Dhaka University Institutional Repository

BEHAVIOR PROBLEMS AMONG MADRASA STUDENTS

Thesis submitted in partial fulfillment of the requirements for the degree of Masters of Philosophy (M. Phil) to the department of Clinical Psychology, University of Dhaka, Dhaka-1000.

Submitted by

KOHINOOR BEGUM

Registration No: 363

Session: 2008-2009

Department of Clinical Psychology

October, 2013

ABSTRACT

The present study was an attempt to assess the nature and frequency of behavior problems among students of Madrasa using the Bengali version of the Teacher's Report Form (TRF, Begum 1993) of Child Behavior Check List (CBCL) and Translated Bengali version of McMaster family assessment Device (Epstein et al, 1983). Considering stratified random sampling 360 students were selected from twelve Madrasas covering male, female and coeducation in Dhaka Metropolitan area. Among 360 participants 180 were boys and 180 were girls and they were divided into two age group: 6-8 and 9-11 years.

Findings of the study indicated that 15.3% students of Madrasa have behavior problems within the clinical range. It was also found behavior problems are higher in boys (56.4%) than girl (43.6%) from this group of students. Students of 9 t0 11 years (58.2%) age group have higher behavior problem than students of 6 to 8 years age group. Male Madrasa (40%) students have higher behavior problems than students of female Madrasa (34.5%) and coeducation Madrasa (22.5%). No significant difference was found between age group of the sample, age and number of siblings, sex and number of siblings, types of Madrasas and number of siblings, and among age, sex and number of siblings. Out of total 118 specific individual items in the TRF significant difference in age groups were found on 5 items (4.23%), sex differences were found in 18 items (15.25%), differences among number of siblings group were found in 33 items (27.96%) and differences among types of Madrasas were found in 10 items (8.47).

Translated Bengali version of McMaster Family Aeeseement Device was employed to problem and non-problem group of children and it was found that problem children (Mean 124.20) scored higher in family functioning than non-problem childhren group (Mean 107.30) which indicated that poor family functioning may lead to develop behavior problem among children.

The findings of this research present a clear idea about the nature and frequency of behavior problem among Madrasa students and that a large portion of students from Madrasa education system are having behavior problems. So it is crucial to take steps to improve this and provide direct or indirect support to Madrasa students.

EXECUTIVE SUMMERY

The present study was an effort to investigate the nature of behavior problems among students of Madrasas in Dhaka city. The total sample of the present study comprised of 360 Madrasa students from twelve government Madrasas of Dhaka Metropolitan area. Among the 360 students, half of the participants were boys and half of the participants were girls. Twelve Madrasas were selected using lottery method where four were boys, four were girls and four were co-education Madrasa. Six students (3 boys and 3 girls) from each coeducation Madrasa, six students (6 boys) from each male Madrasa and six students (6 girls) from each female Madrasa were selected by using systematic sampling procedure from class one to class five. In this way a total of 30 students were selected from a Madrasa. To study the behavioral problems, the students were divided into two age groups, namely 6 to 8 years, 9 to11 years. Bengali version of Teacher's Report Form (TRF) was employed to all the subject of this study.

In the second phase of the study, 20 matched samples were selected on the basis of socio-demographic variables including age, sex, number of siblings and number of family members to compare different aspects of family functioning using McMaster Family Assessment Device.

Findings of the present study:

- Result of this study showed that out of 360 students 55 (15.3%) students of Madrasa had behavior problems in the clinical range.
- Regarding nature and frequency of behavior problem among Madrasa students including all groups the hierarchy of TRF items those are most frequent in research participants were 'bragging', got the highest position in the hierarchy list whereas second one is 'difficulty following directions' and third one is 'fears of doing something bad'.
- Higher proportion of male Madrasa students (40%) had behavior problem compared to female Madrasa (34.5%) and co-education students (22.5).

- Boys (56%) have more behavior problems than girls (43%) according to TRF.
- Students aged 9 to 11 years had more behavior problem than students aged 6 to 8 years.
- Those students who have 1 to 4 siblings manifests higher rate of behavior problems 88.3 % than having above five siblings.
- According to summary of ANOVA, no significant difference was observed between age group of the sample, age and number of siblings, sex and number of siblings, types of Madrasas and number of siblings, and among age, sex and number of siblings. Additionally, similar findings was found among age groups, types of Madrasas and number of siblings. So, variables of this study were not significant effect on each other.
- According to TRF score there were differences between boys and girls on following items of 14, 36, 37, 39, 45, 50, 51, 54, 56 d, 60, 64, 65, 69, 75, 80, 81, 95, and 103. Boys scored significantly higher than girls on item number 36 (Accident prone), 37 (fighting), 39 (Bad friends). Whereas girls scored significantly higher on item number 13 (confused), 14 (cries a lot), 45 (nervous), 50 (fearful or anxious), 51 (Dizzy), 54 (over tired), 56 d (eye problems), 60 (Apathetic or unmotivated) , 64 (Prefers being with younger children), 65 (refuse to talk), 69 (secretive), 75 (shy, timid), 81 (Feels hurt when criticized), 95 (temper tantrums), 103 (Unhappy, sad or depressed).
- Behavior problem items were significantly higher among the age group of 9-11 years than 6-8 years age group students on the following items 32 (needs to be perfect), 33 (feels unloved), 71 (self conscious) and the subsequent problems were significantly higher among the 6-8 years age group students: 14 (cries a lot), 30 (fears school).
- There were significant differences for students of different groups according to number of siblings. Scores of behavior problems items were significantly higher among the sibling group of 1-4 siblings than above 5 group students on the following items 3 (argues an lot), 7 (Bragging),11 (too dependent), 14 (cries a lot), 21 (destroys property), 23 (disobedient at school), 32 (Feels to be perfect), 36 (accident prone), 37 (gets in many fights), 38 (teased a

lot), 51 (feels dizzy), 59 (sleeps in class), 65 (refuse to talk), 71 (self conscious), 77 (demands must be met immediately), 87 (sudden changes in mood or feelings), 91 (talks about killing self), 95(temper tantrums), 111 (withdrawn dose not get involved with others) where the following items of problem behavior were significantly higher among the above 5 scores than 1-4 siblings group item 69 (secretive keeps things to self), 101 (truancy or unexplained absence), 108 (afraid of making mistakes).

- Significant differences were found for students of different groups according to type s of Madrasas. According to TRF item no 14 (cries a lot), 49 (has difficulty learning), 50 (too fearful or anxious), 64 (prefers being with younger children), 71 (self conscious), 81 (feels hurt when criticized), and 86 (stubborn or irritable) got higher in female Madrasas. Male Madrasas got higher score in item number 15 (fidgets) 49 (has difficulty learning), 56 f (physical problems without known medical causes) in compare to female and coeducation Madrasas.
- There is a difference between problem and non problem children according to family functioning in mean and SD score (Table 12). Although the differences in scores of problem and non problem children were small, they proved statistically significant.

It can be assumed that, students of Madrasa have experienced a lot of behavioral problems and sufferings and these nature and frequency of behavior problems need to be addressed for a better society ahead. Madrasa environment in Bangladesh is quite different from other traditional education system in Bangladesh. So there is a growing necessitates concentrating on the area of Madrasa system and its all aspects including students' mental health.

Madrasa system including curriculum for students and training content and facilities should be revised to develop and maintain a positive and motivating environment for study within Madrasa.

ACKNOWLDGEMENT

There are so many people, whom I feel I should acknowledge when I have completed my study. They all have contributed in their unique way through their support, encouragement, friendship and teaching. I will not have enough space to mention them all but I trust they all know how much I have appreciated them.

Firstly I consider myself honoured and privileged to have had got chance to work under the expert supervision and invaluable guidance of Kamal Uddin Ahmed Chowdhury, Associate Professor, Clinical Psychology, University of Dhaka. I am indebted to him for guiding my research from its haphazard origins to the present product. It would have been difficult for me to carry out my study without his inspiration, sincere help and guidance.

I put across my deep and sincere gratefulness to my initial supervisor Late Dr. Roquia Begum, Professor, Department of Clinical Psychology, University of Dhaka, who encouraged me a lot in conceptualizing and understanding this research.

I am fortunate to have been guided by Sabiha Jahan, Project Coordinator & Clinical Psychologist, Dr. Nasirullah Psychotherapy unit. Her unconditional affection, encouragement and support have been instrumental in completion of my work.

I am also very thankful to all the teachers of Clinical Psychology department for their valuable suggestion and encouragement.

Very special thanks goes to Shompa, Trainee Clinical Psychologist, who contributed a lot to this research, without her help data collection would not be possible.

I must have to acknowledge Salma Parveen, Abul Kalam Azad and Ishrat Sharmin Rahman Clinical Psychologist, for their wise advice and previous works which served as the supporting platform for every stage of my research.

My very special thanks go to all the trainees of the Department of Clinical Psychology for their friendly support, which help me in many ways in conducting the current study.

I am indeed grateful to all staffs of Clinical Psychology Department and University of Dhaka for administrative and management support.

The outmost thank goes to all the Madrasas and my respondents for their kind coordination, active participation during data collection on creation of sound environment without which I would be unable to complete my study.

Before concluding I would like to express my thanks to my parents, family members and friends for providing me continuous encouragement and emotional support in every step of my work , especially Jiju, Shankha, Shujan, Jhumur and Ruma. A very special thanks goes to my dearest Bannya Bhabi. I would like to thank my husband for the many sacrifices he has made to support me in my work.
Areesha, my daughter has always been the constant source of inspiration of my life.

Kohinoor Begum

CONTENTS

Content **Page No**

Abstract--- I

Executive Summery--- II

Acknowledgements-- --- VI

List of Tables--- XII

List of Figures-- XIII

List of Appendix--- XIV

CHAPTER -1

Introduction 1

Behavior Problems 1

Definition of Behavior Problems 1

Prevalence of Behavior Problems in children 2

Prevalence of Behavior Problems in children of Bangladesh 3

Sex Differences in Behavioral Problems *4*

Age Differences in Behavioral Problems *5*

Classification of Behavior Problems 6

Externalizing Problems 6

Attention-Deficit Hyperactivity Disorder 6

Oppositional Defiant Disorder 7

Conduct Disorder 8

Dhaka University Institutional Repository

Content **Page No**

Internalizing Problems 9

Separation Anxiety Disorder 9

Post Traumatic Stress Disorder (PTSD) 10

Obsessive-Compulsive Disorder (OCD) 11

Mood Disorders 12

Assessment of Behavior problem 12

Methods of Assessment 13

Interview 13

Interview with the Child 13

Interview with Parents 14

Observation 15

Standardized Interviews, Questionnaires, Check-lists and Rating Scales 15

Psychological Test 16

Risk Factors for Behavior Problems 17

Risk factors in the Child 18

Genetic Vulnerabilities 18

Prenatal and Perinatal Complications 18

Physical insults, injuries and diseases 19

Temperament 20

Intelligences, Self-esteem and Locus of control 20

Risk factors in the Family Environment 21

Parent-Child Factors in Early Life 21

Parental Problem 22

Marital Discord 22

Family Disorganization 23

Community Factors 24

Poverty 24

Content **Page No**

Lack of Social Support 24

Environmental Stress 25

Deviant Peer Group Membership 25

Child Abuse 25

Madrasa 26

Definition of Madrasa 27

Types of Madrasa 27

Difference between Madrasa and Mainstream Education in Bangladesh 29

Children Behavior Problem and Family Functioning 30

The present study 32

Rational of the Present Study 32

Rational for using Teacher's Report form 33

Rational for selecting Informants 34

Objectives of the Present Study 35

CHAPTER-2

Methodology 36

Sample 36

Design 36

Instrument used 36

Bengali version of Teacher's Report Form *36*

Translated Bengali version of McMaster Family assessment device *37*

Procedure 38

Data Analysis 38

Dhaka University Institutional Repository

Content **Page No**

CHAPTER -3

Result 39 - 71

CHAPTER-4

Discussion 72 - 79

REFERENCES 80 - 99

APPENDIX 100 - 112

LIST OF TABLES

TABLE No	Title of the Table	Page No
Table-1 :	Total number of problem behavior and percentage	39
Table-2 :	Hierarchy of most prevalent items of problem behavior among Madrasa students	39
Table-3 :	Total number and percentage of problem behavior according to types of Madrasas	40
Table-4 :	Total number and percentages of Madrasa students who are in the clinical range of behavior problem scores according to Age Level	41
Table-5 :	Total number and percentages of Madrasa students who are in the clinical range of behavior problem scores according to Gender	42
Table-6:	Total number and percentage of problem behavior according to number Of siblings.	43
Table-7:	Summary of the Analysis of Variance of behavior problem scores (TRF) according to sex, age , number of siblings and types of Madrasa	44
Table-8:	Percentage distribution of behavior problem items by sex of the subject	45
Table-9:	Percentage distribution of behavior problem items by age of the subject	51
Table-10:	Percentage distribution of behavior problem items by number of siblings of the subject	56
Table-11:	Percentage distribution of behavior problem items by types of Madrasa of the subject	64
Table-12:	Descriptive scores of clinical and non clinical sample according to family functioning	75

LIST OF FIGURES

Figure No	Title of the Figure	Page no
Figure-1:	The bar diagram of number and percentage of problem behavior according to types of Madrasa	41
Figure-2:	The bar diagram of number and percentage according to age group	42
Figure-3:	The bar diagram of number and percentage of problem behavior among male and female students	43
Figure-4:	The bar diagram of number and percentage of problem behavior according to number of siblings.	44

LIST OF APPENDIX

Appendix No **Page No**

Appendix – 1: **List of Madrasas** **104**

Appendix – 2: **Permission letter for data collection** **105**

Appendix – 3: **Letter for permission to apply Teacher's Report Form (TRF)** **106**

Appendix – 4: **Letter for Permission to apply McMaster Family Assessment Device** **107**

Appendix – 5: **Bengali version of Teacher's Report Form** **108**

Appendix – 6: **Translated Bengali version of McMaster Family Assessment Device** **113**

Dhaka University Institutional Repository

Chapter-01

INTRODUCTION

Generally problem behavior refers to behavior which may lead to different types of psychological problems. These problem behaviors are incomprehensive to others, and those that are antisocial, destructive broadly maladaptive. When child demonstrate behavior which is extreme, hard to manage, have lasted for long time or are not appropriate for his or her age can be termed as problem behavior (Kazdin, 1992). Problem behaviors are common in children which occur in about one quarter of all young children. This problem behavior often remains persistent from early childhood to later childhood particularly when the problems are severe and the child has difficulties in learning. Behavior problem manifest a variety of emotional and conduct problems, ranging from aggressive and disruptive behavior to anxiety, lack of motivation in study and other activities, low self esteem, lack of concentration etc (Yule & Rutter, 1985). These behaviors are often termed as challenging behavior that his or her parent, teachers and others cannot deal effectively.

Normally behavior is considered as problematic when it differs markedly as well as chronically from current social and cultural norms for the children (Richman & Graham, 1971). Problematic behavior of children affects physical, emotional or social well- being of the child or others around the child. A range of literature depicts that children’s emotional and behavioral problems have a substantial adverse impact on families, schools and children’s own long-term well-being (Hirshfeld, 1997). There is also evidence that many such children remarkably fail to develop appropriate social skills to his or her cultural domain. It has been recognized that several behavior problems are common in child such as – lying, over activity, over dependence, attention demanding, shyness, irritability, temperament, jealousy, stealing, aggressive behavior etc. Several researchers have been conducted to assess behavioral problem of children in home and abroad.

Definition of Behavior Problems

The term behavior refers to the way a person responds to a certain situation or experience. Behavior problems addressed the negetive aspects of behavior. Different theories of child psychopathology describes behavior problems in different ways. But there is no single definition of problem behavior that is usually agreed upon or accepted by all (Begum,1997).
According to Herbert M. (1998) ‘behavioral problems in children refers to those behavior that impair the quality of the child’s life, resulting in underachievement in normal social contexts (for example, school), with failure of social development and integration’.

D'Sliva (2007) defined behavior problem as 'when children have shown a permanent pattern of hostile or disruptive behavior towards oneself or towards the society are known as behavior problem or behavior disorder of children'.

Zarakowska and Clements (1988) and Lamb and Ketterlinus (1994) provided some criteria to indicate problem behavior. These were as follows:

- If the degree of severity of the behavior does not match up with the chronological age group and the developmental level of the child.
- If the behavior affects the child himself/ herself in a negetive way as well as other persons in the immediate environment.
- If the behavior causes undue stress to persons close to the child.
- If the behavior is regarded in terms of acknowledged social norms and values as socially unacceptable.

Prevalence of Behavior Problems in children

Children may suffer many types of behavioral and emotional problems. Many studies have been conducted to estimate the prevalence of behavioral and emotional problems among children. Literature regarding behavior problems among children is limited in developing countries. However, Graham (1986) reported that 10 to 20 per cent of children in developing counties suffer from various problems.

In USA, nearly 21 % of children (1-15 years) have a diagnosable mental or behavioral disorder with at least minimal impairment (Shaffer et al., 1996). In a representative sample of 6 to 12 years old, Lapouse & Monk (2010) found that 31 percent of boys and 21 percent girls were considered by their mothers to have behavior problems.

According to Alan Carr (1993) between 10 and 20 percent of children and adolescent undergo from psychological problems serious enough to demand for psychological treatment.

Epidemiological studies point out that over the course of 1 year some 5-15 per cent of 9-10-year-old children suffer from emotional or behavioral disorders of sufficient to handicap them in their everyday life (Rutter et al., 1970; Graham, 1979).Prevalence is greater where measures of impairment are less demanding and lowers where they are more severe (Rutter et al., 1970).

Bird et al. (1988) used Behavior Checklist 9 (CBCL) to find out the prevalence of maladjustment in children aged 4-16 years in Puerto Rico. They mentioned the rate of maladjustment to be 15.85%. In Mauritius 23.3% children (29% boys and 17% girls) aged 7 to 8 years have behavioral problems (Nolan et al., 2001).

Childhood behavioral problems are very common in the school-going period. In an epidemiological longitudinal study (Esser, Schmidt and Woerner, 1990) in Germany, the researchers have found that prevalence rates for psychiatric disorders in 8 and 13 year olds were in the range of 16-18% and between one quarter and third of these children manifested serious disturbances.

After studying 828 representative sample of children aged between 5 and 14 years, Almeida – Filho (1984) found that 23.3% of the children had varying degree of psychological problems.
Simpson (2005) stated that the children aged 5-15years have identical behavioral disorders and the rate of childhood mental disorders varies from 12% to 29%.

Prevalence of Behavior Problems in children of Bangladesh

By using the Child Behavior Checklist (CBCL) Rahman & Begum (2008) conducted a study on 200 children of sex workers in Bangladesh aged 6 – bellow 12 years. The results showed that 53.5% of children fall in the clinical range of behavior problem scores.

Azad & Begum (2006) conducted a study on 300 primary school children in Dhaka city aged 6 – 10 years by using the Bengali version of the Teacher's Report Form (TRF, Begum 1993) of Child Behavior Check List (CBCL). The results showed that 10.33% of children fall in the clinical range of behavior problem scores.

Parveen & Begum (2001) has conducted a study on child behavior problem in Dhaka city aged 6 – 16 years. She found that in Dhaka city 15% of children living with their families, 45% of institutionalized children and 75% of trafficked children have behavior problems in the clinical range.

By using Child Behavior Checklist (CBCL) and Teacher's Report Form (TRF) in Bangladesh Begum (1993) studied the behavior problems of 627 (341 boys and 286 girls) ten years old children in Dhaka city, Bangladesh. The results revealed that mothers reported 11.8 % of boys and 10.7% of girls and teachers reported 12.8% of boys and 11.2% of girls to have behavioral problems in the clinical range.

Chowdhry and Afrose (1998) have studied on the problems of adolescents in Bangladesh and found that 45 percent adolescent have academic problems, 35 percent have psychological problems, and 31 percent have physical problems and 35 percent have social problems.

Hoque (1999) in a study found that among the male juvenile offenders (age ranged from 10-18 years) at Tongi Correction Centre of Dhaka, 86 percent have disruptive behavior disorder (conduct disorder, attention deficit hyperactivity disorder and oppositional defiant disorder) and 29 percent have emotional disorders (anxiety and depression).

By using the Bengali translated version of 'Strengths and Difficulties Questionnaire' (SDQ, Goodman R., 1998) Goodman et al., in 2000 found that in Dhaka City among referred cases aged 11-16 years, 24 % have conduct disorder, 52 % have emotional disorder, 10% , have hyper kinesis and 20% have other problems.

Sex Differences in Behavioral Problems

Sex of the children has been playing a very essential part in the sign of behavioral problems in them. Boys on the whole tend to be more valuable than girls in the face of a wide range of physiological and psychosocial stresses (Werner and Smith, 1992). Boys' problems were more likely to persist than those of girls (Richman et al., 1982).

A recent study conducted by Zhang, M. (2008) examined gender differences in internalizing and externalizing behavioral problems in a large sample of Chinese children aged 6–15 ($N = 4472$). The Chinese Child Behavior Checklist (CBCL) and Teacher Report Form (TRF) were used to assess these problems. Results showed that boys scored higher than girls on externalizing problems by both parents and teachers, while girls were rated higher than boys on somatic problems by teachers. In another study researchers have found that the prevalence of conduct disorders is 6% for boys and 3% for girls aged 5-10 years (Murray & Farrington, 2010).

Weine et al. (1995) have found that girls scored higher on the somatic complaints syndrome of the CBCL, on the other hand boys scored higher on attention problems, delinquent behavior and aggressive behavior syndromes of the CBCL.

Rutter (1994) reported that boys are more affected by developmental and behavioral problems. For example, hyperkinesis, oppositional defiant disorder and conduct disorder are more common in boys than in girls. On the other hand, depressive disorders are more common in girls, particularly in the post pubertal years.

Begum (1993) conducted a study in Bangladesh on the behavior problems of children. The result showed that boys scored significantly higher than girls on most of the items of the CBCL and the TRF.Begum (1994) reported both mothers and teachers rated boys to have significantly more behavior problems ($p < .001$) than girls.

According to Achenbach and Edelbrock (1981), most of the problems reported frequently for boys were under-controlled , externalizing behaviors, but problems more frequently reported for girls were over controlled, internalizing behavior.

Age Differences in Behavioral Problems

Children's behavior problems vary according to age and developmental stages of the children. Because various kinds of development such as physical, emotional, cognitive, moral occur as the child grows older. For example, temper tantrums turn out to be less recurrent among older children because older children have discovered that temper tantrums are considered babyish.

In a study conducted by Zhang, M. (2008) examined age differences in internalizing and externalizing behavioral problems in a large sample of Chinese children aged 6–15 ($N = 4472$). The Chinese Child Behavior Checklist (CBCL) and Teacher Report Form (TRF) were used to assess these problems. Results showed that older children tended to have higher scores than younger children on anxious and somatic problems as reported by teachers.

In USA, a household survey of 1,285 youths aged 9 to 17 years carried out by Lahey B. et al., (2000). They found that levels of oppositional behavior were greater at younger ages, aggression pointed near the middle of this age range. Except depression, for all disorders, prevalence rates go down gradually as boys develop from 10 to 20 years of age. For example, rates of conduct disorder were 16 percent for pre-adolescent boys, 15.8 percent for boys in mid-adolescence, and 9.5 percent for late-adolescent young men (Cohen et al., 1993).

For girls, compared with childhood there appears to be an increased prevalence of conduct disorder, oppositional defiant disorder and major depression around mid-adolescent. Rates of conduct disorder for girls were 3.8 percent in pre-adolescence, 9.2 percent in mid-adolescence, and 7.1 percent in late adolescence (Cohen et al., 1993).

According to DSM- V (2013) hyperactivity occurs with greatest frequency before age 8 and tends to become less frequent and with briefer episodes thereafter. While there are more boys with behavioral problems in the 4-11-year-old age group, girls predominate amongst 12-16-year-olds

(Offord et al., 1987). There was a general tendency that behavior problems decline with age (Achenbach & Edelbrock, 1981).

Classification of Behavior Problems

Behavior problems in children can be classified into two major domains of dysfunction, namely externalizing behaviors and internalizing behaviors (Achenbach & Edelbrock, 1978). The externalizing behaviors are marked by defiance, impulsivity, hyperactivity, aggression and antisocial features whereas internalizing behaviors are evidenced by withdrawal behavior, dysphoria and anxiety. Generally boys exhibit more externalizing behaviors like aggression and girls exhibit more internalizing behaviors like depression (Campbell, 1995).

Externalizing Problems

Externalizing behavioral problems usually comprised of such behaviors those are manifested in children's outward behavior and reflect the child negatively acting on the external environment (Campbell, Shaw, & Gilliom, 2000; Eisenberg et al., 2001).

According to Achenbach (TRF, Child Behavior Checklist,2001) externalizing behavior includes rule breaking behavior (e.g., breaks rules, lacks guilt, bad friends, lies, steals, swears, truant, uses drugs etc.) and aggressive behaviors (e. g. , argues a lot, defiant, mean , destroy things, explosive, has temper, loud etc.). Several researchers reported that, these externalizing disorders consist of disruptive, hyperactive and aggressive behaviors (Hinshaw, 1987).

Externalizing behavior problems are the most common reasons for which children and adolescents are referred for mental health services (Lochman & Lenhart, 1995). Children with externalizing behavior problems not only may negatively affect their outside world, but also may be psychologically suffer internally. Attention Deficit Hyperactivity disorder, conduct disorder, oppositional defiant disorder are some example of externalizing behavioral problem.

Attention-Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders that may continue through adolescence to adulthood. Generally the disorder is characterized by impulsivity, hyperactivity and inattention. Children with this disorder have difficulty in concentrating, sitting still, acting in socially inappropriate ways and taking and waiting for turns.

ADHD is estimated at 3-5 % in school aged children. This disorder may occur across cultures and varies according to gender and age. Hyperactivity is found to be more common in boys than girls (APA, 2013; Hinshaw, 1987).

According to DSM-V (2013), the essential feature of ADHD is a persistent pattern of inattention and hyperactivity – impulsivity. This is more frequent and severe in children at a comparable level of development. Some hyperactive – impulsive or inattention symptoms that cause impairment must be manifested before the age of 7 years and also manifested in at least two settings such as home and school setting. Along with these the disorder causes severe interference with developmentally appropriate social, academic or occupational functioning.

ADHD is predominantly serious problem because children with the core difficulties of inattention, over activity and impulsivity may develop a wide range of secondary academic and relationship problems. Attention difficulties may lead to poor achievement in school. Impulsivity and aggression may lead to difficulties making and maintaining appropriate peer relationship and developing a supportive peer group. Children with ADHD often become confused in chronic conflict relationships with their parents because inattention, impulsivity and over activity make it difficult for them with these attributes to conform to parental expectations.

Oppositional Defiant Disorder

Oppositional defiant disorder is characterized by consistently negative and deviant behavior. When a child shows unacceptably low level of cooperation with their authority this behavior is assessed to be oppositional. This normally means disobedience of adult command and requests, breaking rules and regulations in school and home set up and resistive temper tantrums (Pardini et al., 2010).

Symptoms include throwing tantrums, arguing, and disobedience, revenge-taking and even violence. For diagnosing this disorder, a child must display the symptoms for at least six months. Rates of ODD from 2% to 16% have been reported on the nature of the population sample. These behaviors are very common in preschool children and in adolescents. ODD is more prevalent in males than in females before puberty (DSM-V, 2013).

According to DSM-V the prime features of ODD is a recurrent pattern of negativistic, defiant and hostile behavior toward authority. These behaviors persist for at least six months. The disorder also characterized by frequent occurrence of at least four of the following behaviors: Such as losing temper, arguing with adults, actively defying or refusing to comply with the request or rules of adults, blaming others for their own mistakes or misbehaviors, easily annoyed by others, being

angry and resentful, being vindictive. These behaviors must occur more frequently in children's comparable age and developmental level. These behaviors also lead to significant impairment in social, academic or occupational functioning.

A child diagnosed with ODD may cause considerable distress for the family. It interferes significantly with academic performance or social functioning. Interference might take the form of preventing the child from learning at school or making friends. It also places him or her in harmful situations.

Conduct Disorder

Conduct disorder is one of the chief psychological disorders diagnosed in childhood or adolescence. It presents a repetitive and persistent pattern of behavior in which the basic rights of others or major age appropriate norms are violated. These behaviors are often referred to as "antisocial behaviors" (Hinshaw & Lee, 2003). Symptoms of this disorder are often seen as the precursor to antisocial personality disorder in adult.

In DSM-V (2013) the crucial features of conduct disorder is a repetitive and persistent pattern of behavior. These behaviors fall into four main groupings, such as aggressive conduct that causes physical harm to other people or animals, nonaggressive conduct that causes property loss or damage, theft and serious violation of rules. Three characteristics must have been present during last 12 months, with at least one behavior present in the last six months. The problem in behaviors cause clinically significant impairment in social, academic, or occupational functioning. The behavior pattern is usually present in a variety of settings like home, school or community. It may be diagnosed in individuals who are older than age 18 years.

A child with conduct disorder behaves in socially unacceptable ways. They have difficulty following the rules.Children with this condition are aggressive all the time in a way that causes problems for them and their family and surroundings. They may run away from home, steal, set fires, destroy property or harm animals, siblings or peers.They often lie or try to cheat other people and frequently skip and truant school.

Children diagnosed with conduct disorder may express their overt aggressive behavior in various forms. Children show physical aggression and cruel behavior towards peers because of aggressive antisocial behavior. The children may express hostile, verbally abusive and defiant behaviours

towards adults. They fail to develop social attachment as they have difficulties in peer relationships. Many children are often socially withdrawn or isolated.

Research shows that conduct disorder predisposes a child to delinquency in adolescence and crime as an adult. Conduct disorder is the most frequently diagnosed childhood disorder in outpatient and inpatient mental health facilities. It is estimated that 6 percent of all children have some form of conduct disorder, which is far more common in boys then in girls (Costello, 1989).

Internalizing Problems

Internalizing behaviors refer to a broad group of behaviors in which children express feelings and emotions inmost. Internalizing behavior is commonly contrasted to externalizing behavior. This is the expression of feelings and emotional responses into behaviors that are directed external into wrong or aggressive behavior.

Children may develop internalizing behavior problems such as withdrawn, anxious, inhibited, and depressed behaviors, problems that more centrally affect the child's internal psychological environment rather than the external world. Other terms for this cluster of behavior problems include "neurotic" and "over controlled" (Campbell et al., 2000; Eisenberg et al., 2001; Hinshaw, 1987). Internalizing behaviors are included but not limited to separation anxiety disorder, obsessive compulsive disorder.

Separation Anxiety Disorder

Separation anxiety disorder is a condition in which a child becomes fearful and nervous when away from home or separated from a loved one, usually parent or other caregiver to whom the child is attached. The fear of separation causes great distress to the child and may interfere with the child's normal activities, such as going to school or playing with other children (APA, 2013). The anxiety that is expressed is considered as being different of the expected developmental level and age (Ehrenreich, Santucci & Weinrer, 2008). The severity of the symptoms ranges from anticipatory uneasiness to full-blown anxiety about separation (Masi, Mucci & Millepiedi, 2001).

