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**RESEARCH PAPER**

# Prevalence of behavioral problems among preschool children of Dharwad district

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**Abstract:** The prevalence of behavioral problems was studied on 334 preschool children (3-6 years) of both rural and urban areas of Dharwad district. A multi stage random sampling method was employed where three talukas out of five were randomly selected from Dharwad district and from these selected talukas, two villages each were selected. A total of ten anganwadi's from five villages with 213 children and from six urban anganwadi's from three cities of the selected talukas with 121 children formed the sample. The ASEBA Child Behavior Checklist was administered to the class teachers. The prevalence of behavioral problems revealed that, 47.0 per cent of preschoolers were in the borderline and 13.8 per cent were in the clinical range while only 39.2 per cent were in the normal category for behavioral problems. On internalizing behavioral problems, 49.7 per cent of children were in clinical range and 30.2 per cent in borderline wherein 6.6 per cent were emotionally reactive, 15.6 per cent anxious/depressed, 26.6 per cent with somatic complaints, 2.4 per cent withdrawn symptoms. On externalizing behavioral problems, 26.0 per cent were in clinical range wherein 9.1 per cent had attention problems and 7.8 per cent aggressive behavior. There is need to address the behavioral problems among preschool children during their early years through parent counseling intervention programmes.

**Key words:** Behavioral problems, Counseling, Externalizing, Internalizing

## Introduction

The early years of child sets foundation for lifetime learning, behavior and wellbeing. The skills developed by the child during early childhood period shape brain and child's competence to learn, to get along with others and to respond to the everyday stresses and challenges. The preschool years lays foundation for child's holistic development which take an account of cognitive capacities, physical, social and emotional development.

Furthermore, beside developmental changes, children face many parental and social pressures that also make this period quite stressful and thereby rendering the child more susceptible to develop emotional, psychological and behavioral problems (Rowling, 2006). During their development period, a large number of children suffer from problematic behavior at one time or the other. Many of these problems are of transient in nature and are often not even noticed. However, at times, the severity and their overall effect on the development of the child may be distressing. At times there are some problems which persist and in due course interfere or become obstacles for the normal development of children which may lead to developmental deviations.

The substantial percentage of children will outgrow the behavioral problems during their toddler hood period while there is some evidence that prevalence rates of behavioral problems persist over the period of preschool age (Bayer *et al.,* 2010) into adolescence (Weeks *et al.,* 2016) and predict mental health disorders in adulthood unless treated (Reef *et al.,* 2011). According to a review by Egger and Angold (2006), the prevalence rates of behavioral problems in children aged 2 to 5 years ranged from 14 to 26.4 per cent. Nevertheless, existing facts on behavioral problems during early childhood period reveal inconsistent prevalence rates, perhaps due to deviating assessment methods and age ranges.

Among the many factors involved in the genesis and course of these problems, those related to the quality of parent child relationships have gained attention in the field of developmental psychopathology (Masten *et al.,* 2005). Parents play a significant role in helping children build and refine their knowledge and skills, as well as their learning expectations, beliefs, goals, and coping strategies. Children who are securely attached to their parents are provided a solid foundation for healthy development, including the establishment of strong peer relationships and the ability to empathize with others (Murphy and Laible, 2013). Conversely, young children who do not become securely attached with a primary caregiver (e.g., as a result of maltreatment or separation) may develop insecure behaviors in childhood and potentially suffer other adverse outcomes over the life course, such as behavioral problems and disruption in other social and emotional domains (Bowlby, 2008). To minimize the problem behaviors among children during early years, research suggests that an effective preschool counseling program and parenting intervention programmes addresses the transitions systematically and proactively in efforts to support all children (Dimmitt and Carey, 2007). Inclusion of individualized intervention programmes, guidance and counselling into basic education curriculum will help in promoting quality assurance and also promotes optimal transitions which include lower retention rates, fewer behavior problems and more satisfied parents (NCDPI, 2007). In this context, the present study was undertaken to estimate the prevalence of behavioral problems among preschool children in Dharwad district.

