Introduction
CHAPTER I

INTRODUCTION

Childhood is a long time of life. It is a time when children continue their growth and development in many areas of their lives. They grow physically, which everyone can witness. They also grow intellectually and emotionally, which is harder to perceive concretely. Children are most like adults emotionally. They can feel the same psychological pains that adults feel. They lack the intellectual ability to understand the pain like adults and to control it. They are more vulnerable because they have not developed the cognitive skills necessary to understand their problems and the causes (Medeiros et al, 1983). The mental health, education and socialisation of children have been the joint concerns of many professionals like psychiatrists, psychologists, social workers and counselors, among others (Goldstein, 1978).

Since its appearance more than 50 years ago, emotional disturbance has been an umbrella term for such varied conditions as schizophrenia, autism, psychosomatic disorders, phobias, withdrawal, depression, anxiety, elective mutism, aggression and a host of other psycho-pathology. This
variation in terminology reflects concepts that are unique to particular professions or theoretical positions. Although educators have made great strides in other areas, the field continues to be plagued by a lack of consensus on definition and terminology. The use of differing terms by professionals to denote behavioural / emotional problems does little to clarify the concept or to promote understanding. Although the concept of behavioural and emotional problems has undergone an evaluation of labels in the past six decades, seriously emotionally disturbed is the term promoted for special education services by means of legislation in developed countries like U.S.A. The term emotionally disturbed is also used more frequently than the other terms in research (Wood, 1979).

The term behaviour disorder is often seen as less stigmatizing, less severe, more socially acceptable and more practical than the term emotionally disturbed. The term grew out of the behavioural model which posits that teachers can see and describe disordered behaviour but cannot easily describe disturbed emotions. In common usage today, 'behaviour disorder' is usually applied to less severely disturbed students whereas 'emotionally disturbed' is
reserved for the most seriously impaired (Coleman, 1986). In the present study, the term 'behavioural/emotional problem' has been used as it is the most commonly used term in most of the empirical studies in the same area (Achenbach et al, 1987).

Defining Behavioural/Emotional Problems of Children:

Generally, there are two major reasons for defining and labeling behavioural / emotional problems: for research purposes (Achenbach, 1978), and for provision of clinical services (Hobbs, 1975). It is argued that definitions may describe a general population but are not specific enough to allow individuals to be identified. Hammill (1976) has observed that definitions allow description of children in broad, general terms, but are much too obscure to be used as criteria for selecting individual problem children.

In the United States of America, the definition of emotional disturbance specified in the Public Law 94-142 has been adopted in some form by the majority of State departments of education (Mack, 1980):

'Seriously emotionally disturbed' is defined as follows:
(i) the term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

(a) an inability to learn which cannot be explained by intellectual, sensory, or health factors,

(b) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers,

(c) inappropriate types of behaviour or feelings under normal circumstances,

(d) a general pervasive mood of unhappiness or depression, and

(e) a tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) the term includes children who are schizophrenic or autistic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed (Mack, 1980).

One or more of the noted characteristics could be observed in almost all so called normal children to some
extent at some point; therefore, the crucial difference is that emotionally disturbed children exhibit such characteristics to a marked degree over a period of time (Bower, 1982). According to Bower, the emotionally disturbed children (designated children) were poor learners, although potentially able to learn; they had few if any satisfactory interpersonal relationships; they behaved oddly or inappropriately; they were depressed or unhappy and developed illnesses or phobias. It was also noted that one or more of these characteristics were true of almost all non designated (normal) children to some extent at different times. The crucial differentiation was based on the observation and assessment that in the emotionally disturbed child, the characteristics existed to a marked degree over a period of time (Bower, 1982, p 57).

Bower believes that this definition is practical in educational setting because it avoids presumptions about the child's 'intrapsychic condition' or 'clinical designation'; it stays within an observable setting and within the conceptual range of school personnel; and it assumes that behaviour may vary from setting to setting.
Research over the past 15 years has consistently yielded three factors underlying disordered behaviour in children and adolescents. The classic study of Quay, Morse and Cutler (1966) established these factors, which subsequently have been supported (Conners, 1970; Kaufman, Swan, and Wood, 1979 and Quay, 1966). Quay and his colleagues (1966) analysed teacher ratings of the behaviour of 441 children in public school classes for the emotionally disturbed and found students exhibiting three major profiles:

(1) Conduct disorder, characterised by 'aggressive, hostile and contentious behaviour',

(2) Personality problem, characterised by 'anxious, withdrawn, introvertive behaviour',

(3) Inadequacy - immaturity, a less distinct factor involving preoccupation, lack of interest, sluggishness, laziness, daydreaming and passivity (Quay et al, 1966).

