EFFECTIVENESS OF MULTIDIMENSIONAL PROGRAM ON MENTAL HEALTH AMONG CHILDREN WITH BEHAVIORAL PROBLEM

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by

VANDANA V S

under the guidance of

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POST-GRADUATE AND RESEARCH DEPARTMENT OF PSYCHOLOGY

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TABLE OF CONTENTS

CHAPTERS	TOPICS	Page No.
	List of Tables	
	List of Figures	
	List of Appendices	
Chapter I	INTRODUCTION	
Chapter II	METHOD	
Chapter III	RESULTS AND DISCUSSION	
Chapter IV	SUMMARY AND CONCLUSION	
Chapter V	RECOMMENDATIONS	
	REFERENCES	
	APPENDICES	

LIST OF TABLES

Table No.	Title	Page No.
1	Socio demographic details of the participants	
2	Distribution of problem behavior based on gender	
3	Distribution of problem behavior based on age	
4	Response of presence or absence of behavior problem exhibited by case 1.	
5	Response of presence or absence of behavior problem exhibited by case 2.	
6	Response of presence or absence of behavior problem exhibited by case 3	
7	Response of presence or absence of behavior problem exhibited by case 4	
8	Response of presence or absence of behavior problem exhibited by case 5	
9	Response of presence or absence of behavior problem exhibited by case 6	
10	Mean age of participants / experimental and control groups	
11	Frequency distribution of gender among experimental and control groups	
12	Frequency distribution of siblings among experimental and control groups	
13	Frequency distribution of family status/ characteristics of participants among experimental and control groups	
14	Frequency distribution of substance abuse of parents among experimental and control group	
15	Comparing Occurrence of behavioral problems (DPCL) among children at Pre-test and Post-test Phases of the Intervention	
16	Comparing Factors of Family Interaction between Experimental Group (N =12) and Control Group (N =12) at Pre-Test Phase of the Intervention	
17	Scores of Family Interaction of Experimental Group (N =12) and Control Group (N=12) at Post-Test Phase of the Intervention	
18	Comparing Family Independence between Experimental Group and Control Group at Post-test Phase of the Intervention	
19	Comparing Family Cohesion between Experimental Group and Control Group at Post-test Phase of the Intervention	

20 Comparing Family Achievement Orientation between Experimental Group and Control Group at Post-test Phase of the Intervention

21 Comparing Family Intelligence Orientation between Experimental Group and Control Group at Post-test Phase of the Intervention

22 Comparing Family Conflict between Experimental Group and Control Group at Post-test Phase of the Intervention

23 Comparing Family Social Orientation between Experimental Group and Control Group at Post-test Phase of the Intervention

24 Comparing Family Ethical Complains between Experimental Group and Control Group at Post-test Phase of the Intervention

25 Comparing Family Discipline between Experimental Group and Control Group at Post-test Phase of the Intervention

26 Comparing Family Interaction (Total) between Experimental Group and Control Group at Post-test Phase of the Intervention

27 Comparing Factors of Adolescent Social Competence between Experimental Group (N =12) and Control Group (N =12) at Pre-Test Phase of the Intervention

28 Scores of Adolescent Social Competence between Experimental Group (N =12) and Control Group (N =12) at Post-Test Phase of the Intervention

29 Comparing School Competence between Experimental Group and Control Group at Post-test Phase of the Intervention

30 Comparing Team Organization between Experimental Group and Control Group at Post-test Phase of the Intervention

31 Comparing Gained scores of Peer Social Competence between Experimental Group and Control

32 Comparing Gained scores of Social Cognition between Experimental Group and Control

33 Comparing Gained scores of Home Related Competence between Experimental Group and Control

34 Comparing Gained scores of Social Forethought and Compassion between Experimental Group and Control

35 Comparing Social Emotional Competence between Experimental Group and Control Group at Post-test Phase of the Intervention

36 Comparing Social Flexibility between Experimental Group and Control Group at Post-test Phase of the Intervention

37 Comparing Social Competence between Experimental Group and Control Group at Post-test Phase of the Intervention

38 Comparing Factors of Difficulties in Emotion Regulation between Experimental Group (N =12) and Control Group (N =12) at Pre-Test Phase of the Intervention

39 Scores of Factors of Difficulties in Emotion Regulation between Experimental Group (N =12) and Control Group (N =12) at Post-Test Phase of the Intervention

40 Comparing Lack of Emotional Awareness between Experimental Group and Control Group at Post-test Phase of the Intervention

41 Comparing Lack of Emotional Clarity between Experimental Group and Control Group at Post-test Phase of the Intervention

42 Comparing Difficulties in Controlling Impulsive Behaviour When Distressed between Experimental Group and Control Group at Post-test Phase of the Intervention

43 Comparing Gained scores of Difficulties in Engaging Goal Directed Behaviour When Distressed between Experimental Group and Control

44 Comparing Gained scores of Non-Acceptance of Negative Emotional Response between Experimental Group and Control

45 Comparing Limited Access to Emotional Regulation Strategies between Experimental Group and Control Group at Post-test Phase of the Intervention

46 Comparing Difficulties in Emotion Regulation between Experimental Group and Control Group at Post-test Phase of the Intervention

LIST OF FIGURES

Figure No.	Title	Page No.
1	Phases of the study	
2	Diagrammatic representation of the response of presence or absence of behavior problem exhibited by case 1.	
3	Diagrammatic representation of the response of presence or absence of behavior problem exhibited by case 2.	
4	Diagrammatic representation of the response of presence or absence of behavior problem exhibited by case 3.	
5	Diagrammatic representation of the response of presence or absence of behavior problem exhibited by case 4	
6	Diagrammatic representation of the response of presence or absence of behavior problem exhibited by case 5.	
7	Diagrammatic representation of the response of presence or absence of behavior problem exhibited by case 6	
8	Scores of Family Independence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention	
9	Scores of Family Cohesion of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention	
10	Scores of Family Achievement Orientation of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention	
11	Scores of Family Intelligence Orientation of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention	
12	Scores of Family Conflict of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention	
13	Scores of Family Social Orientation of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention	
14	Scores of Family Ethical Complains of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention	
15	Scores of Family Discipline of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention	
16	Scores of Family Interaction (Total) of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention	

17 Scores of School Competence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

18 Scores of Team Organization of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

19 Scores of Peer Social Competence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

20 Scores of Social Cognition of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

21 Scores of Home Related Competence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

22 Scores of Social Forethought and Compassion of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

23 Scores of Social Emotional Competence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

24 Scores of Social Flexibility of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

25 Scores of Social Competence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

26 Scores of Lack of Emotional Awareness of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

27 Scores of Lack of Emotional Clarity of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

28 Scores of Difficulties in Controlling Impulsive Behaviour When Distressed of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

29 Scores of Difficulties in Engaging Goal Directed Behaviour When Distressed of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

30 Scores of Non-Acceptance of Negative Emotional Response of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

31 Scores of limited access to emotion regulation strategies response of control group and experimental group at Pre-test and Post-test phases of the intervention

32 Scores of Difficulties in Emotion Regulation of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention

LIST OF APPENDICES

Appendices	Title
A	**Screening Assessment Form**
B	**Consent Form**
C	**Personal Data Sheet**
D	**Youth Self-Report (YSR)**
E	**Developmental Psychopathological Checklist (DPCL)**
F	**Family Interaction Scale**
G	**Social Competence Scale**
H	**Difficulties in Emotion Regulation Scale**
I	**Copy of Paper Publication**

ABBREVIATIONS

DPCL	- Developmental psychopathological checklist
YSR	- Youth self-report
ER	- Emotion regulation
SPL	- Social emotional learning
EBD	- Emotional and behavioral disorder
FIS	- Family interaction scale
PMT	- Parent management training
SST	- Social skill Training
PSST	- Problem Solving Skill Training

Chapter 1

Introduction and Literature Review

- **Developmental Aspects of Children, Behavior and Behavioral Problems, Mental Health, and Multidimensional Program**
- **Literature review**
- **Rationale of the study**
- **Research questions**
- **Objectives**
- **Hypotheses**
- **Definitions of key terms**

Chapter 2

Method

Research design

- **Phases of study**
    - **Participants**
    - **Measures**
    - **Administration and procedures**
- **Statistical analysis**
- **Multidimensional Intervention Program module**

Chapter 3

Results and Discussion

- **Analysis of phase I: Pilot study**

    Section A: Descriptive analysis

    Section B- Case Summary

- **Analysis of Phase II: The Multidimensional Program** - descriptive and Inferential analysis (parametric and non-parametric tests) for comparing means

    Section A: Analysis of socio demographic data- frequency and percentage

    Section B: Analysis of developmental psychopathological checklist- Chi square test

    Section C: Effectiveness of multidimensional intervention program on family interaction, social competence, and difficulties in emotion regulation- Independent sample test, Mann -Whitney U test, and ANCOVA.

Chapter 4

Summary and Conclusions

- Resume of the study
- Objectives
- Participants
- Measures for the study
- Procedure
- Statistical analysis
- Major findings
- Tenability of hypotheses
- Conclusion

Chapter 5

Recommendations

- **Recommendation**
- **Implication of the study**
- **Limitations**
- **Suggestion for future research**

Abstract

The behavior of school-aged children is an essential indicator of adaptation in the development; conversely, not all students are successful and may present externalizing or internalizing behavioral problems, articulated within the family or school frameworks. The alarming rise in the number of students having insufficient consideration from mental health professionals for managing their mental health problems remain under consideration. McLeod & Kaiser (2004) stated that the behavioral problems can have many symptoms which include: disobedient behavior, carelessness, disinterest in daily activities, poor emotion expression, low self-esteem or overconfidence, self-injury or harming others. Beside these problems there are many more symptoms of behavioral problems in children such as internalizing (defiant) or externalizing (aggression) problems. Behavioral problems are often expressed in many different ways in girls and boys. Boys may get in fights, harm or steal while girls may lie or break things at home (Sheldrick et al., 2011). As these problems remain unresolved at the earlier stages itself, it will lead to deviant psychological issues in later life, thus resulting in poor mental health. Based on the reviews related to behavioral problems among children, found different psychological factors related with the behavioral issues among children. Among the variables, family, social and emotional factors were found as significant elements to developing the behavioral problems among children, hence the study variables were selected as Developmental Psychopathological Checklists (DPCL) for assessing behavioral problem, and family interaction, social competence, and difficulties in emotional regulation as mental health components. Even Though there researched different interventions for treating children with behavioral problems, a combined form of intervention was lacking in the

intervention level. Hence, the researcher formulated a multidimensional intervention approach including parent management, social skill training, and mindfulness training for intervention among children with behavioral problem thus focusing on the enhancement of mental health among children. The study was aimed to assess the 'Effectiveness of Multidimensional Programs on Mental Health among Children with Behavioral Problem'.

The study was conducted in two phases. During the initial phase, known as the pilot phase, two sections were conducted. Section A involved assessing behavioral problems among school children within the group. The participants were selected among different schools in Thrissur district. The Youth Self Report (YSR) was used to assess the behavioral problems among children. A sample of 228 children, within the age of 11-16 years with 134 boys and 94 girls participated in the study, and the result found that behavioral problems, especially the externalizing behavioral problem were more frequent among children, and is higher among boys than girls. In the section B, a trial study of intervention was conducted among children with behavioral problem. It was recommended that before conducting the actual intervention phase, there should demonstrate a trial intervention study in order to find out the efficacy of intervention modules to be implemented among children with behavioral problems. Hence, the researcher conducted the second section of phase I. For this purpose, the researcher selected participants by Developmental Psychopathological Checklist (DPCL), and the scores obtained in the conduct problem behavior, as it is more suitable with behavioral problems. The participants were selected after the screening of developmental psychopathological checklist, and assessment with school counselors and parents. The researcher established rapport with both children and parents, and informed consent was collected from them. The second section was conducted among six participants,

within the age of 13-15 years with 5 boys and 1 girl. The participant; both parents and children were trained with intervention strategies to reduce behavioral problems. Parents were given ten sessions of parental training, and children were given six sessions of behavioral training. A pre-post assessment of behavioral problems was assessed by the researcher. The results indicated a significant improvement in behavioral problems among participants.

Based on the pilot study, certain modifications were done by the researcher in the intervention module. A combined approach was adopted as the mental health issues concerned with different aspects of psychological issues among children. Thus, the second phase, the multidimensional intervention phase included different intervention sessions like parent management training for parents, social skill training and mindfulness training for children were incorporated in the module. As it was the Covid 19 pandemic conditions, the study was conducted through online mode. With the help of school counselors, a google form of screening assessment was circulated in the school groups, and the participants were selected based on the criterion score in DPCL checklist. A purposive sampling method was adopted for selecting the participants for the study. After the contact with parents, and their consent 24 participants, with the age of 13-15 years were finalized in the third phase. And the participants were randomly assigned to both experimental (n=-12,), and control (n=12) groups, with nine boys and three girls in each group. Hence a pre-test post -test control group design was adopted in the research design. The results indicated that the multidimensional intervention was found significantly effective to reduce behavioral problems, and improve mental health in the aspects of family interaction, social competence, and better emotion regulation skills. The result indicates significant improvements in behavior like disobedience, quarrelsome behavior, aggression, temper tantrums, disruptiveness, and stubbornness

among the experimental groups. Additionally, no significant differences were observed in behavior related to lying, stealing, and truancy post-intervention. The intervention also had a positive impact on family interaction, emotional regulation, and social competence among children with behavioral problems in the experimental group compared to the control group.

Key terms: *Mental health, children, behavioral problem, multidimensional program*

"When our little people are overwhelmed with big emotions, it is our job to share our calm, not join their chaos" - L. R. Knost.

The future of the young generation, the children, is the focus of a nation's growth and development. The environment, including the family and society, frequently works to mould children by providing them with the favorable circumstances necessary for them to reach their maximum potential. Every community has a unique responsibility for the overall health of children and the facilities they make accessible to satisfy those requirements, particularly during adolescence. Children's and teens' behavior has long been a concern for older generations. The shift from "miniature adults" to the "child study movement" emphasizes the maturation of children's development and cognition (Jansz & van Drunen 2004).

Because of various laws and policies, the idea of childhood has been somewhat ambiguous. The ages of childhood vary from not less than 14 years, not less than 18 years, and not less than 21 years. In India, as per "National Policy for Children-2013," a child is anyone below 18 years of old (Ministry of Women and Child Development, 2013). According to the Juvenile Justice (Care and Protection of Children) Act (2000), a child or juvenile is defined as an individual who has not completed 18 years of age. The legislation addresses juveniles involved in legal conflicts and those requiring care and protection. It seeks to ensure the proper nurturing, safeguarding, and management of juveniles, addressing their developmental needs through a child-friendly approach. The Act emphasizes deciding and handling matters in the best interest of children, focusing on their eventual rehabilitation (Ministry of Law, Justice, and Company Affairs, 2000).

Childhood is a period of pseudo-maturity during which a child experiences profound changes in their physical and mental development, as well as improvements in

their self-awareness and interpersonal comprehension. Compared to when they were newborns, children nowadays have a far higher level of environmental adaptation. Children experience a wide range of behavior, abilities, attitudes, and situations that affect their capacity for adaptation during their lives. As a result, early encounters have an impact on both psychological and cognitive abilities. Children spent most of their time in school, where they learned things. They learn to adapt to new skills, values, responsibilities, and emotional and social challenges, which thus promotes their overall mental health. Parenting, social, and environmental factors are also influencing the formation of behavior among children. Nowadays, the identification of behavioral problems is crucial among children, and effective intervention has been implemented properly since mental health among children is a concern. Childhood refers to the stage of enriching healthy development, and many adult mental health problems manifest during this age, so it is necessary to look after the well-being of the group (David,2013).

Developmental Aspects of Children

Child development encompasses various facets, like physical, emotional, social, and cognitive dimensions, all of which contribute to the overall mental health of children. The current study specifically emphasizes the emotional and social development of children, recognizing their role in shaping behavior among this demographic.

Emotional Development

Emotional development pertains to a person's ability to comprehend, express, and manage emotions across different stages of life, along with demonstrating empathy towards the emotions of others. Interactions with parents, siblings, and classmates have a large effect on this developmental process, which involves both positive and negative emotions. It is a key part of human development that involves dynamic internal

modifications for the individual's well-being. Emotional development is multidimensional, comprising physiological, behavioral, cognitive, and attitudinal components, as well as control and coping methods. Our views, as naturally emotional creatures, lead and influence our conduct, with emotions such as love, rage, and fear having an important role in defining an individual's personality, particularly during childhood development (Saikia, 2019).

Emotion can be described as the complex psychophysiological encounter reflecting an individual's mental state as influenced by both internal and external factors. Alternatively, emotion is the sensation or affect that arises when a person is engaged in a situation or interaction that holds significance for them, particularly concerning their well-being (Campos et al., 2004). During the early childhood years, children tend to be inherently self-centred, responding defensively when their ego is under attack or when there's an attempt to encroach upon what they perceive as rightfully theirs. Such reactions can lead to emotional disturbances and an overall imbalance, potentially resulting in further complications. Therefore, it becomes the responsibility of parents, caretakers, or teachers to guide children in learning how to manage and control their emotions, and specific activities designed for this purpose should be implemented. Social and emotional development often go hand in hand. Engaging children in activities like group play, games, storytelling, drawing and painting competitions, exploring significant places together, and participating in collective singing and dancing can play a key role in fostering emotional growth. Through these diverse activities, parents, teachers, and other social sources can significantly contribute to the emotional development of children (Laxmi Devi, 1998).

Social Development

Humans are inherently social beings, finding companionship and safety within the structure of a society alongside their family members. As a child represents the future adult member of society, it becomes crucial for parents, teachers, and other adults to facilitate the development of social qualities in them. This involves fostering proper relationships with peers and elders, promoting harmonious living within the community, and instilling a sense of self-realization and security. Such positive relationships in social interaction with peer groups and teachers lead them to have a positive self-concept, better interpersonal relationships, and overall, wellbeing (Carr, 2006). And also, poor social interaction with others results in inadequate behavioral manifestation either in school, home, or social situations (Hosogi et al., 2012; Furlong et al., 2004; Gresham & Kern, 2004;).

In order to cultivate a socially desirable personality, children must acquire good social habits and manners. Due to their youth, it is imperative for adults to create both direct and indirect initiatives aimed at fostering these attributes in children. Regular engagement with older individuals and active involvement in social activities are integral elements of this developmental journey. Societies vary in their expectations regarding the behavior and manners of their members. Children are expected to grow and develop in accordance with the norms set by their respective societies, even when these norms differ from those of other societies (Martindale et al., 2013). The social feature is relative and subject to alteration based on the evolving needs of the time. Norms could endure frequent and subtle changes, driven by the majority's perception. Adapting to these norms is essential to avoid being labelled as unsocial. When children’s social behavior is judged inappropriately by others, the individual is considered to have problems with social skills, which in turn affects their social skill development and

competence. Such potential for rejection by others puts them at risk of developing different mental health problems (Anita et al., 2011). Violating societal laws classifies an individual as anti-social, leading to exclusion from the community. Hence, it is crucial to develop programs that integrate elements like games, play, storytelling, and singing. These initiatives will facilitate children's social development, aligning with societal expectations, enhancing interpersonal relations, communication skills, and fostering empathy. (Lawson, 2003; Erol & Drth, 2011).

Social development initiates at birth and persists throughout one's life. As newborn human biological entities enter the world with inherent traits and needs, these needs evolve as they grow. Society, from its perspective, engages in the process of socializing individuals to seamlessly integrate into organized ways of life. Hence, social skills are considered an important aspect of development among children, as they are designed to form behavior among them. Effective interpersonal relationships, communication skills, problem solving, and conflict resolution are some of the skills acquired by children during the process of social skill development. And all these factors are also the fundamental aspects of overall mental health among children.

The role of social and emotional development is important in shaping the behavior of children, influencing their overall well-being, and their interactions with the world around them. Social development involves the acquisition of skills and understanding, maintaining relationships, comprehending social cues, and cooperating in group settings. Emotional development, on the other hand, focuses on the child's awareness, expression, regulation of their emotions, and ability to recognize and empathize with the emotions of others. In essence, fostering healthy social and emotional development in children is essential for cultivating positive behavior and thus contributing to the overall wellbeing and mental health of children.

Behavior

Behavior is how a person responds to a given circumstance or interaction. Behavior is the term used to describe the action or response that objects and people take in response to internal and external stimuli. Behavior is outlined as "any observable overt movement of the organism, generally taken to include verbal behavior as well as physical movements" (Bergner, 2011). According to Parrish (2014), behavior has been characterized as "the sum total of the psyche that includes impulses, motivations, wishes, drives, instincts, and cravings as expressed by a person's behavior or motor activity'. A person can be observed engaging in certain behavior. Every behavior a person exhibits is an action. For instance, sitting, yelling, laughing, etc. are also different forms of behavior. What has been observed is described in a behavioral account that describes behavior. It makes no attempt to explain or analyze the action. Additionally, it doesn't discuss the observer's response to the behavior. Behavior in and of itself is neither good nor evil. We assess it as either positive or negative. Behavior is, therefore, something that can be measured and observed. Any kind of deviation in behavior often leads to behavioral problems, and most behavioral issues are formed and identified during the early stages of life, the child and adolescent stages.

Behavioral Problems

As per David Cottrell's and Field's definition in 2011, a behavioral problem is characterized by a quantitative deviation in behavior, thoughts, or feelings from the established norm. Childhood, being a phase of dependency, involves a gradual learning process for children to adapt to their environment. According to Wellestine (Goswami, 2017), "all those children whose behavior and personalities are so abnormal that they become the creators of problems in the home, school, and society are named as problem children. When the problem becomes habitual, the child is called a problem child. They

can be reformed by proper guidance; otherwise, they can develop criminal and antisocial tendencies" (Bhargava, 1994). The behavioral problems in the school context are explained by the terms of the teacher's evaluation; as Eaton et al., (1957) define "problem behavior" as "all forms of misbehaviour in school, including violations of moral standards, rule violations, and work requirements." The 'problem behavior' could be a judgmental factor for teachers when assessing a child with deviated behavior (Woody, 1969). Hence, there are some noticeable limitations associated with using the term problem behavior in children; a satisfactory concept of definition has been formulated. As such, every behavior that disrupts the teaching-learning process and limits the individual to work efficiently, is considered a behavioral problem.

Social, emotional, and behavioral difficulties are the most unique problems in the educational sphere, which could be associated with a level of fear, frustration, guilt, blame, and anger (Cooper et al., 1999). However, complications arise when they encounter challenges that disrupt their ability to adjust to their surroundings. In such instances, children may struggle to behave in a socially acceptable manner, leading to the development of behavioral problems. A child's behavioral issues often signify a conflict between their evolving personality and the expectations set by parents, teachers, peers, siblings, and other children they interact with. The behavior of the child is molded by the remarks of these people (Parul Datta, 2009). Children who experience security and emotional fulfillment in their home relationships are typically less prone to developing behavioral problems. A child receives rewards for acting in accordance with their expectations and punishment for not doing so. The society in which a child lives influences his moral, social, and religious ideals. If the child is able to follow the social norms that have been established, he is welcomed, and family life will go smoothly; however, if he or she resists, the conflict begins, and he or she is classified as a problem

child. Behavior problems in children occur when they deviate from the expected norms of behavior, failing to conform to societal expectations. Such unhelpful behavior can be detrimental to both the individual and society, upsetting other community members and defying accepted social norms and expectations (Verma, 1964).

In most cases, what an adult could describe as a behavioral issue in a youngster is actually quite normal for that age group of kids. If a young individual behaves in a manner consistent with their age group, there is no cause for concern regarding their behavior. Nevertheless, as these are simply indicators or responses to emotional and environmental stress, they should not be linked to the child having a behavioral problem. Yet, if these behavior persist over an extended period, it is likely that the individual is experiencing some kind of mental health difficulty both at school and at home. According to Gongala (2017), determining normal behavior lacks a fixed standard. It is contingent upon factors such as a child's age, personality, emotional development, and the upbringing environment provided by parents. Generally, the perception is that a child's behavior is considered normal when it aligns with social, developmental, and cultural norms. Even if a child's behavior deviates from societal or cultural expectations, it may still be deemed normal as long as it is age-appropriate and non-harmful to others. A behavior issue is any type of behavior that is out of line with the child's age and stage of development. For example, thumb sucking is not an issue in a child under the age of one year, but if the child is still sucking his thumb at the age of five, it usually means that something is amiss. Children with behavior problems deviate from the expected course of behavior since they are growing up in a social and culturally diverse setting. It's crucial to recognize that children displaying behavioral issues are not entirely distinct from those who exhibit typical behavior. There is not a clear-cut boundary separating them from their peer group because almost every child exhibits challenging behavior at

various stages of development. It Is evident that virtually every child, at some point, may tell lies or engage in mischievous behavior for various reasons. Therefore, categorizing one as entirely problematic and another as entirely normal is not a desirable approach. It's common for young children to display mischievous and challenging behavior early in life, but as they grow older, these tendencies often diminish, and they no longer appear to be problem children. These distorted and deviated problem behavior of children are sometimes characterized based on age, the circumstances, and the nature of the place. Thus, children with behavioral problems can be defined in different ways.

Behavioral problem Children are individuals who, due to their inability to cope with external demands and stressors, often stemming from a lack of coping mechanisms, experience significant psychological impact on their personal, personality, and intellectual development. These challenges manifest in problematic behavior, which can adversely affect both the child and those around them. These deviated forms of behavior include stealing, lying, bullying weaker peers, neglecting homework, school avoidance, temper tantrums, selective mutism, shyness, and other conduct issues, reflecting deficiencies in both character and personality (Goswami, 2017). There are different types of behavior problems, like aggression, skipping school, bullying, lying and stealing, violating rules and regulations at school and home, not obeying elders, etc., which are unacceptable and inappropriate to their age and are reported as serious concerns for teachers and parents. This kind of behavior resulted in malpractice of social functioning, ineffective family functioning, poor academic performance, and poor mental health in the children too.