## Material and methods

The prevalence study was conducted during the year 2018-2021 in the selected preschools of both rural and urban localities in the Dharwad district. A multi stage random sampling method was employed where to study the prevailing parent counseling services in preschools of Dharwad district and to study the prevalence of behavioral problems in rural and urban locality, a survey research design was adopted. A differential research design was employed to compare the behavioral problems between rural and urban preschool children. The target population consisted of mother-children dyads where child age ranged between 3 to 6 years. Out of five talukas of Dharwad district, three talukas *viz.,* Dharwad, Kalaghatagi and Kundagolwere randomly selected and from these talukas, two villages were selected randomly. From the selected villages, two anganwadi's each were randomly selected. Children who attended the anganwadi's regularly formed the sample. Hence, the rural sample comprised of 213 children from ten anganwadi's out of five villages. From the sixth village only one anganwadi could be approached and another could not be reached due to lockdown regulations in view of Covid-19 pandemic situation during the data collection period. The urban sample was drawn from one city of the three selected talukas. From the selected cities two anganawadi's were randomly selected. No private preschools were included as they were closed due to Covid-19 pandemic situation. The urban sample comprised of 121 preschool children from six anganwadi's.

The ASEBA Child Behavior Checklist (1½-5 years) developed by Achenbach and Rescorla (2000) was administered toanganwadi teachers to assess specific behavioral, emotional and social functioning problems of children. The behavioral problems can be scored interms of two broad groupings of syndromes *viz.,* Internalizing and Externalizing. Internalizing syndrome scale measures the problems that are mainly within self and externalizing scale comprises problems that mainly involve conflicts with other people and with their expectations for the child. The checklist also measures the components of internalizing behavioral problems *viz.,* emotionally reactive, anxious/depressed, somatic complaints and withdrawn whereas externalizing syndrome scales measures attention problems and aggressive behavior.The total problem score is computed by summing the scores for internalizing and externalizing syndromes. The raw scores were converted to normalized *T* Scores and percentiles and further classified into normal, borderline and clinical range. Frequency and percentages were used to assess the behavioral problems of the preschool children. Modified chi-square analysis was employed to know the association between the problem behavior of children and locality.

## Results and discussion

### Counseling service for the management of behavioral problems

The survey research method was employed to know the counseling services offered for the management of behavioral problems like temper tantrums, aggressive behavior, anxious and depressive symptoms, nail biting, thumb sucking, withdrawn syndromes and attention problems among preschoolers in the twin cities of Hubli and Dharwad.

The results revealed, none of theindependent existing counseling centers offered the counseling service for the management of behavioral problems among preschoolers and their parents in the rural locality. In the urban locality there were seven independent counseling centers established in the twin cities of Dharwad district which cater to the needs of parents, teenagers, adults and school children but not the preschoolers. All the seven centers provided the services for the treatment of behavioral disorders, attention deficit hyperactivity disorder (ADHD), autism, learning disorders, speech and language difficulties, oppositional defiant disorder, bullying, socio-emotional problems, behavioral problems and mental health issues among school children and adults but not for preschoolers. The centers were also providing different therapies and techniques *viz.*, child guidance, cognitive behavior therapy, cognitive training for ADHD treatment, parent counseling, family and child counseling, family therapy, sand therapy, music therapy, psychotherapy and other parenting intervention programmes. It was observed that, these centers offered counseling services for the school age children, teenagers and parents but none for the management of behavioral problems of preschoolers.

