CHAPTER 1

INTRODUCTION

1. INTRODUCTION

India has the highest number of children in the world. More than one third of country's population is below 18 years. The researcher explores the levels of health, nutrition, education and social security of children and government policy and action on child rights. India has made some significant commitments towards ensuring the basic rights of children. There has been progress in overall indicators: infant mortality rates are down, child survival is up, literacy rates have improved and school dropout's rates have fallen. But the issue of child rights in India is still caught between legal and policy commitments to children on the one hand, and the fallout of the process of globalization on the other. Globalized India is witnessing worsening levels of basic health, nutrition and shelter problems. Children are suffering as a result of social sector cutbacks / policies and programs and development initiatives that deprive communities and families of access to and control over land, forest and water resources they have traditionally depended on.

The negative fallouts is visible: children are being deprived of even the scarce social benefits once available, they are displaced by forced and economic migration, increasing the number of children subsisting on the streets, more and more children are being trafficked within and across borders, and rising numbers of children are engaged in part or full time labor.

Family is the basic unit for cultivation of interpersonal and intrapersonal interactions and socio-cultural orientation to children, apart from the school and their neighborhood. It provides a network of relationships that connect together children, parents, aunts, uncles, grandparents, friends, neighbors, communities and professional caregivers. Much of what makes us human beings are the social networks and relationships, while families and society provide these for us. The contemporary society is plagued by several changes that have direct impact on family dynamics, childcare and development. Some of these visible changes are—

- The traditional family roles of caring, nurturing and providing security to all its members irrespective of their economic contribution, are being altered.
- The sex roles have brought about changes in relationships and institutional norms.
- Personal choices are on increase and family obligations are less important, and family relations have become voluntary rather than a necessity.

- People are eager to improve their living standards, which drives many couples to live apart for long periods, subjecting their spouses and children to experience isolation and sometimes depression.
- Social networks and institutions are on the decrease;
- Material prosperity of individuals tends to result in spiritual poverty, subjecting parents and children to experience many forms of stressful situations needing professional interventions.

Our basic childhood training is of profound importance. Failing to get that, the outcome will be “constricted” growth; unable to cope adequately with the outside world as well as within the family resulting in behavioral problems, emotional difficulties, addictions and other deviant behavior. This will be compounded by other coping demands of the modern society. The implications are that, families need to prepare children with adequate interpersonal and problem solving skills to cope with the external demands. The idea is being put forth by Powell (1969) in simpler terms, “what I am at any given moment in the process of becoming a person, will be determined by my relationships with those who love me or refuse to love me, with those I love or refuse to love”.

1.1 Mental Health

Psychiatric disorders are becoming a matter of concern among the non communicable diseases. WHO estimates that psychiatric disorders form 10.5 percent of the total share of global diseases and are likely to further increase? Several studies indicate that mental health problems of children are on the rise. In India, reliable estimates of the state of mental health of children are not available since no attempts have been made to undertake epidemiological surveys at the national level. The study on child and adolescent psychiatric disorders in urban and rural areas conducted by ICMR (2001) indicated the overall prevalence of mental and behavioural disorders among children as 12.8%. If 2001 census was to be given credence, a total of 55 million children would need special attention for one or other mental or behavioural disorders. In India, the assessment and intervention services for these children are provided through the Child Guidance Centres. However despite the introduction of first Child Guidance Centre in 1937, the progress of services in the subsequent years did not match the needs of the population.

Mental health concerns everyone. It affects our ability to cope with and manage change, life events and transitions such as bereavement or retirement. All human beings have mental health needs, no matter what the state of their psyche. Mental health needs can be met in a variety of settings including acute hospital settings, primary care settings, self help groups through social services and of course through counselling and psychotherapy.

The term mental health problems is one that encompasses a range of experiences and situations. Mental health might usefully be viewed as a continuous experience, from mental well being to a severe and enduring mental illness. We all experience changes in our mental health state influenced by social, personal, financial and other factors. Major life events such as a close bereavement or leaving home, can impact significantly on how we feel about ourselves, for example, leading to depression and anxiety.

Mental health is defined as a state of well being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community.

Further, the concept of mental health has undergone a change. The present understanding of mental health has two connotations. The first is the absence of mental disease, and the second the presence of a state of well being where the individual realizes his / her abilities, forms healthy relationships and works productively to contribute meaningfully to the family and society. It is the second aspect that is increasingly drawing attention.

School counselling services were initiated to address the mental health of children. The goal of these services was to identify the factors that caused impediments to the learning process for the child and prevented him / her from gaining fully from the education imparted. School counseling services aim at identifying students with ‘problems’ and providing suitable interventions to overcome these. The other aim is to develop healthy relationships and a positive outlook towards life.

1.2 Evolution of Child Guidance Centre

Child development refers to the biological and psychological changes that occur in human beings between birth and the end of adolescence, as the individual progresses from dependence to increasing autonomy. Because these developmental changes may be strongly influenced by genetic factors and events during prenatal

life, genetics and prenatal development are usually included as part of the study of child development. Developmental change may occur as a result of genetically controlled processes known as maturation, or as a result of environmental factors and learning, but most commonly involves an interaction between the two.

Child guidance in the United States began with an idealistic mission characteristic of Progressive reform: prevention, first of juvenile DELINQUENCY and then of MENTAL ILLNESS by identifying the early stages of problems in children. Over the years, the goal of prevention faded, and child guidance came to treat mild behavior and emotional problems in children. The child guidance movement began in 1922 as part of a program sponsored by a private foundation, the Commonwealth Fund's Program for the Prevention of Juvenile Delinquency. The movement established community facilities, called child guidance clinics, for treating so-called maladjusted children, school-aged children of normal intelligence exhibiting slight behavior or psychological problems. The Program for the Prevention of Juvenile Delinquency introduced eight demonstration clinics in cities across the country, which sparked the creation of some forty-two clinics by 1933. Child guidance clinics employed clinical teams made up of newly established professionals: a psychiatrist, a psychologist, and a psychiatric social worker. Members of these clinical teams pooled their different perspectives to provide treatment sensitive to all aspects of the child's situation. Established as facilities to treat all maladjusted children in a community, the new clinics cooperated with existing social welfare, educational and medical services to reach the widest range of children.

The child guidance movement of the early 1920s embodied the optimism and vigorous outreach of the MENTAL HYGIENE movement–psychiatry's early-twentieth-century push into the community, to educate the public about mental illness, identify its early signs, and it was hoped, to prevent it. The very term *guidance* suggests something between education and nurture on the one hand, and medical models of treatment and cure, on the other. By the 1930s, however, child guidance was a clearly delineated medical endeavor, aimed at treating a population of children with mild behavioral and emotional problems within the confines of clinic offices. Gone was the practice of early intervention in children, the broad local outreach linking clinics to networks of child-helping services, and identifying problems in children appearing in a variety of locations throughout the community, especially immigrant and poor children.

Nevertheless, child guidance continued to direct itself toward the same at-risk population: treatment of the so-called problem child. Child guidance defined the problem child as a child of normal intelligence, exhibiting a range of behavior and psychological problems, which were lumped together in a category called *maladjustment.* Indications of such maladjustments ranged from thumb sucking, nail biting, enuresis, and night terrors in younger children to personality traits such as sensitiveness, seclusiveness, apathy, excessive imagination, and fanciful lying. Also included was a category of undesirable behavior in older children such as disobedience, teasing, bullying, temper tantrums, seeking bad companions, keeping late hours, and engaging in sexual activities.

The problem child in the early movement was a social problem; its definition signified nonconformity to socially defined norms of behavior. The clinics were invested with social importance, responsible for enforcing norms of behavior and preventing social deviance. By 1930, child guidance began to help individual child whose problems were seen as important only to themselves and their families. The focus of problems had changed from an aggressive, extroverted, misbehaving child, to the internal psychological and emotional states of children. Child psychiatrists, psychologists and psychiatric social workers, saw their work as medical; diagnosing psychological disorders in children. This shift brought about a marked change in the social characteristics of the problem child. With this profound change in focus, child guidance clinics became centers of research and treatment of problem children in the community.

In India, the Child Guidance Clinic (CGC) was the first of its kind started in 1937 with the efforts of Dr. Clifford Manshardt, the first Director of the Sir Dorabji Tata Graduate School of Social Work now known as the Tata Institute of Social Sciences (TISS). The CGC of TISS was started on an experimental basis to test out whether the western concept of CGC would be functional in different conditions and what variations in technique would be required. The CGC fulfilled both clinical and educational functions.

However, in India there is paucity of services for children with behavioral and learning problems especially in school setting. In metropolitan cities these have revealed that one of the major complaints with which children are brought to psychiatric clinics / Child Guidance Centres is Scholastic Backwardness. Since CGC has a multi disciplinary team of professionals, they are considered to be a suitable vantage point

for carrying out the coordinated effort required for assessment and management of children with scholastic problems. However, CGC are very few in numbers (barely 156 for the entire country as per study done by NIPCCD) and are all located in big metropolitan cities. In the absence of coordinating body to monitor the activities of the Child Guidance Centre, these service centres are following diverse approaches to the critical issues of guiding children with learning and behavioral problems. The near absence of Statutory Provisions related to assessment processes and monitoring systems add to the confusion. Thus there is lack of unified perspective regarding procedures for assessment, classification and management of Scholastic Backwardness.

1.3 Set up of Child Guidance Centre in NIPCCD

The child Guidance Centre at the NIPCCD has been functioning since 1980. The centre was established with the view to develop an insight into the assessment, intervention and rehabilitation of children with mental health problems. It was envisaged that the hands on experiences gained would supplement the core activities of the Institute viz. training and research.

The CGC provides diagnostic, therapeutic and referral services to children up to 14 years of age with developmental, learning and behavioral problems. The centre delivers these services through a multi disciplinary team comprising a Social Worker, Psychiatrist, Child Development Worker, Clinical Psychologist and Speech Therapist. The experience so acquired at the micro level is integrated to address the macro issues related to child mental health through research and training. Based on this, NIPCCD opened 3 more Child Guidance centres at Regional centres of Lucknow, Guwahati and Bangalore.

1.4 Child Guidance Centre, NIPCCD, Lucknow

The State of Uttar Pradesh boasts to be the first state to recognize the need of counselling services for children. As mentioned else where however, there is a dearth of services including the assessment facilities in cities like, Lucknow, Kanpur and Varanasi leave alone, the smaller cities and towns. Although in Lucknow there are a few organizations viz. Chetna, Asha Jyothi, Noor Manzil, Asmita which are working for mentally challenged children. But the scope in these institutions is limited to psychiatric assessment and institutional care. In addition, there are counselling centres in the city that are run with the assistance from Ministry of Social Justice and Empowerment, Government of India, however, the scope of these centres is limited

to de-addiction of drug abused children. Child Guidance centre for assessment and remedial services for children with special needs are almost non-existent in the city.

Child Guidance Centre was started at Regional Centre, Lucknow in February 2003 to provide services to children up to fourteen years of age having learning and behavioral problems. The services include educational assessment, remedial education, play observation and therapy, I Q testing and other psychological assessments, counselling and guidance to children and their network and referral services. The services of CGC are provided through multi disciplinary team viz., Psychiatrist, Clinical Psychologist, Social Worker and Special Educator. The centre has developed a good infrastructure and playroom (indoor and outdoor) for children with variety of play / educational materials according to needs of children. The centre has built linkages with ninety schools in the city and majority of cases which come to CGC are referred by these schools for assessment and interventions.

1.5 Objectives of Child Guidance Centre

- To identify children between 6 to 14 years having difficulties in learning and behavior.
- To provide professional assessment services for children with difficulties.
- To provide guidance and counselling services to children and parents.
- To refer children to institutions for specialized services and help.