The treatment of young people with emotional and behavioral problems is very costly and emotionally exhausting (National Institute of Health, 2001). Neglecting these issues can lead to the development of disorders that create constant worry for not only

the affected children but also for their families, schools, and communities as well (WHO, 1977; Cummings et al., 2003). Recent research shows that emotional and behavioral issues commonly result in poor academic performance and school dropout. This wastes educational resources and substantially limits the ability of such children to succeed economically and socially. Behavior issues, such as fighting, using harsh language, and delinquent activity, are generally present in schoolchildren. As such behavior formation is regarded as a major concern for the progress of mental health among children, the behavioral problems among children were the focus of the present study.

Classifications of Behavioral Problems

Behavioral problems among children are often noticed at home and school. The occurrence of behavior problems varies with duration, intensity, severity, and also in different forms, ranging in severity from mild to severe (Nikapota & Egdell, 1991). Mild forms of behavioral issues could be seen in the adjustment behavior of the individual. Whenever these mild forms of behavior problems are not noticed and untreated in the early stages of life, they are then classified as some kind of severe behavioral issue in later life. The different forms of behavioral classification are:

- Emotional and behavioral problems are the most common mental health problems in childhood, especially between the ages of 4 and 17. The identification of young people at risk for emotional and behavioral issues has grown more than ever before (Carli et al., 2014). The search for childhood and adolescent emotional and behavioral issues has grown, yet few of these issues fall under the purview of professional treatment services (Anglod et al., 1999). The period of onset of behavioral problems is between 10 and 19 years, which is the transition from childhood to the adolescents' stage (Silinskas et al., 2020). In longitudinal and cross-sectional studies, most behavioral problems begin at the age of 12 and extend

to middle adolescence (Achenbach & Rescorla, 2001; Ostello et al., 2003; Zahn-Waxler et al., 2008).

- Behavioral problems can be categorized as lying, aggressive or acting out behavior, irresponsibility, problems in academics, cheating and stealing, difficulty in peer relationships, and depression (Bullock et al., 1985).
- Behavioral problems among children and adolescents are clinically relevant and often described under two dimensions, like aggression versus inhibition (Miller, 1967) and under control versus overcontrol (Achenbach & Edelbrock, 1978).
- Even though there are different types of behavioral problems, the most accepted classification of behavioral problems is postulated by the theoretical perspective of the developmental psychopathological framework as externalizing problems and internalizing problems (Nunes et al.,2013; Achenbach & Rescorla, 2001; Ogundele 2018; and Merrell 2007).

Internalizing Behavior**:** Internalizing behavior problems in children are characterized by inner emotional distress that may not be readily apparent to others. Internalizing problems are characterized by excessive control or overcontrol of emotions, thoughts, and behavior among young people (Achenbach et al., 1991). These problems manifest as behavior that are overly controlled and primarily affect the child themselves. Examples include anxiety, social withdrawal, inhibition, depression, excessive shyness, selective mutism, timidity, laziness, and frequent crying. Internalizing behavior problems cause subjective distress and psychological pain in children, victimizing them without necessarily harming others, and limited social experiences create obstacles for social and psychological well-being in childhood (Aunola & Nurmi, 2005). Prasad Babu et al. (2019) state that emotional problems, such as anxiety, excessive fear, phobia, heightened sensitivity, shyness, timidity, difficulty

in forming friendships, social withdrawal, mood swings, depression, daydreaming, nail-biting, thumb-sucking, jealousy, school refusal, soiling, emotional factors, and physical illness, can be identified as internalizing behavioral problems. Achenbach (1966) states that social withdrawal, anxiety, depression, and somatic complaints are mentioned as internalizing behavioral problems.

However, they can be challenging for parents, teachers, and society as a whole. Symptoms of internalizing behavior problems include hesitancy, stammering, school avoidance, frustration, fearfulness, thumb sucking, social isolation, frequent weeping, anxiety, physical complaints, and daydreaming. Children with internalizing behavior problems tend to be more introverted, self-contained, and inclined to be alone (Shankar, 1978). They are often less affected by external events and more by their inner experiences. Some impulsive children may also experience emotional disturbances, displaying aggression and hostility either towards others or directed inward, causing self-suffering. These tendencies among children are becoming increasingly common in contemporary society.

Externalizing Behavior Problems: Externalizing behavior problems are common among primary school children and are easily observable by laypeople due to their outward and conspicuous nature, conflict within the environment (Achenbach & Rescorla, 2001), and disturbing the individual's self (Siu, 2007). Children exhibiting externalizing problems typically struggle with limited control or being under control over their cognitive states, emotions, thoughts, and behavior (Achenbach & Edelbrock, 1978). These difficulties, stemming from reduced control, frequently manifest as aggression, impulsive behavior, antisocial tendencies, and challenging behavior, causing emotional distress to others.

Externalizing behavior problems include three types of issues, such as hyperactivity, conduct problems, and oppositional behavior. The intensity and frequency of these behavior lead to the diagnosis of attention deficit hyperactivity disorder, conduct disorder, and oppositional defiant disorder, respectively (APA, 2013). These problems are superficial and have a noticeable impact on others and the environment due to the child's acting-out behavior. Children with externalizing behavior problems may struggle to socialize, engage in illegal activities, and exhibit symptoms such as indecent language, destructiveness, abuse, quarrelsomeness, theft tendencies, fraudulence, rule-breaking, poor school performance, teasing, lying, discontent, and anger (Arthur et al., 2002); aggressiveness, juvenile delinquency, Achenbach (1991); Guttmann ova et al. (2008); Cowan et al., 1996; Zhang et al., 2002). In essence, externalizing behavior problems refer to behavioral issues that are directed outward and are readily apparent to those around the child. Behavioral problems, more prevalent among high school students, encompass behavior like lying, stealing, demanding and stubborn temper tantrums, aggression, truancy, and engagement in gang activities (Prasad Babu et al., 2016).

Children with externalized behavior exhibit outward behavior with a negative effect on the external environment (Eisenberg et al., 2001); hyperactive, aggressive, and disruptive behavior (Hinshaw, 1987; Frick et al.,1993); emotional distress (Orme & Buehler, 2001), which results in maladaptive forms of social expression (Walker et al., 2004). As per the National Research Council and Institute of Medicine (2009), behavior like aggression and non-cooperation pose a risk for both externalizing and internalizing issues in children. Children who are socialized to employ coercive behavior within their family dynamics are at a higher risk of carrying these same techniques into interactions outside the family, thus perpetuating their problematic

behavior. Certain parenting practices, such as the use of physical discipline or inconsistent disciplinary strategies, have been associated with externalizing behavior problems in children (Patterson et al., 1992). Gravener et al. (2012) discovered that parents exert one of the most significant influences on the functioning of children and adolescents. Environments marked by the consistent minimization or dismissal of emotions have been associated with externalizing behavior problems. Their research also indicated that maternally expressed emotion is related to a child's externalizing symptoms, further underlining the importance of parental influence on a child's emotional and behavioral development.

Although some rebellious and deviant behavior is a typical factor in human development, certain children and adolescents exhibit behavior that is not regarded as normal. In these situations, behavior can go to extremes and produce serious issues for the individual, their peers, family, teachers, and the community as a whole. Chronic disrespect for authority figures and, in more severe situations, violations of others' fundamental rights are characteristics of these people. Their actions may have long-term effects that will affect their ability to lead fulfilling lives as adults. They face a significant risk of experiencing various social and emotional issues, as well as physical and occupational trauma. (Jermund Norberg, 2010). Later on, this behavior became a medical diagnosis, and now it is considered one of the most extensive works on behavioral issues, adapting more intervention strategies among the group (Thomas 2010). Children who exhibit high levels of aggression, resistance, and impulsivity during their early years are more likely to engage in major antisocial behavior as adolescents and adults and to commit crimes. Adolescence is a period during which the risk of emotional and behavioral problems increases (Azadyekta, 2011; Bongers et al., 2008; Fairchild et al., 2009; Lubenko & Sebre, 2010).

In summary, internalizing behavior problems refer to behavioral issues that are directed inward, affecting the child's emotional and psychological well-being and mental health. Since behavioral problems are considered crucial for children's mental health, the need to get involved in these issues is significant. Both internalizing (inability to control negative feelings) and externalizing behavioral (problems with controlling unwanted conduct) problems result in dysfunctional emotions, behavior, and interpersonal relationships (WHO, 2017; Eisenberg et al., 2001). Some children who have developed behavioral problems in their early childhood years eventually resolve themselves, but for some children, it could lead to a poor prognosis and be associated with poor mental health and an economic burden for the individual, family, and society as a whole (Scott et al., 2001; Romeo et al., 2006). Hence, the present study focuses on behavioral issues and the intervention strategies to be applied for budding mental health among children. The behavioral problems, especially the externalized features of problems, were taken for the present study.

Causal Factors of Behavioral Problem

Children at the early middle school stage (11 years onwards) literally correspond to early adolescents' stages, which reflect notable psychological conflicts because of the fundamentally confusing transition from childhood to adulthood. There are multiple risk factors for developing behavioral problems among children. Research has pointed out that the development and maintenance of behavioral problems are becoming worse due to different psycho-social factors like parental psychopathology, parental discord, parental acceptance and negligence, and socio-economic factors (Kern, 2015). The behavioral problems among children result in poor mental health. There are so many factors that postulate behavioral problems among children. Childhood behavioral problems obstruct their healthy development of emotional,

social, and cognitive competencies (Wenar & Kerig, 2000; Huang et al., 2003). The primary focus of this study is to examine the influence of family, social and emotional factors on the mental health of children exhibiting behavioral problems, building on previous research finding that suggests these elements play significant causative roles in such conditions. The causal factors for behavioral problems are classified as follows:

- Family interaction and behavioral problems
- Social competence and behavioral problems
- Emotion regulation and behavioral problems

1. Family Interactions and Behavioral Problems. The transition period from childhood to adolescence is a crucial period where they need emotional support from their parents. From an ecological and social system perspective, the most important socializing institutions are family and school (Bronfenbrenner, 1986; Moos, 1990). The ecological model explains the function of environmental settings and family functioning (Meyers et al., 2002). The fundamental unit of analysis in the model is the microsystem, which denotes the immediate and perceived environment of an individual (e.g., how an individual's personality traits impact family interactions). Moving to a broader level, there is the mesosystem, representing the interconnections between multiple microsystems (e.g., the impact of spousal relationships on parent-child interactions). Microsystems and mesosystems are situated within ecosystems, encompassing settings with indirect effects on family interactions (e.g., how a parent's work patterns influence relationships among family members). Finally, the macrosystem pertains to the predominant economic, political, cultural, and social forces that shape individuals (e.g., the influence of social and economic class on family functioning). This ecological perspective aligns with systems theories that form the foundation of many family-related interventions. (Bronfenbrenner, 1979). And thus, it

helps to explore the psychosocial factors that affect the relationship between child development and parenting (Belsky, 1996; Meyers, 1999; Woodworth et al., 1996).

The family is accompanied by the crucial period of children and adolescents, especially when they are in a stage of vulnerability and opportunity. Families are social units characterized by intimate interdependence, selective boundary maintenance, the capacity to change and maintain their identity over time, and the accomplishment of family tasks. Families are groups connected by kinship, residence, or strong emotional bonds (Mattwssich & Hill 1987). Eitzen (2003) defines family as 'a construct of meaningful relationships. Family functioning and individual behavior are strongly connected to each other. Because family is the key source for protecting, guiding, and supporting the children (Petzold, 1998). Whole-family interactions play a significant but relatively understudied role in the development of childhood psychopathology. Emerging research suggests that family dynamics like cohesion, conflict, and control can impact developmental processes (Halpern, 2004).

The family interaction contexts explain two systems: the dyadic context and the triadic context (Lindsey & Caldera, 2006). In the dyadic family context, family interactions like mother-child, father-child, and sibling interactions persist, whereas the triadic context has interactions with more than two individuals (Clarke-Stewart, 1978), which could not capture the dynamics of whole family interactions. Both parental figures appear to be less responsive, less involved, less affectionate, and express negative emotion in triadic interactions than in dyadic contexts (Goldberg et al., 2002), and there is less mother-child engagement across developmental stages (Mc Hale & Rasmussen, 1998; Smetana et al., 2000). These family dynamics and patterns of interaction can significantly influence a child's emotional and behavioral development, potentially contributing to the emergence of mental health challenges and behavioral

issues in children. There are a number of mental health problems related to family interaction constructs like low cohesion, low enmeshment, conflict, low expressiveness, low organization, and control, especially with behavioral problems (Halpern, 2004; Pettit & Bates, 1989; Schoppe et al., 2001), which results in poor academic performance (Smith et al.,2001) and difficulties with social functioning (Feldman & Masalha, 2010; Johnson, 2005) among children. Family organization at an early stage of life predicts externalizing behavioral problems in later life (Johnson et al., 1999). Gravener et al. (2012) explained the role of parents in influencing better mental health functioning among children and adolescents. Externalizing behavioral issues are connected to the persistently limited expression of emotions by parents, especially maternal emotional expression linked to problem behavior among children. Understanding and addressing these family-level factors is crucial for promoting positive mental health outcomes in children.

The family is highlighted as a fundamental social platform that significantly influences children's overall development. It serves as the primary social environment within which children grow and learn (Baumrind, 1978; Paulissen et al., 2008). Both maternal and paternal interaction can lead to variations in a child's behavior (Cummings et al., 2000; Rinaldi & Howe, 2012). The way parents interact with and raise their children can have a profound impact on the development of various behavioral traits.

Factors Influencing Family Interaction and Behavioral Problems

a. Parenting Practices. Different types of parenting strategies are associated with a risk factor for developing different behavioral problems among children (Frick et al., 1993; Hoge & Andrews, 1992; Loeber & Lahe, 1987). Parenting strategies like punitive discipline (nagging, yelling, and threatening), inconsistent parenting, warmth and positive involvement parenting, physical aggression in the form of hitting and

beating, and remarkable or good parenting are involved in the molding of behavior among children (Patterson, 1986; Patterson & Stouthamer-Loeber, 1984). The effect of different parenting strategies is explained by Wahler & Dumas's (1986) predictability hypothesis model of developmental mechanisms, which suggests that when children are faced with inconsistent and unpredictable parents, they tend to express oppositional, defiant, and aggressive behavior with the intention of eliciting predictable, though often negative, responses from their parents. Certain parenting techniques, like physical punishment or uneven discipline tactics, have been linked to children's externalizing behavior issues. These practices can contribute to children adopting coercive or aggressive behavior, leading to difficulties in their interactions with peers, teachers, and others in their social environment. Recognizing the influence of parenting practices on children's behavior is crucial for implementing effective strategies to address and reduce behavior problems in children.

Harsh punitive parenting characterized by extreme physical and verbal aggression is related with the development of children's maladaptive aggressive behavior. According to parental psychopathology (Kazdin, 1995b; Robins & Price, 1991; Rutter & Giller, 1983), child abuse, negligence, alcohol dependence, and substance abuse among parents are associated with behavioral problems in children. Divorce itself is considered a risk factor, but the persistence of hostility, resentment, and hostility between divorced parents is also mentioned as a contributor to maladaptive behavior. Parents may be negligent if a child's care is shared by relatives or assumed by foster parents (Kazdin, 2005). In addition, antisocial children often have unhappy marital relationships, interpersonal conflicts, and aggression in their parental relationships. Furthermore, poor parental supervision and monitoring of the child and

knowledge of the child's whereabouts are also associated with externalized behavioral problems.

b. Parenting Communication. Adolescents may occasionally revert to earlier coping patterns, which means they may exhibit behavior or reactions that seem reminiscent of their earlier years. This can happen during moments of stress or uncertainty. Despite appearing aloof or unaffected by parental values, teenagers are strongly influenced by the attitudes, values, and behavior modelled by their adult caregivers. Parents continue to have a significant impact on their children's development even as they grow older. It is emphasized that adults, particularly parents, should open lines of communication with teenagers and be mindful of the values and behavior they demonstrate. Parents serve as role models for their children, and their actions can shape their children's values and behavior. During this transitional period, teenagers may require increased nurturing, communication demands (Rimm-Kaseman & Pianta, 2000), and support from their parents. Providing a supportive and understanding environment can help teenagers to direct the challenges of adolescence. Children reread in confused and neglectful environments, with poor parental communication frequently struggle with emotional regulation, leading to difficulties in managing emotions such as anger, frustration, and sadness. Families with aggressive children often display a recurring pattern of impulsive and unpredictable verbal and physical hostility (Kaplan & Sadock, 1998).

Hence, effective communication and positive role modelling by adults can have a lasting impact on a teenager's values and behavior as they continue to mature (Hazen et al., 2008).

c. Parental Attachment. Developmental psychologists and social neuroscientists have put forth the hypothesis that empathy and sympathetic concern, which originate within

the family, play vital roles in inhibiting aggression towards others. Insecure parental attachment at early stages of life leads to disruptive behavioral problems, aggressive patterns of behavior and delinquency, limited activation of empathy, and interactions with others (Fonagy & Target, 1997); Lyons-Ruth, 1996); and the offending and non-offending teenager's behavior and attitudes are influenced by attachment and social bonding characteristics (Cota-Rambles & Gamble, 2006; Utting, 1996; Kandel & Wu, 1995). Distress in the family often predicts delinquent behavior among children (Bartlett et al., 2006; Kim & Kim, 2008); problems with anger management (Thornberry et al., 1999).

Responsiveness in parenting is a key aspect, involving a caregiver's capacity to interact with an infant in a manner that aligns with the child's behavioral and emotional requirements. This encompasses the quality of response, the developmental appropriateness, the timing, and the consistency of reactions. Adequate responsiveness to an infant's needs is believed to play a significant role in fostering the development of self-regulation skills. A parent's responsiveness can indirectly influence a child's ability to control anger and aggressive behavior, which are risk factors for behavioral problem in children (Farrington, 2005).

The net effect can be evident in parent-child interaction, in which parents inadvertently engage in patterns that sustain or accelerate antisocial and aggressive interactions (Dumas & Wahler, 1983; Patterson et al., 1991). The accumulated evidence regarding the symptom constellation, risk factors, and course over childhood, adolescence, and adulthood attests to the heuristic value of focusing on individual children. At the same time, there is a child-parent-family-context gestalt that includes multiple and reciprocal influences that affect each participant (child and parent) and the

systems in which they operate (family, and school) (Kazdin, 1993). For treatment to be effective, it is likely that multiple domains will have to be addressed.

In conclusion, the family has the major role in shaping behavioral development during early life stages. Various family theories within developmental psychopathology emphasize the significance of effective family interactions. These interactions encompass parenting practices, styles, communication, and attachment, contributing to the overall quality of the parent-child relationship and influencing behavioral problems in children. Research evidence highlights the importance of fostering a healthy family dynamic in parent-child interactions to reduce adverse effects. Therefore, parental or family interaction is identified as a essential factor in the manifestation of behavioral problems among children.

2. Social Competence and Behavioral Problems. Social competence is the capacity of an individual to get along well with others, establish and maintain good positive relationships, support others, regulate one's emotions and aggression, and solve issues in an adaptable manner (Hartup, 1989). Children and adolescents who are skilled in these competencies have good social competence and, hence, low behavioral problems (Gundersen & Moynahan 2006). Social competence is not a solitary attribute or skill that individuals possess to varying degrees; rather, it represents complex or multidimensional aspects of social and emotional responses (e.g., affect regulation), behavioral (the way individuals communicate with others and exhibit prosocial behavior), cognitive (in the form of the knowledge, processing, and acquisition of information), and motivational aspects that interact differently in various situations the individual encounters. It reflects one's proficiency in focus social interactions, understanding social norms, and establishing and maintaining meaningful connections with others in diverse contexts. Social competence is a broad concept that encompasses

a range of behavior (Schaffer, 2006). It involves the ability to interact effectively in human relationships, demonstrating the capacity to establish and maintain mutually satisfying connections while also avoiding mistreatment or victimization from others. Social competence comprises various qualities and skills, including taking responsibility, showing respect to others, maintaining a positive work attitude, problem-solving abilities, and a willingness to explore new experiences (Welsh, & Bierman 1998). In essence, it signifies an individual's proficiency in managing social interactions, promoting positive relationships, and demonstrating a well-rounded set of interpersonal and life skills.

Social competence could be defined in different ways: -

Social competence is defined as ‘somebody’s judgment that a person’s behavior in a given situation was effective’. (McFall,1982)

According to Rubin and Rose-Krasnor (1992), 'social competence is the ability to achieve personal goals in social interactions while simultaneously maintaining positive relationships with others over time and across situations”.

As per Bierman (2004), social competence can be described as the ability to effectively manage adaptive responses and demonstrate flexibility in addressing diverse interpersonal situations. It involves organizing social behavior in accordance with societal norms and values, while also ensuring personal benefit within different social environments.

Social competence is described as ‘the ability to initiate and maintain satisfying relationships, especially with peers’ (Knight & Hughes, 1995).

Social competence is explained by the transactional theory of Vygotsky (1978), which states that by interacting with others, children develop both cognitive skills (when interacting with others, a different perspective of cognitive orientation develops

than if the child could do it alone) and social skills (a high quality of interaction attained in the social domain). The relationship approaches to social competence are consistent with the method of 'Scaffolding' by Vygotsky (1978). Scaffolding is a process of interacting the child with another person who is skilled and competent in a particular domain, through which the social skill or competence is acquired from a dominant source. It elaborated on social interaction on two levels: horizontal and vertical. The vertical level of interaction enhances the 'scaffolds 'in which, beyond peer group interaction (the horizontal level of social interaction), parents or teachers contribute to the high level of social interaction among children (Hartup, 1989; Ainsworth et al., 1978). Such social attachment leads the child to develop their own social skills, which play an important role in the formation and maintenance of secure attachments (Crittenden, 1992 b).

There are different forms of social competency. Gresham & Elliott (1990) explained contention, cooperation, responsibility, compassion, and self-control as different categories of social competence. These attributes are prominently found among good peer group relationships, which form an ability to establish healthy friendships and to interact well with adults and also influence the number of psychological issues throughout life (Chadwick et al., 2004). Fostering social competence in children involves providing them with the necessary space to interact with friends and relatives while also offering appropriate guidance and support. Children who exhibit good social competence are those who interact well with others while working or playing, show respect to adults, display self-confidence, and engage in prosocial behavior. Social competence represents a child's ability to sustain mutually satisfying relationships and protect themselves from ill-treatment within the context of their interactions with others.

Social competence is based on previously learned knowledge and experience (Spence, 2003) and is the ability to apply these skills in future situations. Social competence is defined as a collection of positive social skills essential for effectively interacting with others and contributing constructively in group settings. This includes: a) showing respect and gratitude toward others; b) recognizing their worth and contributions. b) Collaborating effectively with others, communicating clearly, and actively listening to others' ideas and perspectives. c) Displaying behavior that aligns with social norms and is suitable for the specific social context or situation; and d) Employing a variety of skills and processes aimed at resolving conflicts or disagreements in a constructive manner, promoting positive and harmonious social interactions. And any deficits in such social interaction further affect the competencies and skills in social functioning.

Gresham and Elliott (1987) posited that children deficient in social competence may exhibit the following shortcomings:

1. Skill deficits: are characterized by a lack of the necessary social aptitudes essential for engaging in social interactions.
2. Performance deficits: individuals may possess the knowledge and understanding of social skills yet face cognitive or physical limitations that hinder their ability to execute the required behavior.
3. Self-control skills or performance deficits: marked by irrational anxiety or impulsiveness, impeding the capacity to acquire appropriate skills. Additionally, even if the skills are acquired, there may be a deficiency in the ability to accurately implement them in social contexts.

Skill development, adjustment, and satisfactory well-being among individuals are deeply implicated in social competence (Merrell, 2002). Lack of adequate social skill

adaptability leads the children to inappropriate social competency in their behavior, and it transits into adulthood. Social competence equips individuals with the ability to evoke positive responses from others, engage in effective interactions, and build meaningful relationships with people (Smart & Sanson, 2003). Beyond these immediate social benefits, social competence also wields a profound influence on an individual's adaptive and psychological functioning. Social competence serves as a comprehensive term to assess a child's effectiveness in social interactions with peers as well as adults (Fabes et al., 2006; Rubin et al., 1998). It encompasses a child's capacity to establish and maintain meaningful, high-quality, and mutually satisfying relationships while also being equipped to prevent negative treatment or victimization from others. The conceptualization of social competence, as outlined by Kanning (2002, 2003, cited in Nestler & Goldbeck, 2011), is understood as a multidimensional construct comprising emotional, behavioral, and cognitive components. These components overlap in the context of social interactions. Gresham (1986) further delineated three sub-domains within social competence: flexible behavior, social skills, and approval from peers, and all these are formed through the process of socialization.

Factors Influencing Social Competence and Behavioral Problem

According to Semrud-Clikeman (2007), various factors play a role in determining an individual's social competence and contribute to shaping this construct. These factors include temperament, relationships with teachers, peer groups, the neighbourhood, and the broader community. All these elements collectively influence and define an individual's level of social competence. Social skills are one of the key factors that influence social competence among children. It refers to the knowledge and skill of a child to enact suitable social behavior that is appropriate for the social context. Indeed, a child's social competence extends to their ability to exercise self-control,

restraining egocentric, impulsive, or negative social behavior. This capacity to inhibit such behavior reflects their social skills and demonstrates their ability to engage in socially appropriate and considerate interactions with others. The development of social competence in childhood is shown to be an effective predictor of social competence in later life (Howes, 1987; Monahan & Steinberg, 2011; Rubin et al., 1998). Indeed, it is more consistent with the concept of the Mathew effect of interaction. The Matthew effect refers to a pattern in which those who begin with advantage accumulate more advantage over time and those who begin with disadvantage become more disadvantaged over time (Dannefer, 1987; O'Rand, 1996), for social competence seems to exist: those who are good at making friends early in life seem to be getting better at it, while those who are less competent at it seem to be less competent for developing friends (Flannery & Smith, 2017; Ladd, 1999).