These factors have also been linked to lack of interest in or awareness of the environment and other autisticlike behaviours.
Theoretical Views of Behavioural / Emotional Problems:

Numerous conceptual frameworks have been devised to explain behavioural / emotional problems of children. Rhodes and Tracy (1974) carried out an extensive research project on emotional disturbance which formed the basis for five theoretical models: biophysical, psychodynamic, behaviouristic, sociological, and ecological.

Biophysical Views:

The biophysical view of disturbed behaviour can be understood from Haring's (1963) definition:

The disturbed child is one who because of organic and or environmental influences, chronically displays:

(a) inability to learn at a rate commensurate with his intellectual, sensory-motor and physical development,

(b) inability to establish and maintain adequate social relationships,

(c) inability to respond appropriately in day to day life situations, and

(d) a variety of excessive behaviour ranging from hyperactive, impulsive responses to depression and
withdrawal. The biophysical model is basically a disease-
or-medical model that presupposes that the problem
or pathology lies within the individual.

Psychodynamic Views

The psychodynamic model is a conglomerate of theories
that attempt to explain human behaviour. The diverse
theories of psychoanalysis, ego psychology, phenomenology,
gestalt psychology, and humanistic psychology fall under its
rubric (Coleman, 1986). In this model, the emotionally
disturbed child is so thwarted in satisfaction of his
needs for safety, affection, acceptance, and self-esteem
that he is unable intellectually to function efficiently,
cannot adapt to a reasonable requirement of social regulation
and convention, or is so plagued with inner conflict,
anxiety, and guilt that he is unable to perceive reality
clearly or meet the ordinary demands of the environment
in which he lives (Blackham, 1967, p.73).

Behaviouristic Views

Behaviourists view disturbed behaviours as learned
responses that are subject to learning principles which
govern all behaviour (Coleman, 1986). Behavioural theory is
based on principles of learning established primarily in
laboratory studies with animal subjects. Behaviourists assert that the only differences between most disturbed behaviours and normal behaviours are the frequency, magnitude, and social adaptiveness of the behaviours; if certain behaviours were less frequent, less extreme, and more adaptive, they would not be labeled 'disturbed' (Millon & Millon, 1974). According to their behavioural model, emotional disturbance consists of maladaptive behaviour. As a learned behaviour, it is developed and maintained like all other behaviours (Russ, 1974, p. 102).

Sociological Views

The sociological point of view refers to social norms or expectations which the person violates, subsequently acquiring the label 'emotionally disturbed' or 'behaviour disordered'. According to this model, disturbance is a lack of conformity to implicit or explicit social standards, rules, and norms. The behaviourally disturbed child is the child who cannot or will not adjust to the socially acceptable norms for behaviour and consequently disrupts his own academic progress, the learning efforts of his classmates, and interpersonal relations (Woody, 1969, p. 7).
Behavioural disabilities are defined as a variety of excessive, chronic, deviant behaviours ranging from impulsive and aggressive to depressive and withdrawal acts which violate the perceiver's expectations of appropriateness and which the perceiver wishes to see stopped (Graubard, 1973, p.246).

Ecological Views

Graubard's definition expresses the ecological view in its emphasis on both the perceiver of behaviour and the behaviour being perceived. The definition establishes that there are two parts to defining problem behaviour: some types of behaviour must exist and someone must be offended by such behaviour. Theorists of this model expouse the view that deviance lies in the interaction of an individual with others (the perceivers) in the environment; hence the term ecological (Coleman, 1986, p.101).

Emotional and Behavioural disorders refer broadly to persistent dysfunctional mental processes and their associated effects and behaviours. As a subtype of psychopathology, these disorders conceptually differ from disorders of intelligence and cognitive functioning and are
tied closely to prevailing social values, particularly those that define desirable feelings and acceptable conduct (Thompson, 1962).

