Chapter One

INTRODUCTION

It may be difficult for us to think a world without children, our ancient ancestors perceived children as little adults or 'humuncli' (little men) without personalities of their own (Aries, 1962). In all likelihood, this perception was attributable to the extremely high incidence of infant mortality and to the short life expectancy for every one in those days. Under environmental conditions that argued against survival, it was safer and surely less painful for adults to remain aloof from and uninvolved with their young children.

In medieval world evidence shows the lacked awareness of the unique state of childhood, creatively drawn by Aries (1962) from painting, sculpture, figures on tombstones, diaries, and autobiographies. Childhood was not the interest of medieval world, because it was such a brief period that passed quickly for those few who survived. Though children of all ages mingled freely with adults, they were viewed as weaker and more fragile.

According to Aries (1962) changes began to appear in the 17th century, initially in the upper socio-economic classes. Now adults became more openly attached to and interested in children, they began to stress the need to understand them in order to correct their behaviour, to develop their reasoning ability.

It is an age-old Indian belief that early childhood development is the crux of human development. Also that early childhood development is

**Psychopathological Behaviour**

Psychopathology may be easier to recognize than to define, because psychopathology involves a number of important dimensions that are given differential weight in arriving at a decision. Developmental psychopathology is a special discipline within developmental psychology. This discipline is distinct from abnormal child or clinical child psychology and child psychiatry for two basic reasons:

1. within developmental psychopathology, there is equal concern with child pathology, its relation to non-disordered behaviour and with the origins of disordered behaviour that does not appear in clinical term until adulthood.

2. differential diagnosis, treatment techniques and prognosis - the stock and trade of the clinical child psychologist and child psychiatrist - are of secondary interest to the developmental psychopathologist. The developmental psychopathologist is concerned with the origins and time course of a given disorder.

Descriptive research on the problems of children (e.g. Achenbach's 1966, patterns of "externalizing" and 'internalizing' behaviours) and research on specific childhood disorders like childhood autism (Wing, 1976) are within the influence of developmental
psychopathology. First, developmental psychopathologists are interested in childhood behaviour problems but also in the ties between behaviour problems and normal development and socialization. Second, disordered behaviour is examined in terms of its deviation from the normal developmental course. Third, some pathological conditions such as autism are characterized by a distortion of the developmental process (Rutter and Garmezy, 1983).

Few events in an adult's life are more emotionally drawing than being close to a child who is hurt, physically or psychologically. Children are judged to have few emotional resources with which to cope with problems. The extreme dependency of troubled children on their parents and guardians adds to the sense of responsibility that these people feel. Most of the theories regard children as more malleable than adults and thus more amenable to treatment. The recently published National Plan for Research on child and Adolescent Mental Disorders (National Advisory Mental Health Council, 1990) is likely to have an impact on the future funding and direction of research in child psychopathology.

The classification of childhood disorders has changed radically over last thirty years. A developmentally oriented diagnostic system tailored specifically to childhood disorders was incorporated into DSM-III and expanded in DSM-IIIR and now DSM-IV.

Revisions of the diagnostic manual reflect the growing influence of the field of developmental psychopathology, which studies disorders of childhood within the context of knowledge about normal life span
development. For e.g. defiant behaviour is quite common at age two or three, the persistence of such behaviour at ages five or six is considered much more problematic. There are two broad clusters of childhood symptoms. Children with symptoms from one clusters are called under-controlled, or externalizers and are said to show behaviour excesses. Children who have symptoms from the other cluster are said to be overcontrolled, to be internalizers, or to have behaviour deficits and emotional inhibitions (Achenbach & Edelbrock, 1978). Undercontrol problem are found more often among boys, overcontrol among girls (Weisz et al. 1987). Two-general categories of under controlled behaviour are frequently differentiated, attention-deficit hyperactivity disorder and conduct disorder.

Children with problem of overcontrol frequently complain of bothersome fears and tenseness, of feelings of shyness of being unhappy and unloved, and of being inferior to other children. Three main problems of overcontrolled are childhood fears, social withdrawl, and depression (Quay, 1979).

Two syndromes of early infantile psychoses seem rather clearly distinguishable. One is early infantile autism and the other is symbiotic psychotic syndrome, or interactional psychotic disorder. These syndromes are related to each other and sometimes overlap, and they have atleast two basic features in common. One is alienation, or withdrawl from reality; the other is severe disturbance of the individual child's feelings of self-identity. If these two features are not present, the clinician should not
designated the child's disturbance as psychotic. A third group of childhood psychosis is the more benign group in which autistic, symbiotic, and neurotic mechanisms are used simultaneously or alternatively by the ego.

Kanner, who first described the syndrome of early infantile autism in 1943, recently suggested that it should be seen as a total psychobiological disorder and stressed the need for a comprehensive study of this dys-function of each level of integration - biological, psychological and social. Autism is a clinically and behaviourally defined specific syndrome that is manifested at birth or shortly thereafter and remains throughout the patient's life.