The development of social competence is crucial for enhancing society since it has a major role in reducing the risk of emotional and behavioral issues, thus helps in shaping one's overall well-being, low level of mental health issues, and better function in society (Luthar, 2006; Masten & Coatsworth, 1995); academic success (Caprara et al., 2000; Denham, 2006; Wentzel, 1991); peer acceptance (Merrell, 2002); effective problem-solving tactics (Schaffer, 2006); and success in various aspects of life. A low level of social competence leads to behavioral problems among children (Renwick & Emler, 1991; Webster-Stratton & Hammond, 1998; Najaka et al., 2001; De Rosier, 2004); peer rejection (Larson et al., 2001); aggression and bullying (Warden & Mackinnon, 2003).

In summary, social competence is generally accepted as an effective interactive aspect of social life. Social competence plays an important role in the formation of social attachment during the early life stage itself. It encompasses the ability of a child

to adapt and maintain social relationships in a positive manner. Poor social competence skills are associated with behavioral problems among young people.

3. Emotion Regulation and Behavioral Problems

Over the past two decades, there's been a growing interest in human emotions and their management (Cole et al., 2004; Goleman, 1995), largely due to developmental research emphasizing the importance of teaching children to regulate emotions appropriately, which is significant for optimal development and psychological well-being (Denham et al., 2003).

Thomson (1994) defined emotion regulation as a complex concept that involves both internal and external processes. It involves the control, management, and influence of emotions through mechanisms and strategies. Internal processes involve cognitive processes related to affect and physiological responses. External processes, such as parental support, also play a role in emotion regulation. The dynamic interplay between initiating, maintaining, and modulating emotions is essential for adapting to various situations and social contexts. Emotion regulation is an important aspect of psychological and social functioning, guiding individuals in their emotional experiences and interactions. Younger children primarily regulate their emotions through their activities, and children become more dependent on others as they grow older and reach the adolescent stage, especially their peer groups (Eisenberg & Morris, 2002).

The process model theory of emotional regulation by Gross & John (2003) states that there are two strategies for emotional regulation, like expressive emotion and cognitive reappraisal. The ability to regulate emotion particularly determines the mental and emotional wellbeing among children and adolescents. Cognitive reappraisal is an effective strategy for modifying how one thinks about a situation to regulate their

emotional response (Gross & John, 2003). Expressive suppression, on the other hand, aims to decrease or inhibit emotion-expressive behavior but does not necessarily change the internal emotional experience. Emotions should be managed and expressed in a manner that is appropriate for the circumstances, and maladaptive behavior may occur when this connection is lacking (Cicchetti et al., 1995). The primary objective of the development of emotion regulation, especially in the context of children and adolescents, is to equip them with the skills and understanding necessary to manage their emotions in a socially appropriate manner. This includes learning when and how to express their emotions effectively (Eisenberg & Morris, 2002).

The coercive hypothesis of behavior development by Patterson (1982) explains that the responsiveness of parents as an important step for developing self-regulatory skills among children (Farrington, 2005) is one of the risk factors for molding a delinquent child. A delinquent child has a history of genetic and environmental stress (Scott 1962), a legal history of parents (Robins et al. 1975), poor physical and emotional wellness of parents (Mednick et al., 1977: Suja & Jayan 2018), and experiences more behavior problems.

In developmental psychology, developmental psychopathology, and neuroscience, the concept of emotion regulation (ER) has drawn a great deal of attention. From the standpoint of developmental psychopathology, microsocial, momentary interaction processes are probably essential to comprehending the emergence, development, and contribution of ER capacities to various routes (Bronfenbrenner & Morris, 1998; Cole et al., 2004); significant analysts of developmental psychopathology outcomes (Bradley, 2003; Calkins & Howse, 2004; Calkins, 1994). It has been assumed that parent-child emotional flexibility is related to children's ability to regulate their own emotions, but no research has proved that these

dyadic processes are actually connected to children's ER capacities. Parent-child emotional flexibility has been shown to correlate with and predict child psychopathology to date (Granic & Patterson, 2006). Researchers in the field of child psychopathology state that children who are at risk for psychopathology have emotionally "negative" or "angry" interactions with their families and are at risk for developing emotional and behavioral problems among children (Brody et al., 1987; Morris et al., 2002; Shields et al.,1994). However, the expression of anger or any other negative emotion is not pathological, according to emotion theorists (Izard, 1977; Magai & McFadden, 1995; Tomkins, 1963); all emotions are adaptive and necessary to express in the right situations. Additionally, studies support the idea that healthy development depends on children being able to effectively regulate their emotions (Cole et al., 2004; Southam-Gerow & Kendall, 2002). Research also shows a link between young children's inability to control their emotions and both internalizing (Calkins & Howse, 2004; Calkins, 1994) and externalizing (Eisenberg et al., 2001; Rothbart et al., 1994; Zhou et al., 2007; Silk et al., 2003) outcomes. Emotion dysregulation, a transdiagnostic factor, increases the risk for depression, anxiety, aggressive behavior, and eating pathology outcomes in adolescents, as per a longitudinal study by McLaughlin et al. (2011).

At the same time, developmental research pointed out that parental approaches to different emotion regulation strategies towards children vary as children grow (Dix, 1991; Eisenberg et al., 1991). Parents initiate emotion regulation strategies in children's early childhood, with self-regulation increasing as they grow older. Parents may use physical comfort, facial expression, environmental changes, or gratification to regulate emotions (Kopp, 1989). As children develop cognitive and emotional skills, they become more independent in managing their emotions. Parents' strategies for emotion

regulation become more sophisticated as children age (Eisenberg & Morris, 2002). For instance, parents of school-age children may discuss emotions openly with their children, train them to use cognitive coping mechanisms, and assist them in processing emotions in different manners when faced with emotionally charged situations.

Emotion regulation is not the process of inhibiting negative emotions; rather, it is merely having flexibility with emotions as emotion regulation (Kashdan & Rottenberg, 2010). Children and their parents are essentially exploring different ways of perceiving and responding to the frustrating and frightening components of their interactions when they are able to switch emotional responses more easily, especially during stressful encounters. Through effective regulation, the negative emotions are expressed in such a way that they are led by appropriate solutions to difficult problems too. Hence, a positive parent-child interaction is likely to develop an emotionally flexible relationship with them. Studies support the predictive role of emotional flexibility and behavioral problems among children by showing that aggressive behavior among children was higher among parents with a low level of emotional flexibility than parents with a higher level of emotional flexibility (Hollenstein et al., 2004); reduced aggressive behavior among children whose parents were given a parent management training program; and improved parent-child emotional flexibility (Granic & colleagues, 2007).

Factors Influencing Emotion Regulation and Behavioral Problems

Emotion regulation development is influenced by various factors, including the environment in which children grow. Morris et al. (2007) suggest that emotion regulation is socialized through family dynamics, parent and child characteristics, and the emotional climate of the family. Observing parents' strategies helps children learn about emotions (Parke, 1994).

The research on the theoretical and empirical relationships between the attachment system and the domains of social attribution, emotion regulation, moral development, and socialization in externalizing activities was reviewed by Guttman-Steinmetz & Crowell in 2006. The findings indicated that attachments, security, and other developmental processes have a variety of protective and risky relationships that are connected to externalizing behavioral problems. Parents play a crucial role in children's emotional development by modelling their emotions (Denham et al., 1997). Positive parenting styles can help children learn to regulate emotions effectively, and inadequate parenting leads to inappropriate emotion regulation (Calking et al., 1998; Eisenberg et al., 1998). Parental conflict can also affect children's emotion regulation, leading to both adaptive and maladaptive strategies (Cummings & Davies, 1994; Main & Goldwyn, 1984; Berlin & Cassidy, 2003). Marital conflict can also cause adjustment difficulties for children. Therefore, it's essential to adopt positive parenting styles and model various emotional responses to support children's emotional development (Cummings & Davies, 2002; Davies& Cummings, 1998, 1994). Parental emotional attachment is a strong indicator of children’s socio-emotional development. Children’s prosocial behavior is linked with parental positive emotional expression in the form of emotion understanding, social competence, well-balanced emotionality, and effective interaction with parent and child (Cumberland-Li et al., 2003; Eisenberg et al., 2001). However, parental conflict can have negative consequences for children's emotional well-being and adjustment.

According to earlier research, parent-child interactions between aggressive children are inflexible (as opposed to flexible), and it's possible that these inflexible repertoires are the reason why youngsters struggle to learn how to control their emotions. Emotion regulation issues are linked to low activity in the cerebral cortex's

dorsal systems (such as the anterior cingulate cortex, or ACC). A study on neurocognitive and parent-child emotion control was performed on sixty 8- to 12-year-old children who were referred for treatment due to violence. Using a computerized go/no-go test, dense-array electroencephalography (EEG) was used to measure brain processes associated with emotion control. A study of the source was carried out, and N2 amplitudes believed to tap inhibitory regulation were noted. In the second evaluation, parents and kids were caught on camera attempting to resolve a dispute. Two dynamic flexibility characteristics were extracted from the coded videotapes using state space grids: (1) the number of transitions between emotional states and (2) the dispersion of emotional states, based on proportionate durations in each state. According to regression analysis, there was no relationship between flexibility metrics and N2 amplitudes. The ratio of dorsal to ventral source activation was shown to be strongly correlated with the flexibility measures. Specifically, for transitions, the correlation coefficient was.27, the $F(1, 34) = 13.13$, $p = .001$, and for dispersion, it was.29, the $F(1, 35) = 14.76$, $p < .001$. Therefore, stronger dyadic flexibility was linked to a higher ratio of dorsomedial to ventral activation, supporting their hypothesis that children with more flexible parent-child interactions are able to employ relatively further dorsomedial activity in demanding situations (Meusel et al., 2012).

Sanson et al., (1991) found that a child's temperament, which includes their emotional reactivity and adaptability, can influence their likelihood of developing externalizing behavior issues as they progress through childhood. Understanding these early indicators can be valuable in identifying and addressing potential behavior problems in children to support their healthy development.

Recently, the control of emotions has been acknowledged as a key factor in behavioral problems (Burke et al., 2010). Lack of habit control, emotional instability,

and extreme emotional reactions might be blamed for the difficulty in emotional regulation (Reimherr, 2005). One of the main theories about emotional dysregulation holds that the infrastructure mechanism of externalization and internalization in adolescents is caused by ineffectiveness and disability in emotional regulation, elevated use of regulating negative emotion strategies, as well as accusing oneself and others (Garnefski et al., 2009; Paliziyan et al., 2017).

Family factors associated with aggression are family conflict, negative parenting behavior, disturbances in family organization, and marital conflict among parents (Talwar, 1998); anger levels in youth are often affected by the conflict between parents. For example, Jenkins (2000) argues that when children are exposed to high levels of anger-based marital conflict, they develop an emotional organization in which anger predominates. Along with parental factor, peer group influence also considered for the behavior formation among groups. Peer rejection at age ten, along with academic underachievement and poor parental supervision, may cause a connection with a troublesome peer group by age twelve (Dishion et al., 1991). These aggressive kids, who are rejected by the majority of their peers, frequently look for companions among other rejected kids, resulting in peer groups of violent, social outcast kids. The trend towards violent and criminal behavior may then be exacerbated by such groups of aggressive children influencing one another (Olson ,1992) and forming deviant peer groups that subsequently move to substance abuse (Elliott et al. 1985) and other deviant behavior.

In summary, problem behavior reflects a developmental-ecological view of mental health, where it is believed that the establishment of self-regulatory capacities is heavily embedded in the various contexts or ecologies (such as family, social, and emotional aspects) that are nested within a child's larger environment. The interactions

between parents and children are acknowledged to be influenced by environmental factors that contribute to behavioral problems. Social learning (operant) theory supports the conceptualization of processing of these mechanisms that highlight parental aggression modelling and spiralling parent-child coercion cycles (also known as "reinforcement traps") that are maintained via escape-avoidance conditioning (Hawes & Dadds 2005a; Patterson 1982). There is a lot of evidence suggesting the affective nature of the parent-child relationship is also related to risk pathways to behavioral problems, in addition to parenting techniques linked to behavioral control and monitoring (Stormshak et al. 2000). Along with the role of family interaction, factors like social competence and emotion regulation also play a protruding role in the formation of behavioral problems among children. All these factors contribute to maintaining mental health among children. Hence, understanding the potential risks and predisposing variables is the first step in facilitating the detection of behavioral problems and enabling proper intervention early in childhood, even though the eradication of these diseases is unlikely.

Mental Health

Mental health stands as a crucial level for individual well-being and effective functioning. It represents a delicate balance within oneself and with the surrounding environment, maintaining equilibrium in an individual's life. Various factors, including physical, psychological, socio-cultural, and interrelated elements, collaboratively contribute to achieving this internal equilibrium and aligning with the universal values of society. The state of internal equilibrium is shaped by fundamental cognitive and social skills, the ability to recognize, express, and regulate emotions, empathy towards others, adaptability, coping mechanisms for adverse life events, and the establishment of a harmonious relationship between the mind and body (Galderisi et al., 2015).

Definition of Mental Health

The well-being of an individual's mental health is significantly influenced by the social, economic, and physical environments in their living context (WHO, 2014). Mental health is defined as "a state of well-being in which an individual realizes their own abilities, can effectively cope with life's typical stresses, remains productive in their work, and contributes to their community" (WHO, 2004). Mental health is inherently positive and holistic in its essence.

Mental Health Among Children

Specifically, there are different classification of mental health problem as per international classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM), there still exists a debate on labelling the 'psychiatrization' among young people for defining the mental health problem (WHO,2003). As a result, categorization of mental health problems among young people is commonly clear by employing ICD or DSM criteria. Instead, preference is given to terms such as internalized problems (emotional problems) and externalized problems (conduct and oppositional defiant problems) or behavioral problems, including repeated deviant behavior or aggression among children. (Xue et al.,2005).

Throughout the developmental stages, children encounter challenging situations within themselves, at home, in school, and within society. In instances where they struggle to effectively focus these challenges, their mental health becomes compromised. Mental health issues in children often manifest in aggressive behavior, lying, rule-breaking, theft, and disruptive conduct (Cabrera et al., 2017). Experiencing adverse childhood events, including neglect, domestic violence, and parental incarceration, heightens the likelihood of children facing social, emotional, and cognitive impairments. These challenges, in turn, are linked to poor mental health

functioning and behavioral problems (Brennan & Shaw, 2013: Boden et al., 2010; Hughes et al., 2017; engagement in risky behavior, poor educational achievement, quality of life, future health and life opportunities (Rapport et al.,2001) and mental health problems in later life (Kessler et al.,2005, Kim Cohen et al.,2003). Notably, the mental health impact of the COVID-19 pandemic has further contributed to an increased reporting of externalizing behavioral problems, particularly among boys (Sharma et al., 2021).

The promotion of mental health involves initiatives aimed at enhancing knowledge, skills, and attitudes to nurture social and emotional development, encourage a healthy lifestyle, and foster personal well-being (Thirunavurakasu et al., 2011). To promote healthy development, wellness, and a values-based life, there is a need for primary, secondary, and tertiary interventions that also serve to prevent mental health and psychosocial problems. Family and social functioning are involved in such an intervention program among children with behavioral problems (Maggin et al., 2012). These interventions not only empower individuals but also create supportive conditions at school, home, and in the community. Emphasis is placed on expanding opportunities for personal development, fostering positive attitudes and behavior, enhancing motivation and capabilities to pursue positive goals, resisting negative influences, and overcoming barriers.

Since the adolescent period is a time of transition, the physical, socio-emotional, cognitive, and spiritual dimensions of well-being are also in a shell of production, hence multiple interaction influences (United Nations, 2002). The stage represents detachment from family and parental contact and more attachment toward peer society. The stage may also be in a period of greater vulnerability, stress, and emotional incompetence; at the same time, they are in a stage of change, curiosity, creativity, and

positive growth. Somehow, few face it as more challenging and overwhelming; others move along with relative calm. Such critical and deviant forms of behavioral patterns exhibit some point of mental health concern among children and adolescents. Along with the behavioral problems, the well-being of mental health could be enhanced by improving family interaction, better social functioning and emotional regulation. Based on the information presented and the study findings, the researcher has focused on developing a multidimensional training program which primarily focuses on the mental health indicators of the study. The fundamental purpose of this effort is to reduce behavioral difficulties in children, thereby improving their mental health.

Multidimensional Program

The multidimensional programme implies different aspects of intervention strategies while dealing with behavioral problems among children, thus maintaining better mental health among them. As far as research studies are concerned, multiple intervention found effective than single intervention to deal with children's behavioral problems; hence, the present study uses the term multidimensional programme to intervene among children.

A multidimensional programme involves aspects of different dimensions that support effective functioning among children’s behavioral problems. As a number of risk factors contribute to the development of such issues, like family factors and social, emotional, and cognitive factors, a group of treatment strategies will be effective in managing behavioral problems among children. Based on the previous research findings and theoretical frameworks, family factors, social functioning, and emotional factors are considered the most prominent factors contributing to behavioral problems among children.

Research findings support the notion that multimodal intervention protocols are more effective than training with single-model treatment for mental health problems. Velo et al., (2019) recommended that multimodal therapy significantly improves the psychopathological conditions of children with behavioral problems, aggressive behavior, and attention deficit hyperactivity problems. Multimodal interventions involving both children and parents have proven to be more effective than interventions solely directed at children (Lochman & Wells, 2002; Pappadopoulos et al., 2003; Steiner & Remsing, 2007; Copeland et al., 2009; Kolko et al., 2014).

In conclusion, research supports the idea that when one or more trainings are combined into a single intervention, the effectiveness of the program will be higher than that of a single training program. Hence, the present study focused on a multidimensional training programme to reduce behavioral issues and thus enhance mental health among the group. The different multidimensional training programmes with related to behavioral problems are as follows:

- Parent management Training program
- Social skill training, and
- Mindfulness training

1. Parental Management Training and Behavioral Problem

Since parents are considered to be of prime importance in molding and shaping the behaviour of a child, the researcher focused on parent-focused training for behavioral problems. There are different terms used in the perspective of parent-focused intervention, like the parent behavioral training program, the great families, parent incredible years-basic parent training program, the emotion 1-2-3 magic parenting gram, parent-child interaction emotion coaching parenting programme parent-child interaction therapy, motivation-enhanced parent-child interaction therapy,

the parent management training Oregon model, the coping power , functional family therapy, Hitkashrut parent training programme, multisystemic therapy, functional family therapy, and so on.

Parent management training, based on principles of learning theories and behaviour modification, emphasizes the skills that are useful to improve the behaviour of the child (Leijten et al., 2016). Parent management programmes were developed by Alan Kazdin in the 1980s with the aim of exploring effective parental interaction and thus enabling them to manage children's behavioral problems. During the transition from childhood to adolescence, a wide range of behavior and associated emotions are exchanged between parents and their adolescent offspring. These exchanges can involve both positive and healthy behavior, as well as negative ones. The outcomes for adolescent development can vary, with some reflecting good adjustment and individual and social success, while others indicate poor adjustment and developmental challenges. Human development is a dynamic process (Rutter & Sroufe 2000), which explains the role of risk and protective factors for psychopathology (Rutter 2003; Burke et al. 2002) and the effect of interaction between environment and individual on distinguishing normality and pathology (Rutter & Sroufe 2000). Just like in other aspects of human development, there is a diversity of experiences in parent-child relations during developmental periods. In positive parent-adolescent relationships, one can expect to find feelings of attachment or closeness on the part of the young person towards their parents. Such feelings can be mutually beneficial for both parents and adolescents. When children feel secure in their attachments to their parents, they tend to be more competent in their interactions with peers, experience fewer internalizing problems, and exhibit fewer deviant behavior. Conversely, poor attachment or feelings of anger and frustration in the parent-child relationship are associated with adolescents

showing internalizing or externalizing problems and engaging in deviant behavior. These findings emphasize the critical role that parent-adolescent relationships play in shaping adolescent development, both in terms of emotional well-being and social competence.

The effectiveness of an individualized intervention cantered on attachment for parents of teenagers who are at risk of aggressive behavior was assessed by Moretti & Obsuth (2009). They discovered improvements in affect management, improved social functioning, and a decrease in externalizing and internalizing difficulties among teenagers. Additionally, parents reported a notable decrease in career stress and a substantial rise in parental satisfaction and perceived efficacy.

Several studies have demonstrated intervention programmes that have proven to be effective in addressing behavioral problems in children. Two of the more popular treatment models are problem-solving skills training with in vivo practice and the Coping Power Programme (Lochman & Wells, 2002). In problem-solving skill training, which is used with children aged 7 and over, the child receives individual training in interpersonal cognitive problem-solving techniques in one-hour sessions. The focus is on identifying problem situations, learning a series of problem-solving steps, and applying them first to hypothetical situations, then in roleplay, and finally in real-life situations. Therapeutic strategies include games, therapist modelling, and role-play with therapist feedback. A token system is used in sessions to reinforce children's efforts at practicing target skills. All such activities improve the mental health of children.

Parents are involved periodically in joint sessions and may receive behavioral parent training as an adjunctive treatment. Kazdin et al. (1987) found that problem-solving skill training (PSST) results in a significant decrease in deviant behaviour and

an increase in prosocial behavior and overall mental health. Outcomes were superior to a client-cantered, relationship-based treatment and were maintained at 1-year follow-up. The addition of real-life (in vivo) practice and a parent training component both enhanced outcomes.

In summary, these findings highlight the significance of promoting positive parenting practices that emphasize warmth, support, and non-punitive discipline. Parenting interventions that focus on teaching effective communication, problem-solving, and emotional regulation can be valuable in reducing behaviour problems in children and fostering healthier parent-child relationships. And for the present study, the researcher used a parent management training programme, where the concepts were adapted from parent training and coping power programmes.

2. Social Skill Training and Behavioral Problem

The social skill training programme applies the behaviour techniques or learning activities that enable individuals to acquire instrumental and affiliative skills in domains to meet the interpersonal, self-care, and coping demands of community living (Liberman et al.,1995). The social skill training focuses on children's social skills deficits, highlighting the need for remediation through child-based programmes that address these deficits. These programmes include skills like friendship, conversation, rules, endurance, and responsibility, which contribute to social and behavioral achievement. The World Health Organisation defines social skills as ‘skills for enhancement of psychosocial competence; those skills that enable individuals to deal effectively with the demands and challenges of everyday life’ (WHO, 1994). Bullis et al. (2001) define social skills as specific behavior when interacting with others. Social skill deficiency is a defining characteristic of emotional and behavioral disorders.

Social skills encompass learned behavior that enable individuals to participate in socially acceptable interactions, leading to positive responses from others and helping to avoid negative reactions (Elliott & Gresham, 1993). These skills involve a spectrum of verbal and nonverbal responses that shape how others perceive and respond during social interactions (Spence, 2003). The presence of deficits in social skills can impede the smooth functioning of the social dimension and limit the adaptive potential of individuals. This deficiency carries various consequences, particularly affecting performance and interactions within society (Angelico et al.,2013).

Training in social skills is instrumental in aiding individuals to actively engage and enhance their social capabilities. This training involves the interconnection of cognitive, affective, and emotional processes with social competence, leading to an augmentation of social skills (Ang & Hughes, 2002).

Elliott and Gresham delineated the key objectives of social skills training as follows:

1. Promoting the acquisition of social skills
2. Enhancing the execution of social skills
3. Modifying problem behavior that hinder social interactions
4. Supporting the universal adoption and maintenance of social skills (Elliott et al.,2001).

Social skill training is intended to train and improve appropriate and adaptive social behaviour among children (Frey et al., 2015). Social skill training programmes are multi-component with different training processes such as skill training, behavioral interventions, interpersonal training, individual and group training (Bullis et al.001), activities related to cognitive-behavioral skills, and psycho-education. It is based on

social learning theory, which primarily focuses on observational behaviour (Bandura, 1997). Hence, the different strategies or techniques involved in social skill training are:

1. Setting goals: in which the trainer establishes specific goals during each session. After attainment of particular goals, move on to the next session goals.
2. Modelling: the behaviour of parents, peer groups, and teachers is observed and learned. The process of modelling includes skill instruction, modelling, and skill performance.
3. Skill performance: in which the skills are practiced by the individual and get feedback.
4. Role play: in this process, the trainer enacts the skills towards the individual or group.
5. Rehearsal is a method wherein behavior, responses, and social skills are rehearsed and planned for preparation in anticipation of their actual use in real-life situations.
6. Corrective feedback: after the end of each session, the trainer provides feedback on certain skills, which helps them evaluate the need for such skills and how they will be useful in the future.
7. Homework: After learning each skill, related assignments were provided to individuals to enhance and practice the newly learned skill.

According to the reinforcement hypothesis, when an action is followed by a reward, it is more likely to happen, whether it is positive or negative. Several social skill training programme components are designed to improve children's social skills by clearly and immediately rewarding prosocial behaviour (Ladd & Mize, 2013).

Social skill training was initiated in the child and adolescent psychiatric unit in Bahrain in 1992, which was mainly focused on intervening with children with behavioral problems. The programme, administered twice weekly, covers 25 topics,

including class survival, friendship development, and stress management. The study aims to evaluate the effectiveness of the social skill training programme by assessing the acquired skills. And the results indicate that the mechanism of practicing social skill training has been found effective in skill acquisition (Ansari & Hafeedh, 1998).

Rueda et al., (1980) explained the importance of acquiring self-regulation in connection with cognitive-behavioral skill training among students with behavioral problems. The results indicated that self-regulatory strategies like self-evaluation, self-monitoring, and self-reinforcement were effective with adolescents with disruptive disorders and aggressive behaviour (Wilson, 1984; Polsgrove, 1979; O'Leary & Dubey, 1979); improving social behaviour (Karoly, 1977; Kendall, 1977; Lloyd, 1980).

In conclusion, training in social skills is very useful for children with behavioral problems. As researcher studies explored the areas of behavioral problems among children, a lack of social interaction and social skills led to a low level of social competence. Hence, the researcher opted for implementing social skill training to enhance social interaction among children with behavioral problems, thus enhancing mental health among children.

