearing practiced by the parents. That includes child care and method of bringing up of the child through constant positive stimulation and encouragement (smart and smart, 1966).

BEHAVIOUR PROBLEMS OF CHILDREN

In the present era where every day we are stepping ahead to technological advancement, with the increasing pressure in children to achieve, breaking up of the families and rapidly changing socio-cultural paradigm, rise in the behaviour problems in children are also similarly steep

and disrupting. School being an important catchment area for paediatric population; these data are also similarly worthwhile looking into. Review of recent studies concentrating on mental health problems amongst school going children showed the prevalence figures varying from 6.33% to 43.1% in Indian context. International context showed similar variability. India, a developing country has large population, of whom significant proportions are children attending school. Behavioural problems and psychiatric syndromes in the children are a matter of concern as the consequences can seriously impair their ability to become useful & productive citizens of tomorrow. The vulnerability of the child tends to increase when effective parenting is not available. This study was planned with the aim to assess the prevalence of behavioural problems among school going children. The research findings will help in determining the prevalence, associated factors and predictors that are useful in early diagnosis and management. (Prakash, Mitra, Prabhu, 2008).

Campbell, (1995), studied the correlates of behaviour problems in preschool children. Prospective epidemiological studies and follow-Up studies of clinical/high risk samples indicate that serious externalizing problems identified early, often persist Negative, inconsistent parental behaviour and high levels of family adversity are associated with the emergence of problems in early childhood and predict their persistence in school age. Lorah, Kolko, Elizabeth, Huang, Stein, Musicm, Bukstein (2009). Examined: (a) hormone differences in youth with and without disruptive behaviour disorders (DBDs), and (b) contextual factors as moderators of behaviour problems and hormones. 180 children and adolescents were enrolled (141 boys, mean 9.0 ± 1.7 years). DBD participants met criteria for conduct disorder (CD) and/or oppositional defiant disorder (ODD) (*n* = 111); 69 were recruited as healthy comparisons (HC).

Lousie, Lucy, Helen, Phil **(2014),** peer relationships has been extensively reported during adolescence, when peer influence is generally considered to be at its greatest. Research on social isolation during childhood has found associations with school achievement, future relationships and adult mental health. Much of the evidence is derived from either parent or child-rated assessment of peer relationships, each of which have their limitations. Pro-social Behaviour and Emotional Symptoms subscales, controlling for demographics. There were substantial overlaps between problem scores. Regression models found all social isolation variables to be significantly correlated with social and emotional functioning.

Bryan, (1990), associations between childhood behaviour and personality and adult affective disorder were investigated in a 36-year follow-up of a national birth cohort. A number of early characteristics were significantly related to adult outcome including enuresis, nail-biting, speech problems, truancy and composite indices of behaviour and personality. Continuity was not explained byfactors acting independently on child and adult measures. Prediction of adult disorder, although better for women, was modest in both sexes and sensitivity and specificity would not justify widespread intervention. However, childhood measures should prove valuable in investigating chains of influence on adult disorder, occurring throughout individuals' life histories.

METHODS: -

RESEARCH STRATEGY

The nature of research is invariably influenced by objectives and goals for intervention and change. In the field of child behaviour - the social scientists work with the variables, that are categorical and not enough for understanding the basic relationship between the independent and dependent variables and developing a model for further development of scientific theory Since behaviour is the attribute of individual subject, and; therefore, exist naturally and through child behaviour check list, its level was measured. Furthermore, various types of behaviour problems were also measured.

SAMPLE

The present study was conducted on the large sample of 812 children (5-12 years) and their parents (specifically mothers). The stratified random sampling procedure was followed. The children were selected from different schools situated in New Town Yelahanka Bengaluru, Karnataka. The age and gender wise description of the children are presented in table – 3.1.