### Behavioral problems

The prevalence of behavioral problems among rural and urban preschool children on a sample of 334 (Table 1) revealed that, 47 per cent preschool children were in the borderline and 13.8 per cent in the clinical range while only 39.2 per cent were in the normal level. Similar trend was observed when preschool children were distributed by locality. Among both rural and urban areas, majority of preschool children were in the borderline (46.0 % and 48.8 % respectively), clinical range (12.2 % and 16.5 % respectively) and only 11.7 per cent of urban preschoolers and a higher percentage of rural (41.8 %) were in normal range. The findings also connoted no significant association between behavioral problems among children by locality. Though there was some difference in the family background mainly with the socio economic status of the family and employment of mother and father, children in both rural and urban areas displayed similar levels of behaviour problems. The findings also suggested that, the frequency of behavioral problems in both borderline and clinical range may be due to the poor parenting practices and negative parenting style adopted by the parents in rearing their children. These results were in line with

Table 1. Percentage distribution of rural and urban preschool children by total behavioral problems

| Levels | Rural (n1=213) | Urban (n2=121) | Total (N=334) | Modified $\chi^2$ |
|---|---|---|---|---|
| Normal | 89 (41.8) | 42 (34.7) | 131 (39.2) | 2.15 $^{NS}$ |
| Borderline | 98 (46.0) | 59 (48.8) | 157 (47.0) | |
| Clinical | 26 (12.2) | 20 (16.5) | 46 (13.8) | |

Khan *et al.,* (2009) who reported the prevalence of behaviour problems as 14.6 per cent among 2 to 9-year-old children in rural Bangladesh. According to Abdalla *et al.,* (2018) 17.6 per cent preschool children of Zagazig city of Egypt had total behavior problems. Similarly, Teekavnich *et al.,* (2017) reported 11.9 per cent of preschool children of Bangkok, Thailand in the clinical range of total behavioral and emotional problems. They reported that, parental divorce and severe conflicts in the family were the factors associated with the behavioral problems among preschoolers while Santos *et al.,* (2016) identified 23.5 per cent prevalence of behavior problems among preschoolers from the city of Salvador, Brazil and reported maternal mental health as an important risk factor for the behavioral problems among preschool children.

**Internalizing behavioral problems**

The percentage distribution of both rural and urban preschool children by the level of internalizing and externalizing behavioral problems are presented in Table 2. The results showed that, with regard to internalizing behavioral problems, majority of children were in the clinical range (49.7 %) followed by borderline (30.2 %) and only 20.1 per cent in normal level. Among rural and urban area, higher number of children were in the clinical range (48.8 % and 51.2 % respectively) for internalizing behavioral problems followed by borderline (31.0 % and 28.9 % respectively) whereas only 20.2 per cent and 19.8 per cent children were in the normal category. However, no significant association was observed between internalizing behavioral problems and locality. The findings are in line with the results of Wu *et al.* (2012) who reported 11.2 per cent preschool children aged 2-6 years of Taiwan were in the clinical range for internalizing behavioral problems. Similarly, Santos *et al.,* (2016) reported 9.7 per cent among 4 to 6 years of Brazil. Similarly, Ahmad *et al.,* (2016) reported 28.0 per cent of Malaysian children in the clinical range and 18 per cent in borderline. The prevalence rate of internalizing behavioral problems may be due to the negative parenting style and practices used by the parents and also the child's socio-economic status and temperament which may develop some internalizing problems among preschoolers. Accordingly, children with a depressed parent have a dual risk for showing increase in internalizing behavioral problems.

Table 2. Comparison of rural and urban preschool children by level of internalizing and externalizing behavioral problems

| Locality | Normal | Borderline | Clinical | Modified $\chi^2$ |
|---|---|---|---|---|
| Internalizing Behavioral Problems | | | | |
| Rural | 43 | 66 | 104(48.8) | $0.204^{NS}$ |
| | (20.2) | (31.0) | | |
| Urban | 24 | 35 | 62(51.2) | |
| | (19.8) | (28.9) | | |
| Total | 67 | 101 | 166(49.7) | |
| | (20.1) | (30.2) | | |
| Externalizing Behavioral Problems | | | | |
| Rural | 82 | 86 | 45 | $8.399^{NS}$ |
| | (38.5) | (40.4) | (21.1) | |
| Urban | 33 | 46 | 42 | |
| | (27.3) | (38.0) | (34.7) | |
| Total | 115 | 132 | 87 | |
| | (34.4) | (39.5) | (26.0) | |