3. Mindfulness and Behavioral Problems

Mindfulness is generally defined as "awareness that arises through paying attention, on purpose, in the present moment, non-judgmentally" (Kabat-Zinn, 2009). Training in mindfulness entails cultivating attentive awareness, which is attained by purposefully practicing prolonged, nonjudgmental attention to what is happening in the moment (Kabat-Zinn, 2003). According to Brown & Ryan (2003), mindfulness is a self-regulation technique that entails objectively examining one's own thoughts and feelings, for instance, to determine if there is a 'right' or 'wrong' way to think or feel in the present moment. The Eastern contemplative traditions are the source of

mindfulness practices, which have gained popularity recently as a novel approach to stress reduction and mental health promotion for both adults and children (e.g., Baer, 2003; Greeson, 2009).

The English term mindfulness originates from the Pali word *sati* (Germer et al., 2005), which means ‘to remember’; presence of mind (Bodhi, 2000; Thera, 1973). The concept of mindfulness has its roots in Buddhism, which has a basic observance with widespread cross-cultural applications. The word Pali belongs to the language of Theravada Buddhism, and around 2,500 years ago Buddha used to teach meditation, Satipatthana, or the way of mindfulness (Thera, 1962), which represents the worth of consciousness as ’bare attention (Brown et al., 2007).

Mindfulness can be defined as the process of cultivating a nonjudgmental and accepting awareness of one's moment-to-moment experiences, as articulated by Bishop et al. (2004) and Kabat-Zinn (2005). This practice involves deliberately focusing on one's ongoing sensations, thoughts, and emotions as they arise without categorizing these phenomena as good or bad, true or false, healthy or unhealthy, as described by Baer (2003).

Bishop et al. (2004) operationally broke down mindfulness into two components: the self-regulation of attention and a curious and accepting attitude towards one's experiences. In simpler terms, it can be understood as a mental state characterized by consistent and flexible attention to the present moment, approached with a non-judgmental attitude that incorporates curiosity, openness, and acceptance. This mental state is associated with changes in perception, heightened insight, increased choice, and more deliberate actions. Miners (2008) conceptualized mindfulness as both an enduring disposition and a fluctuating state, with its benefits extending to various aspects of life through both formal and informal meditative practices.

Mindfulness practice refers to the mental approach of cultivating mindfulness, which contributes to an individual's mental and emotional flexibility and clarity. This, in turn, not only deepens one's appreciation of life but also aids in adapting to various life situations, as highlighted by Davis et al., (2007).

Baer et al. (2006) and Carmody and Baer (2008) have categorized mindfulness into five skills: 1) acting with awareness, 2) observing, 3) describing, 4) non-reactivity to inner experience, and 5) non-judging of inner experience, representing a higher order of mindfulness factors. These mindfulness skills are closely linked to various psychological processes, as outlined by Baer et al. (2006):

Acting with awareness: It involves paying attention and spontaneously observing how sensations, thoughts, feelings, and actions interact. Mindfulness stands in contrast to absent-mindedness.

Observing: It requires intentionally focusing attention on stimuli, fully engaging in the present activity, and avoiding automatic or absent-minded behaviour.

Describing: It involves using words to label or describe one's thoughts, feelings, or experiences. This skill is associated with emotional awareness and emotional intelligence and is inversely related to alexithymia. It encompasses the cognitions, affects, and somatic sensations of the present experience.

Non judging: Concentrates on detaching from mental events, treating thoughts just as thoughts and emotions just as feelings, without over-identifying with them. It encourages neutrality and less reactivity to experiences and emotions, fostering acceptance of experiences. This skill contrasts with coping strategies such as avoidance and thought suppression.

Non reactivity: Involves self-regulation behaviour, refraining from automatic reactions to thoughts or feelings. Individuals with non-reactivity skills are less likely to

interpret behavior, demonstrating reduced revengeful and aggressive tendencies in daily life (Heppner & Kernis, 2007).

Chawla & Ostafin (2007) explained that mindfulness enables the individual to observe their internal experience without any kind of judgment. The detached aspects of self-observation help the individual make better and more effective coping strategies for a problematic situation. Thus, a reduced level of impulsivity occurs in individuals, as the behavioral problem among them. Gradually, the individual acquires the capacity to monitor their thoughts and feelings and regulate cognitive processes and behaviour. Such activities reduce the behavior problem and improve mental health among individuals.

Theoretical Framework of Mindfulness and Behavioral Problems

Mindfulness instruction aims to enhance awareness and attunement to internal and external factors with curiosity and without judgment. It facilitates self-regulatory processes and coping, particularly during stressful experiences. The biopsychosocial factor interacts with the neuroendocrine pathway, specifically the hypothalamus-pituitary-adrenal (HPA) axis, which is activated by stress in the hypothalamus or indirectly in the amygdala. High cortisol levels in adolescence can lead to social aggression and impulsivity, affecting the HPA axis's activity (Montoya et al., 2012). Cortisol, a final result of the HPA axis, plays a crucial role in adaptation to stress, both externally and internally. When responding to anger, anxiety, fear, unpleasant situations, or unaccomplished expectations, there could be an increase in HPA axis activity (Fairchild et al., 2008). Persistent stressors stimulate the HPA axis's response, leading to neurobiological profile changes and cognitive problems (Robert, 2005). Mindfulness practice enhances the density of grey matter in connected areas of memory, learning, emotion regulation (Ekblad, 2009; Kishor, 2015), and empathy

(Anderson et al., 2007; Tipsord, 2009). As mindfulness focuses on present-moment awareness, it was found that mindfulness could be effective in preventing overreacting and thus helping to facilitate a better adaptive response to experience (Baer et al., 2004; Segal, Williams, & Teasdale, 2002).

The shared objectives of social-emotional learning (SEL) and mindfulness approaches indicate potential compatibility. In the realm of neuroscience research on mindfulness meditation, the central outcome is often identified as enhanced self-regulation, involving three interrelated processes: attention control, emotional regulation, and self-awareness, as proposed by Tang et al. in 2015. In a study by Feuerborn & Gueldner in 2019, the conceptual alignment between mindfulness-based and SEL frameworks was explored by examining the core SEL components of mindfulness-based programs. The SEL competency of self-management, encompassing self-regulation and executive functioning, was found to be present in all 40 studies reviewed by the researchers. Additionally, both mindfulness-based and SEL interventions share common goals such as promoting emotional regulation and fostering compassion and empathy to cultivate healthy relationships, as highlighted by de Carvalho et al. in 2017.

Nowadays, there has been a growing trend in the popularity of mindfulness-based programmes aimed at enhancing child wellbeing as a part of educational activities (Semple et al., 20 2017), both among children and adolescents in clinical and non-clinical settings too. Still, relatively few evaluations have been conducted among younger children (Maynard et al., 2017). Mindfulness practice for children is similar to that for adults, but exercises can be specific to different ages and abilities. Activities should be clear, concrete, and descriptive, while also incorporating children's imagination. They enjoy movies, cartoons, and fantasy books, and humour can help

them engage with these mediums. It's important to be aware of their experiences and adapt activities accordingly. Teaching mindfulness to children starts with success, so starting with five minutes is more appropriate than 15 minutes for adults. The exercises should be progressive, starting with the external environment, then the body experience, and finally introducing attention to the mind and meditation exercises. This approach helps most children develop a better understanding of mindfulness (Fodor & Hooker, 2008).

Kabat-Zin (2003) states that ‘mindfulness cannot be taught to others in an authentic way without the instructor’s practicing it in his or her own life’. So, it will be beneficial for the instructor to understand the challenges, difficulties, and enjoyment of children while practicing mindfulness (Fodor & Hooker, 2008). Mindfulness among children can range from a simple to a complex process, clarifying their doubts and uneasiness while practicing it. **Firstly,** mindfulness training starts with focusing on external objects. Mindfulness training involves directing children's attention to their environment through activities like drawing pictures of objects. It's important to remind them that the activity isn't about their drawing abilities but rather their best attempt. The child should focus on identifying missing details and drawing the object again, allowing them to quickly notice and appreciate the object's details (Fontana & Slack, 1997).

The **second** step in mindfulness training involves guiding children's awareness of their own experiences in the environment, focusing on their attention to themselves, and encouraging them to write down their daily activities (Fodor & Hooker, 2008). **Finally,** the children can train with external environments; they can be guided to be aware of their own body sensations, which helps them to improve self-awareness among children. This internal body sensation can be achieved with raisin exercise. By practicing raisin exercises, children can become aware of what they are sensing and

feeling. This can best be done by reading the script, for example, aloud to the children in a slow, calm voice. — *Bring your attention to the raisin, observing it carefully as if you had never seen one before. Pick up one raisin, feel its texture between your fingers, and notice its colors. Be aware of any thoughts you might be having about the raisin. Note any thoughts or feelings of liking or disliking raisins if they come up while you are looking at them. Then lift the raisin to your nose and smell it for a while, and finally, with awareness, bring it to your lips, being aware of the arm moving the hand to position it correctly and of your mouth salivating as the mind and body anticipate eating. Take the raisin into your mouth and chew it slowly, experiencing the actual taste of the raisin. Hold it in your mouth. When you feel ready to swallow, watch the impulse to swallow as it comes up, so that even that is experienced consciously. When you are ready, pick up the second raisin and repeat this process with a new raisin, as if it is now the first raisin you have ever seen* (Kabat-Zinn, 1990, as cited in Fodor & Hooker, 2008). The script encourages children to be aware of their thoughts and feelings about the raisin and to engage in the process of eating.

Breath counting is also one of the mindfulness trainings to improve the present-moment experience (Gunaratana, 1991; Fontana & Slack, 1997; Kabat-Zinn, 1990). Proper exercise helps children focus on their current breath, calming the mind and reducing body anxiety. It's beneficial to encourage children to focus on their breathing in daily life, especially when feeling anxious, overwhelmed, stressed, or angry (Fontana & Slack 1997).

Teaching mindfulness to children can cause anxiety due to observing thoughts and sensations related to worries and fears (Kabat-Zinn, 1990). Encourage the child to continue practicing and let go of negative emotions. If the child feels difficulty and

cannot let go, focus on the present moment. If the child still experiences negative experiences, meditation may not be suitable (Fodor & Hooker, 2008).

The debate in mindfulness literature revolves around whether mindfulness is a trait or a state. A trait is an inherent characteristic, while a state is a momentary state lasting a limited time (Brown & Ryan, 2003). Baer et al. (2006) argue that mindfulness can be a concept with both trait-like and state-like qualities. Brown & Ryan (2003) found that mindfulness exhibits both inter- and intrapersonal variations, meaning some people are inherently higher in mindfulness but do not display the same level at all times. Mindfulness is also often seen as a set of skills that can be developed through regular practice (Baer et al., 2006), meaning that while some people have a higher capacity for mindfulness, training can help individuals become more mindful. Mindfulness is a technique often practiced through meditation exercises and being attentive and aware in the present moment during everyday activities like eating, walking, standing, or washing dishes (Kabat-Zinn, 1982; Hanley et al., 2015). With respect to the above notions regarding mindfulness, it was stated that the technique of mindfulness, often exercised through meditation and being attentive present in everyday activities, has demonstrated its potential in addressing behavioral problems among children. Studies, such as those mentioned, highlight positive outcomes, including reductions in aggressive behavior and non-compliance. Therefore, mindfulness training appears to be a valuable approach to promoting behavioral well-being among children, showcasing its potential impact on enhancing adaptive behavior and reducing problematic ones. The mindfulness exercise results in reduced behavior problems, promotes social skills, wellbeing, and better social-emotional competence (Schonert-Reichl & Lawlor, 2010; Joyce et al., 2010; Semple et al., 2010; Beauchemin et al,, 2008; Flook et al., 2010; Salmon et al., 2004).

Apart from inculcating parental interaction and skill training, children with behavioral problems also have problems with self-regulation and stressful conditions. Researchers pointed out that the age period between 10 and 19 years is a transition stage with varying degrees of crisis in the form of mental health like, physical, mental, social, and emotional aspects. Hence, there needs to be a resolution part to resolve these issues by practicing being attentive, self-regulating feelings and emotions, thinking wisely, and so on. Based on the reviews and theoretical explanation, the researcher introduced mindfulness training along with a parent management program and social skill training among children with behavioral problems, with the intention of reducing the behavioral problems and thus promoting better mental health.

Literature Review

Behavioral Problems Among Children

In Kerala, Harikrishnan & Grace (2021) conducted a study on the prevalence of behavioral problems among children between the ages of 13 and 17 among 600 school-going adolescents. The self-reported Strength and Difficulty Questionnaire (SDQ) result indicated that 24.5% of school-going adolescents have an overall prevalence of emotional and behavioral problems. Similarly, Hackett et al., (1999) conducted a study on the prevalence and associations of psychiatric disorders in children in Kerala among 1403 children aged 8–12 years, and a prevalence of 9.4% was found in mental health disorders.

In a study by Malhotra et al. (2000), the relevance of investigating the prevalence of psychiatric disorders among school-going children was emphasized. The study examined 963 (n=963) school children aged 4-11 years in the city of Chandigarh, utilizing a multi-stage random sampling approach. A multi-assessment procedure was employed to gather data from both parents and teachers regarding the children's

psychopathology, applying the Child Behavior Checklist. The results indicated that 6.33% of children met the criteria for psychiatric disorders according to the ICD-10, highlighting the importance of child psychiatric epidemiology.

Gupta et al. (2017) conducted a prevalence study among 500 school children aged 6-18 years, randomly selected from schools in Uttar Pradesh. The study revealed that approximately 22.7% of children exhibited behavioral, cognitive, and emotional problems. This underlines the significance of routinely screening school children to implement both preventive and timely remedial measures.

The National Mental Health Survey (2016), the largest reported survey of mental morbidity in India, reported that the prevalence of mental disorders is found to be 7.3% among children aged 13–17 years, but a notable treatment gap for overall mental morbidity was found to be 84.5%. There are numerous studies that reflect on the occurrence of behavioral problems among children and adolescents. When the adolescent population is taken into account, Shastri (2009) noted that more than 50 million Indian children suffer from mental disorders.

According to the report of the Centres for Disease Control and Prevention (CDC, 2013), parents reported that 5.1% of US children between the ages of 4 and 17 had significant emotional or behavioral problems. Worldwide, 10–15% of children suffer from emotional and behavioral disorders, according to the National Institute of Mental Health (NIMH). Similar studies have been conducted in Lucknow, which estimated that the prevalence of child and adolescent mental disorders was 12.1% and the disease prevalence was 4.16%; in Bangalore, the overall prevalence was found to be 12.5% (Srinath et al., 2005). Additionally, meta-analysis studies among adolescents revealed that 6.5% of community samples and 23.3% of school samples had a prevalence of emotional and behavioral problems (Malhotra & Patra, 2014; Hossain &

Purohit, 2019); among adolescents, 15% reported a high risk of behavioral and emotional problems (Nair et al., 2017). Genie et al. (2014) conducted a study among 562 school students in Sri Lanka using the Child Behaviour Checklist (CBCL), and the result indicates that 13.8% of the study samples reported total behavioral and emotional problems in the clinical range. Behavioral problems like both internalizing (behavioral problems like anxiety, excessive shyness, frequent crying, etc.) and externalizing (behavioral problems like hyperactivity, restlessness, conduct problems, etc.) are reported as %–12.1% and 8.8%–8.9% in both the clinical and borderline ranges.

McLeod & Kaiser (2004) outlined various symptoms associated with behavioral problems, encompassing disobedient behavior, carelessness, a lack of interest in daily activities, inadequate expression of emotions, low self-esteem, overconfidence, and self-injury or harm to others. The manifestation of behavioral problems can differ between boys and girls, with boys potentially engaging in fights, harm, or theft, while girls may resort to lying or breaking things at home (Sheldrick et al., 2011).

Family Interactions and Behavioral Problems

Research on adolescent problem behavior highlights the significance of understanding their development, particularly concerning the influence of perceived school climate and family functioning. However, it's unclear how these factors interact and predict problem behavior in adolescents. A study with 1,072 Chinese junior high school students examined this relationship by Zhang & Wang, S (2020). They found that perceived school climate was negatively correlated with problem behavior, and psychological ‘suzhi’ (a concept related to psychological resilience and adaptability) partially mediated this relationship. Additionally, family functioning moderated the influence of perceived school climate on psychological ‘suzh’i, with significant indirect effects observed in participants with high family functioning. These findings highlight

the interplay between family, school, and personal factors in influencing adolescent behavior, offering insights for prevention and intervention strategies. Family functioning is one of the major indicators of quality of family interaction like in the form of roles and responsibility, communication patterns, emotional reactions, skills in problem solving, and behavioral control among family members (Zaider et al.,2020). Family functioning seeks to manage these different factors of family life, viewing the family as a cohesive system, and analysing its overall operational dynamics. It serves as a crucial part of how well the family unit operates and significantly influences the mental well-being of adolescents (Shek, 2002).

Jogdand & Naik (2014) conducted a study focusing on children who had experienced the loss of one or both biological parents, noting a correlation with behavioral problems. Their research involved a sample of 600 children aged between 6 and 18 years residing in the Miraj district of Sangli. The findings of the study revealed a significant relationship between the prevalence of behavioral problems and certain factors, specifically the absence of one or both biological parents and the presence of alcoholism among the parents or caregivers. This suggests that the family environment, characterized by parental loss and alcoholism, plays a crucial role in influencing the behavioral outcomes of children. Such insights highlight the importance of addressing familial factors and providing appropriate support to reduce the impact of adverse circumstances on children's behavioral well-being.

In a study conducted by Alonso-Arbiol & Gallarian (2012), the impact of parenting practices and parental attachment on adolescent aggressive behavior was examined. Data collected from 554 adolescents aged 16 to 19, who completed assessments of both parents (mother and father) parenting practices, attachment towards parents, and aggressiveness. The study found that the acceptance and active

engagement of each parent had a positive influence on attachment between adolescent and their parents. Conversely, forceful and demanding had a negative, albeit weaker, impact on attachment. Importantly, attachment fully mediated the relationships between parenting socialization practices and aggressiveness in late adolescence.

Straus (2001) discussed the consequences of corporal punishment like spanking and slapping the child and pointed out that these kinds of acts contribute to the development of delinquency, criminal conduct, and aggressive behaviour (APA, 1991; Baumrind, 1991; L. Berkowitz, 1993); coercive punishment and aggressive behaviour (Strassberg, Dodge, Pettit, & Bates, 1994); family violence and problem behaviour (Kashani & Allan,1997). Even though the debate on the appropriate use of coercive punishment in child discipline is discussed by many due to the difference in adverse consequences of punishment among the teens who were grown up without aggressive coercion (Donnelly & Straus, 2005; Larzelere & Merenda, 1994; Straus, 1991). At the same time, after the ban of corporal punishment in Sweden in 1979, the children's involvement in substance abuse, sexual assault, suicide, and criminal conduct was diminished remarkably (Durrant, 1999 b). Children exposed to harsh and disciplinary parenting, marked by severe physical and verbal aggression, are more likely to develop maladaptive aggressive behavior themselves.

Stormshak et al., (2000) pointed out that there are both positive (consistent, warm, and involved parenting) and negative (punitive, inconsistent, and physical aggression) types of parenting behavior that are independent of each other, and the parents who were using punitive discipline had a critical outcome of aggressive, oppositional, internalizing, and hyperactive behaviour among children. They identified punitive discipline by parents as a common risk factor among children exhibiting oppositional, aggressive, hyperactive, and internalizing behavior. They also noted a

correlation between physically aggressive punishment, low parental warmth, and involvement, which could contribute to oppositional child behavior. Parenting and child behavior are influenced by a complex interplay of factors, including genetics, environment, and individual differences. While punitive discipline and low warmth and involvement can be risk factors, they are not the sole determinants of child behaviour problems. Between the ages of 8 and 13 years, children often express the characteristics and behavior they observe in their parents. If they witness their parents yelling or engaging in aggressive behaviour, they may perceive such actions as acceptable. When children don't comprehend the underlying reasons for this behavior, they may resort to attention-seeking actions, even if they are considered unacceptable. Consequently, children might engage in disruptive behavior like shoplifting, bullying, disobedience, or physical altercations at school as a way of seeking attention when they feel neglected or misunderstood.

Minuchin studied the role of family interaction on delinquent adolescents and found that whenever the family's adaptability is interfered with by a hostile environment, family dysfunction develops (Kolevzon & Green, 1985).

Davies & Cummings (1998) found that adverse family conditions, such as inter-parental discord, have been previously demonstrated to contribute to childhood psychopathology. This relationship is often explained by factors like decreased emotional security and heightened emotional reactivity.

Attachment to a parent plays a crucial role in a child's acquisition of prosocial behaviour and the adoption of their values and beliefs. Research by Simons et al., (1994) demonstrated that the quality of parental involvement is predictive of three adolescent outcomes: aggression, delinquency, and psychological disorders. They also found a connection between parental involvement, corporal punishment, and

delinquency during adolescence. This suggests that the quality of attachment to parents plays a crucial role in shaping an adolescent's tendency towards aggressive behaviour.

Social Competence and Behavioral Problems

The role of social competence and behavioral problems are one of the crucial aspects of adolescents' mental health. In 2019, Hukkelberg and colleagues conducted a meta-analysis focusing on the relationship between social competence and behavioral problems in adolescents. They analysed data from 54 independent studies involving a total of 46,828 participants, which included reports from parents, teachers, or both. The results showed a medium-sized correlation ($r = -.42$, $p < .01$) between behavioral problems and social competence. Interestingly, there were no significant differences in this correlation based on the types of behavioral problems or social competence measured. However, there was a notable difference in the correlation based on who provided the reports: when both measures came from the same respondent (either teacher or parent), the correlation was stronger compared to when reports came from both parents and teachers together.

Ma et al., (2000) conducted a study in Hong Kong among Chinese adolescents and found that there is a negative relationship between positive interaction with parents, peer groups, and teachers and the adolescent's delinquent or antisocial behavior. Hence, healthy positive interpersonal relationships among adolescents tend to have a low level of problem behaviour.

In a study by Bandeira et al., (2006); Cia & Barham (2009) found that children who have low social competence show high behavioral problems. That is, a high level of social competence among children indicates a lower level of behavioral issues, and a low level of social skill functioning leads to higher behavioral problems (Anderson, 2008; Campbell et al., 2010; Montroy et al., 2014). Research indicates that a lack of

social competence, encompassing challenges in processing social information, struggles with adapting to various situations, and experiencing rejection from peers, could potentially influence the onset and continuity of behavioral issues (Coie & Dodge, 1998; Loeber & Ferrington, 2001).

Nevertheless, the extent of this connection remains uncertain, given that the correlation fluctuates significantly in different studies (Ren et al., 2017). Clearly, not every child manifesting low social competence exhibiting behavioral problems, and conversely, not all children displaying these issues lack social adeptness. (Eiden et al., 2009; Garner &Lemerise, 2007) It's important to note that not all children demonstrating poor social competence also exhibit behavioral problems, and vice versa. Understanding the nature and strength of the correlation between these two concepts is of great interest. Such understanding can provide insights into the connection among social competence and behaviour problems and direct the development of effective early intervention programmes for children who face challenges in both social functioning and behavior. These programmes can be instrumental in addressing behavioral issues while fostering improved social competence in affected children.

In a study by Clark et al. (2002) explored that there is a relationship between adaptive behavior and behavioral problems among adolescents. They led a study among 110 adolescents comprising of different behavioral problems like, attention deficit hyper activity disorder, oppositional defiant disorder, conduct disorder and normal community control groups. They assessed the socialization and communication skills along with behavioral and executive functioning. The results shows that communication and social competence skills are low among children exhibiting oppositional and conduct problems.

Gee & Williams, (1991) noted that there is a relationship between social competence and mental health among adolescents. They found that adolescents between the ages of 11 and 15 years, had reported externalizing behavioral problems during both ages. And higher social competence related to lower behavioral problems.

Emotion Regulation and Behavioral Problem

The development of disruptive behavior is reasoned by deficits in emotion regulation (Njardvik et al 2022). They examined a total of 125 children, aged 6 to 11 years old, experiencing disruptive behavior issues at school were randomly assigned to either receive intervention or be placed on a wait-list control condition. The intervention was administered within the school setting. Evaluations comprised assessments based on teacher and parent ratings, utilizing the Strengths and Difficulties Questionnaire (SDQ) and the Disruptive Behavior Rating Scale (DBRS), both before and after treatment, as well as at a 6-month follow-up. The findings indicated a significant decrease in behavior problems among those in the treatment condition according to both measures, and these effects were sustained at the 6-month follow-up. Notably, the results were more pronounced in teacher ratings, showing medium to large effect sizes. This suggests that the Tuning Your Temper program holds promise as an early intervention approach for children experiencing disruptive behavior problems at school. The study signifies the importance of relation between emotion regulation and behavioral problems among children.

Shneaar-Golan et al., (2023) reviewed on emotion regulation and subjective well-being among parents of children with emotional and behavioral problems. The results indicated that difficulties in emotion regulation are associated to low well-being among the group. Wills et al., (2006) found in a study that the ability in emotion regulation results in less behavioral problems among children.

Mazhar et al., (2022) conducted a study on behavioral problems, empathy, and emotion regulation among 140 participants aged 14–17. They found that among the participants, boys (M = 56.88) showed more behavioral problems than girls (= 31.10). And the regression analysis explained that empathy (B =.61) and emotional regulation (B =.72) significantly predicted ($p<0.01$) the behavioral problems among the group. Empathy is the ability to identify, comprehend, and share the emotional experiences of others. It is regarded as a fundamental and essential component of authentic and mutual human relationships (Decety & Moriguchi, 2007). Empathy enables individuals to connect with and relate to the feelings and experiences of others, fostering understanding, compassion, and supportive interactions in social contexts. And a deficit in empathy in children leads to one of the causative factors for developing psychopathological conditions too (Blair, 2005); absence of empathy results in aggressive and antisocial behavior among children (Miller et al.,2013). The study also indicates that high emotion regulation is more connected to better prosocial behavior and low level of behavioral problems.

