Chapter I

INTRODUCTION
Millions of children in the world suffer from behaviour related problems. Some of these behavioural problems are general; some are psychological, while some other problems are anxiety related (Kramer et al., 1979). Child development and their behaviour have been observed for countless centuries. A great many explanations have been offered to account for the behavioural problems of children. It is likely that events in early family life, interactions with peers, and educational opportunities shape the course of development. In recent years a number of researches have been carried out to find out the problems amongst the students, and tried to understand how these problems may affect their personality, adjustment and life as a whole. A child’s problem behaviour is decided by his/her actions like the way of presenting himself/herself before other people and also by considering the factors like age, social and cultural surroundings, emotional development of the child and physical condition of the child (Robins et al., 1989).

Development

Development is the process of change over time resulted from interaction between environmental and genetic forces. Development involves progressive, cumulative changes in structure, function, behavior, or organization. Development can refer to change in physical size or shape, mental function, perceptual capacity, or behavior (Bronfenbrenner, 1979). It describes the growth of humans throughout the lifespan, from conception to death. The scientific study of human development seeks to understand and explain how and why people change throughout life, which incorporates all aspects of human growth,
including physical, emotional, intellectual, social, perceptual, and personality development (Reber, 1985). Development is a process of change, but not all changes are developmental (Amsel & Renninger, 1997; Overton, 1998; Piaget, 1985; Sen, 1999; Valsiner, 1998; van Haaften, 1998, 2001; Werner, 1957). The importance of studying human development lies in better understanding how and why people change and grow and then this knowledge can be applied in helping people live up to their full potential (Coscia et al., 2001; Tucker, 2002).

**Developmental Theories**

Interest in the field of child development began to emerge early in the 20th-century, but it tended to focus on abnormal behaviour. An understanding of child development is essential to understand the cognitive, emotional, physical, social and educational growth that children go through from birth and into early adulthood (Bradley & Corwyn, 2002). Some of the major theories of child development are known as grand theories; they attempt to describe every aspect of development, often using a stage approach. Others are known as mini-theories; they focus only on a fairly limited aspect of development, such as cognitive or social growth.

The following are just a few of the many child development theories (e.g. Brandstädter, 1998; Bronfenbrenner & Morris, 1998; Csikszentmihalyi & Rathunde, 1998; Elder, 1998; Feldman, 2000; Fischer & Bidell, 1998; Ford & Lerner, 1992; Gottlieb, 1997, 1998,
Psychoanalytic Child Development Theories

Two major theories within the psychoanalytic approach have been delineated upon are proposed by Sigmund Freud and Erik Erikson.

**Sigmund Freud (1856-1939):** Freud stressed the importance of childhood events and experiences in his theory of child development and very exclusively focused on mental disorders rather than normal functioning. Freud described child development as a series of “psychosexual stages.” In “Three Essays on Sexuality” (1915), Freud outlined these stages as oral, anal, phallic, latency, and genital. Each stage involves the satisfaction of a libidinal desire and can later play a role in adult personality. Freud suggested that if a child does not successfully complete a stage, he or she would develop a fixation that would later influence adult personality and behaviour.

**Erik Erikson (1950):** Theorist Erik Erikson also proposed a stage theory of development, but his theory encompassed development throughout the entire human lifespan. Erikson believed that each stage of development was focused on overcoming a conflict. Success or failure in dealing with the conflicts at each stage can impact overall functioning. The eight stages in personality development described by Erikson (1950) is as follows – Basic trust versus mistrust (birth to 1 year), Autonomy versus shame and doubt (1 to 3 years), Initiative versus guilt (3 to 6 years), Industry versus inferiority (6 to 11 years), Identity
versus identity diffusion (begins at adolescence), Intimacy versus isolation (begins at young adulthood), Generativity versus stagnation (begins at middle adulthood), Ego integrity versus despair (begins at old age).

**Cognitive Development Theory**

Piaget (1896-1980): One of the foremost figures in developmental psychology is Jean Piaget. One of the most interesting facets of his stage theory is its proposition that children learn by constructing knowledge through experience, as opposed to it being directly impacted by environment, or being innate and instinctual. Because of this, Piaget's theory has found a lot of support from those who feel it makes for a successful pedagogical approach. In Piaget’s theory children move through four broad stages of development, each of which is characterized by qualitatively distinct ways of thinking. Sensorimotor (birth to 2 years), Preoperational (2 to 7 years), Concrete operational (7 to 11 years), Formal operational (11 years onwards).

**Behavioural Child Development Theories**

Behavioural theories of child development focus on how environmental interaction influences behaviour and are based upon the theories of John B. Watson (1878-1958) and B. F. Skinner (1904-1990). These theories deal only with observable behaviours. Development is considered a reaction to rewards, punishments, stimuli and reinforcement.
Social Child Development Theories

**John Bowlby (1969):** Bowlby proposed one of the earliest theories of social development. Bowlby believed that early relationships with caregivers play a major role in child development and continue to influence social relationships throughout life (Bretheron, 1992).

**Lev Vygotsky (1929):** Vygotsky believed that adults had the responsibility of aiding in the development of children. His theory has emphasised social context. He viewed that adults only intervene in development during critical stages known as "zones of proximal development", when a child was nearing progression from one developmental stage to the next (Vygotsky, 1978). He made the claim that development began on the social level and trickled down to the individual level over time. In other words, the predominant culture into which an individual is born has a profound effect upon that individual's values and their development. He asserted that culture itself has a responsibility to play in personal development. Vygotsky first put forth these views in a 1929 essay called "The Problem of the Cultural Development of the Child", in which he outlined his experimental methods. His experiments focused on goal-oriented behaviour, such as a child learning to kick a ball for the purpose of making it spin. The implication was that the stimuli and environment put forth by culture would determine the opportunities a child had to learn skills and how to place these skills into an overall hierarchy of values.
**Bandura (1971):** Bandura developed a theory that development occurs through a process of "social learning" wherein behaviours are witnessed, retained, and ultimately re-enacted by children after observing the behaviours of adults. This theory of social learning has had a major impact upon Western society to the extent that most people now feel that observed behaviour has a profound impact upon child development.

In nutshell these major theoretical approaches had made it clear that the optimal development of children is considered vital to society and so it is important to understand the social, cognitive, emotional, and educational development of children.