DSM-V (2013) declared the common features of separation anxiety disorder are excessive anxiety concerning separation from the home or from those to whom the person is attached. The disturbance must last for a period of at least 4 weeks and begin before age 18 years. It causes clinically significant distress in social, academic or other important areas of functioning.

The prevalence of separation anxiety is 2% to 5% in children and adolescence. The manifestation of the disorder may vary with age. It appears in early childhood but peaks in late childhood. In clinical samples the disorder is apparently equally common in males and females. In epidemiological samples the disorder is more frequent in females (DSM-V, 2013).

Children with this disorder often have difficulty at bedtime and may insist that someone stay with them until they fall asleep. The children believe that they or their parents will be harmed if separation occurs. Their beliefs about threat and danger are accompanied by an affective state. These are characterized by feelings of tension, restlessness and uneasiness. Children may outburst in anger if forced to approach the feared stimuli. For example children may have aggressive tantrums if forced to remain at school while their mothers leave. Avoidance is very common in separation anxiety disorder. The avoidance behavior may lead the children to become house-bound. The children may isolate and their peer relationships and school attendance may come to an end. Some children also develop physical symptoms, such as headaches or stomach-aches, at the thought of being separated.

Post Traumatic Stress Disorder (PTSD)

Post traumatic stress disorder (PTSD) is a severe condition of psychological disorders. It may develop when an individual is exposed to one or more traumatic events, such as sexual assault, serious injury or the threat of death. The general diagnostic criteria is a group of symptoms such as disturbing recurring flashbacks, avoidance or numbing of memories of the event, and high levels of anxiety continue for more than a month after the traumatic event (APA, 2013).

In children PTSD occurs as a result of a child's exposure to one or more traumatic events that were life-threatening. Or the child perceived the event to be likely to cause serious injury to self or others. The child must have responded with intense fear, helplessness, or horror. Traumatic events can take many forms, including physical or sexual assaults, natural disasters, traumatic death of a loved one, or emotional abuse or neglect.

According to DSM-V (2013) the main features of PTSD is the development of following symptoms: exposure to an extreme traumatic stressors involving direct personal experience of an event that involves actual or threatened death or serious injury; or unexpected or violent death, serious harm or threat of death or injury experienced by a family member or other close associate. When the children response to the event that involve disorganized or agitated behavior. Persistent avoidance of stimuli is associated with the trauma. Symptoms of PTSD must be manifested and

persist for more than 1 month. Along with these, this condition must causes clinically considerable destruction in social, occupational or other important areas of functioning.
Community based studies revealed life time prevalence for PTSD ranging from 1% to 14%. Women are more likely to experience more high impact trauma, they are more likely to develop PTSD than men (APA, 2013).

In PTSD children have recurrent, intrusive memories of the trauma that lead to intense anxiety. The children try to avoid this by suppressing the memories and avoiding the situations. Avoidance behavior may lead children become house bound. Children may develop an affective state characterized by feelings of tension, restlessness and uneasiness. A moderate level of chronic hyperarousal interrupted when memories of the traumatic event interfere in consciousness. Children may also use alcohol and drugs to reduce negetive affect and suppress traumatic memories. Peer relationship also hampered.

Obsessive-Compulsive Disorder (OCD)

By nature Obsessive – compulsive disorder (OCD) is an anxiety disorder as classified for adult problems. It is characterized by intrusive thoughts that produce uneasiness, apprehension, fear or worry. Also by repetitive behaviors aimed at reducing the associated anxiety or by a combination of such obsessions and compulsions. OCD is rare in childhood. Several related forms of repetitive behavior are common. These repetitive behaviors include preoccupation with numbers and counting, repeated handling of certain objects and hoarding. The preoccupations and rituals of OCD are so severe and extreme that it destroys significant amount of child’s time. Obsessive-Compulsive Disorder may begin in childhood, although it usually begins in adolescence or early adulthood (Flament et al., 1990).

According to ICD-10 (2010), OCD rarely appears in full form before late childhood, though first manifestation of symptoms may appear earlier. The onset may rapid or gradual. OCD in childhood generally be similar to those in adult life. The presenting symptoms are more often rituals than Obsessional thoughts. Washing rituals are the most frequent trailed by repetitive actions and checking. Obsessional thoughts are most often concerned with contamination, accidents or illness affecting the children or another person. The content of symptoms often changes as child grows older. The symptoms may be provoked by external cues such as unclean objects. Children often involve their parents by asking them to give repeated reassurance about the Obsessional thoughts.
In OCD, the obsessions or compulsions cause significant anxiety or distress. They interfere with the child's normal routine, academic functioning, social activities, or relationships (APA, 2013).

The prevalence of OCD in childhood is between 1% and 4%. Intense anxiety develops tension, restlessness and uneasiness in children. Children's interpersonal relationship also may affected by anxiety in different ways.

Mood Disorders

Mood disorders refer to a category of mental health problems that include all types of depression and bipolar disorder. Mood disorders are also known as affective disorders. Children can suffer from mood disorders such as major depression and bipolar disorder.

Children's mood is especially vulnerable to the influences of several social stressors, such as chronic family discord, abuse and neglect and academic failure. Depression is often marked by a lack of interest in activities, sadness and exhibition of poor self-esteem. Bipolar disorder is characterized by periods of depression cycle with periods of mania, can also become apparent by childhood.

Mood disorders increases with increasing age. Mood disorders in preschool age children are rare. About 2.5% of children in the U.S. suffer from depression. Depression is significantly more common in boys under the age of 10. But by age 16, girls have a greater incidence of depression (APA, 2013). The rate of Bipolar Disorder is exceedingly low in children and may take years to be diagnosed.

Although the diagnostic criteria in the fifth edition of DSM-V (2013) for mood disorders are almost identical across all age group, the expression of disturbed mood varies in children according to their age. The common symptoms that are generally seen in young depressed children are mood congruent auditory hallucination, somatic complaints, withdrawn and sad appearance. Symptoms that appear with the same frequency at all the age and developmental status include suicidal ideation, depressed or irritable mood, insomnia and diminished ability to concentrate.

Mood disorders tend to be chronic if they begin early. Children diagnosed with mood disorders suffer from feelings of restlessness, aggression, withdrawal from social activities. School difficulties are very common. Family and peer relationship also hampered due to the difficulties.

Assessment of Behaviour problem

Assessment involves an evaluation of an individual's strength and weaknesses, a conceptualization of the problem and some preparation for alleviating the problem. It is a precondition for planning,

implementing and evaluating effective and efficient service (Achenbach et al., 1987) comprehensive assessment of childhood behavior problems requires measures of behavioral, cognitive and psychological responding, as well as a determination of the social and cultural context in which the problems occur (Barrios, Hartmann and Shigetomi, 1988).

METHODS OF ASSESSMENT

There are different methods of assessment including interviews, psychological testing, self-report questionnaires, behavioral measures, and physiological measures. A careful assessment provides a wealth of information about individual's problem behavior. The data from the various methods complement each other and provide a more absolute picture of the individual (Meyer et al., 2001).

Interview

Interview is the most widely used means of assessment. It is typically a major component of the initial session. An initial interview focuses on gathering information. Clinician generally gathers demographic information and information about various aspects of current problems (Goldfried & Davison, 1994).

- A structured interview is usually used to acquire a broader outlook of the child and family. A semi structured interview is the main medium for the preliminary assessment. Such interview provides two kinds of information:
- They allow an opportunity for direct observation of rather inadequate sample of behavior manifested during the interview circumstances itself.
- The interviewer seeks to secure directly as much information of exact or individual nature from the client as is related to the purpose of the interview (Herbert M., 1998).

Interview with the Child

The interview is the prime diagnostic tool in child and adolescent psychiatry. The clinical interview covers different purposes.

Firstly: the interview serves as initial contact between child and clinician to establish a therapeutic relationship.

Secondly: collected information will help the clinician to make diagnosis and formulating treatment plans.

Thirdly: the interview creates the opportunity to view behavior that could be related diagnostic information.

An interview with the child provides opportunities to explore sensitive material to assess children's coping strategies and the child's view of the problem (Edelbrock & Costello, 1988; Angold, 1989). Research on interviews has also provided some important information about diagnostic child interviewing:

First: usually children are better informants than their parents about their problem (Angold, et al., 1995).

Second: the most noticeable problems may not be the child problems, there be determined attention on co-morbidity (Angold et al., 1995).

Over the years many structured diagnostic interviews were developed for children and adolescence. Only a few gained broader acceptance and are well known and currently used. Among these are the following:

- Child and Adolescent Psychiatric Assessment (CAPA; Angold et al.,1995);
- Child Assessment Schedule (CAS ; Hodge et al., 1981);
- Diagnostic Interview for Children and Adolescents (DICA; Herjanic & Campbell,1977);
- Diagnostic Interview Schedule for Children (DISC; Costello et al., 1984);
- Interview Schedule for Children (ISC ; Kovacas,1983);
- Schedule for Affective Disorders and Schizophrenia for school aged children (K- SADS ; Puig – Anitch & Chambers, 1978).

Interview with Parents:

Interview with parents is another important and relevant research tools for collecting data about child behavior problems. Interview with parents is crucial while conducting research about child health and mental health for several reasons:

Firstly: parents have the first hand experience and effort to handle behavior problem among children.

Secondly: interviewing children can be difficult sometimes, as they cannot always communicate their feelings and thoughts accurately.

Thirdly: parental consent is required to collect data from child.

Fourthly: it is always necessary to collect information from other people in addition to the child to gather actual information about child from all possible aspects.

There are some specific tools to conduct interview with parents and significant others. Some interviews are available in both child and parent version (Alldred, & Gillies, 2002).

Observation

Observation refers to unremarkable watching of behavioral patterns of peoples. It is the most basic method of all research methods is observation (Becker & Geer, 1957). An observational method refers to any procedure or techniques that are used in research to assist in making accurate observations of event. It may use as a major instruments to assess behavior problem. To assess and understand behavior researchers first have to know that what they are dealing with. Behavioral assessment employs observation as a primary research technique (Brown & Canter 1985).

There are some advantages to use observation as a research tool:

Firstly, it helps to collect information about frequency and pervasiveness of the problem behavior.

Secondly, it can explore the maintaining factors for certain behavior.

A variety of observational methods are available. For example, there are naturalistic, analogue, participant and self observational techniques for use with children. Researchers can use a specific type of observation method according to their research objectives.

Standardized Interviews, Questionnaires, Check-lists and Rating Scales

As an assessment method many interviews, questionnaires, check-lists and rating scales have been developed for use in research settings and in clinic. Because these are highly reliable and valid compared to clinical interviews (Azad & Begum, 2006). These tools can be administered parents, teachers and others who are in frequent contact with the child, because these people can respond in terms of their observations and inferences about their child's problem behaviors.

A number of structured interviews for children and adolescences have been developed which are the most directive of all clinical interviews, because the interview set-up, topics, and sequence predetermined. They are concerned with quantification and dimension and consequently with evaluation with respect to either a criterion or norm. Some cover up a comparatively broad range of disorders, others are standardized interview formats for a single disorder or group related disorder. The mainly used structured interviews are DICA and DISC.

Some structured interviews differ from this set-up and identified as "semi structured" interviews. The semi structured interviews make use of a present series of subjects, as well as many fully structured segments. The mainly used semi structured interviews are Kiddie – SADS, the CAS, ISC and the CAPA which have both child and parent versions.

Questionnaires are typically used to screen normal populations for the presence or absence of any psychological problems. Lots of questionnaires are developed to assess child behavior problems. Conner's Teacher and Parent Questionnaire are satisfactory for screening for hyperactivity (Conner, 1973). The Richman Behavior Screening Questionnaire is another widely used tool for assessment (Edelbrock & Costello, 1988).

Checklist is the simplest of all the devices. The use of a checklist ensures a more complete consideration of all aspects of the object, act or task. It requires the respondent to indicate whether a behavior, a problem, a feeling or some other types of response occurs. It may be used as an independent tool or as a part of a questionnaire. If emotional disorders are a real focus of interest, the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) which is much longer, may be more satisfactory.

Rating scale is a recording form used for measuring individual's attitudes, aspirations and other psychological and behavioral aspects. Behavior rating scales provide global vision of the child's behavior as perceived by significant others in the child's environment, usually parents or teachers. This is naturally be used with very little instruction. They can be finished quickly, and their following scoring and explanation are rarely time consuming (Atkenson & Forehand, 1981; Haynes, 1978).

Psychological Test

Psychological Tests are formal and structured tool for assessment. Their use has a special place in clinical practice with children and young people. It helps the clinician to gather objective information for the purpose of making decisions and sorting out questions about the particular child,

adolescent, or adult. A comprehensive test can identify requirements in therapy and emphasize issues that may come up in treatment. It also recommends particular forms of intervention and offer guidance about potential outcomes of treatment (Mellenbergh, 2008).

Psychological tests were formed for three main reasons, all of which are interconnected:

- It's easier to get information from tests than by clinical interview.
- The information from tests is more scientifically consistent than the information from a clinical interview.
- It's harder to get away with lying on a test than in a clinical interview.

Psychological tests can include assessments of personality styles tests of emotional well-being, intellectual (or IQ) tests, tests of academic achievement, tests for possible neurological damage, and tests for specific psychological disturbances and their severity .

Risk Factors for Behavior Problems

Several factors have been linked to the development of behavior problem. The interaction between environmental and social condition and the characteristics of the child can combine to cause significant problems.

Behavior problems stem from a variety of risk factors. There is a great deal of assumption about which factors cause problem behavior in children (Gerdes, 1998; Carson & Butcher, 1992). Behavior is affected by temperament, which is made up of an individual's innate and unique expectations, emotions and beliefs.

Behavior can also be influenced by a range of social and environmental factors including parenting practices, gender, and exposure to new situations, general life events and relationships with friends and Siblings. Risk factors are those which increase the possibility of a child developing an emotional disorder in comparison with a randomly selected child from the common population (Garmezy, 1983).

The risk factors associated with behavior problems can be divided into three groups:

- Child factors which include biological and genetic attributes of the child.
- Family factors which effect both child and family members.
- Community factors that impose on the child and family environment.

Risk factors in the Child

There are some vulnerability factors that make some children more prone to develop behavior problems than other children. Genetic vulnerabilities, the consequences of prenatal and perinatal complications, and the result of early insults, injuries and illness may predispose the child to developing problems in later life (Rutter & Garmezy 1983).

A number of psychological characteristics like low intelligence, difficult temperament, low self esteem and an external locus of control are also important factors in this category (Walker et al., 2011).

Genetic Vulnerabilities

Genetic vulnerability refers to the idea that a person may have a biological predisposition to develop a disorder or condition when certain environmental factors present themselves. The gene or set of genes responsible may remain hidden for a person's entire life if the other factors are never experienced, or the genes may be expressed from a very early age.

Genetic vulnerabilities may predispose children to develop problems in later life. Many studies show that the development of many psychological characteristics such as temperament and intelligences is influenced by genetic factors (Rutter, 1991). Research findings suggest that heredity is an important predisposing causal factor for a number of different disorders such as depression, schizophrenia and alcoholism (Plomin et al., 2001). Genetic factors play a role in developing depression in later life (Kendler, 2001. Research suggests that parents who have ADHD, half of their children are likely to have the disorder (Biederman et al., 1995).

Some psychological disorders such as Conduct Disorder, Obsessive Compulsive Disorder (OCD) and Attention Deficit Hyperactivity Disorder (ADHD) are more frequent among the first degree relatives of children. Unknown genetic factors have been suspected to have a role in development in expressive language disorder, because the relatives of children with learning disorders have a relatively high incidence of expressive language disorder.

Prenatal and Perinatal Complications

Childbirth is an inherently dangerous and risky activity subject to many difficulties. Before and during birth a child may go through many complications. There is a significant association between children who experience prenatal or perinatal distress and the development of psychological disorders. Externalizing behaviors in children are predisposing by prenatal and perinatal factors. It

is suggested that birth complications can cause brain damage and brain damage can predispose to antisocial and violent behavior.

The intrauterine may involve hazards which facilitate the unhealthy development of the foetus (Rutter, 1991). Maternal age, blood-type, incompatibility, malnutrition, smoking, alcohol use and drug use are among the factors that may negatively impact on the intrauterine environment (Steinhausen et al., 2002).

A number of prenatal and perinatal complications have been reported as possible risk factors for autism. These risk factors include maternal and paternal age over 30, bleeding after first trimester, and use of prescription medication during pregnancy and meconium in the amniotic fluid. Maternal high blood pressure and gestational diabetes also related to prematurity, delayed motor milestones.

Perinatal brain insults associated with anoxia or cortical tissue damage can lead to later cognitive impairment. A variety of birth complications are associated with such neurological damage including forceps delivery, breech delivery, a difficult passage through the birth canal and accidental twisting of the umbilical cord (Carr,1999). Neurological damage sustained during the perinatal period by premature infants is most commonly associated in later life with attention problems and hyperactivity (Hinsaw, 2002).

Physical insults, injuries and diseases

Physical insults and injuries can cause psychological and behavioral problem to the children. Among children the principle cause of death are these conditions. Development of cognitive impairment, disinhibition and behavioral problems are associated with head injuries later in childhood. The nature and extent of these sequelae depend upon both the severity and location of the injury. Also depend on the social context within which the injury and recovery occur (Goodman, 1994a; Snow & Hooper, 1994).

The overall psychological consequences for a child who sustains a head injury as a result of abuse which leads to a multi placement experience will be quite different from that of a child who sustains a similar injury through a road traffic accident and who recovers within a stable family context. Secondary reading disorder may be seen in children with postnatal brain lesions in the left occipital lobe resulting in right visual field blindness.
Chronic disease such as asthma or diabetes and life threatening illness such as cancer or cystic fibrosis all may cause psychological problem to the child and family (Lask & Fosson, 1989).

Temperament

Generally temperament means emotional response to something. A temperament describes a person's personality. Rothbart and Bates (1998) defined temperament as “inherent, constitutionally based individual differences in emotional, motor, and attentional reactivity and self regulation". Temperament refers to an individual’s behavior style and characteristics way of responding (Kagan et al., 2007).

Chess & Thomas (1995) classified infants into three subgroups like easy, difficult and slow to warm up temperament children. Temperament patterns act as causative factors in the occurrence of behavior and psychological difficulties (Chess & Thomas, 1994).

Children who were characterised by difficult temperament had more conflict with parents, peers and teachers. For that negetive reaction in early life they tended to choose a peer group later in life that engaged in deviant, risky activities. They also developed more conduct and adjustment problems. Researchers have found that boys who have a difficult temperament in childhood are not willing to continue their formal education as adults. Girls with a difficult temperament in childhood are more likely to experience marital conflict as adults (Wachs & Gandour, 2000).

Kagan (2007) has classified children into with inhibited and uninhibited temperaments. About one in six children may be classified as having inhibited temperaments. Such children are shy, timid and withdrawn in new situation. A higher proportion of children with an inhibited temperamental style have probability to suffer from anxiety and mood disorders in childhood (Goodyer, 1997). Early extremes of temperament can predispose a child to conduct disorder.

Intelligences, Self-esteem and Locus of control

The risk factors that negatively impact on children’s mental health can be Intelligences, self-esteem and locus of control. All these personal characteristics also predispose children to develop psychological difficulties (Rolf et al., 1990). Low intelligence as measured by IQ test is a risk factor for conduct disorder. Low self esteem and locus of control places children at risk for both conduct and emotional disorders (Rutter, 1985). Little control over important sources of reinforcement and significant aspects of one’s situation are also associated with conduct and emotional problems.
A study done by Ferdinamd et al. (1995) shows that those children who have a high external locus of control tend to have higher levels of psychological and physical problems. These children are also more vulnerable to external influences and as a result they become more responsive to stress.

Risk factors in the Family Environment

A variety of familial factors also make children vulnerable to developing psychological difficulties. These factors also play a significant role in perpetuating such problems (Plomin & Rutter, 1998). General psychosocial theories of developmental psychopathology assert that family environment plays a significant role in forming both adaptive and maladaptive functioning of children. The specific feature of the parent-child relationship, exposure to various ongoing family problems, and specific stresses are the influential factors to make child vulnerable (Carr, 1999).

Several studies have shown that insecure attachment and parenting characterized by coldness, rejection, harsh discipline and unsupportive behaviour is positively related to children depressive symptoms (Bowlby, 1978). Children will suffer from ADHD if adverse factors such as severe marital discord, low social class, large family size, paternal criminality and maternal mental disorder are present in family environment.

Parent-Child Factors in Early Life

Parent-child relationships strengthen the emotional health and wellbeing of children. The quality of parent-child attachment and the way of parenting style have highly significant effects on children's later psychological adjustment. Research findings show that bonding, attachment, intellectual stimulation and parenting style influence the children problem behaviors (Bowlby, 1951).

According to bonding theory failure to bond puts children at risk for neglect, failure to thrive and physical child abuse. Children develop psychological difficulties if they have anxiously attached or anxiously avoidant attachment with care giver (Grossman et al., 1988; Fonagy et al., 1991). Lack of children's age appropriate intellectual stimulation at home environment can impair the child intellectual development (Carr, 1993).

Parenting style and use of harsh discipline have related with behavior problems (*Pettit* et al., 1988). If parents are less affectionate to their child behavior problems may arise. Children who have either been harshly disciplined or had little or inconsistent supervision develop adjustment problem. Children are at risk for developing conduct problems and becoming involved in bulling who have been physically punished (Olweus, 1993). By coercive interchanges, lacks of monitoring and consistent discipline children are trained by the family directly in antisocial behavior (Capaldi, 1993).

Parental Problem

Children are at risk for developing psychological difficulties if their parents have significant personal adjustment problem. Those children are also vulnerable who grow up in families characterized by disorganization, marital discord and in which there are deviant siblings.

Study shows that a child can be vulnerable or may develop psychological disorder by parental problems such as depression, alcohol abuse or criminality (Carr, 1999). Research suggests that such family background experiences influence the type of distress (Nilzon & Palmerus, 1997). Because such problems decrease parent's ability to give their child secure attachment relationship. The physical health of the parents also affects the whole family functioning in a variety of ways such as economic, social etc.

Children of parents with mental illness will develop emotional, behavioral or social problems. Parental psychopathology, child abuse and negligence often contribute to conduct disorder. Rutter and Quinton (1984) found that parental psychiatric illness have greatest effect on the behaviors of younger boys. Depression is recognized as very disruptive to the normal bonding processes of parents with their infants, whose development can be affected in a variety of ways (Orvaschel, 1993).

Parental alcohol abuse is one that has attracted considerable theoretical and empirical attention. One study found that children of depressed parents may be at particular risk for the secondary deficits of depression. Such deficits may include physical dysfunction, pain and disability; anxiety, smoking, drinking-related problems and poorer social resources (Timko et al., 2009).Those children who were raised in homes where a parent abused alcohol are believed to be at risk for developing psychopathology in childhood, adolescence, and perhaps into adulthood (Black & Wilder, 1996).

Marital Discord

There is a significant relationship between marital conflict and child mental health. Exposure to marital discord and violence may predispose children to developing psychological difficulties in a number of ways. Marital conflict appears to have considerable effect on children's behavioral problems (Cummings & Davies, 1994; Dadds & Powell, 1991).

Family discord such as the conflict or disharmony accompanying divorce can be instrumental in the development of conduct disorders (Chess & Thomas, 1984). Recent studies have shown that children with recent experience of parental divorce or separation are at a relatively high risk of

behavioral and emotional problems as reported by parents (Holden, & Ritchie, 1991). Domestic violence is an extreme form of conflict in which parents behave violently toward one another (Jenkins, & Smith, 1991). A child who is exposed to domestic abuse during their upbringing will suffer in their developmental and psychological welfare.

The effects of witnessing parental violence have been clearly shown to predispose boys to use violence as a means of conflict resolution (Jaffe et al., 1990). Some emotional and behavior problems that can result due to domestic violence include aggressiveness, anxiety and peer relationship. Depression, emotional insecurity, and mental health disorders can follow due to traumatic experience. Problems with attitude and cognition in school can start developing. Children who witness mother assault are more likely to exhibit symptoms of post-traumatic stress disorder (Dodd, 2009).

Children of divorced parents have more health problems and poorer psychological wellbeing. Those children also exhibit more conduct, social and academic problems. They are also at higher risk for dropping out of school and have higher rates of alcohol and drug abuse (Amato et al., 2006).

Family Disorganization

Family is an old universal institution. The family has faction of reproduction, socialization, affection, security and protection, economic, social that statuses and roles etc. Children are a product of their environments. Children's physical and emotional status as well as their cognitive and social development greatly depends on their family dynamics.

A chaotic family environment may predispose children to emotional problems. A recent study shows that Children who are not living in structure and routine more likely struggle with behavior problem. Children from high chaotic families exhibit more aggression and depressive symptoms reported by their parents and teachers (Shamama-tus-Sabah et al., 2013).

According to Kazdin (1995) inconsistent rules, unclear roles and the absence of regular routines may predispose children to developing psychological problems specifically conduct disorder. As these family environments are highly stressful so they fail to give children secure attachments. Then the authoritative parenting they require for their needs to be met (Carr, 1999). In a study Ross and Hill (2001) shows that the chaotic environment in the home may be the precursors for a child to alcohol abuse in adulthood.

Community Factors

Some community factors can contribute to an increased risk of children maladjustment. Poverty, lack of social support, environmental stress and deviant peer group, these factors can make children vulnerable. Children's conduct and school based psychological difficulties may be maintained by variety of community factors (Garmezy & Masten, 1994; Goodyer, 1990).

Poverty

Poverty is a major determinant for children mental health. Poverty status has statistically significantly effects on child's behavior. In USA a recent study has shown that poverty links with lower levels of child well-being. Poverty is also responsible for children's low birth weight and child mortality. Poor children suffer from emotional and behavioral problems more frequently than do non poor children (Duncan & Gunn, 1997).

For a variety of reasons, when compared with children from more well-off families, poor children are more likely to have low academic achievement, to drop out of school, and to have health, behavioral, and emotional problems (Moore et al.,2009). A recent study shows that children from the poorest families exhibited poorest development. They had poor obstetric status and more difficult temperament

Lack of Social Support

Social support has been shown to protect children many community related adverse situation such as exposure to negetive peer group and internal family strain. There is significant relationship between Social support and positive psychological outcomes.

According to Carr (1999) social support increases personal scenes of well being and offer a forum for receiving guidance on managing problems. Parents and children are usually involved in problem – maintaining interaction patterns if they belongs socially isolated families that have poorly developed social support networks, with little positive contact with the extended family and few friends (Garmezy and Masten, 1994).

Lack of social support emerged as one of the most powerful predictors of persistent suicidal thoughts. As the parents and children have fewer personal resources for coping with problems in the absence of social support so they are more likely to float into problem maintaining interaction pattern (Herbers, 2012).

Environmental Stress

Environment plays an important role in shaping development from the newborn period through adolescence. Many environmental risk factors may predispose children for emotional problems. Researcher revel a significant relationship between environmental stress and autism in children. These are the characteristics in a person's surroundings that the children are more likely to predispose to addict drugs.

Living in a overcrowding and in subsidized housing also has been found to be the risk factor for conduct problems (Rutter & Quinton, 1977; Hawkins et al., 1992).

Deviant Peer Group Membership

The members of peer group are likely to influence children's beliefs and behavior. They can be both good and bad. Peer relationship, group interaction and influences are a part of positive development. Children learn to evaluate themselves through the eyes of their peers.

Deviant peer groups form from socially rejected children or those whose family life is lacking in attention and love. Children's poor academic achievement is associated with maintaining deviant peer relation. Negative peer groups are more prone to go across ages, especially younger age peers, to find companions sympathetic to their antisocial attitudes. Children with conduct or substance abuse problems are members of a delinquent or drug abusing peer group. Interaction with these peers may maintain the children's problem behaviors through modelling and reinforcement (Kazdin, 1996; Hawkins et al., 1992).

Strong evidence exists to suggest that children who socialize and form friendship with deviant peers are at increased risk of developing a wide range of psychosocial adjustment problem including conduct problem, substance abuse and school failure (Robins, 1991).

Child Abuse

Child abuse is an international phenomenon. This condition affects children, family as well as society. Child abuse consists of any acts done by a parent or other caregiver that result in harm, potential for harm, or the threat of harm to a child and even if the harm is done by unintentionally (Gilbert et al., 2009). The five main types of child abuse and neglects are: physical abuse, sexual abuse, emotional maltreatment, neglect, and witnessing domestic violence.

Children and young people are affected by abuse in various ways. There are strong associations between exposure to child abuse in all its forms and higher rates of many chronic conditions. Children who have a history of neglect or physical abuse are at risk of developing psychiatric problems. Disorganized attachment is associated with a number of developmental problems, including anxiety and depression in later life (Lyons-Ruth, K. 1996).

The psychological consequences of child abuse and neglect include the immediate effects of isolation, fear, and an inability to trust. When children cannot trust that someone will be there to meet their needs, they tend to develop low self-esteem, anxiety, depression, and hopelessness. These difficulties can lead to life-long relationship problems and may also lead to the development of anti-social behavioral traits. These children are also more likely to engage in violent behaviors and to be diagnosed with conduct and personality disorders.

A study shows that young adults who had been abused met the diagnostic criteria for at least one psychiatric disorder at age 21. These young adults exhibited many problems, including depression, anxiety, eating disorders, and suicide attempts (Silverman et al. 1996).

In addition to physical and developmental problems, the stress of chronic abuse may result in anxiety and may make victims more vulnerable to problems such as post-traumatic stress disorder, conduct disorder, and learning, attention, and memory difficulties (Dallam 2001; Perry 2001).

Madrasa

Traditionally, madrasa is Islamic learning institutions. The word 'Madrasa' means 'centre of learning' in Arabic. The first institute of Madrasa education was at the estate of Hazrat Zaid bin Arkam near a hill called 'Safa' where Prophet Muhammad was the teacher and the students were some of his followers. Millions of students in the Muslim world receive their education in a Madrasa.

Typically a Madrasa provides young Muslims with a religious foundation in Quran recitation and Islamic values. For some Muslim children, the Madrasa is the only source of formal education. Madrasa is popular educational institutions situated all over Bangladesh. They provide an avenue of educating children in rural and urban areas. From primary to graduate levels there are about 37,000 Madrasa in the country, with a total of 3,340,800 students and 2, 30,732 teachers (Mehdy, 2003).

Definition of Madrasa

According to Encyclopaedia of Islam the Arabic word ‘Madrasa’ generally has two meanings:

(1) In its more common usage, it simply means ‘school’;
(2) In its secondary meaning, ‘a Madrasa is an educational institution offering instruction in Islamic subjects including, but not limited to, the Quran, the sayings (hadith) of the Prophet Muhammad, jurisprudence (fiqh), and law’.

Manaros B. Boransing (2008) reported that ‘Madrasah generally refers to Muslim private schools with core emphasis on Islamic studies and Arabic literacy. It is a privately-operated school which relies on the support of the local community or foreign donors, particularly from Islamic or Muslim countries’.