Otterpohl & Wild (2016) explored that adolescents who indicate employing a maladaptive emotion regulation profile, characterized by a high utilization of maladaptive strategies alongside a low utilization of adaptive strategies, are particularly vulnerable to encountering externalizing behavior issues. These emotion regulation difficulties and maladaptive emotion regulation strategies related to development of externalizing behavioral problems among adolescents (Brinke et al.,2018).

Roll et al. (2012) conducted a review focusing on longitudinal analyses regarding emotional regulation and childhood aggressive behavior. Their findings revealed a connection between emotion dysregulation and psychopathology in children. The primary investigation cantered on the longitudinal correlation between emotion

regulation and aggression, particularly externalizing behavior, spanning the age range of 0 to 18 years. The review encompassed studies conducted between 2006 and 2011. The evidence suggests that emotion regulation serves as a significant risk factor in the development of aggressive behavior and mental health issues among children.

Blandon et al. (2010) investigated a study on how early emotional and social competence relate to later peer acceptance in a group of 440 children aged 2 to 7 years from a community sample. Employing a multi trait-multimethod approach, the researchers evaluated externalizing behavior, emotion regulation, classroom social skills, and peer acceptance. They utilized longitudinal cross-lag models within structural equation modelling to control for shared rater variance. The results indicated consistent patterns in children's externalizing behavior problems and classroom social skills over time. Surprisingly, there were no reciprocal influences between externalizing behavior problems and emotion regulation; however, higher levels of emotion regulation correlated with decreased externalizing behavior later on. Additionally, early social skills were predictive of later peer acceptance. These findings emphasize the complex interplay between emotional and social development in early childhood.

According to Gratz & Roemer (2004), emotional dysregulation is characterized by challenges with awareness, comprehension, and acceptance of emotion, as well as access to adaptive coping mechanisms and the capacity to regulate behaviour during periods of elevated emotional arousal. Adverse family circumstances, such as conflict between parents, have been demonstrated in the past to increase reactivity and impair emotional security in children, which might result in childhood psychopathology. (Cummings &Davies, 1998).

Cole et al. (2003) observed that emotion regulation and conduct problems are related to each other. Their research involved 85 preschool-aged boys and girls

investigating the regulation of anger between mothers and their preschoolers during moments of frustration, in connection to the child's behavioral issues during preschool and school age. Dyads with a child exhibiting stable conduct problems were identified by less mutual positive emotion, increased mutual anger, and more emotional mismatches compared to other dyads. Maternal emotional responses were found to be predictive of conduct problems during school age, particularly among boys. Additionally, maternal emotions played a role in determining whether symptoms remained stable or improved over time. The emotional dynamics observed in exchanges of anger between mothers and preschoolers might redirect conduct problems in girls and contribute to the persistence of conduct issues in boys.

Parent Management Training and Behavioral Problems

Parent training programmes, an evidence-based parental intervention programmes that have the assumption that the process of parenting contributes to the development, succession, and preservation of behavioral problems. Florean et al., (2021) conducted a study on parenting program and mental health issues among adolescents. They conducted the study among a community sample of early adolescents (aged 10-13 years of age), with a sample of 1125 participants. The results demonstrate that poor parental monitoring and behavioral problems are closely related with adolescent mental health problems. parental wellness and better family interaction (Smith et al., 2020).

Barlow & Coren (2018) reviewed the findings of six systematic reviews evaluating the effectiveness of parenting programs on children with behavioral problems. The findings suggests that parenting programs are effective in reducing the emotional and behavioral problems and improving psycho social well- being of parents.

In their meta-analysis, Basto-Pereira & Farrington (2022) examined the influence of developmental factors on offending behavior. Their analysis revealed that family or parental dimensions emerge as the most significant predictors of general offending. Furthermore, they highlighted the key role of family-related developmental factors in the persistence of criminal behavior (Pedersen et al., 2019; Farrington et al., 2017). Repeated interactions between children's inherent biological characteristics and the social settings in which they are raised, especially the parent-child relationship, mould competencies associated with self-regulation of emotions, cognition, and goal-directed behavior. (Rothbart et al.,2006). Parenting techniques are assumed to regulate factors that affect children's behavioral problems and perhaps amplify the expression of biological vulnerabilities, increasing lifelong risk (Dadds et al.,2015).

Hautmann et al. (2009) investigated on the 1 year follow up outcomes of the parent focused training within the prevention program for externalizing behavioral problems, among 270 children aged 3-10 years, exhibiting externalizing behavior issues. The outcome analysis during the 3-month waiting and treatment phases revealed notable treatment effects on all evaluation criteria, signifying a considerable reduction in child behavior problems and a significant increase in parenting due to intervention. Upon the 1-year follow-up, the initial treatment effects on child behavior problems were sustained, while skills continue to improve.

Moretti & Obsuth (2009) studied the effectiveness of an attachment-focused, systematized intervention for parents of adolescent at risk of aggressive issues. "Connect" is a structured ten-week program designed for parents or other caregivers of adolescents at risk, concentrating on fundamental elements of secure attachment: parental responsiveness, collaboration, reflective ability, and successful emotional regulation within parent-child interactions. The study outlines a notable decrease in

adolescent externalizing and internalizing issues both before and after treatment, and also an enhanced improvement in social functioning and a better management of emotions. Furthermore, parents also reported substantial improvement in their satisfaction with parenting, perceived effectiveness, and a decrease in the burden associated with caregiving responsibilities.

In a comprehensive review of 24 meta-analysis studies on parent-child interaction therapy, Thomas and Zimmer-Gembeck (2007) uncovered a notably larger effect size. This larger effect size was associated with reductions in negative parenting behavior, diminished negative child behavior, decreased conduct problems, improved parental mental health, and enhanced parenting skills (Furlong et al., 2013).

Obsuth et al., (2006) investigated how well parenting programmes strengthened the bonds between parents and adolescents. The programme is based on attachment theory and emphasizes the development of skills in the areas of empathy, parental attachment, and successful dyadic effect management. The outcome showed that they felt more competent and satisfied to be parents, which was a substantial improvement. Reduced levels of evidence in the carer-adolescent connection and decreased aggressive behaviour by adolescents were the conclusions drawn from the study.

Turgay's (2005) approach to managing comorbidity in conduct disorder alongside attention-deficit hyperactivity disorder (ADHD) suggested that treatment should encompass parenting skills training along with enhancing the child's peer relationships, academic performance, and adherence to real authority demands. The optimal treatment plan might involve a combination of medications, patient and parent education, support services, as well as individual, group, family, residential, and inpatient interventions to benefit individuals dealing with conduct disorder and ADHD.

Ogden & Hagen (2008) studied parent management training, in a randomized control trial, the Oregon Model in Norway (PMTO). In the PMTO model, the parents have a vital role as they work as the primary change agents within their family. A sample representing all health regions of Norway, comprising 112 children with conduct problems and their families, took part in the study. Families were randomly assigned to either parent management training or a control group receiving regular services. According to a path model analysis, involvement in the training program was linked to enhanced parental disciplinary practices, which in turn predicted increased child compliance, reduced initiation of negative behavior patterns by children, and lower levels of externalizing problems in children.

Clinical and preventive samples have shown good results with the application of the parent management training Oregon model (PMTO). Nineteen boys and girls who had been mentioned for social aggression took part in one of the initial randomized Parent management Training- Oregon clinical trials. The study found that the treatment group's deviancy scores decreased by 63% while the control groups decreased by only 17% (Patterson et al.,1982). In 2001, Martinez and Forgatch observed that mothers who underwent PMTO training were able to decrease adolescent noncompliance and negative developmental outcomes in the treatment group compared to mothers in the no-treatment adolescent group. This study was a more recent randomized prevention study involving 238 recently separated mothers of boys. Clinical and preventive samples have shown good results with the application of PMTO. In one of the first clinical trials using randomized PMTO, increases in academic performance (Forgatch & DeGarmo, 2002), reductions in externalizing and internalizing behaviour (DeGarmo et al., 2004), and drops in delinquency at three and nine years (DeGarmo & Forgatch, 2005) were all outcomes of the intervention among children. Positive parenting and

coercive punishment were included as mediation strategies for the child improvement in each of these investigations. The mechanism was observed in parenting practices once more. The results regarding disobedience, as well as externalizing and internalizing behavior in both home and school settings, were replicated in the randomized preventive trial involving boys and girls from step families, as reported by Forgatch et al. (2005).

Children's behavioral problems are linked to their physical, mental, social, and educational difficulties. Parental care also influences the behaviour and development of children. O'Farrelly et al. (2021) examined the role of parenting programmes among children with behavioral problems. They used the technique of training on video-feedback to enhance parenting skills and a kind of sensitive discipline, with a period of six sessions, to reduce problem behaviour among children. The participants were selected in an age group of 1-2 years with symptoms of impulsivity, aggression, and restlessness. A total of 300 families participated, and half of the families were provided with training lasting five months. The findings revealed that behavioral problems among children whose parents received the video-feedback training programme were reduced compared to the counterpart group of children. Webster-Stratton (1998) found that the children's behavioral problems could be effectively managed by implementing an incredible year-long training programme for parents. The study results show that when there is better parental interaction with children, the negative behaviour among children is reduced, and their prosocial behaviour has improved significantly, especially in classroom settings.

Conner & Frazer, in 2011, reviewed literature on universal violence and child maltreatment prevention programs which targets parents. The review encompassed 23 studies, identifying 16 distinct types of parenting programs. Notably, 91% of these

studies were conducted in developed nations. These programs were designed to prevent violence and maltreatment by promoting positive parenting techniques. However, only seven studies employed randomized controlled trials. Results showed improvements in parenting strategies post-intervention across 18 studies, with 90% of studies reporting enhanced child behavior. The findings emphasized the significance of parenting education programs in universally preventing violence and maltreatment against children.

In 2000, Kazdin & Wassell conducted a study aiming to assess a parent problem-solving (PPS) intervention meant to enhance the effectiveness of evidence-based therapy for children dealing with aggressive and antisocial behavior. The study involved 127 children aged 6-14 years and their families, all of whom received problem-solving skills training (PPS), while parents received parent management training (PMT). Families were randomly assigned to receive an additional component (PPS) addressing parental stress during treatment or not. Results indicated overall improvement in children's behavior following treatment, with the PPS intervention further enhancing therapeutic outcomes for both children and parents. Additionally, it helped alleviate barriers parents encountered during the treatment process. Edwards et al., (2001) explored that parent management training was found effective among children with behavioral problems. Through such interaction between parent and child and family-oriented problem-solving techniques, the overall functioning of the group was significantly improved. Shaw & Bell (1993) noted that the role of parental strategies in enhancing deficient self-regulatory skills, encompassing the control of impulses and expression of emotions in children with behavioral issues.

Social Skill Training and Behavioral Problems

Halla et al., (2022) examined the impact that social skills training has on children with conduct problems in terms of behavioral issues. A "pre- and post-test design" was used, which is a quasi-experimental design. A sample of 30 children diagnosed with conduct disorder was selected conveniently for the study. The Parent Version of the Behavioural Problems Questionnaire, the Social Skills Questionnaire, and the Socio-demographic Data Sheet were used for collecting data. Results indicate that after attending social skills training programme sessions, the conduct disordered children showed significant improvements in their social skills and behavioral problems ($P = 0.005, 0.0001$), respectively. Following training, social skills improved from 83 to 89, and the overall mean scores for behavioral issues dropped from 66.9 to 50.3. The study found that social skills training programmes are very successful in helping children with conduct disorders with their behavioral issues.

January et al. (2011) did a study to evaluate social skills programmes and found that early intervention increases the likelihood of a favorable outcome and may prevent the emergence of harmful behavior. Furthermore, the evaluation of the children component in social skill training has revealed decreased disruptive behaviour, enhanced social competence and cognition in comparison to control, as well as decreased aggressive behaviour and callous unemotional characteristics (Taylor et al., 2017).

Gresham et al., (2004) did a meta-analysis study in which they examined six papers pertaining to social skill training with children who either had or were at risk of developing emotional and behavioral disorders (EBD). According to their findings, social skill training was a successful intervention for children with EBD, as seen by the

64% improvement rate in problems including aggression, externalizing and internalizing behavior, and antisocial behavior when compared to controls.

The impact of social skill training on children with behavioral problems was assessed by Wang et al. in 2007 and found that social skill training is much more helpful for improving psychosocial competence skills among children with behavioral problems. The problem-solving skill training enabled the children with behavioral problems to facilitate in their social and planning abilities and thus reduce behavioral issues (Bakhshayesh, 2014).

Vugt et al. (2012) assessed a social skills training programme that was group-based and aimed at lowering problem behavior. A sample of 161 children aged seven to thirteen was chosen for the study. In a quasi-experimental study, the intervention's effects were evaluated by a follow-up evaluation conducted a year following an optional continuation camp. Only the experimental group demonstrated a slight and favorable change in social anxiety at the post-test, but the control group and the experimental group both showed reduced internalizing and social issues. A 12-month follow-up revealed significant improvements in all outcome measures for a subsample of the experimental group, with the exception of externalizing difficulties, where there was only a negligible impact.

Gresham et al. (2006) state that social skills training aids children in establishing and sustaining healthy social relationships, helps them develop friendships and peer acceptance, leads to satisfactory school adjustment, and enables them to deal with and adjust to the demands of the school environment. A meta-analysis study on social skill training among children and youth with antisocial behavior was conducted by Losel and Beelmann in 2003. The comparison study with treated and untreated youth with

problem behaviour revealed the effectiveness of social skill training on anti-social behaviour.

Kazdin et al. (1992) found the effectiveness of problem-solving skill training and parent management training among children aged 7–13 with severe antisocial behaviour. Social skill training, along with parent management training, has shown remarkable effectiveness among children and youth with behavioral problems (Webster-Stratton et al., 2004).

Mindfulness Training and Behavioral Problems

The literature reviewed consistently affirms the efficacy of using mindfulness as a self-management technique to address maladaptive behavioral patterns in children. Researchers suggest that mindfulness practices a realistic perspective of thoughts, feelings, and behavioral regulation, which leads to executive and better psychological wellbeing among children and adolescents (Williams et al., 2006; Flook et al., 2010).

Hatami et al. (2022) conducted a study on the influence of emotional regulation strategies on behavioral problems in children with intellectual disabilities. The study followed an experimental design incorporating both pretest and post-test assessments, as well as experimental and control groups. The total number of participants was 44, with an age group of 10–18 years old students, as selected by the convenience sampling method. The experimental group was provided with 16 training sessions on emotion regulation, while no training was given to the control group. The results indicated that, after the training session, the behavioral problems among the experimental group were considerably reduced ($P<0.001$) in both externalizing and internalizing problems when compared to the control group.

Franco et al. (2016) explored whether a mindfulness training programme was effective in reducing behavioral problems like impulsivity and aggression among

adolescents in the classroom. A randomized controlled trial with pre-test and post-test measures was used with both the experimental and control groups, a total of 27 participants with an age range of 12 to 19 years of age. The findings show a significant decrease in the levels of aggressiveness and impulsivity in the experimental group when compared with the control group.

Research on neurodevelopmental findings implies that mindfulness has a significant influence on social-emotional learning, which helps in enhanced executive functions in children and adolescents and leads them to have the ability to have balanced emotional fluctuations and inhibitory control, which facilitate better academic performance (Davidson et al., 2012; Sanger & Dorjee, 2015).

Singh et al. (2009) conducted a study utilizing a multiple baseline across participants design, involving two children aged 10 and 12 with attention deficit hyperactivity disorder (ADHD). These children participated in a 12-week mindfulness meditation intervention following a similar intervention undergone by their parents. The parents recorded events related to their children's compliance, showing an increase in child compliance during parent mindfulness training, which further improved during child mindfulness training. Some maintenance of this increased compliance was observed during follow-up. The percentage increase in compliance ranged from 26.7% during the interventions to 10.2% during the 24-week follow-up period. Despite limitations such as small sample size and specific methodology, the intervention's sequential use of mindfulness training for parents followed by children appears viable. It presents a systemic approach that addresses parent-child interactions through mindfulness training.

Singh et al. (2007) conducted a study involving three adolescents aged 13 to 14 with conduct disorders who were at risk of school exclusion. These adolescents

participated in a mindfulness meditation intervention, consisting of 12 individual sessions over four weeks, followed by a 25-week practice phase with monthly instructor-led sessions. The dependent variable measured was the self-reported number of aggressive and non-compliant acts. Results indicated a minimal decrease in these behaviors during the training period, but a more substantial decrease (up to 52%) was observed during the follow-up period. Additionally, all three students successfully completed middle school without further threats of expulsion.

Bogels et al. (2008) investigated the effectiveness of mindfulness training as a intervention for attention and impulsivity issues in adolescents with externalizing disorders. The study involved 14 clinically referred adolescents and their parents, who received mindfulness parenting training. During the waitlist period, no significant improvements were observed in most measured variables. However, following mindfulness training, adolescents self-reported substantial improvements in various areas, including personal objectives, internalizing and externalizing issues, attention deficits, happiness, and mindful awareness. Parents noted improvements in their children's goals, externalizing behavior, attention difficulties, self-regulation, empathy, and social withdrawal. Parents themselves reported improvements in their own goals. These improvements were sustained at the 8-week follow-up. Based on mindfulness theory, increased awareness reported by the adolescents after training was associated with longer-term improvements in parent-rated child symptoms. The results suggest that concurrent mindfulness training for both parents and adolescents shows promise as an effective strategy for clinically referred adolescents who are facing challenges related to attention and impulsivity.

Schonert-Reichl & Lawlor (2010) examined a mindfulness -based program led by teachers for children exhibiting hostility and oppositional defiant behavior. The

program comprised ten lessons and three mindfulness meditation sessions daily. Overall, there was a significant increase in scores on self-report measures of optimism and positive emotions. According to teacher reports, children in the treatment group showed reduced hostility and oppositional behaviour, along with enhancements in their social and emotional skills.

The study conducted by Milani et al. (2013) focused on a sample group of 22 adolescent males residing in a juvenile correction and rehabilitation center in Zahedan province. There were two groups of participants; the treatment or experimental group and the non-treatment or control group. The division was based on a matching method that considered pre-test scores on the aggression questionnaire, ensuring both groups were equivalent in terms of initial aggression levels. Afterwards, the participants were then randomly allocated to either the experimental or control groups. In the treatment group, the researchers administered an 8-session programme of mindfulness-based cognitive training. The study evaluated the effectiveness of this training in reducing anger, physical aggression, and hostility. Measurements were taken during the post-test phase immediately after the training, and in the follow-up, tests were conducted two weeks after the post-test sessions. The results of the study indicated that the mindfulness-based cognitive training was effective in significantly reducing anger, physical aggression, and hostility in the post-test and follow-up test phases. This suggests that mindfulness-based interventions could have a positive influence on reducing aggressive behavior and improving emotional regulation in adolescents in a juvenile correction and rehabilitation center.

Semple et al., (2006) discovered early evidence in support of the practicality and acceptability of using mindfulness to treat anxiety problems in children. It's

interesting to note that these kids' attention, behaviour, and anger issues decreased the most.

A specific study involved thirty-two children identified with behavioral problems, where mindfulness skills training was administered over 16 weeks in a 2-hour group therapy setting. Following the intervention, carers observed a notable improvement in adaptive behavior, while the children themselves reported a remarkable reduction in behavioral symptoms (Nelson-Grey et al., 2006). Gupta & Jena (2018) found that a multicomponent intervention consisting of mindfulness, cognitive behaviour therapy, and management of academic conducted among children with behavioral problems, revealing the significance of training in reducing behavioral problems and improving academic achievement among children.

Rationale of The Study

India boasts the world's second-largest population at 1.236 billion people (R-UNIC-4), one of the world's largest child and adolescent populations, with over 444 million children, with a substantial proportion between the ages of 10 and 24, comprising every third person and every fifth person falling into the adolescent age group of 10 to 19. India leads the world in terms of its child and adolescent population, totalling over 434 million (R-CI-5). This demographic landscape is poised to deliver a significant demographic dividend, with an anticipated workforce of 250 million people by 2030 (R-TR-6). To fully harness this potential for the nation's growth and development, it is crucial that policies prioritize the physical and mental health of children and adolescents. Despite efforts focused on reducing infant and under-five mortality rates, improving immunization, and enhancing nutrition, child and adolescent mental health (CAMH) in India has received limited attention and support (R-MOHFW-7).

As per the UNESCO report in 2008 (UNDP Report, 2008), in India, the psychological disorder that has to be noticeable between the ages of 5 and 15 is around 10%. Around 50 million children under the age of 18 are availing of mental health services. Surprisingly, severe forms of mental health problems among adolescents are around 20 million, and approximately 90% of children with any kind of psychological distress are not getting proper expert care. A descriptive study conducted in India described that 89.34% of children have moderate behavioral problems (Masare et al., 2017); a study conducted in India in 2017 revealed a higher prevalence of combined borderline and abnormal behavioral problems in the age groups of 12–13 years (64.1%) and 13–14 years (30.8%). Additionally, the findings indicated that the prevalence of behavioral problems among girls was greater compared to boys (Potter et al., 2013).

In Kerala, a study conducted by Harikrishnan, & Sailo (2021) found that school-going children have reported emotional problems (11.5%), conduct problems (9.7%), hyperactivity (8.5%), and peer-related problems (6%). The overall prevalence of emotional and behavioral problems among school-going children in Kollam District is found to be 24.5%. In addition to the above studies, the prevalence of behavioral problems among 228 school-going children in Thrissur District found a high prevalence of externalizing problems among school-aged children, followed by other problems and internalized behavioral problems (Vandana & Starlet, 2021). Furthermore, Jayaresmi & Kavitha (2023) pointed out the prevalence of behavioral problems among 235 school-going children in Trivandrum District, and the results show that 54% of the children had a normal pattern of behaviour, while 45.5% reported mild behavioral problems, 0.4% reported moderate behavioral problems, and none of them reported severe behavioral problems.

Behavioral problems refer to deviations from normal behaviour, and based on the previous research findings, their prevention is crucial due to the escalating frequency of such issues in children. Timely intervention is essential to facilitate the child's recovery from behavioral disorders. The primary objective of treatment is to prevent the persistence of problems from childhood into adulthood, thereby preventing more severe consequences.

Earlier research findings state that the mental health of children is influenced by a variety of factors, and family interaction, as well as social and emotional wellness, play significant roles in shaping a child's psychological well-being. Research and studies have consistently demonstrated the impact of these factors on children's mental health. When considering family interaction, the quality of interactions within a family can have a profound impact on a child's mental health. Positive, nurturing, and supportive family environments are generally associated with better mental health outcomes for children. Conversely, poor parent-child interaction, characterized by neglect, conflict, or a lack of emotional support, can contribute to behavioral problems in children. Social interaction with peers and within the community is crucial for a child's development. Inadequate social interaction can result in difficulties in forming relationships, lower self-esteem, and potential social isolation, all of which can negatively impact mental health. Emotional regulation, or wellness, is the child's ability to manage and express their emotions, which is a key aspect of their emotional well-being. Difficulties in managing emotions can lead to increased stress, anxiety, and other emotional challenges, which may manifest as behavioral issues. Hence, behavioral problems such as aggression, difficulties in social interaction, or the inability to manage emotions can be early signs of mental health issues in children. It's important to

recognise and address these problems promptly, as they can lead to more severe mental health issues later in life if left unattended.

From the reviews, it’s important to recognise that research on the association between family dynamics, social and emotional aspects, and mental health outcomes in the context of specific intervention programmes for children with behavioral problems is a complex and evolving field. Parent management training is a well-established approach for addressing behavioral problems in children. It typically involves teaching parents’ effective strategies for managing their child's behavior. There is a significant body of research supporting the effectiveness of these programmes, but there is always room for further investigation and refinement of these interventions. Social skills training aims to improve a child's ability to interact with others, which can contribute to a positive impact on their emotional and social well-being. Research in this area has shown positive outcomes, but the effectiveness can vary based on the specific programme and the child's individual needs. Mindfulness training, which focuses on promoting emotional regulation and self-awareness, is another approach that has gained attention in recent years. It has shown promise in helping children manage their emotions and behavior. However, the body of research on mindfulness training for children is still growing, and more studies are needed to fully understand its impact.

Addressing the research gaps in these areas is crucial for developing evidence-based interventions and improving outcomes for children with behavioral problems. As research continues, it can provide more specific insights into the most effective strategies and their long-term impact on children's mental health. Furthermore, interdisciplinary research that integrates family, social, and emotional factors into intervention programmes is valuable for a holistic understanding of child development

and mental health. This can help develop more comprehensive and personalized interventions that consider the unique needs of each child.

In summary, while there may be limited studies on the specific intersection of family dynamics, social and emotional aspects, and interventions like parent management training, social skill training, and mindfulness training, it's a positive step to address these research gaps. Such efforts can lead to more effective, evidence-based interventions for children with behavioral problems and contribute to the overall improvement of child mental health outcomes.

Statement of The Problem

Children with behavioral problems often experience significant challenges in their family, social and emotional functioning, which can adversely affect their mental health. While various interventions exist to address behavioral issues independently, there is a gap in comprehensive, multidimensional programs designed to simultaneously focus behavioral problems and promote mental health among this population. Hence, the present study entitled "***Effectiveness of Multidimensional Program on Mental Health among Children with Behavioral Problem".***

Research Questions

1. What is the frequency distribution of behavioral problem among school going children, along with different socio demographic variables?
2. What are the observed changes in mental health indicators such as family interaction, emotion regulation, and social competence following participation in the multidimensional program among children with behavioral issues?
3. Are there noticeable modifications in behavioral symptoms among children after their engagement in the multidimensional program designed for addressing behavioral problems?

Objectives

1. To assess the changes in mental health aspects such as family interaction, social competence, emotion regulation between children who have completed a multidimensional program and those who have not participated in such a program.
2. To examine whether there is any difference in behavioral problems between children who have participated in a multidimensional program and those who have not undergone such intervention.