**Stages of Development**

To understand the development throughout life the researchers have emphasized upon the stages of development based on the criteria of age and major social, cognitive, emotional, physical change during the period. The concept of stages, phases, or developmental periods is rooted deep in history. Christopher Schaefer mentioned that the Chinese talked about three phases: receiving from the world (0-21 years), fighting in the world (21-42 years), and the age of peace and wisdom (42-death). The Greeks looked at 10 periods of life comprised of seven year periods: (0-7 years) was the time of fantasy, (7-14 years) was middle childhood where learning began, (14-21 years) was the time of discipline and military service, (21-28 years) was when one established a basis for one’s life, and so forth.
Pre-natal development: Pre-natal development is of interest to psychologists investigating the context of early psychological development. For example, some primitive reflexes arise before birth and are still present in newborns. One hypothesis is that these reflexes are vestigial and have limited use in early human life. Piaget theory of cognitive development suggested that some early reflexes are building blocks for infant sensorimotor development. For example the tonic neck reflex may help development by bringing objects into the infant's field of view (Butterworth & Harris, 1994). Other reflexes, such as the walking reflex appear to be replaced by more sophisticated voluntary control later in infancy. This may be because the infant gains too much weight after birth to be strong enough to use the reflex, or because the reflex and subsequent development are functionally different (Bremner, 1994). It has also been suggested that some reflexes (for example the moro and walking reflexes) are predominantly adaptations to life in the womb with little connection to early infant development (Butterworth & Harris, 1994).

Infancy: Infancy is a period of origins. It is when a child’s capabilities, individuality, and first relationships begin to develop. Infancy is the period that follows the neonatal period and includes the first two years of life. During this time tremendous growth, coordination and mental development occur. Most infants learn to walk, manipulate objects and can form basic words by the end of infancy (Van De Graaff, 2002).
**Babyhood:** The period from 2 years to 4 years is called babyhood. Intelligence is demonstrated through the use of symbols, language use matures, and memory and imagination are developed. Thinking is done in a non-logical, no reversible manner. Egocentric thinking predominates. Socially, toddlers are little people attempting to become independent at this stage. They walk, talk, use the toilet, and get food for themselves. Self-control begins to develop. If taking the initiative to explore, experiment, risk mistakes in trying new things, and test their limits is encouraged by the caretaker, the child will become autonomous, self-reliant, and confident. If the caretaker is overprotective or disapproving of independent actions, the toddler may begin to doubt their abilities and feel ashamed for the desire for independence. The child's autonomic development will be inhibited, and be less prepared to successfully deal with the world in the future (*Bronfenbrenner, 1979*).

**Early childhood:** Also called "pre-school age," "exploratory age" and "toy age." When children attend preschool, they broaden their social horizons and become more engaged with those around them. Impulses are channelled into fantasies, which leaves the task of the caretaker to balance eagerness for pursuing adventure, creativity and self expression with the development of responsibility. If caretakers are properly encouraging and consistently disciplinary, children are more likely to develop positive self-esteem while becoming more responsible, and will follow through on assigned activities. If not allowed to decide which activities to perform, children may begin to feel guilt upon contemplating taking initiative. This negative association with independence will lead them to let others make decisions in place of
them (Bruce, 2003).

**Late childhood:** At this stage, intelligence is demonstrated through logical and systematic manipulation of symbols related to concrete objects. Operational thinking develops which means actions are reversible and egocentric thought diminishes. Children go through the transition from the world at home to that of school and peers. Children learn to make things, use tools, and acquire the skills to be a worker and a potential provider. Children can now receive feedback from outsiders about their accomplishments. If children can discover pleasure in intellectual stimulation, being productive, seeking success, they will develop a sense of competence. If they are not successful or cannot discover pleasure in the process, they may develop a sense of inferiority and feelings of inadequacy that may haunt them throughout life. This is when children think of themselves as industrious or as inferior (Siegler, 2006).

**Adolescence:** Adolescence is marked by striking biological events that signal the initiation of the sequence of biochemical, physiological, and physical transformations of child into adult. The term “Adolescence” is derived from adolescence, the present participle of adolescere, to grow up or to grow from childhood to maturity (Mussen, 1990). Developmental psychologists prefer this term because its etymology is most consistent with the physical and behavioral characteristics of this era. In contrast to the developmental significance of adolescence are the chronological implications of a number of synonyms in current usage among social scientists. Adolescence is the period of life between the onset of puberty and the full commitment to an adult social role, such as
worker, parent, and/or citizen. It is the period known for the formation of personal and social identity and the discovery of moral purpose. Intelligence is demonstrated through the logical use of symbols related to abstract concepts and formal reasoning. A return to egocentric thought often occurs early in the period. Only 35% develop the capacity to reason formally during adolescence or adulthood (Huitt, & Hummel, 1998). It is divided into two parts namely: Early Adolescence (13 to 16 years) and Late Adolescence (16 to 19 years).

**Adulthood:** The term "adult" refers to a fully developed person from maturity (the end of puberty) onward. The age at which a person is physiologically an adult is age 17 years for females and age 18 years for males. Adulthood can also refer to a person's ability to care for them independently, and raise a family of their own. For example in United States graduating high school, residing in one's own residence and attaining financial independence are all synonymous with adulthood (Starr & McMillan, 2001) but same is not the case for other cultures.

**Middle age:** Adulthood is further understood as middle age which generally refers to the period between ages 40 to 60 years. During this period, the middle-aged experience a conflict between generatively and stagnation. They may either feel a sense of contributing to the next generation and their community for other or a sense of purposelessness. Physically, the middle-aged experience a decline in muscular strength, reaction time, sensory keenness, and cardiac output. Also, women experience menopause and a sharp drop in the hormone estrogens. Men do have an equivalent to menopause; it is called andropause which is a
hormone fluctuation with physical and psychological effects similar to menopause. Lowered testosterone levels result in mood swings and a decline in sperm count and speed of ejaculation and erection. Most men and women remain capable of sexual satisfaction after middle age.