Emotional disorders are defined usually by groupings of symptoms that represent disruptive affective states of consciousness (e.g., fear, worry, sadness, anxiety). These states are experienced subjectively, appear to exist on a continuum (e.g., happy-depressed) and have physiological correlates and sometimes behavioural manifestations. The threshold at which a symptom or a group of symptoms becomes an emotional disorder, in the diagnostic sense, depends on duration, intensity of feeling and associated impairment. These three criteria are easier to state than to measure. There are mainly two problems in measuring the above mentioned three criteria. Firstly, the verbal expression of these symptoms usually evolve during later childhood and adolescence, thus making it difficult to obtain and to interpret information from the child about the characteristics of these symptoms. Secondly, the basis for making inferences about the presence and meaning of symptoms from external referents is crude. The inner life is 'hard to read'.

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Behavioural disorders are defined usually by a grouping of symptoms that represent socially undesirable patterns of behaviour (e.g., fighting, stealing, lying). These patterns of behaviour are manifested externally and often reflect deficient interpersonal competence and/or violation of age-appropriate social norms. The seriousness of the symptoms (e.g., attacking with a knife, arguing, inattention) and persistence define the threshold for specifying a diagnosis of disorder. These criteria have the advantage of being observable and of requiring less interpretation than the criteria used to define emotional/behavioural problems (Boyle & Jones, 1985).

Understanding the Behavioural/Emotional Problems of Children:

The prevention of behavioural/emotional problems among children is one of the major objectives of Comprehensive health care system in India. Progress in this area depends on the availability of well-developed, acceptable and generally applicable approaches to measuring these problems. The need for adequate measures to classify and to assess behavioural/emotional problems of childhood has been documented by Achenbach and Edelbrock (1978) and it is also reflected in the recent attempts to bring operational clarity to childhood psychiatric diagnoses (American Psychiatric
Researchers and clinicians have aligned themselves with two different approaches to solving the problem of defining and measuring behavioural/emotional problems. One approach emphasizes a conceptual model whereby subcategories of behavioural/emotional problems are tied closely to the conceptual nature of psychiatric illness and diagnostic entities. The second approach to defining and measuring behavioural / emotional problems of childhood emphasizes an empirical model whereby factor analyses and related statistical techniques are applied to checklists of problem behaviours to derive syndromes. There has been a gradual convergence between the conceptual and empirical approaches. This trend offers some hope that a basis exists for a useful classification system (Boyle & Jones, 1985).

Etiology of Childhood Behavioural/Emotional Problems:

It is not easy to simplify this matter since children's behavioural/emotional problems may have their origin in a single factor or in a combination of different factors such as constitution, physical, intellectual and
situational ones. When we consider the etiology of behavioural/emotional problems, we have to take in to account many factors which are unique to a child. From birth up to a few years after, the child is a helpless creature which is extremely dependent on the people in the environment for fulfillment of its basic needs. For normal physical growth, the child needs food and physical care of the body. In the same way, for normal emotional growth, the child needs affection understanding, security and discipline. Ineffective parenting plays a very important role in the causation of childhood problems. The child's personality, growth and maturation are affected by a variety of forces: hereditary, somatic, cultural and particularly interpersonal ones. The emotional atmosphere in which the child is brought up plays a crucial role in the child's personality development.

The effect of adverse environmental forces and parental attitudes such as parental disharmony, broken homes, alcoholism, hostility, rejection, cruelty, over-protection and excessive parental ambition are of great significance in the genesis of neurotic problems in children. Early separation from parents, especially from the mother will express itself
as emotional apathy in the young child, to feeling of inadequacy in forming relationships with others in later life. Sibling rivalry, jealousy, parental favouritism and a feeling of being supplanted by the birth of a younger sibling may cause certain problems. Parental over-protection and over-solicitude is also harmful. Children of dominantly over-protective mothers will display anxieties, fears, shyness and submissive behaviour. On the other hand, children of indulgent over-protective mothers will have their infantile demands and expectations even in later life and their behaviours will be characterised by disobedience, impudence, tantrums and aggressively demanding attitude.

