A STUDY OF CHILDHOOD PSYCHOPATHOLOGY
IN RELATION TO TEMPERAMENT FROM
ADVANTAGED AND DISADVANTAGED GROUPS

ABSTRACT

THESIS
SUBMITTED FOR THE AWARD OF THE DEGREE OF
Doctor of Philosophy
IN
PSYCHOLOGY

BY
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UNDER THE SUPERVISION OF
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ALIGARH (INDIA)
2002
ABSTRACT

The aim of the present endeavour was to study the problem entitled, "A study of Childhood Psychopathology in relation to Temperament from Advantaged and Disadvantaged Groups". The problem of the study was quite challenging. However, the entire work leading to Ph.D. degree in Psychology consist of five standard chapters.

The chapter I has presented the theoretical aspects of the nature of numerous variables which have been studied to achieve the objective of the present endeavour. It is described that childhood psychopathology studies started with pioneering work of Aries (1962). He said that childhood development was initially started in 17th century and initially in the upper socio-economic classes. After his work, the attention towards children still remains an important phenomenon which is widely being studied.

Having given the emphasis to childhood psychopathology, the chapter also discuss the concept of temperament which was perceived to be an important factor in relation to childhood psychopathology.

The main objectives of the present study are:
1. To examine the difference between the overall mean score of advantaged and disadvantaged boys on temperament measurement schedule.
2. To examine the difference between the overall mean score of advantaged and disadvantaged girls on temperament measurement schedule.

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

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

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

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

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

Chapter II has highlighted comprehensive details of the relevant available literature pertaining to the present aims and goals of the study. The chapter has well documented the significance of the present study in the light of past researches.

Chapter III has provided the methods and procedure opted in carrying out the present investigation where details about sample, tools used and statistical analysis have been given in detailed.

Results and discussion have been given in chapter IV. In all, results consisted of 12 tables have been described and discussed in detailed. Gender differences were determined on
childhood psychopathology and temperament from advantaged and disadvantaged children.

Chapter V highlights the main findings of the study and on the basis of that some suggestions are made for further researches, some intervention programme are also suggested for the well being of the children belonging to both advantaged and disadvantaged groups.
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2002
DEDICATED

TO

MY BELOVED GRANDFATHER

(Late Mr. Ahsanul Haque)
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Dr. Naima K. Gulrez  
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Dated: .....................................

Certificate

This is to certify that Ms. Iram Chaudhary has worked under my supervision for the Ph.D Thesis entitled "A study of childhood Psychopathology in relation to temperament from advantaged and disadvantaged groups". This study was carried out by her and it is an original piece of work. This thesis is fit for submission to the examiner for its evaluation.

Naima K. Gulrez  
Supervisor
ACKNOWLEDGEMENT

The accomplishment of this endeavour would not have been possible without the will of Almighty.

I take this opportunity to express my sincere appreciation and grateful thanks to my supervisor, Dr. Naima Gulrez, Reader, Department of Psychology, A.M.U. Aligarh for sparing her valuable time and her able guidance and benevolent attitude which have been a constant source of encouragement for me. Her valuable suggestions, many editorial efforts and moral support enabled me to accomplish this work.

I would also like to thank Professor Shamim Ahmad Ansari, Chairman, Department of Psychology, A.M.U. Aligarh, for providing best available facilities in conducting the present endeavour along with his expert comments and suggestions.

I would also like to thanks Prof. Akbar Hussain, Department of Psychology, A.M.U. Aligarh has helped me in my statistical analysis and in my literature work.

I would also like to thanks Prof. (Mrs) Hamida Ahmad, Prof. Saeeduzzafar, Dr. S. Mehmood Khan and other teachers of the Department, for their continuous help and moral support time to time to boost my interest in this study.

Mr. Shariq Ahmad Seminar Incharge, and Mr. Majaz-ul-Haq, Journal Incharge, Department of Psychology, A.M.U. Aligarh, help me a lot in my research work by providing books and journals.
I fail to choose proper and appropriate words for expressing regard to my beloved parents, Mr. Ghufran-ul-Haque and Mrs. Murtazai Begum who had been a lifetime source of encouragement and inspiration for achieving the goal.

I would also like to thank my brother Imraan ul Haque and Farrukh Sayeed, sisters, Shazia Ghufran and Sadaf who were a constant source of inspiration to me in keeping my interest alive and help me in my work.

Miss Shabana Nesar, Reshma Siddiqui, Deepshikha, Huma, Reshma Apa, Rehana, Sadaf, Mr. Zaki Akhtar, Daud, Nasir and my colleagues who always stood by me and deserve special thanks for their cooperation during the whole period of study.

I would also like to pay my special thanks to all the teachers of Zakir Hussain School, Green Crescent School, Union School and Chungi School of Aligarh, without their cooperation the work would have not been accomplished.

I would also like to thank Mr. H.K. Sharma, for typing the manuscript.

My thanks are also due to all those who are one way or the other supported me by their inspiring attitude and kind acts in accomplishing my research work.

(IRAM CHAUDHARY)
Chapter One

INTRODUCTION

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

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

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

It is an age-old Indian belief that early childhood development is the crux of human development. Also that early childhood development is
an integral and critical part of antipoverty strategies. Early childhood
represents the best opportunity for breaking inter-generational cycle of
multiple disadvantages - chronic undernutrition, poor health, gender
discrimination and low socio-economic status.

Psychopathological Behaviour

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TEMPERAMENT

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

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

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

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

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

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

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

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

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

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

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

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

On factor analysis nine variables of temperament dimensions brought out three functionally significant typologies of temperament which were named as:
1) **The easy child**  This child quickly establishes regular routines in infancy, is generally cheerful, and adapts easily to new experience.

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

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

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

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

The theory suggests four temperaments:

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

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

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

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

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

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**For example**  Sociability and activity may partially merge. A sociable person is expected to initiate contacts with others, and such type of behaviour may require an output of energy, than unsociable person. Highly active person may well be energetic both socially and non-socially so can emotionality, the emotional person reacts intensely and powerfully. In terms of temperament, an active person might appear more impulsive than an inactive person. Similarly, an emotional person reacts intensely and therefore has a greater problem in controlling his emotions. If he shows his fear, or express his moods, he will be seem as impulsive. So we expect a modest correlation between impulsivity and both activity and emotionality.

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

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

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

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

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

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

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

Combinations of Two Temperament

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THEORIES OF TEMPERAMENT

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

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

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

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

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

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

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

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

Types of Temperaments

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

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

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

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

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

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

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

The main objectives of the present study are:

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

2. To examine the difference between the overall mean score of advantaged and disadvantaged girls on temperament measurement schedule.
3. To examine the difference between the overall mean score of advantaged and disadvantaged boys on childhood psychopathology measurement schedule.
4. To examine the difference between the overall mean score of advantaged and disadvantaged girls on childhood psychopathology measurement schedule.
5. To examine the difference between the mean score of advantaged and disadvantaged girls on the factor of temperament measurement schedule.
6. To examine the difference between the mean scores of advantaged and disadvantaged boys on the factor of temperament measurement schedule.
7. To examine the difference between the mean scores of advantaged and disadvantaged girls on the factor of childhood psychopathology measurement schedule.
8. To examine the difference between the mean scores of advantaged and disadvantaged boys on the factor of childhood psychopathology measurement schedule.
9. To examine the difference between the mean scores of advantaged girls and advantaged boys on the factor of temperament measurement schedule.
10. To examine the difference between the mean scores of disadvantaged girls and disadvantaged boys on the factor of temperament measurement schedule.
11. To examine the difference between the mean scores of advantaged girls and advantaged boys on the factor of childhood psychopathology measurement schedule.

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

The assessment of childhood psychopathology and temperament in children healing from advantaged and disadvantaged groups have been studied here with a view that the findings of the present study may have relevance to improve their quality of life.
A review of literature helps us to understand the problem clearly. It also makes the predictions regarding the outcome of manipulation of different variables possible, thus, facilitating formulation of hypotheses.

Therefore, literature from various sources was extensively reviewed and studied in the light of present investigation. The main variables under study were childhood psychopathology and temperament in relation to advantaged and disadvantaged groups.

Accordingly, in this chapter the various empirical findings related directly or indirectly to the aims of the present study are reviewed under the following main headings:

(a) Childhood psychopathology
(b) Temperament

CHILDHOOD PSYCHOPATHOLOGY

Asarnow et al. (1995) summarizes retrospective and cross sectional neurobehavioral studies of schizophrenic children. Retrospective studies of schizophrenic children reveal that during early childhood, prior to the 1st onset of schizophrenic symptoms, most schizophrenic children showed delays in language acquisition or impairments and delays in visual-motor coordination. These impairments appear to be developmental delays rather than fixed neurobehavioral impairments, because cross-sectional studies conducted when the children are at least 10 yr. of age, after the 1st
onset of psychosis, fail to detect the same deficits. The results of 
behavioural cognitive/neuropsychological studies as well as the study of 
event related potentials measured during performance of cognitive task 
suggest that schizophrenic children suffer from limitations in processing 
resources.