**Old age:** This stage generally refers to those over 60 years and above years. During old age, people experience a conflict between integrity vs. despair. When reflecting on their life, they either feel a sense of accomplishment or failure. Physically, older people experience a decline in muscular strength, reaction time, stamina, hearing, distance perception, and the sense of smell. They also are more susceptible to severe diseases such as cancer and pneumonia due to a weakened immune system. Mental disintegration may also occur, leading to dementia or Alzheimer's disease. However, partially due to a lifetime's accumulation of antibodies, the elderly are less likely to suffer from common diseases such as the cold.

Development, developmental theories and stages of development are discussed so far to understand the life cycle of a child and now the researcher had tried to explain kinds and types of behavioural problems in children and adolescents and the causative factors in the emergence of the problems.

**Behavioural Problems –An Overview**

Developmental considerations assume major importance in the provision of a classification scheme for children and adolescents, and, indeed, for adults as well (Zigler & Glick, 1986). Some disorders such
as autism have their origin in a specific developmental period, whereas others are frequently associated with developmental problems (e.g., Courgette syndrome may be associated with attentional difficulties).

The developmental approach to classification is used whenever disorders are viewed in the context of the unfolding of basic developmental processes. The use of standard, developmentally based assessment instruments such as tests of intelligence or communication skills exemplifies this approach. In contrast, many categorical and dimensional classification systems rely on assessment of deviant behaviour. The use of such an approach is often complicated because issues of how deviant behaviour is to be evaluated and how instruments are to be “normed” become quite important, and reliability among examiners can be low. Both the *ICD-10* and the *DSM-IV* systems include some categories in which the definition is fundamentally developmental (e.g., mental retardation, articulation disorders), whereas in others the deviant nature of the disorder predominates (e.g., autism, schizophrenia of childhood onset).

Behavior patterns that go against social norms and expectations may cause harm to other people and the doer himself/herself and are disruptive, have been denoted in several different ways in the literature when describing child psychopathology. Categorical (as in different diagnostic manuals) as well as dimensional (i.e. externalizing behavior problems, conduct problems, antisocial problems) approaches have been used (*Fonseca & Perrin, 2001*).
There may be reasons behind certain behaviour patterns of children which may remain unknown for a long time. One reason for such behavioural problems in children is the casual attitude of the parents and other elders associated with the child (Glen, 2003). Sometimes, parents give a particular instruction and then immediately change it causing a lot of confusion in the mind of the children (Polit & Falbo, 1987). The environment at home and school has a direct effect on the behaviour of the children, as they spend most of their time at these two places. So, keeping this thing in mind, parents and teachers should try their level best to provide safe and protective environment which will not cause any behaviour problems in children (Erikson, 1950; Hall, & Lindzey, 1957).

The basic assumption underlying the present piece of work is that there are some factors which influence the personality, adjustment and the social activities of children and adolescents.

Many Behaviour Problems are seen from time to time in most children and are not of great concern. As children develop, however we expect different levels of self-control. When the frequency of misbehaviour persists, causes distress and interferes with a child’s daily functioning at home, with peers, and in school consultation is warranted. Because Behavioural Problems impact other people in a child’s life (e.g. parents, peers, and in schools) they account for most referrals to mental health professionals (Carr, 2000; Rutter & Taylor, 2002). Accurate diagnosis is essential to evaluate the child’s capabilities, family environment, and other social issues (Hartley-Brewer, 1994). The
diagnosis serves as the basis of an individual treatment plan and determines if the behavioural problems are accompanied by other disorder such ADHD, Anxiety, or depression (Scott, Shaw & Joughin, 2001).

Punishing the child by hitting or by using any such violent means, should be strictly avoided (Taylor & Biglan, 1998). By giving real life examples the child can be taught about what is right and what is wrong, give the child time to understand, as the power to interpret taught things in children is lower than that in adults (Brewer et al. 1995; Forehand & Long 1996). Many adults do not realize this, which makes their kids angry, short-tempered and impatient. Shouting at children and enforcing a very strict discipline and routine can make the kids rebellious (Elliott & Gresham, 1993). Let your child learn the ways of behaving in home and in public slowly and steadily (Dishion & McMahon, 1998). Meditation and playing indoor and outdoor games can prevent and reduce the behaviour problems in children (Brewer et al. 1995; Durlak & Wells, 1997). These things help to increase the energy and concentration levels which are the most essential things to curb the behavioural problems in children. Take special efforts to ensure that the health of the child is fine by giving good, healthy and nutritious food as children suffering from diseases and health related issues have more behaviour problems as compared to the 'fit and fine' kids(Peters & McMahon, 1996; Brennan & Raine, 1997). The parents need to understand child psychology and try and behave as per the kid's wish most of the times they have to consult a child psychologist or a paediatrician if the situation goes out of their control (Yehuda, 2000).
The child psychologists suggest various ways to improve the situation by good child care.

The rates of behaviour problems among young disabled children, and especially children with learning difficulties are three to four times higher than among non-disabled children (Baker, Blacher, Crninc, & Edlbrock, 2002; Volmar & Dykens, 2002). These behaviour problems typically continue to persist into later childhood and adolescence (Emerson, 2003) and, as the child increases in size, strength and speed, become more severe. This puts the child at increased risk of harm and also means they become more and more difficult for parents and schools to manage. Challenging behaviour is the main reason why children are placed in 38 or 52 week placements in residential schools (Abbott, 2000), and is also a key factor for families being unable to access short breaks (or respite care), and/or the child being unable to access educational, therapeutic and/or community or social activities (Kahng & DeLeon, 2008).

Over the past several decades there has been increased interest in the social and emotional development of students. Prior to this shift in focus, the common belief among parents, professionals, and researchers was that difficulties exhibited by young children were due to their developmental immaturity and that they would outgrow their problems (Deiner, 1999; Fisher & Ashkanasy, 2000; Larsen, 2000; Rosenberg & Fredrickson, 1998; Weiss, 2001). It is certainly true that preschool and kindergarten years are a time of tremendous development and change, so some instability in behaviours is to be expected. However, it has
become increasingly clear that many children who exhibit emotional and behavioural problems in their early childhood years will continue to have such problems over time and perhaps throughout their adolescent and even adult years.

In Australia, the prevalence of mental health problems has been assessed in a national survey of a sample of 4500 children and young people (Sawyer, 2001). In this survey, the prevalence of mental health problems among children and adolescents aged 4 to 17 years was 14% (Sawyer, 2001). Depression is one of the most common mental health problems affecting young people in Australia today. Up to one in four young people in the general population experience an episode of major depression by the time they are 18 years old (NSW Health, 1999; NHMRC Clinical Practice Guidelines, 1997).