**Externalizing behavioral problems**

With regard to externalizing behavioral problems, majority of children were in the borderline (39.5 %) and 26.0 per cent in clinical range (26.0 %) while only 34.4 per cent were in normal level. With regard to locality, among the rural areas, 40.4 per cent of children were found to be in borderline and 21.1 per cent in the clinical rangefor the externalizing behavioral problems while only 38.5 per cent were in normal level. Whereas, among the urban areas, majority of the children were found to be in borderline (38.0 %) followed by clinical range (34.7 %) and 27.3 per cent in normal level. However, the chi-square analysis revealed no significant association between the levels of externalizing behavioral problems and locality. Ahmad and Mansor (2016) reported that, out of 1198 children 174 were in the borderline and clinical range for externalizing behavioral problems among preschool children in Malaysia. Similarly, Santos *et al.,* (2016) reported 25.2 per cent among 3 to 6 years old in Brazil. According to Abdalla *et al.,* (2018), 20.6 per cent of preschool children aged 3-6 years in Egypt had externalizing behavioral problems. Navitha *et al.,* (2019) also reported that, 25 per cent of children were with moderate level of hostile and aggressive problems and were involved in fighting, kicking, biting, hitting other children. Findings have been quite consistent in indicating that insecure and disorganized attachment and negative control in parenting (hard and inconsistent punishment, high coercion, *etc.*) have been considered as contributors to externalizing behavioral problems among preschool children (Volckaert and Noel, 2016).

**Specific behavioral problems**

Among the behavioral problems, 65.9 per cent of preschool children were in the normal category on emotional reactive while 27.5 per cent in borderline and 6.6 per cent in the clinical range. Both the localities were similar ($\chi^2$=5.597$^{NS}$) where 70.4 per cent of rural children and 57.9 per cent urban preschoolers were found to be in normal category followed by 23.5 per cent from rural and 34.7 per cent from urban area in the borderline whereas 6.1 per cent from rural and 7.4 per cent from urban area were in the clinical range. The chi-square analysis showed no significant association between the levels of emotionally reactive syndrome and locality. The results are in line with Pourhossein *et al.,* (2015) who reported 10.7 per cent of 5 to 7 years aged children had emotionally reactive syndrome while Teekavnich *et al.,* (2017) reported that 11.9 per cent of 4 to 6 year aged children with emotional reactivity symptoms. Emotional reactivity is the tendency of the preschooler to experience frequent and intense emotional arousal. Preschoolers who learn to self-regulate their emotions can develop a better attention and problem solving abilities. Child's emotional dysregulation is linked to behavioral disorders like Oppositional Defiant Disorder, and it can put a child at a significant risk of developing emotional disorders such as anxiety disorders, eating disorder and clinical depression (Buckholdt *et al*., 2013).

With regard to anxious / depressed syndrome, 27.2 per cent of preschool children were in the borderline and 15.6 per cent in the clinical range while 57.2 per cent of children were in the normal level. Both the localities were in similar trend where no significant association was observed with anxious/depressed syndromes and locality. Among the rural locality, 27.7 per cent and from urban 26.4 per cent were in borderline while 16.0 per cent from rural and 14.9 per cent from urban were in clinical range while 56.3 per cent rural and 58.7 per cent urban were in the normal level. Most of the studies estimated the prevalence of preschool anxiety disorders in the range of 10-20 per cent (Petresco *et al.,* 2014). Abdalla *et al.,* (2018) reported 21.2 per cent of 3-6 year Egyptian preschoolers exhibited anxious depressed syndrome while Coskun and Kaya (2015) reported 16.5 per cent of 1 ½ to 5 yearspreschoolers in Turkey had anxiety disorders. Though the early childhood period is considered as a time of happiness and joy, still the preschoolers experience anxiety and depression. Impairment in preschool anxiety disorders and depression is due to several psychosocial and child characteristics which have been associated with some risk factors like negative family environments, parenting stress, parental avoidance, child temperament, problematic peer relationships, disruption of family functioning and stressful life events (De-Pauw *et al.,* 2009). Some authors also reported that, parental history of depression and related psychopathology leads to preschool onset depression in their children (Hopkins *et al.,* 2013).