Kontos et al. (1997) examined the contributions of classroom 
context (activity settings, teacher behaviour, contact with peers, and 
teachers) to children's cognitive and social competence in early childhood 
classrooms. 114 male and female children, aged 2.6-6.4 yrs. were 
observed in their early childhood classrooms during free play time. 
Children's cognitive and social competence were measured by observing 
their interactions with peers and objects. A preliminary analysis revealed 
that teacher behaviour was negatively related to one child characteristics, 
cognitive competence, but was unrelated to children's age, sex or social 
competence. A multiple regression showed that when child age and 
cognitive competence were controlled children's social competence was 
positively related to peer contact and teacher involvement, and negatively 
related to teacher contact. Children's cognitive competence was positively 
related to participation in "high yield" activities and negatively related to 
teacher contact with age controlled. Puura, Kaija, Almquist et al. (1998) 
Studied that whether parents and teacher report depressive symptoms in 
children with self-reported depression and which features are connected 
with sought psychiatric care. Children of age 8-9 yrs was assessed with 
children's Depression Inventory (CDI), the Rutter A2 scale for parents 
(RA) and Rutter B2 scale for teachers (RB). In stepwise regression
analysis of parents report depressed mood, unpopularity, social withdrawal, disobedience, inattentiveness and stealing were associated with high CDI scores. The items of the teacher report associated with high CDI scores included poor school performance, restlessness, Somatic complaints, unresponsiveness, and absenteeism from school. The parents and teachers readily saw and reported depressive symptoms in children with multiple depressive symptoms had psychiatric care been sought or even considered. The results indicate that a large number of children with multiple depressive symptoms are left without necessary psychiatric assessment and help.

Garner et al. (1997) examined whether mothers and fathers reported using different emotion socialization strategies and whether these differences were related to preschoolers gender and emotional expressiveness during peer play. The positive expressive behaviour of 82 preschoolers (aged 41-67 months) participating in 2 conflict eliciting situations with 2 sessions were averaged. All of the mothers and fathers were administered 3 emotion socialization questionnaire. Girls expressed more positive emotion than boys. The findings shows that mothers and father's reported to children's emotionally expressive behaviour during peer play. In addition, father's emotion socialization practices accounted for unique variance in children's emotionally expressive behaviour over and above that explained by the maternal emotion socialization variables.

Egger et al. (1998) examined the association between chronic headaches and psychiatric disorders including depression, anxiety, conduct
disorder, oppositional defiant disorders, and attention deficit hyperactivity disorder, in a population based sample of children and adolescents. Headaches that lasted at least 1 hr and occurred at least once a week during 3 month prior to the interview were studied. Girls with depression and anxiety disorders had a significantly greater prevalence of headaches than girls without an internalizing disorder. Conduct disorders was significantly associated with headaches in boys. Each of these association was constant with age. This study suggests that a distinct gender difference exists between boys and girls in the associations between headaches and psychopathology. B.J. Cassoll's (1983) theory of dysfunction in central pain regulation as an underlying cause of depression is discussed in relation to the proposed serotonergic dysregulation common to headaches, depression, anxiety, aggression and pain.

Wilcox-Herzog et al. (1998) examined the nature of teacher talk in early childhood classrooms as well as how such talk is related to children's level of play with objects and peers during free play. The purpose of the study was to determine what levels of teacher talk were related to child functioning. 89 children (42 girls, 47 boys, age range = 31 through 63 months) enrolled in three early childhood programs participated in the study. Results demonstrated that 81% of the time. Although previous research suggests that high level teacher talk should be related to high level play with objects, the results indicated that high level teacher talk was related to lower levels of play with objects and unrelated to play with peers on the part of the children.
Duncan et al. (1998) discuss that why parental socio-economic-status (SES) correlates strongly with various measures of child and adult achievement is an important and controversial research question. The findings from recent contributions to this literature, we conduct 2 sets of analyses using data from the panel study of income Dynamics. Completed schooling and non-marital child bearing are related to parental income during early and middle childhood, as well as adolescence. These analyses suggest that family economic conditions in early childhood have the greatest impact on achievement, especially among children in families with low incomes. Estimates from sibling models support the hypothesis that economic conditions in early childhood are important determinants of completed schooling.

Roberts et al. (1998) identified and reviewed 52 studies done over the part 4 decades that attempted to estimate the overall prevalence of child and adolescent psychiatric disorders. Subjects ages ranged from 1-18 yrs. Rutter's criteria were the most frequently used for case definition, although more recent studies were more likely to use DSM-criteria. The most frequently used interview was the Rutter schedule. Prevalance estimated of psychopathology ranged from approx. 1-52% median rates were 8% for Preschoolers, 12% preadolescents, 15% for adolescents, and 18% in studies including wider range. This evidence is less informative than expected because of several problems that continue to plague research on child and adolescent disorders.

Recent research of McLoyd (1998) shows that persistent poverty has more detrimental effects on IQ, School achievement, and socio
emotional functioning than transitory poverty, with children experiencing both types of poverty generally doing less well than never poor children. Higher rates of perinatal complications reduced access to resources that buffer the negative effects of perinatal complications increased exposure to lead, and less home based cognitive stimulation partly account for diminished cognitive functioning in poor children. These factors along with lower teacher expectancies and poorer academic - readiness skills also appear to contribute to lower levels of school achievement among poor children. The link between socio-economic disadvantage and children's socio-emotional functioning appears to be mediate partly by harsh, inconsistent parenting and elevated exposure to acute and chronic stressors.

Lavigne et al. (1998) examines the relationship between psychopathology and health care utilization beginning in preschool (ages 2-5 yrs). 510 preschool children were enrolled through 68 primary care physician. The test battery used for diagnosis included the child Behaviour checklist a developmental evaluation, the Rochester Adaptive Behaviour Inventory, and a video taped play session. Consensus DSM-III R diagnosis were assigned using best-estimate procedures. Frequency of primary care visits was established through 1 yrs retrospective record review, mothers estimated total visits and emergency department(ED) use logistic regression models showed that a DSM-III R diagnosis was related to increased ED use but not primary care or total visits. Total internalizing, and externalizing behaviour problem scores were associated with increased primary care and total visits. It is concluded that there is a consistent
relationship between health care use and child psychopathology beginning in the preschool years.

Ackerman et al. (1999) explored the relations between additive and cumulative representations of contextual risk, caregiver emotionality, child adaptability, and teacher reports of the problem behaviours of 6 and 7 year old children (N = 155) from economically disadvantaged families. The results showed relations between both risk representation and child problem scores and provided evidence that the relation for cumulative risk may be moderated by care giver negative emotionality and care giver positive emotionality and partially mediated by child adaptability. The results suggest the importance of exploring alternative representations of contextual risk and the conditions under which contextual risk influences child behaviour.

Pace et al. (1999) examined the relationship between children emotional and behavioural problems and teachers social responding. Elementary school students completed the children's Depression Inventory and parent completed the child Behaviour checklist. Teachers rated children on measures of interpersonal attractiveness and personal rejection. Teachers rating of student interpersonal attractiveness were significantly correlated with the level of student depression, internalizing problems, externalizing problems, and overall psychopathology. However, teacher's rating of social acceptance of student's only correlated with externalizing behaviour problems. Family income was also related to child adjustment and teacher ratings. Externalizing behaviour problems best
predicted both lower interpersonal attractiveness and increased personal rejection, even after controlling for family income.

Jain et al. (1999) explores the relationship between parental aspirations and behaviour problems in children. The sample consisted of 300 children (aged 5-12 yrs.,) and their parents. The child psychopathology Measurement schedule (Malhotra et al. 1988) was administered to the parents to determine the overall psychopathology in children, the parental Aspiration Questionnaire (Grover, 1987) was administered individually to all parents. Result indicated that only father's aspirations had a significant impact on behavioural problems in children. However, mothers aspiration has no significantly influence. Children of high aspirant fathers manifested significantly higher conduct disorder, depression, special symptoms, and somatisation. Mothers high aspirations were positively correlated with conduct disorders in boys and anxiety in girls.

Ollendick et al. (1999) examined developmental theory and its relevance for the practice of clinical child psychology. A brief review of basic principles of developmental psychology and developmental psychopathology, implications of a developmental perspective are explored for the diagnosis assessment, and treatment of childhood disorders. Although it is obvious that many developmental issues confront the clinical child psychologist and that we have learned much about translating developmental theory into clinical practice we conclude that we have a long way to go before we can assert that a true developmental clinical child interface has been realized.
Biederman et al. (1999) argues that while histories of stresses are common in youth with depression, their etiological role vis-a-vis depression remain uncertain. It is maintained that it can be argued that considering the ubiquitous stress in children's lives the association between stress and depression could be just coincidental. Equally plausible is the fact that stress can precipitate depression in predisposed youth and that depression itself can be a stressor. Although depression in childhood and adolescents is defined in the DSM. The importance of the age of onset of depression, gender distribution in the difference between juvenile and adult depression familial link with bipolarity in juvenile depression, pattern of psychiatric comorbidity, and diagnostic issues are examined.