With the increasing recognition that emotional and behavioural problems often do not decline naturally, there has been an increased focus on intervention and prevention efforts geared toward school students. Understanding the root causes of behavioural problems in children is critical to ensuring proper treatment. Too often people go on the old standard theories and treat the child with a purely “Behavioural Approach”. These theories are not the “be all and end all” answer for every behaviour, which too many assume it to be. This research work tried to provide an intervention plan that may have been found to be effective or appear promising for use with young children and adolescents.
Factors related to Behavioural Problems

The specific factors of behavioural problems remain elusive. The reasons why such problems arise in a particular child are usually difficult to identify precisely, and the problems is likely to be the result of multiple and overlapping factors (Ryan, 1971). At least four general areas can contribute to emotional and behavioural problems: Biological factors, Family factors, School factors and Peer group related (Hill, 2002).

Biological Factors: Human beings are complex living organisms that can be characterized by their appearance and behaviour at each point in the life cycle. Many of these characteristics are uniquely human, such as the array of languages that facilitate interpersonal communication and permit a meaningful interplay of ideas and emotions (Brooks-Gunn & Warren, 1989). Scientific advances over the past 150 years clearly indicate that hereditary factors are transmitted from generation to generation and account for much of the observed variation among and within species. Although the complexities of human existence cannot be reduced simply to the effects of genes, it is inescapable that genetic factors provide the biological basis for many of our potentialities and vulnerabilities as human beings (Leckman & Mayes, 1998).

Genetic factors also contribute to variations within species. A large number of physical and psychological traits, including gender, height, and intelligence, have been shown to be under at least partial genetic control. Some of these interspecies differences, such as gender,
are owing to actual differences in the number and type of genes present in the individual.

Just as for many other problems, more and more biological and genetic causes for emotional or behavioural problems are being identified (Forness & Kaveale, 2001). Psychological models of behaviour cannot account for all behavioural variation in children. On the other hand advances in medicine, genetics, and physiology make the suggestion of a biological basis for all behaviour disorders, plausible. Undeniably, the central nervous system is involved in all behaviour involves neurochemical activity. Furthermore, genetic factors alone are potentially sufficient to explain all variation in human behaviour (Eiduson & Giller, 1962). It may seem reasonable to believe that disordered behaviour always implies a genetic accident, disease, brain injury, brain dysfunction, or biochemical imbalance.

Certain neuropsychological indicators (influences in the brain that are linked to psychological functioning) are linked with aggression. Aggression and impulsiveness are associated with abnormalities related to thought processing and inhibition of behaviour (Plomin, DeFries, McClearn, & McGuffin, 2000). Deficits in certain neurochemical, including serotonin and norepinephrine, are also linked to behaviour problems. Reductions in the functioning of autonomic nervous system, which is responsible for the regulation of bodily processes, is also linked to chronic conduct problems whatever their theoretical orientation, for example, attachment or social learning (Shaw & Bell, 1993; Shaw, et. al., 2003).
Researches (Bombard, 1953, Byrd, 1938, Ritter, 1954, Burney, 1952, Collins, Macoby, Steinberg, Hetherington & Bornstein, 2000, Ge, Conger, Caboret, Neiderhiser & Yates, 1998, Polmin, Reiss, Hetherington, 1994) accentuate a dynamic interplay between biological and environmental factors and propose that most of the effects of a person’s biological constitution on conduct disorder are mediated through disrupted parenting and peer environments. There is some evidence that child-onset conduct disorder, characterized by antisocial behaviour and hyperactivity, may have stronger biological underpinnings than later-onset conduct disorder. Exploration of reciprocal transactions between genes and environment suggests that children may evoke reactions from parents and others that contribute to antisocial behaviour (Rutter et al., 2002).

Some theorists propose that individuals actively select environments and relationships consistent with their genetic disposition (Scarr, 1993; Tsuang et. al., 2004), with antisocial youth selecting peers who reinforce deviance. Although little research focuses on the biological characteristics that contribute to the influence of deviant peers in early adolescence many other biologically oriented constructs (Dadds, 1997; Keenan & Wakschlag, 2004; Lavigne, Cicchetti, Gibbons et al., 2001; McMahon & Wells, 1998) have been proposed, but none have clarified whether such constructs are causally unique or simply by products of being raised in a harsh family environment from an early age.
At this point, several facts need to be clarified, first, in nearly all cases of mental illness no reliable direct evidence of biological disease or disorder can be found. One must, therefore, presume the presence of a physical basis for the disorder if one wishes to implicate biological factors (Szasz, 1960, Goldenberg & Huxley, 1992). Environmental factors influence certainly do interact with and modify the behavioural manifestations of biological processes. (McClearn, 1964, Smith, 1998, Collins et. al, 2000, Plomin, Reiss, Hetherington & Howe, 1994).

**Family Factors**: Despite the interest of developmentalists and clinicians in the effects of the environment on behaviour, few studies have examined continuities of contextual risk, because such studies are complex. Nevertheless, there is strong evidence that the best predictors of competence during early childhood are (a) the number of years a family has spent in poverty (Duncan et al., 1994) and (b) the number of distinct adversities children and families have experienced (Sameroff et al., 1993).

Genetic endowment and maturational forces strongly predispose to the relationships and intimacies that draw the infant into the human race, one interaction at a time. But it is the family in all its permutations that ultimately embraces that child's maturational promise.

Theories of parenting based on classical psychoanalytic or learning principles have failed to stand up to modern empirical findings because they do not sufficiently explain important aspects of children's development. Conversely, increasing evidence considers parenting to be
based on genetic principles and the laws of developmental psychopathology \cite{Rutter et al., 2001}, thereby highlighting the importance of genetic and functional factors (e.g., parental emotional support, the role of an intimate confiding relationship) and structural factors (e.g., low socioeconomic status or mental illness in the family) for the quality of parenting. Thus, the emphasis has shifted from the classical psychoanalytic position in which undue importance was placed on the very early years of a child's life to determine later mental health to conceptualizing life as an ongoing developmental process.