Behaviour problems in the school setting often accompany problems related to academic achievement. The assessment of children with behaviour problems in school should include screening procedures to determine whether academic learning deficiencies are also present. The most common academic problems associated with behaviour problems are intellectual retardation, below average rates of learning, and specific learning disabilities. Behaviour problems in school settings have been classified in many different ways. In the diagnostic and statistical Manual of Mental Disorders (1968), for e.g. a school behaviour problem may be classified under Transient Situational disturbances, Neurosis, or Behaviour Disorders of childhood and Adolescence within each of these classifications, subcategories are available for a more precise description of the problem. For e.g. Behaviour Disorders of childhood and Adolescence classification include Hyperkinetic (overactivity) Reaction,
withdrawing Reaction, Overanxious Reaction, Runaway Reaction, Unsocialized Aggression Reaction, and Group Delinquent Reaction.

An interview with the parents is always conducted when a child is referred to a clinic and often when the problem is assessed in the school setting. The clinician is interested in obtaining the factual information about the child and about the problem. Clinician asks whether the child has presented behaviour problem in home setting. Sometimes a behaviour considered to be a problem in school has been observed in the child from an early age. Behaviours such as hyperactivity and social withdrawl are apt to be reported as long term patterns. Parental perception of the behaviour is determined by many factors, such as the parent's previous experience with children's behaviour and the behaviour's interference with household routines. The parents are also asked about the child's feeding history, and toilet training experiences.

The second edition of the diagnostic and statistical Manual Disorders of Mental Disorders (DSM-II) separates the categories of transient situational disturbances and behaviour disorders of childhood and adolescent. The DSM-II classifies the behaviour disorders into six different "reactions". It is thus often difficult to limit a description of a child's behaviour to only one category. With the exception of the hyperkinetic reaction, which appears to have a strong organic or developmental component, behaviour disorders are most often seen as resulting from a chronic problem in parental attitudes or methods of discipline.
**Hyperkinetic Reaction**  The four primary characteristics features of hyperkinetic reaction, all of which may or may not be present in a particular child, are hyperactivity, short attention span, distractibility and aggressiveness. This disorder is characterized by overactivity, restlessness, distractibility, and short attention span, especially in younger children; the behaviour usually diminishes in adolescence. The hyperkinetic reaction may not be evident until after the child enters school and begins facing increasing demands for his attentiveness. The symptoms are more obvious when the child is functioning in a group, such as in the classroom, rather than when the child is relating one to one as when being evaluated by a physician. Teachers can be advised to expect work from the child only within the limits of his attention span and to cut down on distracting stimuli in the classroom when the child is attempting to study. The parents often must be given support in providing consistent firm discipline.

**Withdrawing Reaction**  This disorder is characterized by seclusiveness, detachment, sensitivity, shyness, humidity. "This diagnosis should be reserved for those who cannot be classified as having schizophrenia and whose tendencies towards withdrawl have not yet stabilized enough to justify the diagnosis of schizoid personality". This condition frequently first presents itself in early latency when the conditions may be precipitated by such events as beginning school, the loss of an important family member. These children often have previously been somewhat slow in venturing from the home to meet peers and strange adults. The parents may encourage this through overprotectiveness or over restrictiveness, or they may try to push the child outside when he feels unprepared for such a venture.
**Over anxious Reaction** The DSM-II says that "this disorder is characterized by anxiety, excessive and unrealistic fear, sleeplessness, nightmares, and exaggerated autonomic responses. The patient tends to be immature, self conscious, grossly lacking in self-confidence, conforming, inhibited dutiful, approval seeking, and apprehensive in new situations and unfamiliar surroundings. It is to be distinguished from neurosis" The presenting symptoms may be such things as sleeping or eating disturbance, specific phobias, and school avoidance. These children often rely on others to make decisions for them and may tend to have passive and dependent relationships with adults to whom they relate with fearful compliance. Because such children are often highly obedient, the parent's may not be concerned with this behaviour until their child's clinging dependency or sleeplessness become problems to them.

**Runaway Reaction** These are children who, according to DSM-II "Characteristically escape from threatening situations by running away from home for a day or more without permission. Typically they are immature and timid, and feel rejected at home, inadequate, and friendless. They often steal furtively" Runaway reaction and the unsocialized aggressive reaction are one the two "predelinquent" categories of the behaviour disorders. The essential difference between these two is that the runaway child reacts by fleeing, whereas the unsocialized aggressive child reacts by standing his place and fighting. Temperamentally and physically the runaway child is often less aggressive and less adept. He may have poor relationships with peers and has received little experience in dealing with direct expression of aggression. The home environment is often quite
poor, with neglect, rejection, and frequently even cruelty. The child thus feels helpless, has poor self-esteem, and sees no one within his environment to whom he can turn for help. Treatment of these cases often must start with radical changes within the home environment, if the home environment changes, than these children can find support and an improved self-image by interaction with peers through activities in which they are able to succeed.