Kring et al. (1999) examined that emotional disturbances are central to diverse psychopathologies. Here the author argue that the functions of emotions are comparable for persons with and without psychopathology. However, impairment in one or more components of emotional processing disrupts the achievement of adaptive emotion functions. Adopting a theoretical conceptualization of emotional processes that stresses activity in centrally mediated approach and withdrawal systems, the authors discuss the role of emotion in several forms of psychopathology, including major depression, some of the anxiety disorders, psychopathy, and schizophrenia. In doing so, the nature of emotion disturbance and attendant behavioural and cognitive deficits is highlighted. Finally the author discuss the merits of this approach for conceptualizing emotional disturbance in psychopathology.
Hursti et al. (1999) reviews the literature on factors influencing food choice in children as well as in adults. Based on the research it is concluded that the development of children's food habits is influenced by a multitude of factors. Parents play an important role in the formation of food habits and preferences of young children. They can influence their children's food choice by making specific foods available by acting as models for their children and by their behaviour in specific situations. Children tend to be afraid of new foods and do not readily accept them. However, experiences is known to enhance preference and earlier experiences of a particular food are the major determinants of the development of children's food acceptance patterns.

Raner et al. (1999) examined relations between children's emotional self regulation, attentional control, and peer social competence (as reported by both teacher and peers) for 51 low income, 3.82-5.67 yrs. Old enrolled in Head start using a short delay of gratification task administered at head start sites, children's use of self distraction was found to be positively associated with their success in handling the delay, replicating previous, laboratory based research. Children's use of self distraction was found to be unrelated to their attentional control, as assessed during a computer task. Hierarchial regression analysis revealed that children's use of self distraction predicted significant variance in both peer and teacher reports of children's competence with peers, even after children's attentional control was statistically taken into account. These findings are discussed in light of current models of reactivity and regulation in predicting young children's social behaviour.
This prospective research by Bandura (1999) analyzed how different facets of perceived self efficacy operate in concert within a network of socio cognitive influences in childhood depression. Perceived social and academic inefficacy contributed to concurrent and subsequent depression both directly and through their impact on academic achievement prosocialness and problem behaviours. In the shorter run, children were depressed over beliefs in their academic inefficacy rather than over their actual academic performances. In the longer run, the impact of a low sense of academic efficacy on depression was mediated through academic achievement problem behaviour and prior depression. Perceived social inefficacy had a heavier impact on depression in girls than in boys in the longer term. Depression was also more strongly linked over time for girls than for boys.

Kerns et al. (2000) a number of measures have been developed to assess parent child attachments, validity data on middle-childhood measures are lacking. The present study tested attachment based measures of parent-child relationships designed for the latter middle-childhood years (9-12 yr.) self report from children assessed perceptions of security and avoidant and pre-occupied coping. Some children also completed a projective interview assessing attachment state of mind. Mothers and fathers reported their willingness to serve as an attachment figure and were rated for responsiveness. Data were collected from a cross-sectional sample of 3rd and 6th graders and their parents. A 2 yr. follow up on the younger sample provided data on the stability of the measures. The attachment based measures were also related to teacher ratings of children's school adaptation.
Owens et al. (2000) examined a variety of common sleep behaviours in a group of 494 elementary school children, grades kindergarten through fourth, using a battery of sleep questionnaires that included parent, teacher and self-report surveys. The prevalence of parent-defined sleep problems ranged from 3.7% (sleep-disordered, breathing) to 15.1% of (Bed time Resistance), with 37% of the overall sample described as having significant sleep problems in at least one sleep domain. Younger children were more likely than older children to have sleep problems noted by parents (particularly bed time struggles and night walkings), as well as by teacher and self-report children tended to identify more sleep problems by self-report, particularly sleep onset delay and night walkings, than did their parents overall, approximately 10% of the sample was identified by all three measures as having significant problems with day time sleepiness. The results of this study emphasize the importance of screening for sleep disorders in this age group in the clinical setting. The need for consensus regarding the use of sleep screening instruments and the definition of "problem" sleep in school aged children is also discussed.

Newman (2000) examined an important way in which elementary and middle school students regulate their own learning and intellectual development is by obtaining assistance from others at times of need. At school a child who engages in adaptive help seeking monitors his or her academic performance, shows awareness of difficulty he or she cannot overcome independently, and remedies that difficulty by requesting assistance from teachers and classmates. In this article, the author discusses how parents, teachers and peers contribute to the development
of children's skills and attitudes associated with adaptive help seeking. The article traces early help-seeking behaviours in particular, in the home and link these to help seeking behaviours in the classroom.

Gardner et al. (2000) studied that conduct problems in childhood are detrimental to emotional well being. Children with conduct problems have increased rates of depression, peer problem, and school failure. The authors examine the definition of children's conduct problems, why conduct problems are so important, why the development of conscience is important, research methods for assessing parenting style and its contribution to child behaviour, parenting and conduct problems, and parenting and conscience development.

Compas et al. (2001) progress and issues in the study of coping with stress during childhood and adolescence are reviewed. Definitions of coping are considered, and the relationship between coping and other aspects of responses to stress (e.g. temperament and stress reactivity) is described. Questionnaire, interview, and observation measures of child and adolescent coping are evaluated with regard to reliability and validity. Studies of the association of coping with symptoms of psychopathology and social and academic competence are reviewed. Initial progress has been made in the conceptualization and measurement of coping, and substantial evidence has accumulated on the associations between coping and adjustment. Problems still remain in the conceptualization and measurement of coping in young people, however, and aspects of the development and correlates of coping remain to be identified.
McDougall et al. (2001) reviews literature on the effects of peer rejection on children's well being. The author show what has been learned about the consequences of childhood peer rejection. Since the publication of J.G. Parker and S.A. Asher's review in the mind 1980s. This chapter examines both intrapersonal internalizing problems that arise from peer rejection (such as depression, loneliness, poor self concept, and psychopathology) and interpersonal externalizing problems (such as aggression, school misbehaviour, delinquency, and criminality). The author begins with a review of the links between early peer rejection and 4 broad types of long term outcomes: academic, general psychopathology, internalizing problems, and externalizing problems. After considering the consequences associated with early peer rejection, how and why rejection contributes to later adjustment.

Banerjee et al. (2001) addressed the social cognition of socially anxious, children, with particular emphasis on their ability to understand others mental states in interpersonal situations. The heterogeneous sample used in this investigation consisted of 63 primary school children in England (aged 8-9 yrs) and the US (aged 6-11 yrs). The children completed measures of social anxiety, Shy negative affect, and various social cognitive abilities, and teacher ratings of social skills were additionally available for the US subgroup.

Results showed that feelings of social anxiety are not associated with any basic deficit in the understanding of recursive mental states which concern facts about the physical world. However, there was evidence that
socially anxious children - particularly those with high levels of shy negative affect do experience specific social cognitive difficulties in understanding the links between emotions, intentions and beliefs in social situations. Providing further support for this link, socially anxious children were rated by their teachers as poorer, than non-anxious children only on social skills that require insight into others mental states.

Molteno et al. (2001) discuss a sample of 355 children with intellectual disability (ID) attending special schools in cape town, south Africa, were assessed on the Developmental Behavioural checklist - Teacher version (DBC-T). A prevalence rate of 31% for psychopathology was found. Boys manifested more behaviour problems than girls, especially in relation to disruptive, self absorbed and antisocial behavioural difficulties than those in the mild and moderate categories. Specific behaviour problems were self absorbed and autistic behaviours in children with profound ID communication problems and anxiety in those with severe ID and antisocial behaviour in children with mild ID. Epilepsy, but not cerebral palsy was associated with higher total behaviour scores. Ambuland children were more disruptive and antisocial, while non-ambulant children were more anxious. Non-verbal children had higher scores on all of the subscales except for disruptive behaviour.

In another study Carlson et al. (2002) studied the relationships of age at onset and childhood psychopathology to 2-year clinical and functional outcomes in first admission patients with bipolar I disorder were examined. Patients with bipolar I disorder (N = 123) presenting with
psychotic symptoms were followed over a 2 year period. Age at onset was stratified into less than 19 and 19 years. Childhood psychopathology was categorized as behaviour problems, other psychopathology, and non. Functional and clinical outcomes were rated with standard measures. Childhood psychopathology and age at onset were independently related to poorer functional and clinical outcome. In the multivariate models that included psychopathology, age at onset, sex, and education, early age at onset was related to functional outcome. Childhood psychopathology and age at onset contribute independently to outcomes of bipolar disorder. Childhood psychopathology is a much stronger predictor of functioning than age at onset.