Hypotheses

1. There is a significant difference in the pretest level of behavior problems between children in the intervention group and those in the non-intervention group.
2. There is a significant difference in the post-test level of behavior problems between children in the intervention group and those in the non-intervention group.
3. There is a significant difference in the pretest level of family interaction and its dimensions (independence, cohesion, achievement orientation, intellectual orientation, conflict, social orientation, ethical emphasis, and discipline) between children in the intervention group and those in the non-intervention group.
4. There is a significant difference in the post-test levels of family interaction between children in the intervention group and those in the non-intervention group. The following sub-hypotheses at the post-test level include family interactions and its dimensions.

   4.1: There is a significant difference in the post-test level of independence between children in the intervention group and those in the non-intervention group.

   4.2: There is a significant difference in the post-test level of cohesion between children in the intervention group and those in the non-intervention group.

4.3: There is a significant difference in the post-test level of achievement orientation between children in the intervention group and those in the non-intervention group.

4.4: There is a significant difference in the post-test level of intellectual orientation between children in the intervention group and those in the non-intervention group.

4.5: There is a significant difference in the post-test level of conflict between children in the intervention group and those in the non-intervention group.

4.6: There is a significant difference in the post-test level of social orientation between children in the intervention group and those in the non-intervention group.

4.7: There is a significant difference in the post-test level of ethical emphasis between children in the intervention group and those in the non-intervention group.

4.8: There is a significant difference in the post-test level of discipline between children in the intervention group and those in the non-intervention group.

5. There is a significant difference in the pretest level of social competence and its dimensions (team organizing, peer social competence, social cognition, home related social competence, social emotional competence, social forethought and compassion, social flexibility, and school competence) between children in the intervention group and those in the non-intervention group.

6. There is a significant difference in the post-test level of social competence between children in the intervention groups and those in the non-intervention group.

   The following sub-hypotheses at the post-test level include social competence and its dimensions.

6.1: There is a significant difference in the post-test level of team organizing competence between children in the intervention group and those in the non-intervention group.

6.2: There is a significant difference in the post-test level of peer social competence between children in the intervention group and those in the non-intervention group.

6.3: There is a significant difference in the post-test level of social cognition between children in the intervention group and those in the non-intervention group.

6.4: There is a significant difference in the post-test level of home related social competence between children in the intervention group and those in the non-intervention group.

6.5: There is a significant difference in the post-test level of social emotional competence between children in the intervention group and those in the non-intervention group.

6.6: There is a significant difference in the post-test level of social forethought and compassion between children in the intervention group and those in the non-intervention group.

6.7: There is a significant difference in the post-test level of social flexibility between children in the intervention group and those in the non-intervention group.

6.8: There is a significant difference in the post-test level of school competence between children in the intervention group and those in the non-intervention group.

7. There is a significant difference in the pretest level of difficulties in emotion regulation and its dimensions (lack of awareness, lack of clarity of emotion, non-acceptance of emotional response, limited access to emotional regulation strategies, difficulties in controlling impulses, and difficulties engaging in goal directed behavior) between children in the intervention group and those in the non-intervention group.
8. There is a significant difference in the post-test level of difficulties in emotion regulation between children in the intervention group and those in the non-intervention group.

   The following sub-hypotheses at the post-test level include difficulties in emotion regulation and its dimensions.

   8.1: There is a significant difference in the post-test level of lack of awareness of emotional response between children in the intervention group and those in the non-intervention group.

   8.2: There is a significant difference in the post-test level of lack of clarity of emotion between children in the intervention group and those in the non-intervention group.

   8.3: There is a significant difference in the post-test level of non-acceptance of emotional response between children in the intervention group and those in the non-intervention group.

   8.4: There is a significant difference in the post-test level of limited access to emotional regulation strategies perceived as effective between children in the intervention group and those in the non-intervention group.

   8.5: There is a significant difference in the post-test level of difficulties in controlling impulses when experiencing negative emotions between

children in the intervention group and those in the non-intervention group.

8.6: There is a significant difference in the post-test level of difficulties engaging in goal-directed behavior when experiencing negative emotions between children in the intervention group and those in the non-intervention group.

Definitions of Key Terms

Mental health

According to WHO (2001), mental health is defined as '…a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

Mental health is operationally defined as the wellbeing of children in family interaction, social competence, and good emotion regulation.

Children

The Convention on the Rights of the Child (Rights of the Child, 1989): Article 1 defines: 'A child means every human being below the age of 18 years'

For the present study**,** children refer to both male and female school-going children between the ages of 11 and 16y years in schools in Thrissur District. It refers to children who were screened by parents and school counselors for behavioral problems.

Behavioral Problem

Behavioral problems are defined as patterns of behaviour among children that are disruptive and that have resulted in problems at school, home, or in social situations (Grell & Williams, 2023).

For the current investigation, behavioral problems are defined as children with behavior like stubbornness, lying and stealing, aggression, temper tantrums, disobedience, disruptiveness, quarrelsomeness, and truancy. The risk of behavioral problems is measured in terms of the scores obtained from the structured tool.

Family Interaction

Family interaction is a pattern of family dynamics where interactions among parents, children, and relatives and their roles and responsibilities shape their interactions (Gunn & Eberhardt 2019).

Family interaction operationally defined to the opportunity to establish, maintain, and promote parent-child relationships. Through family interaction, both parents and children get an opportunity to evaluate the relationships between them and also to adopt new skills to enrich the parenting process. For the present study, family interaction is the score obtained on the family interaction scale. The sub dimensions of family interactions like independence, cohesion, achievement orientation, intellectual orientation, conflict, social orientation, ethical emphasis, and discipline were also scored to assess the indicators of family interaction.

Social Competence

Social competence is defined as a person's age-appropriate knowledge and skills for functioning peacefully and creatively in his or her own community or social environment' (Orpinas & Horne 2006).

For the current study, social competence refers to the ability to integrate thinking, feeling, and behaviour to achieve social tasks and outcomes valued in the host context and culture. Social competence refers to the scores obtained by the children on the social competence scale, and its sub dimensions like, team organizing competence, peer social competence, social cognition, home related social competence, social

emotional competence, social forethought and compassion, social flexibility, and school competence.

Emotion Regulation

Emotion regulation is defined as ‘involving the (a) awareness and understanding of emotions, (b) acceptance of emotions, (c) ability to control impulsive behavior and behave in accordance with desired goals when experiencing negative emotions, and(dd) ability to use situationally appropriate emotion regulation strategies and the flexibility to modulate emotional responses as desired in order to meet individual goals and situational demands’ (Gratz & Roemer, 2004).

Emotional regulation consists of people’s active attempts to manage their emotional states. Emotion regulation subsumes the regulation of all states that are emotionally charged, including moods, stress, and positive or negative affect.

Difficulties in emotion regulation: a maladaptive pattern of regulating emotions that may involve a failure of regulation or interference in adaptive functioning. For the present study, difficulties in emotion regulation refer to the scores obtained by the children on the scale of difficulties in emotion regulation and its subdimensions like lack of awareness of emotional response, lack of clarity of emotion, non-acceptance of emotional response, limited access to emotional regulation strategies perceived as effective, and difficulties in controlling impulses when experiencing negative emotions, and difficulties in engaging goal directed behavior when distressed.

Multidimensional Program

A multidimensional approach refers to a holistic approach to understanding wellbeing, which includes biological, psychological, and spiritual experiences to maintain the individual as a unique one. (Hutchison,2015).

For the present study, a multidimensional program refers to intervening with a person or a group of persons with different types of treatment modalities, specifically the multidimensional program involves a parental management program, social skill training, and mindfulness training.

Parent Management Program

Parent management training refers to an intervention program that trains parents to effectively manage their children's behavioral problems (APA, 1993).

For the present study, the training module implemented parenting sessions to improve the child-parent relationship. The program was adopted from the Coping Power Program by Lochman et al. (2008) and parent management training by Kazdin (2005).

Social Skill Training

Social skill has been defined as the 'ability to express feelings or to communicate interests and desires to others' (Liberman et al., 1975).

Social skill training is a form of behavior therapy used by teachers, therapists, and trainers to help individuals who have social skill deficits. In this study, the researcher focuses on social skills like communication, empathy, problem solving, conflict resolution, and anger management.

Mindfulness Training

Mindfulness is defined as 'an awareness that arises by paying attention on purpose, in the present moment, and nonjudgmentally to the moment-to-moment experience' (Kabat-Zinn, 2013).

Mindfulness training is a set of practices to help children increase the awareness that emerges through paying attention to purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment (Kabat-Zinn, 2003).

Mindfulness training helps an individual learn and recognise their thoughts and feelings, with the aim of improving and creating new skills to adapt to challenging daily situations. In mindfulness training, observing, listening, and experiencing the present moment were practiced. The sessions were planned to pay attention to what they were doing, feeling, or thinking.

Chapter Summary

The present chapter describes an in-depth exploration of the introduction and literature review relevant to the study's focus on the effectiveness of a multidimensional program on mental health among children with behavioral problems. The chapter focuses on various factors influencing behavioral problems, particularly emphasizing family interaction, social competence, and emotion regulation based on extensive literature review. In addition, it scrutinizes the interconnectedness of these factors with behavioral problems, emphasizing their important role in the study's context. Furthermore, the chapter explained by synthesizing insights from diverse intervention approaches, including parent management training, social skill training, and mindfulness training, aimed at reducing behavioral problems and enhancing children's mental health. Finally, the chapter concludes by stating the research problem, followed by the research objectives and hypothesis, which explain the research gap, leading to the method of the research.

The effectiveness of a scientific research work focuses largely on the appropriate methodology employed in the research process. Research methods encompass the description of the research process or a series of procedures adopted in a study. This chapter addresses research design, participant selection, sampling procedures, collection of data, and the statistical analysis applied in the study.

Research Design

The research method is the blueprint of research which consists of the procedure through which the investigator conducts the study to make it more precise. Scientific methodology is defined as the systematic approach to arranging methods; referring to the logical procedure employed in scientific study (Best & Kahn, 1993). The research perspective is an inquiry into reality about something by testing an assumed hypothesis. The present study focuses on the effectiveness of a multidimensional approach to mental health among children with behavioral problems. The data were collected through questionnaire method. Thus, a quantitative research approach is applied. A 'quantitative research' is an approach for testing objective theories by examining the relationship among variables which can be measured (on instruments) and resulting data in numbers can be analysed using statistical procedures, which help for generalization and replication' (Creswell, 2014). In quantitative research behavioral attributes can be measured by assessing the presence and absence of certain attributes. In the present study, Mental health and its dimensions can be measured with quantitative value by denoting whether there is any improvement or not in mental health among children. This study adopts an experimental approach, organized into two groups—one receiving treatment and another serving as the untreated control group. In this research, it consists of both control and experimental groups. The participants are assigned randomly to either experimental or control groups. A pre-test comparison

between experimental and control group was tested before the intervention process and the intervention program was administered exclusively for the experimental group, and the effect of multidimensional program was analysed on both experimental and control group, as the post-test assessment. (Cooper & Schindler,2014; Hastijario,2019). Hence, a pretest-post-test control group design was employed to structure and conduct the study.

Variables Used for the Present Study

A variable is a concept that can assume various quantitative values. The quantitative values can be measured in terms of height, weight, and the presence or absence of an attribute. The variables of the present study are classified into two categories like, Independent, and Dependent variables. The independent variables are manipulated and vary in the experimental study which act as a causal variable for some change or effect in the dependent variable. A dependent variable is dependent or is the consequence of a manipulated variable. Hence, a dependent variable depends on an independent variable (Kothari, 2004).

Independent Variable

The independent variables in the present study are the Multidimensional Program, which include;

- Parental management program
- Social skill training
- Mindfulness training

Dependent Variable

The dependent variables in the present study are the Mental health and its dimensions like dimensions;

- Behavioral problem

- Family interaction
- Difficulties in Emotion regulation
- Social competence

Phases of The Study

The current investigation unfolded in two distinct phases, phase I and Phase II.

Phase I: The Pilot Study

The phase I of the pilot study was conducted in two sections, the first section aims to understand the frequency or distribution of behavioral problem among school going children and the second section entailed a trial study involving six children with behavioral problems to assess the effectiveness of intervention strategies intended for implementation in the main study.

Section A: Frequency or Distribution of Behavioral Problems Among School Going Children

Participants. The process of sampling is selecting a relatively small number of individuals for observing and analysing and to infer characteristics about the entire population, from which samples are drawn (Best & Kahn, 1995). A sample is called the representative proportion of the population (Koul, 2009). As the general characteristics of the sample can make inferences about the population where it has been selected, then the results obtained from the sample can be applied to the concerned population.

During this phase, the researcher aimed to determine the frequency distribution of behavioral problems among school-going children. Participants for this investigation were selected from the 11-16 years age group, with a specific focus on high school sections within the Thrissur district. A total of 228 children, including 134 boys and 94 girls, spanning across six schools, actively took part in this section of the study.

Inclusion Criteria

- Children aged between 11- and 16-year-old
- Both boys and Girls
- School going children

Exclusion Criteria

- Children who are having any psychiatric mental health problem

Measures. The following measures were used in the first section of phase I of data collection.

1. Personal Data Sheet: The researcher prepared the personal data sheet collect basic demographic details of the participant like age, gender, type of school, annual income and parenthood.

2. Youth Self Report (YSR): The present study utilized the English form designed for individuals aged 11-18 years by Achenbach (1991). The YSR comprises 112 items across various dimensions, serving as a tool to assess the severity of behavioral and emotional problems. These dimensions include internalizing problems such as anxiety/depressive symptoms, somatic complaints, and withdrawal/depression. Externalizing problems encompass rule-breaking behavior and aggressive behavior, while other problems include social relationship issues, attention problems, and thought-related challenges.

Accessible to youth with fifth-grade reading skills, the YSR can also be administered orally. The dimensions of the Youth Self-Report are articulated through single-sentence items, prompting respondents to indicate the severity of each issue. Respondents used a three-point scale for rating, where 0 signifies "not true," 1 denotes "sometimes true," and 2 represents "very true." The scores for each subscale item were then summed to derive the total score for each respective subscale. The raw score of

each subscale was converted to *T* score, with a mean of 50 and standard deviation of 10, and the percentiles corresponding to each *T* score vary.

The test validity and reliability were found to be 0.62 to 0.68. Permission was taken from the school authority and from children to conduct the study. The answered checklist was collected and scored as per manual

Sampling Procedure. In the initial phase of the study, Section A was executed to assess the occurrence of behavioral issues among children. Participants were specifically chosen from high school sections located in the Thrissur district for this purpose. The researcher visited different schools to conduct the study. The purpose and ethical concerns of the study were explained to the school authorities. After getting consent from the school authorities and parents, the researcher did a face-to-face interaction and made rapport with children. Children between the ages of 11-16 years, who are studying in VIII to X standard were taken for the study. The children from three streams of educational institutions like Government, Aided, and Unaided sections were part of the study. A total of 228 children from six schools were the participants for the study. Thus, a purposive sampling method was used in the present phase of study. Confidentiality of responses were ethically maintained.

The collected data are analysed and reported in chapter III

Section B: Trial study to find out the effectiveness of intervention strategies among children with behavioral problem

Based on the insights gained from the frequency distribution on behavioral problems, it became evident that these issues are notably relevant and require focused attention on both understanding the problems and implementing effective management strategies. The section B of the pilot study highlights the common occurrence of

behavioral problems among school-going children, with externalizing problems emerging as the most commonly reported issues.

In response to these findings, the researcher directed attention to the management of externalized problem behavior, specifically addressing conduct-related behavioral issues among children. Drawing from existing literature, it was identified that an individualized training program incorporating elements such as individual counselling, parental counselling, behavioral contracting, relaxation training, and the promotion of healthy routines could be instrumental in reducing behavioral problems among children (Petrenko,2013). Motivated by the goal of developing a comprehensive training module, the researcher recognized the necessity to evaluate the effectiveness of such a training program. Consequently, the second section of phase I was designed as an experimental trial, featuring a concise yet impactful duration of the training program. This experimental phase aimed to assess the viability and potential efficacy of the training module in addressing and reducing behavioral problems among children. In the present section, the pre and post assessment of behavioral problems were analysed through diagrammatic representation and each participant's detailed case summary were done.

Participants. In order to understand the effectiveness of intervention programs among children with behavioral problems, a brief training module was prepared and implemented among groups. The participants of the present study were six school children, within the age of 13-15 years with five boys and one girl.

Inclusion Criteria

- Children among the age group of 13-15 years
- Children who scored four and above in the Developmental psychopathological checklist

Exclusion Criteria

- Children who not met with the criterion score in Developmental psychopathological checklist

Measures

1. ***Personal data sheet.*** The personal data sheet used to collect age, gender, class of study of participants.
2. ***Developmental psychopathological checklist (DPCL).*** The Developmental Psychopathological checklist for children (Kapur et al.,1995) as a screening instrument designed to assess psychopathology in children, it is a brief, thorough, yet developmental in perspective and require minimal training for effective use. The DPCL has 124 items with six subscales. one of the subscales of DPCL is Conduct problem subscales, a behavioral problem which has eight items, they are (1) stubbornness, (2) Disobedience, (3) Disruptiveness, (4) Quarrelsomeness, (5) aggressiveness, (6) Temper tantrums. (7) Truancy, and (8) Lying and stealing. The behavioral problems of eight items are described as:

Stubbornness: a stubborn behavior is characterized by a strong determination to pursue their own desires and exhibits great reluctance to change their view points.

Disobedience: a behavior characterized by refusal to comply with authority figures directiveness.

Disruptiveness: a behavior that regularly intimidates or produces fear in others, or socially disrupts community and social norms.

Quarrelsomeness: a behavior being quick to argue or disagree.

Aggressiveness: a manifestation of behavior responds in a hostile manner toward sibling, peer or adults including both physical and verbal aggression.

Temper tantrums: a behavior characterized by disruptive and unpleasant behavior or emotional outbursts, typically arising in reaction to unfulfilled desires or needs.

Truancy: absence from school without permission

Lying and Stealing: lying is a behavior to get favor or to avoid responsibilities. Stealing is a behavior characterized by taking something from other people or stores, without consent.

Administration And Scoring. The scales can be administered individually to parents of children selected for the study. There are eight sub sections in conduct problems, and a score of '0' given for absence of conduct problems, and a score of '1' is given for the presence of conduct problems. Thus, the total score for the conduct problem is eight, and the cut off score is four. The sample who scored at least 4 considered the study with conduct problems. The tool has applicability with both children and adolescents and has been used in a number of Indian studies.

Reliability And Validity. The scale has been standardized on the Indian population and was validated against CBCL (Child behavior checklist) (Achenbach & Edelbrock, 1983) specifically on two dimensions, i e., internalizing and externalizing problems. The correlation coefficient is between internalizing and emotion disorders is 0.29, ($p>0.05$). The correlation coefficient of externalizing problems is 0.598 with conduct disorder and 0.43 with Hyperkinesis ($p>0.01$ for both). The reliability of the entire checklist is 0.97.

Adaptation of The Scale. A Malayalam version of the DPCL is used in the present study. The English version of the tool was translated to simple Malayalam language without losing the conceptual meaning of the items by proficient experts in both English and Malayalam . This was back translated into English by another expert who is equally competent in both the languages. Since, there was no difference between the original

English version and the back translated English version, the Malayalam version was decided to use in the present study.

Sampling Procedure. Second section of first phase intended to evaluate the intervention trial among children with behavioral problem. The purposive sampling method was used by the researcher for the data collection process. The researcher contacted a school counsellor, who is appointed by the school authority/ government to ensure the mental health among school children. After consultation with the school counselor, the children with behavior problems were selected for the study, with consent from school authorities and parents. Developmental psychopathological checklist was used for assessing behavior problems and samples were collected based on the cutoff point for concerned behavior issues. Thus, six children were selected and their parents were given the informed consent form and were explained about the training programs which each child and parent have to undergo and conducted an intervention program.

Procedure for Trial Intervention Strategy: Section B of the Pilot Study. The second section of the study was conducted in 12 sessions. The sessions were conducted once a week and each session were carried out for 50 minutes each day. In the initial session, both parents and children explained the nature and procedure of the study. Before starting the training, consent letters were collected from parents and children. The personal data sheet and pre assessment of behavioral problems was collected during the first one session. And the post assessment of behavioral problems and feedback was collected in the last session.

Both parents and children were given the training program. Parents were given six sessions and children were given ten sessions of training. The training program started with the second session onwards. As the group consists of children of different

ages, initial sessions were carried out individually. Groupwise sessions were also conducted for explaining and discussing certain intervention activities. Rapport with children and parents were established before the intervention program.

Sessions for Parents. Parental training sessions were primarily focused on improving mental health and reducing behavioral problems among children. Parents were trained to understand and manage the behavioral problems exhibited by the children. A total of six sessions were conducted among parents, once a week with 50 minutes duration. The parental sessions deal with planning and implementing a healthy routine among parents and children, for this purpose the basic strategies like healthy diet, exercise, and helping and supporting in study time were implemented. A systematic and specific procedure was implemented among parents to address behavioral issues in children. This process involved observing and recording various behavioral patterns exhibited by their children, like physical fights, anger, lying, stealing, sadness, and happiness. Subsequently, parents received guidance on effective communication strategies, emphasizing both verbal and nonverbal interactions, as well as setting specific limits and boundaries. This approach aimed to enhance positive and constructive interaction between parents and children. Additionally, parents were instructed on timely expressions of appreciation, fostering a nurturing environment within the family. Furthermore, relaxation techniques were provided to parents, equipping them with techniques to manage stress and promote calmness in challenging situations. Through this comprehensive intervention, parents were enhanced with strategies and skills necessary to address and manage behavioral problems effectively. Overall, the present intervention program fostered a supportive and positive behavior and healthy parent-child relationships.

Session for Children. Children were identified based on the assessment by school counselors and discussion with parents, indicating the presence of behavioral issues. To address these challenges, comprehensive interventions were implemented. Total of 10 sessions were conducted among children, once in a week, and 50 minutes duration for each session. Children received training and skill development sessions focused on establishing healthy daily routines and providing academic support, as children with behavioral problems have difficulties in these aspects too. Moreover, they were engaged in discussions addressing various behavioral problems such as anger, disobedience, lying, and stubbornness. Through these discussions children gained insight into their behavioral patterns and emotional expressions, enabling them to better manage their emotions and behavior. They were taught to reflect on their actions, identify what happened before such action, and gradually learn strategies to address and manage their behavior. Furthermore, children were encouraged to recognize and appreciate their own achievements as well as those of others. Group discussions facilitated this appreciation, fostering a culture of mutual respect and support among peers. Additionally, moral values were emphasized, aiming to instil principles of honesty and integrity that could help reduce lying and stealing behavior. By providing such holistic approaches that address both emotional and behavioral aspects, these interventions aim to facilitate the management of behavioral challenges effectively and foster positive relationships within the families and communities.

The feedback and post assessment of behavioral problems were collected in the last session.

The collected data were recorded, analyzed, and discussed in chapter III.

Modifications Done in Intervention Package After Phase I Pilot Study (Section B)

1. The intervention program was reorganized into three sections: parental sessions, social skill training, and mindfulness training. This restructuring was based on the insight gained from the IInd phase of pilot study. Initially, the pilot study exclusively focused on parental sessions, and some behavioral strategies were conducted among children. However, it became evident that addressing other factors of mental health, such as social and emotional aspects, was crucial in the main study. Therefore, additional interventions like social skill training and mindfulness training were also incorporated into the program as a multidimensional program aimed at improving mental health among children. Ultimately, the recognized intervention program aims to empower children with the skills they need to thrive emotionally and socially, leading to improved overall well-being and reduced behavioral problems.
2. Recognizing the need for a more comprehensive approach, the number of sessions for both children and parents were increased, with a particular emphasis on parental and skill-oriented training.
3. To assess the effectiveness of the training program, both experimental and control groups were established for the main study. For the selection purpose, the participants were selected based on the responses through google form circulated through school counselors. The final selection of participants was done after the preliminary screening, followed by parental information regarding the behavioral problems exhibited by the children. As the study was scheduled to conduct in pretest and post-test, with both experimental and control group, participants were selected purposely, and through randomization process participants were allotted in both experimental and control groups.

4. The main study primarily focused on the mental health among children with behavioral problems. Based on the previous studies, the psychological variables which are found most relevant to studying mental health of children with behavioral problems are related with family, social and emotional functioning. Hence, family interaction, social competence, and emotion dysregulation, were chosen and included in the main study.
5. Due to the prevailing COVID 19 pandemic conditions, the training program was conducted online mode. To make the online mode more effective, each parent and child were called personally, and the convenient time for the training program was arranged. A subsequent time arrangement was also done if any one failed to attend the training program on time. Before conducting the training program, the details and effectiveness of the program were explained to parents and consent from both parents and children was obtained through a Google form.
6. A program overview was provided to both parents and children, accompanied by a discussion to address any doubts and gather suggestions. Through such interaction, they provided a platform for open communication between researcher, parents and children, which enhanced the roles of both parents and children in actively participating and engaging in the interventions.
7. Due to the online mode of the program, an extra time was allocated for individualized skill training and evaluation for both parents and children. The additional time provided an opportunity for in-depth instruction and practice of specific skills related to parental techniques, social interactions, and mindfulness practices in a virtual setting.

After the above-mentioned modification from phase I, the researcher conducted the phase II of the study.

Phase II: Multidimensional Intervention Program

Phase II involved a detailed examination of multidimensional intervention programs and their efficacy in enhancing the mental health of children exhibiting behavioral problems. In the second phase, the research activities encompass a multifaceted approach and intervention program aimed at enhancing mental health and modifying behavioral problems among children. Building on the insights gained from phase I (section A and section B) the researcher arrives at a conclusive understanding that behavioral problems are notably dominant among school children, necessitating strategic interventions to uplift their mental well-being.

Exploring into the literature review focused on the mental health of children, key factors emerge, including challenges in family interaction, deficiencies in emotional regulation, and deficits in social competence, all of which contribute significantly to the development of behavioral problems and subsequently impact mental health negatively. The literature also points out the positive influence of improved family interaction, facilitated through parental counseling, and the cultivation of emotional and social competencies, achieved through interventions such as social skill training and mindfulness training, on the social and emotional wellness of children.