1.6 services available at CGC

- Educational Assessment
- Remedial Education
- I.Q and other Psychological Assessment
- Medicinal Intervention
- Counselling and Guidance to children and parents
- Play Observation and Therapy
- Referral Services

1.7 The professionals involved at CGC

- Social Worker, M.A in Social work
- Special Educator, M.A Psychology and Diploma in Special Education
- Psychologist, M.A in Psychology and Clinical experience
- Doctor (Psychiatrist), M.D in Psychiatry

A counselor will listen to the client attentively, supports and helps the person to find his / her own answers to whatever is troubling. The counselor empathizes with the client with an equal relationship. The counselor will focus on how the client can live effectively in the society, knowing and honoring his / her own needs and wishes. Counseling is a series of problem solving purposeful conversations. It is a process and a method of exploring and identifying personal problems and seeking out solutions which will lead to personal growth and development.

1.7.1 The Multiple Measures used during the Assessment in CGCs are—

- **Developmental History:** Through parental interviews to obtain a baseline regarding the child's early development, medical and educational history and to understand child's current level of adaptive and play behavior.
- **Play Observations:** For rapport formation, understanding child's inner world, behavior, temperament, attentional skills and coping mechanism and also for knowing child's own perception of the problem.
- **Psychiatric Assessment:** Through parental interviews, observations of the child, review of past medical records and treatment to identify significant medical factors or psycho social stressors contributing to the problem.
- **Psychological Assessment:** a)Through standardized intelligent tests to ascertain cognitive capacity, to obtain a profile of the child's strengths and limitations in various cognitive processes such as memory, attention comprehension, reasoning, abstract thinking, language, perceptual skills etc. b) Special scales of Assessment to ascertain involvement of specific problems like ADHD, Autism. c) Personality assessment for understanding personality type, interpersonal conflicts and coping mechanisms of the child.
- **Functional and Educational Assessment**: Through criterion referenced curriculum based tasks, Tests of basic Academic skills. To ascertain the child's optimal level of functioning in basic academic skills, areas of Reading, Writing, Arithmetic and their sub components (word reading, oral reading, reading / listening comprehension, spellings, written, expression, handwriting, arithmetic concept, knowledge of arithmetic operations and application skills).
- **Social Investigations:** Through parental interviews and home visits to understand the child's home environment, family dynamics, interpersonal relations, parenting styles, stressors on the family, support network etc. Through school visits to understand school environment, child's interaction

with peers, processes of teaching learning, evolution and parent teacher interaction followed by the school.

1.7.2 Out Reach Programs of CGC

Besides clinical services, the CGC organizes series of sensitization programs for school principals, teachers and parents as part of its advocacy program for promoting child's mental health. These advocacy programs were appreciated by school management and principals and they realized the dire need of effective counselling and guidance services in school premises to promote mental health and healthy development of children. During the year, CGC has conducted 12 orientation programs for teachers and staff on learning and behavioral problems of children including teachers training institute like DIET.

1.7.3 Extension work of CGC

Once in a week the CGC also provides assessment and intervention services to children living in shelter homes, like Don Bosco – Ashalayam and Blue Heaven Children's Home Lucknow.

1.8 Rationale of the study

Child Guidance Centre is an action project of the Regional Centre of NIPCCD Lucknow established in February 2003 for promotion of child mental health. As a pioneer project providing assessment and intervention services such as parental counselling, play therapy, individual counselling, remedial education, behavior management, medical intervention, family therapy and strategies with children and their family through multi disciplinary team consisting of psychiatrist, clinical psychologist, social worker and special educator. In addition, the team also conducts visits to home, school, hospitals and referral centres. The centre has developed a good infrastructure that includes cubicles for multidisciplinary team and play room (indoor and outdoor) for child with variety of play / educational materials according to needs of children. The centre has linkages with ninety schools and referral centres to promote child mental health. Besides clinical services, as indicated earlier the CGC organizes series of advocacy programs on learning and behavioral problems of children for School Principals, Teachers and Parents. These advocacy programs have been appreciated by School Managements and Principals and they realized that there is a need for effective counselling and guidance services in school premises to promote child mental health. Because of these efforts, number of children with learning and behavioral problems has increased. Since it is a unique

Children have played little part in shaping of their own identities and social position.

program in the State of Uttar Pradesh, the present documentation was undertaken to analyze the data of children reported to Child Guidance Centre for initiating counseling and guidance services to children in schools. Further this documentation would also be very useful for institutions working for children having learning and behavioural problems.

1.9 Objective of the Project Study

- To analyze cases reported to CGC with various difficulties;
- To document processes involved in assessment, intervention and management of children with difficulties;
- To disseminate the documentation among other organizations working for promotion of child mental health;

1.10 Methodology

The study was essentially exploratory in nature, based on the analysis of the cases that had attended the CGC and based on the secondary data from case profiles of children which was available in CGC. The analysis was carried out with respect to the nature, clinical assessment and management of the problem.

In the study five case studies have been documented to provide details of the processes involved in managing and understanding the learning / behavioral problems of the children. The study could facilitate the schools who are intending to set up Child Guidance Centres. The present document has been prepared on the basis of cases of children having learning and behavioral problems reported to CGC for assessment and intervention services.

1.11 Sample

The sample for the study was taken from the inception (2003) of CGC to year 2007. In all 372 clients were registered, of which 108 were selected through purposive sampling technique. They went through complete assessment and intervention services of Psychiatrist, Special Educator, Clinical Psychologist and Social Worker. The rest of the clients came for general enquiry / management of problems of their children; some were referral cases such as hospitals and specialists. Few children later dropped out due to long distance, non availability of time with parents. Children who were above 18 years were referred to other centres.

1.12 Tool for the data Collection

Information tool for children had been developed, to analyze the qualitative data about children reported to child guidance centre for assessment and intervention services. This included children's profile, family background, educational status, learning, behavioural problems, assessment and intervention services rendered by professionals.

1.13 Data Processing and analysis

The data was collected with the help of project assistant. She was oriented thoroughly about information tool for obtaining data from case files of children reported to CGC. After collecting the data through tool developed for children information were checked properly and computerized.

1.14 Presentation of the Report

The report of the study has been presented in 5 chapters. Chapter 1 covers Introduction, mental health, evolution of CGC, set up of CGC in NIPCCD, rationale of the study, objectives of the study, methodology adopted and the presentation of chapters. Chapter 2 covers Results and Discussion, Chapter 3 illustrates Case Studies, Chapter 4 reports major findings and Chapter 5 provides suggestions and recommendations.

CHAPTER 2

RESULTS AND DISCUSSION

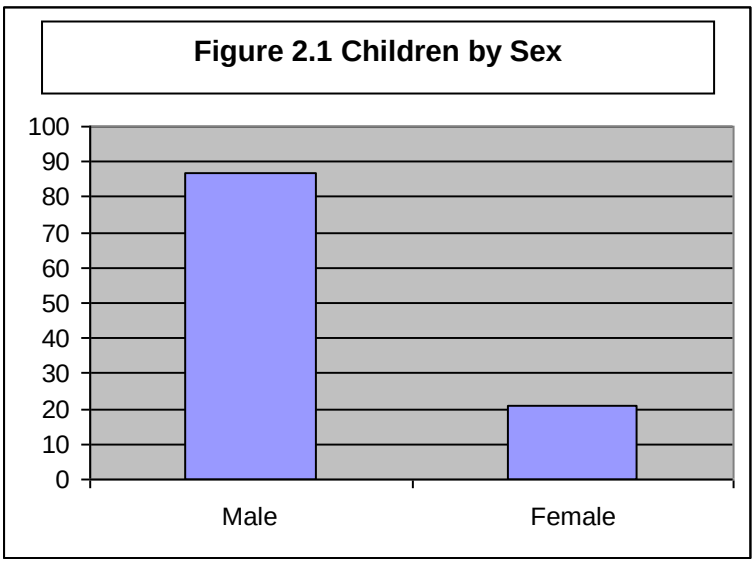
2. RESULTS AND DISCUSSION

The present chapter gives interpretation of 108 cases having learning and behavioral problems reported to CGC for assessment and intervention. The study describes the profile of children, family background, education, learning and behavioural problems, and assessment and intervention services rendered by the professionals.

2.1 Profile of Children

2.1.1 Sex

Gender is used to describe those characteristics of women and men, which are socially constructed, while sex refers to those which are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men. This learned behavior makes up gender identity and determines gender roles. The sex distribution of the children revealed that majority of the children was male and describes problems of children in their developmental perspective. Through the Figure 2.1, one comes to know that the boys are the ones who suffer from different problems. One of the major complaints of the parents was that their children were scholastically backward, lack concentration so they needed guidance in CGC.

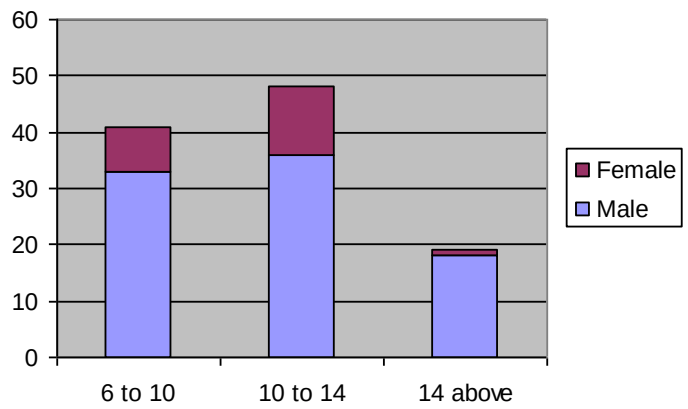


2.1.2 Age

The age of a person expresses chronologic age of a normal person showing the same proficiency in study. Age forms stages of life; as, the age of infancy, youth, etc. Maturity age is especially, the time of life at which one attains full personal capacities. The Figure 2.2 indicates that majority of the children were belonging to 6 to 14 years and the rest were above 14 years. These children needed guidance for healthy development. During this age the healthy developing child learns to imagine, to broaden the skills through active play of all sorts, including fantasy, cooperate with

others, hangs on the fringes of groups, continues to depend unduly on adults and is restricted both in the development of play skills and imagination. As the child grows, the child learns to master more formal skills of life i.e. relating with peers according to rules, progressing from free play to that which may be elaborately structured by rules and may demand formal teamwork, mastering social studies, reading, arithmetic gradually for need for self discipline increases.

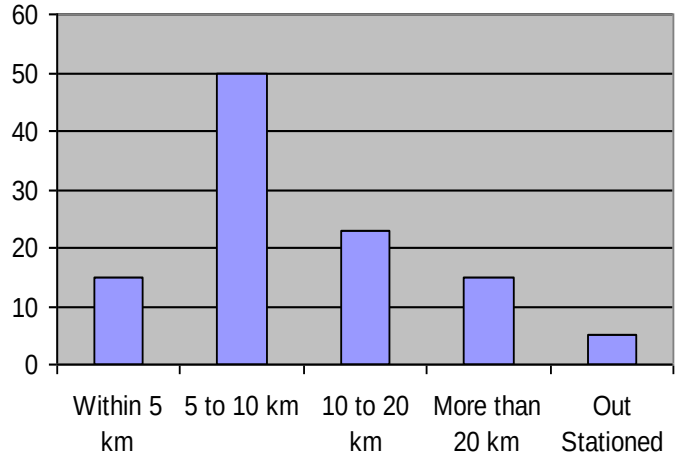
Figure 2.2 Children by Age



2.1.3 Distance of Children from Residence to the CGC

Inception stage CGC was mainly concentrating within the radius of 10 kilometers. Later the CGC took the initiative to spread beyond 10 kilometers. The professionals besides the activities at the centre also initiated various other activities such as training workshops and awareness programs for the parents and teachers. As a result of these programs, many children were reported to CGC from far distance.

Figure 2.3 Distance of Children



The distance distribution of the children reveals that majority of the children were coming from more than 5 kilometers of their residence to CGC for the assessment intervention.

3. 2. Family Background

Families play a large role in the process of developing competence among children when they are young. Families can do well in raising their children, when

they have good social support systems and network of institutions in their neighborhood. Only those families that have good interactions within their environment and those that have good support systems and means of livelihood could be successful. While the disadvantaged families, lacking these opportunities sink in their struggles to survive. Professionals must be conversant with all such survival strategies and tactics, so as to intervene, when necessary and shape the environment in order to help families that were in crisis.