Unsocialized Aggressive Reaction The DSM-II describes this as being "characterized by overt or covert hostile disobedience, physical and verbal aggressiveness, and destructiveness. Temper tantrums, voluntary stealing, lying and hostile teasing of other children are common. These patients usually have no consistent parental acceptance and discipline. This diagnosis should be distinguished from antisocial personality, runaway reactions of childhood, and group delinquent reaction of childhood."

Unsocialized aggressive child is more temperamentally able to stand up for himself. In some cases the parents overtly or covertly protect the child from the consequences of his antisocial and destructive behaviour. The family situation is often very unstable with a great deal of disagreement between the parents on handling the child, resulting in an inconsistent approach to the child's behaviour.

In treating these children both the child and his parents must learn that his behaviour can be controlled. It is therefore important to start with these children at as early an age as possible when their behaviour can infact be controlled by parental discipline. When these children's
behaviour has not been successfully dealt with at an early age, their behaviour can lead into delinquency upon reaching adolescence.

**Group Delinquent Reaction** The DSM-II describes these children as having "acquired the values, behaviour, and skills of a delinquent peer group or gang to whom they are loyal and with whom they characteristically steal, skip school, and stay out late at night. The condition is more common in boys than in girls. When group delinquency occurs with girls at usually involves sexual delinquency, although shoplifting is also common". Delinquency also seems to be highly correlated with the improverished social conditions of big city slums where the excitement and status of gang membership may be a relief from an otherwise depressing and non-rewarding living situation. Often in the above social conditions there is a lack of adequate 'healthy' adult role models within the family or within the community. Although there is often inadequate parenting and family disruption these family problems may themselves be results of the same sociocultural factors. Although the group delinquent child may occasionally become involved problem behaviours, such as lying, and stealing, the child's delinquent acts are usually done together with or under the direction of the gang in which he participates. Associated with these behaviours the child may demonstrate poor School performance or school truancy, or both. Because the child's underlying personality structure is often fairly healthy the prognosis is frequently good for these children. This is especially so if the child is able to relate to some favourable adult model whom he may find among local civic leaders, recreational councillors, probation officers many
children do wind up in institutions such as training or reformatory schools which may act to dissuade them from further delinquent acts and may provide them with important growing experiences which can turn them to more constructive behaviour. On the other hand, these institutions may give them an opportunity to become more involved in gangs, learn more delinquent behaviours, and continue the delinquent life-style.

Another important behavioural problem found in children is conduct disorder. The term conduct disorders encompasses a wide variety of undercontrolled behaviour. Aggression lying, destructiveness, theft, and traunchy are actions usually covered by the general, and rather vague, category of conduct disorders. Two types of conduct disorders are commonly identified (American Psychiatric Association, 1987, Quay, 1986). The diagnosis conduct disorder group type applies to children who perpetrate frequent antisocial or delinquent acts - traunchy, serious lying, stealing as part of a group of peers, conduct disorder. Solitary aggressive type is the diagnosis when the essential features by the individual not as part of a group.

Perhaps more than any other childhood disorder, conduct problems are defined by the impact of the child's behaviour on people and surroundings. Conduct problems are from three to ten times more frequent in males than in females, although their incidence in females may be increasing (Herbert, 1978).

Another is psychosomatic disorders of childhood should be founded upon an adequate diagnostic evaluation and the subsequent
weighing of the degree of operation of somatic and psychological factors. Respiratory Disorders are one of the physiological disorder of childhood.

Bronchila asthma is seen twice as frequently in boys as in girls. In families with an allergic diathesis, asthmatic attacks may be triggered by fears of separation from the parent, open conflict between child and parent, and other situational conflicts. During an asthmatic attack the parent may fear that the child will die from suffocation. This frequently results in overanxious and overprotective parental behaviour leading in turn to over-dependent child behaviour.

In a study by Block and her colleagues children scoring low on an allergic potential scale (APS) showed greater psychopathology, with more conflict in family and parent child relationships than did those with higher allergic potential. The major psychological issues to be dealt with are separation anxiety, guilt, and anger towards the parents. Psychological support must be offered to the parents, especially the mother, to help them with their feelings of guilt, and inadequacy in aiding their child. Some children show intense autonomic responses to emotional conflicts or stressful situations. Children with essential hypertension have not been extensively studied from a psychophysiological basis. It is recognized however, that the disorder does occur fairly commonly in childhood and adolescence. Since parental hypertension is significantly more common in the families of hypertensive children, a biological predisposition to the development of hypertension is probably involved.
Another important problem which is found in children is Gastrointestinal Disorders. This category includes a wide variety of disorders. Among the major disorders are, peptic ulcer, ulcerative colitis.