Equipped with this comprehensive understanding, the researcher formulates a multidimensional training program. The overarching objective of this program is to holistically improve mental health and concurrently reduce behavioral problems among children. By integrating various components, including parental counselling and training, social skill development, and mindfulness training, the researcher aims to address the root causes of behavioral challenges and promote a positive impact on the mental well-being of the participating children. This multidimensional approach aligns with the recognized factors influencing behavioral problems and mental health,

fostering a comprehensive and individualized intervention strategy for positive outcomes among the target group. The multidimensional program developed by the researcher by reviewing with the coping power program and parent management training program and selected most relevant activities to be included in the present study. Based on the theoretical framework and literature reviews on mental health among children with behavioral problems, the researcher formulated the multidimensional intervention program with sessions of parent management training, social skill training, and mindfulness training. The prepared module was reviewed by experts in the field of clinical psychology, and psychotherapy and suggested modification was done in the final intervention package.

Participants

For the present study a sample of 24 children were selected, with age groups of 13-15 years of both sexes from different schools in Thrissur district. Among them 12 children were randomly assigned to the experimental group, consisting of 9 boys and 3 girls, and 12 children were allotted to the control group comprising of 9 boys and 3 girls.

Inclusion Criteria

- Children between the ages of 13-15 years of both sexes
- Children who got a cut off of score of 4 or above four taken as behavior problem children in conduct problem subscale of Developmental psychopathological checklist for children
- Children with aggressive behavior (as reported by parents)
- School going children
- Children with parents (single /both)

Exclusion Criteria

- Children with presence of pervasive developmental disorder
- Presence of any psychotic and neurotic symptoms
- Taking medications for mental illness

Measures

The following measures was used to collect data from the participants

1. Personal data sheet
2. Developmental Psychopathological Checklist for children - DPCL (Kapur et al. 1995).
3. Family Interaction scale (C B Asha 1987)
4. Social Competence Scale (Devassy & Raj, 2012)
5. Difficulties in Emotion Regulation (Gratz & Roemer, 2004)

1. Personal Data Sheet. *The* details of the participant are prepared by the researcher and it includes age, gender, class of study, number of siblings, staying with father/mother/both/others, and use of any substance (alcohol/smoking).

2. Developmental Psychopathological Checklist (DPCL). Kapur et al. (1995) developed the Developmental Psychopathological checklist for children as a screening tool to assess psychopathology in children, which is brief, comprehensive yet developmental in perspective and can be used with relatively minimal training.

The DPCL has 124 items with six subscales. Conduct problem subscales of DPCL has eight items, they are (1) stubbornness, (2) Disobedience, (3) Disruptiveness, (4) Quarrelsomeness, (5) aggressiveness, (6) Temper tantrums. (7) Truancy, and (8) Lying and stealing. The scores in the conduct problem subscale taken as a behavior problem for this study.

Administration And Scoring. The scales can be administered individually to parents of children selected for the study. There are eight sub sections in conduct problems, and a score of '0' given for absence of conduct problems, and a score of '1' is given for the presence of conduct problems. Thus, the total score for the conduct problem is eight, and the cut off score is four. The sample who scored at least 4 considered the study with conduct problems. The tool has applicability with both children and adolescents and has been used in a number of Indian Studies.

Adaptation of The Scale. A Malayalam version of the DPCL is used in the present study. The English version of the tool was translated to simple Malayalam language without losing the conceptual meaning of the items by an expert in both languages. This was back translated into English by another expert who is equally competent in both the languages. Since, there was no difference between the original English version and the back translated English version, the Malayalam version was decided to use in the present study.

Reliability And Validity. The scale has been standardized on the Indian population and was validated against CBCL (Child behavior checklist) (Achenbach & Edelbrock, 1983) specifically on two dimensions, i.e., internalizing and externalizing problems. The correlation coefficient is between internalizing and emotion disorders is 0.29, ($p>0.05$). The correlation coefficient of externalizing problems is 0.598 with conduct disorder and 0.43 with Hyperkinesis ($p>0.01$ for both). The reliability of the entire checklist is 0.97.

3. The Family Interaction Scale (FIS) -Asha C B (1987. The family Interaction Scale was developed by Asha C B (1987) to measure the family environment. The eight sub-scales of FIS measure the social and environmental features of all types of families. The scale comprises 56 items, covering the subscales like, independence, cohesion,

achievement orientation, intellectual orientation, conflict, social orientation, ethical emphasis, and discipline.

Family interaction: Family interaction is the interaction between all the members of the family.

Independence: Independence defines the degree to which family members are assertive and self-sufficient and make their own decisions.

Cohesion: Cohesion is described as the degree of commitment, assistance, and support family members provide for each other.

Achievement orientation: Achievement orientation describes the extent to which activities (such as school and work) are cast into an achievement-oriented or competition-oriented framework.

Intellectual orientation: intellectual orientation defines the degree of interest in and involvement in intellectual and creative activities.

Conflict: Conflict is the amount of openly expressed anger, aggression, and conflict among family members.

Social Orientation: social orientation defines the degree of interest in social, political, and cultural activities.

Ethical emphasis*:* Ethical emphasis describes the degree of importance on ethical and religious issues and values.

Discipline: Discipline is the degree of organization and structure in planning family activities and responsibilities, the degree to which a set of rules and procedures are used to run family life.

Administration and Scoring. The FIS can be administered in groups as well as individually as per the requirement. Respondents are presented with options to mark their responses, ranging from the 'Most acceptable' to 'Least acceptable' description of

their family interaction. Each subscales included both positive and negative scoring items. Scoring is facilitated using scoring keys. Positive items are scored from 4 to 0, while negative items are scored from 0 to 4. Thus, a high score signifies a well-functioning family, and a low score indicates family in distress. On the contrary, in the subscale conflict, a high scale indicates less conflict.

Reliability and Validity. The study assessed the test-retest reliability of individual scores on eight subscales, involving 58 participants from 15 families who underwent testing twice with a six-week interval. The correlation coefficients for the all subscales ranged from .71 to .87, while the odd-even reliability coefficients varied from .73 to .83.

Validity was tested with the FIS's ability to distinguish between two criterion groups: normal and distressed families. The study included 109 members from 34 normal families and 94 members from 27 distressed families. The scale demonstrated satisfactory internal validity as well.

4. Social Competence Scale (Devassy & Raj 2012). The adolescent social competence scale is a measure to assess social competence. Among adolescents, was constructed and validated by Viju P Devassy & John Michale Raj (2012). The scale with 37 items on a five-point scale in line with the Likert scale, measures eight dimensions of adolescent social competence such as; school competence, team organizing competence, peer social competence, social cognition, home related social competence, social emotional competence, social forethought and compassion, and social flexibility respectively.

Social competence: For the study, social competence is operationally defined as the scores an adolescent obtains from the social competence scale.

School competence: Here, school competence is operationally defined as the scores an adolescent obtains on the school competence subscale of the social competence scale.

Team organizing competence: Team organizing competence is operationally defined in the present study as the scores an adolescent obtains on the team organizing competence dimension of the social competence scale.

Peer social competence: In the present study, peer social competence is operationally defined as the scores an adolescent obtains on the peer social competence dimension of the social competence scale.

Social cognition: In the context of this study, social cognition is operationally defined as the scores an adolescent obtains on the social cognition dimension of the social competence scale.

Home-related social competence: For this study, home-related social competence is operationally defined as the scores an adolescent obtains on the home-related social competence subscale of the social competence scale.

Social emotional competence: In this particular study, social emotional competence is operationally defined as the scores an adolescent obtains on the social emotional competence subscale of the social competence scale.

Social forethought and compassion: In this current investigation, social forethought and compassion are operationally defined as the scores an adolescent obtains on the social forethought and compassion subscale of the social competence scale.

Social flexibility: Here, social flexibility is operationally defined as the scores an adolescent obtains on the social flexibility subscale of the social competence scale.

Administration and Scoring. The scale was created using the "Likert scale" concept and included five possible responses: *always, often, sometimes, rarely, and never, with scores of 5, 4, 3, 2, and 1* accordingly. There was no reverse scoring in the scale. The

total score acquired for all 37 items, which is determined by adding the items in each subscale, represents the person's overall social competence score. Thus, higher the score, higher the competence in each area, and higher the total score indicates the children's social competence is also high. To determine if a score indicates low, moderate, or high competency, the scores are compared to the norms.

Reliability and Validity. The scale has outstanding face validity, content validity, item validity, intrinsic validity, and factorial validity. Additionally, it exhibits high reliability. The overall reliability of the scale was determined using Cronbach's alpha, resulting in a high coefficient. The total split-half reliability score of the scale is .87. The measure of intrinsic validity of the scale was considered by taking the square root of Guttmann split-half reliability and was found to be .93.

5. **Difficulties in Emotion Regulation Scale-DERS (Gratz & Roemer, 2004).** The self-reported form of the scale was used widely to assess the emotional deviations among individuals. The concept of emotion Dysregulation is being increasingly utilized to elucidate various forms of psychopathology throughout the lifespan. It is a 36-item self-reported questionnaire to provide a comprehensive measure of the difficulties in emotion regulation in adolescents. It was developed originally by Gratz & Roemer and the adolescent form was standardized by Weinberg & Klonsky (2009).

Concept interpretation

The test consists of six dimensions, like

- Lack of awareness of emotional responses
- Lack of clarity of emotional responses
- Non acceptance of emotional responses
- Limited access to emotion regulation strategies perceived as effective
- Difficulties in controlling impulses when experiencing negative emotions

- Difficulties engaging in goal-directed behavior when experiencing negative emotions (Gratz & Roemer,2004)

Lack of Emotional Awareness*:* It reflects a lack of awareness or inattention to emotional responses.

Lack of Emotional Clarity: Lack of emotional clarity reflects the extent to which the individual knows and is clear about his or her emotions.

Difficulties in controlling Impulsive behaviour when distressed: it denotes the challenges of maintain control over one's behavior when faced with negative emotions.

Difficulties Engaging in goal-directed behavior When stressed: it is the trouble in concentrating and/or accomplishing tasks when feeling negative emotions.

Non-Acceptance of Negative Emotional Response: It refers to the inclination to respond negatively or with non-acceptance to one's own distress.

Limited Access to Emotion Regulation Strategies: It implies the perception or belief that an individual ha restricted capacity to control their emotions once they become upset.

Administration and Scoring. Responses on the DERS were scored on a scale from 1 to 5, where, 1 *corresponded to 'practically never' (0–10% of the time), 2 represented 'occasionally' (1–35% of the time), 3 indicated 'roughly half the time' (36–65% of the time), 4 denoted 'the majority of the time' (66–90% of the time), and 5 signified 'almost usually' (91–100% of the time).* The DERS is assessed so that higher levels of difficulty in emotion regulation are reflected in both the overall score and the subscale scores. As a result, the tool's minimum score requirement was 36 and its maximum projected score for a subject was 180. Higher results on DERS tests, or greater emotion Dysregulation, were always indicative of greater difficulty in emotion regulation.

For the current study, the investigator used the standardized version of the Malayalam questionnaire by Milu & Jayan (2018), DERS with 29 items selected for the present study. Lack of Emotional Awareness, Lack of Emotional Clarity, Difficulties in controlling Impulsive behavior when distressed, Difficulties Engaging in Goal-Directed Behavior When Distressed, Rejection of Negative Emotional Reactions, and Limited Access to Emotion Regulation were the subscales.

The scores for each item range from 1 (nearly never) to 5 (almost usually) on a 5-point scale. The related items are added to produce the subscale scores. It was preserved in its original scale. Participants could thus receive a score between 29 and 145. High emotional regulation difficulty was indicated by the high score.

Reliability and Validity. A community sample of 428 adolescents (aged 13 to 17) was used by Weinberg and Klonsky (2009) to explore the psychometric features of the DERS. An exploratory factor analysis that included all six DERS subscales well supported a 6-factor framework. The subscales' internal consistency was determined to be good to exceptional (alphas varied from.76 to.89). The construct validity of the DERS was affirmed by the measure's strong relationships with clinical indicators associated with emotion Dysregulation, including depression, anxiety, suicidal ideation, eating disorders, alcohol and drug use. The DERS is a reliable and valid tool for assessing teenagers' abilities to regulate their emotions. Internal consistency (r) for undergraduates' ranges from.80 to.89 on subscales and is.93 overall. Correlations between items and totals (r) range from.16 to.69.

For the present study, the revised Difficulties in emotion regulation by Milu & Jayan (2018) was used and the instrument's dependability was evaluated using Cronbach's alpha. The whole scale reliability coefficient for DERS was discovered to be 0.875. Lack of Emotional Awareness (0.339), Lack of Emotional Clarity (0.629),

Difficulties in controlling Impulsive behavior when distressed (0.694), Difficulties Engaging in Goal Directed Behavior When Distressed (0.656), Non-Acceptance of Negative Emotional Response (0.704), and Limited Access to ER Strategies (0.621) were found to have the highest reliability for the subscales. The instrument has strong face validity.

Sampling Procedure

The pilot study and related reviews revealed a significant frequency of problem behavior among children and adolescents, emphasizing the critical impact on family and social-emotional programs in improving the mental health of those with behavioral problems. During the second phase of study, a screening form for behavioral problems was circulated through Google form (due to the COVID-19 pandemic, offline programs/activities were restricted by both central and state Governments) among school counselors' WhatsApp groups in Thrissur district. Samples were selected based on the cutoff point of conduct problem behavior in the Developmental psychopathological checklist. After screening of behavior, the researcher individually contacted the eligible children and parents and explained about the intervention program. Children with mild behavioral problem symptoms were selected for the present study, and those with severe behavioral problems were referred for clinical treatment. Before starting the intervention, signed consent forms from both parents and children were collected. A purposive sampling method was used to select participants for the study. By using purposive sampling, the researcher could focus on the children with mild behavioral problems, ensuring that the sample accurately represented the targeted population. A total of 60 responses were received, among them, 26 responses did not meet the criteria for the study, and 10 samples were dropped out in between the

study. Thus 24 samples remained for the present study, with 12 samples as the experimental group and 12 samples as the control group through randomization.

Multidimensional Intervention Program

The multidimensional intervention program conducted mainly by three steps:

Step 1: Pre intervention

Step 2: Intervention

Step 3: Post intervention

Step 1: Pre-Intervention

In the pre-intervention stage, both parents and children established rapport with clear understanding about the objective of the problem behavior and intervention program. The children were assessed by the Developmental psychopathological checklist (DPCL checklist). After the assessment with DPCL, the mental health assessment measures like family interaction, social competence, and difficulties in emotion regulation were also done. All the participants were informed about the time and duration of the training period. The training session occurred weekly, each lasting for 45 minutes. Since, the training was conducted as online mode, most of the sessions were conducted individually. Group sessions were also performed once every two weeks.

Step 2: Intervention

The intervention programs were divided into different sections based on the study objectives. The module is intended to meet the enhancement of mental health among children through family interaction, emotion regulation, and social competence. The intervention packages were formulated with the discussion of experts like clinical psychologists, behavior therapists, and psychologists, in the field of child and adolescent clinical settings. Hence, the sections were planned as follows: -

I. Parent Management Program: The training module implemented the parenting sessions to improve the child-parent relationship. The program was adopted from the Coping Power Program by Lochman et al (2008) and parent management training by Kazdin (2005). The parent management training focuses on social learning techniques where parents are taught to modify the behavior of their children and adolescents through communication and interactions at home. Parent management training comprised of four components like, (a) a conceptual framework addressing social, emotional, and behavioral challenges (b) a collection of of principles and techniques that stem from this conceptual perspective (c) development of specific parenting skills through interactive sessions with children (d) integration of assessment and evaluations in to training process. Grounded in operant conditioning, the approach specifies on antecedents, behavior and consequences as a way to shape and modify behavior. This involves different kinds of teaching on principles of general statements about relations between behavior and events that precede or follow this behavior. Based on these principles, parents were trained to develop various skills such as observation, recording, responsive communication, role play by the researcher of how to interact and change the behavior of children through active training. Parent management training also directed to improve the child behavior through parental involvement, and thus parents were guided to establish new goals or modify existing ones to achieve positive outcomes in the parent-child relationship.

The parent management training adopts an initial focus on enhancing the skills of both parents and the child, recognizing the reciprocal nature of their responses. Central to this training is the incorporation of reinforcement techniques, a key element that ensures children's heightened attention and active participation by offering appreciation or rewards for positive behavior. This strategic use of reinforcement

creates a conducive environment within the family, fostering smaller yet impactful steps in promoting proper child interaction.

Within the framework of this training, the emphasis is placed on breaking down the intricate dynamics of family interaction into manageable steps. By doing so, children are facilitated in developing the necessary skills for effective communication and interpersonal engagement. The training empowers parents to not only comprehend but also become aware of their child's behavior, fostering a deeper understanding of their needs. Moreover, it instils in parents the ability to communicate effectively with their children and provide crucial support.

A key component of the parent management training involves the implementation of specific rules and responsibilities within the family structure. This structured approach contributes to the creation of a nurturing environment, promoting positive behavior among children. Through this training, parents gain valuable insights and skills that enable them to focus the complexities of child-rearing, ultimately fostering a harmonious family dynamic grounded in effective communication, mutual understanding, and the establishment of essential rules and responsibilities.

A total of 15 sessions were conducted among parents with individual and group sessions. Each session lasts for about 45 minutes, organized once in a week. The parent sessions are as follows: -

a) ***Introductory Session (session 1):*** The group session was conducted in the introductory session, as the session focused on the discussion on parental training. The primary objective of the initial session was to provide parents with an understanding of the nature and procedure of the program. A detailed overview was planned to give parents about the program. The session was designed to be interactive, by providing an opportunity to discuss the behavioral problems they were faced with children and were

also encouraged to have an open discussion on the demands and concerns regarding the program and behavioral problems among children. The initial session was focused on rapport building with parents and was oriented about the relevance of parental training. Parents should be aware about their roles and responsibilities for molding the behavior of their children. And they were able to understand the behavior pattern of their children, only then effective management could be effective. The session ended with a homework assignment.

b) ***Academic Support (session 2):*** The second session starts with feedback from the first session. In the second session, parents were encouraged to discuss the study patterns of their children, and the difficulties faced by parents and children while learning. Because, children with behavioral problems usually exhibit poor academic performance, and lack of interest in studies. In order to identify the difficulties in studies of children, parents need to be aware about their children's study skills also. For this purpose, parents were taught about the individual difference on acquiring certain skills as their own. Because every child has their own potential and limitations in study pattern. The parents were acknowledged with the concern that to observe the study pattern and be there with children while they are studying. Parents were asked to contact their child's respective teacher, so it made it easy to get the difficulty level of the concerned child and thus parent-teacher interaction could be facilitated. Additionally, all of them were guided to develop a flexible schedule for their children’s academic process. Then, supportive learning atmosphere strategies are implemented, also suggesting time and place for studying. It is stated that whenever effective monitoring of homework or studying habits are formed, some academic problems can be avoided. The parents were suggesting to prepare a parent signature page and indicate whether or not their child completed the school work. Such kind of on time assessment of progress

evaluation of learning, also helps the parent-child interaction too. The session ended with homework assignments.

c) ***Behavior Support (session 3 & 4):*** In the behavior support sessions, parents were equipped with defining, observing, and recording the behavioral patterns exhibited by the child effectively. The emphasis was placed on providing positive attention to instil good behavior in children. Parents were given information regarding identifying and addressing the specific behavioral problem along with guidance on understanding various types of behavior commonly exhibited by children. They were taught about different types of behavior and problem behavior usually occurs in children. The concept behavior was explained to parents, that behavior is an action which can be observable by others like clapping hands, or walking. And also informed that thoughts, feelings, and attitudes are not behavior since these cannot be observable to others. Rather than resorting to punishment for undesirable behavior, parents were instructed to focus on recognizing and reinforcing positive behavior. The process of reinforcement was introduced, explaining how rewarding a specific behavioral response increases the likelihood of its repetition. Parents also taught about making a positive opposite of the behavioral problem. Every problem behavior has a positive opposite, which is the key to improve the positive behavior. Instead of giving punishment for problem behavior, parents were taught to identify the positive behavior of a child. By observing the child very carefully, the parents are able to see what all the behavior are happening in the child.

By making eye contact, parents were encouraged to talk with children with excitement and non-judgmentally. For small improvements, children were given positive attention by parents. Small rewards, like a favourite snack, stickers, cards, and so on. The process of reinforcement is introduced to the parents. Reinforcement is a

concept that facilitates the desired behavior by giving some kind of reward toward a specific behavioral response. The parents were informed that the child's behavior could be modified by using helpful consequences to reward healthy behavior. It is the likelihood that if the children were given positive consequences for their good behavior, that behavior should repeat in future also. Parents were also explained about the rules for selecting and using reinforcers for respective behavior. Thus, the concept of 'catching your child being good' was applied to this session. Which indicates making eye contact, observing a child's behavior, and giving some kind of reinforcement. Along with this the effect of parent child quality time was also recommended. Quality time indicates spending 10 or 15 minutes each day to interact with a child in a relaxed manner, by talking with the child about the day. This will help them to maintain a healthy and positive interaction and healthy relationship with parent and child. Thus, the concepts of social learning theory were introduced among the parents and were given a common discussion platform to share their views regarding the behavior and response of their children at home. Also, parents were informed about the concept of punishment. Punishment is considered a behavioral correction strategy by most parents. But it does not ensure a promising behavior modification. For the parents with behavioral issues physical and verbal punishments were common. The researcher instructed parents to use reprimands, like expressing disapproval for their misbehaviour, and mild punishments for reinforcing positive behavior. Parents were explained to express appreciation for positive behavior, and effective reprimands like a nonverbal expression of disapproval for inappropriate behavior. The session ended with a homework assignment to the parents regarding the behavior.

*d****). Positive Time Out (session 5):*** The session starts with a discussion about the previous session's views and home assignments. The parents were asked to review their

home assignments, and if anyone failed to complete the assignments, they were asked about the reasons and suggested they do it for the next session. They introduced the concept of positive time out as a reinforcer to improve the desired behavior. Time out is removing the child from where the misbehaviour has happened, to enhance positive behavior. Time out, basically from a positive reinforcement concept, with an aim to acknowledge and understand parents about the behavioral problems among children. In this session, instead of using punitive time out, the parents were instructed to follow a positive time out among children. When the children are behaving unacceptably or misusing their privileges, the parents were instructed to talk to them pleasantly like, 'ok, take some time to relax and think about it, you can go where you feel good to sit'. Here, parents are giving the child to 'choose' to go instead of being sent, in a calm, and non-threatening manner. This session could help the children to understand their faults in behavior, and thus helps to improve the desired or appropriate behavior. After time out, if both are willing to explain the problem behavior, direct parents to resolve the issue. Hence, parents were encouraged to apply the 'feel better, do better' principle as time out. The researcher informed the parents about the correct explanation, and effective use of time out.

e). Planned Ignorance (Sessions 6 & 7): the Antecedent behavior and consequence of programs explained planned ignorance which involves deliberate parental attention to the occurrence of the target child's behavior. The parents were encouraged to ignore the minor disruptive behavior of their children. It is one of the extinction procedures where it refers to or discontinuing a reward to / being attended to a behavior that has previously been rewarded/ attended by parents. There are some precautions to be taken by parents while implementing planned ignorance because there has occurred a change in the expected response outcome from parents toward children. So, it is essential to a)

be consistent with the planned ignoring, ii) reinforce other behavior, and get ready for an extinction burst. If the child exhibited any disruptive or negative behavior, the parents are taught about to practice planned ignorance that is deliberately ignoring the undesired behavior in order to reduce it. This session aims to manage parents when the children are having minor problems such as teasing, quarrel with siblings, through planned ignorance. Parents are taught to notice the behavior exhibited by the child. Child's disturbing behavior will be reduced if parents provide firm attention towards their behavior in a pleasing manner. When the parents are trained to ignore certain behavioral problems of children, the undesired behavioral expression of children gradually decreases. The different forms of ignoring skills like turning away, just leaving the place, or talking to someone else are recommended to practice by parents. Parents were taught about the antecedent, behavior and consequence chart as well as positive and negative consequences, to help manage their children's undesired behavior. Using the ABC model, parents learned to identify why certain behavior happen and the triggers behind them, leading to specific outcomes. They were encouraged to note whether the consequences of the behavior were desirable or undesirable. For example, if a child exhibits behavioral problems, parents could use the ABC chart to understand what happened before and after the behavior. If the behavior was undesirable, parents could work on modifying it into desired behavior. Additionally, parents were instructed to praise and appreciate their children for displaying desirable behavior. While using praise, they were taught to use labelled parise, which indicates praising the child's exact behavior for doing good. Eventually it will help the child to understand what behavior makes them desirable or not. Such effective interaction with parents, the child's behavior could be modified. The session ended with recording of praise and ignoring behavior tracking homework assignments.

f). Active Communication (Session 8 & 9): Communication skills are the key elements for transferring messages between the sender and receiver. Sometimes, lack of or improper communication leads to conflicts between individuals. The present session provided guidelines for a proper communication process between parents and children. It is important to give proper instructions, with maintaining eye-to-eye-contact with the child for better adaptive functioning. The session started with feedback on the previous session's home assignments. In this session, parents were instructed to express clear and specific directions/rules or commands while interacting with children. They were also instructed to have commands as simple statements, and not at all in a negative tone or modulation but in a firm manner. Provide clear and concise instruction, focusing on one or two tasks at a time. After giving instructions, allow for a silence of approximately 10 seconds to ensure understanding. Through this session, the parents were trained to communicate with the child in a more effective manner, so the child could be free to communicate thus building a better parent-child interaction.

g). ***Relaxation Training (Session 10 & 11):*** the session started with feedback on last home assignments. Each parent was encouraged to discuss the kind of challenges and opportunities they are facing during the period. Importance of stress management introduced for parents. Stress is a state of pressure or tension that leads to change, which can affect both individual and family relationships, so taking care of 'yourself' was the key element of stress management among parents. Parents were informed about the harmful effect of stress that it will lead to spilling over into child rearing and which results in less affectionate and low responsiveness towards children. Parents were instructed to draw a circle on which they were instructed to divide the circle into different sections with time spent for each activity per day. Evaluation of each activity is explained and most parents do not mention a particular time for 'self-care/self-

soothing. There, the researcher introduced the importance of having time for relaxation for parents. An active relaxation training was introduced and was instructed to follow the same daily. The steps involved in the active relaxation training as follows:

- *Get comfortable in your chair: place your arms on the arms of the chair... Close your eyes and keep them closed throughout the entire exercise.*
- *Become aware of the various muscle groups in your body (e.g., hands, and arms; face, neck, and shoulders; chest and stomach; hips, legs, and feet)*
- *Bend your arms at the elbow. Then, make a tight fist with both hands while tightening the biceps and forearms. Hold for 5 seconds. Pay attention to the tension. Then relax. Pay attention to the relaxation.*
- *Tense your entire face and shoulders, tightly shut your eyes and wrinkle your forehead, pull the corners of your mouth toward your ears, tighten your neck and hunch your shoulders. Hold for 5 seconds. Pay attention to the tension. Then relax. Pay attention to the relaxation.*
- *Take in a deep breath and arch your back. Hold this position for 5 seconds. Now relax. take in another deep breath and press out your stomach. Hold…….and relax.*
- *Raise your feet off the floor while keeping your knees straight. Pull your feet and toes back toward your face and tighten the muscles in your shins. Hold……. And relax. Now curl your toes down toward the floor, tighten your calves, thighs and buttocks and hold……and relax.*
- *Scan each muscle group in your mind and relax and tense muscles.*
- *Now, become aware of your breathing. Slow your breathing down as you breathe in and out, in and out.*

- *With your next deep breath, count slowly from 1 to 5 as you breathe in and count from 6-10 as you breathe out. Your stomach should expand and deflate with each breath.*
- *Repeat this deep, slow, breathing…..in and out….in and out……. Stop when you are feeling deeply relaxed.*
- *Say the word 'relax' to yourself approximately 20 times every time you exhale.*
- *Now, gradually let your breathing return to normal and open your eyes.*

The relaxation session aims to reduce the stress level of parents when they are dealing with children with behavioral problems. So, it could be beneficial for parents to get relaxed and effective interaction could be maintained in such situations. Thus, cognitive model of stress management was evaluated during the session. The concept of time management was also instructed among parents, in which they were explained about the prioritize their time based on time for taking care of personal needs, like reading a book, taking a warm bath, going a leisure walk, so that they could be manage their own personal needs and reduce stress and manage time more effectively.

h). Family Bonding (Sessions 12 & 13): The session mainly focused on family cohesion, conflict resolution, and changes in punishment activities. Family cohesion is a kind of emotional bonding between family members. Cohesiveness maintains the family to be understandable, and considerable thus resulting in unity. Parents were allowed to explore team building within the family by taking up the role of initiator/mediator for enhancing family cohesion. For that, they were instructed to have an epithetical consideration for the family member's behavior. Parents were directed to follow some family rules, and responsibilities, sharing of emotional feelings, have some time for recreational activities, and record the changes within the family.

