Findings and Conclusion
CHAPTER IV

FINDINGS AND CONCLUSION

In this chapter, the salient findings of the present exploratory study have been presented.

Salient Findings of the Present Study:

1. The proportion of female children whose YSR total problem scores are within 'clinical range' is slightly greater than male children. However, the difference between males and females is statistically not significant.

2. From the analysis of the data pertaining to YSR withdrawn syndrome sub-scale, more male children have been found to report withdrawn behaviours which fall within the 'clinical range'. But the level of severity of withdrawn behaviours as indicated by the mean score, is found to be greater among the females.

3. Female children have reported a higher degree of somatic complaints than the males.

4. Though the number of male children reporting anxious/depressed behaviours is greater, the extent of severity of this category of problems is greater among the females, as compared to somatic problems.
5. Social problems are prevalent among a greater proportion of female children than males. The level of severity is also greater among the females.

6. Thought problems are reported more frequently by male children. The severity of thought problems is also greater among males. Nearly 5 per cent of males as against 1 per cent of females were in the clinical range.

7. It is found that 10 per cent of the male children were found to be in the clinical range, whereas only about 5 per cent of the females were in the clinical range with reference to attention problems.

8. There is significant difference between the two sexes of the respondents in the area of delinquent behaviours. Moreover, the mean score of male respondents (5.46) is more when compared to female respondents (4.4). The proportion of male children in the clinical range is 6.9 per cent which is greater than that of the females (3.1 per cent).

9. The mean score of male children (12.11) and the proportion (5.4 per cent) seem to be relatively greater than the mean score (11.36) and proportion (4.2 per cent) of female children as far as aggressive behaviours are concerned. However, this difference is statistically not significant.
10. It is observed in the present study that the female children scored higher (mean score 7.33) while, the male children scored low (mean score 6.84) in the area of self-destructive behaviour. The proportion is relatively higher among the females (31.5 per cent) than the males (30.5 per cent). This difference is statistically not significant.

11. There is a statistically significant difference (Z=1.98) between the male and the female children with regard to internalising problem broad-band scale of YSR. This scale consists of three sub-scales which measure withdrawn behaviours, somatic complaints and anxious/depressed behaviours. It is found that the male children seem to have higher mean score (32.37) than the female children (mean score 27.28).

12. The male children have scored 23.14 (mean score) whereas the female children have scored 19.39 (mean score) in the externalising problem broad-band scale of YSR which consists of the two sub-scales which measure delinquent and aggressive behaviours. The difference between the two sub-groups studied seems to be statistically significant (Z=1.992).

13. While analysing the scores of Teacher's Report Form of the child Behaviour Checklist (TRF of CBCL) there are
statistically significant differences between the male and the female children only in the two areas of somatic complaints and delinquent behaviours. The scores of the other six sub-scales which are mentioned in TRF, remain statistically insignificant.

14. Domicile, education of father/mother, occupation of father/mother, family size, number of siblings, order of birth, family type, single parent status, parental death, family history of alcoholism, family history of suicide and parental separation.

15. An attempt has been made to classify the entire sample (N:415) into three sub-groups namely 'normal', 'borderline clinical' and 'clinical' on the basis of the total score of YSR. Moreover, comparison was also made among the male and female children in this attempt. Out of the selected socio demographic variables, the following variables seem to have significant difference between the male and female children only in the "clinical" group.

However, such significant differences between the male and female children in other two sub-groups, namely, 'normal' and 'borderline clinical' are not found.

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16. As mentioned in the research methodology chapter, at the second stage of sample, 15 males and 15 females were randomly selected using lottery method, from the three sub-groups namely, 'normal', 'borderline clinical' and 'clinical'. This sample consisted of 45 males and 45 females. It was found that there is no significant association between the selected socio-demographic variables and total problem scores of the YSR.