TABLE 3.1

SCHEMATIC BREAKUP OF THE SAMPLE (N=812)

Sl. No.	Age of Children (In Months)	Gender of children		Total
		Female	Male	
1	A1 (60 - 90)	121	180	301
2	A2 (91 - 115)	124	104	228
3	A3 (116 - 146)	132	151	283
	Total	**377**	**435**	**812**

TOOLS USED: -

CHILD BEHAVIOUR CHECKLIST (CBCL) - ACHENBACH 1986

In the present study, Achenbach's 1986 child behaviour checklist with 4-point scale, a standardized tool was used to assess the manifestation of Behaviour Problems in children across three age groups and gender. The term behaviour refers to manifestation of Internalization, Externalization, withdrawn behaviour, Somatic Complaints, Anxiety/Depressed, Social problems, thought problems, Attention problems, Aggressive/Deliquent Behaviour, Conduct disorders and maladjustment with peer group in everyday life. Further the researcher tested the communicability, utility, validity of this questionnaire among the pilot group.

RESULTS

TABLE 1

LEVEL OF BEHAVIOUR PROBLEMS IN CHILDREN (N=812)

Table-1 contains Mean and Standard deviation of different components of behaviour problem across the age. Most of the behaviours found to be showing improvement corresponding to advancing in age. However, a close perusal of Table 1, depicted the gradual increase in all most all behaviour problems in middle age and there after behaviour disposition of children in older age.

MEAN & STANDARD DEVIATION BEHAVIOUR PROBLEMS IN RELATION TO AGE OF CHILDREN (N=812)

Sl. No.	Components of behaviour problems	Age in months		
		A1 – (60 – 90)	A2 -(91– 115)	A3-(116 – 146)
1	Internalization	43.95 ± 6.08	43.37 ± 5.12	43.18 ± 4.61
2	Externalization	50.44 ± 7.00	51.09 ± 5.91	49.32 ± 5.10
3	Withdrawn	33.67 ± 4.53	33.61 ± 3.85	33.11 ± 3.24
4	Somatic complaints	21.44 ± 2.01	22.10 ± 2.53	21.84 ± 2.30
5	Anxiety / Depressed	44.84 ± 4.92	45.75 ± 4.37	44.64 ± 3.92
6	Social problem	21.94 ± 3.10	22.29 ± 2.76	21.59 ± 2.62
7	Thought problem	27.40 ± 3.55	27.26 ± 3.37	27.29 ± 3.09
8	Attention problem	17.55 ± 3.04	17.63 ± 2.77	17.42 ± 2.58
9	Aggressive/Delinquent	42.94 ± 5.81	42.61 ± 4.90	41.67 ± 4.49
10	Conduct disorder	38.97 ± 5.31	38.81 ± 4.33	37.60 ± 3.74
11	Maladjustment	22.12 ± 2.91	22.46 ± 2.73	21.37 ± 2.11
12	**Total**	210.50 ± 21.20	211.85 ± 18.48	207.30 ± 14.51

MEAN & STANDARD DEVIATION BEHAVIOUR PROBLEMS IN RELATION TO AGE OF CHILDREN (N=812)

Table – 2 consisted of level of Internalization behaviour problem in relation to the age of children. As for as quality of internalization behaviour is concerned 50% of children suffered from internalizing their stress ranging from deficient to severely deficient behaviour problem irrespective of age. But it was found that younger children possess the problem of internalization (38%) more as compared to middle (34%) and older age (35%) children.

TABLE 2

LEVEL OF INTERNALIZATION BEHAVIOUR PROBLEM IN RELATION TO AGE OF CHILDREN (N=812)

Sl. No.	Age in months	Level of behaviour problem		
		Normal	Deficient	Severely deficient
1	A1 (60 – 90)	144 (47.84%)	44 (14.61%)	113 (37.54%)
2	A2 (91 -115)	110 (48.24%)	41 (17.98%)	77 (33.77%)
3	A3 (116-146)	139 (49.11%)	44 (15.54%)	100 (35.33%)

Table 3 the externalization behaviour problem was analyzed qualitatively, it was found that qualitative externalization increases with advance in age and the inverse pattern was seen in case of deficiency in externalization in children. However, middle age children exhibited severely deficient externalization as compared to young and children of older age.