TEMPERAMENT

Owens-Stively (1997) discuss the children without significant sleep disturbance seen at a primary care clinic for well child care were compared on measures of temperament parenting style, daytime behaviour, and overall sleep disturbance to three diagnostic subgroups identified in a pediatrics sleep clinic: children with obstructive sleep apnea (n=33), parasomnias (night terrors, sleep walking, (n=16) and behavioural sleep disorders (limit-setting disorder (n=31). The mean age of the entire sample was 5.7 yrs. Temperamental emotionality in the behavioural sleep disorders group was associated with a higher level of sleep disturbance, parenting laxness was associated with sleep disturbance in the general pediatric population, and intense and negative temperament characteristics seemed to be associated with clinically significant behavioural sleep
disturbances. In effective parenting styles and daytime disruptive behaviours were more likely to be associated with the milder sleep disturbances found in children in a primary care setting.

Sajaniemi et al. (1998) examined whether 80 preterms differed from 80 full terms in temperament profile at 24 month and explored the relationship between temperament, neurodevelopment, and behaviour. Temperament was assessed using the Toddler temperament Questionnaire, which defines 9 temperament dimension, activity, rhythmicity, approach/withdrawl, adaptability mood, intensity, distractibility, persistence, and sensory threshold. Neurodevelopment was assessed by the Bayley scales of Infant Development and neuropediatric examination. Behaviour was assessed using the Infant Behaviour Record (IBR), which is a part of the Bayley Scales. When temperament was considered, the preterms were significantly less active, more adaptive, more positive in mood, less intense and lower in threshold to respond than the controls. The results on IBR showed that preterms were significantly less goal directed, less attentive, and lower in endurance than the controls. The preterms performed significantly less well than the controls on the Bayley test. Low Bayley scores correlated with temperament scores of high rhythmicity, positive mood, low persistence, and high threshold and with IBR scores of poor social orientation, negative emotional tone, poor co-operation, short attention span, and poor endurance.

Harrington et al. (1998) examined the relationships among neglect, perceived child temperament, and family context and characteristics in a sample of 121 urban low-income mothers (mean age
24.7 yrs) with a child under 30 month old. Maternal reports of more difficult child temperament predicted emotional neglect, family context was indirectly related, as mothers in well functioning families with more support reported their children as being less difficult. Neither child temperament nor family context was related to physical neglect.

Katainen et al. (1998) studied development of temperament dimensions of activity sociability, and negative emotionality, in a random sample of 386, 6 yrs old over a 9 yrs period childhood temperament dimensions and the mother's report, and self-reports of adolescent temperament were obtained at age 15. The structural modeling analysis indicate that the development of temperament may be a function of both sex differentiated maternal child rearing attitudes and constitutional behavioural factors. First, the sex differentiated role of maternal disciplinary style was found. The mother's low level of strict disciplinary style in childhood predicted a low level of negative emotionality in girls, and a high level of strict disciplinary style predicted low sociability and high negative emotionality in boys. Second, heterolypic behavioural continuity was indicated in girls for adolescent sociability that was predicted by childhood sociability, and for negative emotionality that was predicted by a combination of low-sociability and high activity. In boy, in turn, adolescent sociability was predicted by childhood activity, adolescent, activity being predicted by childhood sociability as well as activity.

Aksan et al. (1999) studied the number and nature of temperamental types in 488 children aged 3 yrs 6 months, on the basis of
a broad set of temperamental characteristics, including positive and negative emotionality and the attentional and behavioural control domains. Configural frequency analysis methods showed clear support for two temperament types: controlled nonexpressive and noncontrolled expressive. These types showed meaningful differences against external criteria related to a wide range of problem behaviours from the emotional social and attentional domains. The reports of problem behaviours were obtained contemporaneously from fathers and care givers. These findings replicated a year later when children were aged 4 yrs 6 months. Furthermore, the findings showed that infants and toddler-age temperamental characteristics differentiated these preschool-aged types. The author discuss the implications of the results for a categorical view of temperament personality.

Novosad et al. (1999) examined temperament of 55 children (including 15 sibling pairs) was assessed annually using separate instruments for the years 4-7 (Behavioural style Questionnaire) and 8-11 (the Middle childhood. Temperament Questionnaire). Mothers made differential ratings of siblings, and the 2 questionnaires showed continuity and stability. There were consistently significant correlations with respect to individual differences ever the full range of ages, and no evidence of variation across age or developmental change.

Raikkonen et al. (2000) examined development of hostile attitudes in a random sample of 225 females and 214 males in a 12 year longitudinal study beginning at 3 yrs old. Maternal reports of
temperament, reflecting perceived child difficultness (high activity and anger and low cooperativeness) and mother's hostile child rearing attitudes were obtained at 3 and 6 yrs. Self reported hostile attitudes of children were obtained at age 15. Maternal perceptions of child difficultness and hostile maternal child rearing served as independent predictors of subsequent, hostile attitudes. However, this developmental pattern was different for females than for males. Maternal perceptions of child difficultness were emphasized in the development of females hostile attitudes, whereas hostile maternal child rearing attitudes were emphasized in the development of males hostile attitudes. Although child temperament and maternal attitudes were associated in early and middle childhood, this reciprocity did not play a significant role in the development of hostile attitudes.

Seifer (2000) studied the style of infant and child behaviour is a nexus where many factors affecting normative and pathological development converge, providing a unique opportunity for understanding a variety of children's pathways through development. During the past 40 years, temperament in infants and children has been a focus of normative work in human development and has been advanced as a potential contributor to psychopathology in children and adolescents of particular interest is the extension of temperament to the relationship processes between children and their care givers, particularly during the first year of life. This provides a brief overview of issues addressed by temperament researchers, reviews knowledge about basic developmental phenomena related to temperament, identifies empirical evidence that temperament is
associated with incompetence and/or psychopathology, and discusses goodness of fit models as a coherent framework for understanding the interplay of infant characteristics and parental behaviour in the context of explaining variation in developmental outcomes. The view on temperament advanced in this review is a less individualistic and less biologically deterministic than is typically found in today's human development literature.

Rothbart et al. (2000) reviews how a temperament approach emphasizing biological and developmental processes can integrate constructs from subdisciplines of psychology to further the study of personality. Basic measurement strategies and findings in the investigation of temperament in infancy and childhood are reviewed. These include linkage of temperament dimensions with basic affective motivational and attentional systems, including positive affect/approach, fear, frustration/anger, and effortful control contributions of biological models that may support these processes are then reviewed. Research indicating how a temperament approach can lead researchers of social and personality development to investigate important person-environment interactions is also discussed. Lastly, adult research suggesting links between temperament dispositions and the big five personality factors is described.

Kagan et al. (2001) discusses the role of temperament in rendering some individuals more capable than others to experience anxious emotions. This article detail research examining infant reactivity and child inhibition and addresses childhood risk for developing social anxiety. A discussion of temperament and anxiety in modern culture is also included.
Walker et al. (2001) investigated the relationship between sex, social status, and temperament in a sample of preschool-aged children (mean age 62.4 month) Sociometric interviews were conducted with 92 boys and 90 girls. Status groups of popular, rejected, neglected, controversial, and average children were identified according to previously established criteria. In addition, teachers rated children's temperament. Results indicate that rejected children displayed a more difficult temperament than popular children in terms of higher activity levels, higher distractibility, and lower persistence. Both rejected and neglected children were rated as displaying lower adaptability and more negative mood than popular children. Boys were also rated as more active, more distractible, and less persistent than girls. Results are discussed in terms of the relevance of particular temperament dimensions to successful social functioning for boys and girls.
Chapter - Three

METHODOLOGY

Any scientific research programme has to be systematic, controlled, empirical and critical investigation of hypothetical proposition, about the presumed relationship among different variables. It involves systematic and sound procedures in order to achieve objectivity in findings our results. In order to enhance the objectivity as well as predictive value of the findings, it becomes imperative to choose an appropriate research design. Selection and/or development of the relevant standardized tools and tests, identification of adequate sampling for collecting data, and lastly the careful tabulation and analysis of data by administering the appropriate statistical techniques and finally the interpretation of results in accordance with the problem. The present endeavour aims to study childhood Psychopathology in relation to temperament among the children of advantaged and disadvantaged Group.

To meet this objective the following methodology was adopted.

SAMPLE

In behavioural research sample is always chosen from the large population. Mohsin (1984) contended that sample is a small part of the total existing events, objects or the informations, Kerlinger (1983) believes that "Sampling is taking any portion of a population or universe as representative of that population or universe as representative of that population a universe". Thus sampling is a portion of population selected
for observation so it is possible to draw the reliable information or to make generalizations on the population as a whole from where the sample is drawn.