Types of Madrasa

There are primarily two types of Madrasas in operation in Bangladesh.

- The Aaliyah Nissab Madrasa
- The Qawmi Nissab Madrasa

The Aaliyah Nissab Madrasa (commonly known as Sunni Madrasa) is operated with state support under state control. On the other hand The Qawmi Nissab Madrasa (commonly known as Wahabi Madrasa) is operated beyond state control or support with voluntary labour and both foreign and local funding. The Aaliyah Nissab Madrasa functions under the Bangladesh Madrasa Education Board, an independent body funded by the government.

The Bangladesh Madrasa Education Board was established in 1978. This board is charged with establishing Madrasa, assigning teachers, and formulating the curriculum. This system mandates teaching modern subjects like English, Bangla, Science, Social Studies, Mathematics, Geography, History, and a modified version of the Dars-i-Nizami system.

In addition to these, Maktab or Forqania Madrasa exists to teach the Qaeda (the Arabic alphabet), Aampara, and the Quran and the Hifzul Quran Madrasa which train Quran Hafizes (students who completely memorize the Quran). There are also some government and non-government project based short-term teaching centres.

The Aaliyah Nissab Madrasa system has five levels of education. Beginning with the primary level it takes a total of 16 years to complete. The different levels of education are the:

- Ebtedayee (primary level: 5 years),
- Dakhil (secondary level: 5 years),
- Alim (higher secondary level: 2 years),
- Fazil (graduate level: Pass Course 2 years, Honors Course 3 years), and
- Kamil or Title (Post graduate level: 2 years for the Fazil Pass Course completers and 1 year for the Fazil Honors Course completers)

Ebtedayee Madrasa

After liberation war the primary level Maktab operated as feeders to the New-Scheme Madrasa. Later, following the recommendations of an Education Commission, the Maktab was transformed into Ebtedayee Madrasa. This is equivalent to primary level of general education. The first level of Madrasa education is comprised of 5 years of schooling (grades I - V). Normally, the children of 6 years of age begin in class 1 and finishes class V at the age of 11 years.

Now a day’s Ebtedayee Madrasa has mushroomed all over the country. This government approved Madrasa are operated through donations from the local community, government grants, and sometimes grants from the local government. Reliable information regarding the number of Ebtedayee Madrasa is unavailable.

In addition to all Madrasa having an Ebtedayee section (primary section), there are a number of separate Ebtedayee Madrasa. According to Mehdy (2003), there are 1,363,572 students in the Ebtedayee sections closest to the Dakhil, Alim, Fazil and Kamil Madrasa.

Dakhil and Alim Madrasa

The Dakhil and Alim levels are equivalent to secondary and higher secondary school respectively. Dakhil is for 5 years and Alim for 2 years duration. Currently there are four sections in the Dakhil level: Dakhil General Section, Dakhil Science Section, Dakhil Mujabbid Section and Dakhil Hifzul Quran Section. Under the New Scheme policy, both the Dakhil and Alim levels place emphasis on science.

In Bangladesh, currently there are 4,865 Dakhil and 1,090 Alim Madrasa that are government approved (Mehdy, 2003).

Fazil and Kamil Madrasah

Fazil and Kamil are the last two levels of the government approved Madrasa system. The Fazil level includes both Honors and Pass Courses. The duration of Honors Course is 3 years and Pass Course duration is 2 years. The Kamil level is 2 years for the Fazil Pass Course completers and 1 year for the Fazil Honors Course completers.

There are 1,000 Fazil Madrasa and 141 Kamil Madrasa (among which there are 3 completely state owned Kamil Madrasa) in Bangladesh ((Mehdy, 2003).

Difference between Madrasa and Mainstream Education in Bangladesh

Education influences the values of society, and the kind of society people want to be. The quality of education that is generated from a particular kind of education system depends much on the syllabus, curriculum, the teachers and the teaching methods. The experience of the individuals who develop the curriculum , how well they understand the psychology of students of a certain age , how sincere and committed they are towards the history and tradition of the nation, how well they comprehended the realities of modern life are issues that need to be taken in to consideration. It is unfortunate that the expertise of those who are responsible for developing the curriculum for the Bangladesh Madrasa Education Board is not beyond doubt. In spite of constant revision of the curriculum, its current state does not ensure mental or intellectual development of the students (BANBEIS, 1999).

The aim of the mainstream education is facilitate all young people to become successful learners who enjoy learning. Make confident individuals who are able to live safe and also become a responsible citizen who make a positive contribution to society.
In mainstream education students can choose to receive their education in English or Bangla. Private schools tend to make use of English-based study media while government-sponsored schools use Bangla.

On the other hand the Madrasa Education System focuses on religious education, teaching all the basics of education in a religious environment. In this system the main aim of life is believed to be comprehension of the divine by the individual. The only objective of education becomes to provide an understanding of divine. As the practice of religion is the primary objective of Madrasa education, this concept takes priority.

Under the general education system, government grant allocation is implemented under separate management. For instance, the Directorate of Primary Education is responsible for primary allocation, the Directorate of Secondary and Higher Education is responsible for allocation junior high schools, college and local offices. The National University is responsible for allocation to universities. On the other hand, under the Madrasa Education System a single board is responsible for all allocations for Ebtedayee, Dakhil, Alim, Fazil and Kamil all five levels of education (Mehdy, 2003). But the government of Bangladesh grant the “Islamic Arabic University” in August 19th, 2013. The university will be set up to prepare the curriculum, conduct exams and confer degrees of Fazil and Kamil level madrasa students and teachers. Islamic University in Kushtia has been performing these duties (The daily Star, 2013).

Children Behavior Problem and Family Functioning

Research indicates that the development of a child’s behavior is strongly influenced by how well his or her family functions. Because children are dependent upon adults to meet their needs and their concept of the importance of family develops. Elkin and Handel (1978) defined “the family as the first unit with which children have a continuous contact and the first context in which socialization patterns develop”.

Stevenson – Hinde (1990) explained that the development of children is significantly influenced by interpersonal relationships within the family. Affection and protection are evidently crucial for the health of a child. Thus children need to receive love and protection for their healthy emotional development.

According to Petzold (1998), the concept of family functioning is very important in studying children’s behavior, as the family is responsible for supporting, protecting and guiding the children. Family functioning can be described from several viewpoints, for example focusing on parenting styles (Cusinato, 1998), intergenerational relationships, family composition and structure (Petzold, 1998), and familial interaction patterns (Marvin & Stewart, 1990).

It is assumed that family functioning is somehow related to child development and to child behavior problems. The parent-child relationship, family structure, and parent-child communication respectively, as aspects of family life that may contribute to the origin and maintenance of child behavior problems.

The literature on parenting approach generally focuses on two dimensions, that is, support and control. Studies on parental behavior indicate that parental support and demanding control are related to positive developmental outcomes in children, while coercive control is related to children's social incompetence and behavior problems (Shucksmith et al., 1995). It appears that harsh disciplinary practices (and severe punishment) as well as negligent, inconsistent, inconsistent discipline are associated with children's externalizing behavior problems (Coie & Dodge, 1998; Kazdin, 1995).

The intergenerational theory on family functioning tries to explain child behavior problems from the quality of the relationship between child and parents. The key concept of this theory is loyalty, which is considered crucial for the parent-child relationship (Boszormenyi-Nagy,Grunebaum & Ulrich, 1991). When problems arise in a family, the loyalty bonds of family members should be looked at, to explain these problems. Loyalty problems may result in children showing problem behavior; internalizing behavior problems (e.g. anorexia, psychosis, and phobia) as well as externalizing behavior problems (e.g., acting out behavior, delinquency, avoidance, coldness, indifference).

Theories on family structure try to explain the parent-child relationship and the association between the structure and organization of the whole family system and child behavior problems. Concerning family structure, problems may arise when the boundaries between family subsystems are overly rigid or overly weak. When the boundaries are overly rigid, there is emotional distance between family members, and a lack of mutual emotional support, nurturance, and protection. This lack of involvement with each other may result in high tolerance for deviation, such as children's problem behavior.

The concept of disengagement is used to describe this situation of rigid boundaries. When the boundaries are overly weak, there is over involvement and extreme proximity between family members, which is called enmeshment. This may result in a lack of individual differentiation and autonomy. Children may develop problem behavior since the child's social development and development of autonomy is delayed. According to Colapinto (1991), enmeshment appears to be related to psychosomatic as well as antisocial child behavior, where disengagement appears to be related primarily to antisocial behavior.

Family communication processes are considered crucial for healthy family functioning and organization (Walsh, 1995). In the literature, child externalizing behavior problems are often related

to the communication and interactions between parents and children. The quality of the relationship between family members is supposed to be expressed in these interactions and child behavior problems are assumed to be related to dysfunctional interactions between parents and children. Dysfunctional interaction patterns are characterized by power struggle, misunderstanding, criticizing, and attacking each other. Parents and child blame each other of having caused the trouble. Without being aware that it is an interactional problem and that most of the time it is difficult or even impossible to find out who initiated the problem (Lange, 1994). This may lead either to endless escalating conflicts or to avoidance of conflicts.

Rational of the Present Study

During childhood and adolescence mental and behavioral problems are found very common and frequent. WHO (World Health Report, 2001) estimated that around the world 10-20 percent of all children have one or more mental or behavioral problems, with 3-4 percent requiring treatment.

There is a huge lack in information related to identification and treatment of the emotional and behavioral problems of children living in developing countries (Stubbe, 1993). Knowledge base regarding child mental health in developing country is highly needed in respect of the nature, frequency and the extent of emotional and behavioral problems in different arena as well as finding culture-specific risk factors for developing such problems to prevent behavioral problems among child and adolescents.

According to literature most of the behavioral problems in children occur in childhood and many of them are identified only after they enter the school (Schwarz, 1989). Behavioral and emotional problems can lead to school failure, underachievement leading to dependency, family discord, and involvement in criminal activity, the use of illicit drugs and co-morbid medical conditions (Rutter & Giller, 1983). In addition to these, many of the disorders more commonly found among adults can begin during childhood. Azad & Begum (2006) conducted a study on ‘Behavioral Problems in Primary School Children of Dhaka city’. But no study so far has been conducted in Bangladesh to have a clear picture of childhood emotional and behavioral problems of Madrasa students.

Children are the future of a nation. Every child has the “right to education”. This right refers to attitudes, skills and knowledge that every person in a given society requires for an effective and satisfying adulthood. Hence, the objectives of primary education include emotional development, social development, moral development as well as intellectual development. Emotional and

behavioral problems affect the overall development of the child. Untreated mental illness at this stage of life can have lifelong consequences.

In Bangladesh, there are 1,363,572 Ebtedayee Madrasa going children closest to the Dakhil, Alim, Fazil and Kamil Madrasa (Mehdy, 2006). Early detection, management and prevention of behavioral problems of Madrasa students are very essential. It is hoped that the present study will help us to understand the various aspects of behavioral problems students of Madrasa of Bangladesh and to take appropriate measures accordingly.

Madrasa education is a different type of education in our country. Its teachers, teaching methods, syllabuses are different. Not only education system, it is well known in general community that family background and socio-economic status of madrasa students' usually deferent from students' of traditional education system. Behavioral problems among madrasa students may not identified or properly treated in generally.

The present study is an attempt to find out childhood behavior problems and identify some family factors as risk factors among Madrasa students in Dhaka city.

Rational for using Teacher's Report Form (TRF)

The teacher's version of Child Behavior Checklist (CBCL), the Teacher's Report Form (TRF) is the most effective, dependable and most widely used instrument for assessing childhood behavior problems of school children (ages 4-18). It is one of the most rigorously developed and standardized child behavior rating scales currently available for assessing the most common dimensions of child psychopathology (Barkley, 1988). This rating instrument was developed by Achenbach and Edelbrock (1986) through cluster analysis of the inter correlations among rated symptoms of problem children. Briefly, they developed symptom-rating scales for several behavior clusters that fall broadly under two general dimensions, internalizing and externalizing, which describe the tendency to deal with problems through internal processes versus external means of acting against the environment.

Although TRF was developed in USA, many researchers have used it to study the nature and prevalence of behavioral and emotional problems in children and adolescents of both developed (Achenbach et al., 1986) and developing countries and it was also found to be suitable for the children of Bangladesh (Begum, 1993). The TRF has been translated into 69 languages and has been used in thousands of published studies (Achenbach, 1991).

Advantages of TRF are that firstly it provides systematic data collection. The TRF is useful in picking up co-morbidity since it covers a wide range of symptoms (Anderson et al., 1987).

Secondly, as a checklist TRF is economical, teachers can fill it out without any help.

Thirdly, it can be used for both general and more specific purposes as there is provision for both broad-band and narrow-band syndromes (McMahon & Forehand, 1988).

Fourthly, self-report questionnaires can function as self-monitoring instruments. Fifthly, self-report questionnaires can be valuable in assessing change.

Improvement or deterioration may be assessed in terms of changes in scores along dimensions. Manuals for most checklists give rules for interpreting change scores, which take into account the psychometric properties of the instrument.

For all these reasons the Bengali version of the TRF (Begum, 1993) was used to study behavioral problems of students of Bangladesh.

Rational for selecting Informants

In the present study teachers of the Madrasas were selected as prime informants for assessing Childs' problem behavior and parents were the key informants to compare family functioning.

As one of the central adults in many children's life, teachers are in a position to identify behavioral problems in them. In a study conducted in Bangladesh (Begum, 1993) it was found that correlations between mother's report and teacher's report on total behavior problem scores were highly significant for both boys ($r=0.80, p<0.001$) and girls ($r=o.77, p<0.001$). So it can be said that teacher's information about children is comparable to that of mother's.

Although parents are a key source of information in the assessment of children's behavioral problems, teacher's assessments are often equally important for the following reasons:

1. Teachers are often the second most important adults in children's lives, ranking only behind parents.
2. School is a central development arena in which problems arises that may not be evident elsewhere.

3. By virtue of training, experience and opportunities for observation of children in groups, teachers can report aspects of children's functioning no evident to parents.

4. Teachers are often involved in the referral and assessment of children for special services, both within the school and elsewhere.

Objectives of the Present Study

The objectives f the present researches are:

General Objectives:

To find out the nature of behavior problems of Madrasa students

Specific Objectives:

1. To identify the total number and percentages of Madrasa students who are in the clinical range of behavior problem score.
2. To see whether the total behavior problem scores of Madrasa students vary according to sex, age, number of siblings and types of Madrasas.
3. To see whether each individual item scores of behaviour problem varies according to sex, age, number of siblings and types of Madrasas.
4. To find out whether problem and non-problem children vary in family functioning

Chapter-02

METHODOLOGY

The current study was conducted in two phases. The first phase focused on assessing nature and frequency of behavioral problems among Madrasa students. While the goal of the second phase was to assess family functioning among students who got high and low score in problem behavior.

Sample

The total sample of the present study comprised of 360 Madrasa students from twelve government madrasa of Dhaka Metropolitan area. Among 360 students half of the participants were boys and half of the participants were girls. Twelve Madrasas were selected using lottery method where four were bays, four were girls and four were co-education Madrasas. Six students (3 boys and 3 girls) from each coeducation Madrasa, six students (6 boys) from each male Madrasa and six students (6 girls) from each female Madrasa were selected by using systematic sampling procedure from class one to class five. In this way a total of 30 students were selected from a Madrasa. To study the behavioral problems, the students were divided into two age groups, namely 6 to 8 years and 9 to11 years.

To compare different aspects of family functioning in the second phase of the study 20 matched samples were selected on the basis of socio-demographic variables including age, sex, number of siblings and number of family members.

Design

The aim of the present research was to assess the nature of behavior problems among Madrasa students. To fulfil this purpose quantitative research approach, specifically survey design was adopted.

Instrument used

Teacher's Report Form (TRF) of Child Behavior Checklist,

The Bengali version of the Teacher's Report Form (TRF, Begum, 1993) of the Child Behavior Checklist (CBCL) originally developed by Achenbach and Edelbrock (1986) was used to study behavioral problems of the children.

The results of the translation reliability of the Bengali TRF showed that the two sets of problem scores in English and Bengali version of the TRF have a high positive correlation. The reliability

and validity of the Bengali version of the TRF were studied on Bangladeshi subjects. The test-retest reliability of the problem scores for boys and girls were highly significant ($p<0.001$). The test-retest reliability coefficient of the total problem score over a period of one month was 0.90 for boys and 0.94 for girls.

The TRF consists of 118 specific problem items and each of them is rated on a 3 point scale ("not true'=0, "sometimes or somewhat true"=1, "very often true"2). The total behavior problem score of a particular child is the sum of the 1s and 2s circled by teachers. The higher is the total problem score the more is the behavioral problem.

Behavioral problem scores form two broadband groupings in all age/sex groups. These groups assess internalizing and externalizing behavior. There are some narrow-band scales. The behavior problem scales for each sex/age group are scored on the Child Behavior Profile in order to have a complete picture of the behavior problem of a child. This profile indicates the childes standing on various narrow-bands (e.g. hyperactive, depressed etc.) and broad-band (interesting and externalizing) syndromes.

McMaster Family assessment device

Translated Bengali version of McMaster Family Assessment Device (Epstein et al, 1983) was used to assess and compare the family functioning of the problem and non-problem children in matched group.

It is a 60 item questionnaire developed by Epstein et al, 1983. The questionnaire is able to provide scores of family functioning and can assess the following aspects of family functioning:

- problem solving
- Communication
- Family roles
- Affective response
- Affective involvement
- Behavior control
- General functioning

The device was translated into Bengali first. Then the translated version was judged by 15 specialist professionals. These professionals are Psychiatrist and Clinical Psychologists including in order to finding test retest reliability. Correlation co-efficient was found 0.78 which is satisfactory.

Procedure

A total twelve government Madrasas were selected randomly from the list of government Madrasas in Dhaka Metropolitan City. After taking permission from head of respective Madrasas, data was collected.

All class teachers were informed about the nature and purpose of the research. Teachers were also informed that the confidentiality of their responses will be strictly maintained and data will be use only for research purpose. A written handout about the purpose of the research and notes of confidentiality was given to each teacher before administering the Teacher's Report Form (TRF).TRF and additional form containing demographic and other information of the particular student was then given to the teachers of the selected students in the class.

Based on TRF score samples were divided into two matched (above clinical score and below clinical score) groups to assess and compare family functioning Translated Bengali version of McMaster Family Assessment Device was employed to these two groups.

Collected data were analyzed and reported following research objectives.

Data analysis

Statistical analysis especially descriptive analysis was done to accomplish the purpose of the study by using SPSS programme (15.0 versions).

Dhaka University Institutional Repository

Chapter-03

RESULTS

The major goal of this study is to assess behavior problems among Madrasa students where specific objectives were to find out the total number and percentages of Madrasa students who manifest clinical range of behavior problem scores, to see whether the total behavior problem scores of Madrasa students vary according to sex, age, number of siblings and types of Madrasas, to see whether each individual item scores of behavior problem varies according to sex, age, number of siblings and types of Madrasas, to find out whether problem and non-problem children vary in family functioning . Major variables of the study were age, gender, types of Madrasas and number of siblings.

For conducting the study, 360 Madrasa students were taken from twelve Madrasas as sample of the present research where types of Madrasas were male, female and coeducation Madrasa system. The age ranges of students were 6 to11 years and this age range of the sample students were divided into two age groups where one is 6-8 years and 9-11 years.

Tools and measures used in this study were the Bengali version of the Teacher's Report Form (TRF) to assess behavior problems of students of Madrasa and Translated Bengali version of McMaster Family Assessment Device to assess family functioning of the children who got higher scores in behavior problems.

The results of the study are presented in the current chapter according to specific objectives set for the research. Collected data of the present research were analyzed by using the following statistical techniques.

1. The cut off score of clinical range and percentages of behavior problems was used as described in the manual of the TRF to identify the total number and percentages of Madrasa students who are in the clinical range of behavior problem scores. The result is presented in a tabular and graphical form in Table - 1, 2, 3, 4, 5, 6 and figure -1, 2, 3 and 4.

2. To see whether the total behavior problem scores of Madrasa students vary according to sex, age, number of siblings and types of Madrasas, the obtained scores were analysed by one way Analysis of Variance and the results of the ANOVA are presented in Table- 7.

3. To see whether each individual item scores of behavior problem varies according to sex, age, number of siblings and types of Madrasas, the distribution of the each item of the TRF

by sex, age , number of siblings and types of Madrasas together with the probability of difference furnished by chi-square test are presented in Table - 8,9,10,11.

4. Measures of central tendency specifically mean and Standard Deviation was use to find out whether problem and non-problem children vary in family functioning and it is shown in Table - 12.

According to the manual of the Teacher's Report Form (TRF), the cut of score for total behavior problem of 6 to 11 years old boys and girls is 49 and 38 respectively. Behavior problem scores above these cut off scores are considered to be in the clinical range.

Table - 1: Total number of problem behavior and percentage

Total number of problem behavior	Total Percentage
55 (N-360)	**15.3 %**

Table -1 shows the total number and percentage of problem behavior among Madrasa students and that 15% of the Madrasa students had behavior problem.

Table - 2: Hierarchy of most prevalent items of problem behavior among Madrasa students

SL	Problem Item	False		Sometimes true		Very or Often true		X^2 test	p-value
		6 to 8 years	9 to 11 years	6 to 8 years	9 to 11 years	6 to 8 years	9 to 11 years	---	---
7	Bragging, boasting	39.1%	60.9%	39.3%	60.7%	.0%	100.0%	0.64	0.726
22	Difficulty following directions	38.9%	61.1%	42.9%	57.1%	.0%	100.0%	2.09	0.553
31	Fears he/she might think or do something bad	38.8%	61.2%	100.0%	.0%	.0%	100.0%	4.42	0.220
35	Feels worthless or inferior	38.8%	61.2%	100.0%	.0%	.0%	100.0%	4.42	0.220
45	Nervous, high strung, or tense	38.8%	61.2%	50.0%	50.0%	.0%	100.0%	2.53	0.469
50	Too fearful or anxious	38.4%	61.6%	46.7%	53.3%	.0%	100.0%	2.07	0.559
56b	Physical problems without known medical causes (b) headaches	41.9%	58.1%	27.3%	72.7%	.0%	100.0%	6.78	0.076
59	Sleeps in class	39.0%	61.0%	40.0%	60.0%	.0%	100.0%	1.28	0.732
69	Secretive, keeps things to self	43.0%	57.0%	31.4%	68.6%	.0%	100.0%	5.84	0.120
72	Messy work	40.1%	59.9%	33.3%	66.7%	.0%	100.0%	2.17	0.538
87	Sudden changes in mood or feeling	38.8%	61.2%	42.0%	58.0%	.0%	100.0%	2.11	0.549
94	Teases a lot	39.5%	60.5%	38.1%	61.9%	.0%	100.0%	2.60	0.457
99	Too concerned with neatness/cleanliness	40.6%	59.4%	20.0%	80.0%	.0%	100.0%	6.59	0.086
101	Truancy or unexplained absence	40.1%	59.9%	33.3%	66.7%	.0%	100.0%	2.11	0.549
107	Dislikes school	38.2%	61.8%	60.0%	40.0%	.0%	100.0%	4.15	0.245

Table - 2 presents the items which are most frequent in Madrasa students in hierarchy basis.

Table - 3: Total number and percentages of Madrasa students who are in the clinical range of behavior problem scores according to Types of Madrasas

Variable		Number	Percentage
Types of Madrasas	Male	22	40
	Female	19	34.5
	Coeducation	14	25.5

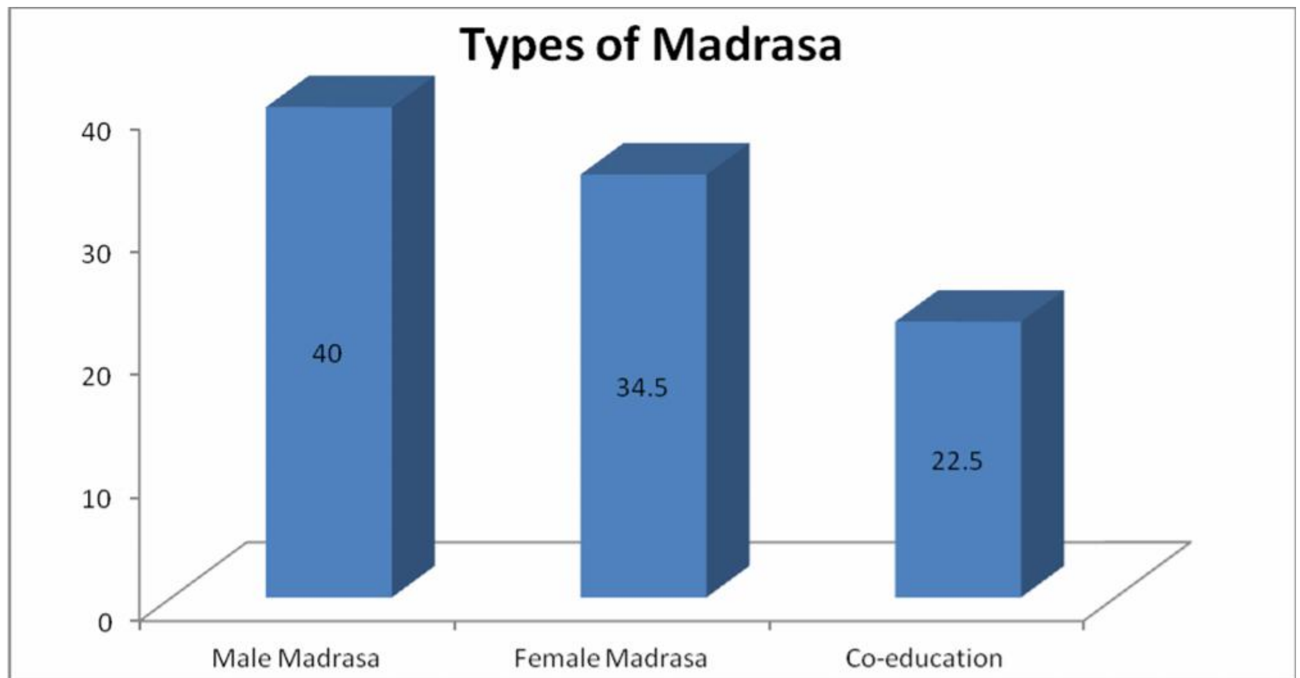

Figure - 1: The Bar diagram of number and percentage of problem behavior according to types of Madrasas.

The result presented in Table - 2 demonstrate that out of 120 male Madrasa students 22 (40%) student were in clinical range of behavior problem scores. Similarly out of 120 female Madrasa students 19 (34%) fall in the clinical range of behavior problem scores. This table also reveals that out of 120 co education Madrasa student 14 students crossed the cutoff point of behavior problem scores. Table - 2 also indicates that higher percentage of male Madrasa students fall in the clinical

range on behavior problem scores as compared to female Madrasa and coeducation students. This result is also represented in the bar chart (figure - 1).

Table - 4: Total number and percentages of Madrasa students who are in the clinical range of behavior problem scores according to Age Level

Variable		Number	Percentage
Age	6-8 years	23	41.8
	9-11 years	32	58.2

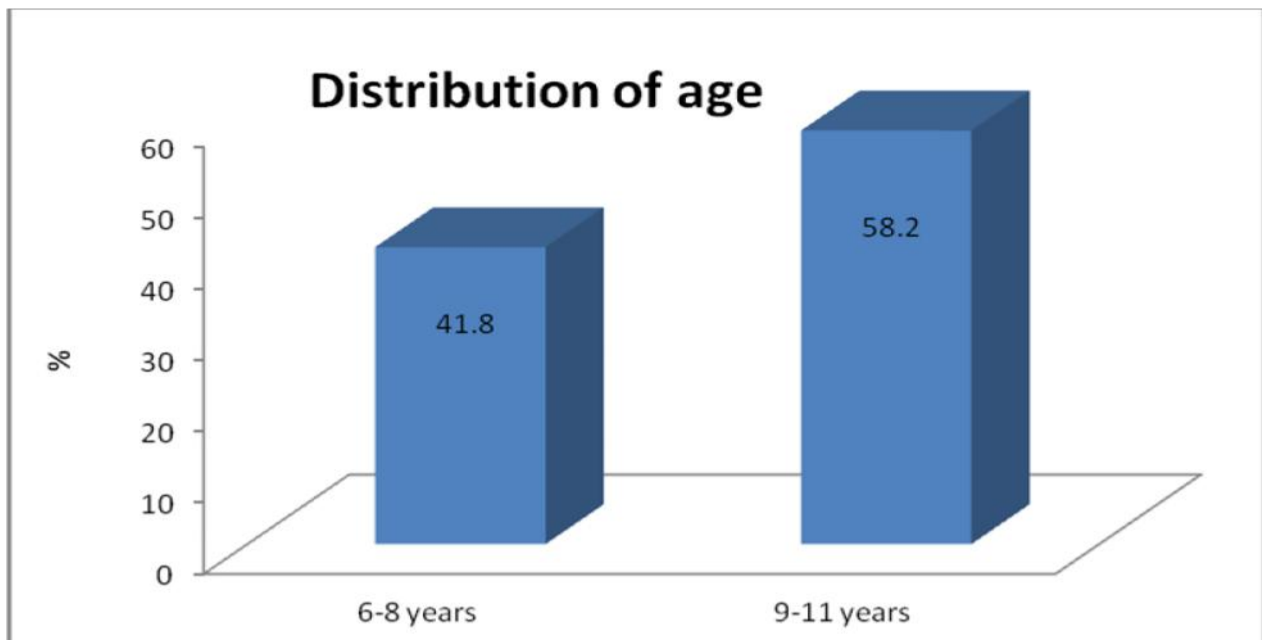

Figure - 2: The bar diagram of number and percentage of problem behavior according to Age Level

From table - 4 it appears that among two age groups, higher proportion of students of aged 9 to 11 years group (58%) fall in clinical range of behavior problem scores than students aged 6 to 8 years (41%). This result is also depicted in the bar chart (figure - 2).