Table 2.1
Children According to the Type of Family

S. No	Type of Family	No. of Children (N=108)	%
1.	Joint	19	17.59
2.	Nuclear	86	79.62
3.	Extended	03	02.77

The study indicates that majority of the children were belonging to nuclear families. Changing trends in social and economic conditions of families have implications on psychological satisfaction of members and children.

Children completely depend on parents and families in their first few years of life, and this biological fact necessitates protection, nurturing and teaching of children. Family is also described as "headquarters" for human development (Garbarino 1982:62). It is a place for love, care, learning and socialization of children.

2.3 Religion

Table 2.2
Children by Religion

Religion	Total (N=108)	%
Hindu	93	86.11
Muslim	14	12.36
Sikh	01	00.32

Religion plays a very important role in shaping the personality of the child, because teachings of religion learn to understand the true meaning of religion. The fundamental definition of religion is just man's psychological reaction to the universe of life, in which he finds himself. By psychological is meant intellectual and emotional, sensual and spiritual, the experience of the psyche or conscious faculty in man. The Table 2.2 indicates that majority of the children belong to Hindu Religion (86%). This is consistent with the proportion of Hindu's population in the country.

2.4 Family Income

The well-being of children appears to be almost always associated with the household income of their family. Regardless of the child's age or how household income is measured, higher income tends to be related to better physical, social/emotional, cognitive and behavioral well-being among children.

Poverty limits children's chances to achieve economic self sufficiency. Source of Income is seen as spending the amount for the necessity of an individual, family or a group. The income of the family indicates that 32.40 per cent of children belonged to upper class, at the same time there were 20.37 per cent of the families belonging to lower middle class. This indicates the developmental problems can effect children of any class. It also indicates Income of the family does not matter much for academic backwardness.

Table 2.3
Children According to the Income of the Family

S. No	Categories	No (N=108)	%
1.	Low	17	15.74
2.	Lower Middle	22	20.37
3.	Middle	18	16.66
4.	Upper Middle	16	14.81
5.	Upper	35	32.40

2. 5 Educational Status of the Parents

Family influences have a much more powerful effect upon children's attitudes and achievements than either school or neighbourhood factors – even when these are added together. The level of education and skill obtained within a discipline or profession is usually referred to as a generalist or specialist in a discipline. Education captures distinctive aspects of social position. The educational status of the parents indicates that 52 per cent of the children's fathers and 44 per cent mothers were graduates. This suggests that children had good educational background in the family for the study. The parents could guide, counsel and help the children in their studies. At the same time 6 per cent of the mothers were illiterate and other 6 per cent of the mothers of the children could barely read and write who were unable to help their children in their studies.

Table 2.4
Children by Educational Status of the Parents

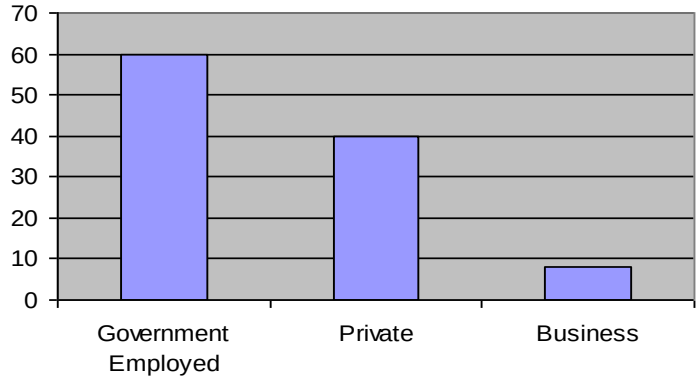
Category	Father (N=108)	%	Mother	%
Illiterate	-	-	07	06.48
Up to Middle	-	-	06	05.55
Secondary	26	24.07	22	20.37
Graduate	56	51.86	48	44.44
Post Graduate	26	24.07	25	23.14

2.6 Children according to the Occupational status of their Father

Children achieve more when schools and parents work together. Parents can help more effectively if they know what the school is trying to achieve

and how they can help. Family income has a profound influence on the educational opportunities available to children and on their chances of educational success. According to occupational status of children's parents it was found that all children's' fathers were engaged in work. In spite of being capable of supervising and helping their children the fathers of the children were not able to spend much time with their children. The some times fathers fail to do so because of their engagement in various occupational work.

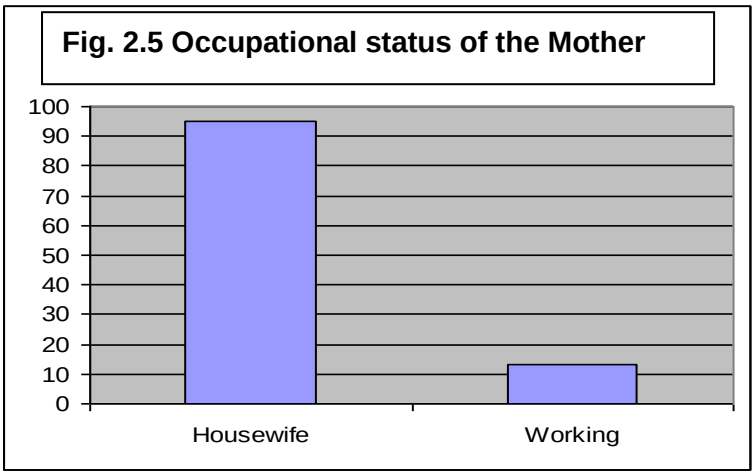
Fig. 2.4 Occupational status of the Father



2. 7 Children According to the Occupational status of the Mother

Mothers being housewife is the benefit for the children to get the utmost pleasure and love. The Figure 2.5 indicates that majority of the mothers were housewives so the mothers could give much of their time for their children, helping them in development and growth, in their studies, listening to their stories, observing daily activities and sharing their own life experiences. But due to lack of knowledge regarding parenting they were not able to understand their children and manage.

Fig. 2.5 Occupational status of the Mother



2.8 Children by Single Parent

Majority of the children (88.88%) were having parents who lived together in a family. Hence the children were able to receive love from both the parents. Where as 12 children's (11.11%) parents were separated or there was death of one of the parent.

Separation of parents or loss of a parent is another equally important dimension of child's suffering and stress, depriving the child of love and affection of the other parent. Separated children experience feelings such as, sadness, disappointment, anxiety and anger and gradually may develop behavioral problems.

Table 2.5
Children by Single Parent

S. No	Category	No. of Children (N=108)	%
1.	Yes	12	11.11
2.	No	96	88.88

2.9 Children's Attachment with Family Members

Attachment is a biologically based strategy that provides emotional and physical protection for children. Secure attachment results when parents respond sensitively to their children's cues and responses. Research has indicated that school age children who are securely attached are more cooperative with their parents, more inclined to competently explore the environment and more likely to get along with their peers. The above Table 2.6 indicates that all the children were attached with their father or mother where as 18 children (16.66%) were attached to others than their parents.

Table 2.6
Children according to Attachment with Family Members

S. No	Attached to	No. of Children (N=108)	%
1.	Mother	50	46.29
2.	Father	40	37.03
3.	Other Family Members	18	16.66

Attachment is fundamental part of children's development that affects the growing brain, insecure attachment shows itself in many different ways. Children may have trouble with learning, may be aggressive and act out, be excessively clingy, have difficulty making friends, suffer anxiety or depression, or be developmentally delayed.

2.10 Children afraid of someone in the house

The study indicates that about 80 % he children were not afraid of anyone in the house and the remaining (less than one fourth) children were afraid of someone in the house. This is mainly due to the lack of healthy relationship between children and parents and also lack of time spent with the children by family members.

Table 2.7 Children as per afraid of someone in the house			
S. No	**Afraid of**	**No. of Children (N=108)**	**%**
1.	Yes	22	20.37
2.	No	86	79.62

2.11 Children's Participation in Routine Household work

Developmental psychologists have since long noted that parents serve as role models, shaping the behaviors and habits of their children. Children whose parents act as strong positive models may be more likely to withstand harmful pressures from peer groups. The study reveals that the parents assign household chores to children as a socializing experience i.e. to promote responsibility. They focus on the importance of performing household chores in developing children's character and teaching children about family relationships. The above Table 2.8 indicates that majority of children (71.29%) were involved in household works. Historical studies on the value of children's contribution to their families households demonstrate that children's productive role in pre-industrial households has shifted with industrialization.

Table 2.8 Children according to the Participation in Routine Household work			
S. No	**Household work**	**No. of Children (N=108)**	**%**
1.	Yes	77	71.29
2.	No	31	28.70

2.12 Educational Background of Children

Schools play a crucial and formative role in the spheres of cognitive, language, emotional, social and moral development of a child. A student's performance is assessed on academic skills such as reading, writing and mathematics. A learning problem may therefore engender feelings of anxiety, inadequacy and shame, leading to behavioral disturbances in children of school age. Any negative feedback from school is likely to have an impact on the emotional, social and family functioning of a child. Children with learning disorders are those who exhibit academic difficulties out of proportion to their intellectual capacities. They have impaired ability in learning the academic skills of reading, writing, arithmetic or spelling.

2.13 Children according to of admission Age to School

Apart from age related experiences during infancy and early school going age there are several challenging situations that children have to face in their life.

Some of the negative events are accident, violence and serious illness of a parent or sibling, loss of a parent and loss of income due to loss of job, destruction of property or natural calamity. Positive events include improvement in family circumstances such as additional income, resolution of a family dispute etc. Studies have also shown that the capability to handle and cope with negative impact will be more in case of those children who were subjected to various kinds of challenges in their childhood. Majority of the children (73.15 %) were admitted to the school at the age of 3 to 5 years, at these stage children are playful and think of purposefulness of their life.

Table 2.9
Children according to of admission to School

S. No	Age	No. of Children (N=108)	%
1.	Before 3 years	21	19.44
2.	3 + 5 years	79	73.15
3.	5 years	08	07.40

2.14 Children's Educational Status

Table 2.10
Children by Educational Status

Category	No. of Children (N=108)	%
LKG – 1st	12	11.11
2nd – 5th	32	29.62
6th – 8th	43	39.81
9th – 10th	17	15.74
Above 10th	01	00.92
Other (MR 2, Going special school 1)	03	02.77

The educational status of the children indicates that maximum number of children (39.81 %) who were in grade 6th to 8th were reported to CGC for intervention. Followed by 29 percent who were in grade 2nd to 5th were reported to the CGC for intervention. This is the age where children develop various problems related to education and behaviour.

2.15 Children according to interest in going to School

Education is very important for the future development of the child as well as for the nation as they are the future asset of the nation. In India one of the Policies speaks of

compulsory and free education for children up to 14 years. Therefore there is a need to find out the lacunae why children lack interest to go to school. Some of the reasons are children lack encouragement, support, interest, lack friends and poor quality of education. The above Table 2.11 indicates that majority of the children (87.96%) were interested to go to school. 13 children (12.4%) were not interested to go to school, these children needed interactive learning. Recreational activities i.e. sports, singing, painting, outing should be used for according to these children who are not interested in going to school, which can create interest to go to school.

Table 2.11

Children according to Interest in going to School

S. No	Interest in School	No. of Children (N=108)	%
1.	Yes	95	87.96
2.	No	13	12.04

Create suitable environment, support the children right way, trying to make the child confident of oneself, need to preserve sense of self worth of the children. It is important to view the needs of the

2.16 Children as per repeating the Grade

The Table 2.12 indicates that roughly two third of the children have not repeated the grade, where as one third of the children have repeated the grade. Repeating the grade always has a negative effect on performance of the children. In fact, students tend to fall further behind during their second year in the same grade. Young children often repeat grades because teachers or parents feel they have not acquired the appropriate academic or social skills to advance to the next grade. One of the studies mentions, that children who had repeated a grade showed poorer social

Table 2.12

Children as per repeating the grade

S. No	Category	No. of Children (N=108)	%
1.	Repeated the grade	36	33.33
2.	Not repeated grade	67	62.04
3.	Not aware about special schools as the schools were at a distance	05	04.62

Support the child at home. This may mean reading with child, taking field trips together to museums and other places where the child can get hands on experience and making sure your child has the tools they need to do well at school.

adjustment, more negative attitudes towards school, more problem behaviors and poor attendance. These children need special time to clear their concepts and ideas and complete their assignments so that repeating the same grade may not arise.