17. It was found that there were highly significant differences among the 'normal', 'borderline clinical' and 'clinical' groups with regard to YSR total problem scores, externalising and internalising problems. The mean scores of the clinical group seems to be the highest in the clinical group whereas it is the lowest in the 'normal' group.

18. While analysing the total score of family typology scale, we could say that the mean score of the 'clinical' sub-group is the highest and hence it could be perceived that the family pathology is relatively more in this group.

19. A careful study of the analysis of score of the family typology scale reveals that normal cohesive aspects seem to be the lowest in the clinical group when compared to the remaining two sub-groups. This implies that the children in
the clinical range hail from families having lowest degree of normal cohesive aspects.

20. It could be observed in the present study that the mean scores of altruistic, egoistic and anomic dimensions of family typology scale are found to be highest in the 'clinical group' when compared to the other two sub-groups. A further analysis reveals that the scores of clinical group in altruistic and anomic dimensions are not significantly different whereas, they are significantly different in egoistic dimension.

21. Six dimensions of family interaction were studied by administering the family interaction scale to find out the degree/level of family interaction. Among the six dimensions the clinical sub-group in the present study seems to possess a low level of cohesiveness when compared to the other two sub-groups. In the remaining five dimensions, the clinical group has the highest mean scores. This implies latent unhealthy patterns of family interaction. There are significant differences among the normal, borderline clinical and clinical sub-groups with regard to the family interactional dimensions of role, communication and cohesiveness.
The study reveals that the level of pro-social behaviour as measured by the PSBQ, was the lowest in the clinical sub-group whereas it is the highest in the normal sub-group.

A careful examination and analysis of the data of the present exploratory study reveals that the sub-groups namely normal, borderline clinical and clinical do not differ significantly in terms of socio-demographic variables. In addition to this, the same sub-groups do not differ significantly with regard to total competence as measured by the YSR scale. The level of pro-social behaviour, as measured by PSBQ is the lowest in the clinical sub-group. The level of family pathology as measured by family typology scale is the highest in the clinical sub-group. The cohesiveness, as measured by the family interaction scale seems to be the lowest in the clinical group among the three sub-groups. Finally, it could be said that lowest level of pro-social behaviour, highest level of family pathology and lowest level of cohesiveness as an aspect of family interaction are apparently associated with relatively high level of behaviours/emotional problems. However, as discussed earlier, the level/degree of behaviours/emotional problems do not seem to have any significant association with the selected socio demographic variables and total competence as revealed in the present study.
Suggestions for Practice:

1. School social workers may be appointed in the schools and they could identify children having behavioural/emotional problems at different levels and offer social casework, counselling, psychotherapy, group therapy and follow-up services.

2. Routine screening of children for behavioural/emotional problems using the Youth Self Report Form (YSR), Teacher's Report Form (TRF) and the Parent's Report Form of the CBCL or any other relevant tools by the school authorities for early identification and management.

3. There may be periodical assessments by the teachers regarding the behavioural/emotional problems of children. Like the academic/scholastic achievement/performance, the assessment of behavioural/emotional problems may be properly recorded and monitored by the teacher, social worker and the head of the institution.

4. Like academic performance progress reports, a periodical behavioural/emotional problems report may be sent to the parents. Whenever necessary, such assessments could be discussed with the parents and suitable methods of modifying the behaviour could be decided upon and carried out.
5. The teachers and parents are to be given a proper orientation regarding behavioural/emotional problems of the children with the active involvement of the local mental health professionals. Parent Teacher Association (PTA) of the school can organise such orientation programmes.

6. Teachers should be trained by mental health experts, in administering behaviour rating scales and in conducting counselling for mild problems and in basic behaviour modification methods.

7. Schools can constitute a mental health advisory committee consisting of a honorary psychiatrist, psychologist, social worker, counselor, parents and teachers.

8. A referral system may be established between the school and the local mental health care centres. When the teachers are confronted with severe behavioural/emotional problems they can refer the children to a mental health professional.

Suggestions for further Research:
1. The same study may be repeated with large samples consisting of representatives from government schools, government aided schools and other private schools.