There are different aspects which either cause or contribute to the causation of behavioural/emotional problems among children. The role of heredity and environment seem to be equally important. There have been studies which indicate that children of psychiatrically ill parents are more prone to develop behavioural/emotional problems. Specifically, children of schizophrenic individuals and children of alcoholic parents can be considered as important risk groups. Long term follow-up studies have found that many of the children in the risk groups, who display behavioural/emotional problems, actually develop some
psychiatric illness when they grow up. The role of
environment can be understood from the extensive research
studies on role of families in the causation and maintenance
of psychiatric illnesses such as schizophrenia and
depression. Of late, there has been a growing realisation
among researchers in mental health field with regard to the
role of social network and support in the etiology of mental
illness. Research studies have also brought out the fact
that children from disturbed families tend to display
problems. The present day Indian educational system,due to
its highly achievement-oriented and competitive nature, adds
to the stress experienced by the children. Unfortunately,
the teachers are insensitive to the behavioural/emotional
problems and needs of the children. In this context,many
children experience frustration and take up unhealthy
patterns of behaviour.

Epidemiological Aspects :

Epidemiological research can make a variety of
important contributions to our understanding of child
psychopathology. Many children who are brought for mental
health care services come with problems that most children
manifest at some point in their development. Epidemiological
studies can provide us with valuable data which would enable us to determine the criteria for finding out which children have a particular problem (Achenbach et al, 1990).

Epidemiological studies on the prevalence and patterns of childhood psychiatric disorders in India are very few. Verghese and Beig (1974) reported a prevalence rate of 81.7 per 1000 among children in the age group of 4 - 12 years. Lal and Sethi (1977) reported 35.4 per cent prevalence. In a WHO collaborative study (1970) carried out in 9 countries, it was found that 12 - 29 percent of children (21 per cent in India) attending a primary health care facility had some mental health problem.

Epidemiology of psychiatric disorders among children in India is not well investigated and empirical enquiries in this area are scanty. Several attempts have been made to estimate prevalence of childhood psychiatric disorders in the community in India but the focus has mostly been on adults and children formed only a negligible part of such studies. Investigators who have attempted to study the problems in children have more often confined themselves to the study of individual problems (Ilango, 1991).
Studies in India have indicated the prevalence of mental health problems among children to be ranging from as low as 5 to as high as 40 per cent (Bassa, 1962; Chacko, 1964; Raju et al, 1969; Verghese et al, 1973; Manchanda and Manchanda, 1977; Nagaraja. J, 1978; John, 1980 and Parvatha Vardhini, 1983). These investigators have conveniently used terms like behaviour problems, neurotic disorders, emotional problems, emotional disturbances, behaviour disorders and mental health problems.

In the west, the results of Berkeley Growth Study (MacFarlane et al, 1954) showed that many of the normal children exhibited a wide variety of behaviours that were problematic. The epidemiological study conducted by Lapouse and Monk (1964) revealed consistent results. Leslie (1975) in his survey of Blackburn in England found a prevalence rate of 13 per cent in boys and 6 per cent in girls. Rutter et al (1975) reported 5-15 per cent prevalence of problems of sufficient emotional or conduct problems of sufficient severity to handicap them in their everyday life.

Another important study (Rutter, 1981) pointed out that the evidence of psychosocial problems of various kinds, scholastic backwardness and emotional disturbances, tended to
be much higher in cities rather than in areas of small towns or rural communities. Stone and Beth (1981) in their analysis of normative baseline data obtained from elementary school children with behaviour problems, concluded that sex and intellectual level were important variables associated with behaviour problems, but that grade level was not a significant variable.

In India, epidemiological work relating to behavioural/ emotional problems of children is scanty and there has been a lack of uniformity with regard to the methodological aspects. Most of the studies pertaining to child psychiatry in India are confined to analysis of clinical data and a few relating to monosymptomatic disorders like enuresis, speech problems, abdominal pain and mental retardation (Moorthy et al, 1974). Verghese et al, (1973) reported a prevalence rate of 66.8 per 1000 children, in their epidemiological study conducted in Vellore town. However, the study does not spell out the specific details concerning the problems of Children.

In a study of neurosis among children, Manchanda and Manchanda (1977) reported that the prevalence of neurosis was higher in females (73.5 per cent) in the age range of 10-12 years than males in the same age group. Nagaraja (1978)
reported that the prevalence of adjustment problems was more among primary school children whereas among adolescents, neurotic complaints were more prevalent. John (1980), in his epidemiological survey of urban children, reported 3.06 per cent prevalence of conduct disorders and 1.1 per cent of mixed disturbances of conduct and emotion.