2.17 Children according to the no. of Schools changed

Table 2.13
Children According to the no. of Schools changed

S. No.	No. of School Changed / not changed	No. of Children (N=108)	%
1.	1 School	03	02.78
2.	2 Schools	41	37..96
3.	3 Schools	15	13.89
4.	4 Schools	09	08.33
5.	5 Schools	03	02.78
6.	Not changed	37	34.26

Nowadays parents have choices and alternatives and the resources for finding a school that might be more suitable for their child. With increasing options, parents may be too quick to pull their child out of one school and go searching for another. The Table 2.13 indicates that about sixty five percent of children have changed 2 to 5 schools till the time they had come to the CGC. The reason for changing school was due to the long distance, unhappy with the schools and transfer of jobs of their parents. Relocation to a new school can be stressful, because newcomers to a school must learn about new school routines and academic standards. Student's academic adjustment to a new school typically takes a full school year.

It's very disruptive for children to change schools. Children who change schools frequently are more likely to have behavioral issues.

2.18 Children according to the Problems Related to Studies

There are many reasons for children to underperforms at school including lack of motivation to do well, problems at home or with peers, poor work habits or study skills, emotional and behavioral problems, learning disabilities, attention deficit hyper activity disorder, mental retardation or below average intelligence and other medical problems including anxiety and depression. The study indicates that three fourth of the children (75.92 %) had poor memory and attention, 69.44 % had poor academic performance and 53.70 per cent were lacking motivation for studies. Learning disabilities can affect how children listen, think, store, retrieve, write, read and

communicate information or perform mathematical calculations. Specific integration disabilities include sequencing disabilities in which child confuse the sequence of words, letters, maths problem etc.

Table 2.14

Children According to the Problems Related to Studies

S. No	Problem	No. of Children (N=108)	%
1.	Poor Academic Performance	75	69.44
2.	Poor memory and attentive	82	75.92
3.	Difficulties related to handwriting, spellings, maths and written work	41	37.96
4.	Lack motivation for studies	58	53.70
5.	Deterioration in studies	56	51.86
6.	Headache, vomiting before going to school / during exams	04	03.70

2.19 Facilities for Children regarding Education

Sharing room with other children during study is good for developing social skills and also helps to achieve the goal of establishing a close relationship and learning from each other. Children who stay together and share a room will be comfortable, secure and have high level of self esteem, lesser guilt and anxiety. The above Table 2.15 indicates that about 70 percent children do not have separate room for study. These children's parents did not feel the need of having separate room for the study. Tuition is indeed beneficial for certain children who have difficulties in learning and grasping. If the child can pay attention in school then there is nothing beyond his

Children who do poorly at school may be under a lot of stress and will develop different ways to cope with this stress. Some may externalize their feelings, which can lead to acting out and behavior problems or becoming the class clown. Other children will internalize their feelings and will develop almost daily complaints of headaches or stomachaches.

Table 2. 15

Children as per having Separate Room for Study

S. No	Separate room for study	No. of Children (N=108)	%
1.	Yes	32	29.63
2.	No	76	70.37

understanding. Even if the child can pay attention in school, it all depends on the child's understanding abilities, intelligence and how fast the child can grasp what the teacher is teaching. The above Table 2.16 indicates 55 per cent children had the facility for the tuition. It is not only a poor child who should take tuitions but also a child who is very intelligent can take tuitions because practice makes a person perfect and the tutors make them practice so that they understand the concepts in a better way.

Table 2.16
Children with Tuition Facilities

S. No	Tuition Facilities	No. of Children (N=108)	%
1.	Yes	60	55.55
2.	No	48	44.44

2.20 Recreation Facilities for Children

Children learn from both inside and outside the school. Children start gravitating toward their preferred activities. Some choose a sports, others a creative pursuit like music. Some want to do everything. Others will have trouble finding even a single activity that interests them. The Table 2.17 indicates that majority of the children (91.67 %) were involved in the recreational activities however 8.33 percent were not involved in any kind of recreational activity. Parents need to devote same time for recreational activities with children. The social skills that children learn in a game or sports are incredible. There is a particular type of etiquette that they have to use to communicate with others during the game and sports. For children it makes smoother if a parent is there to help.

Table 2.17
Children as per Involvement in the Recreational Activities

S. No	Facilities	No. of Children (N=108)	%
1.	Yes	99	91.67
2.	No	09	08.33

Play is a rite and a quality of mind in engaging with one's worldview. Play may consist of amusing, pretend or imaginary interpersonal and intrapersonal interactions or interplay. The rites of play are evident throughout nature and are perceived in people and animals particularly in the cognitive development and socialization of children. Children's involvement in play with others indicates that more than 80 per cent children (81.48%) were involved in play where as 20 children (18.61 %) were not involved in play.

Table 2.18 Children According to Involvement in Play with others			
S. No	**Play**	**No. of Children (N=108)**	**%**
1.	Yes	88	81.48
2.	No	20	18.61

Play is freely chosen, intrinsically motivated and personally directed. Free and unstructured play is healthy and in fact essential for helping children reach important social, emotional and cognitive developmental milestones as well as helping them manage stress and become resilient.

2.21 Communication Skills

Communication skills are the skills needed to use language (spoken, written, signed or otherwise communicated) to interact with others and communication disorders are problems related to the development of these skills. The Table 2.19 indicates that two third of children (69.44%) were receptive and expressive in communication. We communicate constantly, and tend to assume that what we are communicating is what we mean to communicate. Often this is the case. However, sometimes, especially during difficult conversations or misunderstandings, the meaning gets lost in the delivery and the ending conversation has little to do with the original meaning. Learning effective communication skills can greatly improve communications in all your relationships and generally reduce the level of conflict. It is important that as much as possible both participants have the same ground rules for communicating.

Table 2.19 Children as per the Communication Skills			
S. No	**Communication Skills**	**No. of Children (N=108)**	**%**
1.	Receptive	15	13.88
2.	Non Receptive	14	12.96
3.	Expressive	04	03.70
4.	Receptive + Expressive	75	69.44

2.22 Self Help Skills

Children and their issues are the first priority in every family. In an ideal family children are loved, cared and their needs are met. Every parent's dreams of bringing up their children, who become very important, liked and loved in family as well as in community. Parents work and earn, take risks, put in extra labour, face all types of

problems, all for the purpose of developing their children, in bringing them up with a good start in life and keeping them safe until they are old enough to be independent. What every family expects their children to experience is healthy socialization that constitutes several goals, they develop positive self concept, they become socially and functionally competent, they grow up as self reliant individuals, who can provide for their needs, they learn to provide necessary emotional support when required, they learn life skills that are necessary to meet the needs of their children and families as adults. Skills for handling or coping with stressful situations are a primary resource that is generally obtained through experienced members of the family. The Table 2.20 indicates that majority of the children (73.14 %) were able to manage all the self help skills.

Table 2.20
Children According to Self Help Skills

S. No	Self Help Skills	No. of Children (N=108)	%
1.	Able to Manage	79	73.14
2.	Not able to Manage	29	26.85

2.23 Children's Relationship with Neighbourhood

The fondest childhood memories of most adults comprise the hours spent with playmates and with the neighbor's children, once in a while smashing a window or two or simply going around looking for things and exploring new things. Socializing with friends and getting involved in activities outside of school are a big part among children. The study indicates majority of the children (90.74 %) were aware of their neighbourhood.

Table 2.21
Children according to the Awareness of neighbourhood

S. No	Awareness	No. of Children (N=108)	%
1.	Yes	98	90.74
2.	No	10	09.25

2.24 Friendly nature Children

The early years of a child's life are crucial for cognitive, social and emotional development. Therefore, it is important that we take every step necessary to ensure that children grow up in environments where their social, emotional and educational needs are met. The table no. 2.22 indicates that more than two third of the children

Table 2.22 Children according to friendly nature			
S. No	**Friendly**	**No. of Children (N=108)**	**%**
1.	With Neighbors	01	00.92
2.	With School	22	20.37
3.	Both	85	78.70

were friendly with their neighbors as well as with the school environment. Keeping relationship with neighbors will help children to grow healthy and have friendly relationship.

Socializing with friends and getting involved in activities outside of school are a big part among the children of being socializing with others.

2.25 Early Developmental History

Milestones are changes in specific physical and mental abilities (such as walking and understanding language) that mark the end of one developmental period and the beginning of another. It indicates a stage transition. Some milestones are receptive

Table 2.23 Children According to Early Development Milestones			
S. No	**Milestone**	**No. of Children (N=108)**	**%**
1.	Delay in Specific area	09	08.33
2.	Delay in all areas	06	05.55
3.	Delay in Speech	15	13.88
4.	Normal	78	72.22

speech indicators do not show much variation among children with normal hearing, but expressive speech milestones can be quite variable. Increasing knowledge of age specific milestones allows parents and others to keep track of appropriate development. Many aspects of developmental change are continuous and do not display noticeable milestones of change. The Table 2.23 indicates that more than two third of the children (72.22 %) had normal Early Development Milestones.

2.26 Children according to the Development History

Developmental history of children reveals that many children (about 70%) suffer from one or the other problem either during birth or immediately after birth such suffering have effect on later development of these children. The contributory factors that were explored for all the children included sensory and organic factors, Intelligence,

Table 2.24 : Children according to the Development History			
S. No	**Development History**	**No. of Children (N=108)**	**%**
1.	High Risk Pregnancy	14	12.96
2.	Delayed Birth	08	07.40
3.	Pre Maturity	13	12.04
4.	Low Birth Weight	10	09.25
5.	Severe Illness soon after birth	09	08.33
6.	Kept in Incubation	10	09.25
7.	Meningitis	01	00.93
8.	Head Injury	03	02.77
9.	Diarrhea with Dehydration	05	04.62
10.	Jaundice	01	00.93
11.	Polio Effected	01	00.93
12.	Normal	33	30.55

processing difficulties, socio emotional factors and socio cultural factors affecting the learning context of the child. To isolate significant sensory and organic factors the early developmental and medical history as also the pertinent sensory, motor and medical factors that were currently affecting the child were explored. The result reveals that even less than one third of the children (30.55%) had normal birth and 14 children's (12.96%) mother's had high risk pregnancy, 10 children (9.25%) were kept in incubation, 9 children (8.33%) had illness soon after the birth and 8 children (7.40%) went through the delayed birth, 5 children (4.62%) had Diarrhea with dehydration.

2.27 Behavioural Problems of Children

Behavioural problems are on the rise nowadays among school going children due to unprecedented stresses, changing family structure, increasing pressure for environment. Typical problems of school children show up in the form of aggressive behaviour, depression, attention deficit disorders, excessive tension, scholastic

Table 2.25 :Children According to the Behaviour Pattern

S. No	Category	No. of Children (N=108)	%
1.	Acceptable	90	83.33
2.	Acceptable to some extent	09	08.33
3.	Not acceptable	09	08.33

backwardness, anxiety, withdrawal etc. Children with these problems often need professional help and guidance to overcome their difficulties. The above Table 2.25 indicates that majority of the children's (83.33%) behaviour was acceptable and 9 children's (8.33%) behavior was acceptable to some extent and 9 children's (8.33%) behavior was not acceptable.

