EMOTIONAL AND BEHAVIOURAL PROBLEMS AMONG SCHOOL CHILDREN IN PAKISTAN

Pages with reference to book, From 181 To 183

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ABSTRACT

The prevalence of emotional and behavioural problems in school children using Rutters children behavioural questionnaire was 9.3% with antisocial disorders being the commonest one. These disorders are not only present in this culture but also differ in terms of psychopathology with different levels of schooling. The findings are discussed in terms of their relevance to mental health of children with comparison of results from other countries (JPMA 42: 181, 1992).

INTRODUCTION

The majority of the community epidemiological surveys of childhood psychiatric disorders estimate the rate of clinical maladjustment among children between 5-15 percent[1-4]. Although most of these surveys have gathered data on general maladjustment rather than information on specific disorders. Recent studies have focussed on two major categories of disturbed children, i.e., the aggressive group[5-7] and the neurotic or anxious group[8,9]. These categories represent not only the most common psychiatric problems in children but also reflect a variety of characteristics that may influence the future mental health of these individuals[10-12]. The instruments used to measure these disorders consist of check-list information obtained from parents, teachers or the child or data from structured interviews carried out with a parent, child or some other source[13-17]. One check-list procedure, Rutter questionnaire[16] has been most commonly used in different countries[17,18]. This questionnaire, completed by teachers, has been able to discriminate children who have problems from those who do not, as well as different types of emotional and behavioural problems. The present paper reports the prevalence of emotional and behavioural problems of school children using this questionnaire. This epidemiological investigation was aimed to find out the pattern of psychological problems in school children and to compare the results with those from other countries and with reports involving the use of same scale.

SUBJECTS AND METHODS

Two hundred and twenty five students of 4th and 5th classes aged 9-11 years attending three different schools (one public and two ordinary) were included in the study. Teachers were approached to complete the Ruuers childrens' behaviour questionnaire. It has 26 items and the scoring is done on each item as 'certainly applies', 'applies somewhat' or 'does not apply'. The scores are indicated as 2, 1 or 0 respectively and children scoring nine or more on the total are considered to show evidence of some disorders, Antisocial score is obtained by summing of the rating for six items (destructive, fights, disobedient, lies, steals and bullies) and neurotic or emotional sub category is calculated from the sum score of four items, i.e., worries, miserable, fearful and sheds tears at school. The larger of the two sub scores determines the particular category while children with equal antisocial and neurotic sub scores are classified as mixed. Fifty students of the same age range attending a special education centre were also included in the study. Their clinical diagnosis was mild to moderate sub normality with varying degree of hyperactivity, autism, speed disorders and developmental delays.

RESULTS

The general information about the sample with the number of children with deviant scores and their sub-categories are shown in Tables I and II.

TABLE I. Sample.

Age	9-11 years
Sex	Male
Class	Students of 4th and 5th primary class

Children with deviant scores.

	Antisocial type	Neurotic type	Mixed type	Total
General schools n = 225	11 (4.8%)	6 (2.6%)	4 (1.7%)	21 (9.3%)
Government school n = 145	9 (6.2%)	3 (2.0%)	3 (2.1%)	15 (10.3%)
Public school n = 80	2 (2.5%)	3 (3.7%)	1 (1.2%)	6 (7.5%)
Special school n = 50	20 (40.0%)	10 (20.0%)	2 (4.0%)	32 (64.0%)

TABLE II. Deviant scores and socio-geographical backgrounds.

		General school n = 21	Special School n = 32
Age	Younger (9-10 years)	8 (3.5%)	12 (24%)
	Older (10-11 years)	13 (5.7%)	20 (40%)
Sib	Size		
	1	4 (1.8%)	5 (10%)
	2	5 (2.2%)	7 (14%)
	3	3 (1.3%)	11 (22%)
	4	3 (1.3%)	6 (12%)
	5	6 (2.6%)	3 (6%)
Sib	Order		
	1st	7 (3.1%)	5 (10%)
	2nd	3 (3.1%)	8 (16%)
	3rd	2 (0.8%)	10 (20%)
	4th	4 (1.7%)	3 (6%)
	5th or more	5 (2.2%)	3 (6%)
Both parents alive		19 (8.4%)	31 (62%)
Only mother alive		1 (0.4%)	1 (2%)
Only father alive		1 (0.4%)	-

TABLE III. Rutter scale item distribution among deviant scores.