Parvatha Vardhini (1983) conducted a survey among rural school children and found 30 per cent of conduct disorders, 15 per cent of neurotic disorders and 37 per cent of mixed emotion and conduct disorders.

Behar and Stewart (1984) in a review of the work done in correlating social class, sex and age with psychopathology among children, mentioned point that these are 'risk factors' as indices of psychopathology. In their work, the authors divided 58 affected children into two groups on each of the three factors and compared the group on 175 variables. They found little evidence that the children's difficulties varied with social class, sex or age.

In a study conducted by Malhotra and Chaturvedi (1984) with the primary aim of studying certain demographic and diagnostic characteristics of children attending the Child
Guidance Clinic for their behavioural / emotional problems, majority (about 82 per cent of children attending the C.G.C were in the age range of 6 to 14 years, those under 5 years being comparatively less. There was a consistent 3:2 ratio between males (445) and females. Twenty Eight to Thirty Three per cent of all the cases had mental retardation. Of the functional disorders, neurosis was found to be predominant (10 to 17 per cent of all the cases) of which 90 per cent was hysteria and psychosis was seen in only 2 per cent of cases.

Rao et al (1983) made an attempt to study the classroom behaviours of children which were perceived as "problems" with the help of interview schedules prepared specially for teachers, parents and children. Out of the 1522 children covered by the study, teachers identified 72 children as problem children. This group was compared with the control group of 'non-problem' children. The boys presented different problems as compared to girls. Teachers considered boys problematic when they damaged or destroyed others' property or were disobedient or inattentive in the class or quarrel with the other children in the school. The teachers also identified problems such as irritability, aggression and nervous behaviours. Problems like being
silent all the time and not mixing with others were observed more frequently among the girls. This study revealed that there was a statistically significant relationship between scholastic performance and behavioural problems.

The above mentioned Indian studies conducted by different investigators seem to have certain inherent limitations. Most of the studies have covered specific psychiatric problems like neurosis, anxiety and mental retardation. They have not dealt with behavioural/emotional problems of children in particular. Such inadequate research attempts do not enable one to gain more insight into the behavioural/emotional problems of children in general and school children in particular. Hence, research attempts are required to study the behavioural/emotional problems of school children. The present study is an exploratory attempt to meet this felt-need.

Identification and Diagnosis of Behavioural/Emotional Problems of children:

In identifying and diagnosing behavioural/emotional problems of children, a perennial issue has been whether diagnosis should be categorical or dimensional. Clinical-Diagnostic systems which are fundamentally categorical, lead
to a decision of whether a particular disorder is present or absent. Based on the symptoms and other criteria (e.g., their duration, or the absence of the other explanations for their occurrence) a diagnosis is made. On the other hand, multivariate approaches typically are dimensional. Rating scales are used and the scores are factor analysed to identify domains of symptoms that correlate. Different factors (subscales) each consisting of several individual items (symptoms) are identified. Separate scores obtained by the individual on the different scales provide a profile of symptoms. Profiles can be studied through quantitative techniques (e.g., cluster analysis) to identify patterns of symptoms that go together and a typology of disorders which indicate particular diagnosis.

In diagnosing behavioural/emotional problems of children, we have to consider three options, namely, the focus on the symptoms, profiles and syndromes. The classificatory systems like DSM-III-R and ICD-10 focus on syndromes or disorders. A syndrome refers to a constellation of symptoms or several characteristics that co-occur. Standardised rating scales such as the Child Behaviour Checklist (CBCL) developed by Achenbach and Edelbrock (1983) focus on symptom profiles which involves assessment of children on a set of several
different characteristics. To understand the individual, the interviewer diagnoses the presence or absence of a particular disorder. The focus of such an assessment is on the presence of several symptoms which constitute a syndrome. Another level of focus is on the individual symptoms. Despite the fact that symptoms are part of a larger constellation of behaviour, individual variations of symptomatology are taken care of by this approach. Moreover, investigation of symptoms yields unique information about process that may serve as building blocks for understanding problems (Kazdin, 1988). In the present exploratory study, individual symptoms and profiles have been studied whereas the syndromes specified by the DSM - 3R and ICD - 10 systems of classification have not been studied.