Peptic ulcer and ulcerative colitis begin to appear with some frequency in the school age period; both have been reported at birth and in the neonatal period. These early cases, however probably represent a response by pituitary - adrenal mechanisms to stress or medication. This may be related to the higher gastric acidity and higher level of adrenocortical steroids which occur during the first few hours and days of life. In school age children and adolescents, the symptoms of peptic ulcer are different from those in adults. Abdominal pain is not well localized and symptoms are not clearly related to meals. Nausea and vomiting are common, and anorexia, headaches, and early morning pain are often seen. Children who develop peptic ulcers have difficulty in handling feelings of anger. They are generally tense, overcompliant, passive, and dependent. However, they often demand affection. The mother is usually dominant and overprotective. The father frequently is distant and passive, although occasionally rigid and punitive.

Ulcerative colitis is a potentially severe, life threatening disorder. Children with ulcerative colitis are generally overdependent, passive, inhibited, and show compulsive behaviours. Often a core of depression exists. The initial onset in childhood involves bleeding more frequently than it does diarrhoea. The precipitation of a fulminating type of colitis usually takes place in a situation involving actual or threatened
loss of emotional support, usually a parent. Treatment of this potentially life-threatening illness should always include both medical and psychotherapeutic measures. Langford, (1964) and Prugh (1969) have demonstrated the contribution of psychotherapy to physiological improvement. However, Arajarvi (1962) suggest that only the patient's psychological adjustment is helped. In early phases of psychotherapy, it is limited to supportive measures.

TEMPERAMENT

From ancient times down to the present comes doctrine that a person's temperament is determined largely by the "humors" (glandular secretions) of the body. Hippocrates tried to explain the dominance of certain emotional patterns as resulting from an imbalance in one of the five fundamental body humors - blood, black bile, yellow bile, phlegm, and the nervous humor. For eg., a person with predominance of black bile would have a melancholy temperament; he would be persistently sad, easily depressed, slow, unpleasant, and undemonstrative. Now modern studies have not only disproved the existence of body humors but they are pointing the way to an understanding of how the emotions, as determined by both environmental and physical factors, influence personality and, even more important, how the damaging effects can be controlled. Pressey and Kuhlen (1998) explain that the impact of emotionality on life adjustment is probably greatest during the early years of life.

The predominance of a particular kind of emotional reaction - the person's "prevailing emotional state" - determines his temperament.
Temperament is the aspect of personality which is revealed in the tendency to experience mood changes in characteristic way. "Temperament refers to the characteristic phenomena of an individual's emotional nature including his susceptibility to emotional stimulation, his customary strength and speed of response, the quality of his prevailing mood, and all peculiarities of fluctuation and intensity in mood, these phenomena being regarded as dependent upon constitutional make-up, and therefore largely hereditary in origin (Allport 1961). According to this concept, it is assumed that children start life with certain inherited personality dispositions manifesting in the form of individual differences in infancy.

The New York Longitudinal study initiated in 1956 by Alexander Thomas and Stellachers, is the most comprehensive and longest lasting study of temperament. Results showed that temperament is a major factor in increasing the chances that a child will experience psychological problems, or alternatively, be protected from the effects of highly stressful home life. However, Thomas and Chess (1977) also found that temperament is not fixed and unchangeable. Environmental circumstances also modify children's emotional styles. These findings stimulated a growing body of research on temperament, including its stability, its biological roots, and its interaction with child-rearing experiences. There are nine temperament dimensions:

1) **Activity Level** The extent to which motor component exists in the child's functioning.

2) **Rhythmicity** The predictability and or unpredictability in time of
such function as the sleep wake cycle, hunger, feeding.

3) **Approach or withdrawal** The nature of the response to the new stimulus like; new food, new toy, new person. Approach responses are positive, withdrawal reactions are negative.

4) **Adaptability** The ease with which the response is modified in the desired direction.

5) **Threshold of responsiveness** The intensity of level of stimulus that is necessary to evoke a discernible response eg. reaction to sensory stimulus, environmental object etc.

6) **Intensity of reaction** The energy level of response, irrespective of its quality or direction.

7) **Quality of mood** The amount of pleasant, joyful, friendly behaviour as contrasted with unpleasant crying and unfriendly behaviour.

8) **Distractibility** The effectiveness of extraneous environmental stimuli in interfering with or in alternating the direction of on going behaviour.

9) **Attention Span and persistence** Attention span concerns the length of time a particular activity is pursued and persistence refers to the continuation of an activity in the face of obstracles.

On factor analysis nine variables of temperament dimensions brought out three functionally significant typologies of temperament which were named as:

1) **The easy child**  This child quickly establishes regular routines in infancy, is generally cheerful, and adapts easily to new experience.