In case of somatic complaints, 26.6 per cent of preschoolers were in clinical range while 19.5 per cent were in the borderline and 53.9 per cent were in the normal level. Preschoolers from rural locality exhibited more number of somatic complaints than urban preschoolers ($\chi^2$=9.510*). Majority (31.9 %) of rural preschoolers were in the clinical range in comparison with urban preschoolers (17.4 %). Both rural (19.7 %) and urban (19.0 %) preschoolers found to be similar in the borderline while 48.4 per cent rural and 63.6 per cent urban preschoolers were in normal level for somatic complaints. Young children dealing with emotional and behavioral issues will complain of somatic/ physical illness symptoms like head ache, stomach pain, joint pain, giddiness etc. The child who is undergoing emotional turmoil may exhibit higher number of somatic problems. Maternal anxiety, depression and maternal mental health have been identified as a risk factor for somatic complaints among preschoolers (Engel *et al.,* 2018). The most frequent complaints reported were abdominal pains (38.8%), tiredness (20.4%), headaches (16.7%), leg pains (16.6%), and dizziness (2.2%).

With regard to withdrawn syndrome, 31.4 per cent were in borderline and 2.4 per cent in the clinical range while 66.2 per cent were in normal level. Both the localities were similar where 32.4 per cent of rural and 29.8 per cent of urban preschoolers were in borderline and 2.8 per cent of rural and 1.7 per cent of urban were in clinical range while 64.8 per cent of rural and 68.6 per cent of urban preschoolers were in the normal level. The chi-square analysis also revealed no significant association between withdrawn syndromes and locality. Abdalla *et al.,* (2018) reported 15.3 per cent of preschool children (3 to 6 years) exhibited clinical range for withdrawn syndrome and Doni and Giosta (2017) reported it to be 10.9 per cent. Negative and harsh parenting with strict rules and discipline measures at home may be the risk factors for withdrawal syndrome among children.

Table 3. Comparison of preschool children by locality on components of behavioral problems

| Locality | Normal | Borderline | Clinical | Modified $\chi^2$ |
|---|---|---|---|---|
| Emotionally Reactive | | | | |
| Rural | 150 | 50 | 13 | 5.597$^{NS}$ |
| | (70.4) | (23.5) | (6.1) | |
| Urban | 70 | 42 | 9 | |
| | (57.9) | (34.7) | (7.4) | |
| Total | 220 | 92 | 22 | |
| | (65.9) | (27.5) | (6.6) | |
| Anxious / Depressed | | | | |
| Rural | 120 | 59 | 34 | 0.177$^{NS}$ |
| | (56.3) | (27.7) | (16.0) | |
| Urban | 71 | 32 | 18 | |
| | (58.7) | (26.4) | (14.9) | |
| Total | 191 | 91 | 52 | |
| | (57.2) | (27.2) | (15.6) | |
| Somatic Complaints | | | | |
| Rural | 103 | 42 | 68 | 9.510* |
| | (48.4) | (19.7) | (31.9) | |
| Urban | 77 | 23 | 21 | |
| | (63.6) | (19.0) | (17.4) | |
| Total | 180 | 65 | 89 | |
| | (53.9) | (19.5) | (26.6) | |
| Withdrawn | | | | |
| Rural | 138 | 69 | 6 | 0.777$^{NS}$ |
| | (64.8) | (32.4) | (2.8) | |
| Urban | 83 | 36 | 2 | |
| | (68.6) | (29.8) | (1.7) | |
| Total | 221 | 105 | 8 | |
| | (66.2) | (31.4) | (2.4) | |
| Attention Problems | | | | |
| Rural | 196 | 17 | - | 2.381$^{NS}$ |
| | (92.0) | (8.0) | | |
| Urban | 105 | 16 | - | |
| | (86.8) | (13.2) | | |
| Total | 301 | 33 | - | |
| | (90.1) | (9.9) | | |
| Aggressive Behavior | | | | |
| Rural | 147 | 61 | 5 | 24.38* |
| | (69.0) | (28.6) | (2.3) | |
| Urban | 73 | 27 | 21 | |
| | (60.3) | (22.3) | (17.4) | |
| Total | 220 | 88 | 26 | |
| | (65.9) | (26.3) | (7.8) | |