Table - 5: Total number and percentages of Madrasa students who are in the clinical range of behavior problem scores according to Gender

Variable		Number	Percentage
Gender	Male	31	56.4
	Female	24	43.6

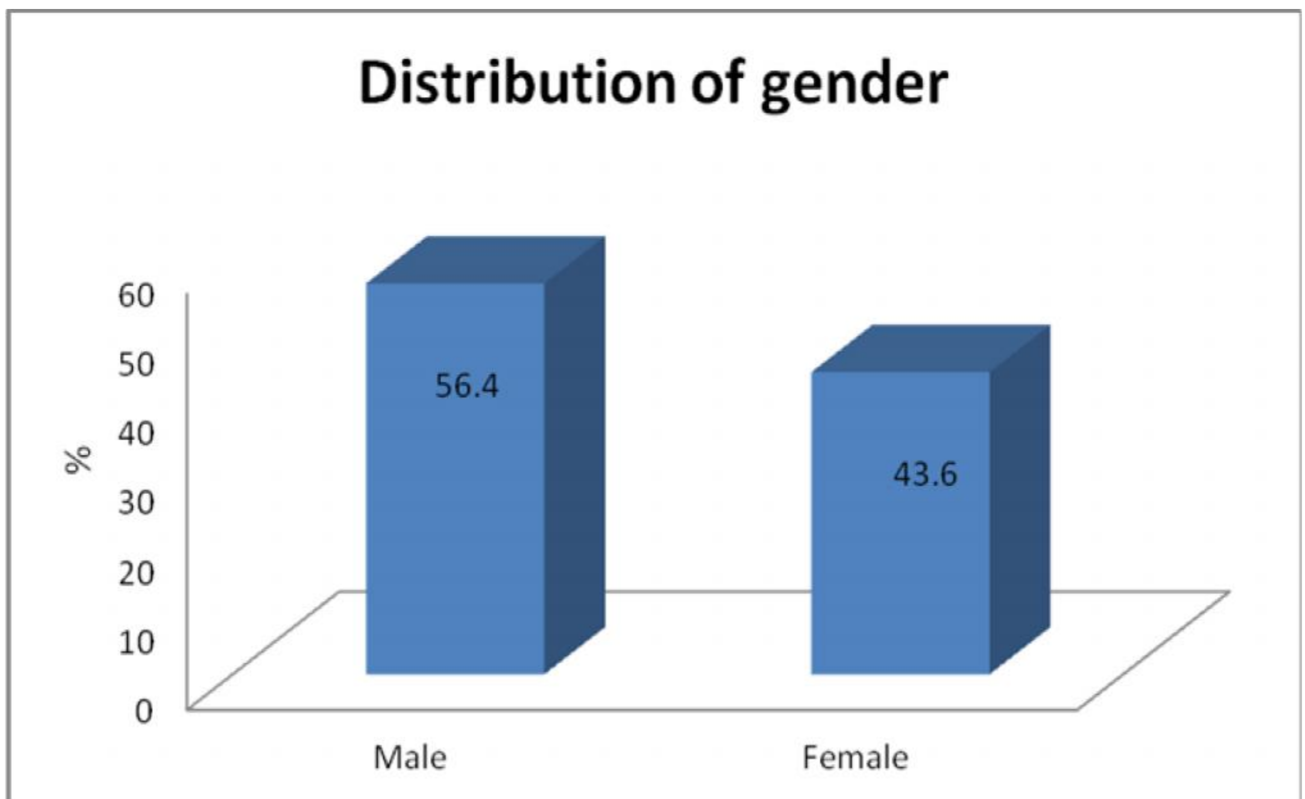

Figure - 3: The bar diagram of number and percentage of problem behavior according to Gender

Result presented in table - 5 showed that out of 180 boys 31 (56%) and out of 180 girls 24 (43%) crossed the cutoff point of behavior problem scores. Boys got higher score than girls.
This results also described in the bar chart (figure - 3).

Table - 6: The number and percentage of problem behavior according to number of siblings.

Variable		Number	Percentage
Number of siblings	1-4	318	88.3
	Above 5	42	11.7

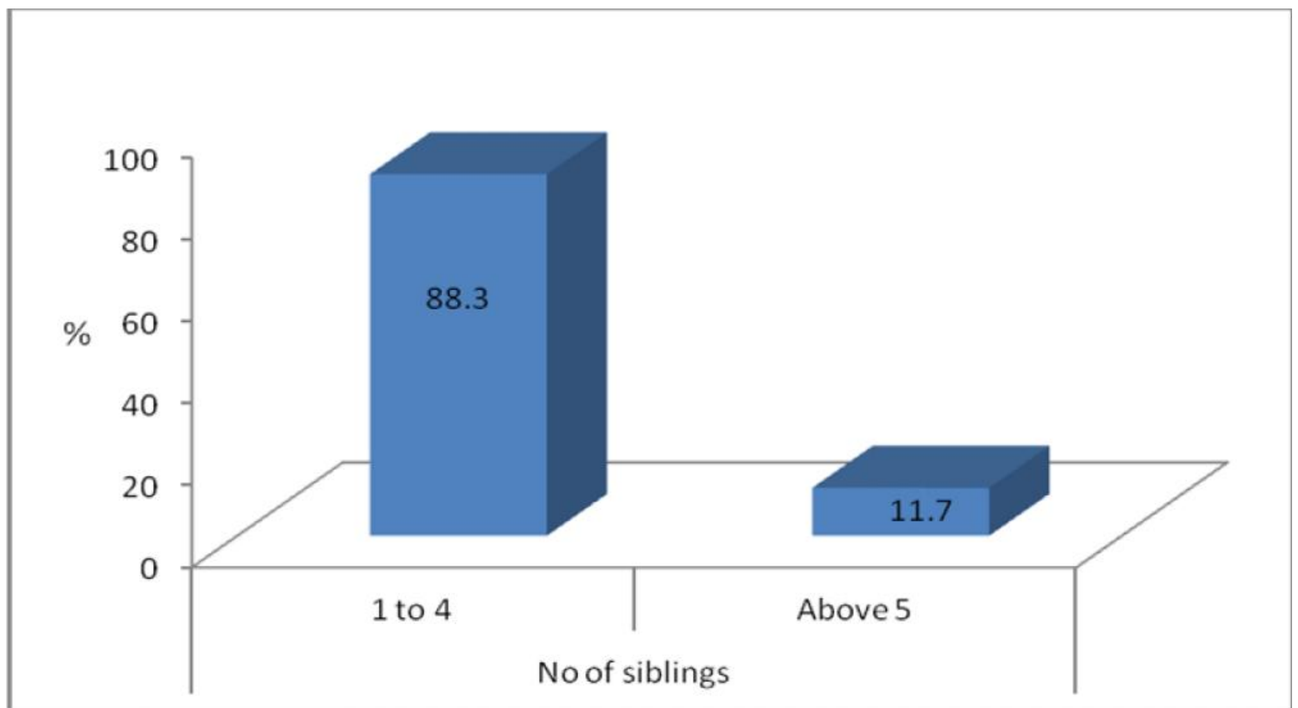

Figure - 4: The bar diagram of number and percentage of problem behavior according to number of siblings.

From table - 6 it is clear that among 360 students 88.3% student crossed cut off point of problem scores who have 1 to 4 siblings. This result also presented in bar chart (figure - 4).

Table - 7: Summary of the Analysis of Variance of behavior problem scores (TRF) according to sex, age, number of siblings and types of madrasa

Sources of variance	df	SS	MS	F	Sig.
Age	1	401.200	401.200	2.000	.158
Sex	1	42.765	42.765	.213	.645
Type of Madrasas	2	271.724	135.862	.677	.509
Number of siblings	1	2.666	2.666	.013	.908
Age X Sex	1	83.235	83.235	.415	.520
Age X Types of Madrasas	2	160.015	80.007	.399	.671
Age X Number of siblings	1	121.647	121.647	.607	.437
Sex X Number of siblings	1	2.342	2.342	.012	.914
Types of Madrasas X Number of siblings	2	11.122	5.561	.028	.973
Age x sex x No. of siblings	1	2.235	2.235	.011	.916
Age X Types of Madrasas X no. of siblings	2	111.652	55.826	.278	.757
Error	344	68994.928	200.567		

Table - 7 shows the main effect of age, gender, types of Madrasas, number of siblings on behavior problem score in ANOVA. No significant difference was observed between age group of the sample, age and number of siblings, sex and number of siblings, types of Madrasas and number of siblings, and among age, sex and number of siblings. Additionally, similar findings was found among age, types of Madrasas and number of siblings.

Each item of the TRF

Each item of the TRF is useful for both 6 – 11 years boys and girls. The distribution of each item on the TRF by sex, age, number of siblings and types of Madrasas of the subjects together with the probability of difference furnished by a chi-square test are presented in Table 7; Table 8; Table 9 and table 10respectively.

Table - 8: Percentage distribution of behavior problem items by sex of the subject

SL	Problem Item	False		Sometimes true		Very or Often true			
		Male	Female	Male	Female	Male	Female	X^2	p-value
1	Act too young for his or her age	50.0%	50.0%	51.9%	48.1%	50.0%	50.0%	1.03	0.795
2	Hums or make other odd noises in class	48.2%	51.8%	63.2%	36.8%	57.1%	42.9%	5.15	0.272
3	Argues a lot	47.9%	52.1%	71.4%	28.6%	75.0%	25.0%	8.73	0.068
4	Fails to finish things he/she starts	51.1%	48.9%	49.0%	51.0%	47.1%	52.9%	2.19	0.701
5	Behaves like opposite sex	50.0%	50.0%	100.0%	.0%	---	---	1.99	0.370
6	Defiant, talks back to staff	48.8%	51.2%	76.5%	23.5%	---	---	5.94	0.051
7	Bragging, boasting	50.3%	49.7%	46.4%	53.6%	100.0%	.0%	2.14	0.543
8	Can't concentrate, can't pay attention for long	52.4%	47.6%	46.1%	53.9%	61.1%	38.9%	3.25	0.354
9	Can't get his/her mind off certain thoughts; Obsessions	50.3%	49.7%	40.0%	60.0%	---	---	1.20	0.549
10	Can't sit still, restless or hyperactive	48.3%	51.7%	53.1%	46.9%	50.0%	50.0%	1.72	0.632
11	Clings to adult or too dependant	50.4%	49.6%	25.0%	75.0%	---	---	2.01	0.365
12	Complains of loneliness	50.6%	49.4%	.0%	100.0%	.0%	100.0%	4.03	0.258
13	Confused or seems to be in a fog	51.6%	48.4%	18.8%	81.3%	---	---	7.59	**0.022**
14	Cries a lot	52.9%	47.1%	25.7%	74.3%	.0%	100.0%	11.36	**0.010**
15	Fidgets	50.0%	50.0%	49.2%	50.8%	75.0%	25.0%	2.00	0.571
16	Cruelty, bulling or meanness to others	48.5%	51.5%	66.7%	33.3%	100.0%	.0%	5.63	0.131
17	Daydreams or gets lost in his/her thoughts	50.0%	50.0%	51.4%	48.6%	---	---	1.02	0.602
18	Deliberately harm self or attempts suicide	50.4%	49.6%	.0%	100.0%	---	---	3.01	0.222
19	Demands a lot of attention	52.2%	47.8%	50.3%	49.7%	33.3%	66.7%	4.00	0.261
20	Destroys his or her own things	49.3%	50.7%	75.0%	25.0%	25.0%	75.0%	6.06	0.109

21	Destroys property belonging to others	49.9%	50.1%	54.5%	45.5%	100.0%	.0%	2.08	0.555
22	Difficulty following directions	49.8%	50.2%	57.1%	42.9%	.0%	100.0%	3.56	0.313
23	Disobedient at school	48.3%	51.7%	65.0%	35.0%	50.0%	50.0%	4.97	0.174
24	Disturbs other pupils	48.1%	51.9%	57.1%	42.9%	71.4%	28.6%	3.98	0.264
25	Doesn't get along with other pupils	48.3%	51.7%	58.6%	41.4%	57.1%	42.9%	3.20	0.362
26	Doesn't seem to feel guilty after misbehaving	51.3%	48.7%	44.9%	55.1%	40.0%	60.0%	2.11	0.549
27	Easily jealous	51.1%	48.9%	41.7%	58.3%	25.0%	75.0%	2.80	0.423
28	Eats or drinks things that are not food	50.1%	49.9%	---	----	---	---	---	---
29	Fears certain animals, situations, or places other than school	50.0%	50.0%	100.0%	.0%	---	---	1.99	0.370
30	Fears going to school	49.9%	50.1%	58.3%	41.7%	---	---	1.32	0.516
31	Fears he/she might think or do something bad	50.3%	49.7%	50.0%	50.0%	.0%	100.0%	2.00	0.572
32	Feels she/he has to be perfect	53.2%	46.8%	47.3%	52.7%	25.0%	75.0%	7.30	0.063
33	Feels or complains that none love him or her	50.3%	49.7%	46.7%	53.3%	50.0%	50.0%	1.07	0.785
34	Feels others are out to get him/her	50.0%	50.0%	57.1%	42.9%	100.0%	.0%	1.13	0.769
35	Feels worthless or inferior	50.6%	49.4%	.0%	100.0%	.0%	100.0%	4.03	0.258
36	Gets hurt a lot, accident prone	47.4%	52.6%	76.5%	23.5%	---	---	11.41	**0.003**
37	Gets in many fights	47.6%	52.4%	67.3%	32.7%	.0%	100.0%	8.61	**0.035**
38	Gets teased a lot	49.2%	50.8%	58.7%	41.3%	.0%	100.0%	4.46	0.216
39	Hangs around with others who get in trouble	49.0%	51.0%	84.6%	15.4%	.0%	100.0%	8.36	**0.039**
40	Hears things that are not there	50.1%	49.9%	---	---	---	---	---	---
41	Impulse or act without thinking	51.7%	48.3%	46.7%	53.3%	57.1%	42.9%	1.93	0.586
42	Likes to be alone	52.1%	47.9%	47.5%	52.5%	.0%	100.0%	4.71	0.194
43	Lying or cheating	50.9%	49.1%	48.4%	51.6%	33.3%	66.7%	1.80	0.614
44	Bites fingernails	50.6%	49.4%	47.2%	52.8%	.0%	100.0%	2.15	0.542

45	Nervous, high strung, or tense	51.6%	48.4%	16.7%	83.3%	.0%	100.0%	8.67	**0.034**
46	Nervous movement or twitching	50.4%	49.6%	.0%	100.0%	---	---	3.01	0.222
47	Over conforms to rules	51.6%	48.4%	20.0%	80.0%	33.3%	66.7%	7.07	0.069
48	Not liked by other pupils	49.4%	50.6%	59.0%	41.0%	25.0%	75.0%	3.29	0.348
49	Has difficulty learning	53.1%	46.9%	44.0%	56.0%	50.0%	50.0%	3.62	0.306
50	Too fearful or anxious	53.0%	47.0%	20.0%	80.0%	.0%	100.0%	14.01	**0.003**
51	Feels dizzy	51.1%	48.9%	.0%	100.0%	---	---	8.17	**0.017**
52	Feels too guilty	51.0%	49.0%	22.2%	77.8%	33.3%	66.7%	4.24	0.237
53	Talks out of run	49.4%	50.6%	54.3%	45.7%	16.7%	83.3%	4.39	0.223
54	Overtired	51.8%	48.2%	17.6%	82.4%	---	---	8.53	**0.014**
55	Overweight	50.4%	49.6%	40.0%	60.0%	---	---	1.41	0.493
56a	Physical problems without known medical causes (a) Aches or pains	49.7%	50.3%	63.6%	36.4%	50.0%	50.0%	1.82	0.611
56b	Physical problems without known medical causes (b) headaches	50.9%	49.1%	48.5%	51.5%	.0%	100.0%	3.13	0.371
56c	Physical problems without known medical causes (c) Nausea, feels sick	50.6%	49.4%	25.0%	75.0%	.0%	100.0%	3.03	0.386
56d	Physical problems without known medical causes (d) Problems with eyes	50.8%	49.2%	.0%	100.0%	---	---	6.09	**0.048**
56e	Physical problems without known medical causes (e) Rashes or other skin problems	50.3%	49.7%	.0%	100.0%	---	---	2.00	0.368
56f	Physical problems without known medical causes (f) Stomach aches or cramps	50.8%	49.2%	41.9%	58.1%	100.0%	.0%	2.87	0.412
56g	Physical problems without known medical causes (g) Vomiting, throwing up	49.9%	50.1%	100.0%	.0%	---	---	2.99	0.224

56h	Physical problems without known medical causes (h) Other........................	50.1%	49.9%	---	---	---	---	---	---
57	Physically attack people	48.8%	51.2%	64.5%	35.5%	---	---	1.37	0.240
58	Picks nose, skin or other parts of body	49.9%	50.1%	100.0%	.0%	---	---	3.79	0.150
59	Sleeps in class	51.4%	48.6%	36.0%	64.0%	.0%	100.0%	4.19	0.241
60	Apathetic or unmotivated	53.7%	46.3%	39.6%	60.4%	---	---	6.44	**0.040**
61	Poor school work	51.4%	48.6%	48.9%	51.1%	44.4%	55.6%	1.45	0.694
62	Poorly coordinated or clumsy	52.1%	47.9%	46.4%	53.6%	44.4%	55.6%	2.09	0.552
63	Prefers being with older children	49.7%	50.3%	75.0%	25.0%	33.3%	66.7%	3.33	0.343
64	Prefers being with younger children	51.2%	48.8%	50.0%	50.0%	.0%	100.0%	8.18	**0.042**
65	Refuses to talk	54.5%	45.5%	42.1%	57.9%	.0%	100.0%	8.83	**0.032**
66	Repeats certain acts over and over, compulsions	50.6%	49.4%	28.6%	71.4%	50.0%	50.0%	2.32	0.509
67	Disrupts class discipline	48.2%	51.8%	57.1%	42.9%	50.0%	50.0%	2.92	0.405
68	Screams a lot	48.2%	51.8%	63.6%	36.4%	50.0%	50.0%	4.64	0.199
69	Secretive, keeps things to self	56.5%	43.5%	38.0%	62.0%	.0%	100.0%	12.99	**0.005**
70	Sees things that are not there	50.0%	50.0%	100.0%	.0%	---	---	1.98	0.370
71	Self conscious, or easily embarrassed	50.2%	49.8%	50.6%	49.4%	.0%	100.0%	2.00	0.571
72	Messy work	48.0%	52.0%	63.0%	37.0%	.0%	100.0%	6.09	0.107
73	Behaves irresponsibly	50.1%	49.9%	50.0%	50.0%	---	---	0.99	0.609
74	Showing off or clowning	50.1%	49.9%	50.0%	50.0%	---	---	0.99	0.609
75	Shy or timid	56.5%	43.5%	42.2%	57.8%	.0%	100.0%	11.07	**0.011**
76	Explosive and unpredictable behavior	51.3%	48.7%	31.6%	68.4%	.0%	100.0%	4.80	0.186
77	Demands must be met immediately, easily frustrated	49.9%	50.1%	75.0%	25.0%	.0%	100.0%	4.99	0.172
78	Inattentive easily distracted	50.9%	49.1%	47.8%	52.2%	63.6%	36.4%	2.15	0.542
79	Speech problem	50.9%	49.1%	33.3%	66.7%	.0%	100.0%	4.09	0.252

80	Stares blankly	51.7%	48.3%	35.9%	64.1%	100.0%	.0%	5.47	0.140
81	Feels hurt when criticized	59.5%	40.5%	44.2%	55.8%	14.3%	85.7%	12.71	**0.005**
82	Steals	50.0%	50.0%	100.0%	.0%	---	---	1.98	0.370
83	Stores up things he or she doesn't need	49.9%	50.1%	100.0%	.0%	---	---	2.99	0.224
84	Strange behavior	49.9%	50.1%	100.0%	.0%	---	---	2.99	0.224
85	Strange ideas	50.4%	49.6%	50.0%	50.0%	.0%	100.0%	3.01	0.389
86	Stubborn or irritable	49.5%	50.5%	51.7%	48.3%	37.5%	62.5%	1.67	0.642
87	Sudden changes in mood or feeling	49.2%	50.8%	58.0%	42.0%	.0%	100.0%	4.35	0.226
88	Sulks a lot	53.4%	46.6%	39.2%	60.8%	.0%	100.0%	6.94	0.074
89	Suspicious	49.7%	50.3%	66.7%	33.3%	---	---	2.00	0.368
90	Swearing or obscene language	49.3%	50.7%	66.7%	33.3%	.0%	100.0%	4.39	0.222
91	Talks about killing self	50.4%	49.6%	50.0%	50.0%	.0%	100.0%	3.01	0.389
92	Underachieving, not working up to potential	51.9%	48.1%	49.0%	51.0%	41.2%	58.8%	1.83	0.607
93	Talks too much	50.7%	49.3%	50.8%	49.2%	.0%	100.0%	5.06	0.167
94	Teases a lot	48.7%	51.3%	64.3%	35.7%	.0%	100.0%	7.62	0.055
95	Temper tantrums or hot tempered	47.9%	52.1%	69.8%	30.2%	20.0%	80.0%	10.05	**0.018**
96	Seems preoccupied with sex	49.7%	50.3%	100.0%	.0%	---	---	4.00	0.135
97	Threatens people	50.7%	49.3%	33.3%	66.7%	---	---	2.39	0.302
98	Tardy to school or class	51.2%	48.8%	44.3%	55.7%	100.0%	.0%	4.07	0.254
99	Too concerned with neatness/cleanliness	51.6%	48.4%	35.0%	65.0%	.0%	100.0%	7.15	0.067
100	Fails to carry out assigned tasks	51.0%	49.0%	49.6%	50.4%	20.0%	80.0%	2.90	0.407
101	Truancy or unexplained absence	49.8%	50.2%	51.0%	49.0%	100.0%	.0%	2.01	0.570
102	Under active, slow moving, lacks energy	51.8%	48.2%	40.4%	59.6%	---	---	3.31	0.191
103	Unhappy, sad, depressed	53.4%	46.6%	30.0%	70.0%	---	---	10.41	**0.005**
104	Unusually loud	49.6%	50.4%	64.3%	35.7%	---	---	2.15	0.340
105	Uses alcohol or drugs	50.0%	50.0%	100.0%	.0%	---	---	1.98	0.370
106	Overly anxious to please	52.9%	47.1%	39.7%	60.3%	50.0%	50.0%	4.98	0.173

107	Dislikes school	50.1%	49.9%	46.7%	53.3%	100.0%	.0%	2.06	0.560
108	Is afraid of making mistakes	51.5%	48.5%	25.0%	75.0%	.0%	100.0%	6.28	0.099
109	Whining	50.6%	49.4%	36.4%	63.6%	---	---	1.85	0.396
110	Unclean personal appearance	50.9%	49.1%	41.9%	58.1%	---	---	1.90	0.386
111	Withdrawn, doesn't get involved with others	54.2%	45.8%	40.0%	60.0%	.0%	100.0%	8.63	0.035
112	Worrying	50.3%	49.7%	48.6%	51.4%			1.03	0.598
113	Any other problem the pupil has that were not listed above	50.6%	49.4%	.0%	100.0%	---	---	4.03	0.133

Table **-** 8 shows that there were differences between boys and girls on following items on TRF-item 13, 14, 36, 37, 39, 45, 50, 51, 54, 56 d, 60, 64, 65, 69, 75, 80, 81, 95, and 103.

Boys scored significantly higher than girls on item number 36 (Accident prone), 37 (fighting), 39 (Bad friends).

Where girls scored significantly higher on item number 13 (confused), 14 (cries a lot), 45 (nervous), 50 (fearful or anxious), 51 (Dizzy), 54 (over tired), 56 d (eye problems), 60 (Apathetic or unmotivated) , 64 (Prefers being with younger children), 65 (refuse to talk), 69 (secretive), 75 (shy, timid), 81 (Feels hurt when criticized), 95 (temper tantrums), 103 (Unhappy, sad or depressed).

Table - 9: Percentage distribution of behavior problem items by age of the subject

SL	**Problem Item**	**False**		**Sometimes true**		**Very or Often true**		X^2 test	p-value
		6 to 8 years	**9 to 11 years**	**6 to 8 years**	**9 to 11 years**	**6 to 8 years**	**9 to 11 years**	---	---
1	Act too young for his or her age	39.4%	60.6%	33.3%	66.7%	50.0%	50.0%	0.48	0.788
2	Hums or make other odd noises in class	40.3%	59.7%	34.2%	65.8%	14.3%	85.7%	2.90	0.234

3	Argues a lot	40.2%	59.8%	28.6%	71.4%	25.0%	75.0%	3.08	0.544
4	Fails to finish things he/she starts	38.8%	61.2%	42.3%	57.7%	23.5%	76.5%	2.62	0.269
5	Behaves like opposite sex	38.8%	61.2%	100.0%	.0%	---	---	2.21	0.331
6	Defiant, talks back to staff	39.8%	60.2%	23.5%	76.5%	----	---	1.16	0.281
7	Bragging, boasting	39.1%	60.9%	39.3%	60.7%	.0%	100.0%	0.64	0.726
8	Can't concentrate, can't pay attention for long	39.2%	60.8%	40.1%	59.9%	27.8%	72.2%	1.67	0.642
9	Can't get his/her mind off certain thoughts; Obsessions	39.5%	60.5%	.0%	100.0%	---	---	1.19	0.160
10	Can't sit still, restless or hyperactive	38.4%	61.6%	40.8%	59.2%	34.6%	65.4%	0.43	0.806
11	Clings to adult or too dependant	39.4%	60.6%	.0%	100.0%	---	---	1.19	0.160
12	Complains of loneliness	39.0%	61.0%	.0%	100.0%	100.0%	.0%	2.84	0.241
13	Confused or seems to be in a fog	39.9%	60.1%	18.8%	81.3%	---	---	2.04	0.153
14	Cries a lot	36.2%	63.8%	62.9%	37.1%	100.0%	.0%	11.63	**0.009**
15	Fidgets	39.4%	60.6%	38.1%	61.9%	25.0%	75.0%	1.01	0.799
16	Cruelty, bulling or meanness to others	39.9%	60.1%	30.0%	70.0%	.0%	100.0%	2.42	0.489
17	Daydreams or gets lost in his/her thoughts	41.0%	59.0%	21.6%	78.4%	---	---	5.87	0.053
18	Deliberately harm self or attempts suicide	38.9%	61.1%	50.0%	50.0%	---	---	0.741	0.691
19	Demands a lot of attention	41.4%	58.6%	36.2%	63.8%	37.5%	62.5%	1.58	0.662
20	Destroys his or her own things	38.6%	61.4%	50.0%	50.0%	25.0%	75.0%	1.80	0.615
21	Destroys property belonging to others	38.6%	61.4%	54.5%	45.5%	.0%	100.0%	2.42	0.490
22	Difficulty following directions	38.9%	61.1%	42.9%	57.1%	.0%	100.0%	2.09	0.553
23	Disobedient at school	39.7%	60.3%	37.5%	62.5%	.0%	100.0%	3.29	0.348
24	Disturbs other pupils	39.8%	60.2%	39.7%	60.3%	.0%	100.0%	4.54	0.103
25	Doesn't get along with other pupils	38.1%	61.9%	46.6%	53.4%	14.3%	85.7%	5.21	0.157
26	Doesn't seem to feel guilty after misbehaving	40.7%	59.3%	36.7%	63.3%	.0%	100.0%	7.49	0.058

27	Easily jealous	38.4%	61.6%	50.0%	50.0%	25.0%	75.0%	2.24	0.523
28	Eats or drinks things that are not food	39.0%	61.0%	---	---	---	---	---	---
29	Fears certain animals, situations, or places other than school	38.8%	61.2%	100.0%	.0%	---	---	2.21	0.331
30	Fears going to school	37.8%	62.2%	75.0%	25.0%	---	---	7.41	**0.025**
31	Fears he/she might think or do something bad	38.8%	61.2%	100.0%	.0%	.0%	100.0%	4.42	0.220
32	Feels she/he has to be perfect	44.8%	55.2%	24.2%	75.8%	35.0%	65.0%	11.81	**0.002**
33	Feels or complains that none love him or her	39.2%	60.8%	40.0%	60.0%	.0%	100.0%	12.64	**0.005**
34	Feels others are out to get him/her	38.9%	61.1%	42.9%	57.1%	.0%	100.0%	1.93	0.587
35	Feels worthless or inferior	38.8%	61.2%	100.0%	.0%	.0%	100.0%	4.42	0.220
36	Gets hurt a lot, accident prone	38.8%	61.2%	41.2%	58.8%	---	---	0.713	0.700
37	Gets in many fights	39.2%	60.8%	38.8%	61.2%	.0%	100.0%	1.28	0.733
38	Gets teased a lot	38.9%	61.1%	39.1%	60.9%	50.0%	50.0%	0.741	0.863
39	Hangs around with others who get in trouble	39.1%	60.9%	38.5%	61.5%	.0%	100.0%	1.28	0.733
40	Hears things that are not there	39.0%	61.0%	---	---	---	---	---	---
41	Impulse or act without thinking	40.4%	59.6%	37.7%	62.3%	14.3%	85.7%	2.72	0.436
42	Likes to be alone	40.2%	59.8%	36.1%	63.9%	66.7%	33.3%	2.18	0.536
43	Lying or cheating	39.2%	60.8%	40.3%	59.7%	16.7%	83.3%	1.94	0.584
44	Bites fingernails	38.5%	61.5%	44.4%	55.6%	.0%	100.0%	1.76	0.624
45	Nervous, high strung, or tense	38.8%	61.2%	50.0%	50.0%	.0%	100.0%	2.53	0.469
46	Nervous movement or twitching	38.9%	61.1%	50.0%	50.0%			0.74	0.691
47	Over conforms to rules	38.7%	61.3%	40.0%	60.0%	66.7%	33.3%	1.62	0.654
48	Not liked by other pupils	38.3%	61.7%	46.2%	53.8%	25.0%	75.0%	1.87	0.599
49	Has difficulty learning	40.2%	59.8%	37.9%	62.1%	.0%	100.0%	3.39	0.335
50	Too fearful or anxious	38.4%	61.6%	46.7%	53.3%	.0%	100.0%	2.07	0.559

51	Feels dizzy	38.9%	61.1%	42.9%	57.1%			0.683	0.711
52	Feels too guilty	38.9%	61.1%	44.4%	55.6%	33.3%	66.7%	0.792	0.851
53	Talks out of run	39.8%	60.2%	39.1%	60.9%	.0%	100.0%	4.55	0.207
54	Overtired	39.5%	60.5%	29.4%	70.6%			1.33	0.515
55	Overweight	39.5%	60.5%	20.0%	80.0%			2.20	0.333
56a	Physical problems without known medical causes (a) Aches or pains	39.3%	60.7%	36.4%	63.6%	.0%	100.0%	1.96	0.580
56b	Physical problems without known medical causes (b) headaches	41.9%	58.1%	27.3%	72.7%	.0%	100.0%	6.78	0.076
56c	Physical problems without known medical causes (c) Nausea, feels sick	38.7%	61.3%	50.0%	50.0%	100.0%	.0%	2.42	0.490
56d	Physical problems without known medical causes (d) Problems with eyes	38.7%	61.3%	60.0%	40.0%			1.58	0.454
56e	Physical problems without known medical causes (e) Rashes or other skin problems	38.8%	61.2%	100.0%	.0%			2.21	0.331
56f	Physical problems without known medical causes (f) Stomach aches or cramps	37.6%	62.4%	51.6%	48.4%	100.0%	.0%	4.54	0.208
56g	Physical problems without known medical causes (g) Vomiting, throwing up	38.9%	61.1%	50.0%	50.0%			0.741	0.691
56h	Physical problems without known medical causes (h) Other........................	39.0%	61.0%					0.987	0.321
57	Physically attack people	38.7%	61.3%	41.9%	58.1%			0.761	0.683
58	Picks nose, skin or other parts of body	38.9%	61.1%	50.0%	50.0%			0.741	0.691
59	Sleeps in class	39.0%	61.0%	40.0%	60.0%	.0%	100.0%	1.28	0.732