2) **The difficult child**  This child has irregular daily routines, is slow to accept new experiences, and tends to react negatively and intensely.

3) **The slow to warm up child**  This child is inactive, shows mild, low-key reactions to environmental stimuli, is negative in mood, and adjusts slowly to new experiences.

Of the three temperamental types, the difficult pattern has sparked the most interest, since it places children at high risk for adjustment problems. In the New York longitudinal study, 70 percent of young preschoolers classified as difficult developed behavior problems by school age, whereas only 18 percent of the easy children did (Thomas, Chess, & Birch, 1968). Unlike difficult youngsters, slow-to-warm-up children do not present many problems in the early years. They face special challenges later, after they enter school and peer group settings in which they are expected to respond activity and quickly. Thomas and Chess found that by middle childhood, 50% of these children began to show adjustment difficulties (Chess & Thomas, 1984).

A second model of temperament, devised by Mary Rothbart (1981). Rothbart's system has fewer dimensions because it combines those of Thomas & Chess that overlap (for e.g. "distractibility" and attention span and persistence" are merged into "undistrubed persistence"). They also show special emphasis on emotional self-regulation, such as soothability and distress to limitation.
FOUR TEMPERAMENTS

The theory suggests four temperaments:

1. activity
2) Emotionality
3) Sociability
4) Impulsivity

Level of Activity refers to total energy output. The active person is typically busy and in a hurry. He likes to keep moving and they never be tired. His actions and speech are vigorous.

Emotionality is equivalent to Intensity of reaction. The emotional person is easily aroused, it may appear as a strong temper, a tendency toward fearfulness, violent mood swings, or all these together. The autonomic nervous system is usually involved in such arousal, and with this the expressive aspects of emotional arousal.

Sociability Consists mainly of affiliativeness a strong desire to be with others. For the sociable person interaction with others is more rewarding than nonsocial person. Sociable persons are more responsive togethers.

Impulsivity involves the tendency to respond quickly rather than inhibiting the response. There are two main components: (i) resisting versus giving into urges, impulses, or motivational states (ii) responding immediately to a stimulus versus lying back and planning before making a move.
Table of Four temperaments

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<tr>
<th>Temperament</th>
<th>Extremes of dimension</th>
<th>Aspect of behaviour</th>
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<tr>
<td>Activity</td>
<td>Active-lethargic</td>
<td>How much</td>
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<tr>
<td>Emotionality</td>
<td>Emotional-impassive</td>
<td>Intensity</td>
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<tr>
<td>Sociability</td>
<td>Gregarious-detached</td>
<td>How close to others (proximity seeking)</td>
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<tr>
<td>Impulsivity</td>
<td>Impulsive-deliberate</td>
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For example  Sociability and activity may partially merge. A sociable person is expected to initiate contacts with others, and such type of behaviour may require an output of energy, than unsociable person. Highly active person may well be energetic both socially and non-socially so can emotionality, the emotional person reacts intensely and powerfully. In terms of temperament, an active person might appear more impulsive than an inactive person. Similarly, an emotional person reacts intensely and therefore has a greater problem in controlling his emotions. If he shows his fear, or express his moods, he will be seem as impulsive. So we expect a modest correlation between impulsivity and both activity and emotionality.

Activity and emotionality both involve a kind of "push", each of a different kind. Impulsivity involves inhibitory control which may be used to oppose any motivational push. And sociability is a directional tendency, which cuts across the push to activity. It might be possible to devise a set of temperaments that would not overlap one another, but we are not able to find such a set that would meet the criteria for temperaments.
CRITERIA FOR TEMPERAMENTS

Few criteria to be used in deciding which personality dispositions should be called temperaments. The crucial one is inheritance. An inherited component leads forward to developmental expectation of stability during childhood and retention into maturity.

Genetic components The most important criterion of temperament is inheritance, this is what distinguishes temperament from other personality dispositions. Many aspects of personality derive from socialization practices and the experiences of the developing child, but a theory of temperament cannot be concerned with them. A theory of temperament must demonstrate a genetic component in man's personality dispositions.

Stability during Development An inherited tendency can be expected to be manifest throughout development. It is presumes, that something inheres in the child as he matures, so it should be stable throughout development. For example, the child moves from social interaction exclusively with the immediate family (especially parents) to a wider world of adults and peers, this means that sociability become manifest in different ways. We cannot expect a smooth curve of development in any trait, including such genetically determined anatomical traits as height and body built. But the criterion must be applied and there are two reasons for doing so. First, it follows that if a disposition is inherited, it will be relatively stable during childhood. Second, if there is no stability, it must be assumed that it is covered purely environmental variables.