Regarding attention problems, only 9.1 per cent were in the borderline while 90.1 per cent were in the normal level. None of them were in the clinical range. The chi-square analysis showed no significant association between attention problems and locality where 8.0 per cent of children from rural and 13.2 per cent of children from urban were in borderline while 92.0 per cent from rural and 86.8 per cent from urban area were in normal level. Ponde *et al.,* (2017) estimated the prevalence of inattention as 11.3 per cent while Abdalla *et al.,* (2018) estimated

17.6 per cent among preschool children. Children with attention problems get easily distracted and are unable to focus on the tasks. Coercive parenting, maternal history of anxiety and depression, negligence of overprotection by parents, difficult child and parental temperament, lower maternal education and lower socio economic status may be the risk factors for child's inattention.

For aggressive behavior, 26.3 per cent of preschoolers were in borderline and 7.8 per cent in clinical range wherein 65.9 per cent were in the normal level. The chi-square analysis showed a significant association between aggressive behavior and locality where urban preschoolers exhibited more aggressive behavior than rural preschoolers as 17.4 per cent of urban preschoolers fell under clinical range in comparison with 2.3 per cent of rural preschool children. Similarly, 28.6 per cent from rural and 22.3 per cent from urban were in the borderline for aggressive behavior while 69.0 per cent from rural and 60.3 per cent from urban were in the normal range. During early years, aggression is conceptualized as a part of difficult temperament and anxious attachment with parents where children tend to resort to instrumental and physical expression of aggression such as snatching toys and pushing a playmate. Navitha *et al.,* (2019) reported that 25 per cent of children with moderate level of hostile and aggressive problems were involved occasionally in fighting, kicking, biting, hitting other children. Similarly, Abdalla *et al.,* (2018) reported 18.8 per cent preschool children with aggressive behavioral problems while Khan *et al.,* (2014) reported 36.7 per cent of 6 year children with aggressive behaviour. Other risk factors of aggressive behavior include the effects of disturbed family dynamics, parental characteristics like maternal age, antisocial behavior of father, and alcohol abuse of parent, negative parenting practices, use of harsh discipline, difficulty in parenting, the impact of exposure of child to the violence in the early years and the inter-parental conflicts may cause aggression among children (Tremblay *et al.,* 2004).

**Conclusion**

Behaviour problems such as aggressive behavior, attention problems, temper tantrums, withdrawn symptoms, somatic complaints, anxious depressed syndrome were in the clinical range among the preschool children which were seen around 13 to 15 per cent in both rural and urban localities. The study also highlighted that, none of the preschools offered any counseling services for the parents and children in management of behavioral problems. The behavioral problems that emerged during early childhood years can cause serious trouble for children in later years as well as for parents too. Hence, to manage the behavioral and emotional problems, counseling services and educational intervention programmes can be provided to the parents and children. Professional school counselors can be allottedto the preschools and anganwadi's to assist in the promotion of effective learning of the young children, through increased collaboration and consultation with both teachers and parents by using behavior modification techniques and different therapies.

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