60	Apathetic or unmotivated	38.8%	61.2%	39.6%	60.4%			0.654	0.721
61	Poor school work	39.0%	61.0%	40.5%	59.5%	27.8%	72.2%	1.71	0.635
62	Poorly coordinated or clumsy	38.3%	61.7%	41.8%	58.2%	22.2%	77.8%	2.11	0.549
63	Prefers being with older children	39.1%	60.9%	37.5%	62.5%	33.3%	66.7%	0.687	0.876
64	Prefers being with younger children	38.3%	61.7%	38.9%	61.1%	71.4%	28.6%	3.80	0.284
65	Refuses to talk	40.9%	59.1%	33.3%	66.7%	100.0%	.0%	7.24	0.064
66	Repeats certain acts over and over, compulsions	39.4%	60.6%	28.6%	71.4%	.0%	100.0%	2.26	0.519
67	Disrupts class discipline	40.0%	60.0%	36.4%	63.6%	.0%	100.0%	2.26	0.520
68	Screams a lot	39.6%	60.4%	36.4%	63.6%	.0%	100.0%	2.09	0.553
69	Secretive, keeps things to self	43.0%	57.0%	31.4%	68.6%	.0%	100.0%	5.84	0.120
70	Sees things that are not there	38.8%	61.2%	100.0%	.0%			2.21	0.331
71	Self conscious, or easily embarrassed	43.6%	56.4%	24.1%	75.9%	.0%	100.0%	11.52	**0.009**
72	Messy work	40.1%	59.9%	33.3%	66.7%	.0%	100.0%	2.17	0.538
73	Behaves irresponsibly	39.2%	60.8%	.0%	100.0%			0.16	0.523
74	Showing off or clowning	38.3%	61.7%	50.0%	50.0%			1.83	0.400
75	Shy or timid	41.6%	58.4%	35.4%	64.6%	33.3%	66.7%	2.09	0.552
76	Explosive and unpredictable behavior	38.3%	61.7%	52.6%	47.4%	.0%	100.0%	2.82	0.420
77	Demands must be met immediately, easily frustrated	39.0%	61.0%	50.0%	50.0%	.0%	100.0%	2.32	0.508
78	Inattentive easily distracted	39.7%	60.3%	40.3%	59.7%	9.1%	90.9%	4.92	0.178
79	Speech problem	38.8%	61.2%	44.4%	55.6%	50.0%	50.0%	0.858	0.835
80	Stares blankly	37.3%	62.7%	53.8%	46.2%	.0%	100.0%	5.28	0.152
81	Feels hurt when criticized	43.1%	56.9%	36.7%	63.3%	14.3%	85.7%	3.98	0.263
82	Steals	39.1%	60.9%	.0%	100.0%			1.28	0.527
83	Stores up things he or she doesn't need	38.9%	61.1%	50.0%	50.0%			0.741	0.691
84	Strange behavior	38.9%	61.1%	.0%	100.0%			0.741	0.610
85	Strange ideas	39.1%	60.9%	50.0%	50.0%	.0%	100.0%	2.12	0.547

86	Stubborn or irritable	41.1%	58.9%	37.6%	62.4%	12.5%	87.5%	3.49	0.321
87	Sudden changes in mood or feeling	38.8%	61.2%	42.0%	58.0%	.0%	100.0%	2.11	0.549
88	Sulks a lot	37.3%	62.7%	45.6%	54.4%	.0%	100.0%	3.06	0.382
89	Suspicious	39.4%	60.6%	22.2%	77.8%			1.73	0.421
90	Swearing or obscene language	39.8%	60.2%	28.6%	71.4%	.0%	100.0%	2.32	0.508
91	Talks about killing self	39.1%	60.9%	50.0%	50.0%	.0%	100.0%	2.12	0.547
92	Underachieving, not working up to potential	43.4%	56.6%	34.0%	66.0%	35.3%	64.7%	3.88	0.274
93	Talks too much	38.7%	61.3%	41.3%	58.7%	25.0%	75.0%	1.12	0.773
94	Teases a lot	39.5%	60.5%	38.1%	61.9%	.0%	100.0%	2.60	0.457
95	Temper tantrums or hot tempered	40.2%	59.8%	34.9%	65.1%	.0%	100.0%	4.33	0.228
96	Seems preoccupied with sex	39.0%	61.0%	33.3%	66.7%			0.679	0.712
97	Threatens people	39.8%	60.2%	16.7%	83.3%			3.24	0.198
98	Tardy to school or class	39.4%	60.6%	35.7%	64.3%	100.0%	.0%	4.10	0.250
99	Too concerned with neatness/cleanliness	40.6%	59.4%	20.0%	80.0%	.0%	100.0%	6.59	0.086
100	Fails to carry out assigned tasks	41.1%	58.9%	35.4%	64.6%	20.0%	80.0%	2.45	0.484
101	Truancy or unexplained absence	40.1%	59.9%	33.3%	66.7%	.0%	100.0%	2.11	0.549
102	Under active, slow moving, lacks energy	38.8%	61.2%	40.4%	59.6%			0.687	0.709
103	Unhappy, sad, depressed	37.5%	62.5%	48.0%	52.0%			2.62	0.270
104	Unusually loud	39.1%	60.9%	35.7%	64.3%			0.704	0.703
105	Uses alcohol or drugs	39.1%	60.9%	.0%	100.0%			1.28	0.527
106	Overly anxious to please	41.1%	58.9%	30.1%	69.9%	50.0%	50.0%	3.86	0.277
107	Dislikes school	38.2%	61.8%	60.0%	40.0%	.0%	100.0%	4.15	0.245
108	Is afraid of making mistakes	38.3%	61.7%	50.0%	50.0%	100.0%	.0%	3.08	0.378
109	Whining	38.8%	61.2%	45.5%	54.5%			0.83	0.658
110	Unclean personal appearance	38.4%	61.6%	45.8%	54.2%			1.18	0.554
111	Withdrawn, doesn't get involved with others	38.2%	61.8%	40.0%	60.0%	100.0%	.0%	3.88	0.274

112	Worrying	40.4%	59.6%	27.0%	73.0%			3.12	0.210
113	Any other problem the pupil has that were not listed above	38.5%	61.5%	100.0%	.0%			5.37	0.068

Table **-** 9 shows that there were significant differences for students of different age groups on item no 14, 30, 32, 33, and 71.

Percentage distribution of behavior problems items were significantly higher among the age group of 9-11 years than 6-8 years age group students on the following items 32 (needs to be perfect), 33 (feels unloved), 71 (self conscious).

The following problems were significantly higher among the 6-8 years age group students: 14 (cries a lot), 30 (fears school).

Table - 10: Percentage distribution of behavior problem items by number of siblings of the subject

SL	Problem Item	False		Sometimes true		Very or Often true		X^2	p-value
		Number of Siblings		Number of Siblings		Number of Siblings			
		1 to 4	Above 5	1 to 4	Above 5	1 to 4	Above 5		
1	Act too young for his or her age	89.1%	10.9%	85.2%	14.8%	50.0%	50.0%	10.86	0.012
2	Hums or make other odd noises in class	89.5%	10.5%	84.2%	15.8%	85.7%	14.3%	16.20	0.003
3	Argues a lot	89.3%	10.7%	82.1%	17.9%	100.0%	.0%	**16.98**	**0.002**
4	Fails to finish things he/she starts	88.2%	11.8%	90.4%	9.6%	82.4%	17.6%	8.72	0.068
5	Behaves like opposite sex	88.5%	11.5%	100.0%	.0%			7.72	0.021
6	Defiant, talks back to staff	88.9%	11.1%	83.4%	17.6%			8.26	0.016
7	Bragging, boasting	87.9%	12.1%	96.4%	3.6%	100.0%	.0%	**9.55**	**0.023**
8	Can't concentrate, can't pay attention for long	88.4%	11.6%	90.1%	9.9%	77.8%	22.2%	9.99	0.019
9	Can't get his/her mind off certain thoughts; Obsessions	88.4%	11.6%	100.0%	.0%			8.23	0.016
10	Can't sit still, restless or hyperactive	91.1%	8.9%	86.2%	13.8%	80.8%	19.2%	11.15	0.011

11	Clings to adult or too dependant	88.7%	11.3%	75.0%	25.0%			**8.32**	**0.016**
12	Complains of loneliness	88.5%	11.5%	100.0%	.0%	100.0%	.0%	7.97	0.047
13	Confused or seems to be in a fog	88.9%	11.1%	81.3%	18.8%			8.46	0.015
14	Cries a lot	89.8%	10.2%	77.1%	22.9%	100.0%	.0%	**12.62**	**0.006**
15	Fidgets	88.7%	11.3%	87.3%	12.7%	100.0%	.0%	**8.20**	**0.042**
16	Cruelty, bulling or meanness to others	89.6%	10.4%	76.7%	23.3%	100.0%	.0%	**12.20**	**0.007**
17	Daydreams or gets lost in his/her thoughts	88.8%	11.2%	86.5%	13.5%			7.76	0.021
18	Deliberately harm self or attempts suicide	88.5%	11.5%	100.0%	.0%			7.84	0.020
19	Demands a lot of attention	92.5%	7.5%	83.2%	16.8%	91.7%	8.3%	14.70	0.002
20	Destroys his or her own things	88.8%	11.2%	87.5%	12.5%	75.0%	25.0%	8.34	0.039
21	Destroys property belonging to others	88.8%	11.2%	81.8%	18.2%	100.0%	.0%	**8.21**	**0.042**
22	Difficulty following directions	88.4%	11.6%	89.3%	10.7%	100.0%	.0%	7.86	0.049
23	Disobedient at school	89.2%	10.8%	82.5%	17.5%	100.0%	.0%	**9.65**	**0.022**
24	Disturbs other pupils	88.6%	11.4%	87.3%	12.7%	100.0%	.0%	**8.58**	**0.035**
25	Doesn't get along with other pupils	88.4%	11.6%	87.9%	12.1%	100.0%	.0%	**8.51**	**0.037**
26	Doesn't seem to feel guilty after misbehaving	90.0%	10.0%	79.6%	20.4%	90.0%	10.0%	12.04	0.007
27	Easily jealous	88.8%	11.2%	83.3%	16.7%	100.0%	.0%	**8.76**	**0.033**
28	Eats or drinks things that are not food	88.6%	11.4%						
29	Fears certain animals, situations, or places other than school	88.5%	11.5%	100.0%	.0%			7.71	0.021
30	Fears going to school	88.5%	11.5%	91.7%	8.3%			7.72	0.021
31	Fears he/she might think or do something bad	88.5%	11.5%	100.0%	.0%	100.0%	.0%	7.79	0.047
32	Feels she/he has to be perfect	89.9%	10.1%	85.7%	14.3%	85.0%	15.0%	**8.99**	**0.029**

Dhaka University Institutional Repository

33	Feels or complains that none love him or her	88.6%	11.4%	86.7%	13.3%	100.0%	.0%	7.89	0.048
34	Feels others are out to get him/her	88.6%	11.4%	85.7%	14.3%	100.0%	.0%	3.05	0.384
35	Feels worthless or inferior	88.5%	11.5%	100.0%	.0%	100.0%	.0%	7.97	0.047
36	Gets hurt a lot, accident prone	89.2%	10.8%	82.4%	17.6%			**9.00**	**0.011**
37	Gets in many fights	89.0%	11.0%	85.7%	14.3%	100.0%	.0%	**8.16**	**0.043**
38	Gets teased a lot	89.1%	10.9%	84.8%	15.2%	100.0%	.0%	**8.56**	**0.036**
39	Hangs around with others who get in trouble	88.7%	11.3%	84.6%	15.4%	100.0%	.0%	7.92	0.048
40	Hears things that are not there	88.6%	11.4%						
41	Impulse or act without thinking	92.2%	7.8%	81.1%	18.9%	100.0%	.0%	17.30	<0.001
42	Likes to be alone	87.2%	12.8%	91.0%	9.0%	100.0%	.0%	9.10	0.028
43	Lying or cheating	90.0%	10.0%	80.6%	19.4%	100.0%	.0%	12.73	0.005
44	Bites fingernails	89.4%	10.6%	80.6%	19.4%	100.0%	.0%	10.20	0.017
45	Nervous, high strung, or tense	89.0%	11.0%	75.0%	25.0%	100.0%	.0%	10.04	0.018
46	Nervous movement or twitching	88.5%	11.5%	100.0%	.0%			7.84	0.020
47	Over conforms to rules	88.6%	11.4%	86.7%	13.3%	100.0%	.0%	8.02	0.045
48	Not liked by other pupils	89.9%	10.1%	76.9%	23.1%	100.0%	.0%	13.75	0.003
49	Has difficulty learning	89.1%	10.9%	87.9%	12.1%	75.0%	25.0%	8.42	0.038
50	Too fearful or anxious	89.0%	11.0%	83.3%	16.7%	100.0%	.0%	8.58	0.035
51	Feels dizzy	88.6%	11.4%	85.7%	14.3%			**7.64**	**0.022**
52	Feels too guilty	88.5%	11.5%	100.0%	.0%	66.7%	33.3%	10.13	0.017
53	Talks out of run	89.3%	10.7%	88.0%	12.0%	66.7%	33.3%	10.53	0.015
54	Overtired	89.2%	10.8%	76.5%	23.5%			10.13	0.006
55	Overweight	88.5%	11.5%	90.0%	10.0%			7.61	0.022
56a	Physical problems without known medical causes (a) Aches or pains	88.2%	11.8%	100.0%	.0%	100.0%	.0%	9.30	0.026

56b	Physical problems without known medical causes (b) headaches	90.4%	9.6%	80.3%	19.7%	100.0%	.0%	13.14	0.004
56c	Physical problems without known medical causes (c) Nausea, feels sick	88.4%	11.6%	100.0%	.0%	100.0%	.0%	8.23	0.041
56d	Physical problems without known medical causes (d) Problems with eyes	88.4%	11.6%	100.0%	.0%			8.23	0.016
56e	Physical problems without known medical causes (e) Rashes or other skin problems	88.5%	11.5%	100.0%	.0%			7.71	0.021
56f	Physical problems without known medical causes (f) Stomach-aches or cramps	89.0%	11.0%	83.9%	16.1%	100.0%	.0%	8.44	0.038
56g	Physical problems without known medical causes (g) Vomiting, throwing up	88.5%	11.5%	100.0%	.0%			7.84	0.020
56h	Physical problems without known medical causes (h) Other...............	88.6%	11.4%						
57	Physically attack people	88.7%	11.3%	87.1%	12.9%			7.66	0.022
58	Picks nose, skin or other parts of body	88.5%	11.5%	100.0%	.0%			7.84	0.020
59	Sleeps in class	88.9%	11.1%	84.0%	16.0%	100.0%	.0%	**8.25**	**0.041**
60	Apathetic or unmotivated	87.7%	12.3%	91.2%	8.8%			8.41	0.015
61	Poor school work	87.1%	12.9%	90.8%	9.2%	88.9%	11.1%	8.66	0.034
62	Poorly coordinated or clumsy	87.5%	12.5%	90.9%	9.1%	88.9%	11.1%	8.44	0.038
63	Prefers being with older children	88.2%	11.8%	100.0%	.0%	100.0%	.0%	9.02	0.029
64	Prefers being with younger children	88.3%	11.7%	94.4%	5.6%	85.7%	14.3%	8.27	0.041
65	Refuses to talk	88.4%	11.6%	88.6%	11.4%	100.0%	.0%	7.97	0.046

66	Repeats certain acts over and over, compulsions	88.6%	11.4%	85.7%	14.3%	100.0%	.0%	7.90	0.048
67	Disrupts class discipline	89.3%	10.7%	85.7%	14.3%	100.0%	.0%	8.59	0.035
68	Screams a lot	89.5%	10.5%	81.8%	18.2%	100.0%	.0%	10.03	0.018
69	Secretive, keeps things to self	88.6%	11.4%	89.3%	10.7%	.0%	100.0%	**15.26**	**0.002**
70	Sees things that are not there	88.5%	11.5%	100.0%	.0%			7.71	0.021
71	Self conscious, or easily embarrassed	88.7%	11.3%	88.0%	12.0%	100.0%	.0%	7.75	0.051
72	Messy work	89.1%	10.9%	85.2%	14.8%	100.0%	.0%	8.41	0.038
73	Behaves irresponsibly	88.5%	11.5%	100.0%	.0%			7.84	0.020
74	Showing off or clowning	88.7%	11.3%	86.4%	13.6%			7.70	0.021
75	Shy or timid	88.0%	12.0%	89.1%	10.9%	100.0%	.0%	8.07	0.045
76	Explosive and unpredictable behavior	88.8%	11.2%	84.2%	15.8%	100.0%	.0%	8.08	0.044
77	Demands must be met immediately, easily frustrated	88.5%	11.5%	87.5%	12.5%	100.0%	.0%	7.85	0.049
78	Inattentive easily distracted	88.8%	11.2%	88.8%	11.2%	81.8%	18.2%	8.09	0.044
79	Speech problem	88.8%	11.2%	77.8%	22.2%	100.0%	.0%	8.88	0.031
80	Stares blankly	88.1%	11.9%	92.3%	7.7%	100.0%	.0%	8.32	0.040
81	Feels hurt when criticized	88.9%	11.1%	89.4%	10.6%	57.1%	42.9%	14.46	0.002
82	Steals	88.8%	11.2%	.0%	100.0%			15.22	<0.001
83	Stores up things he or she doesn't need	88.5%	11.5%	100.0%	.0%			7.84	0.020
84	Strange behavior	88.5%	11.5%	100.0%	.0%			2.99	0.224
85	Strange ideas	88.4%	11.6%	100.0%	.0%	100.0%	.0%	8.36	0.039
86	Stubborn or irritable	90.6%	9.4%	85.9%	14.1%	87.5%	12.5%	9.43	0.024
87	Sudden changes in mood or feeling	89.3%	10.7%	84.0%	16.0%	100.0%	.0%	**8.99**	**0.029**
88	Sulks a lot	90.3%	9.7%	82.3%	17.7%	100.0%	.0%	11.58	0.009
89	Suspicious	88.6%	11.4%	88.9%	11.1%			7.59	0.022
90	Swearing or obscene language	88.7%	11.3%	85.7%	14.3%	100.0%	.0%	7.89	0.048
91	Talks about killing self	88.4%	11.6%	100.0%	.0%	100.0%	.0%	**8.36**	**0.039**

92	Underachieving, not working up to potential	90.5%	9.5%	87.6%	12.4%	76.5%	23.5%	10.81	0.013
93	Talks too much	90.4%	9.6%	81.0%	19.0%	75.0%	25.0%	12.81	0.005
94	Teases a lot	89.5%	10.5%	81.0%	19.0%	100.0%	.0%	10.59	0.014
95	Temper tantrums or hot tempered	89.1%	10.9%	83.7%	16.3%	100.0%	.0%	**9.28**	**0.026**
96	Seems preoccupied with sex	88.5%	11.5%	100.0%	.0%			7.97	0.019
97	Threatens people	88.8%	11.2%	83.3%	16.7%			7.92	0.019
98	Tardy to school or class	88.9%	11.1%	87.1%	12.9%	100.0%	.0%	8.00	0.046
99	Too concerned with neatness/cleanliness	88.1%	11.9%	95.0%	5.0%	100.0%	.0%	8.98	0.029
100	Fails to carry out assigned tasks	88.4%	11.6%	90.3%	9.7%	60.0%	40.0%	11.87	0.008
101	Truancy or unexplained absence	89.3%	10.7%	86.3%	13.7%	.0%	100.0%	**15.60**	**0.001**
102	Under active, slow moving, lacks energy	87.9%	12.1%	92.3%	7.7%			8.41	0.015
103	Unhappy, sad, depressed	88.3%	11.7%	90.0%	10.0%			7.70	0.021
104	Unusually loud	88.7%	11.3%	85.7%	14.3%			7.70	0.021
105	Uses alcohol or drugs	88.5%	11.5%	100.0%	.0%			7.71	0.021
106	Overly anxious to please	89.3%	10.7%	86.3%	13.7%	83.3%	16.7%	8.25	0.041
107	Dislikes school	88.6%	11.4%	86.7%	13.3%	100.0%	.0%	7.77	0.051
108	Is afraid of making mistakes	88.9%	11.1%	87.5%	12.5%	.0%	100.0%	**15.25**	**0.002**
109	Whining	88.8%	11.2%	81.8%	18.2%			8.09	0.017
110	Unclean personal appearance	89.3%	10.7%	80.6%	19.4%			9.66	0.008
111	Withdrawn, doesn't get involved with others	88.5%	11.5%	88.4%	11.6%	100.0%	.0%	7.84	0.049
112	Worrying	89.1%	10.9%	83.8%	16.2%			8.51	0.014
113	Any other problem the pupil has that were not listed above	88.5%	11.5%	100.0%	.0%			7.97	0.019

Table **-** 10 shows that there were significant differences for students of different groups according to number of siblings.

Scores of behavior problems items were significantly higher among the sibling group of '1-4 years' siblings than 'above 5' group students on the following items 3 (argues an lot), 7 (Bragging), 11 (too dependent), 14 (cries a lot), 15 (fidgets), 16 (cruelty), 21 (destroys property), 23 (disobedient at school), 24 (disturbs other pupils'), 25 (doesn't get along with other pupils), 27 (easily jealous), 32 (feels to be perfect), 36 (accident prone), 37 (gets in many fights), 38 (teased a lot), 51 (feels dizzy), 59 (sleeps in class), 87 (sudden changes in mood or feelings), 91 (talks about killing self), 95(temper tantrums).

The following problems were significantly higher among the above 5 scores than 1-4 siblings group item 69 (secretive keeps things to self), 101 (truancy or unexplained absence), 108 (afraid of making mistakes).

Table - 11: Percentage distribution of behavior problem items by types of Madrasas of the subject

SL	Problem Item	False			Sometimes true			Very or Often true			X^2 value	p-value
		Male Madrasa	Female Madrasa	Coeducation	Male Madrasa	Female Madrasa	Coeducation	Male Madrasa	Female Madrasa	Coeducation		
1	Act too young for his or her age	33.6 %	33.9 %	32.4%	29.6 %	25.9 %	44.4%	50.0 %	50.0 %	.0%	4.68	0.585
2	Hums or make other odd noises in class	32.6 %	33.9 %	33.5%	34.2 %	28.9 %	36.8%	57.1 %	42.9 %	.0%	8.16	0.417
3	Argues a lot	31.6 %	34.7 %	33.7%	50.0 %	21.4 %	28.6%	50.0 %	25.0 %	25.0%	8.69	0.368
4	Fails to finish things he/she starts	35.4 %	31.6 %	32.9%	30.8 %	35.6 %	33.7%	23.5 %	41.2 %	35.3%	5.72	0.679
5	Behaves like opposite sex	32.6 %	33.9 %	33.5%	34.2 %	28.9 %	36.8%	57.1 %	42.9 %	.0%	8.16	0.417
6	Defiant, talks back to staff	33.7 %	33.1 %	33.1%	.0%	50.0 %	50.0%	.0%	100.0 %	.0%	5.02	0.541
7	Bragging, boasting	33.9 %	32.7 %	33.3%	28.6 %	42.9 %	28.6%	.0%	.0%	100.0 %	5.21	0.516
8	Can't concentrate, can't pay attention for long	34.9 %	31.7 %	33.3%	30.3 %	35.5 %	34.2%	44.4 %	33.3 %	22.2%	4.30	0.636
9	Can't get his/her mind off certain thoughts; Obsessions	32.0 %	33.8 %	34.1%	46.7 %	30.0 %	23.3%	100.0 %	.0%	.0%	6.86	0.334
10	Can't sit still, restless or hyperactive	30.5 %	29.1 %	40.4%	38.5 %	38.5 %	23.1%	30.8 %	42.3 %	26.9%	13.77	0.032

11	Clings to adult or too dependant	35.4%	31.6%	32.9%	30.8%	35.6%	33.7%	23.5%	41.2%	35.3%	5.72	0.679
12	Complains of loneliness	33.7%	33.1%	33.1%	.0%	50.0%	50.0%	.0%	100.0%	.0%	5.02	0.541
13	Confused or seems to be in a fog	33.4%	33.1%	33.4%	35.7%	32.1%	32.1%	.0%	100.0%	.0%	6.07	0.415
14	Cries a lot	34.4%	29.7%	35.9%	25.7%	65.7%	8.6%	.0%	100.0%	.0%	24.07	0.001
15	Fidgets	36.0%	33.2%	30.8%	19.0%	34.9%	46.0%	75.0%	25.0%	.0%	13.61	0.034
16	Cruelty, bulling or meanness to others	32.0%	33.8%	34.1%	46.7%	30.0%	23.3%	100.0%	.0%	.0%	6.86	0.334
17	Daydreams or gets lost in his/her thoughts	35.4%	31.6%	32.9%	30.8%	35.6%	33.7%	23.5%	41.2%	35.3%	5.72	0.679
18	Deliberately harm self or attempts suicide	33.7%	33.1%	33.1%	.0%	50.0%	50.0%	.0%	100.0%	.0%	5.02	0.541
19	Demands a lot of attention	38.7%	30.6%	30.6%	29.5%	36.2%	34.2%	16.7%	37.5%	45.8%	8.73	0.189
20	Destroys his or her own things	32.2%	33.3%	34.5%	62.5%	25.0%	12.5%	25.0%	75.0%	.0%	12.28	0.056
21	Destroys property belonging to others	32.9%	33.1%	34.0%	45.5%	45.5%	9.1%	100.0%	.0%	.0%	6.98	0.322
22	Difficulty following directions	33.4%	33.1%	33.4%	35.7%	32.1%	32.1%	.0%	100.0%	.0%	6.07	0.415
23	Disobedient at school	32.7%	33.7%	33.7%	37.5%	30.0%	32.5%	50.0%	50.0%	.0%	4.40	0.622
24	Disturbs other pupils	31.8%	33.6%	34.6%	38.1%	33.3%	28.6%	57.1%	28.6%	14.3%	5.19	0.519
25	Doesn't get along with other pupils	32.0%	34.4%	33.7%	39.7%	29.3%	31.0%	42.9%	28.6%	28.6%	3.62	0.728
26	Doesn't seem to feel guilty after misbehaving	33.7%	32.0%	34.3%	30.6%	38.8%	30.6%	40.0%	50.0%	10.0%	5.51	0.480
27	Easily jealous	33.2%	32.0%	34.7%	37.5%	45.8%	16.7%	25.0%	75.0%	.0%	9.11	0.167
28	Eats or drinks things that are not food	33.7%	33.1%	33.1%	.0%	50.0%	50.0%	.0%	100.0%	.0%	5.02	0.541
29	Fears certain animals, situations, or places other than school	31.8%	33.6%	34.6%	38.1%	33.3%	28.6%	57.1%	28.6%	14.3%	5.19	0.519
30	Fears going to school	32.0%	34.4%	33.7%	39.7%	29.3%	31.0%	42.9%	28.6%	28.6%	3.62	0.728

31	Fears he/she might think or do something bad	33.4%	33.4%	33.1%	50.0%	.0%	50.0%	.0%	100.0%	.0%	5.00	0.543
32	Feels she/he has to be perfect	36.3%	30.2%	33.5%	30.8%	40.7%	28.6%	10.0%	40.0%	50.0%	10.82	0.094
33	Feels or complains that none love him or her	33.0%	33.0%	33.9%	40.0%	40.0%	20.0%	50.0%	50.0%	.0%	4.25	0.643
34	Feels others are out to get him/her	33.4%	33.1%	33.4%	28.6%	42.9%	28.6%	100.0%	.0%	.0%	3.29	0.771
35	Feels worthless or inferior	33.7%	33.1%	33.1%	.0%	50.0%	50.0%	.0%	100.0%	.0%	5.02	0.541
36	Gets hurt a lot, accident prone	32.0%	34.4%	33.7%	39.7%	29.3%	31.0%	42.9%	28.6%	28.6%	3.62	0.728
37	Gets in many fights	32.7%	34.0%	33.3%	38.8%	28.6%	32.7%	.0%	100.0%	.0%	4.85	0.563
38	Gets teased a lot	34.1%	34.1%	31.8%	30.4%	26.1%	43.5%	.0%	100.0%	.0%	8.57	0.199
39	Hangs around with others who get in trouble	33.6%	33.9%	32.5%	30.8%	15.4%	53.8%	.0%	100.0%	.0%	7.04	0.317
40	Hears things that are not there	33.0%	33.0%	33.9%	40.0%	40.0%	20.0%	50.0%	50.0%	.0%	4.25	0.643
41	Impulse or act without thinking	33.9%	28.7%	37.4%	31.1%	41.8%	27.0%	57.1%	42.9%	.0%	12.60	0.050
42	Likes to be alone	34.2%	32.9%	32.9%	32.8%	33.6%	33.6%	.0%	66.7%	33.3%	4.09	0.664
43	Lying or cheating	34.7%	29.9%	35.4%	27.4%	46.8%	25.8%	33.3%	66.7%	.0%	12.63	0.049
44	Bites fingernails	33.9%	32.6%	33.5%	30.6%	38.9%	30.6%	.0%	100.0%	.0%	4.58	0.599
45	Nervous, high strung, or tense	34.2%	32.2%	33.6%	16.7%	58.3%	25.0%	.0%	100.0%	.0%	9.73	0.137
46	Nervous movement or twitching	33.0%	33.0%	33.9%	40.0%	40.0%	20.0%	50.0%	50.0%	.0%	4.25	0.643
47	Over conforms to rules	35.2%	32.8%	32.0%	.0%	46.7%	53.3%	.0%	33.3%	66.7%	12.17	0.058
48	Not liked by other pupils	33.9%	33.2%	32.9%	33.3%	30.8%	35.9%	.0%	75.0%	25.0%	5.65	0.458
49	Has difficulty learning	38.5%	31.0%	30.5%	22.4%	37.9%	39.7%	50.0%	50.0%	.0%	13.14	0.041
50	Too fearful or anxious	35.4%	30.5%	34.1%	13.3%	63.3%	23.3%	.0%	100.0%	.0%	17.86	0.007
51	Feels dizzy	33.0%	33.0%	33.9%	40.0%	40.0%	20.0%	50.0%	50.0%	.0%	4.25	0.643
52	Feels too guilty	34.0%	32.9%	33.1%	11.1%	44.4%	44.4%	33.3%	66.7%	.0%	6.07	0.415
53	Talks out of run	34.1%	31.8%	34.1%	32.6%	35.9%	31.5%	16.7%	66.7%	16.7%	5.56	0.474