The nuclear family, consisting of father, mother, and children has been traditionally considered a central factor in early personality development in many societies \cite{Lamb, 1997}. Size of family, birth order of children, stability of family, employment of mother, absence of father, and presence of stepparents, grandparents, or other relatives in the home, for example, have not been shown to be in themselves sufficient to produce behavioural pathology \cite{Biller & Davis, 1973, Herzog & Sudio, 1973, Rutter, 1979, Yarrow, 1964}. Control techniques, marital relationships, maternal and paternal dominance, parental personality, or role assignment within the family are not, when considered alone, predictive of mental health or behavioural problems \cite{Becker, 1964}.

Such family variables appear to be predictive of the child’s behaviour development only in complex interactions with each other and with other factors such as socioeconomic status, ethnic origin, and the child’s age, sex, and temperamental characteristics. Nevertheless,
broken homes, father absence, parental separation, divorce, chaotic or hostile family relationship, and low socioeconomic level appear to increase children’s vulnerability to behavioural problems (Hetherington & Martin, 1979; Fergusson, Horwood & Lynskey, 1994; Axford et. al, 2005).

Rutter’s (1979) review of research on mental deprivation and family factors in behavioural problems points out some of the complexities in family child from one or both parents always works serious mischief with the child’s psychological and behavioural development. The effects of maternal depression on children have often been described (Cogill et al., 1986; Field, 1988; Kurstjens & Wolke, 2001; Puckering, 1989). Findings suggest that these children display a wide range of behaviour-management problems.

Parenting practices and parent-child relationships affect adolescent adjustment. The capacity of parents to adopt their parenting practices to the changing needs of their children affects adolescent adjustment. The single most consistent predictor of adolescent mental health and well being in the quality of the relationship adolescents have with their parents (Resnick, Bearman, Blum et al, 1997; Spoth, Redmond & Shin, 2001).

Adolescent is a time of dramatic physical, cognitive, emotional and social change which is often associated with increased negative affect in teenagers (Larson & Amussen, 1991; Larson, Csikszentimihalyi & Graef, 1980). While teenagers welcome a reduction in restrictions and increased freedom, parents can find it challenging to parent in ways that
continue to promote their teenager’s development during this transitional period. Steinberg and Silk (2002) argue that parents of early adolescents need access to accurate information about normal adolescent development, how to access a healthy trajectory, how to facilitate healthy adolescent development, and how to access assistance when needed.

Family processes affecting the socioemotional functioning of children living in poor families and families experiencing economic decline are reviewed. It is argued that poverty and economic loss diminish the capacity for supportive, consistent, and involved parenting and render parents more valuable to the debilitating effects of negative life events. A major mediator of the link between economic hardships parenting behaviour is psychological distress deriving from an excess of negative life events, undesirable chronic conditions, and the absence and the disruption of marital bonds. Economic hardship adversely affects children’s socioemotional functioning in part through its impact on the parent’s behaviour toward the child, and father-child relations under conditions of economic hardship depend on the quality of relations between the mother and father.

**School Factors:** The role of the school in the development of children’s behaviour disorders deserves particularly careful scrutiny by educators. Certainly outside factors influence children’s behaviour in school and some children presents behaviour problems prior to their entry into the education system. Besides the family, the school has probably the most important socializing influence on the child. Thus, how the school
affects the child’s emotional or behavioural development will depend, at least to some extent, on the child’s characteristics upon entering the education system.

Schools are the major source of formal learning and training within any society, so there is an expectation that schools provide the best possible curriculum and maximize the learning opportunities for all students. Schools are also expected to assist students to develop social skills to allow them to integrate fully within their own society and become good citizens. Participation in the education system is particularly important for students with social and emotional problems, as schools provide a strong institutional tie to community when family connections breakdown (Broadbent, 2008; Burdekin, 1998; Omaji, 1992).

An examination of school culture is important because, as Goodlad's study (1984) points out, "alike as schools may be in many ways, each school has an ambience (or culture) of its own and, further, its ambience may suggest to the careful observer useful approaches to making it a better school" (p. 81).

The culture of the school reflects the local culture in many ways (Rossman, Corbett & Firestone, 1988; Welch, 1979). When schools seek to improve, a focus on the values, beliefs, and norms of both the school and the environment outside the school is necessary (Sarason & Sarason, 1982; Deal & Peterson, 1990, 1996).
Goldenberg and Gallimore (1991) found those teachers' assumptions about students and their families reinforced their views about child development and academic learning in general. Teachers tend to blame the family for the child's at-risk condition rather than the child or the school (Richardson, Casanova, Placier, & Guilfoyle, 1989; Montecel-Robledo, 2005). These beliefs slant teachers' choices of classroom activities, and their evaluation of student performance toward goals. The teachers' perceptions of the child and of the child's family are strongly affected by the teachers' beliefs and expectations about academic performance and classroom behaviour, the characteristics of the rest of the students in the classroom, and the school setting (Richardson et al., 1989).

**Peer group related factors:** Besides, the above mentioned factors, some of the other factors about the origin of behavioural problems are such as peer pressure. A number of behavioural and emotional problems that can prevent a child from functioning at a level commensurate with his or her same age or same grade peers are commonly evidenced in the school setting. Some of the more common behavioural and emotional problems that cause such impairments include anxiety, attention deficit, hyperactivity disorder, anger/aggression, conduct problems, depression, delinquency, posttraumatic stress disorder and bullying (Asher & Wheeler, 1985; La Greca & Stone, 1993; Strauss, Lahey, Frick, Frame, & Hynd, 1988).

adolescents’ substance use, violence and suicidal behaviour were related to their friends’ substance use, violence and suicidal behaviours. Friends’ prosocial behaviour was negatively associated with
adolescents’ violence and substance use (Prinstens, Boergers & Spirito, 2001).

Friends’ delinquent behaviour is related to adolescents’ aggression and illegal behaviour (Dahlberg, 1998) and risk behaviour over time (Gottman, & Mettetal,(1986). Adolescents’ perceived peer rejection has also been associated with depression, substance use and suicidality (Prnistein et.al, 2001).

One of the possible mechanisms through which deviant peers’ one thought to exert their negative influence is “deviancy training” (Capaldi et.al. 2001) and the antisocial and aggressive means of interacting with others tends to be reinforced in antisocial peer context (Dishion, 2000).