The sample of the present study consisted of 200 school students representing advantaged and disadvantaged groups. But students have returned only 162 forms. The sample of advantaged group was drawn from Aligarh Public School, Green crescent school, and Zakir Hussain Public School. And the sample of disadvantaged group was drawn from, union school, and chungi school, respectively. The break up of the sample is represented in the following table.

**SHOWS THE TOTAL NUMBER OF SAMPLE**

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of student</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantaged</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Disadvantaged</td>
<td>82</td>
<td>162</td>
</tr>
</tbody>
</table>

**Disadvantaged Group**

For this group we will take union school, and Chungi school. Here the condition of the schools are not very good, and the children are from low socio-economic class.

**Advantaged Group**

For this group we will take Aligarh Public School, Zakir Hussain Public School, Green crescent Public School. Here the conditions of the school are very good, method of teaching is also very good. All the children are from high socio-economic class.
We have decided to take two different groups, just to study the distinction between the children of two schools. It is expected that childhood psychopathologies are more often found in disadvantaged group. Questionnaire method was adopted, since the sample and the type of study required the questionnaire method. Each questionnaire consist a number of statement, every respondent is bound to respond to each statement as per the instruction given in the Questionnaire.

TOOLS USED:

In order to have clear objective or clear cut understanding of human behaviour certain psychological tests are used. To understand the specific aspect of the behaviour, under study relevant tools/measures/invention/scale etc. are used for the present study.

The following test/scales were used for the present study.

CHILDHOOD PSYCHOPATHOLOGY MEASUREMENT SCHEDULE

Purpose of this test is to measure psychiatric symptoms in children. It is used for screening children for psychiatric disturbance and to measure nature of psychopathology. This test is prepared by savita Malhotra (1984). It is in both the languages i.e. English & Hindi. Test has 75 items with "yes" and "No" responses. Test measures 8 factorially derived syndromes i.e. low intelligence, conduct disorder, Anxiety, Depression, Psychotic Symptoms, Special Symptoms, Somatization, and Physical illness. For "yes" category the score is "1" and for "No" category the score is "0". This test has reliability and validity. Test retest reliability of the test is "0.78 to 0.91". Inter rater reliability coefficient is "0.88 to 0.96"
Factorial and construct validity are high. Criterion validity is also found.

TEMPERAMENT MEASUREMENT SCHEDULE

It is used to measures the temperament of the children. This is prepared by Savita Malhotra and Anil Malhotra (1982). It is available both in English and Hindi languages. It is used for temperament assessment of children seeking psychiatric help as well as normal children. It may be used for research as well as for clinical assessment of children. Test has 9 categories and in each there are 5 items. these categories are Activity level, Rhythmicity, Approach withdrawal, Adaptability Mood, Intensity, Threshold, distractibility, Persistence. Test has its reliability and validity. Test-retest reliability is = 0.83 to 0.94; Inter rater reliability = 0.88 to 0.96. The factorial and construct validity studied and was found satisfactory.

Two extreme scores of 1 and 5 were provided with extreme frequency and intensity on the negative and positive direction with average at point 3; 1 = Hardly ever; 2 = once in a while; 3 = sometimes; often = 4; 5 = Almost always.

PROCEDURE

The data was collected from the mother's of the children. Prior to data collection, subjects were assured that their responses would be kept strictly confidential and will be used only for research purpose. Both the scales i.e. Temperament Measurement schedule and childhood Psychopathology Measurement schedule was administered on the subjects. The respondents generally took one hour time in completing both the
scales. After data collection the scoring was done according to the prescribed procedure.

**STATISTICAL ANALYSIS**

The investigator had to compare two groups one is Advantaged group and the other is Disadvantaged group. Further, the influence of two variables namely Childhood Psychopathology and Temperament were needed to be assessed. The researcher therefore used the 't' test so that the significance of the difference between the means could be found. 't' is an inferential statistics and is commonly used to compute the significance of difference between two means. Since our research questions aims to answer questions relating to intergroup difference on certain dimensions 't'-test was applied by the researcher.
Chapter - Four

RESULTS AND DISCUSSION

The data analysed by means of 't' test are presented in the following tables.

Table 1. Indicating the difference between the overall mean scores of Advantaged and Disadvantaged boys on Temperament Measurement schedule.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantaged boys</td>
<td>141.58</td>
<td>23.37</td>
<td>0.04</td>
<td>.05</td>
</tr>
<tr>
<td>Disadvantaged boys</td>
<td>142.69</td>
<td>22.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Indicating the difference between the overall mean scores of Advantaged and Disadvantaged girls on Temperament Measurement schedule.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantaged girls</td>
<td>136.657</td>
<td>26.54</td>
<td>0.52</td>
<td>.05</td>
</tr>
<tr>
<td>Disadvantaged girls</td>
<td>149.8</td>
<td>23.04</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3. Indicating the difference between the overall mean scores of Advantaged and Disadvantaged boys on Childhood Psychopathology Measurement schedule.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantaged boys</td>
<td>11.93</td>
<td>5.06</td>
<td>1.45</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>Disadvantaged boys</td>
<td>25.95</td>
<td>13.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4. Indicating the difference between the overall mean scores of Advantaged and Disadvantaged girls on Childhood Psychopathology Measurement schedule.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantaged girls</td>
<td>10.94</td>
<td>4.16</td>
<td>1.78</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>Disadvantaged GIRLS</td>
<td>27.34</td>
<td>13.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5. Indicating the difference between the mean scores of Advantaged girls and Disadvantaged girls on the factors of Temperament Measurement Schedule.

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>Advantage Girls</th>
<th>Disadvantaged Girls</th>
<th>t-values</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Activity level</td>
<td>14.857</td>
<td>4.20</td>
<td>15.914</td>
<td>4.49</td>
</tr>
<tr>
<td>Rhythmicity</td>
<td>14.857</td>
<td>4.20</td>
<td>15.914</td>
<td>3.47</td>
</tr>
<tr>
<td>Approach withdraw</td>
<td>15.45</td>
<td>4.9</td>
<td>18.8</td>
<td>4.21</td>
</tr>
<tr>
<td>Adaptability</td>
<td>15.742</td>
<td>4.23</td>
<td>17.657</td>
<td>3.05</td>
</tr>
<tr>
<td>Mood</td>
<td>15.942</td>
<td>4.40</td>
<td>17.914</td>
<td>3.21</td>
</tr>
<tr>
<td>Intensity</td>
<td>14.257</td>
<td>4.16</td>
<td>14.0</td>
<td>4.33</td>
</tr>
<tr>
<td>Threshold</td>
<td>15.086</td>
<td>4.34</td>
<td>15.428</td>
<td>3.03</td>
</tr>
<tr>
<td>Distractibility</td>
<td>16.429</td>
<td>4.3</td>
<td>15.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Persistence</td>
<td>16.829</td>
<td>4.01</td>
<td>16.485</td>
<td>4.01</td>
</tr>
</tbody>
</table>
Table 6. Indicating the difference between the mean scores of Advantaged boys and Disadvantaged boys on the factors of Temperament Measurement Schedule.

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>Advantaged Boys</th>
<th>Disadvantaged Boys</th>
<th>t-values</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Activity level</td>
<td>17.4</td>
<td>3.70</td>
<td>7.311</td>
<td>3.36</td>
</tr>
<tr>
<td>Rhythmicity</td>
<td>13.177</td>
<td>2.8</td>
<td>14.777</td>
<td>7.5</td>
</tr>
<tr>
<td>Approach withdrawl</td>
<td>16.822</td>
<td>4.25</td>
<td>17.2</td>
<td>3.82</td>
</tr>
<tr>
<td>Adaptability</td>
<td>14.933</td>
<td>3.61</td>
<td>16.33</td>
<td>3.08</td>
</tr>
<tr>
<td>Mood</td>
<td>16.622</td>
<td>3.81</td>
<td>16.53</td>
<td>2.64</td>
</tr>
<tr>
<td>Intensity</td>
<td>14.688</td>
<td>4.14</td>
<td>14.26</td>
<td>4.0</td>
</tr>
<tr>
<td>Threshold</td>
<td>16.733</td>
<td>3.80</td>
<td>14.02</td>
<td>3.56</td>
</tr>
<tr>
<td>Distractibility</td>
<td>15.266</td>
<td>3.15</td>
<td>14.26</td>
<td>4.56</td>
</tr>
<tr>
<td>Persistence</td>
<td>16.977</td>
<td>4.32</td>
<td>14.73</td>
<td>3.74</td>
</tr>
</tbody>
</table>
Table 7. Indicating the difference between the mean scores of Advantaged girls and Disadvantaged girls on the factors of Childhood Psychopathology Measurement schedule.