54	Overtired	32.0 %	34.4 %	33.7%	39.7 %	29.3 %	31.0%	42.9 %	28.6 %	28.6%	3.62	0.728
55	Overweight	34.2 %	32.2 %	33.6%	16.7 %	58.3 %	25.0%	.0%	100.0 %	.0%	9.73	0.137
56a	Physical problems without known medical causes (a) Aches or pains	33.8 %	34.1 %	32.1%	27.3 %	18.2 %	54.5%	.0%	.0%	100.0 %	8.61	0.197
56b	Physical problems without known medical causes (b) headaches	34.0 %	32.6 %	33.3%	31.8 %	36.4 %	31.8%	.0%	50.0 %	50.0%	3.35	0.763
56c	Physical problems without known medical causes (c) Nausea, feels sick	33.9 %	33.6 %	32.5%	.0%	.0%	100.0 %	.0%	100.0 %	.0%	12.12	0.059
56d	Physical problems without known medical causes (d) Problems with eyes	34.2 %	32.2 %	33.6%	16.7 %	58.3 %	25.0%	.0%	100.0 %	.0%	9.73	0.137
56e	Physical problems without known medical causes (e) Rashes or other skin problems	32.0 %	34.4 %	33.7%	39.7 %	29.3 %	31.0%	42.9 %	28.6 %	28.6%	3.62	0.728
56f	Physical problems without known medical causes (f) Stomach aches or cramps	33.3 %	31.5 %	35.2%	32.3 %	54.8 %	12.9%	100.0 %	.0%	.0%	12.85	0.045
56g	Physical problems without known medical causes (g) Vomiting, throwing up	33.0 %	33.0 %	33.9%	40.0 %	40.0 %	20.0%	50.0 %	50.0 %	.0%	4.25	0.643
56h	Physical	33.9	33.6	32.5%	.0%	.0%	100.0	.0%	100.0	.0%	12.12	0.059

	problems without known medical causes (h) Other......................	%	%				%		%			
57	Physically attack people											
58	Picks nose, skin or other parts of body	36.3 %	30.4 %	33.3%	26.4 %	39.1 %	34.5%	44.4 %	44.4 %	11.1%	7.97	0.240
59	Sleeps in class	33.9 %	32.7 %	33.3%	28.0 %	40.0 %	32.0%	.0%	100.0 %	.0%	4.63	0.592
60	Apathetic or unmotivated	33.5 %	34.2 %	32.3%	31.8 %	27.3 %	40.9%	50.0 %	50.0 %	.0%	4.45	0.616
61	Poor school work	37.6 %	33.3 %	29.0%	26.7 %	32.1 %	41.2%	33.3 %	44.4 %	22.2%	9.87	0.130
62	Poorly coordinated or clumsy	36.3 %	30.4 %	33.3%	26.4 %	39.1 %	34.5%	44.4 %	44.4 %	11.1%	7.97	0.240
63	Prefers being with older children	33.0 %	33.9 %	33.0%	62.5 %	12.5 %	25.0%	.0%	33.3 %	66.7%	7.30	0.294
64	Prefers being with younger children	34.7 %	32.6 %	32.6%	22.2 %	22.2 %	55.6%	.0%	100.0 %	.0%	20.29	0.002
65	Refuses to talk	33.9 %	29.8 %	36.4%	33.3 %	41.2 %	25.4%	.0%	33.3 %	66.7%	9.88	0.130
66	Repeats certain acts over and over, compulsions	33.9 %	32.5 %	33.6%	22.2 %	55.6 %	22.2%	.0%	100.0 %	.0%	8.12	0.229
67	Disrupts class discipline	35.0 %	32.1 %	32.9%	27.3 %	37.7 %	35.1%	50.0 %	50.0 %	.0%	4.72	0.580
68	Screams a lot	33.5 %	34.2 %	32.3%	31.8 %	27.3 %	40.9%	50.0 %	50.0 %	.0%	4.45	0.616
69	Secretive, keeps things to self	36.3 %	31.2 %	32.5%	28.1 %	37.2 %	34.7%	.0%	100.0 %	.0%	6.59	0.360
70	Sees things that are not there	33.0 %	33.9 %	33.0%	62.5 %	12.5 %	25.0%	.0%	33.3 %	66.7%	7.30	0.294
71	Self conscious, or easily embarrassed	31.3 %	31.3 %	37.5%	41.0 %	39.8 %	19.3%	.0%	100.0 %	.0%	13.49	0.036
72	Messy work	33.9 %	33.9 %	32.2%	31.5 %	29.6 %	38.9%	.0%	100.0 %	.0%	4.94	0.551
73	Behaves irresponsibly	33.4 %	32.9 %	33.7%	50.0 %	50.0 %	.0%	.0%	100.0 %	.0%	8.04	0.235
74	Showing off or clowning	33.9 %	32.5 %	33.6%	22.2 %	55.6 %	22.2%	.0%	100.0 %	.0%	8.12	0.229
75	Shy or timid	35.9 %	30.6 %	33.5%	30.6 %	36.7 %	32.7%	.0%	66.7 %	33.3%	5.72	0.454
76	Explosive and unpredictable behavior	34.5 %	32.2 %	33.3%	15.8 %	52.6 %	31.6%	.0%	100.0 %	.0%	8.18	0.225

77	Demands must be met immediately, easily frustrated	33.5%	33.5%	33.0%	37.5%	12.5%	50.0%	.0%	100.0%	.0%	7.77	0.225
78	Inattentive easily distracted	33.4%	32.9%	33.7%	50.0%	50.0%	.0%	.0%	100.0%	.0%	8.04	0.235
79	Speech problem	33.9%	32.5%	33.6%	22.2%	55.6%	22.2%	.0%	100.0%	.0%	8.12	0.229
80	Stares blankly	33.9%	32.0%	34.2%	28.2%	46.2%	25.6%	100.0%	.0%	.0%	7.19	0.303
81	Feels hurt when criticized	36.6%	24.2%	39.2%	32.2%	38.7%	29.1%	.0%	85.7%	14.3%	19.62	0.003
82	Steals	33.7%	32.9%	33.4%	25.0%	50.0%	25.0%	.0%	100.0%	.0%	6.54	0.366
83	Stores up things he or she doesn't need	33.4%	32.9%	33.7%	50.0%	50.0%	.0%	.0%	100.0%	.0%	8.04	0.235
84	Strange behavior	34.2%	30.8%	34.9%	31.7%	41.3%	27.0%	.0%	100.0%	.0%	12.85	0.045
85	Strange ideas	33.4%	32.9%	33.7%	50.0%	50.0%	.0%	.0%	100.0%	.0%	8.04	0.235
86	Stubborn or irritable	31.2%	28.7%	40.1%	36.9%	38.3%	24.8%	25.0%	62.5%	12.5%	14.48	0.025
87	Sudden changes in mood or feeling	33.2%	32.6%	34.2%	36.0%	36.0%	28.0%	.0%	100.0%	.0%	6.76	0.343
88	Sulks a lot	35.5%	31.9%	32.6%	26.6%	38.0%	35.4%	.0%	100.0%	.0%	6.29	0.391
89	Suspicious	33.7%	32.9%	33.4%	25.0%	50.0%	25.0%	.0%	100.0%	.0%	6.54	0.366
90	Swearing or obscene language	32.9%	34.1%	32.9%	42.9%	23.8%	33.3%	.0%	.0%	100.0%	5.24	0.514
91	Talks about killing self	33.7%	32.9%	33.4%	25.0%	50.0%	25.0%	.0%	100.0%	.0%	6.54	0.366
92	Underachieving, not working up to potential	33.3%	28.0%	38.6%	33.3%	37.9%	28.8%	35.3%	52.9%	11.8%	11.44	0.075
93	Talks too much	34.2%	30.8%	34.9%	31.7%	41.3%	27.0%	.0%	100.0%	.0%	12.85	0.045
94	Teases a lot	32.8%	32.8%	34.4%	40.5%	33.3%	26.2%	.0%	100.0%	.0%	9.44	0.150
95	Temper tantrums or hot tempered	32.5%	33.8%	33.8%	41.9%	25.6%	32.6%	20.0%	80.0%	.0%	9.02	0.172
96	Seems preoccupied with sex	34.2%	30.8%	34.9%	31.7%	41.3%	27.0%	.0%	100.0%	.0%	12.85	0.045
97	Threatens people	34.8%	32.2%	33.0%	6.3%	56.3%	37.5%	.0%	100.0%	.0%	10.49	0.105
98	Tardy to school or class	33.1%	32.1%	34.8%	34.3%	40.0%	25.7%	50.0%	.0%	50.0%	5.51	0.480

99	Too concerned with neatness/cleanliness	34.9%	33.1%	31.9%	15.0%	40.0%	45.0%	.0%	25.0%	75.0%	9.05	0.171
100	Fails to carry out assigned tasks	35.7%	31.5%	32.8%	30.1%	36.3%	33.6%	.0%	60.0%	40.0%	6.11	0.411
101	Truancy or unexplained absence	33.9%	32.2%	33.9%	31.4%	41.2%	27.5%	.0%	.0%	100.0%	5.69	0.459
102	Under active, slow moving, lacks energy	33.3%	28.0%	38.6%	33.3%	37.9%	28.8%	35.3%	52.9%	11.8%	11.44	0.075
103	Unhappy, sad, depressed	35.5%	31.9%	32.6%	26.6%	38.0%	35.4%	.0%	100.0%	.0%	6.29	0.391
104	Unusually loud	34.2%	30.8%	34.9%	31.7%	41.3%	27.0%	.0%	100.0%	.0%	12.85	0.045
105	Uses alcohol or drugs	33.3%	28.0%	38.6%	33.3%	37.9%	28.8%	35.3%	52.9%	11.8%	11.44	0.075
106	Overly anxious to please	35.0%	30.0%	35.0%	28.8%	47.9%	23.3%	16.7%	16.7%	66.7%	13.74	0.033
107	Dislikes school	33.8%	33.2%	32.9%	26.7%	40.0%	33.3%	.0%	.0%	100.0%	4.44	0.617
108	Is afraid of making mistakes	34.8%	32.2%	33.0%	6.3%	56.3%	37.5%	.0%	100.0%	.0%	10.49	0.105
109	Whining	32.5%	33.8%	33.8%	41.9%	25.6%	32.6%	20.0%	80.0%	.0%	9.02	0.172
110	Unclean personal appearance	33.4%	32.9%	33.7%	50.0%	50.0%	.0%	.0%	100.0%	.0%	8.04	0.235
111	Withdrawn, doesn't get involved with others	35.9%	31.3%	32.8%	27.4%	38.9%	33.7%	.0%	50.0%	50.0%	5.77	0.449
112	Worrying	34.2%	30.8%	34.9%	31.7%	41.3%	27.0%	.0%	100.0%	.0%	12.85	0.045
113	Any other problem the pupil has that were not listed above	35.7%	31.5%	32.8%	30.1%	36.3%	33.6%	.0%	60.0%	40.0%	6.11	0.411

Table - 11 shows that there were significant differences for students of different groups according to types of Madrasas.

According to TRF item no 14 (cries a lot), 49 (has difficulty learning), 50 (too fearful or anxious), 64 (prefers being with younger children), 71 (self conscious), 81 (feels hurt when criticized), and 86 (stubborn or irritable) got higher in female Madrasa.

Male Madrasa got higher score in item number 15 (fidgets) 49 (has difficulty learning), 56 f (physical problems without known medical causes) in compare to female and coeducation Madrasa.

Another objective of the current research was to see whether problem and non-problem children vary in family functioning. To address this objective measure of central tendency was taken. The following table will describe the difference between problem and non problem children in respect of family functioning.

Table - 12: descriptive scores of clinical and non clinical sample according to family functioning

Statistic	Clinical	Non-clinical
Mean	124.20	107.30
Std. Deviation	11.448	16.813

From table - 12 it was found that in case of family functioning score mean score (124.20) of clinical cases were higher than non clinical group (107.30) of the sample.

Chapter-04

Dhaka University Institutional Repository

DISCUSSION

The prime goal of this study was to assess behavior problems among Madrasa students where specific objectives were to find out the total number and percentages of Madrasa students who are in the clinical range of behavior problem scores, to see whether the total behavior problem scores of Madrasa students vary according to sex, age, number of siblings and types of Madrasas, to see whether each individual item scores of behavior problem varies according to sex, age, number of siblings and types of Madrasas, to find out whether problem and non-problem children vary in family functioning .

The relevant findings of the present research were presented in different tables in the previous section.

Considering the major goal of the research, result showed that out of 360 students 55 (15.3%) students of Madrasa had behavior problems in the clinical range (Table - 1).

Children are a precious gift and trust from God. The responsibility of parents and teachers is to help them develop into responsible, confident and mature adults. Any failure on their part could potentiality harm the children or impede their maturing process for which the society will have to pay a price at a later stage.

Probable explanation of such findings might be students of Madrasa system are usually from low economic background. People with low economic background experience high rate of economic and family stress, corruption and antisocial behavior. These reasons might lead to develop and manifest behavior problem in clinical range among Madrasa students.

According to Professor Sirajul Islam Chowdhury the poor of the country study at Madrasa and become poorer .Through the Madrasa system that need is met in such a manner that a large number of poor children spend years and years in Madrasa in the name of education and in reality remain uneducated and unqualified for the workplace. The children of the ruling class with opportunities and education maintain their power and position in society by keeping the poor Madrasa educated people in the dark ((Mehdy, 2006).

Research findings also showed that low income has proven negative consequences for children (Duncan & Gunn, 1997). Children who experience persistent poverty face developmental deficits

(Duncan,Gunn & Klebanov, 1994; Miller & Korenman, 1995). Another study reveals that one reason may be that low-income families are not able to afford adequate food, shelter, and other material goods that foster healthy cognitive and social development of children (Hanson, McLanahan, & Thomson, 1997; Hall et al., 1985).

Another explanation is might be strict rules and regulations of Madrasa education system, where they are regular victims of physical and mental abuse. Often they are tortured by their teachers and seniors and also they are punished by their teachers. According to Goldman, Salus, Wolcott, Kennedy (2003), all types of maltreatment-physical abuse, neglect, and psychological or emotional maltreatment can affect a child's emotional and psychological well-being lead to behavior problems.

Beside this, the quality of education currently provided under the Madrasa education system, does not provide much scope for students to develop as modern human beings. The conservative attitudes of the authorities, low quality teaching aids, unskilled teachers – all these factors combine to ensure that a good teaching learning environment does not exist within the Madrasa system which does not contribute to the development of good mental health in Madrasa students.

For the above mentioned explanations the students of Madrasa develop behavior problems in the clinical range.

Table - 2 describes the nature and frequency of behavior problem among Madrasa students including all groups as the table show the hierarchy of TRF items those are most frequent in research participants. 'Bragging' got the highest position in the hierarchy list whereas second one is 'difficulty following directions' and third one is 'fears of doing something bad'. Madrasa environment are very strict and restricted as education system and in general rules and regulations are introduced as strict as sin to children. So it is quite natural for these children to have fear of doing something very bad. People are tending to be aggressive toward strict rules and regulations where childhood is the time to play and enjoy. Children may feel annoyed and express arrogance being in a Madrasa system.

Higher proportion of male Madrasa students (40%) had behavior problem compared to female Madrasa (34.5%) and coeducation Madrasa students (22.5%) (Table - 3; Figure - 1). Madrasa education system in Bangladesh is quite different from traditional education system. Madrasa education system is usually established and maintained rules and regulations strictly to students.

Females may cope with this nature of Madrasa system easily where boys may express their unwillingness through manifestation of behavior problem.

More boys (56%) have behavior problems than girls (43%) according to TRF (Table - 4, Figure - 2). These findings are consistent with other researchers (Rahman & Begum, 2008; Azad & Begum, 2006; Dallam S. J., 2001; Patterson et al. Wang et al., 1990; Wang et al., 1989; Rutter & Garmezy, 1983).

Sex difference in behavior problem can be explained in different ways. Firstly, researchers (Werner and Smith, 1992) have found that on the whole boys tend to be more vulnerable to biological and psychological stresses than the girls. For example, boys are more vulnerable to peri-natal complications, early infections and defects which predispose them for later development of behavioral problems (Dallam S. J. 2001). Males do vary to some extent in biological indicators (e.g. testosterone hormone, Y chromosome) that have been linked to aggressive behavior (Hill and Lynch, 1983; Collaer and Hines, 1995).

According to researchers (Khurshid & Begum, 1999) parents in Bangladesh expect better performance and ability from a male student. If he cannot fulfill their expectations he gets more punishment and rejected behavior from the parents. This may lead to the development of anxiety, tension, depression, low self-esteem and other symptoms of behavior problems.

Students aged 9 to 11 years had more behavior problem than students aged 6 to 8 years (Table - 5, Figure - 3). This finding is consistent with other research findings (Rahman & Begum, 2008; Cohen et al., 1993 & Achenbach & Edelbrock, 1981). During this age (9-11 years) children’s body prepare themselves for coming puberty age, so different internal physiological changes occur and child has to adjust with this. As well as this is the time to introduce with wider community and social circumstances to adjust with. These may lead to experience lots of stress and threats during this time and manifests different problem behavior.

In most societies, students go through an important transition during early adolescence. Many students experience this transition at 9 years old. Most students thus enter adolescence during middle school, with ensuing transformations in their relationships with parents and peers. Peers become more important and parents allow their children to spend unsupervised time with friends (Mayseless et al., 1998). In a recent study Bronfenbrenner and Morris (2006) found that from a bioecological perspective parents and peers are the two aspects of adolescents’ Microsystems that

are most likely to generate socialization influences through frequent interactions at a sensitive time of development.

Because of these changes in the peer and family environment, it is not astonishing that in early adolescence there is also an increased prevalence of problem behavior (Lacourse et al., 2002). Another recent study reveals that problem behavior in adolescence, especially if it starts at a young age, is a reliable predictor of substance use, criminality, and police arrests in adulthood (Dishion and Patterson, 2006).

Those students who have 1 to 4 siblings manifests higher rate of behavior problems 88.3 % (Table - 6, Figure - 4) than above 5 siblings. This finding is not supported the findings of researchers who explained that overcrowding or large family size is a risk factor for the development of emotional or behavior problems (Kolvin et al., 1988 & Rutter, 1987). Here single child and small family have found more problematic that larger one. This can be explained such a way that now days, both parents are working outside home whatever the socio-economic status are. So, children's are growing up with their loneliness, anger and destruction, school and peer stress and so on. This situation may play as a factor for developing and maintaining behavior problem among Madrasa students.

According to summary of ANOVA (Table - 7), no significant difference was observed between age group of the sample, age and number of siblings, sex and number of siblings, types of Madrasa and number of siblings, and among age, sex and number of siblings. Additionally, similar findings was found among age groups, types of Madrasa and number of siblings. So, variables of this study were not significant effect on each other.

According to TRF score (Table - 8) there were differences between boys and girls on following items of 14, 36, 37, 39, 45, 50, 51, 54, 56 d, 60, 64, 65, 69, 75, 80, 81, 95, and 103. Boys scored significantly higher than girls on item number 36 (Accident prone), 37 (fighting), 39 (Bad friends). Whereas girls scored significantly higher on item number 13 (confused), 14 (cries a lot), 45 (nervous), 50 (fearful or anxious), 51 (Dizzy), 54 (over tired), 56 d (eye problems), 60 (Apathetic or unmotivated) , 64 (Prefers being with younger children), 65 (refuse to talk), 69 (secretive), 75 (shy, timid), 81 (Feels hurt when criticized), 95 (temper tantrums), 103 (Unhappy, sad or depressed). The reason behind these findings could be cultural perception and attitude towards gender. In Bangladesh girls tend to be emotional, sensitive and introvert whereas boys are more extrovert, outgoing and aggressive. More importantly society approved this tend to some extent.

Table - 9 indicates that behavior problem items were significantly higher among the age group of 9-11 years than 6-8 years age group students on the following items 32 (needs to be perfect), 33 (feels unloved), 71 (self conscious) and the subsequent problems were significantly higher among the 6-8 years age group students: 14 (cries a lot), 30 (fears school). From these findings it can be said that relatively younger children are more likely emotional and attached with parental figure, on the other hand older children are more active with outside world.

Table -10 shows that there were significant differences for students of different groups according to number of siblings. Scores of behavior problems items were significantly higher among the sibling group of 1-4 siblings than above 5 group students on the following items 3 (argues an lot), 7 (Bragging),11 (too dependent), 14 (cries a lot), 15 (fidgets), 16 (cruelty), 21 (destroys property), 23 (disobedient at school), 24 (disturbs other pupils'), 25 (doesn't get along with other pupils), 27 (easily jealous), 32 (Feels to be perfect), 36 (accident prone), 37 (gets in many fights), 38 (teased a lot), 51 (feels dizzy), 59 (sleeps in class), 65 (refuse to talk), 71 (self conscious), 77 (demands must be met immediately), 87 (sudden changes in mood or feelings), 91 (talks about killing self), 95(temper tantrums), 111 (withdrawn does not get involved with others) where the following items of problem behaviour were significantly higher among the above 5 scores than 1-4 siblings group item 69 (secretive keeps things to self), 101 (truancy or unexplained absence), 108 (afraid of making mistakes). The description above indicates having behavior problems in the 1-4 siblings group. So, single or small family are in the focus group of having problems. May be single children or less siblings has poor adjustment or coping mechanisms than larger family. Because they (single or less siblings) cannot share their feelings, cannot cope with wider community smoothly.

Table -11 shows that there were significant differences for students of different groups according to types of Madrasas. According to TRF item no 14 (cries a lot), 49 (has difficulty learning), 50 (too fearful or anxious), 64 (prefers being with younger children), 71 (self conscious), 81 (feels hurt when criticized), and 86 (stubborn or irritable) got higher in female Madrasa. Male Madrasa got higher score in item number 15 (fidgets) 49 (has difficulty learning), 56 f (physical problems without known medical causes) in compare to female and coeducation Madrasa. This results can be defined from our cultural perspective of approving females are being introvert, internalized and emotional than boys where boys should be aggressive and arrogant than girls. So, our culture has some social cognition and belief that may influence developing and expressing behavior problems.

There is a difference between problem and non problem children according to family functioning in mean and SD score (Table - 12). Although the differences in scores of problem and non problem children were small, they proved statistically significant. This finding is similar with another research (Schucksmith, Hendry, & Glendenning, 1995). So it can be assumed that poor family functioning may contribute to develop behaviour problem among Madrasa students. According to Walsh (1995) family communication processes are considered crucial for healthy family functioning and organization. In another study also reveals that there are strong and influential links between family functioning and individual behavior. Dysfunctional family functioning is related to child behavior problems (L'Abate (1998).

Implication of this research

Findings of this research provide a clear idea about the nature and frequency of behavior problem among Madrasa students. No research from psychological perspective has been done in this area so far in Bangladesh, so it can be a pioneer research in this field.

This research will offer the importance of providing psychological support to Madrasa students and will be a pathway to provide support to students of Madrasa education system.

Findings of this research suggested changing some of the management and policy issues of Madrasa education system. So, this research can act as a negotiator with higher authority of Madrasa system.

Limitations of the present research

This current research is not beyond limitations as it is an academic research by nature. The following section presents some limitations of the research:

- A vital limitation of the study is unavailability to seek holistic information from multiple informants. Parents interview were not taken due to practical causes. Children were not the major participants as information provided by young children is not considered reliable all time.

- The sample size of the research should be larger than the present one to maximize the scope of generalizing the findings. Though the research can provide a clear picture of the nature and frequency of behavior problem among Madrasa students.

- The participants of the research were the age group of 6 years to 11 years. It would be better if all age group of children were taken into account.

- For present research, researcher collected data from Dhaka Metropolitan city only which restricted the generalization of the study in respect of study location.

Recommendation:

It can be strongly recommend that there is a need to address theses behavior problem of Madrasa students to prevent development of other psychiatric disorders in children's.

Identifying signs and symptoms of behavior problem can be recommended to add into the training curriculum of Madrasa teachers so that they can identify and refer their students for psychological support.

Different workshops and seminars can be arranged for parents, care givers and teachers to prevent behavior problems among students by establishing positive parenting along with reinforcing environment within the Madrasa.

With these findings of present research service providers of psychological support may negotiate with madrasa authorities to initiate service program for these students having behavior problem.

Finally, some recommendations can be proposed to address the limitations of the current study as well as to cover all psychological aspects of Madrasa education system.

Research with large sample size and covering nationwide survey would be recommended to make a significant generalization regarding behavior problems of Madrasa students.

Along with survey it is also recommended to conduct qualitative study in this area to explore variables and interrelations among variables.

Dhaka University Institutional Repository

References

Achenbach, T.M. (1991). *Manual for the Child Behavior Checklist*. 4-18. Burlington, VT:University of Vermont- Department of Psychiatry.

Achenbach, T.M. (2001). *Child Behavior Checklist for Ages 6 to 18*. Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M, and Edelbrock, C. S. (1978). 'The classification of Child Psychopathology: A review, & analysis of empirical efforts'. *Psychological bulletin*, *85*, 1275-1300.

Achenbach. T.M. and Edelbrock, C.S. (1981). *Behavioral problems and competencies Reported by parents of normal and disturbed children aged 4 through 16*. Monographs of the Society for research in Child Development, 46. (Serial no. 188).

Achenbach, T.M., and Edelbrock, C.S. (1983). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile.* Burlington: University of Vermont. Department of Psychiatry.

Achenbach, T. M., McConaughy, S. H., & Howell, C. T. (1987). 'Child/ adolescent behavioral and emotional problems: Implications of cross informant correlations for situational specificity'. *Psychological Bulletin, 101,* 213-232.

Alldred, P. & Gillies, V. (2002). Eliciting research accounts: Producing modern subjects? In M. Mauthner, M. Birch, J. Jessop, & T. Millar (Eds.), *Ethics in qualitative research* (pp. 146–165). London: Sage.

Almeida-Folho, N. De. (1984). 'Family Variable and child mental disorders in a third world urban area (Bahia Brazil)'. *Social Psychiatry*, *19*, 23-30.

Amato, P. and Keith, B. (2006). 'Parental divorce and well-being of children: A Meta analysis'. *Psychological Bulletin*. *110,* 26-46.

Amato, P. (1993). 'Children's adjustment to divorce: Theories, hypotheses and empirical support'. *Journal of Marriage and the Family. 55, 23-38.*

American Psychiatric Association (1994). Author; *Diagnostic and statistical manual of mental disorders:* 4th ed. Washington. DC.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Ed.). Arlington, VA: American Psychiatric Publishing. pp. 271–280.

Anderson. J. C. Williams, S, Mc Gee. R., *&* Silva, P. (I987). 'DSM III disorders in Preadolescent children'. *Archives of General Psychiatry*, *44*, 69-76.

Angold A. (1989). Structured assessment of psychopathology in children and adolescents. In: Thompson C. (ed), *The Instruments of Psychiatric Research*, 271-304. John Wiley. Chichester.

Angold A., Cox A. Prendergast M. & Rutter M. (1995). *The Child and Adolescent Psychiatric Assessment (CAPA). Developmental Epidemiology Program*. Duke University Medical Center. Durham, North Carolina, USA.

Atkenson, B.M., & Forehand, R. (1981), Conduct disorders. In E.J. Mash & L.G. Terdal (EDs.), *Behavioral Assessment of childhood disorders* (pp. 185-219). New York: Guilford Press.

Azad, S.M.A & Begum, R (2006). 'Behavioral Problems in Primary School Children of Dhaka city'. *Bangladesh psychological Studies*, *16,* 67-78.

BANBEIS (1999). Preliminary Report of the National Education Survey (Post Primary).

Barrios, Hartmann and Shigetomi (1988). 'Behavioral Assessment and Treatment of Overanxious Disorder in Children and Adolescents'. *Western Psychiatric Institute and Clinic Behav Modif ,23,* 234-251.

Becker, H. S., & Geer, B. (1957). ' Participant observation and interviewing: a comparison'. *Human Organization, 16*(3), 28-32.

Begum. R. (1993) . 'A study of behavioral problems in children in Dhaka city, Bangladesh'. Unpublished Ph. D. thesis, University of Vienna, Australia.

Begum. R. (1994). ‘ Relationship of behavior problem with social competence, school Performance and adaptive functioning in children’. *The Dhaka University Journal of Biological Sciences, 3, No.2,* 159-164.

Begum. R. (1997). ‘Need for identification and assessment of behavior problems in children’. *Dhaka Univ. J. Psychology*, *21*, 37-24.

Biederman, J., Wilens, Mick, T.E., Milberger, S., Spencer, T.J. and Faraone, S.V. (1995). ‘Psychoactive substance use disorders in children with attention deficit hyperactivity disorder ADHD: Effects of ADHD and psychiatric comorbidity’. *American Journal of Psychiatry 152*, 1652–1658.

Bird, H.R. Canio, G., Rubio-Stipec, M., Ribera, J., Sesman, M., Woodbury. M., Huertas-Goldman. S., Pagan, A., Sancheda-Lacay, A., and Moscosa, M. (1988). ‘Estimates of the prevalence of childhood maladjustment in a community survey in Puerto Rico’. *Archives of General Psychiatry*, 45, 1120-1126.

Black, C., Bucky, S.F., & Wilder-Padilla, S. (1996). ‘The interpersonal and emotional consequences of being an adult child of an alcoholic’. *International Journal of Addiction, 21,* 213-231.

Bronfenbrenner U. & Morris, P. A. (2006). The ecology of developmental processes. In R. M. Lerner (Ed.), *Handbook of Child Psychology.* pp. 993–1028. New York: Wiley.

Boszormenyi-Nagy, I., Grunebaum, J. & Ulrich, D. (1991). Contextual family therapy. In A.S. Gurman, & D.P. Kniskern (Eds.), *Handbook of family therapy. Vol. 2* (pp. 200-238). NewYork: Brunner/Mazel.

Bowlby, J. (1951). ‘Maternal care and mental health’. *World Health Organization Monograph No. 2.* Geneva: WHO.

Bowlby, J. (1978). *Attachment and loss*. vol. 1: Attachment. New York: Penguin.

Brown, J. and D. Canter. The Uses of Explanation in the Research Interview. M. Brenner, J. Brown, and D. Canter (Ed), *The Research Interview: Uses and Approaches*. New York: Academic, P. 217-245.

Campbell S.B., Shaw DS, Gillioim M. (2000). 'Early externalizing behavior problems: Toddlers and preschoolers at risk for later maladjustment'. *Development and Psychopathology.* 12, 467-488.

Campbell, S.B. (1995). *Behavior problems in preschool children: Clinical & developmental issues*. Guilford Press, New York.

Capaldi, D. M., Pears, K. C., Kerr, D. C. R., Owen, L. D., & Kim, H. K. (2012). 'Growth in externalizing and internalizing problems in childhood: A prospective study of psychopathology across three generations'. *Child Development, 83,* 1945-1959.

Carr, A. (1993). 'Epidemiology of psychological disorders in Irish Children'. *Irish Journal of Psychology,* 14, 546-60.

Carr, A. (1999). *The Handbook of Child and Adolescent Psychology*. *A Contextual Approach.* pp-48.

Carson, R.C. & Butcher, J.N. (1992). *Abnormal Psychology and Modern Life*. NewYork : Harper Collins.

Chess, S., & Thomas, A. (1989). Issues in the clinical application of temperament. In G. A. Kohnstamm, J. E. Bates, & M. K. Rothbart (Eds.), *Temperament in childhood*. (pp. 378-386). Chichester: Wiley.

Chess, S. and Thomas, A. (1995). *Temperament in Clinical Practice*. New York: Guilford.