**Some Behavioural Problems at different ages**

**Pre School (1-5yrs):** The child of this age has an increased capacity for reality testing; in addition, he or she continues to have the facility for magical thinking as well as more advanced capacities for guiding integration of competing wishes and aims. His or her ability for daydreaming, fantasy, and pretend play allows greater access to wishes that do not need to be compromised too quickly by reality. The child is thus protected in fantasy from the recognition of ultimate frustration. An increased capacity for symbolic representation opens the door to more elaborate forms of binding anxiety and expressing bodily urges in thought and imaginative activities (Tremblay, 2000).
Behavioural and relationship problems cause significant impairment for many preschool aged children and can be precursors for long-term antisocial behaviours and mental health problems (Campbell, 2002; Campbell & Ewing, 1990; Gagnon, Craig, Tremblay et al., 1995; White, Moffitt, Earls et al., 1990). Behaviours such as temper tantrums, yelling, fighting, and refusal to comply with instructions can interfere with the child's functioning at home and with their peers (Kazdin, 1995). Problems such as aggressive, oppositional, defiant, and disruptive behaviours can be severe, persistent, and frequent enough to warrant clinical attention or diagnoses (Dadds, 1997; Keenan & Wakschlag, 2004; Lavigne, Cicchetti, Gibbons et al., 2001; McMahon & Wells, 1998).

Some preschool aged children also exhibit internalising problems such as anxiety (Dadds, Spence, Holland et al., 1997) and shyness and withdrawal from peers (Spence & Donovan, 1998). Children may also have interpersonal relationship problems including deficits in core social and problem-solving skills (Shure, 2001; Spivack & Shure, 1989) as well as attachment difficulties with parents (Bowlby, 1998; Greenberg, Speltz & DeKlyen, 1993).

Children in this age range often feel helpless and experience an intense fear and insecurity because of their inability to protect themselves. Many children lack verbal skills and conceptual skills needed to cope effectively with sudden stress. The reactions of their parents and families often strongly affect them.
Typical Behavioural Problems

- Bed wetting
- Fear of the darkness or animals
- Physical and emotional "clinginess" to parents and teachers
- Night terrors
- Loss of bladder or bowel control, constipation
- Speech difficulties (e.g. stammering)
- Loss or increase of appetite
- Cries or screams for help
- Immobility, with trembling and frightening expressions
- Running either toward an adult or in aimless motion
- Fear of being left alone or strangers
- Confusion

Childhood (5-11yrs): In the age of childhood they do not go completely underground, the degree of preoccupation with sexual impulses and interests that are explicitly connected with the assumption of parental roles is significantly diminished. In fact, it would seem that in the sexual curiosity, excitement, and joking that can be observed among latency-age children, notions about parents as sexual objects/beings must be denied or avoided. Activities and attitudes seen as infantile—dependency on parents, fearfulness, and the like—also need to be avoided at all costs. In the face of conflicts established in the preoedipal and oedipal phases, infantile and incestuous longings are repressed, and a widening array of adaptive defences, including intellectualization,
humour, identification, obsessional interests, and sublimation, are utilized to support the diversion and alteration of the original impulses (Becker, 1990; Bornstein, 1992; Freud, 1969;).

The middle years of childhood, spanning the age from when a child enters primary school through age 10 years, are also called the school-age period because of the critical importance of school in development in our society. This time has been characterized by many classical theorists as the period when a child enters society and begins to establish the basis for becoming a contributing member of his or her community.

The school age child is able to understand permanent changes or losses. Fears and anxieties predominate in this age group. Imaginary fears that seem unrelated to the unwanted situation may appear. Some children however become preoccupied with the details of the unwanted situation and want to talk about it continuously. This can get in the way of other activities (McEwen, 2008; Deater-Deckard, Dodge, Bates & Pettit, 1998).

**Typical Behavioural Problems**-

- Thumb sucking
- Irritability
- Whining
- Clinging
- Aggressive behaviour at home or school
• Competition with younger siblings for parental attention
• Night terror, nightmares, fear of darkness
• School avoidance
• Withdraw from peers
• Loss of interest and poor concentration in school
• Regressive behaviour
• Headaches or other physical complaints
• Depression
• Fears about weather, safety

**Preadolescence (11-14yrs):** Peer reactions are especially significant in this age group. The child needs to know that his/her fears are both appropriate and shared by others. Helping should be aimed at lessening tensions, anxieties and possible guilt feelings (*Kupersmidt & Coie, 1990*).

**Typical Behavioural Problems—**

• Sleep disturbance
• Appetite disturbance
• Rebellion in the home
• Refusal to do chores
• School problems (e.g. fighting, withdrawal, loss of interest, attention seeking behaviours)
• Physical problems (e.g. headaches, vague pains, skin eruptions, bowel problems, Psychosomatic complaints)
• Loss of interest in peer social activities.

Adolescence (14-18yrs): Nearly 100 years after G. Stanley Hall (1904) proposed that adolescence is inherently a time of storm and stress, his view continues to be addressed by psychologists. For the most part, contemporary psychologists reject the view that adolescent storm and stress is universal and inevitable (e.g., Eccles et al., 1993; Offer & Schonert-Reichl, 1992; Petersen et al., 1993; Steinberg & Levine, 1997).

Adolescence is also a time when individuals make many choices and engage in a wide range of behaviours likely to influence the rest of their lives. For example, adolescents pick which high school courses to take, which after-school activities to participate in, and which peer groups to join. They begin to make future educational and occupational plans and to implement these plans through secondary school course work and out-of-school vocational and volunteer activity choices. Finally, some experiment with quite problematic behaviours such as drug and alcohol consumption and unprotected sexual intercourse.