Diagnosis of Childhood Psychiatric Disorders - Classificatory Systems:

The following are the two major approaches to diagnoses of behavioural/emotional problems of children:

i) Clinical Approach:

Although isolated efforts to identify and classify childhood psychiatric disorders appeared over the last 50 years, few have resulted in a systematic or widely adopted
nosology (Dreger, 1981). The ninth edition of the World Health Organisation's International Classification of Diseases (ICD-9) was published in 1978. It was a major landmark in the classification of child psychiatric disorders for several different reasons: it was the first edition which provided explicit coverage for childhood psychiatric disorders, it was accompanied by a glossary and guidelines on usage, it was based on international case history exercises and the testing of new approaches, it was followed by systematic assessment of reliability and validity in different countries, and it was accompanied by the introduction of multiaxial systems of classification (Rutter, 1989).

The American Psychiatric Association's (APA) first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I), brought out in 1952, accorded little attention to children. Adjustment reactions and childhood schizophrenia were identified, although categories for adult disorders could also be applied to children. The second edition of DSM (APA, 1968) improved upon DSM I with regard to children and adolescents by including Behaviour Disorders of Childhood and Adolescence (e.g., hyperkinetic reactions, under socialized, aggressive reaction, running away reaction, adjustment reactions of infancy, childhood and adolescence
and schizophrenia -childhood type). The third edition of DSM (APA, 1980) reflected a quantum leap from DSM II in the attention accorded to children. It introduced five major categories of disorders emerging in infancy, childhood and adolescence, namely, Intellectual (Mental Retardation), Behavioural (e.g., Conduct Disorder), Emotional (e.g., Anxiety Disorder), Physical (e.g., Eating Disorder) and Developmental Disorder (e.g., Pervasive Developmental Delay). One of the distinguishing features of DSM is its use of five different axes of dimensions to evaluate dysfunction: Clinical Syndromes (Axis I), Personality and Developmental Disorders (Axis II), Physical Disorders and Conditions (Axis III), Severity of Stressors (Axis IV) and Highest level of Adaptive Functioning (Axis V) (Kazdin, 1988).

The World Health Organisation brought out ICD-10 in 1988 with a view to remedy the deficiencies identified in ICD-9 through systematic research. In ICD-10, two major divisions cover child psychiatry: F 80 - 89 for developmental disorders and F 90-99 for emotional and behavioural disorders. There is a separate division for mental retardation. On the whole, the format and content of the psychiatric section of ICD-10 constitute substantial improvements over both ICD-9 & DSM-III (Rutter, 1989).
In the United States, revised criteria have emerged after re-evaluation of the diagnostic categories of the DSM-III (APA, 1987). The DSM-III-R which is the current and official DSM criteria has the major groups of disorders, the multiaxial approach, and the descriptive criteria which are quite similar to those of the previous edition. In DSM-III-R, several disorders have been identified as arising in infancy, childhood, and adolescence and on the whole, it has accorded markedly greater attention to children than the previous editions. (Kazdin, 1988).

As mentioned earlier, there are two different approaches to defining and measuring behavioural/emotional problems among children:

(i) Conceptual Approach:

Researchers and Clinicians have aligned themselves with two different approaches to solving the problem of defining and measuring behavioural and emotional disorders. This first approach emphasizes a conceptual model whereby subcategories of emotional and behavioural disorder are tied closely to a conceptual nature of psychiatric illness and diagnostic entities (Boyle and Jones, 1985). Early attempts (GAP, 1966 & APA, 1968) to define and measure childhood
psychopathology in this way have been criticised for being poorly delineated and unreliable (Achenbach & Edelbrock, 1978). To overcome these criticisms, recent attempts have broadened the framework for classifying disorders and have incorporated specific inclusion and exclusion criteria for measuring them (WHO, 1978 and 1988; APA, 1980 and 1987).

ii) Empirical Approach:

The second approach to defining and measuring emotional and behavioural disorders of childhood emphasizes an empirical model whereby factor analyses and related statistical techniques are applied to lists of problem behaviours to derive syndromes. Unlike the conceptual approach as discussed earlier the syndromes measured in this way are scored on an intensity continuum. In spite of being radically different methods, the two measurement models mentioned above show some convergence. Clinical diagnoses of child psychiatric disorders predominantly center on two broad-based categories: emotional and conduct disorder (Rutter, 1976 and Quay, 1979). The content of these diagnostic entities closely resembles two major symptom-clusters that have been derived empirically in a number of different studies (Achenbach and Edelbrock, 1978). Furthermore, some overlap exists on subcategories of
disorders in the conceptual model. Thirteen of 17 (76%) empirically derived narrow-band syndromes are represented to some extent in DSM III. There are, however, ten diagnostic categories in DSM III undefined by empirically derived syndromes (Achenbach, 1980).