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>Advantaged Girls</th>
<th>Disadvantaged Girls</th>
<th>t-values</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Low Intelligence with behavioural problem</td>
<td>3.285</td>
<td>1.08</td>
<td>6.085</td>
<td>2.99</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>0.942</td>
<td>0.72</td>
<td>5.428</td>
<td>3.69</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0.285</td>
<td>0.50</td>
<td>1.6</td>
<td>0.84</td>
</tr>
<tr>
<td>Depression</td>
<td>1.028</td>
<td>1.04</td>
<td>3.571</td>
<td>2.75</td>
</tr>
<tr>
<td>Psychotic symptoms</td>
<td>1.285</td>
<td>1.36</td>
<td>2.8</td>
<td>1.63</td>
</tr>
<tr>
<td>Special symptoms</td>
<td>0.314</td>
<td>0.38</td>
<td>1.2</td>
<td>0.78</td>
</tr>
<tr>
<td>Somatization</td>
<td>3.114</td>
<td>1.88</td>
<td>5.314</td>
<td>3.73</td>
</tr>
<tr>
<td>Physical Illness</td>
<td>0.971</td>
<td>0.52</td>
<td>1.342</td>
<td>0.87</td>
</tr>
</tbody>
</table>
Table 8. Indicating the difference between the mean scores of Advantaged boys and Disadvantaged boys on the factors of Childhood Psychopathology Measurement schedule

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>Advantaged Boys</th>
<th>Disadvantaged Boys</th>
<th>t-values</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Low Intelligence with behavioural problem</td>
<td>2.957</td>
<td>1.35</td>
<td>5.978</td>
<td>2.90</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>1.531</td>
<td>0.73</td>
<td>5.106</td>
<td>2.88</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0.234</td>
<td>0.42</td>
<td>1.468</td>
<td>0.87</td>
</tr>
<tr>
<td>Depression</td>
<td>1.191</td>
<td>0.94</td>
<td>3.829</td>
<td>2.32</td>
</tr>
<tr>
<td>Psychotic symptoms</td>
<td>1.340</td>
<td>0.67</td>
<td>3.0</td>
<td>1.89</td>
</tr>
<tr>
<td>Special symptoms</td>
<td>0.468</td>
<td>0.31</td>
<td>1.021</td>
<td>0.65</td>
</tr>
<tr>
<td>Somatization</td>
<td>3.978</td>
<td>1.86</td>
<td>4.510</td>
<td>3.10</td>
</tr>
<tr>
<td>Physical Illness</td>
<td>1.021</td>
<td>0.45</td>
<td>1.297</td>
<td>1.10</td>
</tr>
</tbody>
</table>
Table 9. Indicating the difference between the mean scores of Advantaged girls and Advantaged boys on the factors of Temperament Measurement schedule.

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>Advantaged Girls (N=35)</th>
<th>Advantaged Boys (N=45)</th>
<th>t-values</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Activity level</td>
<td>14.857</td>
<td>4.2</td>
<td>17.4</td>
<td>3.3</td>
</tr>
<tr>
<td>Rhythmicity</td>
<td>14.8</td>
<td>4.2</td>
<td>13.1</td>
<td>2.8</td>
</tr>
<tr>
<td>Approach withdrawl</td>
<td>18.8</td>
<td>4.9</td>
<td>16.8</td>
<td>4.2</td>
</tr>
<tr>
<td>Adaptability</td>
<td>15.74</td>
<td>4.2</td>
<td>14.93</td>
<td>3.6</td>
</tr>
<tr>
<td>Mood</td>
<td>15.94</td>
<td>4.4</td>
<td>16.6</td>
<td>3.8</td>
</tr>
<tr>
<td>Intensity</td>
<td>14.25</td>
<td>4.16</td>
<td>14.68</td>
<td>4.14</td>
</tr>
<tr>
<td>Threshold</td>
<td>15.08</td>
<td>4.34</td>
<td>16.73</td>
<td>3.80</td>
</tr>
<tr>
<td>Distractibility</td>
<td>16.42</td>
<td>4.3</td>
<td>15.26</td>
<td>3.15</td>
</tr>
<tr>
<td>Persistence</td>
<td>16.82</td>
<td>4.01</td>
<td>16.97</td>
<td>4.32</td>
</tr>
</tbody>
</table>
Table 10. Indicating the difference between the mean scores of Disadvantaged girls and Disadvantaged boys on the factors of Temperament Measurement schedule.

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>Disadvantaged Girls</th>
<th>Disadvantaged Boys</th>
<th>t-values</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Activity level</td>
<td>15.91</td>
<td>4.9</td>
<td>7.31</td>
<td>3.7</td>
</tr>
<tr>
<td>Rhythmicity</td>
<td>15.91</td>
<td>3.47</td>
<td>14.77</td>
<td>7.5</td>
</tr>
<tr>
<td>Approach withdrawl</td>
<td>15.43</td>
<td>4.2</td>
<td>17.2</td>
<td>3.8</td>
</tr>
<tr>
<td>Adaptability</td>
<td>17.65</td>
<td>3.05</td>
<td>16.33</td>
<td>3.08</td>
</tr>
<tr>
<td>Mood</td>
<td>17.91</td>
<td>3.2</td>
<td>16.53</td>
<td>2.6</td>
</tr>
<tr>
<td>Intensity</td>
<td>14.0</td>
<td>4.3</td>
<td>14.26</td>
<td>4.0</td>
</tr>
<tr>
<td>Threshold</td>
<td>15.42</td>
<td>3.0</td>
<td>14.02</td>
<td>3.5</td>
</tr>
<tr>
<td>Distractibility</td>
<td>15.8</td>
<td>4.8</td>
<td>14.2</td>
<td>4.5</td>
</tr>
<tr>
<td>Persistence</td>
<td>16.48</td>
<td>4.01</td>
<td>14.73</td>
<td>3.74</td>
</tr>
</tbody>
</table>
Table 11. Indicating the difference between the mean scores of Advanced girls and Advantaged boys on the factors of Childhood Psychopathology Measurement scale.

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>Advantaged Girls (N=35)</th>
<th>Advantaged Boys (N=47)</th>
<th>t-values</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Low Intelligence with behavioural problem</td>
<td>3.28</td>
<td>1.08</td>
<td>2.95</td>
<td>1.35</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>.94</td>
<td>.72</td>
<td>1.53</td>
<td>.73</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.28</td>
<td>.50</td>
<td>.23</td>
<td>.42</td>
</tr>
<tr>
<td>Depression</td>
<td>1.02</td>
<td>1.04</td>
<td>1.19</td>
<td>.94</td>
</tr>
<tr>
<td>Psychotic symptoms</td>
<td>1.28</td>
<td>1.36</td>
<td>1.34</td>
<td>.67</td>
</tr>
<tr>
<td>Special symptoms</td>
<td>.31</td>
<td>.38</td>
<td>.46</td>
<td>.31</td>
</tr>
<tr>
<td>Somatization</td>
<td>3.11</td>
<td>1.88</td>
<td>3.97</td>
<td>1.86</td>
</tr>
<tr>
<td>Physical Illness</td>
<td>.97</td>
<td>.52</td>
<td>1.02</td>
<td>.45</td>
</tr>
</tbody>
</table>
Table 12. Indicating the difference between the mean scores of Disadvantaged girls and Disadvantaged boys on the factors of Childhood Psychopathology Measurement schedule.

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>Disadvantaged Girls (N=35)</th>
<th>Disadvantaged Boys (N=47)</th>
<th>t-values</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Low Intelligence</td>
<td>6.08</td>
<td>2.9</td>
<td>13.87</td>
<td>2.90</td>
</tr>
<tr>
<td>with behavioural problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>5.42</td>
<td>3.6</td>
<td>5.10</td>
<td>8.3</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.6</td>
<td>.84</td>
<td>1.46</td>
<td>.87</td>
</tr>
<tr>
<td>Depression</td>
<td>3.57</td>
<td>2.75</td>
<td>3.82</td>
<td>2.32</td>
</tr>
<tr>
<td>Psychotic symptoms</td>
<td>2.8</td>
<td>1.63</td>
<td>3.0</td>
<td>1.89</td>
</tr>
<tr>
<td>Special symptoms</td>
<td>1.2</td>
<td>.78</td>
<td>1.02</td>
<td>.65</td>
</tr>
<tr>
<td>Somatization</td>
<td>5.31</td>
<td>3.35</td>
<td>4.51</td>
<td>3.10</td>
</tr>
<tr>
<td>Physical illness</td>
<td>1.34</td>
<td>.87</td>
<td>1.29</td>
<td>1.10</td>
</tr>
</tbody>
</table>
The perusal of table 1 indicates the overall difference between the mean scores of advantaged and disadvantaged boys on temperament measurement schedule.

The value of 't' does not show any significant difference between the advantaged and disadvantaged boys. In the present study, the socio-economic status of the boys did not play a significant role as far as the temperament is concerned, because the boys in our society enjoy an advantageous position as compared to girls. This may be attributed to the fact that parents try to fulfill the needs of their male children going beyond their means. So the low socio-economic status of the boys don't affect the temperament.