As children get older, their responses begin to resemble adult reaction to trauma. They may also have a combination of some more children like reactions mixed with adult responses. Teenagers may show more risk-taking behaviours than normal (reckless driving, use of drugs, etc.). Teens may feel overwhelmed by their emotions, and may be unable to discuss them with their families.
Contemporary research confirms that in the United States and other Western and also some Eastern countries, the teens and early twenties are the years of highest prevalence of a variety of risk behavior (i.e., behavior that carries the potential for harm to self and/or others). This pattern exists for crime as well as for behavior such as substance use, risky automobile driving, and risky sexual behavior (Arnett, 1992; Moffitt, 1993). Unlike conflict with parents or mood disruptions, rates of risk behavior peak in late adolescence/ emerging adulthood rather than early or middle adolescence (Arnett, 1999). Rates of crime rise in the teens until peaking at age 18, and then drop steeply (Gottfredson & Hirschi, 1990). Rates of most types of substance use are peak at about age 20 (Johnston, O'Malley, & Bachman, 1994). Rates of automobile accidents and fatalities are highest in the late teens (U.S. Department of Transportation, 1995). Rates of sexually transmitted diseases (STDs) peak in the early twenties (Stein, Newcomb, & Bentler, 1994), and two thirds of all STDs are contracted by people who are under 25 years old (Hatcher, Trussell, Stewart, & Stewart, 1994).

**Typical Behavioural Problems**

- Headaches, or other physical complaints
- Depression
- Confusion/Poor concentration
- Poor Performance
- Aggressive behaviour
- Withdrawal and isolation
- Changes in peer group or friends
- Psychosomatic symptoms (e.g. rashes, bowel problems, asthma)
- Appetite and sleep disturbance
- Agitation or decrease in energy level
- Indifference
- Irresponsible and/or delinquent behaviour
- Decline in struggling with parental control.

**Counselling and Intervention for Behavioural Problems**

The need for guidance, counselling and nurturing of human potential is one of the most basic needs of human being especially during the growing years where the foundation of healthy growth and development for entire life is laid, within the individual were forces that could be stimulated and guided towards goals beneficial to both the individual and the world community (Gibson & Mitchell, 1995).

The counselling is being recognized for its role not only for remediation but for prevention of society’s ills. Behavioral interventions tend to be comprehensive and complex, characterized by a range of intervention techniques and the provision of high levels of structure and reinforcement provided at high intensity using precise teaching techniques. Interventions are designed to achieve long term, generalized behavior change in target and related skill areas (McGahan, 2001).

Behavioural Intervention is essential for providing behavioural support to those people who display challenging behaviours. Interventions lead people to improved behavior so they can achieve success. Different types of people behavior require different types of
intervention. Differences in intervention needed are discussed with respect to variations in the degree of problem manifested and include exploration of environment accommodation, behavioural strategies and medication. Identification of problems at the initial stages tends to pay dividends in terms of preventing maladjustments. An assessment to guidance needs of students (Pant, 1998) suggests the desirability of their assessment extensively and periodically since need change with time and also vary across geographical, socio-economic, caste, age, grades, groups etc.

In India there is a need to bridge the gap between education, work and real life. Education is considered important for preparing pupils to lead productive, happy and satisfying lives. Asthana (1993) revealed that dropouts (156 pupils of classes V to VII) experienced problems related to adjustment, home-work, time-table, attending school, less satisfaction with class room teaching then there non-dropout counterparts. Parents and teacher in the study expressed poverty, sex discriminations and difficult course content to be the major causes of dropout.

There are reports of a large number of a female student’s dropping- out at secondary/senior secondary stages. This was substantiated by Pandya (1999) who found a higher proportion of females than males among the dropouts. Poverty, unhealthy home environment and lack of parental support of child’s education, boring teaching style, fear of failure, punishment by the teacher, lack of interest inability to follow classroom instructions etc are the causative factors.
The first generation learners (FGL) in Mrinal and Rekha’s (1994) study reported illogical fears and depression as compared to non first generation learners. Patil’s (1995) study of drug addicts found unemployment to be the major cause of drug addiction. Studies have shown loneliness, prolonged deprivation and feelings of inferiority in adolescents affecting their mental health. Upmanyu and Upmanyu (1995) found adolescents of grade X and XI manifesting high levels of loneliness than those of other age groups. A significant relationship was also found in adolescent girls on feelings of inferiority with emotional, social, educational and general adjustment (Gupta, 1996).

Surveys of student problems to provide an understanding of developmental demands and challenges faced by youngsters would also help in devising suitable guidance strategies for various age groups. The problems of students and children of growing age have emphasized the need to intervene in way and time. There are a number of intervention and counselling techniques for children and adolescents with behavioural problems have been developed and worked upon. Some of the techniques are given below-

**Cognitive-Behavioural Intervention**

Cognitive behaviour interventions (CBT) have been increasingly applied to remediate self control and behaviour problems in children. CBT can be broadly defined as a combination of cognitive and behavioural therapeutic approaches used to modify maladaptive thoughts and behaviours (Beck, Rush, Shaw, & Emery, 1979). CBT is
often considered a ‘short-term’ therapy, which generally consists of approximately 8 to 12 sessions where the client and therapist work collaboratively to identify problem thoughts and behaviours, in order to enable the therapist to provide the client with tools and techniques to alter the way in which they think, feel and behave in a given situation. There are a variety of CBT-based techniques used for different populations and different presenting issues.

Pioneers in the development of CBT include Albert Ellis (1929-), who developed rational-emotive therapy (RET) in the 1950s, and Aaron Beck (1976), whose cognitive therapy has been widely used for depression and anxiety. CBT has become increasingly popular since the 1970s. Growing numbers of therapists have come to believe that their patients’ cognitive processes play an important role in determining the effectiveness of treatment.

The central concept in CBT is that you feel the way you think. Therefore, CBT works on the principle that you can live more happily and productively if you’re thinking in healthy ways. CBT draws upon the rich traditions of behavior modification and rational-emotive or cognitive therapy (Meichenbaum, 1976), paying attention to social cognition (Dodge, 1993) as well as individual constructions of reality (Mahoney, 1993). It may combine a variety of techniques such as relaxation, cognitive restructuring, problem-solving, and stress inoculation, but rather than being a mere form of technical eclecticism, it is theoretically unified by principles of learning theory and information processing.
CBT with children, as well as with adults, emphasizes the effects of maladaptive beliefs and attitudes on current behaviour. The assumption is made that a child's reaction to an event is influenced by the meanings he or she has attached to the event. Or, in other words, emotional and behavioural responses to events in one's life are a function of how these events are perceived and recalled, in that the events affect one's self-perceptions and the pursuit of one's goals.

CBT is a structured and short-term psychotherapy; treatment is directed towards helping patients to reach explicit goals agreed at the start of the intervention and at each meeting. Accordingly, the treatment goal is for children to develop a new cognitive structure or a modified existing structure through which he or she can function adaptively in the world (Kendall, 2000).