TABLE 3

LEVEL OF EXTERNALIZATION BEHAVIOUR PROBLEM IN RELATION TO AGE OF CHILDREN (N=812)

Sl. No.	Age in months	Level of behaviour problems		
		Normal	Deficient	Severely deficient
1	A1 (60 – 90)	141 (46.84%)	67 (22.25%)	93 (30.89%)
2	A2 (91 -115)	89 (39.03%)	56 (24.56%)	83 (36.40%)
3	A3 (116-146)	146 (51.59%)	58 (20.49%)	79 (27.90%)

The level of withdrawn behaviour problem (Table 4) found to be 55% - 60% deficient to severely deficient across all the age groups. Furthermore, middle age children manifested more severely deficient behaviour as compared to older and younger age children.

TABLE 4

LEVEL OF WITHDRAWN BEHAVIOUR PROBLEM IN RELATION TO AGE OF CHILDREN (N=812)

Sl. No.	Age in months	Level of behaviour problem		
		Normal	Deficient	Severely deficient
1	A1 (60 – 90)	125 (41.52%)	71 (23.58%)	105 (34.88%)
2	A2 (91 -115)	86 (37.71%)	54 (23.68%)	88 (38.59%)
3	A3 (116-146)	129 (45.58%)	64 (22.61%)	90 (31.80%)

A close perusal of Table 5 indicated that, the prevalence of anxiety/depressed behaviour disorders and social problem was found to be normal or deficient to severely deficient in all age groups. It was found that majority of the children manifested either normal level (50%) or deficient behaviour problem (50% plus) for anxiety/depressed behaviour disorder and social problem equally. Alike other behaviour problems the incidence of severely deficient anxiety/depressed disorder and social problem was considerably low among middle aged children.

TABLE 5

LEVEL OF ANXIETY/DEPRESSED BEHAVIOUR IN RELATION TO AGE OF CHILDREN (N=812)

Sl. No.	Age in months	Level of behaviour problem		
		Normal	Deficient	Severely deficient
1	A1 (60 – 90)	149 (49.50%)	44 (14.61%)	108 (35.88%)
2	A2 (91 -115)	98 (42.98%)	42 (18.42%)	88 (38.59%)
3	A3 (116-146)	145 (51.23%)	52 (18.37%)	86 (30.38%)

The prevalence of aggression/delinquent behaviour problem (Table – 6) was found in 50% of the children from normal or severely deficient in all most all age groups. The prevalence of deficient aggressive behaviour problem was found to be less. A gradual decrease in severe aggressive problem was noted with age progression, on the contrary normal aggression increased with age.

TABLE 6

LEVEL OF AGGRESSIVE / DELINQUENT BEHAVIOUR IN RELATION TO AGE OF CHILDREN (N=812)

Sl. No.	Age in months	Level		
		Qualitative	Deficient	Severely deficient
1	A1 (60 – 90)	138 (45.84%)	50 (16.61%)	113 (37.54%)
2	A2 (91- 115)	102 (44.73%)	59 (25.87%)	67 (29.38%)
3	A3 (116 –146)	141 (49.82%)	55 (19.43%)	87 (30.74%)

Table 7 consisted level of conduct disorder behavior problem prevailing in children. The entire sample was broadly divided into two extreme categories either, children had normal conduct (50%) or severely deficient conduct disorder ranging from 28 – 37%. But a decreasing trend was noted for severely deficient conduct disorder with age significantly.

TABLE 7

LEVEL OF CONDUCT DISORDER BEHAVIOUR PROBLEM IN RELATION TO AGE OF CHILDREN (N=812)

Sl. No.	Age in months	Level		
		Qualitative	Deficient	Severely deficient
1	A1 (60 – 90)	137 (45.51%)	51 (16.94%)	113 (37.54%)
2	A2 (91 -115)	103 (45.17%)	44 (19.29%)	81 (35.52%)
3	A3 (116-146)	147 (51.94%)	55 (19.43%)	81 (28.62%)

DISCUSSION

The variation in manifested behaviour problem due to the age and gender can be attributed to preferences for male child which is the socio-cultural reality in Indian society (Vidya, Rathna, Tripathi, 2014). The variation in manifest of severely deficient problem with advancement in age is the result of permissive parenting and repeated exposure through electronic media. The young children imitate the behaviour of older whereas older children manifest the behaviour problem due to adventurous psyche (Cathy, Ann, Kaiser, 2003).