Combinations of Temperaments We acknowledge that temperaments
do not occur in isolation but in combinations. Theoretically, all combinations of two, three, or four temperaments might occur, but this does not mean that they exist in nature.

Here the focus is on those combinations that have been identified by researchers and clinicians. An eg. of a combination identified by researches is introversion - extroversion, which comprises sociability and impulsivity, a clinical eg. is hyperkinesis, which combines activity and impulsivity.

Four temperaments are clearly in sufficiently to account for the many patterns of personality. In each instance, if a temperament is ignored, it is assumed to be unimportant in identifying the pattern. Thus introversion - extroversion is defined by a combination of sociability and impulsivity.

**Combinations of Two Temperament**

**Activity and Impulsivity** A person who is high in both activity and impulsivity suffers from a problem. Here we talk about the hyperkinetic child. This child is merely overactive, he is excessively active in contexts that require relative immobility, quiet, and focused attention. A high active child who is average or below in impulsivity will not be seem as hyperkinetic. The impulsive child simply cannot command such control over his level of activity. Hyperkinesis is a serious childhood problem, that has been studied intensively (Fish 1971, Kenny et al, 1971; and Werry & Sprague, 1970). They learn not only to suppress motility in places such as the school room and library but also to organize their activity into
socially acceptable channels. For many hyperkinetic children, however, distractibility remains a serious problem even into adolescence, and many hyperkinetic boys become delinquents when they reach adolescence (Weiss et al., 1971).

Temperament theory may contribute to a better understanding of hyperkinesis, which includes not only children high in two temperaments but also children of very low intelligence and those with at least minimal brain damage. Surely it would help to separate hyperkinetic children into two types. One type includes children with various biological deficits (organic brain damage). The other type consists of biologically normal children who are temperamentally active and impulsive, they may need special handling because of their personality dispositions, but they should not be referred to clinics.

**Activity and Emotionality** The opposite pattern - low activity and high emotionality - would seems to be maladaptive. This shows the characteristics of neurotic or agitated depressive, whose lack of coping behaviour is accompanied by intense fear of dying or of being abandoned.

**Activity and Sociability** These two temperaments are correlated. The pattern of high activity and low sociability is frequent enough to identify a particular kind of person, such a person directs his energies into solitary activities, avoiding social interaction whenever possible.

More frequent and certainly more noticeable is the combination of high activity and high sociability. Such type of persons make new friends, forms new groups, attend meetings., Such a person is usually well
adjusted and liked by others. It is difficult to maintain privacy when such a person is around because he feels difficult to understand why people want to rest or to be alone or both.

**Emotionality and Impulsivity** High emotionality would seem to predispose a person toward maladjustment. Whether it is fear or anger, the emotion needs to be controlled. High emotionality intensifies the problem of control, and control is the crucial issue for the temperament of impulsivity. Thus, when high emotionality combines with extreme of impulsivity, adjustment problems become more likely. When the combination of high emotionality and high impulsivity occurs in men, the problem is more of controlling anger, one combination has been clearly identified for women. Such a person tends to be childish and possessed of numerous bodily complaints. The syndrome is called hysteria.

The combination of high emotionality (fear) and low impulsivity may well fit for another kind of maladjustment: psychosomatic problems. Temperament cannot supply a complete explanation for such bodily disturbances, but this particular temperamental pattern does describe many psychosomatic patients. The last combination of emotionality and impulsivity consists of person low on both. They ordinarily do not suffer from maladjustment. They should be easy to socialize because there is little emotionality to control and a strong inhibitory mechanism to use if needed.

**Emotionality and sociability** A highly emotional person, by definition is easily aroused, and the major emotion is often fear. A person who is
high in both emotionality and sociability tends to be socially anxious. He is strongly motivated to seek the company of others but is inhibited by strong fear. With increasing knowledge of other and having deep friendship, the socially anxious person discovers that there is nothing to fear. This removes the negative end and allows a person to think positive, relaxed and socialized and it is attributed to the combination of two temperaments; high emotionality and high sociability. The combination of high emotionality (fear) and low sociability may provide difficulties in adjustment. The low sociability means that others have little to offer and there is no reason to seek their presence. The high emotionality means that the aversive aspects of social interaction become in large.

**Sociability and Impulsivity** The combination of these two temperaments comprises the best known and most researched pattern of personality. The person who is high in both sociability and impulsivity is called an extravert and the person who is low in both is called an introvert. Eysenck (1947, 1957, 1967, 1970) has developed a comprehensive theory of introversion - extraversion, which attempts to integrate a variety of personality.

A typical extravert is sociable, like parties, has many friends, needs to have people to talk to. He prefers to keep moving and doing things, tends to be aggressive and loses his temper quickly.