Existing Measures of Behavioural / Emotional Problems of Children:

The assessment of psychiatric disorder in general populations of children is a relatively new attempt. Almost all the instruments reflect a negative orientation based on a measurement approach that exclusively considers symptoms and problem behaviour. Only Langner et al. (1976) and Rutter et al. (1967) developed instruments for use in epidemiological surveys to assess the prevalence of childhood disorder. These instruments were designed to determine globally which children have an emotional/behavioural disorder. The teacher and parent questionnaires developed by Rutter are also intended to differentiate antisocial and neurotic children. Achenbach (1983) developed the Child Behaviour Checklist (CBCL) which is a descriptive instrument intended to classify comprehensively behavioural/emotional problems of children in the age group of 4-16 years. Quay (1979) has also developed a comprehensive Behaviour Problem Checklist. Except Rutter
and colleagues, who used a conceptual framework, the other instruments were developed from empirically derived syndromes. Considering the reliability and validity estimates reported by the authors, the measures developed by Rutter et al (1967), Achenbach (1983) and Quay (1979) are found to be useful in studies of general populations. These measures fulfill the criteria of acceptability and applicability, and they demonstrate acceptable levels of reliability and validity. Besides, the procedures used by these measures to define and to operationalise disorders appear to be adequate (Boyle and Jones, 1985).

Approaches to Identification of Behavioural/Emotional Problems:

In general, there are four major approaches to the identification of behavioural/emotional problems of children.

i) Psychiatric Approach:

The psychiatric approach which is clearly an application of the medical model, emphasizes the discovery of the underlined etiology as necessary for determining the existence of emotional disturbance. The preferred diagnostic methods are subjective, usually involving informal
observation and the clinical interview. The psychiatric approach occurs in clinical settings and uses parental and teacher inputs about the child's behaviour and the environment.

ii) Psychological Approach:

The Psychological approach which also applies the pathological model, aims to determine whether emotional disturbance is an underlying cause of maladaptive behaviour and to make a differential diagnosis among disturbed conditions. While the psychiatric approach relies mostly on subjective criteria, the psychological approach places greater emphasis on the use of objective criteria for diagnosis. The identification of a disturbed state is dependent largely on the child's performance on measures of intelligence, perceptual motor skill, auditory and visual acuity and oral language.

iii) Behavioural Approach:

The behavioural approach to identification reflects a deviance perspective of emotional disturbance in that it is based on measuring the extent to which a child's behaviour deviates from established norms. This is basically based on principles of learning. The emphasis is on the specific
maladaptive behaviours a child displays and not on the emotional conditions that may or may not cause such behaviours. Teachers are usually the individuals who undertake these identification procedures. Formal observation of the behaviour and detailed record-keeping are essential in this approach. Obviously, this approach focuses directly on the child's activities and hence it has great attractiveness for teachers who seek to eliminate behaviours that deviate from group standards.

iv) Educational Approach:

Like the behavioural approach, the educational approach also primarily reflects a deviance model of emotional disturbance. Though the teacher is the principal identifying agent, parent, peer and self-ratings contribute alternate identification criteria.

Debate is going on as to which approach is most effective. Advocates of the psychiatric and psychological approaches maintain that teachers are not qualified to identify emotional disturbance in children since they have received little instruction in psychopathology. They feel that assessment of abnormality should be done by highly trained clinical specialists who would be responsible for
Those who support the behavioural and educational approaches argue that children's classroom activities are the most important source of information regarding their emotional adjustment. They believe that problems may be caused, precipitated or worsened by children's inability to interact well with teachers and peers, learn readily, conform to behavioural standards, and function as group members.