Table 2 indicates the difference between the overall scores of advantaged and disadvantaged girls on temperament scale. Even though the value of 't' does not show any significant difference between the two groups. There is difference between the means of the two groups. As compared to boys, the mean score of girls is found more with respect to temperament. This shows that socio-economic status does play a role to some extent in case of the girls. The high mean score of disadvantaged girls on the temperament scale suggests that it may be due to lack of material comfort and deprivation.

Table 3 indicates the difference between the overall mean scores of advantaged and disadvantaged boys on childhood psychopathology measurement schedule. The value of though statistically non-significant
shows a considerable difference between the two groups. It shows that the socio-economic status does play a role with respect to childhood psychopathology. This may be attributed to the fact that when the parents are not able to meet the requirements of their children due to financial constraints, this may lead to constant tension and anxiety in the parents which may directly or indirectly affected the behaviour of the child. Lack of proper attention love and care, and the quality time spent with the child, feeling of material as well as emotional deprivation may be a potential cause of childhood psychopathology.

Table 4 indicates the difference between the overall mean scores of advantaged and disadvantaged girls on childhood psychopathology measurement schedule. The same trend is visible for the girls as it is with the boys. In fact the 't' value is even greater with respect to the two groups of girls. The same reasons may be attributed to the two groups of girls as it is with the boys. For further interest, a detail factor wise analysis is done for each component of both the variable i.e. temperament measurement schedule and childhood psychopathology separately with regards to boys and girls of the advantaged and disadvantaged groups. Each group of advantaged and disadvantaged boys and girls were compared with respect to the factors of the variable.

Table 5 indicates the difference between the mean scores of advantaged girls and disadvantaged girls on the factors of temperament measurement schedule. The perusal of the table shows that the two groups do not show any significant difference in terms of the factors of
temperament. All the values of 't' in the 9 factors of temperament schedule are non-significant. The two groups do not show any considerable difference with respect to the 9 factors of temperament. So far as the girls are concerned whether they belong to high or low social stratification system does not make any difference in their temperament. This may be attributed to the fact that in prevailing norm of our society girls are not expected to show any temperamental impulsive and emotional behaviour.

Table 6 indicates the difference between the mean scores of advantaged boys and disadvantaged boys on the factors of temperament measurement schedule. The table shows that the value of 't' except in one factor i.e. "Activity level" all other eight values of 't' are statistically non-significant. The two group of boys differ significantly with respect to the factor "Activity level" \( (t = 2.82, p < 0.01) \). This may be explained in terms of the fact that the socio-economic status does play an important role so far as the activity level of the boys are concerned. The disadvantaged boys show lesser degree of activity level imply that they are subject to a subdued personality, due to pressure in the family. They may be expected to do some household activities rather than showing temperamental behaviour. They may be facing hardship in the family which may reduce the activity level of the child.

Besides the overall comparison of boys and girls in the two variables, with respect to the advantaged and disadvantaged status, sex wise comparison of advantaged and disadvantaged boys and girls separately in relation to the factors of childhood psychopathology and factors of
temperament is also done to see if any difference exist between the two sexes.

Table 7 indicates the difference between the mean scores of advantaged girls and disadvantaged girls on the factors of childhood psychopathology. The table indicates that none of the eight factors of psychopathology shows statistically significant difference between the two groups. But the two groups show considerable difference in respect to four factors out of eight factors. They are: conduct disorder, anxiety, depression and special symptoms. The corresponding values of t-test are: 1.66, 1.90, 1.201 and 1.45 respectively. The tendency of childhood psychopathology representing to these factors may be attributed due to the status of the family. Because of the lower position in the social stratification system the girls of the disadvantaged group might be experiencing a lot of problems in fulfilling their basic needs and aspirations. Besides, the parents might be showing lack of concern, aggression and hostile behaviour towards their children, when they fail to fulfill their demands due to their economic constraints. All these may relate well with the factors of childhood psychopathology.

Table 8 indicates the difference between the mean scores of advantaged boys and disadvantaged boys. The pattern shows more or less the same trend as that of the two groups of girls. None of the values of t-test is found to be significant on all 8 factors of childhood psychopathology.
Table 9 indicates the difference between the mean scores of advantaged girls and advantaged boys on the factors of temperament scale. The table shows that there is no significant difference between the two groups i.e. advantaged girls and advantaged boys. The value of 't' in all nine factors of temperament scale is statistically non-significant. It seems that no differential treatment is mated out to boys and girls by the members of the family in the advantaged group. This may be attributed to the fact that recently there is lot of stress by the government and media for equal treatment to the girl child. This might have contributed to the fact that equal treatment is mated out to boys and girls in the relatively affluent families.

Table 10 indicates the difference between the mean scores of disadvantaged girls and disadvantaged boys on the factors of temperament measurement schedule.

Table 11 indicates the difference between the mean scores of advantaged girls and advantaged boys on the factors of childhood psychopathology measurement schedule. The table shows that there is no significant difference between the two groups in terms of the factors of childhood psychopathology. Here the sex does not play any significant role in the factors of psychopathology measurement schedule. As stated earlier the fact that both the groups belong to the advantaged status and the members of their family do not discriminate on the basis of sex while treating their children.
Table 12 indicates the difference between the mean scores of disadvantaged girls and disadvantaged boys on the factors of childhood psychopathology measurement schedule. The table shows the two groups differ with respect to only one factor of childhood psychopathology i.e. "low intelligence with behavioural problems" (t = 2.60, p < .05). This shows the disadvantaged boys manifest more behavioural problems with low intelligence as compared to the disadvantaged girls. Or, the disadvantaged boys express more reactions because of their disadvantaged position. The difference between disadvantaged girls and disadvantaged boys in terms of the factor "low intelligence with behavioural problems" may be due to differential treatment mated out to boys and girls by the members of the family.
CONCLUSION AND FURTHER RESEARCH SUGGESTIONS

The main findings of the present study have led to certain conclusions.

CONCLUSION

There is no significant difference between the overall means of advantaged and disadvantaged boys in temperament measurement schedule. On the contrary the study shows considerable difference between advantaged and disadvantaged girls with respect to temperament measurement schedule.

On the variable of childhood psychopathology both advantaged and disadvantaged boys and advantaged and disadvantaged girls show considerable difference.

The girls of advantaged and disadvantaged groups do not differ with respect to the factors of temperament measurement schedule. However, the boys of the two groups differ significantly with respect to "activity level" (the value of 't' 2.82, significant at .01 level).

With respect to temperament measurement schedule the advantaged girls and advantaged boys do not show any significant difference. However, in the disadvantaged group of boys and girls the two groups differ significantly with respect to the factor "activity level".
In the childhood psychopathology measurement schedule there is no difference between advantaged boys and advantaged girls. However, in case of disadvantaged boys and disadvantaged girls, the two groups differ significantly with respect to one factor i.e. "low intelligence with behavioral problems".

**FURTHER RESEARCH SUGGESTIONS**

The present study is conducted on childhood psychopathology and temperament from advantaged and disadvantaged groups. Further, variables should explore certain demographic correlates of childhood psychopathology and temperament (rural/urban, educational status of the parents, children with various types of disabilities - physical, social biological and psychological.

- Further research should examine the relationship between types of childhood psychopathology and type of children temperament among various groups.

- Longitudinal studies are required to study in the adolescents and late adolescents samples with respect to childhood psychopathology and temperament.

- As regards to the assessment of child psychopathology and temperament, difference between teachers rating and parents ratings should be explored.

- There is a need to examination the impact of childhood psychopathology and temperament on personality development and
psychosocial adjustment in normal and children with various types of disabilities.

Social skills training intervention programme should be run particularly in case of disadvantaged children as the findings show that anxiety and depression is more prevalent among disadvantaged group as compared to the advantaged group. Moreover the disadvantaged boys score comparatively higher on the factor "low intelligence with behavioural problems".

Some kind of rehabilitation counselling programme should be run by the schools particularly for the emotional well being and adjustment of the children. This is required for advantaged and disadvantaged boys and girls both rehabilitation counselling will be great help for positive psychological status of the children.
REFERENCES


Dear Respondents,

It's a moment of pleasure for me to meet you for the purpose to collect some information in the context of my doctoral thesis. The accomplishment of this task is not possible without your gentle cooperation. The aim of the present endeavour is to study the child illness and behaviour during the last 12 months in relation to the child's temperament. To make my research work or thesis true and successful, it is very important for me to get your wholehearted cooperation, by receiving your response in a way of gentle and true views of each statement / questions. I honestly assure you that all those information given by you will be kept confidential. Kindly extend your cooperation by filling this questionnaire carefully and without any hesitation and don't leave any item undone.

This is my humble request to you please don't leave undone.

Thanking you.

Iram Chaudhary
Research Scholar
Dept. of Psychology
A.M.U., Aligarh-202002
CHILDHOOD PSYCHOPATHOLOGY MEASUREMENT SCHEDULE

Name: .................................................. Age: .............. Sex: ..............

Education: ..............................................

Residence: (Address) .................................................................