Table 2.26

Children According to Common Behaviour Problems *

S. No	Behaviour Problems	No. of Children (N=108)	%
	Externalizing Behavioural Disorders		
1.	Angry, violent behavior	29	26.85
2.	Lying, stealing, truancy, jealousy	38	35.18
3.	Restless, disobedience, poor attention	31	28.78
4.	ADHD	28	25.92
	Internalizing Behavioural Disorders		
1.	Anxiety	04	03.70
2.	Depressed, lost feelings, Inferiority complex, Negativity in behavior	24	22.22
3.	Examination phobia	08	07.40
4.	Social phobia	07	06.48
5.	Bed wetting	17	15.74
6.	Problem in sleeping	29	26.85

**** Multiple responses***

Lying is a common phenomenon among the people. Children lie to escape the wrath of their parents. They lie when they prefer being secretive. Children steal because they haven't yet learned

Helping children who steal means understanding why it is happening as well as knowing some ways to help them learn to be honest.

that taking other people's things is wrong. Some children steal because they are upset or worried about something. Truant children stay away from school without good cause and without permission from parents and teachers for a particular reason, to escape an examination or a punishment. Almost every child has some feelings of envy and rejection when s/he has to compete with others. Jealousy among children in the family has ancient and tragic traditions. The above table no. 2.26 indicates that three fourth (35.18%) of the children were engaged in lying, stealing, truancy and jealousy.

Tips to handle a lying child—

- One needs to explain the importance of telling the truth. An open and warm relationship should be fostered between the child and the parent.
- Discipline the child when s/he lies. One can have separate punishment for lying.
- Be consistent in your treatment towards a lying child. The same set of rules should apply. Parents should trap a child in telling them whether he lied or not. Do not demand for confessions. Be sure that they have actually committed a mistake before punishing them.
- Parents should try to observe the pattern of lying in their child. Solutions to change this pattern should be found if a child is lying to boost up his or her self esteem, then efforts should be made to enhance his or her self image.
- One should praise truthfulness. If being truthful is being appreciated, then the child will repeat that behavior again.
- Professional help should be sought for consistent lying.

Tips for parents for handling Stealing—

- Don't react too quickly if you find your child has stolen. Give yourself time to think about it first so you can talk to the child calmly.
- Try to find the cause and fix it.
- Teach and show the things you want your children to learn, i.e. why it is important to respect other's belongings.
- Make sure that your children do not see you do things like avoiding paying fares for example.
- Children learn much more from what you do than from what you say.
- Give children and young people opportunities to learn to be responsible with money, i.e. some pocket money to manage.

- Support the child or young person in returning or paying back what she has taken without making this too dramatic.
- Teach problem solving if it is needed to help with other problems.
- If pocket money is “docked” as a punishment, make sure the child or young person still has some money left to spend.
- Give the child or young person some chances to succeed, i.e. get something from the shop and bring you the change.
- Teach children why it is important to respect others and show respect for the child.
- If problem persists after utilizing all the above mentioned tips, one may approach to counselors / CGC

Following are the Effective categories for reducing truancy—

- Systemic renewals.
- School – community collaboration.
- Safe learning environment.
- Family engagement.
- Early childhood education.
- Early literacy development.
- Mentoring / tutoring.
- Service learning.
- Alternative schooling.
- After school opportunities.
- Professional development.
- Active learning.
- Educational technology.
- Individual instruction.
- Career and technical education.
- If problem persists after utilizing all the above mentioned tips, one may approach to counselors / CGC.

Experts agree that truancy is the first sign of trouble, a gateway to crime and that high school rates of truancy are linked to daytime burglary rates and vandalism ad are a known risk for serious juvenile delinquency.

Guidelines for parents to acquaint themselves in treating the jealousy

- Always treat children as individuals and not simply as a collective group of young members of the family. No matter their age, each child has a unique individuality and shows this in the way he/she sleeps, eats, plays and relates

with people around him / her. Each child should be treated differently according to his/her temperament.

- Avoid comparing one child with another. No person is the same as another, so there is really no basis for comparison. If you don't like what your child is doing, simply tell him/her that you do not like it instead of saying that why can't s/he be like his / her younger brother / sister or like the neighbor's kid.
- Learn how to nurture and develop the skills of your children. If your child is aware that you are supportive of his/her skills and talents, you are building up his/her self esteem and making him/her more successful in life later on. Your support, be it of athletic, creative and artistic or educational talents is a sure fire way of treating jealousy between children and maintains the needed balance among them.

Treating jealousy and managing it effectively as early as possible is one way of building up children's strength of character and making them more responsible members of the community.

- Make sure to spend quality time with each kid. Your kids will only be kids for a short time, spend as much quality time with them as you possibly can to develop the necessary closeness. The time spent by parents with their kids is the well of strength children draw on when they become adults and have children of their own.
- Be firm and accurate when it comes to defining the limits and extent of your personal space and theirs. Teach your children self respect and respect for others so they do not overstep their unseen boundaries later on in life.
- If problem persists after utilizing all the above mentioned tips, one may approach to counselors / CGC.

The Table 2.26 indicates that 28.78 percent children were restless, disobedience and poor attention. Almost all children show behaviors like **'restless'**, 'not on task', 'not listening', 'non stop talking from time to time. But when such behaviors are chronic, interfere with learning and are accompanied by a short attention span, disorganization, impulsiveness or excessive restlessness, they may be signs of attention deficit / hyperactivity disorder. Some children are restless and lacking in concentration. The extent to which a child is able to concentrate depends upon his /

her age, mental and physical health, intellectual capacity, temperamental quality and training or discipline. Small children naturally have a short span of attention and so have the intellectually backward, as compared with the more intelligent. Parents need to structure the activities of the child by introducing the child to certain interesting activities like playing with sand / clay, separating the colour or different shaped beats, painting, music, dance, yogasanas etc. Accordingly the child start improving as it grows.

Obedience is doing the right things – all the time, living by the rules. Obedience is a responsibility of oneself. Children are taught obedience not only to protect themselves, but to impress upon them the importance of respect for others. Parents need to remain calm, cooperative, and consistent when the child is disobedient. The child will learn to be respectful if the parents are respectful towards the child and to the family members. When the child is obedient and respectful, parents need to compliment for that behavior. Reward the healthy behavior, including cooperation and resolution of disagreements.

Results also reveal that 26.86 per cent of the children had developed behaviours such as anger and violent behavior.

Like happiness, sadness and anxiety, anger is a human emotion felt by everyone. How people deal with their anger or allow it to manifest is one of the things that make us individual.

Anger is a natural human emotion, one of many responses we can express when we are frustrated and prevented from reaching our goals. Since anger is a universal emotion, it seems logical to conclude that there is nothing wrong with feeling angry. The problem occurs when anger leads to inappropriate actions or behavior. The problem is not getting angry but dealing with angry feelings in an ineffective way.

Anger management strategies for parents:

Parents can take to steps to help their children deal more comfortably, effectively and adaptively with anger. These interrelated steps include—

- Serve as appropriate models for children: Children are more likely to do what parents do. A key component of teaching anger management is, to manage anger and model effective anger coping strategies for children.
- Be empathetic: teach children to express anger constructively. Parents need to ask questions from themselves like am I speaking to my children so they

will learn from me rather than resent me, would I want anyone to speak with me the way I am speaking with children.

- Involve your child as much as possible in the process of dealing effectively with anger: what makes me angry? What are different options for dealing with anger? What might be the consequence of each option? What option might be most effective? Reinforce belief in children that they can learn to control anger rather than anger control them. This provides a sense of ownership, self discipline and resilience.
- Remember the proverb, “an ounce of prevention is worth a pound of cure”: engage in prevention and “planned parenting” and prepare a “plan of action” in advance.
- Discipline in a way that lessens frustration and anger and reinforces self discipline: parents who remain calm while disciplining, who have clear expectations, who use realistic, natural and logical consequences and who remember that discipline is a teaching process, will lessen outbursts of anger in their children, while reinforcing self control.
- Show your children unconditional love and spend “special times” with them: when parents accept their children and show them unconditional love, children are less likely to become frustrated or intensely angry. Parents should spend time with children while playing, reading and going out, this will create an opportunity to develop positive relationship.

Violent behaviour in children can include a wide range of behaviors i.e. explosive temper tantrums, physical aggression, fighting, threats or attempts to hurt others, use of weapons, cruelty toward animals, fire setting, intentional destruction of property and damage. Violent behavior in a child at any age always needs to be taken seriously. It should not be dismissed as “just a phase they’re going through”.

The goal of treatment in violent behavior is to focus on helping the child to learn how to control his/her anger, express anger and frustrations in appropriate ways; be responsible for his/ her actions; and accept consequences.

Therapy for violent behaviour—

- Challenge the idea that masculinity is always getting aggressive.
- Reduce the family’s tolerance for violent behavior.
- Reduce the child’s tolerance for violent behavior.

Effective parenting, evaluation of “at risk behaviors” and timely supportive intervention are keys to preventing children’s violence

- Improve verbal communication skills.
- Build impulse control.
- Eliminate alcohol or other drug use.
- Help children and their parents develop the ability to remain calm during conflict;

Results indicate one fourth of children were having Attention Deficit Hyperactivity Disorder (ADHD). ADHD usually considered being a neurobehavioral developmental disorder. It affects about 3 – 5% of children with symptoms starting before seven years of age. It is characterized by a persistent pattern of impulsiveness and inattention with or without a component of hyperactivity. ADHD is a chronic disorder.

Methods of treatment usually involve some combination of medications, behavior modifications, life style changes and

The results also indicates that among internalizing behavioural disorders 22.22 per cent children were having depression, lost feelings, inferiority complex and were negative in behaviour.

Many people believe that severe depression did not occur in childhood. Today, experts agree that severe depression can occur at any age. Studies show that two of every 100 children may have major depression (National Institutes of Health, 1999). The disorder is marked by changes in—

- Emotions: children often feel sad, cry or feel worthless.
- Motivation: children lose interest in play activities or schoolwork declines.
- Physical well being: children may experience changes in appetite or sleeping patterns and may have vague physical complaints.
- Thoughts: children believe they are ugly, unable to do anything right or that the world or life is hopeless.

It is important to become aware that some children with depression may not value their lives, which can put them at risk for suicide

A trained counselor, psychologist or psychiatrist will be able to diagnosis depression and treat the child with individual and family counselling.

Sleep problems are common among school going children, but they are often not recognized by parents. As per the researchers both genetic and environmental factors influence sleep problems among school aged children. Weissbluth says sleep

problems among school children often manifest as behavioral and academic issues at school. But sleep deprivation is rarely recognized as the cause of classroom problems. Weissbluth says “sleep is an under appreciated health habit”, we all know that junk food is unhealthy for our children, but so is junk sleep. “Healthy sleep is to the brain what healthy food is to the body”. “Sleep is a learned behavior”, “you don’t grow out of sleep problems. They just show up in different ways throughout life”. The above table indicates 29 children (26.85%) were having problems to sleep.

Lost feeling is listed as an alternate name or description for symptom of numbness. Numbness usually arises from damage or disease of nerves. Children who are introvert spend hours in solitary pursuits. These children need to have variety of opportunities for group interactions. Parents can help the children by –

- Making children to realize their own strength.
- Having a sense of humor of oneself and shortcomings.
- Listening to the children without criticism.
- Being kind and complimenting.
- Understanding the children and to be empathetic.
- Accepting children without complaining.
- Helping children to build friendships which compliment each other.

Some people may start life with some feelings of **inferiority**. Subsequent success or failure is determined by the ability to adjust the inferiority feeling to the demands of life. Adler believed feeling of inferiority typically begins in childhood. Children may have developed feelings of inferiority on the basis of real shortcomings or from misinterpretations about their body or their social or physical relationship with their environment. Normal development requires the recognition of one’s limitations and capacities in order to achieve a profitable balance in emotional maturity.

Treatment: The primary indication of mental health in Adlerian psychotherapy is the person’s feeling of community and connectedness with all aspects of life. Attempts to compensate, for an exaggerated inferiority feelings by a fictional final goal of superiority over others, is a major hindrance to development of a feeling of community. This sense of unity provides the real key to the individual’s genuine feeling of security and happiness. When adequately developed, it leads to a feeling of equality, an attitude of cooperative interdependence and a desire to contribute. Consequently, the central goal of Adlerian psychotherapy is to strengthen this feeling of community.

The therapeutic process is simultaneously focused on three aspects of change—

- The painful, exaggerated feelings of inferiority are reduced to a level that can be used to promote growth, development and a healthy striving for significance.
- The patient's destructive striving for superiority over others, manifested in a compensatory lifestyle, must be released.
- Fostering of equality and feeling of community. Underlying this approach is a firm belief in the creative power of the individual to freely make choices and correct them when given sufficient information – an extremely optimistic view of human nature and our ability to change.