Teacher's Role in Identification:

Observations of children's classroom behaviours provide an operational view of mental health - a perspective of the child's ability to function that cannot be obtained through other procedures, including psychometric evaluation. The teacher is therefore in the best position to constantly recognise children's behavioural/emotional problems. Bower (1969) conducted a rather extensive study of teacher's abilities to identify emotionally disturbed children. He reported that teachers selected, as poorly adjusted, 87 percent of the children clinically diagnosed as emotionally disturbed. Other studies (Lambert, 1963; Maes, 1966; Stennet, 1966 and Reinert, 1976) support Bower's conclusion that teacher and peer-ratings are highly accurate indices of
children's emotional adjustment. Ullman (1952 and 1957) used six indices including teacher, peer and self ratings. He found that teachers were the best predictors for children who act out their problems.

Teachers are an undeniably important source of information regarding the behavioural / emotional problems of children. They understand the child for long periods of time, in situations requiring sustained attention and within a complex social system (Edelbrock and Achenbach, 1984 and Conners, 1969). Teachers, being very familiar with children of a given age, are generally able to assess a child relative to appropriate standards of normal development (Conners, 1969). Teacher's reports of a child's school behaviour are most conveniently quantified by using Teacher Rating Scales (Funderburk and Eyberg, 1989).

Teacher rating scales have an essential place within the assessment of problem children. They permit the description of a broad range of behaviours and assessment of low frequency behaviours for which direct observation is impractical (Barkley, 1988). They allow rapid uniform administration and provide data that are readily quantifiable for comparisons with other information and for development of
norms (Eyberg and Ross, 1978). There are currently only a few well-developed teacher rating scales. Most of these are broad-band scales designed for the assessment of several factors. (e.g., Achenbach and Edelbrock, 1983; Behar and Stringfield, 1974; Goyette, Conners and Ulrich, 1978; Miller, 1981 and Walker, 1976).

Self - Ratings by Children:

One of the useful predictors of disturbance in the educational approach is self-ratings which provide data about the individual's self concept. It is difficult to assess the value of self ratings. There is a widely prevalent notion that they are invalidated by deliberate distortion by the children. Bower (1969) suggests that self-ratings are most useful when compared with peer ratings. Some authors have expressed the view that children appear to be better reporters of symptoms related to private or internal experiences, whereas significant others such as parents and teachers are better informants of children's overt behaviours (Edelbrock et al, 1986). Some others feel that children tend to report fewer symptoms related to the reports that parents and clinicians provide of the children (Kazdin et al, 1983, Orvaschel et al, 1982, Tisher & Lang, 1983 & Kazdin et al, 1986). This might be due to the fact
that children are not likely to view their behaviours as 'problems' or as in need of 'treatment'. Age of the child also influences the self-ratings. It has been reported that younger children (6 - 11 years old) tend to show greater agreement with other sources than older children (12 - 19 years old) (Achenbach et al, 1987). This may be due to their spontaneous responses.

Rationale of the Empirical Model used in the Present Study:

Decisions regarding normality of childhood behaviours are necessary when one attempts to discriminate such children. The question of what is normal childhood behaviour is one that concerns parents, teachers and mental health professionals. Definitions of normality change with the times and continue to reflect cultural beliefs. It is a relative term. The question of what is normal child behaviour takes on importance whenever a professional has to make a decision to treat or not to treat a child. The mere presence of problems in a child does not automatically, nor does it necessarily determine which children will be offered professional help. A child's problem becomes something for us to worry about or do something about if it is severe and lasts a long time, or if it threatens school performance or even the continuation of schooling. Much of the
epidemiological work relating to psychiatric morbidity among children in India has so far been based on rigid clinical approaches which attempt to label children with behavioural/emotional problems on the basis of strict diagnostic criteria (conceptual model). The approach of the present study is based on the assumption that a disease model would not be absolutely useful to promote mental health among children for it would only be dealing with problems at peripheral level only (Ilango, 1989). An empirical model of the assessment of behavioural/emotional problems of children forms the basis of the present study. The level of focus of assessment would be on individual symptoms and symptom profiles. Unlike most of the earlier studies, an attempt has been made to assess the extent of association among behavioural/emotional problems, relevant socio-demographic variables and other related variables such as family typology, family interaction and pro-social behaviour.