Items	Govt. school n = 15 Certainly applies	Public school n = 6 Certainly applies	Special school n = 32 Certainly applies
Anti-social subscale			
Destructive	4 (26.6%)	2 (33.3%)	6 (18.7%)
Fights	6 (40%)	2 (33.3%)	15 (46.8%)
Disobedient	5 (33.3%)	1 (16.6%)	12 (37.5%)
Lies	5 (33.3%)	2 (33.3%)	4 (12.5%)
Steals	1 (6.6%)	2 (33.3%)	3 (9.3%)
Bullies	5 (33.3%)	1 (16.6%)	4 (12.5%)
Neurotic subscale			
Worries	4 (26.6%)	3 (50%)	6 (18.7%)
Miserable	4 (26.5%)	2 (33.3%)	1 (3.1%)
Fearful	3 (20%)	2 (33.3%)	8 (25%)
Tears at school	1 (6.6%)	2 (33.3%)	2 (6.2%)

Table III shows the subscales distribution among three groups of students who scored more than 9 on the scale. The ratings were more marked in Government school children for anti-social scores whereas public school children showed more emotional disturbances. The special school attenders showed an overall increase of scores in all items than other two groups.

DISCUSSION

The findings reported here are based on data gathered by information collected from teachers. This method has certain disadvantages. The frequency with which individual symptoms are reported could be extremely high and may simply represent the rating pattern of individual teachers with certain biases. The other methodological issue in epidemiological study of this kind is its cross-sectional nature. In such studies, disorders with a longer duration are over represented and those with a shorter duration are under-represented. These facts should therefore be kept in mind while interpreting the results of the study. In this study the prevalence of children with deviant scores among general school children was 9.3% and 64% for clinical cases. When compared with other studies using the same scale, the total deviance was found somewhat different from other countries (Fable IV). The ratio of the antisocial subtype to the neurotic subtype among deviant scorers was higher than children from Japan[19], China[20] and Newzealand[21] but less than those of England[22], Uganda[23] and Mauritius[24]. These differences may be due to variations in the frequency of different subtypes, differences in the effect of cultural backgrounds and social and family circumstances on mental health or the limitation of the scale in accurate detection of two subcategories. The prevalence of emotional and behavioural disturbances as previously reported[25], higher in the children attending the special school indicating an overall increase for all categories of psychiatric disorders among those who had co-existing brain pathology. The number of children with deviant scores were different in public school (7.5%) than

those studying in ordinary schools (10.3%). Antisocial behaviour was more common in schools run by the State and neurotic or emotional disorders in the public school. A high prevalence of behavioural problems has been reported in the inner city areas[26], but it does not include the effect of schooling on different sub categories. The overall behavioural problems were more frequent and categories were different in older children. They had less neurotic and more antisocial trends. Similar pattern has also been observed by others[27]. Despite the demographic differences most of the studies reported a high incidence of behaviour or emotional problems in the only children or the first born children[23,25]. The deviancy in this study was also more marked in the first born children. The sub size did not show a significant difference although children from larger families had more problems. Children in one parent family have more difficulties. The separation and detachment from parents lead to a number of adverse responses and traumatic experiences like this contribute to many psychosocial difficulties at a later stage[28]. In the present study, this finding was not confirmed. This might be due to small number of children from one parent family in the sample but. could also reflect the extent of socioeconomic diffIculties of these families which may lead to less schooling for these children. The present data provides the extent and pattern of two more common childhood psychiatric disorders in Pakistani school children. Although the social and cultural settings differ from country to country, the comparison of findings in this study with those of other countries did not show a major difference in the overall deviancy. The results have several clinical implications as well as future directions. These two disorders are very important from the developmental point of view as their presence may influence the normal course of the general upbringing of children. It becomes therefore imperative to obtain data about these disorders which can later on be used for preventive as well as interventional purposes. This information could also be used to identify social-influences and possible risk factors associated with these disorders. It is suggested that information should be collected from multiple sources and from different age groups. As the standardised instrument has made it possible to compare the result across cultures, it will be useful to relate specific risk factors with these common childhood psychiatric disorders and clarify the casual associations in emotional and behavioural problems of children.

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