The table indicates that less than one fourth per cent (15.74%) children were bed wetting. **Bedwetting** is involuntary urination while asleep after the age at which bladder control would normally be anticipated. Bedwetting is the most common health issue. It may occur at any time of the day or night. Bedwetting is regarded as something only small children do, but it's a problem that can affect a surprising number of teenagers and even adults – and that can be solved. Developmental delay causes most bedwetting, frequently associated with a family history of the condition. Only a small percentage of bedwetting cases are caused by specific medical situations. Other factors can include anxiety, stress, constipation, urinary tract infection and occasionally diabetes or kidney failure.

Doing nothing or punishing the child, are both common responses to bedwetting, which does not help. The child needs reassurance that bedwetting is common and can be helped.

Treatment ranges from behavioral based options such as bedwetting alarms to medication such as hormone replacement;

- Protect or improve self esteem.
- Counseling the parents and the children.
- Do not shame or punish the child.
- Guide the child to go to the bathroom at normal times during the day and evening and does not hold urine for long periods of time.
- Before going to sleep assure that child has gone to bathroom.
- Reduce the amount of fluid the child drinks a few hours before bedtime.
- Give incentives / gift when child does not do bed wetting.
- If the problem persists contact the doctor.

The study also indicates that 7.40 per cent and 6.48 percent children had examination phobia and social phobia respectively. Everyone knows that hypersensitivity to anything is not desirable and that includes examination also. Being too anxious, concerned or worried is not a state of mind suitable for exams. The best state of mind is a quit confidence that is borne out by adequate preparation to face the exam. Undue anxiety is counterproductive. Fear more imaginary than real will sap the energy that is to be used for intelligent learning. Stress up to a certain level acts as a motivation to study. Students who become too nervous during exams, cut down on their sleep and food and get into a desperate mode of study. These behaviour are likely to be harmful. The human brain functions best when the mind is calm and the body is healthy.

The human brain functions best when the mind is calm and the body is healthy. Giving up sleep and food in the run up to the exam is a recipe for disaster.

- Children need to increase self awareness about the exam process and shun self defeating statements to do well in exam.
- Children need rest well, exercise and deep muscle relaxation in order to free the tension.
- Long walks and cycling are excellent ways to release nervous energy and maintain stamina during the exam period.
- Every serious student must be prepared to put in real hard work for the exams.
- It is a fact that the human brain can be most receptive during pressing circumstances, like exams.
- Read back of your exam timetable sheet most carefully for the rules and regulations,
- Do reduce anxiety and awkwardness by checking the time and place of each exam.
- Arrive a few minutes early and make sure that you have all the materials you need for the exam.
- Make sure you have your student ID / admit card as you will not be able to take the exam without it.

Social phobia is a persistent and irrational fear of situations that may involve scrutiny or judgment by others, such as parties and other social events. It is an

Social phobia is a strong fear of being judged by others and of being embarrassed.

anxiety disorder characterized by overwhelming anxiety and excessive self consciousness in everyday social situations. Social phobia can be limited to only one type of situation such as fear of speaking in formal situations or eating or drinking in front of others or in its most severe form, may be so broad that a person experiences symptoms almost anytime they are around other people. Children with social phobia have a persistent, intense and chronic fear of being watched and judged by others and being embarrassed or humiliated by their own actions. Their fear may be so severe that it interferes with work or school and other ordinary activities. Physical symptoms often accompany the intense anxiety of social phobia and include blushing, profuse sweating, trembling, nausea and difficulty in talking.

Social phobia sometimes runs in families, but no one knows for sure why some people have it, while others don't. When chemicals in the brain are not at a certain level it can cause a person to have social phobia.

2.28 Learning Problems

A **slow learner** is a child of below average intelligence, whose thinking skills have developed significantly more slowly than the norm for his / her age. This child will go through the same basic developmental stages as other children, but will do so at a significantly slower rate. Slow learner term is used to describe a child whose learning ability in all areas is delayed in comparison to children of the same chronological age. These children are not considered learning disabled because there is no discrepancy between cognitive expectations and academics achievements. The major problem with these children is poor logical reasoning. The above Table 2.27 indicates that less than one fourth (12.96%) children were slow learners and 17.59 per cent had learning problems who needed guidance and assistance by professionals for improving the learning skills.

Table No. 2.27
Learning Problems

S. No	Learning Problem	No. of Children (N=108)	%
1.	Learning Disability	19	17.59
2.	Slow Learners	14	12.96
3.	General Guidance	74	68.51

Characteristics of Slow Learner

- Developmental: may have immature language patterns or speech problems.
- Social: poor judgment, immature social behavior, prefers company of younger children.

- Personal: frustration, aggression, anxiety.
- Academic: may have proficiency with particular tasks rather than a subject areas, poor memory, difficulties in understanding several steps in a task.
- Learning: needs to have new information linked to old, difficulties in transferring information learned in one situation to other situations.

Practical Suggestions

- Alternatives to traditional home work tasks: Homework is an endless source of problems for the kids and their parents. So modify tasks, or if this is too time consuming, cut back the amount a child has to do. Minimize written work.
- The opportunity for intensive sessions: by using individual or small group sessions with the child, use interesting, challenging, self correcting, extension work for the rest of the class while you spend time over teaching (not over telling).
- Allow the child to use crutches i.e. reminders stuck to the desktops, markers to keep place, taped messages, calculators etc.
- Consider alternative responses and assessments: Do more oral work and have short, easy to read / write assignments.
- A good supply of reference books and supplementary readers appropriate in terms of interest level and competency level.
- Teach the child specific reading techniques: i.e. pre-reading routine, word attack techniques, self correcting skills and give very specific instructions to a teacher aid.
- Try implementing a Parent Tutor program, Peer Tutor program, Teacher Aide program: Give plenty of training and very specific instructions when working with learning disabled children.
- Praise the child at every opportunity: Grab every chance to let this child shine in the classroom. Learning disabled children, in particular, show learning abilities as well as disabilities.
- Implement a friend system to ease supervision of daily work: Let the child choose his / her own friend – within reason.
- Chat with child: Let him / her know privately that you are on his / her side;
- Chat with parents: Collect from the parents any extra information that will help, engage their help in providing a quiet, well organized place a home in

which the child can work and in supervising home tasks. Find plenty of positive to talk to the parents.

- Adjust your expectations: Learning disabled children can, with the right help, be expected to attain chronologically appropriate academic levels in time.

Many of these suggestions will be more suitable to either the slow learner or the learning disabled child. It is vitally important to make classroom are safe and non threatening environment for all the children in the class. Every child needs to understand that given any circumstances s/he is not put down by anyone. Encourage children to help each other with daily tasks but be prepared for a more noise in the class. It is worth to see how nurturing and supportive children can be.

Specific **learning disability** means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include children who have problems that are primarily the result of visual, hearing or motor disabilities or mental retardation, emotional disturbance or of environmental, cultural or economic disadvantage. A child with specific learning disablity is one of average or above average intelligence who has specific difficulties which can make learning very difficult. There may be deficits in any of the basic central nervous system functions, which have to do with the acquisition and use of listening, speaking, reading, writing, reasoning, mathematical ability, attention, memory, language, auditory and visual perception, motor coordination and planning, spatial orientation, impulse control and sequencing.

Characteristics of Learning Disabled

- Academic: (a) reading: confuses similar words and letters, loses place, repeats words, does not read fluently, persists in using fingers to follow along, does not like to read. (b) Spelling: uses incorrect order of letters in words, it has difficulty of associating correct sound with appropriate letter, reverses letters.
- Mathematics: has difficulty associating number with symbol, cannot remember number facts, confuses columns and spacing, has difficulties with story problems, and comprehending maths concepts.

- Physical: perceptual motor difficulties, visual perception difficulties, poor visual decoding, general coordination deficits (balance, eye – hand), poor auditory memory (difficulty following sequence of directions), attention deficit, mixed dominance (hand, foot, eye), lack of adequate eye movement control.
- Psychological: emotional instability (violent reactions), difficulty in learning by ordinary methods, low social acceptance (disturbed peer relations), low self concept / self esteem, general disorganization (time and actions).
- Social / emotional / behavioral: hyperactivity (gross, noisy, constant movements), hypo activity (quiet, nervous, fidgety), impulsivity, poor concentration span (distractibility), low frustration tolerance, emotional (highs and lows), seems paradoxical (may remember past events in minute detail, cannot remember number facts and spelling just learnt, may build the most intricate models that may be so clumsy s/he trips over his / her feet, make other most fanciful stories start cannot sit long enough to hear same one).

2.29 Consultations

The maximum children had consulted Social Worker and the Psychiatrists followed by Special Educator and Psychologists. This indicates professional staff needs to go through the developmental history, including the family atmosphere during childhood, behavior during schooling, handling of different family and social roles, stability and effectiveness at work, pattern of social life helps in appraising personality. This indicates that the services of Social Worker and the Psychiatrist are very essential as they are exclusively involved in counselling.

Table 2.28

Children as per No. of Consultations with Professionals

No. of Consultation	Social Worker	%	Special Educator	%	Psychiatrist	%	Psychologist	%
One	76	70.37	06	05.55	59	54.62	08	07.40
Two	26	24.07	12	12.13	19	17.59	13	12.03
Three	03	02.78	21	19.44	13	12.03	44	40.74
Four	01	00.92	28	25.92	07	06.48	16	14.81
Five	01	00.92	20	18.61	06	05.55	12	12.13
Six	01	00.92	11	10.18	01	00.92	02	01.86

Seven	-		01	00.92	01	00.92	01	00.92
Eight	-		-		01	00.92	01	00.92
Nine	-		-		01	00.92	01	00.92
	108		**99**		**108**		**98**	

2.30 Referral Services

As discussed earlier CGC have limited basic services. Besides these services the children were referred to other various organizations where the service was available such as speech therapy, rehabilitation services to the mentally challenged children, orthopedics, etc. The study indicates that majority of the children (87.04%) received guidance at CGC, whereas 14 children (12.96%) were referred to other centres for the services as per their problems.

Table 2.29
Children as per Referral Services

S. No	Referral Services	No. of Children (N=108)	%
1.	Yes	14	12.96
2.	Guidance given at CGC	94	87.04

2.31 Source of Referral to CGC

As part of advocacy CGC created awareness among the school principals, teachers, parents, medical and para medical professionals through training / workshops as it was unique program in Lucknow city. Besides, it also created awareness among participants of other training programs organized in the institute time to time. As a result out of 108, 50 children were referred by various schools and other children

Table 2.30
Children as per Source of Referral to CGC

S. No	Source of Referral	No. of Children (N=108)
1.	Schools	51
2.	Other Clients / Self Referral	17
3.	NIPCCD Staff	07

4.	Doctors / Hospital	12
5.	Special Schools / Organizations	04
6.	Advertisement	13
7.	Referred through child line	02
8.	Through teachers who attended training in NIPCCD	02

came by various sources, such as self referral, advertisement, doctors / hospitals etc. This indicates there is a need to create awareness among school teachers and principals regarding importance of child guidance centre for the promotion of positive child mental health, so that the problems of children to be identified at early stage and intervention services may be provided appropriately.

2.32 Improvement in Academics and Behaviour

It was observed by the para professional staff that qualitatively progress has taken place in the life of children. The Table 2.31 indicates that majority of children had improvement in academics (51.85%) as well as in behavior (41.66%). This indicates that there was a need of counselling for children as well as for parents for preventing learning and behavioural problems at the early stage. So the counselling could bring about changes in children's life. After the series of counselling with children and parents it was observed quite clear progress in parent's attitudes and expectations towards their children. Changes in home environment and in school environment also contributed towards the progress of the children.