A number of studies have compared the effectiveness of CBT to several tricyclic antidepressant medications (Elkin et al., 1989; Hollon et al., 1992; Rush, Beck, Kovacs, & Hollon, 1977; Simons, Murphy, Levine, & Wetzel, 1986).

**Psychodynamic Approaches**

Psychodynamic therapy is an evidenced based approach to clinical practice that falls within the psychoanalytic tradition (Lambert & Ogles, 2004). Psychodynamic therapy originated with the work of Sigmund Freud, who reported a number of cases of psychodynamic therapy based on dynamic principles. Within this therapy it is assumed that psychological problems arise because dysfunctional psychological
defenses mechanisms have been used to manage anxiety and inhibitory affects about the expression of potentially adaptive, but forbidden feelings and impulses (Leigh McCullough, 2003).

Within Psychodynamic Therapy, specific therapeutic strategies are used to restructure defences, to restructure forbidden feelings and affects, and to restructure psychological representations of self and others.

**Humanistic Approach of Counselling**

Humanistic theory is a model that continues to give people a way of accepting inherent and increasing pressures and a means of dealing with them in a humanistic manner through relationship with other humans.

Hope and positive expectations for individuals are key parts for humanistic theories. They are tried to an actualizing theme that views people as continuously theme that views people as continuously involved in self- growth by seeking to “maximize and enhance the organism” (Roger, 1959, p.196). The humanistic counselor and client bring their separate lives, bodies, minds and experiences together in ways that allow them to share their uniquely perceived worlds and learn from the communion between them.

**Existential Approach**

Existential counseling is best described as a philosophical approach to counseling. The existential approach helps people who are
isolated, alienated, and not finding. Existential theorists emphasize self-
determination, choice, and the responsibility of the individual to raise 
environmental forces.

The existential perspective is more a philosophical position than 
a formal scientific theory. Existential writers believe that scientific 
psychology misses the mark if it dwells on observable behavior and 
neglects the individual’s inner life, particularly motivation and 
personality styles (Cain & Seeman, 2002; Schneider, 2001)

**Adjustment**

Adjustment means a state of harmonious relationship between a 
person and his environment (Talukdar & Talukdar, 2008). It also refers 
to a continuous process by which a person changes his/her own behavior 
or tries to change the environment or brings change in both to yield 
satisfactory relationship with his/her environment. It also means how 
proficiently an individual performs his/her duties in various situations. 
Parameswaran and Beena (2004) cited by Talukdar & Talukdar (2008, 
p. 268) affirmed that adjustment is a process by which an individual 
acquires a particular way of acting or behaving or changes an existing 
form of behavior or action. People have to adjust to external conditions 
and to internal conditions also. As a person grows older a balance 
between these two adjustments become crucial. Adjustment is a very 
significant factor in determining the degree of achievement of students. 
It consists of the psychological processes by means of which the
adolescent manages or copes with various demands or pressures. According to Chaube (2002), it has been indicated earlier that with the onset of adolescence there come many physical and mental changes in the individual. Problems of adjustment vary in degree. At the ‘normal’ level are nervousness and worry, feelings of inferiority, and some lesser degrees of anxiety, and of defensive behavior. Shek (1997) has found that family factors play an important role in influencing the psychosocial adjustment, particularly the positive mental health, of Chinese adolescents. Rani Mohanraj (2005) observed that family environment appeared to influence home adjustment as well as academic performance. Adjustment therefore has been considered as an index to integration; a harmonious behavior of the individual by which other individuals of the society recognize the person as well adjusted (Pathak, 1990, Shah & Sharma, 2012). Comer & Haynes (1991) stated that throughout the critical time in a teenager’s life, families and schools need to work together. Families provide the social, cultural and emotional support that youth need to function well in school. Schools provide opportunities for children’s positive interactions with significant adults and other adolescents to enhance their home experiences and to support their continued development and related learning.
Statement of the Research Problem and Objectives of the Study

The research evidences in the field as well as the experiences of general public showed that the incidence of behavioural problems in children and adolescents are rising. Adolescents account for about 1/5th of India’s population. Recent researches suggest that more young people are beginning to report mental health problems, as they perceive more stress. It is estimated that six to nine million children and adolescents in the United States have mental or behavioral problems. Indian Council of Medical Research reported that about 12.8 per cent of children (1-16 years) suffer from mental health problems. According to findings (Vawda, 2002) 69.56 per cent of adolescents had suicidal behavior due to parent-child problems, about 17.39 per cent due to partner relational problems, 8.69 per cent due to adjustment disorders and 4.35 per cent of children due to depression. A current estimate suggests that 7% to 25% of children are affected with one or other of the behavioural problems. These behavioural problems typically continue to persist into later childhood and adolescence (Emerson, 2003) and, as the child increased in size, strength and speed, become more severe. This puts the child at increased risk of harm which meant that they become more and more difficult for parents and schools to manage. Challenging behaviour is the main reason why children are placed in 38 or 52 week placement in residential schools (Abbott, 2000) and is also a key factor for families being unable to access educational, therapeutic and community or social activities (Kahng & Deleon, 2008). Over many years, behavioural
theory and principles have been used to inform and determine interventions to address problem behaviour.

There is growing awareness of the applicability of the methods and findings of counselling to an ever widening range of problems. Current interventions tend to be comprehensive and complex, characterized by a range of intervention techniques and the provision of high levels of stricter and reinforcement provided at high intensity using precise techniques. The overall approach of interventions for behavioural problems involves identifying what causes the problem behaviour and what is reinforcing the behaviour and using the information to develop a strategy by which the behaviour can be modified through changing reinforces sometimes, punishment (Emerson, 2001)

After analyzing and synthesizing the research evidences the following major objectives and research questions were framed.

- Keeping in view the importance of the problems the main aim is to identify the behavioural problems in children and adolescents of rural areas of eastern Uttar Pradesh region.

- In the light of above context, the second aim of this study is to know how the problem behaviours affect the self adjustment the children and adolescents.

- There is a need to not only identify the problematic behaviour of children and adolescents but also provide some rectification of the problem behaviour. Therefore, another aim of this present investigation is to
provide counselling to the children with the problem behaviour and also compare the effectiveness of counselling intervention in counselled and not counselled groups.

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