2. A comparative study with a sample consisting of school children and other children who do not attend school, could be undertaken.
3. The present study deals with children belonging to the age group of 11 - 18 years. A similar study may be conducted with children below 11 years since separate rating scales are available for relatively younger children.

4. The present study appears to be a cross-sectional attempt. Hence a longitudinal study may be conducted with a purpose of rendering mental health services, preventive and promotive as well.

5. An experimental design may be evolved by applying social work intervention with the children having severe behavioural/ emotional problems and compare them with children having mild behavioural/ emotional problems and normal children. This may enable one to gain more insight into the behavioural/emotional problems of children.

Conclusion:

The present exploratory study has dealt with various behavioural/emotional problems of children. Attempts have been made to find out the association/relationship among behavioural/emotional problems, pro-social behaviour, competence, family typology and family interaction. Though the careful analysis and examination of data reveals many aspects of behavioural/emotional problems of children, it has
certain inherent limitations. The realistic and honest opinion is that any research attempt is subjected to limitations. To overcome such limitations and inadequacies, suggestions have been made for practice and further research in this field.
SUMMARY

The present exploratory study was carried out with the aim of identifying the different types of behavioural/emotional problems of high school children studying in classes/standards VI to X. The association among behavioural/emotional problems and variables such as Family Typology, Family Interaction and Pro-Social Behaviour have been studied. A representative sample of 410 Children (315 male and 95 female) were screened for behavioural/emotional problems using the Youth Self Report (YSR) and Teacher's Report Form (TRF) of the Child Behaviour Checklist (CBCL) developed and standardized by Achenbach (1991). Through the screening, 112 Children (89 male and 23 female) were found to be in the 'normal range', 75 Children (57 male and 18 female) in the 'borderline clinical range' and 223 Children (169 male and 54 female) in the 'clinical range'. For analysing the differences among the three groups, with reference to the family typological, family interactional and pro-social behaviour variables, sub-samples of 90 Children, 30 each (15 male and 15 female) from the normal, borderline clinical and clinical categories were drawn. The extent and types of family pathology was assessed using the Family Typology Scale. (Bhatti and Channabasavanna, 1986). The level of family interaction was assessed with the help of Family Interaction Scale (Channabasavanna and Bhatti, 1982). The Pro-Social Behaviour Questionnaire (PSBQ) (Weir et al, 1980)
was used to measure the level of pro-social behaviour among
the three sub-samples.

The results of the present study revealed the following
salient findings:
1. While the prevalence of 'withdrawn behaviours' is more
among the male children, the severity of such problems
is greater among the female children.
2. Higher degree of 'somatic complaints' is observed among
the female children.
3. Although 'anxious / depressed behaviours' are more
prevalent among male children, the level of severity of
such problems is greater among the female children.
4. The extent of prevalence and level of severity of 'social
problems' is greater among the female Children.
5. 'Thought problems', 'delinquent behaviours' and 'aggressive
behaviours' are more discernible among the male children.
6. Male children have more internalising and externalising
problems.
7. Family pathology level is the highest among children
(both male and female) having the highest degree of
behavioural/emotional problems. Normal-cohesive aspects
seem to be at the lowest level among children having
problems in the 'clinical range'.
8. In the analysis of family interactional dimensions,
cohesiveness level is the lowest in the families of the
children in the 'clinical range'.

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9. The level of pro-social behaviour is the lowest among children having behavioural/emotional problems in the 'clinical range'.

In the light of the above findings, suggestions for practice such as appointing school social workers, routine screening of children for behavioural/emotional problems, periodical behavioural assessment by the teachers, orientation to the teachers, setting up of a School Mental Health Advisory Committee and establishment of a suitable referral system have been made by the researcher. For further research, replication of the study with larger samples, studies of children below 11 years of age, comparative studies of school children and children not attending school, longitudinal investigation and experimental work in the same area are suggested.