Table 2.31

Children as per the Improvement in Academics and Behaviour

S. No	Improvement (N=108)	Yes	No
1.	Academics	56 (51.85%)	04 (3.70%)
2.	Behavioural	45 (41.66%)	03 (2.77%)
3.	Academics & Behavioral	75 (69.44)	0.00

CHAPTER 3

CASE STUDIES

3. CASE STUDIES

Case No.1

Ravi (name changed)

Family Background

Ravi lived with his father, mother, sister and twin brother. His father worked as an Investment Consultant and mother was a housewife. His sister and his twin brother both were going to school. But Ravi was not admitted to any school. He lived in a nuclear family. His Grandfather was suffering from schizophrenia and maternal aunt also was having mental illness.

Problems of the Client

Ravi was a 5 year old boy. He was referred to CGC by a private doctor and brought by parents with the following complaints—

- Speech problem;
- Restlessness;
- Lack of Head control;
- Had difficulties in Learning;
- Squint eyes;

Case History

Some of the significant data that emerged from the case history were as follows—

- The client's mother took abortive pills when she was two months pregnant. She had itching problem in 8th months of pregnancy;
- The client was born full term with caesarian delivery;
- Client had undergone treatment for jaundice after a week of his birth;
- Almost all the Milestones were delayed;

Types of Assessment

Ravi had the benefit of psychiatric, psychological and educational assessment at the centre. Besides observation of the child at play and interviewing the parents, the following psychological tests were administered to him.

- Vineland social maturity scale;
- Seguin Form Board;

Motor Development

Even though the gross and fine motor coordination were delayed, but Ravi had no impairment due to early stimulation administered to him.

Speech and Language Development

Ravi could speak or imitate simple words and was able to follow simple instructions. Child's receptive language was not age appropriate. Ravi required help in expressing his feelings / needs. During observation client was unable to express his feelings, emotions and warmth verbally.

Psychological Assessment

VSMS revealed that his social age is 34.8 months and his social quotient is 58 which fall in the mild category of social development as compared to the chronological age. The cognitive assessment revealed Ravi with mild mental retardation. His IQ was in the range of 55-60, specifically 60. He could be placed in educable group.

Educational Assessment

Ravi's pre-educational assessment revealed that he was able to identify all the familiar pictures and could draw vertical / horizontal lines and something similar to circles. Regarding note and meaningful counting he required prompting. He was able to match different shapes, size and colors (red and green) but required help in identifying and naming the above mentioned concepts.

Play Observation

It was observed that Ravi was restless during play therapy but later he was very co-operative and showed interest to play with ball. Every game was boring him if it prolonged.

Psychiatrist Assessment

Psychiatrist Assessment revealed that Ravi was having mild mental retardation and the problem of ADHD.

Intervention

- Counselling to the parents;
- Play Therapy;
- Setting of Time Table;
- Referred to Speech Therapy.

Achievements

- Ravi was able to learn more vocabulary i.e. simple 2 letter words with alphabets and also recognizes the alphabets in Hindi and English.
- He was able to dress himself without the help of his parents.
- Interested in T.V shows i.e. cartoons.
- Able to manage his daily living activities.

Case No.2

Rohit (Name changed)

Family Background

Rohit lived with his grandfather and his mother. Mother had her own beauty parlor. Rohit's grandfather was a government employee and received his pension so he could support Rohit's family financially.

Problems of the Client

Rohit was an eleven year old boy studying in 4th grade in a private school. He was quite, calm and thin built boy. He was brought to CGC by his grand father with the following complaints—

- Problem in memorizing the lessons and spelling. The main problems were to learn the question answers;
- Lack of appetite;
- Lack of confidence;
- Forgetfulness;
- Lack of identifying similar sounding letters;
- Takes time to understand;
- Misarticulated writing;
- Poor Comprehension skill.

Case History

Rohit lost his father when he was sixteen months old due to tuberculosis. Physically Rohit was weak and malnourished. He also suffered from a collarbone injury when he was 3 years old. After his father's death both Rohit and his mother underwent treatment for T.B as his father had open T.B. His weight was just twenty two kilograms and height was one hundred thirty two centimeters. It was found that Rohit was able to retain other events and things, such as movie stories but retaining lessons was his main problem. Rohit had friends and had good communication with them. At home he was attached to his grand father.

Types of Assessment

Rohit had the benefits of psychiatric, psychological and educational assessment at the centre. Besides observation of the child at play and interviewing the parents, the following psychological tests were administered to him.

- Vineland social maturity scale;
- Colored Progressive Matrices ;
- Bhatia Battery;

Motor Development

Milestones revealed his gross motor development was average and Fine motor development was o.k.

Psychological Assessment

As per psychological assessment Rohit was suppressed and unable to convey his inner feelings to others. Basically he was shy in nature. He had lots of complexes. Whenever he is in tension his palms sweat, start shivering, sometimes suffocating and lacked concentration.

Rohit's Cognitive Assessment showed that his intellectual abilities were below average level. His IQ was within the range of 80 -89 specifically 86. His Performance I Q was below average level. The Vineland Social Maturity Scale revealed that his social age was of 8 years 6 months while his social quotient was 85, which falls in below average category.

Educational Assessment

Educational Assessment revealed that Rohit was slow learner and his verbal performance was better than his written performance. His comprehension performance was also very poor. He fails to express his thoughts in written form. In English he takes much time than other subjects.

Play Observation

Rohit was lacking confidence to start any game. He was introvert, not able to mix with people.

Psychiatrist Assessment

As per the assessment of psychiatrist Rohit was a slow learner.

Intervention

- Counselling to the parents;
- Setting of Time Table;
- Reducing the load of written assignment;
- Additional time to complete writing work, exams;

Achievements

- Able to retain question answers and word meaning.
- Improved study pattern.
- Doing his daily activities by himself.

- Taking balanced diet.
- Following the regular time table.
- Mixingup with the classmates and playing with them freely which has increased his confidence.

Case No.3

Rani (Name changed)

Family Background

Rani was the only child and lived with her mother. Rani's mother was separated from her father. Her mother was post graduate and worked in a computer centre.

Problems of the Child

Rani was 10 years old and was studying in a private school. They had come to know the services of CGC through NIPCCD staff. Rani was brought to CGC by her grand father with the following complaints—

- Poor concentration.
- Attention seeking behavior.
- Restlessness.
- Fearful.
- Self pitying.
- Headache, cough, giddiness.

Case History

After 3 months of Rani's birth she had pneumonia, so she was been under medication. She was daily administered with injections and medicines. She could not recover fully from her illness. She had continual cold and cough even after her treatment. Later she was diagnosed for TB and treatment was given for 1 year. Treatment for TB did not stop her cold and cough. So she was referred to Post Graduate Medical Institute where she was diagnosed to have membrane in the heart. So she had to go through heart surgery. After the heart surgery she was completely recovered from her illness. Rani had normal milestones. Her fine and gross motor and speech was very clear. Later she developed temporal Epilepsy.

Rani was shy, timid, introvert and sometimes impulsive. She liked activities such as watching T.V programs, car driving and study. She was not happy to be in the crowd.

Types of Assessment

Rani had the benefits of psychiatric, psychological and educational assessment at the centre. Besides observation of the child at play and interviewing the mother and the grand father, the following psychological tests were administered to her.

- Seguin Form Board (SFB);
- Draw a Man Test;
- Vineland Social Maturity Scale;

Psychological Assessment

Rani was a case of psychosomatic disorder. According to SFB Rani's mental age was 8.3 years and IQ 79 (Borderline Deficiency)and SQ was 92. According to Vineland Social Maturity Scale (VSMS) her social age was 9.6 months and social quotient was 92 which falls on normal range.

Educational Assessment

The client was given tips regarding the time table and management of daily activities. School teachers were given guidance to handle the client during school hours. Regular counselling sessions were arranged to the client and her guardians.

Psychiatrist Assessment

Psychiatrist Assessment revealed that Rani had psychosomatic disorder along with other behavioral problems. She was given medicinal intervention.

Intervention

- Parents Counselling;
- Setting up Time Table;
- Extra time was given to complete the written work and exams;

Achievements

Rani could study by herself after getting assistance at CGC. There was tremendous improvement in her behavior. Her irritating habit had changed. Physical illness such as headache, cough and giddiness had disappeared and she had become friendly with her classmates. Her mother could send her for shopping.

Case No.4

Rohan (Name Changed)

Family Background

Rohan was the 5th child in the family. His father worked as an executive superintendent and mother was a teacher. Being the youngest child he was pampered by his parents, elder brothers and sisters.

Problems of the Client

Rohan was referred to CGC by his school teacher. He was fifteen years old boy. He was brought to the Child Guidance Centre by his parents with the following complaints—

- Poor in studies;
- Lack of confidence;
- Improper attention in the class;
- Not able to complete the school work;

Case History

Rohan suffered with jaundice when he was 2 years old. He was treated by home remedies. Some of the significant data that emerged from the case history was as follows—

- The child was born full term and it was a normal delivery;
- All his milestones were normal;
- The child had high moral values and hence gets irritated easily when he hears any immoral remarks or statements about himself or persons close to him;
- Child had introvert personality due to which his interaction was very much limited, even with the family members;
- Child appeared to be depressed and sad and had tendency to bursts into tears during conversation.

Types of Assessment

Rohan was a young boy, well built and well nourished. He could follow verbal instructions and answer verbally. The following psychological tests were administered on him.

- Intelligence Scale for Indian Children (ISIC);

Psychological Assessment

The cognitive assessment placed him at an average level in terms of his intellectual abilities. His IQ was within the range of 105 – 110, specifically 106. The assessment further revealed that his areas of strength were comprehension, capacity to use

social judgment and logical thinking, similarities, where he had to use abstract verbal reasoning. His verbal IQ was 109 which was better than his performance IQ i.e. 104.

Educational Assessment

The educational assessment revealed that his sight and oral reading of English language was appropriate to his grade. But he needed efforts in reading polysyllable words. His vocabulary in Hindi language was quite good. The assessment revealed that Rohan's functioning at an average level in his intellectual abilities and was suffering from mixed depression anxiety neurosis and Dyslexia.

Play Observation

Rohan was given age appropriate puzzle to be solved. He solved it with adequate concentration and within the time limit. His performance was excellent during mechanism game. He liked to play outdoor games i.e. cricket and indoor game i.e. video game.

Psychiatrist Assessment

Psychiatrist Assessment revealed that Rohan had some kind of learning problems.

Intervention

- Parents Counselling;
- Child's Counselling;
- Setting up Time Table;
- Provision of appropriate reading materials to improve communication skills;
- Restructuring the environment;
- Support from friends and teachers to complete his study / assignments;

Achievements

- Good communication between family members and classmates which enabled him to gain confidence.
- Parents spend time with their children especially with Rohan.
- Rohan could share his problems with family members.
- Followed the time table to complete work.
- Parents and teachers were satisfied with his improvements.

Case No.5

Ranveer (Name changed)

Family Background

Ranveer was 8 years old child. He was admitted to school when he was 3 years old. Ranveer was the only child and attached to his parents. Ranveer's father was transferred to other District so the whole family was shifted to the new place. Ranveer had problems to adjust to the new place and new situation and was not ready to study from his parents.

Problems of the Client

Ranveer was referred to CGC by school principal who had attended the workshop in NIPCCD. He was brought by his parent's with following complaints—

- Running away from the house to play without informing;
- Temper tantrum;
- No eye to eye contact;
- Weak in studies;

Case History

Ranveer's Physical appearance was neat and well built. He was interested in outdoor games like badminton, football etc. He liked to play and was interested in Maths.

The social development of Ranveer shows that it was of low average level. Due to Autism his self help skills had not developed. He was cooperative and familiar only to those whom he knows well or to his family members.

Due to Autism he had communication problem also. He was lacking confidence. He understood mostly what was told to him. Due to his inability to express, he disliked going to school but once he was in the school he liked the school. He was cooperative and shared his things with others but always depended on his mood. Ranveer was very sensitive child.

Types of Assessment

Ranveer had the benefits of psychiatric, psychological and educational assessment at the centre. Besides observation of the child at play and interviewing the parents, the following psychological tests were administered to him.