The typical introvert is a quiet, retiring sort of person, introspective, fond of books rather than people, he is reserved. He does not like excitement, takes matters of every day life with proper seriousness, and likes a well ordered mode of life. He keeps in feelings under close control, and does not lose his temper easily.
TEMPERAMENT AND THE PARENT CHILD INTERACTION

Here is complete model of the parent child interaction as it relates to temperament. Here we focus on the three processes involving the child's temperament; how the effect of parental practices is modified by the temperament, the impact of the child's temperament on the parent's, and child's modelling of the parent.

The two dimensions of parental practices love and control may not be equally relevant to all of the child's temperaments. The dimension of love is more important for sociability, and the dimension of control is more important for emotionality and impulsivity. The child's temperament can elicit new parental behaviours or changes in child rearing practices. The principal direction of change in the parent is toward more control over the child, especially for limiting behaviour. It is usually the "trouble some child" for which parent take special pains, and the trouble typically concerns the child's excessive impulsivity or emotionality.

The last process in the parent child interaction is modelling. Imitation learning has been documented (Bandura & Walters, 1963) and it found very common that young children tend to model themselves after their parents. Our concern is with the temperamental aspects of modelling. The degree of similarity between the child and his parents is an important determinant of modelling. One reason for this is that a child wishes to be like, and identifies more with, persons who are similar (for eg, boys with father and girls with mothers). A more important reason is that the child will already be disposed to behave like a parent whose temperament is
similar (for eg, a temperamentally high-active child already has the energy level to copy the behaviour of a high active parent).

The parent-child interaction has three components; Parental child rearing practices, the impact of which is in part determined by the child's temperament, the eliciting effects of the child's temperament, which are in part determined by parental temperament, and modelling, the extent of which is partly determined by parental temperament.

The four temperaments are not equally acted on during the course of development. Society, through various socializing agents, pay less attention to variations in activity level, in general a child must be either hyperactive or extremely lethargic to warrant special attention and strong pressure for change. Emotionality receives more attention in most cultures, and there is pressure for control of affect. The extremes of sociability are also subjected to attempts at modification, love demanding child are pressured to change their behaviour. Finally, a major aspect of socialization is the development of tolerance for frustration.

THEORIES OF TEMPERAMENT

Varieties of Temperament  The word temperament is likely to say "Sheldon" ever since the appearance of varieties of temperament (1942), Sheldon’s name has been linked with the constitutional approach to personality. His major contribution was to insist that there are three basic body types, each type with its corresponding temperament. The body type are essentially fat, muscular, and lean and the associated personality types are viscerotona, Somatotonia, and cerebrotonia, respectively. Sheldon
reported very high correlations between body type and personality type. There are three possible compounds. The worst compound was that the same person who estimated body type also evaluated personality.

Other research by other investigators corrected this basic flaw, and the correlation between body type and personality fell to lower levels. Davidson et al. 1957, Walker, 1962, and Corles and Gatti 1965). Evidently there is a relationship between body build and personality. This type of relationship is build in. For eg. the personality type of the fat person contains such items as love of physical comfort, love eating, socialization of eating, and pleasure in digestion. Of greater importance are personality characteristics that do not desire from the body build for eg. Fat persons are more sociable than muscular persons and they are less sociable. Sheldon did not establish that his personality types were inherited, and their factorial unity is questionable. He did not able to explain the nature of the temperaments. He also did not spelt out their implications for personality except to suggest that body build is an important variable.

Development of Personality The development of personality is the focus of the temperament theory of Thomas et al. (1968, 1970). They suggest that there are nine inborn characteristics, present at birth, that are the building blocks of personality.

1. Level of activity
2. Rhythmicity or regularity of functions (eating, eliminating, etc.).
3. Acceptance or withdrawal from a new person or object.
4. Adaptability to changes in the environment.
5. Threshold or sensitivity to stimuli
6. Intensity or energy level of responses.
7. General mood or disposition
8. Distractibility

These nine features are presumably the "origins of personality". They assessed these nine characteristics in children soon after birth, and then traced the youngsters until 10 yrs of age. Thomas et al. claim that the individual differences held up over the yrs, with children continuing to manifest their temperamental traits over the years. There is also some evidence that children with "difficult" temperaments (moody, overly sensitive, etc.) tended to develop behaviour problems later in childhood.

Thomas et al present a temperament theory that starts out with nine tendencies present at birth and traces these tendencies as they develop throughout childhood. This theory has value as a temperamental approach to the development of personality. But this theory has some problems. Thomas et al. present no data bearing on the relationships among the nine factors.

A second problem concerns the developmental course of the temperaments. It is hard to see how some of the behaviours falling under a temperament during infancy belong together with behaviour listed under the same temperament at the age of 10 yrs. For eg. under Distractibility, the following behaviours indicate a child who is not distractible; at two months, will not stop crying when diaper is changed, and at 10 yrs, can
read a book while television is at high volume. Both sets of behaviours, at two months and at 10 years, are indications of low distractibility. Thomas et al. need to provide evidence that they are measuring the same temperament in late childhood that they are in infancy.