In recent studies on prevalence of behaviour problem in children indicated that due to parental pressure and syllabus overload, at school children acquired behaviour disorders (American Psychiatric Association, 1994, Ann, Frank Robert and Margot, 2006, Vidya and Tripathi, 2008). The similar trend was confirmed by studies. The most striking featurethat emerged was most of the children (55%+) manifested various behaviour problems ranging from deficient to severely deficient. The trend of increase in middle age may be attributed to parental expectation from their children with regard to academic performance which was the cause of gradual increase in the middle age.In younger age parents and teachers take the behaviour disposition of the children bit casually (Brendel, Kristen; Maynard, Brandy 2014; McWayne, Cheung 2009; Melissa Stormont, 2002). But the moment child crosses 7 years plus the scholastic expectations increases vertically and might have caused the gradual increasing trend for behaviour manifestation; the decrease in behaviour problem at older age can be attributed to the adaptation process and healthy coping with scholastic demand as well as parental expectations with regard to academic achievements (Campbell, Shaw, Gilliom, 2000; Helen, Jane, Alaattin, Adrian, 1999; Kessler, Soukup, Davis, Foster, Wilkey, Van, Eisenberg).

Due to more academic pressure and parental expectation (Ann, Frank, Robert and Margot, 2006; Asher, Hymel, 1981; Collins, Sabrina; Woolfson, Lisa Marks; Durkin, Kevin, 2014; Paul, Alan, Jonathan, Thomas, 2005) children find it difficult to meet the demands as a result they start internalizing things (Calcutta paper: Lynn and John, 1993; Morgan, Judith, 2010).

Internalizing behaviour is negative, problematic behaviour that are directed toward the self. People with internalizing behaviour have difficulty coping with negative emotions or stressful situations, so they direct their feelings inward. For example, a young girl may respond to being bullied by a peer by blaming herself or withdrawing from social activities, because they occur on the inside, internalizing behaviour are usually not visible to others. The internalization behaviour includes social withdrawal, feelings of loneliness or guilt, unexplained physical symptoms, i.e., headaches and stomach aches, not due to a medical condition, not talking to or interacting with others,

feeling unloved (Joshua, Elizabeth, Naimi, Kipling, Victoria, Julie, 2009; Rogers, Adamson, McCarthy, 1997; Steinhausen, Muller, Metzke, 2009). Feelings of sadness, nervousness or irritability, fearfulness, Internalization involves the integration of attitudes, values, standards and the opinions of others into one's own identity or sense of self. In psychoanalytic theory, internalization is a process involving the formation of the super ego. Many theorists believe that the internalized values of behaviour implemented during early socialization are key factors in predicting a child's future moral character.

The pattern of externalization (Jianghong, 2004; Joshua, Elizabeth, Naomi, Kipling, Victoria, Julie,2009) indicated that maturity behaviour disposition comes naturally with age. It may be attributed to the affective structure of family, conducive to promote behaviour of externalization (Vidya and Tripathi 2001).High incidence of withdrawn behaviour irrespective of the age can be attributed to scholastic pressure and high expectation of parents (Vidya, Rathna, Tripathi, 2014; Campbell, Shaw, Gilliom 2000; McElroy, Rodriguez, 2008) The process of withdrawn behaviour acquired by children are just to escape from academic realities (Diana, Edward and Sonya, 2005; Paul, Alan, Jonathan, Thomas, 2005; Erin, Eric, Brian, 2011; Torbjorn, Bente,2001).

An extensive review of literature revealed that behaviour problems manifested by children in everyday life is determined and directed by so many socio-cultural factors prevailing in the ultimate environment of child at macro and micro level. At micro level the nature and dynamics of family affective structure and Psycho-Socio-Somatic health status of the mother has a direct bearing on incidences of aberration of behaviour in children; these issues has not been addressed by researchers in order to understand its detrimental impact. Therefore the present study was formulated to investigate empirically, the association and correlation between Family Affective Dynamics & Psycho-Socio-Somatic Health Status, age, gender and nutritional status of children and incidence of behaviour problems.

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