- Vineland social maturity scale;
- Seguin Form Board;

Motor Development

Ranveer's gross motor development was well developed and he could ride bicycle too. Fine motor development was not appropriate.

Speech and Language Development

Ranveer had problems to speak complete sentences. He had good receptive language but unable to narrate himself. He had ability to communicate with simple 2 or 3 words.

Psychological Assessment

Ranveer's IQ was 62 which indicated that he was having mild Mental Retardation with typical Autism. He belonged to educable group.

Educational Assessment

As per educational assessment Daily Living activities were not appropriate. He recognized the alphabets and was able to read all the alphabets and some simple words in English, was able to write his name and simple words. He counted up to 100 like parrot but meaningful counting up to 10 and was able to write up to 6. Ranveer knew regarding the date, time and day.

Play Observation

Client was cooperative and understood the instructions properly. He liked to play outdoor games.

Psychiatrist Assessment

Psychiatrist assessment revealed that he was having Autism with Mental Retardation.

Intervention

- Parents Counselling;
- Child's Counselling;
- Setting up Time Table;
- Support from friends and teachers to complete his study / assignments;

Achievements

- He was able to go to school regularly and was regular to complete the home work and with the help of parents took the initiatives to study at home.
- Good communication with the parents.
- Started to inform the parents regarding his activity.

CHAPTER 4

MAJOR FINDINGS

4. MAJOR FINDINGS

The major findings that emerged out after analysis of the data, personal observations, interviewing the various stakeholders and discussions with CGC staff were as follows—

- The sex distributions of the children revealed that majority of the children were male. It describes problems of children in their developmental perspective. Through this one comes to know that the boys are the ones who suffer from different problems. One of the major complaints of the parents was that their children were scholastically backward, lack concentration so they needed guidance in CGC.
- Age of the children indicates that majority of the children were belonging to 6 to 14 years and the rest were above 14 years. This is the period when children are filled with energy, competition and want to do things on their own and these children needed guidance for healthy development.
- The distance distribution of the children reveals that majority of the children were coming from more than 5 kilometres of their residence to CGC for the assessment intervention.
- Changing trends in social and economic conditions of families have implications on psychological satisfaction of members and children. Majority of the children were belonging to nuclear families.
- Majority of the children belong to the Hindu religion (86%). This is as per proportion of the country's population.
- The income of the family indicates that the 32.40 per cent of the children belong to upper class, at the same time there were 20.37 per cent of the families which belong to lower middle class. This indicates the developmental problems can affect any children of any class, also it indicates that income of the family does not count for academic backwardness.
- The education status of the parents indicates 52 per cent of the children's fathers and 44 per cent mothers were graduates. This implies that the children had good educational background in the family for study.
- Occupational status of children's parents was found that all children's' fathers were employed. The fathers of the children were capable of guiding their children but due to their engagement in various professional works were not giving as much time to their children as needed.
- Majority of the mothers were housewives so the mothers could give much of their time for their children, helping them in development and growth, in their

studies, listening to their stories, observing daily activities and sharing their own life experiences.

- Separation of parents or loss of a parent is another equally important dimension of child's suffering and stress, depriving the child of love and affection of the other parent. The study indicates that 12 children's (12.13%) parents were separated or there was death of one of the parents.
- Attachment is a biologically based strategy that provides emotional and physical protection for children. The study indicates that all the children were attached with their father or mother where as 18 children (16.66%) who were attached with others than parents.
- The study indicates that more than two third percentages of the children were not afraid of anyone in the house and the remaining less than one fourth children were afraid of someone in the house. This is mainly due to the lack of healthy relationship between children and parents.
- Historical studies on the value of children's contribution to their families and households demonstrate that children's productive role in pre-industrial households has shifted with industrialization, being defined as useful being. The study indicates majority of children (71.29%) were involved in household works.
- Education is very important for the future development of the child as well as for the nation as they are the future asset of the nation. Majority of the children (87.96%) were interested to go to school. 13 children (12.4%) were not interested to go to school, these children needed interactive learning.
- Majority of the children have not repeated the grade, where as one third of the children have repeated the grade. Repeating the grade always has a negative effect on performance of the children.
- Relocation to a new school can be stressful, because newcomers to a school must learn about new school routines and academic standards. Children according to the number of Schools changed indicates that sixty five percent of children have changed 2 to 5 schools till the time they had come to the CGC. The reason for changing school was due to the long distance, dissatisfaction with the schools and transfer of jobs of their parents.
- Children according to the problems related to studies indicates that three fourth of the children (75.92 %) had poor memory and attention, 69.44 per cent had poor academic performance and 53.70 per cent were lacking motivation for studies.

- Facilities for Children regarding education indicate that about 70 percent children do not have separate room for study. These children's parents did not feel the need of having separate room for the study.
- Tuition is indeed beneficial for certain children who have difficulties in learning and grasping. The study indicates 55 percent children had the facility for the tuition.
- Play is a rite and a quality of mind in engaging with one's worldview. Children's involvement in play with others indicates more than one third children (81.48%) were involved in play where as 20 children (18.61 %) were not involved in play.
- Communication skills are the skills needed to use language to interact with others and communication disorders are problems related to the development of these skills. The study indicates that two third of children (69.44 %) were receptive and expressive in communication.
- Children and their issues are the first priority in every family. In an ideal family children are loved, cared and their needs are met. The study indicates that majority of the children (73.14 %) were able to manage all the self help skills.
- Socializing with friends and getting involved in activities outside of school are a big part among children. The study indicates majority of the children (90.74 %) were aware of their neighbourhood.
- Socializing with friends and getting involved in activities outside of school are a big part among the children of being socializing with others. The study indicates that two third of the children were friendly with their neighbours as well as with the school environment.
- Milestones are changes in specific physical and mental abilities (such as walking and understanding language) that mark the end of one developmental period and the beginning of another. The study indicates that almost two third of the children (72.22 %) had normal Early Development Milestones.
- People who suffered from early traumatic experiences did not have proper upbringing which have effected the family or cultural influences. The data reveals only one third of the children (30.55%) had normal birth and 14 children's (12.96%) mother's had high risk pregnancy, 10 children (9.25%) were kept in incubation, 9 children (8.33%) had illness soon after the birth and 8 children (7.40%) went through the delayed birth, 5 children (4.62%) had Diarrhoea with dehydration.

- Behavioural problems are on the rise nowadays among school going children due to unprecedented stresses, changing family structures, increasing pressure for achievements, influence of mass media etc. The study indicates that majority of the children's (83.33%) behaviour was acceptable and 9 children's (8.33%) behaviour was acceptable to some extent and 9 children's (8.33%) behaviour was not acceptable.
- Children according to the common behaviour problems indicates that three fourth (35.18%) of the children were engaged in lying, stealing, truancy and jealousy and 28.78 percent children were restless, disobedient and had poor attention.
- Specific learning disability means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or to do mathematical calculations. The study indicates 17.59 per cent children had learning problems and less than one fourth (12.96%) children were slow learners who needed guidance and assistance by professionals for improving the learning skills.
- The study indicates that the maximum children had consulted Social Worker and Psychiatrist followed by Special Educator and Psychologist. This indicates that the services of Social Worker and the Psychiatrist are very essential as they are exclusively involved in counselling.
- The study indicates that majority of the children (87.04%) received guidance at CGC, whereas 14 children (12.96%) were referred to other centres for the services as per their problems.
- Source of Referral to CGC indicates out of 108, 50 children were referred by various schools and other children came by various sources, such as self referral, advertisement, doctors / hospitals etc. This indicates that there is a need to create awareness among school teachers and principals regarding importance of child guidance centre for the promotion of positive child mental health, so that the problems of children to be identified at early stage and intervention services may be provided appropriately.
- The study indicates that majority of children had improvement in academics (51.85%) as well as in behaviour (41.66%). This indicates that there was a need of counselling for children as well as for parents for preventing learning and behavioural problems at the early stage.

CHAPTER 5

SUGGESTIONS AND RECOMMENDATIONS

5. SUGGESTIONS AND RECOMMENDATIONS

Many children are born in warm and loving homes with genetic traits that contribute to their growth and development. A number of theories seek to explain human growth and development and to predict success in life. Yet, with all the knowledge our society possesses concerning growth and development, the number of children encountering difficulties as they progress toward adulthood continues to grow. In addition to inherent developmental problems, the home environment, school, peer group and the society at large often contributes to children's difficulties. The problems of children are increasing with serious rapidity, giving cause for grave concern.

The developmental, learning and behavioral problems require individualized psycho-social interventions and certainly these cannot be addressed by the medical or health infrastructure. These needs specialized counselling and guidance services network to help children having various kinds of difficulties.

Services

The concept of mental health has expanded from its disease oriented model to encompass social, emotional and spiritual well being. At the beginning stage, the CGC concentrated its services around 10 kilometers of the centre. Later the CGC extended its services to longer areas covering entire Lucknow city. It needs to explore more areas and extend its services to all the other unexplored areas. Therefore mental health care needs to have planned services.

Para Professionals

The services of CGC were provided through multi disciplinary team viz. psychiatrist, Clinical psychologist, social worker and Special Educator. The team needs to regularize the home visits, school visits, hospitals and referral centres, in order to follow up the cases and give guidance. The Para Professionals not only require specialization in skills of providing interventions but also of planning program services that realistically address the needs of the clients. This requires redefining of Para Professionals roles, which will demand that they transfer skills to other Para Professionals in the community, schools etc. rather than deliver all the services themselves.

Assessment

The services included multi disciplinary clinical assessment and interventional services i.e. parent counselling, play therapy, behavior modification, medical interventions, remedial education, individualized educational planning and referrals.

Infrastructure

The centre has developed a good infrastructure and playroom (indoor and outdoor) for children with variety of play / educational materials according to needs of children. To create more attraction towards the centre more of pictures / posters, tips to parents / children need to display on the notice board.

Group Counselling

Plan to organize group counselling to parents having similar problematic children. This will help the parents to be sensitive towards each other and also plan group counselling for children and adolescents for child mental health.

Outreach Programs

The CGC had organized series of sensitization programs for school principals, teachers and parents as part of its advocacy program for promoting child's mental health. These advocacy programs were appreciated by school management and principals and they realized the dire need of effective counselling and guidance services in school premises to promote mental health and healthy development of children. During the year, CGC had conducted 12 orientation programs for teachers and staff on learning and behavioral problems of children including teachers training institute like DIET. These programs need to be continued and extended to other teachers training institutes, B.ed, M.ed centres, Social Work departments, Psychology departments and Hospitals.

Extension work

Once in a week the CGC staff also provides assessment and intervention services to children living in shelter homes, like Don Bosco – Ashalyam and Blue Heaven Children's home Lucknow. Today the focus is on development of services in local setting and in establishment of community support systems rather than clinical and institutional models of service delivery mechanism. Therefore, one of the visible strategies to ensure coverage could be to create linkage and integrate services in settings where children are already available i.e. child care programs, schools, juvenile homes, orphanages etc.

Linkage / Networking

The centre has built linkage with 90 schools in the city and majority of cases which come to CGC were referred by these schools for assessment and interventions. The para medicals need to have good rapport with these schools and continue to explore new schools and Children's home and Observation homes where the services have not yet reached.

Conclusion

Guidance is a universal need and one which is present at all stages of development. The young children need guidance to enable them to make a satisfactory transition from home to the school. At home the children are relatively free to do what they like and the social relationships are restricted mainly to their parents and siblings. In the school certain limits and controls are imposed. Here the children learn new social skills. Sometimes transition is not easy for some children. As a result of difficulties in adjustment at this stage, undesirable attitudes towards school and life may be developed which lead to more serious difficulties at a later stage. If children are given guidance at early stage of their life, it is likely that they will have fewer problems in later life or at least the problem will be less severe. The children at this stage are much more receptive and flexible and behavior patterns have not established.

Child Guidance Centre is a unique program in the State of Uttar Pradesh, so it was felt to document on activities of Child Guidance Centre for initiating counseling and guidance services to children in schools as essential services so that further this documentation be used for institutions working with children having difficulties in learning and behavioural problems.

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