The most serious problem with this theory is its failure to establish that the personality features it specifies are really inherited. The fact that individual differences are present at birth is consistent with inheritance but does not prove the point.

Types of Temperaments

It was Diamond (1957) who insisted that we should take the comparative approach and learn from the personality dispositions. He formulated four temperaments shared by man and animal close to man; fearfulness, aggressiveness, affiliativeness, and impulsiveness. Fearfulness includes both a physiological tendency to become aroused and a behavioural tendency to cover, freeze, and avoid dangerous situations. Aggressiveness is simply the tendency to fight, whether in attacking or defending against attack. Affiliativeness refers to seeking contacts with others and avoiding solitude. Impulsiveness has two components; inhibitory control and level of activity or energy expenditure.

This brief description shows the similarities between this theory and Diamond's theory. Only one of the temperaments is the same as Diamond's; our sociability is essentially the same as his affiliativeness. This theory have no temperament of aggressiveness and there are 3 reasons for this. First, there is no clear evidence that aggressiveness is inherited.
Second, we believe that the anger component in aggressiveness is better viewed as having differentiated from the more primitive emotionality temperament present of birth-distress. Third, as there is a temperament input into aggressiveness, it would appear to desire from three different temperaments; activity, emotionality, and impulsivity.

Our impulsivity temperament is different from Diamond's. He includes activity level our's does not. Out emotionality temperaments is also different from Diamond's.

Diamond's theory appeared slightly less than 20 yrs, ago, and there was little evidence bearing on temperaments. The absence of data at the time Diamond formulated his theory cannot be blamed on Diamond. The fact remains that his theory did not generate any research Diamond's theory must be considered a fascinating set of speculations, but it lacks any confirming data and it has led to any subsequent research.

**Personality Theory** Eysenck's approach may have led to more research than any other theory in the area. Further, unlike the first three theories mentioned, Eysenck's is supported by at least some evidence of heritability. His theory is also valuable in the way it integrates experimental Laboratory research with personality dispositions.

But our concern is with temperament and Eysenck's theory has several problems. Its best known variable is extraversion, a composite of sociability, impulsivity, and perhaps several other components. Sociability appears to be a mixed bag of excellent evidence for its heritability. Persons high in sociability and low in impulsively would seem to be
entirely different in personality (and easy to socialize) from persons low in sociability and high in impulsivity.

The other relevant factor is neuroticism, which bears a passing resemblance to our temperament of emotionality. But neuroticism is different in several ways. Neuroticism refers not only to a tendency to become distressed easily (inherited) but also a combination of acquired fears and worries. Eysenck claims that his various factors (neuroticism, extraversion, etc.) emerged from correlation matrices involving these three sources of data (self-reports of personality, laboratory measures such as reaction time, and demographic variables). One of the defects of Eysenck's theory as a theory of temperament is this mixture of diverse components. The mixture may be acceptable for his original theoretical goals, but it is not if the goal is a theory of temperament. Eysenck's theory is regarded as a temperament theory; its factorial unity is questionable and the heritability of the variables is in doubt. Eysenck has nothing to say about the developmental course of either extraversion or neuroticism.

The main objectives of the present study are:

1. To examine the difference between the overall mean score of advantaged and disadvantaged boys on temperament measurement schedule.

2. To examine the difference between the overall mean score of advantaged and disadvantaged girls on temperament measurement schedule.
3. To examine the difference between the overall mean score of advantaged and disadvantaged boys on childhood psychopathology measurement schedule.

4. To examine the difference between the overall mean score of advantaged and disadvantaged girls on childhood psychopathology measurement schedule.

5. To examine the difference between the mean score of advantaged and disadvantaged girls on the factor of temperament measurement schedule.

6. To examine the difference between the mean scores of advantaged and disadvantaged boys on the factor of temperament measurement schedule.

7. To examine the difference between the mean scores of advantaged and disadvantaged girls on the factor of childhood psychopathology measurement schedule.

8. To examine the difference between the mean scores of advantaged and disadvantaged boys on the factor of childhood psychopathology measurement schedule.

9. To examine the difference between the mean scores of advantaged girls and advantaged boys on the factor of temperament measurement schedule.

10. To examine the difference between the mean scores of disadvantaged girls and disadvantaged boys on the factor of temperament measurement schedule.
11. To examine the difference between the mean scores of advantaged girls and advantaged boys on the factor of childhood psychopathology measurement schedule.

12. To examine the difference between the mean scores of disadvantaged girls and disadvantaged boys on the factor of childhood psychopathology measurement schedule.

The assessment of childhood psychopathology and temperament in children healing from advantaged and disadvantaged groups have been studied here with a view that the findings of the present study may have relevance to improve their quality of life.