Chess, S., & Thomas, A. (1984*). Origins and evolution of behavior disorders*. New York: Bruner/Mazel. (Reprinted in paperback in 1987, Harvard University Press.)

Chowdhury, S. M. & Afrose, D. (1998). 'An Investigation of Adolescent's Problems in Bangladesh'. *Dhaka University Journal of Psychology, Vol. 22*, pp. 13-26.

Cohen, P., Cohen, J., Kasen, S., Velez, C., Hartmark, C., Johnson, J., Rojas, M., Brook, J. and Streuning, E. (1993). 'An epidemiological study of disorders in late childhood and adolescence-1. Age and gender-specific prevalence'. *Journal of Child Psychology and Psychiatry,* 34, 851-867.

Coie, J. D. & Dodge, K. A. (1998). Aggression and antisocial behavior. In W. Damon (Series Ed.) & N. Eisenberg (Vol. Ed.), *Handbook of Child Psychology*. Vol. 3. Social, emotional and personality development (pp. 779-862). New York: Wiley.

Colapinto, J. (1991). Structural family therapy. In A.S. Gurman & D.P. Kniskern (Eds.), *Handbook of family therapy. Vol. 2* (pp. 417-443). New York: Brunner/Mazel.

Collaer, M. L., and Hines, M. (1995). 'Human behavioral sex differences: A role for gonadal hormones during early development?'. *Psychol. Bull. 118***,** 55–107.

Conners, C. K. (1969). 'A Teacher rating scale for use in drug studies with children'. *American Journal of Psychiatry,* 126, 884 - 888.

Conners, C. K. (1973). 'What parents need to know about stimulant drugs & special education?'. *Journal of learning Disabilities, 6,* 13-15.

Costello. A. J., Edelbrock C.S., Dulcan. M.K., Kalas, R., & Klari, S.H. (1984). The NIMH Diagnostic Interview Schedule for Children (DISC): Final Report. National Institute of Mental Health, Betheseda, MD.

Costello. E. J. (1989). 'Developments in child psychiatric epidemiology'. *Journal of the American Academy of Child and Adolescent psychiatry, 2,.* 836-841.

Cummings, E. M., & Davies, P (1994). *Children and marital conflict: The impact of family dispute and resulation*. NewYork: Guilford Press.

Cusinato, M. (1998). Parenting styles and psychopathology. In L. L'Abate (Ed.), *Family psychopathology. The relational roots of dysfunctional behavior* (pp. 158-184). New York: The Guilford Press.

Dallam S. J. (2001). The long-term medical consequences of childhood maltreatment. In: Franey K, Geffner R, Falconer Reditors (Eds), *Family Violence & Sexual Assault Institute*. (pp. 1-14). San Diego.

Dishion, T. J., & Patterson, G. R. (2006). The development and ecology of antisocial behavior. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 3. Risk, disorder, and adaptation* (2nd ed., pp. 503–541). Hoboken, NJ: Wiley.

Dodge K.A., Pettit, G.S., & Bates, J.E. (1994). ‘ Socialization mediators of the relation between socioeconomic status and child conduct problems’. *Child Development*, 65, 649-665.

Dodd, L. W. (2009). ‘Therapeutic group work with young children and mothers who have experienced domestic abuse’. *Educational Psychology in Practice* 25: 21–36.

Duncan, G.J., and Brooks-Gunn, J. (1997). *Consequences of growing up poor.* (Eds). New York: Russell Sage Foundation.

Duncan, G.J., & Brooks-Gunn, J., (1994) . ‘Economic deprivation and early-childhood development’. *Child Development* 65, (2), 296–318.

Edelbrock, C. & Costello, A. J. (1988). Structured psychiatric interviews for children. In: Rutter M., Turns A, H. & Lann I.S. (eds), *Assessment and Diagnosis in Child Psychopathology* (pp. 87-112). Fulton, London.

Eisenberg, N, Cumberland, A., Spinrad, TL. Fabes, RA., Shepard, SA. Reiser, M., (2001). ‘The relations of regulation and emotionality to children's externalizing and internalizing problem behavior’. *Child Development*, 72, 1112-1134.

Ehrenreich, J. T; Santucci, L. C., Weinrer, C. L. (2008). ‘Separation anxiety disorder in youth*:Phenomenology, assessment, and treatment*’. doi:10.1901/jaba.2008.16-389.

Elkin, K. & Handel, G. (1978).*The child and society: The process of socialization* . New York: Random House.

Emery, R.E. (1982). 'Interparental conflict and the children of discord and divorce'. *Psychological Bulletin*, 92, 310-330.

Emery, R. E. (1989). 'Family violence'. *American Psychologist*, 44, 321-328.

Epstein, N. B., Baldwin, L. M. and Bishop, D. S. (1983). 'The McMaster Family Assessment Device'. *Journal of Family and Marital Therapy*, 9, 171–180.

Esser G, Schmidt MH, Woerner W. (1990). 'Epidemiology and course of psychiatric disorders in school-age children--results of a longitudinal study'. *Child Psychol Psychiatry*. Jan;31(2), 243-263.

Ferdinamd. R. F. & Verhulst, F.C. and Wiznitzer, M. (1995). 'Continuity and change of self reported problem behaviors from adolescence into young adulthood'. *Journal of the American Academy of Child & Adolescent Psychiatry,* 34(5), 680-690.

Flament, M. F.Evans, D. W., Leckman, J. F., Carter, A., *et al.* (1997). Ritual, Koby, E., Rapoport, J.L., *etal.* (*1990*). 'Childhood obsessive-compulsive disorder: A prospective follow-up study'. *Journal of Child Psychiatry* . ISBN 978-0-89042-555-8.

Fonagy, P., Steele, M. and Steele, H. (1991). ' Intergenerational patterns of attachment: maternal representations during pregnancy and subsequent infant-mother attachments'. *Child Development ,* 62, 891-905.

Garmezy, N. (1993). ' Children in poverty: Resilience despite risk'. *Psychiatry*, 56, 127-136.

Garmezy, N. (1983). Stressors of childhood. In N. Garmezy & Rutter (Eds.), *Stress, coping and development in children* (pp. 43-84). New York: Mc. Graw Hill.

Germezy, N., & Rutter, M. (1983). *Stress, coping and development in children*. New York: McGraw-Hill.

Garmezy, N. and Masten, A. (1994). Chronic adversities. In M. Rulter, *E.* Taylor and L. Hersov (eds), *Child and Adolescence Psychiatry: Modem Approaches* (third edition, pp. 191-208). Oxford: Blackwell.

Gerdes, L. (1998). *Bringing up parents and children*. Pretoria: New York: Academic, 217-245.

Gilbert, R., Spatz Widom, C., Browne, K., Fergusson, D., Webb, E., & Janson, J. (2009). 'Burden and consequences of child maltreatment in high-income countries'. *The Lancet, 373*, 68-81.

Goldfried, M.R., Davison, G.C. (1994). *Clinical behavior therapy: Expanded edition*. New York: Wiley.

Goldman. J., Salus, M.K., Wolcott, D., & Kennedy, K.Y. (2003*).* A coordinated response to child abuse and neglect: The foundation for practice. Child Abuse and Neglect User Manual Series.Washington, DC: Government Printing Office.

Goodman, R. (1994). Brain Disorders, In M. Rutter, E. Taylor and L, Hersov (eds*), Child and adolescent Psychiatry: Modern Approaches* (third edition, pp.172-190), Oxford: Blackwell.

Goodman R (1998). 'The Strengths and Difficulties Questionnaire: A Research Note'. *Journal of Child Psychology and Psychiatry*, 38, 581-586.

Goodyer, I. M. (1990). 'Family Relationships, Life Events and Childhood Psychopathology'. *Journal of Child Psychology and Psychiatry,* 31 (1), 161–192.

Goodyer, I. M., Herbert, J., Tamplin, A., Secher, S. and Pearson, J. (1997). ' Short-term outcome of major depression II. Life events, family dysfunction, and friendship difficulties as predictors of persistent disorder'. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 474–480.

Graham, P. (1986). *Child Psychiatry: A developmental approach London*: Oxford University press.

Graham, P. (1979). Epidemiological studies. In: Quay H. C. & Werry, J. (eds), *Psychological Disorders of Childhood,* pp. 185-209. Wiley, NewYork.

Grossman, K., Fremmer-Bombik, E., Rudolph, J. and Grossman, K. (1988). Maternal attachment representations as related to patterns of infant-mother attachment and maternal care giving during the first year. In R. Hinde and J. Stevenson-Hinde (eds), *Relationships Within Families: Mutual Influences* (pp. 241-260). Oxford: Clarendon.

Hall, L. A., Williams, C. A., & Greenberg, R. S. (1985). 'Supports, stressors, and depressive symptoms in low-income mothers of young children'. *American Journal of Public Health*, 75, 518-522.

Hanson, T. L., McLanahan, S., & Thomson, E. (1997). Economic resources, parental practices, and children's well-being. In G. J. Brooks- Gunn (Eds.), *Consequences of growing up poor* (pp. 190-238). NewYork : Russell Sage Foundation.

Haque, P. & Islam, S. (1996). 'Behavior Problem Among the institutionalized Children'. *Dhaka University Journal of Psychology*, Vol. 20, p 26-33.

Hoque, N. (1999). 'Psychitric morbidity among juvenile offenders'. An unpublished M.Phil thesis , Department of Psychiatry, BSMMU.

Hawkins, J., Ctalano. R, and Miller, J, (1992). 'Risk and protective factors for alcohol and other drugs problems in adolescence and early childhood: Implications for substance use prevention'. *Psychological Bulletin*, 112, 64-105.

Haynes, S.N. (1978). *Principles of behavioral assessment.* New York: Wiley.

Herbert, M. (1998). *Clinical Child Psychology*. New York: John Wiley & Sons.

Herbers, J. E.; Cutuli, J. J.; Supkoff, L. M.; Heistad, D.; Chan, C.-K.; Hinz, E.; Masten, A. S. (2012). 'Early Reading Skills and Academic Achievement Trajectories of Students Facing Poverty, Homelessness, and High Residential Mobility'. *Educational Researcher 41* (9), 366–374.

Herjanic B. & Campbell W. (1977). 'Differentiating psychiatrically disturbed children on the basis of a structured interview'. *Journal of Abnormal Child Psychology,* 5, 127-134.

Hill, J. P., and Lynch, M. E. (1983). The intensification of gender related role expectations during early adolescence. *In* J. Brooks- Gunn and A. C. Petersen (Eds.), *Girls at Puberty: Biological and Psychosocial Perspectives,* pp. 201–228. Plenum, New York.

Hinshaw S.P (1987). 'On the distinction between attentional deficits/hyperactivity and conduct problems/aggression in child psychopathology'. *Psychological Bulletin*; 101, 443-463.

Hinshaw, S. P. (2002). 'Preadolescent girls with attention-deficit\hyperactivity disorder: I. Background characteristics, comorbidity, cognitive and social functions, and parenting practices'. *Journal of Consulting and Clinical Psychology, 70,* 1086-1098.

Hinshaw, S. P., & Lee, S. S. (2003). Conduct and oppositional defiant disorders. In E. J. Mash & R. A. Barkley (Eds.), *Child psychopathology* (pp. 144-198). New York: Guilford Press.

Hirshfeld, D.R., Biederman, J., Brody, L., Faraone,S.V., & Rosenbaum, J.F. (1997). 'Associations between expressed emotion and child behavioral inhibition and psychopathology: A pilot study'. *Journal of the American Academy of Child and Adolescent Psychiatry,* 36, 205–213.

Hodges, K., Klein. J. Fitch, P., McKnew. D., & Cytryn, L. (1981). 'The child assessment schedule'. *Catalogue of Selected Documents in Psychology*. 11. 56.

Holden, G. W., & Ritchie, K. L. (1991). 'Linking extreme marital discord, child rearing, and child behavior problems: Evidence from battered woman'. *Child Development*, 62, 311-327.

Jaffe, P. C., Hurley, D. J., & Wolfe, D. (1990). 'Children's observations of violence: 1. Critical issues in child development and intervention planning'. *Canadian Journal of Psychiatry*, 35 (6), 466-470.

Jenkins, J. M., & Smith, M. A. (1991). 'Marital disharmony and children's behavior problems: Aspects of poor marriage that affect children adversely'. *Journal of Child Psychology and Psychiatry, 32*, 793-810.

Kagan, J., Snidman, N., Kahn, V., & Towsley, S. (2007). 'The Preservation of Two Infant Temperaments into Adolescence'. *Monographs of the Society for Research in Child Development,* Serial No. 287, 72(2),p.vii.

Kazdin, A. E, (1992). ‘Child and adolescent dysfunction and paths toward maladjustment: Targets for intervention’. *Clin. Psychol. Rev., 12, 795-818.*

Kazdin, A. E. (1995). *Conduct Disorder in Childhood and* Adolescence (second edition). Thousand Oaks, CA: Sage.

Kazdin, A. E. (1996a). ‘Combined and multimodal treatments in child and adolescent psychotherapy: Issues, challenges, and research directions’. *Clinical Psychology: Science and Practice, 3,* 69-100.

Kendler , K. S., Neale MC, Kessler RC, et al. ,(1993). ‘Major depression and phobias: the genetic and environmental sources of comorbidity’. *Psychol Med*, 23, 361–371.

Khurshid, M. & Begum (1997). ‘Behavior problems among mentally retarded and normal children’. An unpublished M.sc. Dissertation, University of Dhaka.

Kovacas, M. (1983). The children's depression inventories: a self-rated depression scale for school-aged youngsters. Western Psychiatric Institute and Clinic, Department of Psychiatry, University of Pittsburg School of Medicine, Pittsburgh, Pennsylvania, USA.

Kolvin, F. J., Miller, J.W., Fleeting, M., & Kolvin, P.A. (1988). ‘Social and parenting factors affecting criminal offense rates: Findings form the Newcastle thousand family Study (1947-1980)’. *British Journal of Psychiatry,* 152, 80-90.

Korenman, S., Miller, J. E., & Sjaastad, J. E. (1995). ‘Long-term poverty and child development in the United States: Results from the NLSY’. *Children and Youth Services Review,* 17 (1/2), 127-155.

L'Abate, L. (Ed.) (1998). *Family psychopathology. The relational roots of dysfunctional behavior.* New York: The Guilford Press.

Lacourse, E., Cote, S., Nagin, D., Vitaro, F., Brendgen, M., & Tremblay, R. (2002). ‘A longitudinal-experimental approach to testing theories of antisocial behavior development’. *Development and Psychopathology*, *14*, 909-924.

Lahey, B., Loeber, R., Quay, H., Frick, P., & Grimm, J., (2000). ' Oppositional defiant and conduct disorders: Issues to be resolved for the DSM-IV'. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 539-546.

Lamb, M.C. & Ketterlinus, R (1994). *Adolescent problem behavior: issues and research*. NewYork:Garland.

Lange, A. (1994). *Gedragsverandering in gezinnen [Behavior change in families]*. Groningen: Wolters-Noordhoff.

Lapouse, R.& Mary A. Monk (2010). 'Behavior Deviation in a Representative Sample of Children Variation by Sex, Age, Race, Social Class and Family Size'. *American Orthopsychiatric Association,* 34 (3), 436–446.

Lask, B. (1980). 'Evaluation why and who'. *Journal of Family Therapy*. 2, 119-210.

Lask B. & Fosson A. (1989). *Childhood Illness: The Psychometic Approach*. J. Wiley, Wiley series in family psychology. New York

Lochman, J. E., *&* Lenhart, L.A. (1995). Cognitive behavior therapy for aggressive children: effects of schemas. In H. PJ. Van Bilsen, P.C, Kendall, & J.H. Slavenburg (Eds.), *Behavioral approaches for children and adolescents: Challenges for the Next century*, (pp. 145-166). New York: Plenum.

Lyons-Ruth, K. (February 1996). 'Attachment relationships among children with aggressive behavior problems: the role of disorganized early attachment patterns'. *Journal of Consulting and Clinical Psychology*, 64 (1), 64–73.

Manaros B. Boransing (2008). "Official Definition of Madrasah*." Department of Education undated issuance from the Office of the Undersecretary for Mindanao Affairs*. http://www.deped.gov.ph/about_deped/organizationlinks.

Marvin, R. S., & Stewart, R. B. (1990). A family systems framework for the study of attachment. In M. Greenberg, D. Cicchetti, & E. M. Cummings (Eds), *Attachment in the preschool years: Theory, research, and intervention* (pp. 51-86). Chicago: University of Chicago Press.

Mayseless, O., Wiseman, H., & Hai, I. (1998). 'Adolescents' relationships with father, mother and same gender friend'. *Journal of Adolescent Research*, 13, 101–123.

McCubbin, M. A. & McCubbin, H., I. (1988). Family systems assessments. In P. Karoly (Ed.), *Handbook of child health assessment: Biopsychosocial perspectives*. New York: Willey-inter-science.

Mc Mahon, RJ. & Forehand, R. (1988). Conduct Disorders. In. E.J. Mash & L.G. Terdal (eds), *Behavioral assessment of childhood disorders*. (2nd ed., pp. 105151). New York: The Guilford Press.

Masi, G.; Mucci, M.; Millepiedi, S. (2001). 'Separation anxiety disorder in children and adolescents: epidemiology, diagnosis and management.' *CNS Drugs,* 15 (2), 93–104.

Mehdy M. (2003).Madrasa Education: An Observation. Published by Bangladesh Nari progati Shangha. Bangladesh.

Mellenbergh, G.J. (2008). Chapter 10: Surveys. In H.J. Adèr & G.J. Mellenbergh (Eds.), (with contributions by D.J. Hand). *Advising on Research Methods: A consultant's companion* (pp. 183-209). Huizen, The Netherlands: Johannes van Kessel Publishing.

Meyer, G. J., Finn, S. E., Eyde, L. D., Kay, G. G., Kubiszyn, T. W., Moreland, K. L., Eisman, E. J., & Dies, R. R. (2001). *Benefits and costs of psychological assessment in healthcare delivery: Report of the Board of Professional Affairs Psychological Assessment Work Group, Part 1.* Washington, DC: American Psychological Association.

Miller, J. E., & Korenman, S. (1994). 'Poverty and children's nutritional status in the United States'. *American Journal of Epidemiology, 140*, 233-243.

Moore KA, Redd Z, Burkhauser Mbwana K, & Collins A (2009*). Children in Poverty: Trends, Consequences, and Policy Options.* Child Trends Research Brief. Washington DC, USA.

Moore, D.R., &. Arthur, J,L. (1983). Juvenile Delinquency. In T.H. Ollendick and M, Harsen (Eds.), *Handbook of Child Psychology* (357-387). New York: John Wiley & sons.

Murray, J., & Farrington, D. P. (2010). 'Risk factors for conduct disorder and delinquency: Key findings from longitudinal studies'. *The Canadian Journal of Psychiatry, 55* (10), 633-642.

Nilzon, K. R. & Palmerus, K. (1997). 'The influence of familial factors on anxiety and depression in childhood and early adolescence'. *Child and Adolescence Psychiatry,32 (128),* 935-943.

Nolan, E.E., Gadow, K.D., & Sprafkin, J., (2001) . 'Teacher reports of DSM-IV ADHD,ODD, and CD symptoms in school children.' *J Am Acad Child Adolesc Psychiatry, 40*(2), 241-249.

Offord, D. R., Adler R.J., & Boyle, M.H. (1986). 'Prevalence and socio demographic correlates of conduct disorder'. *American Journal of social psychiatry,* 6, 272-278.

Olweus, D. (1979). 'Stability of Aggressive Reaction Patterns of Mail: A Review'. *Psychological Bulletin* 86. 852- 875.

Olweus, D. (1993). *Bullying at school: What we know and what can we do*. Oxford: Blackwell.

Orvaschel, H. (1993). Maternal depression and child dysfunction. In B. Lahey & A. Kazdin (Eds.), *Advances in Clinical Child Psychology* (Vol. 6, pp. 169–197). New York: Plenum Press.

Pardini, D.A., Frick, P.J., & Moffitt, T.E. (2010). ' Building an Evidence base for DSM-5 Conceptualizations of Oppositional Defiant Disorder and Conduct Disorder: Introduction to the Special Section'. *Journal of Abnormal Psychology*, 119(4), 683-688.

Parveen, S.& Begum R. (2001). 'A comparative study of behavior problems among trafficked children, institutionalized children and children living with their families'. Unpublished M. phil. Thesis. University of Dhaka.

Patterson, C. J., Kupersmidt, J.B. and Vden, N. A. (1990). 'Income level, gender, ethnicity and household composition as predictors of children's school-based competence'. *Child Development,* 61,485-495.

Perry BD (2001) The neurodevelopmental impact of violence in childhood. In: Schetky D, Benedek E.(eds), *Textbook of child and adolescent forensic psychiatry* (p. 221–238). Washington (DC): *American Psychiatric Press*.

Pettit, G.S., Dodge, K.A., & Brown, M. M. (1988). 'Early family experience , social problem solving patterns, and children's social competence'. *Child Development, 59*, 109-120.

Petzold, M. (1998). The concept of 'the family' in family psychopathology. In L. L'Abate (Ed.), *Family psychopathology. The relational roots of dysfunctional behavior* (pp. 60-74). New York: The Guilford Press.

Plomin, R., DeFries, J. C., McClearn, G. E., & McGuffin, P. (2001). *Behavioural genetics* (4th Ed.). New York:Worth.

Plomin, R., & Rutter,M. (1998). 'Child development, molecular genetics, and what to do with genes once they are found'. *Child Development, 69,* 1221–1240.

Puig-Antich J. & Chambers W. (1978). *The schedule for affective disorders and schizophrenia for school-aged children*. New York Slate Psychiatric Institute. New York.

Raadal, M., Milgrom, P., Cauce, A.M., & Manel, L. (1994). 'Behavior problems in 5 to 11 year old children from low income families'. *Journal of the American Academy of Child and Adolescent: Psychiatry,* 33, 1017-1025

Rahman, S. I. & Begum, R., (2008). 'Assessing Behavior Problems of Children of Sex Workers and Their Need for Psychological Services'. Unpublished M. phil. Thesis. University of Dhaka.

Richman, N. and Graham, P.J. (1971). 'A behavioral screening questionnaire for use with three year old children: Preliminary findings'. *Journal of Child Psychology and Psychiatry,* 12, 5-33.

Richman, N., Stevenson, J. & Graham, P. (1982). *Preschool to school: a behavioural study*. London and NewYork: Academic Press.

Robins, L.N. (1985). 'Epidemiology: reflections on testing the validity of psychiatric Interviews'. *Archives of General Psychiatry*, *42*,918-924.

Robins, L, N. (1991). 'Conduct disorder'. *Journal of Child Psychology and Psychiatry, 32,* 193-212.

Rolf, J., Masten, A., Cicchetti, D. *et al.* (1990). *Risk and Protective Factors in the Development of Psychopathology* . New York: Cambridge University Press.

Ross, L. T., & Hill, E. M. (2001). 'Drinking and parental unpredictability among adult children of alcoholics: A pilot study'. *Substance Use & Misuse*, *36* (5), 609-638.

Rothbart,M. K., & Bates, J. E. (1998). Temperament. In W. Damon (Series Ed.) & N. Eisenberg (Vol. Ed.), *Handbook of child psychology*: Vol. 3, Social, emotional and personality development (5th ed.,pp. 105-176). NewYork: Wiley.

Rutter, M. (1972). *Maternal Deprivation Reassessed*. Harmonds worth. Penguin.

Rutter, M. (1994). *Helping Troubled Children*. Penguin, Harmonds worth: Penguin Book.

Rutter, M., (1987). *Child and Adolescent Psychiatry*. Blackwell Science. London

Rutter, M,. (1991). 'Stress, coping and development: Some issues and some questions'. *Journal of Child Psychology and Psychiatry,* 22,323-356.

Rutter, M. (1985b). 'Family and school influences on behavioral development'. *Journal of Child Psychology and Psychiatry,* 26, 349-368.

Rutter M. & Gramezy N. (1983). Developmental Psychopathology. In: Hetherington E.M. (ed), *Socialization, personality and Social Development:* Vol.4. *Mussen's Handbook of Child Psychology*, (pp.775-911). Wiley, New York.

Rutter, M., Quintan, D. (1977). Psychiatric Disorder: Ecological factors and concepts of causation. In. H. McCruck (ED.), *Ecological factors in human development*. Amsterdam: North Holland Publishing.

Rutter, M., & Gould, M. (1970). Classification. In Rutter, M., & Hersov, L., (eds), *Child and adolescence Psychiatry: Modern Approaches,* 2nd edition, pp.304-432. Blackwell Scientific Publication , Oxford.

Rutter, M., & Quinton, D. (1984). 'Parental Psychiatric Disorder: Effects on Children'. *Psychological Medicine*, 14. 853-80.

Rutter. M., Tizard. J., & Whitmore, K. (1970). *Education, health and behavior*. London: Longman.

Rutter, M. & Giller, H, (1983). *Juvenile delinquency: Trends and perspectives.* New York: Penguin Books.

Schucksmith, J., Hendry, L.B., & Glendinning, A. (1995). 'Models of parenting: implications for adolescent well-being within different types of family contexts'. *Journal of Adolescence, 18*, 253-270.

Schwarz, J. C. (1979). 'Childhood origins of psychopathology'. *American Psychologist*, 34, 879-885.

Shamama-tus-Sabah, S. et al. (2013). 'Chaotic home conditions and children's adjustment: Study of gender differences'. *Pakistan Journal of Psychological Research,* 27 (2),297-313.

Shaw, D.S., *& Emery*, R.E. (1988). 'Chronic family adversity and school-age children's adjustment'. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27, 200-206.

Shaffer, D., Fisher, P., Dulcan, M.K., & Davies, M. (1996). 'The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC 2.3): Description, acceptability, prevalence rates, and performance in the MECA study'. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 865–877.

Silva, R. D. (2007). *Child Behavior: Behavior Problems in Children*. Retrieved April 9, from http:/www.buzzle.com./articles/child-behaviour-problems-in children .html.

Silverman AB, Reinherz HZ, Giaconia RM. (1996). 'The long-term sequelae of child and adolescent abuse: a longitudinal community study'. *Child Abuse and Neglect*, 20(8),709–723.

Simpson GA, Bloom B, Cohen RA, Blumberg S, Bourdon KH. (2005). U.S. children with emotional and behavioral difficulties: *Data from the 2001, 2002, and 2003 National Health* Interview Surveys. Advance data from vital and health statistics; no 360. Hyattsville, MD: National Centre for Health Statistics.

Snow, C. and Hooper, S. (1994). *Pediatric Traumatic Brain Injury*. Thousand Oaks, CA: Sage.

Steinhausen, H. C., von Gontard, A., Spohr, H. L., Hauffa, B.P., Eiholzer, U. Backes, M., Willms, J., Malin, Z.(2002) . 'Behavioral phenotypes in four mental retardation syndromes: Fetal Alcohol Syndrome, Prader - Willi Syndrome, Fragile - X Syn drome and Tuberosis Sclerosis'. *American Journal of Medical Genetics*, 111, 381-387.

Stevenson – Hinde, J. (1990). 'Attachment within the family system: An overview'. *Infant Mental Health Journal*, 11, 218-227.

Stubbe, D., Gwendolyn, E., Zahner, P., Goldstein, M. and Leckman, J. (1993).' 'Diagnostic specificity of a brief measure of expressed emotion: a community study of children'. *Journal of Child Psychology and Psychiatry,* 34, 139–154.

Timko C, Cronkite RC, Swindle R, et al. (2009) . 'Parental depression as a moderator of secondary deficits of depression in adult offspring'. *Child Psychiatry Hum Dev*, 40(4), 575-588.

The Daily Star (2013). Madrasa Bill, 2013 passed at parliament. (19thSeptember), Bangladesh.

Wachs, T. D., & Gandour, M. J. (2000). 'Temperament, environment, and six-month cognitive intellectual development: A test of the organismic specificity hypothesis'. *International Journal of Behavioral Development*, 6, 135-152.

Walker S, Wachs TD, Grantham-McGregor S, Black M, Nelson C, Huffman C et al (2011). 'Inequality in early childhood: risk and protective factors for early child development'. *Lancet*, 378, 1325-1338.

Walsh, F. (1995). From family damage to family challenge. In R.H. Mikesell, D.D. Lusterman, & S.H. Mcdaniel (Eds.), *Integrating family therapy. Handbook of family psychology and systems theory* (pp. 587-606). Washington: American Psychological Association.

Wang, F-Y., Shen Y-C, GU, B-M. Jia, M-X and Zhang. A-L (1989). 'An epidemiological study of behavior problems in school children in urban areas of Beijing'. *Journal of Child Psychology and Psychiatry, 30,* 907-912.

Weine, A.M.: Philips, J.S. & Achenbach, J.M. (1995). 'Behavioral & Emotional Problems among Chinese and American Children: Parents and teacher report for ages 6 to 13'. *Journal of Abnormal Child Psychology*, 23(5), 619-639.

Webster-Stratton, C. (1989). 'The relationship of marital support, conflict, and divorce to parent perceptions, behaviors, and childhood conduct problems'. *Journal of Marriage and the Family*, 51, 417-430.

Werner. E. Edler Smith, R.S. (1992). *Vulnerable but invincible longitudinal study of resilient children and youth.* New York: McGraw Hill.

World Health Organization (2010). *Multi-Axial Classification of Child and Adolescent Psychiatric Disorders: The ICD-10 Classification of Mental and Behavioral Disorders in Children and Adolescents.* Cambridge. Cambridge University Press.

World Health Report (2001). Mental Health: New Understanding, New Hope, World Health Organization.

Yeung, W. J., Duncan, G. J., & Hill. M. S. (2000). Putting fathers back in the picture: Parental Activities and children's adult outcomes. In H. E. Peters, G. W. Peterson, S. K. Steinmetz. & R, D. Day (Eds.), *Fatherhood: Research, interventions and policies* (pp.97-113). New York, NY: Hayworth Press.

Young. J. G., O'Brien J.D., Gutterman E. M. & Cohen P. (1987). 'Research on the clinical. Interview'. *Journal of the American Academy of Child and adolescent psychiatry, 26.613-620.*

Yule, W. & Rutter, M (1985). Reading and other learning disabilities. In: M. Rutter & L. Hersov (Eds.), *Child and Adolescent Psychiatry, Modern Approaches* (2nd ed). Oxford: Blackwell Scientific Publications.

Zarakowska, E. & Clements, J. (1988). *Problem behavior in people with severe learning disabilities*. London:Croom Helm.

Zhang, M. (2008). 'Behavioral problems and their family correlate in Chinese school children'. *Psychological Development and Education,* 12, 39-44.