Informant: ..............................................................................

What are the main problems with the child which necessitates psychiatric consultation?

Complaints: (in chronological order) Duration
1. ......................................................................................... .................
2. ......................................................................................... .................
3. ......................................................................................... .................
4. ......................................................................................... .................

I will ask you certain questions regarding the child illness and behaviour during the last 12 months. All the questions may not be applicable to your child but these are to be asked for the sake of completion. Please answer whether it is often true or very much true (score 2) sometimes true (score 1) or often not true (score 0)

Items given below are in the form of question. Please use additional probes where ever necessary. Score 8 if you are not sore.

1. Acts too young for his age. 0 1 2 8
2. Does he go to school - yes - No Poor school work 0 1 2 8
3. Has your child ever repeated a grade? 0 1 2 8
4. Poorly coordinated or clumsy 0 1 2 8
5. Prefers playing with younger children. 0 1 2 8
6. Argues a lot. 0 1 2 8
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Clings to adults or too dependent?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>8.</td>
<td>Demands a lot of attention.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>9.</td>
<td>Destroys his or her own things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>10.</td>
<td>Destroys things belonging to other family members or children.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>11.</td>
<td>Disobedienece at school.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>12.</td>
<td>Disobedienece at home.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>13.</td>
<td>Cruel to animals.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>14.</td>
<td>Cruelty, bullying, meanness to others.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>15.</td>
<td>Physically attacks people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>16.</td>
<td>Steals at home.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>17.</td>
<td>Steals outside home.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>18.</td>
<td>Subborn, obstinate, irritable.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>19.</td>
<td>Threatens people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>20.</td>
<td>Gets in many fights.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>21.</td>
<td>Impulsive or acts without thinking.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>22.</td>
<td>Runs away from home.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>23.</td>
<td>Nervous, high strung, tense.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>24.</td>
<td>Abnormal movements.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>25.</td>
<td>Withdrawn, does not get involved with others.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>26.</td>
<td>Gets hurt a lot, accident prone.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>27.</td>
<td>Likes to be alone.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Cries a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>29.</td>
<td>Deliberately harms self or attempts suicide?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>30.</td>
<td>Repeats certain acts over and over (Compulsions)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>31.</td>
<td>Screams a lot.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>32.</td>
<td>Fear certain animals, situations, places other than school.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>33.</td>
<td>Fears going to school.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>34.</td>
<td>Too fearful or anxious.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>35.</td>
<td>Shy or timid.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>36.</td>
<td>Temper tantrum or got temper.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>37.</td>
<td>Unhappy, sad or depressed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>38.</td>
<td>Worrying.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>39.</td>
<td>Can't concentrate or pay attention for long.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>40.</td>
<td>Can't get his mind off certain thoughts (Obsession)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>41.</td>
<td>Complaining of loneliness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>42.</td>
<td>Confused or seems to be in a fog.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>43.</td>
<td>Day dreams or get lost in his/her thought.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>44.</td>
<td>Feels and complains so one loves him.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>45.</td>
<td>Feels other are out to get him.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>46.</td>
<td>Feels worthless and inferior.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>47.</td>
<td>Stares blankly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>48</td>
<td>Secretive, keeps things to self.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Strange behaviour, specify certain thoughts (obsession)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Strange ideas, specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Irrelevant talking.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Talks about killing self.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Talks too much.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>54</td>
<td>Teases a lot.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>55</td>
<td>Poor memory</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>56</td>
<td>Too concerned with neatness on cleanliness.</td>
<td></td>
<td></td>
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<tr>
<td>57</td>
<td>Does not eat well.</td>
<td></td>
<td></td>
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<tr>
<td>58</td>
<td>Eats or drinks things that aren't food.</td>
<td></td>
<td></td>
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<tr>
<td>59</td>
<td>Overeating.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>60</td>
<td>Get teased a lot.</td>
<td></td>
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</tr>
<tr>
<td>61</td>
<td>Hangs around with children who gets in trouble.</td>
<td></td>
<td></td>
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<tr>
<td>62</td>
<td>Bites finger nails.</td>
<td></td>
<td></td>
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<tr>
<td>63</td>
<td>Nightmares</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Sets fire</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>Trouble sleeping</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>66</td>
<td>Sleeps less than most children.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>67</td>
<td>Sleeps more than most children.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>68</td>
<td>Swearing or obscene language</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>69.</td>
<td>Talks or walks in sleep.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>70.</td>
<td>Thumb sucking</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>71.</td>
<td>Wets the bed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>72.</td>
<td>Wets self during the day.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>73.</td>
<td>Uses alcohol, tobacco, or drugs.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>74.</td>
<td>Physical problem without known medical cause.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Aches and pains</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Headaches</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
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<tr>
<td></td>
<td>Fits</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
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<tr>
<td></td>
<td>Nausea</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
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<tr>
<td></td>
<td>Stomach aches</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Vomiting</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
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<tr>
<td></td>
<td>Overtired</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
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<td></td>
<td>Constipated</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
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<tr>
<td></td>
<td>Feels dizzy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Over weight</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Nervous movements and twitching.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
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<tr>
<td></td>
<td>Ties</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>75.</td>
<td>Any other physical complaints (Specify) e.g. allergy, asthma, diarrhoea, epileptic fits.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>
TEMPERAMENT MEASUREMENT SCHEDULE

Name: ............................................. Age: .............. Sex: ............... 
Education: ........................................
Residence: (Address) ........................................

Informant: ........................................

Introductions:
Information is to be obtained regarding the child's temperament before the onset of symptoms if he has an illness or about when the children has been his most usual self if he has no illness. Informant should be one of the parents, preferably the mother. Each item explores into some area of routine activities of the child which may be repetitious at places and measures different aspects of the temperament. Items are generally the probes and minor elaboration are permitted whenever necessary. Score all items on a five point scale, where 1 and 5 denote the two extremes of frequency and intensity on the negative and positive direction with average at point 3; 1= Hardly ;ever; 2= Once in a while; 3= Sometimes; Often= 4; 5= Almost always.

Activity Level

1. How active is your child? Do you find him so active that he runs rather than walks or is he so inactive that he hardly moves.

   1  2  3  4  5

2. Can he keep still or does he have difficulty in doing so and keeps moving and fidgeting?

   1  2  3  4  5

3. Can he sit still while listening to story, joke or some interesting happening?

   1  2  3  4  5

4. While eating does he run and jump about being actively involved or does he quietly move about?

   1  2  3  4  5
While eating does he eat staying still or does he keep moving about?

1 2 3 4 5

**Rhythmicity**

1. Does your child feel hungry at approximately the same time every day? Are you able to tell roughly at what time he is bound to feel hungry

1 2 3 4 5

2. Does your child eat roughly the same amount of food every day or does it vary from one day to the next? Do you have an idea of how big or small an appetite he generally has?

1 2 3 4 5

3. Does your child go to sleep approximately the same time every night? What time does he generally go to sleep?

1 2 3 4 5

4. Does your child have the bowel movement at about the same time every day?

1 2 3 4 5

**Approach Withdrawl**

1. What is your child's first reaction when he meets a stranger (relative; neighbours, doctor, shopkeeper, bus conductor etc.)? Does he approach the stranger, talk to him or does he feel shy, frightened?

1 2 3 4 5

2. What is your child's first reaction when he meets children of his age for the first time? Does he approach them, get friendly or does he feel hesitant, shy, frightened?

1 2 3 4 5

3. If he is given a new food (or placed in a new situation) what is his first reaction will he try it or does he refuse to do so?
4. When your child is introduced to a new game or activity does he join it at once or initially prefers to sit on the side and watch?

5. What is your child's first reaction when he is offered a new toy, game or clothes? Does he accept it with enthusiasm or does he hesitate, watch from fear, preferring his familiar toys, games and clothes?

Adaptability

1. Food that he refused earlier or disliked earlier does he still refuse it or has he now accepted it? After now long does he accept it?

2. If your child has been shy with some stranger earlier, how long does it take time to get friendly? Just a few minutes or a long time?

3. If your child has been shy with some children earlier how long does it take him to mix up and get friendly just a couple of minutes or a long time?

4. If he initially hesitates to join a game how long does it take him to start participating in it? Immediately, after sometimes or never?

5. Does he settle back into school routine quickly after a long holiday or does it take him a long time to do so?

Mood

1. Is your child generally happy, satisfied or generally unhappy
discontented?

1  2  3  4  5

2. When with other children does he seem to be happy and having a good time? Is he generally dissatisfied, angry, irritable?

1  2  3  4  5

3. When playing with other children does he argue / fight with them or does he not?

1  2  3  4  5

4. If your child cannot have or do something he wants, then for how long does he remain annoyed - only momentarily or for a long time?

1  2  3  4  5

5. When he is given sometime that he found of and wants, what is his reaction? Is he happy, smiles only momentarily or for a long time?

1  2  3  4  5