Dhaka University Institutional Repository

Appendix

Appendix-1: List of Madrasa

Coeducation Madrasa

1. Kazipara Siddikia Fazil Madrasa
2. Baytul Fazal Islamia Dakhil Madrasa
3. Hazi Moron Ali Fazil Madrasa
4. Gaousia Islamia Fazil Madrasa

Male Madrasa

1. Kaderia Taieebia Kamil Madrasa
2. Noatola A. U. N. Kamil Madrasa
3. Khilgao Railway Fazil Madrasa
4. Mohalhali Darul Ulum Hossania Kamil Madrasa

Female Madrasa

1. Modinatul Ulum Model Institute Girls Madrasa
2. Noatola A. U. N. Kamil Mohila Madrasa
3. Darul Ulum Mohila Kamil Madrasa
4. Adarsha Islami Mission Mohila Madrasa

Appendix-2: Permission letter for data collection

বরাবর

অধ্যাক্ষ

....
....

জনাব

আমি ঢাকা বিশ্ববিদ্যালয়ের এম ফিল শেষ পর্বের একজন ছাত্রী। আপনার সদয় অবগতির জন্য জানাচ্ছি যে, আমি আমার শিক্ষা কার্যক্রমের অংশ হিসেবে মাদ্রাসার ছাত্র-ছাত্রীদের আচরণগত সমস্যা (Behavior Problems among Madrasa Students) বিষয়ে বর্তমানে গবেষনা করছি। আমার গবেষনার সুপারভাইজার ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগের **সহযোগী** অধ্যাপক ডঃ কামা**ল উদ্দীন আহমেদ চৌধুরী**। এই গবেষনার কাজে আপনার আন্তরিক সহযোগিতা একান্ত কাম্য। আমার গবেষনার কাজ সফল করতে আপনার প্রতিষ্ঠানের শিক্ষকদের সাথে কাজ করা জরুরী ।আপনার সদয় সহযোগিতার জন্য বিশেষ অনুরোধ জানাচ্ছি।

ধন্যবাদান্তে

(কোহিনুর বেগম)

এম ফিল গবেষক
চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়

Appendix-3 : Letter for permission to apply Teacher's Report Form (TRF)

সম্মানিত শিক্ষক/ শিক্ষিকা,

আপনার সদয় অবগতির জন্য জানাচ্ছি যে, আমি ঢাকা বিশ্ববিদ্যালয়ের এম ফিল শেষ পর্বের একজন ছাত্রী। আমার শিক্ষা কার্যক্রমের অংশ হিসেবে "মাদ্রাসার ছাত্র-ছাত্রীদের আচরণগত সমস্যা" (Behavior Problems among Madrasa Students) বিষয়ে আমি বর্তমানে গবেষনা করছি। এই গবেষনার কাজে আপনার আন্তরিক সহযোগীতা আপনার ছাত্র-ছাত্রীদের মানসিক স্বাস্থ্য ও শিক্ষার উন্নয়নে সাহায্য করবে তথা সমাজ ও দেশের কল্যাণে বিশেষ অবদান রাখবে। এই উদ্দেশ্যে আপনার নিকট থেকে কিছু তথ্য আবশ্যক। এই উদ্দেশ্যে একটি প্রশ্নমালা দেয়া হল। আপনার দেয়া তথ্য কেবল গবেষণার কাজে ব্যবহার করা হবে এবং সম্পুর্ণ গোপন রাখা হবে। আপনার সদয় সহযোগীতার জন্য বিশেষ অনুরোধ জানাচ্ছি।

ধন্যবাদান্তে

(কোহিনুর বেগম)

এম ফিল গবেষক
চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়

Appendix-4: Letter for Permission to apply McMaster Family Assessment Device

সম্মানিত অভিভাবক (মাতা)

আপনার সদয় অবগতির জন্য জানাচ্ছি যে, আমি ঢাকা বিশ্ববিদ্যালয়ের এম ফিল শেষ পর্বের একজন ছাত্রী। আমার শিক্ষা কার্যক্রমের অংশ হিসেবে ”মাদ্রাসার ছাত্র-ছাত্রীদের আচরণগত সমস্যা” (Behavior Problems among Madrasa Students) বিষয়ে আমি বর্তমানে গবেষনা করছি। এই গবেষনার কাজে আপনার আন্তরিক সহযোগীতা আপনার সন্তানের মানসিক স্বাস্থ্য, পারিবারিক জীবন ও শিক্ষার উন্নয়নে সাহায্য করবে তথা সমাজ ও দেশের কল্যাণে বিশেষ অবদান রাখবে। এই উদ্দেশ্যে আপনার নিকট থেকে কিছু তথ্য আবশ্যক। এই উদ্দেশ্যে একটি প্রশ্নমালা দেয়া হল। আপনার দেয়া তথ্য কেবল গবেষণার কাজে ব্যবহার করা হবে এবং সম্পুর্ণ গোপন রাখা হবে। আপনার সদয় সহযোগীতার জন্য বিশেষ অনুরোধ জানাচ্ছি।

ধন্যবাদান্তে

(কোহিনুর বেগম)

এম ফিল গবেষক
চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়

Appendix-5: Bengali Version of Teacher's Report form

ছেলেমেয়ের আচরণ নিরীক্ষণ তালিকা শিক্ষকের বিবরণী ফরম

ছাত্র/ছাত্রীর নামঃ

ছাত্র/ছাত্রীর ঠিকানাঃ

বিদ্যালয়ঃ

ছাত্র/ছাত্রীর বয়সঃ

মোট ভাই-বোনের সংখ্যাঃ

ছাত্র/ছাত্রীর লিঙ্গ

☐ ছেলে ☐ মেয়ে

সম্প্রদায় বা জাতি

পিতা-মাতার কাজের ধরণ (দয়া করে যতদূর সম্ভব যথার্থভাবে বর্ণনা করুন- যেমন, গাড়ীর মিস্ত্রী, উচ্চবিদ্যালয়ের শিক্ষক, গৃহ নির্মাতা, শ্রমিক, মেশিন চালক, জুতা বিক্রেতা, সেনাবাহিনীর সার্জেন্ট।)

শ্রেণীঃ

বিগত শ্রেণীর বার্ষীক পরীক্ষার ফলাফল (%)ঃ

বিগত পরীক্ষার ফলাফল (%)ঃ

তারিখঃ

এই তালিকাটি পূরণ করেছেন

☐ শিক্ষক/শিক্ষয়িত্রী (নাম)ঃ

☐ উপদেষ্টা (নাম)ঃ

☐ অন্য কেউ (উল্লেখ করুন)

নামঃ ________________

পিতার

কজের ধরণঃ ________________

শিক্ষাগত যোগ্যতাঃ

মাতার

কাজের ধরণঃ ________________

শিক্ষাগত যোগ্যতাঃ

দয়া করে যতদূর সম্ভব প্রত্যেকটি উক্তির সম্পূর্ণ উত্তর দিতে চেষ্টা করবেন, যদিও পূর্ণ বিবরণী আপনার জানা নেই।

১। এই ছাত্র/ছাত্রীটিকে আপনি কতদিন থেকে চেনেন?

২। আপনি তাকে কত ভালভাবে চেনেন ☐ খুব ভাল ☐ মোটামুটি ভাল ☐ ভাল না

৩। সে প্রতি সপ্তাহে কতটুকু সময় আপনার ক্লাশে কাটায়?

৪। এটা কোন ধরণের ক্লাশ (দয়া করে সুনির্দিষ্টভাবে লিখুন যেমন, ২য় শ্রেণী, ৫ম শ্রেণী, অংক ইত্যাদি)ঃ

৫। তাকে কি কখনও বিশেষ ক্লাশে, বিশেষ পরিচর্যায় অথবা সাহায্যে জন্য পাঠানো হয়েছে?

☐ না ☐ জানিনা ☐ হ্যাঁ কি ধরণের এবং কখন?

৬। সে কি কখনও একই শ্রেণীতে পুনরায় পড়েছে?

☐ না ☐ জানিনা ☐ হ্যাঁ - শ্রেণী এবং কারণ

নিচে কতগুলি উক্তির তালিকা আছে যা দিয়ে ছাত্র/ছাত্রীদের বর্ণনা করা যায়। যে উক্তি ছাত্র/ছাত্রীর ক্ষেত্রে এখন থেকে গত দুই মাসের মধ্যে খুবই সত্যি অথবা প্রায়ই সত্যি হয় সে উক্তিটির পাশে [২] এর উপর একটি টিক চিহ্ন দিন। যদি উক্তিটি ছাত্র/ছাত্রীর ক্ষেত্রে কিছুটা অথবা কখনো কখনো সত্যি হয় তাহলে [১] এর উপর একটি টিক চিহ্ন দিন। যদি উক্তিটি ছাত্র/ছাত্রীর ক্ষেত্রে সত্যি না হয় তাহলে [০] এর উপর একটি টিক চিহ্ন দিন। দয়া করে আপনার সাধ্যমত সবগুলি উক্তির উত্তর দিন যদিও কিছু কিছু উক্তি এই ছাত্র/ছাত্রীর ক্ষেত্রে প্রযোজ্য বলে নাও মনে হতে পারে।

---

[০] - সত্যি নয় (যতদূর আপনি জানেন) [১] - কিছুটা অথবা কখনো কখনো সত্যি [২] - খুবই সত্যি অথবা প্রায়ই সত্যি।

[০] [১] [২] ১। বয়সের তুলনায় ছোটদের মত ভাব করে

[০] [১] [২] ২। শ্রেণীতে গুনগুন শব্দ করে অথবা অন্য কোন রকম ভীষণ হট্টগোল করে

[০] [১] [২] ৩। অনেক তর্ক করে

[০] [১] [২] ৪। যে কাজ শুরু করে তা শেষ করতে ব্যর্থ হয়

[০] [১] [২] ৫। বিপরীত লিংগের ন্যায় আচরণ করে

[০] [১] [২] ৬। প্রকাশ্যভাবে বিরোধিতা করে, কর্মচারীদের মুখের উপর কথা বলে

[০] [১] [২] ৭। বড়াই অথবা অহংকার করে

[০] [১] [২] ৮। মনোনিবেশ করতে পারে না, বেশিক্ষণ মনোযোগ দিতে পারে না

[০] [১] [২] ৯। কোন কোন চিন্তা মন থেকে দূর করতে পারে না, বদ্ধসংস্কার ব্যতিক (বর্ননা করুন)

----

[০] [১] [২] ১০। শান্ত হয়ে বসতে পারে না, অস্থির অথবা কর্মচঞ্চল

[০] [১] [২] ১১। বড়দের কাছ ঘেঁষে থাকে অথবা অতিরিক্ত নির্ভরশীল

[০] [১] [২] ১২। নিঃসংগতা সম্পর্কে অভিযোগ করে

[০] [১] [২] ৩। বিভ্রান্ত অথবা মনে হয় অস্পষ্টতার মধ্যে আছে

[০] [১] [২] ১৪। অনেক কান্নাকাটি করে

[০] [১] [২] ১৫। উসখুস ভাব

[০] [১] [২] ১৬। অন্যের প্রতি নির্দয়, তর্জন গর্জন অথবা হীণ ব্যবহার করে

[০] [১] [২] ১৭। দিবা স্বপ্ন দেখে অথবা নিজের চিন্তায় মগ্ন থাকে

[০] [১] [২] ১৮। ইচ্ছাকৃতভাবে নিজের ক্ষতি করে অথবা আত্ম হত্যার চেষ্টা করে

[০] [১] [২] ১৯। অধিক মনোযোগ দাবী করে

০ - সত্যি নয় (যতদূর আপনি জানেন) ১ - কিছুটা অথবা কখনো কখনো সত্যি ২ - খুবই সত্যি অথবা প্রায়ই সত্যি

---

০ ১ ২ ২০। নিজের জিনিসপত্র বিনষ্ট করে

০ ১ ২ ২১। অন্যের জিনিসপত্র বিনষ্ট করে

০ ১ ২ ২২। নির্দেশ মেনে চলতে অসুবিধা হয়

০ ১ ২ ২৩। বিদ্যালয়ে অবাধ্য

০ ১ ২ ২৪। অন্য ছাত্র/ছাত্রীকে বিরক্ত করে

০ ১ ২ ২৫। অন্য ছাত্র/ছাত্রীর সংগে মিলে-মিশে থাকতে পারে না

০ ১ ২ ২৬। অসদ্ব্যবহার করার পর নিজেকে অপরাধী মনে করে না

০ ১ ২ ২৭। সহজেই ঈর্ষাপরায়ণ

০ ১ ২ ২৮। খাদ্য নয় এমন জিনিস খায় অথবা পান করে (বর্ণনা করুন)

----

০ ১ ২ ২৯। বিদ্যালয় ব্যতীত কোন কোন জীবজন্তু, পরিস্থিতি অথবা জায়গাকে ভয় পায় (বর্ণনা করুন)

----

০ ১ ২ ৩০। বিদ্যালয়ে যেতে ভয় পায়

০ ১ ২ ৩১। খারপ কিছু করতে অথবা চিন্তা করতে পারে বলে সে ভয় পায়

০ ১ ২ ৩২। নিজেকে নিঁখুত হতে হবে বলে মনে করে

০ ১ ২ ৩৩। কেউ তাকে ভালবাসে না বলে মনে করে অথবা অভিযোগ করে

০ ১ ২ ৩৪। অন্যরা তাকে হামলা করবে বলে মনে করে

০ ১ ২ ৩৫। নিজেকে অপদার্থ অথবা নিকৃষ্টতর বলে মনে করে

০ ১ ২ ৩৬। প্রায়ই ব্যথা পায়, দূর্ঘটনা প্রবণ

০ ১ ২ ৩৭। প্রায়ই মারামারিতে লিপ্ত থাকে

০ ১ ২ ৩৮। অনেকে তাকে ক্ষেপায়

০ ১ ২ ৩৯। যে সমস্ত ছেলে মেয়ে সমস্যায় লিপ্ত থাকে সে তাদের সংসর্গে থাকে

০ ১ ২ ৪০। নানা জিনিস শোনে যদিও সেগুলি সেখানে নেই (বর্ণনা করুন)-----

----

০ ১ ২ ৪১। আবেগ বশতঃ অথবা চিন্তা না করে কাজ করে

০ ১ ২ ৪২। একা থাকতে পছন্দ করে

০ ১ ২ ৪৩। মিথ্যা কথা বলে অথবা প্রতারণা করে

০ ১ ২ ৪৪। আংগুলের নখ কামড়ায়

০ ১ ২ ৪৫। ভীত সন্ত্রস্ত, সহজেই উত্তেজিত অথবা উদ্বিগ্ন

০ ১ ২ ৪৬। চলাফেরায় ভীত সন্ত্রস্ততা অথবা কাঁপুনী (বর্ণনা করুন) ------

----

০ ১ ২ ৪৭। অতিরিক্তভাবে নিয়মকানুন মেনে চলে

০ ১ ২ ৪৮। অন্য ছাত্র/ছাত্রীরা তাকে পছন্দ করে না

০ ১ ২ ৪৯। পড়াশুনা শেখার অসুবিধা আছে

০ ১ ২ ৫০। অতিরিক্ত ভীত অথবা উদ্বিগ্ন

০ ১ ২ ৫১। মাথাঘোরা অনুভব করে

০ ১ ২ ৫২। অতিরিক্ত অপরাধী ভাবে

০ ১ ২ ৫৩। অনর্থক কথা বলে

০ ১ ২ ৫৪। অতিরিক্ত ক্লান্তি বোধ করে

০ ১ ২ ৫৫। অতিরিক্ত ওজন

৫৬। ডাক্তারী কারণ ছাড়া শারীরিক সমস্যাঃ

০ ১ ২ ক) ব্যথা অথবা বেদনা

০ ১ ২ খ) মাথা ব্যথা

০ ১ ২ গ) বমিবমি ভাব, অসুস্থবোধ

০ ১ ২ ঘ) চোখের সমস্যা(বর্ণনা করুন)

----

০ ১ ২ ঙ) ফুসকুড়ি অথবা অন্যকোন চর্ম সমস্যা

০ ১ ২ চ) পাকস্থলিতে ব্যথা অথবা খেঁচুণী

০ ১ ২ ছ) বমি করা, উদগিরন করা

০ ১ ২ জ) অন্য কোন (বর্ণনা করুন)

----

০ - সত্যি নয় (যতদুর আপনি জানেন) ১ - কিছুটা অথবা কখনো কখনো সত্যি ২ - খুবই সত্যি অথবা প্রায়ই সত্যি

০ ১ ২ ৫৭। অন্য লোকদের শারীরিক আক্রমণ করে

০ ১ ২ ৫৮। নাক, চর্ম অথবা শরীরের অন্যকোন অংশে চুলকায় (বর্ণনা করুন) ----------- -----------------

০ ১ ২ ৫৯। ক্লাশে ঘুমায়

০ ১ ২ ৬০। উদাসীন অথবা প্রেষনাবিহীন

০ ১ ২ ৬১। বিদ্যালয়ের কাজ নিম্নমানের

০ ১ ২ ৬২। অনিপুণভাবে কাজ করে অথবা অগোছাল

০ ১ ২ ৬৩। তার চেয়ে বয়সে বড় ছেলে মেয়েদের সংগে থাকতে বেশী পছন্দ করে

০ ১ ২ ৬৪। তার চেয়ে বয়সে ছোট ছেলে মেয়েদের সংগে থাকতে বেশী পছন্দ করে

০ ১ ২ ৬৫। কথা বলতে চায় না

০ ১ ২ ৬৬। কোন কোন কাজ বার বার পুনরাবৃত্তি করে; বাধ্যবাধকতা বাঁতিক (বর্ণনা করুন) ------------------ ------------------

০ ১ ২ ৬৭। শ্রেণী-শৃংখলা ভংগ করে

০ ১ ২ ৬৮। খুব চেঁচামেচি করে

০ ১ ২ ৬৯। গোপনীয়ভাব, সবকিছু নিজের মধ্যে রাখে

০ ১ ২ ৭০। কোন জিনিস না থাকা সত্ত্বেও তা দেখে (বর্ণনা করুন) ----- ------------------

০ ১ ২ ৭১। আত্ম সচেতন অথবা সহজেই বিব্রতবোধ করে

০ ১ ২ ৭২। বিশৃংখল কাজ

০ ১ ২ ৭৩। দায়িত্বহীনভাবে আচরণ করে (বর্ণনা করুন) ----------- -----------------

০ ১ ২ ৭৪। বড়াই অথবা ভাঁড়ামী করে

০ ১ ২ ৭৫। লাজুক অথবা ভীতু

০ ১ ২ ৭৬। হঠাৎ অতিরিক্ত উত্তেজিত হয় এবং অনির্ণয়মুলক আচরণ করে

০ ১ ২ ৭৭। অবিলম্বে দাবী পুরণ করতে হয়, সহজেই হতাশাবোধ করে

০ ১ ২ ৭৮। অমনোযোগী, সহজেই অন্যমনস্ক হয়

০ ১ ২ ৭৯। কথা বলার সমস্যা (বর্ণনা করুন) -------------------- --------------------

০ ১ ২ ৮০। ভাবলেশহীনভাবে তাকিয়ে থাকে

০ ১ ২ ৮১। সমালোচনা করলে আঘাত পায়

০ ১ ২ ৮২। চুরি করে

০ ১ ২ ৮৩। যে সমস্ত জিনিস তার প্রয়োজন নেই সেগুলো জমা করে (বর্ণনা করুন) ------------------ ------------------

০ ১ ২ ৮৪। অদ্ভুত আচরণ করে (বর্ণনা করুন) -------------------- --------------------

০ ১ ২ ৮৫। অদ্ভুত ধারণাকরে (বর্ণনা করুন) ---- --------------------

০ ১ ২ ৮৬। একগুঁয়ে, জেদী অথবা রাগচটা

০ ১ ২ ৮৭। ভাব অথবা অনুভূতির হঠাৎ পরিবর্তন

০ ১ ২ ৮৮। খুব বেশী অভীমান করে

০ ১ ২ ৮৯। সন্দেহ পরায়ন

০ ১ ২ ৯০। অশ্লীল অথবা নোংরা ভাষা ব্যবহার করে

০ ১ ২ ৯১। নিজেকে হত্যা করার কথা বলে

০ ১ ২ ৯২। কম সাফল্য লাভ করে, ক্ষমতার তুলনায় কাজ করে না

০ ১ ২ ৯৩। অতিরিক্ত কথা বলে

০ ১ ২ ৯৪। অতিরিক্ত ক্ষেপায়

০ ১ ২ ৯৫। বদ মেজাজ অথবা গরম মেজাজ

০ - সত্যি নয় (যতদূর আপনি জানেন) ১ - কিছুটা অথবা কখনো কখনো সত্যি ২ - খুবই সত্যি অথবা প্রায়ই সত্যি

০ ১ ২ ৯৬। মনে হয় যৌণ বিষয় নিয়ে মগ্ন থাকে

০ ১ ২ ৯৭। লোকদের শাসায়

০ ১ ২ ৯৮। বিদ্যালয় অথবা শ্রেণীতে দেরী করে আসে

০ ১ ২ ৯৯। পরিষ্কার পরিচ্ছন্নতা নিয়ে বেশী উদ্বিগ্ন

০ ১ ২ ১০০। তাকে যে সব কাজ করতে দেওয়া হয় সেগুলি সম্পাদন করতে ব্যর্থ হয়

০ ১ ২ ১০১। বিদ্যালয় পলায়ণপরতা অথবা কারণবিহীন বিদ্যালয়ে অনুপস্থিতি

০ ১ ২ ১০২। কমসক্রিয়, শিথিল চলাফেরা অথবা উদ্যমের অভাব

০ ১ ২ ১০৩। অসুখী, দুঃখিত অথবা মনমরা

০ ১ ২ ১০৪। অস্বাভাবিক চিৎকার করে

০ ১ ২ ১০৫। মদ অথবা মাদকদ্রব্য সেবন করে (বর্ণনা করুন) -------
----

০ ১ ২ ১০৬। অন্যকে সন্তুষ্ট রাখতে অতিরিক্ত উদ্বিগ্ন থাকে

০ ১ ২ ১০৭। বিদ্যালয় অপছন্দ করে

০ ১ ২ ১০৮। ভুল করছে বলে ভয় পায়

০ ১ ২ ১০৯। ঘ্যান ঘ্যান করে

০ ১ ২ ১১০। অপরিচ্ছন্ন ব্যক্তিগত চেহারা

০ ১ ২ ১১১। নিজেকে গুটিয়ে রাখে অন্যের সংগে জড়াতে চায় না

০ ১ ২ ১১২। উদ্বিগ্ন থাকে

০ ১ ২ ১১৩। উপরোক্ত তালিকা ছাড়া ছাত্র/ছাত্রীটির যদি অন্যকোন সমস্যা থাকে তাহলে দয়া করে লিখুন

সবগুলি উক্তির উত্তর দিয়েছেন কিনা দয়া করে দেখে নিন।

কোন কিছু সম্বন্ধে আপনি উদ্বিগ্ন বোধ করলে তার নিচে দাগ দিন

*স্বত্ত্বাধিকার : টি, এম, আখেনবাখ
বাংলা সংস্করণ : রোকেয়া বেগম

বিঃদ্রঃ এই প্রশ্নমালাটি উপরোক্ত লেখকদ্বয়ের লিখিত অনুমতি ছাড়া কোন গবেষণা কার্যে বা প্রকাশনায় বা অন্য কোন কাজে ব্যবহার করা সম্পূর্ণ নিষিদ্ধ।

Dhaka University Institutional Repository

Appendix-6:Translated Bengali Version of McMaster Family Assessment Device

ম্যাকমাস্টার ফ্যামিলি অ্যাসেসমেন্ট ডিভাইস (McMaster Family Assessment Device)

আইটেম নং	আইটেমসমূহ	পুরোপুরি একমত (১)	একমত (২)	ভিন্নমত (৩)	পুরোপুরি ভিন্নমত (৪)
১	পরিবারের মধ্যে কোন কাজ নিয়ে পরিকল্পনা করা কঠিন কারণ আমরা একে অন্যকে ভুলভাবে বুঝি				
২	আমরা আমাদের পরিবারের প্রতিদিনের সমস্যা গুলো সমধান করি				
৩	যখন পরিবারের একজন দুঃখে থাকে, তখন অন্যরা তা বুঝতে পারে				
৪	পরিবারের কাউকে কিছু করতে বলা হলে , সেটা খেয়াল রাখা হয় সে করেছে কিনা				
৫	পরিবারের কেউ কোন ধরনের সমস্যায় পড়লে, অন্যরা খুব সাহায্য করে				
৬	পরিবারের কোন সংকটের সময়, আমরা একে অন্যকে সাহায্য করি				
৭	পরিবারের মধ্যে কোন ধরনের সংকটের সময় আমরা কি করব তা জানিনা				
৮	যখন আমাদের কিছু প্রয়োজন, তখন সেটা পাওয়ার চেষ্টা করি				
৯	আমরা একে অন্যের ভালবাসার প্রতি অনিহা প্রকাশ করি				
১০	আমরা নিশ্চিত থাকি যে পরিবারের সদ্যরা তাদের দায়িত্ব পালন করবে				
১১	দুঃখের মধ্যে থাকলে আমরা একে অন্যের সাথে কথা বলিনা				
১২	সমস্যার মধ্যে পড়লে আমরা আমাদের সিদ্বান্ড় দেই				
১৩	অন্যরা আমাকে যখন গুরত্ব দেয়, শুধু তখনই আনন্দবোধ করি				

১৪	পরিবারের সদস্যরা মুখে যা বলে তা থেকে তাদের অনুভূতি সর্ম্পকে ধারনা করতে পারেন না				
১৫	পরিবারের কর্মকান্ড সমন্ধে সবাই বেশী একটা অবগত নন				
১৬	একজন যেমনই হোক পরিবারের মধ্যে তার গ্রহণযোগ্যতা আছে				
১৭	পরিবারের কোন নিয়ম ভঙ্গ করলে , সহজেই পার পাওয়া যায়				
১৮	কোন ধরনের ইঙ্গিত না দিলেও পরিবারের সদ্যরা সঠিকভাবে বুঝে তা প্রকাশ করতে পারে				
১৯	পরিবারের সদ্যরা কেউ আবেগীয়ভাবে প্রতিক্রিয়া করে না।				
২০	একটি জরুরী পরিস্থিতিতে কি করতে হবে তা আমরা জানি				
২১	ভয় ও উদ্বেগের জন্য পরিবারের যে কোন আলোচনা থেকে বিরত থাকি				
২২	মৃদু ধরনের আবেগীয় বিষয় নিয়ে পরিবারের সদস্যদের মধ্যে কথা বলা কঠিন				
২৩	টাকা পয়সা নিয়ে আলোচনা করতে গেলে সমস্যার সন্মুখীন হতে হয়				
২৪	কোন সমস্যা সমাধানের পর এর ভাল মন্দ নিয়ে আলোচনা করিনা				
২৫	পরিবারের সবাই নিজে নিজেকে নিয়ে চিন্তিত বা ব্যস্ত থাকি				
২৬	অনুভূতিগুলো একে অন্যের সাথে শেয়ার করতে পারি				
২৭	আমাদের প্রসাধন বা সাজসজ্জার অভ্যাস **(Toilet habits)** সর্ম্পকিত কোন সুস্পষ্ট প্রত্যাশা নেই				
২৮	একে অপরের প্রতি ভালবাসা প্রকাশ/প্রর্দশন করিনা				
২৯	আমরা মানুষের সাথে পরোক্ষভাবে না বলে বা তৃতীয় অবলম্বন না করে সরাসরি কথা বলি				

৩০	আমাদের পরিবারের সদস্যদের নিদিষ্ট কিছু দায়িত্ব ও কর্তব্য রয়েছে				
৩১	পরিবারের মধ্যে যথেষ্ট তিক্ত অনুভূতি আছে				
৩২	মারামারি নিয়ন্ত্রন করার জন্য পারিবারিক নিয়ম আছে				
৩৩	যখন নিজেদের মধ্যে কোন পছন্দীয় বিষয় মিলে যায়, তখনই কেবল আমরা একত্রিত হয়				
৩৪	ব্যক্তিগত পছন্দীয় বিষয়গুলো বোঝার জন্য আমরা কম সময় দেই				
৩৫	আমরা যা বুঝি তা প্রায়ই প্রকাশ করিনা				
৩৬	আমরা যা তা সহজভাবেই গ্রহন করতে পারি				
৩৭	আমরা একে অন্যের প্রতি আগ্রহ প্রকাশ করি যখন আমরা ব্যক্তিগত ভাবে কোন সুবিধা পেতে পারি				
৩৮	পরিবারের মধ্যে বেশীরভাগ আবেগীয় সমস্যাগুলো সমাধান করতে পারি				
৩৯	অন্যান্য বিষয়ের তুলনায় ¯েœহশীলতা গৌন ভূমিকা আছে				
৪০	পরিবারের গৃহস্থালী কাজগুলো কে করবে সে বিষযে আলোচনা করি				
৪১	আমাদের পরিবারের সিদ্বান্ড় গ্রহন করাটা একটা সমস্যা				
৪২	আমরা তখনই একে অন্যের প্রতি আগ্রহ প্রকাশ করি যখন কোন কিছু থেকে সুবিধা পাই				
৪৩	আমরা একে অন্যের প্রতি স্পষ্টভাষী				
৪৪	পরিবারের কোন নিযমনীতি বা আর্দশ নেই				
৪৫	পরিবারের কাউকে যদি কিছু করতে বলা হয় , তবে তাদের মনে করিয়ে দিতে হয়				
৪৬	সমস্যা সমাধানের জন্য আমাদের সিদ্বান্ড় গ্রহনের ক্ষমত্া আছে				
৪৭	পরিবারের কোন নিয়ম যদি ভঙ্গ করা হয়, আমরা জানিনা এর পরিনাম কি হতে পারে				
৪৮	আমাদের পরিবারের যে যা খুশি তাই করতে পারি				

৪৯	আমরা পরিবারের সদস্যদের প্রতি ¯েœহ প্রর্দশন করি				
৫০	আমরা পরিবারের আবেগীয় সমস্যাগুলোকে মোকাবিলা করতে পারি				
৫১	আমাদের পরিবারের মধ্যে একাত্ববোধের অভাব রয়েছে				
৫২	আমরা রেগে গেরে একে অন্যের সাথে কথা বলা বন্ধ করি না				
৫৩	পারিবারিক যে কাজগুলো আমাদের করতে হয় তা নিয়ে আমরা সাধারণত অসন্তুষ্ট থাকি				
৫৪	ভাল করার ইচ্ছা থেকেই আমরা একে অন্যের বিষয়ে খুব বেশী মাত্রায় অনধিকার চর্চা করি				
৫৫	বিপদজনক পরিস্থিতি বিষয়ে পারিবারিক নিয়ম রয়েছে				
৫৬	আমরা একে অন্যের ব্যাপারে আস্থাশীল				
৫৭	আমরা কাঁদতে স্বাচ্ছন্দ্যবোধ করি				
৫৮	আমাদের পরিবারে যথোপযুক্ত পরিবহণ ব্যবস্থা নেই				
৫৯	পরিবারের কেউ অপছন্দীয় কাজ করলে আমরা তাকে বলি				
৬০	আমরা পরিবারের সমস্যাগুলো সমাধান করার জন্য বিভিন্ন উপায় নিয়ে চিন্ড়া করতে পারি				