Problems and conflict management are to be taken at most in the session too. For that parents were given activities to handle problems and conflict in a better manner. Parents were provided a situation where they had to define the problem, find out the possible solutions and concerned consequences, and finally, were given the choice to select the most relevant solutions. Here, parents were informed that even for one problem there will be different choices, and it is one's perception that decided to choose the better one. Thus, the process of perspective taking; identifying the problem, based on each person's viewpoint of the situation, was explained to parents. Based on the process through problem identification, identify choices, identify consequences, to choosing the best solution and implementation of the solution the problem-solving techniques were discussed among parents. Parents were also taught about the importance of having family communication, so there can be an effective and active open discussion on specific problems or issues that they need to resolve. The present session aims to build cohesiveness within the family through active interaction, minimum conflict within family members which helps to improve better parent-child interaction and reduce behavioral problems.

i). Give And Take (Sessions 14): *The* session starts with a discussion about previous home assignments. Clarifications and suggestions were discussed between parents. Both Parents and children together were included in the session A mutual understanding and negotiation of problem behavior were explained in the session. The child is encouraged to discuss the situations, where they need effective management and support from their parents. Dealing with emotion, and listening skills were practiced among parents. Behavioral contracts were instructed to parents, where self-control strategies were applied among children to reduce aggression, stealing, and lying, and improve communication.

j). Feedback And Termination (Session 15): In the last session, feedback of last sessions was discussed. The role of parenting among children was explained by each parent, and each session's activities were explained in detail. The new form of parenting skills is discussed and reviewed.

II. Social Skill Training for Children: social skills are essential for effectively directing for exchanging information, engaging in conversation, establishing and maintaining healthy relationships, seeking help from others, and providing clear instructions. It was designed for children to improve behavioral and social skilful modifications in day-to-day life situations. Social skill training is a multimodal simple to complex training which helps children to understand and differentiate appropriate behavior in various settings. In social skill training children were taught about various skills and proficiencies which might be useful for them especially in dealing with familial and other social situations. Being a part of group and individual activities, each child could get a chance to understand their own abilities and limitations and also get an idea how to manage or modify certain behavior. Children were not forced to change their behavior rather they were helped to understand their nature of behavior and temperament. The social skill training consists of 12 sessions for children, with a duration of 45 minutes for each session, once in a week, and is classified in to different aspects like: -

a) Introduction (session 1): The session starts with rapport building among children. Children introduced themselves to basic information. The researcher described the concept of social skill training and the relevance of behavior modification. Necessities required for the sessions were explained like active participation; maintaining eye contact, carrying a book and pen, completing home assignments and tasks, and the relevance of following a healthy routine like exercise, and a healthy diet. The children

were encouraged to express their hobbies, skills or achievements in any specific areas and also their ambitions. The initial session was conducted as a group session, so that every child got a chance to interact with each other. The session ended with giving appreciation for everyone in their respective areas of achievements.

b) Academic Support (Session 2): A brief analysis of previous sessions was discussed. As for the academic concern, a convenient schedule for study patterns was discussed. Children were instructed to follow the guidelines and daily reports submitted in the group. The researcher also informed about the importance of concentrating on academics as well. Children were discussed about their study pattern, easy and difficult subjects in study. With the parent -teacher interaction the child's study patterns were discussed and a supportive study plan was established with children. Children with behavioral problems could have difficulties in managing studies so such academic support enhances the children to improve their study skills. Session ends with setting a study plan as homework.

c). Know Your Emotions (Session 3&4): The session starts with a discussion on homework done in the previous session. Children were explained about different emotions they usually have in a day and were allowed to memorize and write down the names of different emotions they have. Emotional expressions are the feeling of their response in a particular situation. After the discussion, about different types of emotions, they were given cards of different emojis to write stories on each. Each story was discussed and explained in the group and analyzed about why, when, and how each expresses different emotions. They were also discussed about each emotion, positive and negative emotions and the consequences of each emotion. The concept of coping with emotions was introduced in the group. If any negative emotions were expressed in a particular situation, they were asked to respond to an alternative of that emotion and

evaluate how the new response would work. A list of incomplete sentences was given to each and they were instructed to complete the sentences, thus teaching the idea about how to respond to a situation hierarchically and logically. Corrections and suggestions were clarified among the group.

For example: When I am upset and alone,

First, I will --

Next, I will --

Then I will---

Finally, I will --

The session helps the children to understand their emotions and get able to manage their emotions in an effective manner. They were to learn to regulate their emotions, and to reduce their impulsivity in emotional expression also. The session ends with discussing incomplete emotional responses.

d). Interpersonal Relationship (Sessions 5& 6): The importance of interpersonal relationships, following social rules and values emphasized in the present session. The researcher explained social skills through simple activities in which mutual respect and understanding, and working for common goals were appreciated. Children are allowed to list out their strengths and limitations, which helps them to self-reflect and also to understand others. As interpersonal relationships among children affected by thinking structure, the children taught about 'thinking steps' in which children were taught to think rationally before they act. The children were taught about how to respond or react in a particular situation. The children were encouraged to discuss the situations where they faced problems on irrational thinking. And they were also discussed about the possible alternatives for those irrational thoughts as well. Such activity aims to improve the thought pattern of children thus reducing the nonfunctional thinking structure and

negative interpersonal relationships. They were discussed about the rules and norms of various situations, especially when they are in certain groups, how to respond with non-verbal languages and help them to choose the appropriate pro-social skills in groups. After that children were informed about the importance of cooperation and self-control while they are in a group. Because these two values are marked as an important role when dealing with common groups, with common goals, and thus helps to improve the group cohesion. The importance of practicing unique contributions in group discussion and also how to maintain socially suitable emotional manners were also described. The session ended with homework assignments for practicing group skills.

e). Communication (Session 7): Communication plays a crucial role in fostering trustworthy relationships, promoting clarity, and facilitating the exchange of ideas and opinions, particularly when individuals or groups are involved. Children were introduced to fundamental principles of communication, emphasizing skills such as active listening, clear expression, and awareness of both verbal and non-verbal cues. Children were encouraged to recognize various communication modalities and understand their impact on daily life situations. For instance, practical demonstrations illustrated how modulating communication can influence outcomes, such as when a child needs something from a parent or friend. The aim was to empower children with the ability to effectively convey messages and comprehend diverse feedback.

As part of the educational approach, the researcher personally demonstrates key communication skills. This involved delivering messages appropriately, maintaining eye contact during information transfer, and providing clear, specific, and simple directions for task execution. Rather than simply instructing behavior, children were able to observe and internalize effective communication practices. Thus, children were able to get a positive impact of refined communication skills. Through these interactive

sessions, children were not only taught about communication but were also given tangible examples and experiences to emulate, fostering a more profound understanding and application of effective communication in various aspects of their lives. This session helps the children to have effective communication ways to deal with interpersonal challenges, and establish a positive relationship between children and their peers, teachers, and family members.

f). Problem-Solving And Conflict Resolution (Sessions 8 & 9): application of problem-solving through discussion and activities were presented in the session. The main objective of this session was to help children with effective problem-solving skills through a thoughtful and rational process. The first step involved guiding the children in identifying the problem at hand. Instead of reacting spontaneously, they were encouraged to engage in a systematic analysis of the issue.

To initiate the problem-solving process, the children were instructed to carefully note down the details of the problem. This deliberate act of documentation served as a valuable step, promoting a more analytical and thoughtful approach to addressing challenges. By putting the issue into words, children not only clarified the nature of the problem but also set the stage for a more intentional problem-solving journey. Following the identification phase, the next step involved exploring various alternative solutions to the identified problem. This step aimed to broaden the children's perspective and encourage creativity in thinking about potential ways to address the issue. Each child was encouraged to brainstorm and document multiple alternatives, fostering a sense of autonomy and ownership in the problem-solving process. The final stage of the model focused on helping the children evaluate and choose the most effective solution among the alternatives they had generated. This critical thinking aspect emphasized the consideration of potential consequences associated with each

option. By weighing the pros and cons, children developed a deeper understanding of the decision-making process, honing their ability to make informed choices. In essence, the approach taken in this session not only taught children how to identify and define problems but also equipped them with a structured and rational framework for generating, evaluating, and selecting solutions. This method fosters a proactive and empowered mindset, enabling children to approach challenges with confidence and a well-rounded problem-solving skill set. When the children learn to resolve conflict in an effective manner, they feel a kind of respect for themselves, they are less likely to engage in disruptive behavior or aggressive behavior. The session also helps the children to manage conflicts constructively, communicate effectively and better social and emotional outcomes. The session ended with mentioning different problems or conflicts they were faced with along with possibilities of different alternatives as homework assignments.

g). *Anger Management (Session 10):* Anger control techniques explained in this session. The participants were trained to observe and respond to the triggering situations/events which resulted in feelings of anger. The physiological sensations were noted. Children were instructed to use self-instructional messages to avoid such triggering situations. Simple anger management strategies like breathing exercises, counting backward, relief, and diverting from the situation were practiced by children. The children were taught about values, how to express a complaint, how to prepare a stressful conversation, responding to anger, helping others, keeping out of fights, expressing affection, forgiving others, and responding to failure. By acknowledging different situations, the group were asked about how to respond or react in the particular situation. They were also taught about the importance of expressing gratitude to one self and others after achieving something. They also trained with writing down anger

journals. In which they were instructed to write the thoughts and feelings they may have at the time of an anger provoking situation, and then write about how they behaved in the situation, and how they should behave or feel when the same situation might happen in future. Children were helped to mark and review the situations in the group. The session aims to reduce the anger provoking situations, being able to be aware of various triggers and circumstances that lead to the development of anger. The children could learn effective anger management strategies in more adaptive and productive ways. Thus, by understanding and regulating their anger, children could learn to reduce behavior problems as well.

h). *Empathy (Session 11):* session deals with developing pro-social relationships, sharing, valuing, and respecting others in terms of thinking, feeling, and behaving. Following social rules, altruistic thinking, theory of mind, and perspective-taking. The researcher was provided a situation to make empathy, instead of saying sorry for his/her misbehaviour, the child was trained to ask /think what might he have been thinking/ feeling in that situation. The children were taught that it is the ability of an individual to see and think about a difficult situation from their view points. Such kind of perspective taking helps them to think and feel from others perspective. Learning empathic understanding could enhance the children to have better social and emotional management skills, since they would be able to think and behave from the viewpoints of others too. The family interaction could enhance, resulting in less conflict with parents, peers, and other social settings, better pro social behavior and thus reduced behavioral problems.

i). *Termination And Feedback (Session 12):* In the last sessions children were discussed about various skills they were learnt and reviewed about various skills which helped them most.

III. Mindfulness Training for Children. Mindfulness training helps an individual to learn and recognize their thoughts and feelings, with an aim for improving and creating new skills to adapt to daily challenging situations. In mindfulness training, observing, listening, and experiencing the present moment were practiced. The sessions were planned to pay attention to what they are doing, feeling, or thinking. The following techniques were applied in the training with eight sessions, lasting about 45 minutes of each session, and the sessions were conducted once in a week.

a). *Mindfulness Breathing Exercise: (Session 1 & 2)* The breathing exercise focuses on three steps, firstly, simply being aware of the present situation. The main moment is to focus on the present situation. Secondly, the moment is spent on keeping mindfulness on the breath. Thirdly concentrate on body sensations and feel the physical sensations while being mindful and being mindful in breathing and feel how it is left of the body.

b). *Deep Relaxation Technique (Session 3 & 4):* the participants were given a physiological based deep breathing technique. The deep breathing techniques involve-focusing on observing and reducing breathing which occurs during periods of anxiety, stress, or worry.

Steps to deep breathing

Step 1: The children were taught about the importance of deep breathing and summary of the procedures and possible benefits.

Step 2: The children were instructed to place one hand on their abdomen, positioning the little finger about 1 inch above the navel, and to place the other hand on their chest.

Step 3: The children were requested to focus on their breathing and take a brief pause, allowing them to evaluate their breathing pattern. They were then prompted to identify which hand was experiencing more movement. Ideally, the hand placed on the abdomen

should be the one moving, while the hand on the chest should remain still. This ensured that the breaths were deep and diaphragmatic.

Step 4: The children were directed to enhance their breathing depth by ensuring that the hand placed over the stomach moved more significantly than the hand placed over the chest, which should exhibit minimal movement. The children were informed that the hand on their stomach should move out as they breath in and breathe out.

Step 5: The children were asked to continue slow, even, deep breaths. To regulate their breathing, they were suggested to say the words ‘in’ and ‘out’ slowly, matching their pace with inhalations and exhalations. They were encouraged to aim for breaths lasting around 3 seconds each.

Step 6: The children were asked if they noticed any changes in breathing and feelings of relaxation. They were also asked for general feedback about the technique.

Step 7: The breathing exercises were repeated three or more times until the child reported understanding the skill and experiencing benefits from the practice.

Step 8: The children were asked if they could identify situations when deep breathing might be appropriate.

Step 9: The children were instructed to continue practicing outside of the session and were assigned homework tasks that encouraged the application of deep breathing techniques in situations where they experienced stress.

c). *Mindful Eating (Session 5):* children practiced being mindful while having food. They learned to concentrate on eating by avoiding distractions like television, phone, computer, radio, and other distracting agents to allow all these senses to focus on eating.

d). *Mindful Answering (Session 6):* while talking or listening with others, observing what and when to talk, listening to others, then responding to situations. With respect to this mindfulness of thought and feelings were also explained to children. Focusing

on the present situation is important. What is happening in the present moment is to be focused.

e). *Taking Care of Pets/Planting/Gardening (Session 7):* This session focuses on spending a definite time being with all such hobbies they have. They were encouraged to observe and experience the activities they do.

f). *Mindfulness Meditation (Session 8):* This relaxation techniques involves 10 minutes of warm-up exercise followed by a 20- minute meditation session.

Throughout meditation sessions, participants in the experimental group received consistent guidance from the investigator to direct their attention towards their mind and body. They were encouraged to observe their bodily sensations and the thoughts present in their minds at at the time. These sessions, conducted once a week for eight weeks, involved 30- minute practice overseen by the investigator.

Techniques

"Sit, relax the body, and relax the mind. Be as still as possible".

- Assume a comfortable seated position with the spine upright and properly supported.
- Allow your thoughts to flow naturally without attempting to control them. Simply observe your thoughts and sensations as they arise.
- Allow your breath to flow naturally and gently.

Steps

1. Find a comfortable posture.
2. Focus your eyes.
3. Pay close attention to your breath
4. Place your hands in a relaxed and comfortable position.
5. Stay mindful and aware.

6. Gradually come back to your usual state of consciousness.

Through mindfulness practice the children are able to manage thoughts and emotions by identifying them as transient, and some thoughts are not real. Mindful breathing exercise could help the children to get more relaxed and to be calm especially while interacting with others. They could learn to regulate their emotions, anger, and be able to maintain social interactions too. Through mindful eating and answering techniques, children learn to observe, and analyze what is going on within themselves, which helps them to focus on their emotions, respond in a calm and quiet manner. Behavioral problems like aggressiveness, disobedience, quarrelling could be reduced through mindfulness training.

Step 3: Post-Intervention

After the training period among parents and children, the researcher assessed psychological variables like behavior problem checklist, family interaction scale, social competence scale, and difficulties in emotion regulation to understand the efficacy of training.

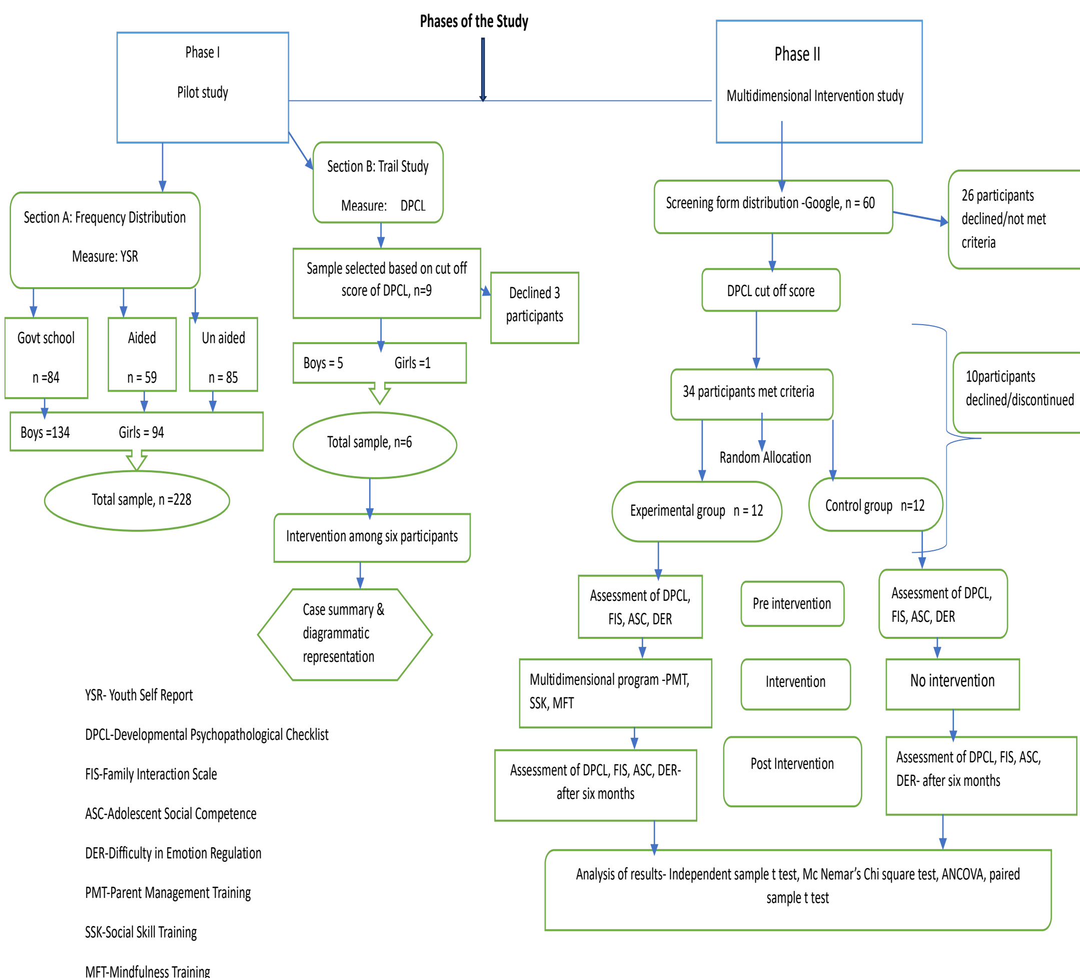


Figure 1: *Flow chart Representing Phases of the Study*

Statistical Analysis

The statistical analysis of collected data is used to convey meaningful inferences. Microsoft Word and Microsoft Excel were used to generate tables. The statistical analysis was carried out using statistical software SPSS.23. For quantitative analysis, both parametric and non-parametric tests are used for result analysis. The parametric tests are used for analysing the data in which samples are normally distributed, samples having same variance (homogeneity of variance), randomly drawn samples from population, and observations within the group are independent to each other (Ali & Bhaskar 2016). Non parametric tests are used for analysing the data where samples are not normally distributed. Hence, non-parametric tests are called

distribution free tests or assumption free tests (Sheskin,2011). While using non parametric tests, there is no necessity to meet the assumptions of parametric tests for drawing analysis of the sample. For nominal or ordinal data, interval or ratio scale (not normal distributed sample) non parametric tests can be used (Walsh, 1962). Before analysing the data, especially when the sample less than 30, the researcher should check whether the data is symmetrical or normally distributed. If the data met with the requirements of parametric assumptions, can use parametric tests; otherwise, analyze the data with non-parametric tests. There are different types of normality tests developed by experts for fixing what type of statistics can be used with the collected data.

For the present study, the researcher checked data with normality tests, and for normally distributed variables, parametric tests were applied and those with non-normally distributed variables, non-parametric tests were applied. The following statistical tests are used for the present study:

- Normality of data
- Descriptive statistics
- Inferential statistics
- Mc Namer's Chi- square test
- Independent sample t test
- Mann Whitney U test
- Univariate ANCOVA

Normality of Data

For the present study the researcher tested the normality of the sample by using the Shapiro- Wilk test. Shapiro & Wilk (1965) developed the Shapiro-Wilk test statistic. The Shapiro-Wilk test, known for its strong power characteristics, relies on correlation

within the given data and related normal scores. It is widely used for diagnosing the assumption of normality. The power of a test indicates the ability to detect the non-normal distribution within a sample. The null hypothesis is "sample distribution is normal," and the normality test compares the sample's scores to a set of scores that are normally distributed and have the same mean and standard deviation. The distribution is considered non-normal if the test is significant (Ghasemi & Zahediasl 2012).

Descriptive Statistics

Descriptive statistics are used to summarize the data and to culminate the main properties of the entire group of data into small numbers. Organizing descriptive statistics in research is a fundamental element, and which is usually conducted before inferential statistical comparisons. Descriptive statistics have different types of variables in form of nominal, ordinal, ratio, and interval and also have different types of measures of frequency, central tendency, and dispersion or variation.

For the present study, the researcher has used frequency and percentage for summarizing the data into simpler form. For the normally distributed variables, mean and standard deviation was computed and that for non- normally distributed variables median and quartile deviation was assessed. The researcher used descriptive statistics to analyze the socio demographic details of the participants.

Inferential Statistics

Veeraraghavan & Shetgovekar (2016) stated inferential statistics as “Inferential statistics refers to the mathematical methods based on probability theory and helps in reasoning and inferring the characteristics features of the sample drawn from the larger population”. Inferential statistics are used to predict or estimate the characteristics of a population and are likely to obtain a set of results from a single sample. It is also known as to test statistical significance of the sample measures. Based on the normality of the

sample, the researcher used both parametric and non-parametric inferential statistics for estimating the sample results. The following tests were used to infer the results for the present study: -

Mc Nemar's Chi Square Test

Chi square tests, (X2) is one of the common nonparametric tests used to test the hypothesis of categorical variables i.e., nonnumeric variables (Kothari, 2007). It is used to determine whether the observed data is significantly different from what is expected from the data. If there is a high difference between the observed data and expected data, chi square is statistically significant. Chi square test is symbolized as X2 and there are assumptions like, samples are selected randomly, and items of the samples are independent to each other, while using the test.

For the present study, the researcher used Mc Nemar's chi square test, which is the repeated measure version of the chi square test of independence. Here, also the Mc Nemar's analyzed the number of occurrences of observations in the DPCL checklist before and after the intervention, to check whether the treatment was found effective or not.

Independent Sample 't' Test

Independent sample t test is one of the parametric tests used for assessing the group difference where samples are normally distributed. The test is used to define whether the means of the two groups are different from each other (Kothari, 2007). The assumption of normality, independence and assumption of homogeneity of variance; the variance of the dependent variables should be equal among two groups, be met while using an independent sample t test.

For the present study, the researcher used an independent sample t test in pretest assessment for the variables which are normally distributed. The researcher used an

independent sample t test for comparing some of the mental health variable subdimensions of family interaction,(sub variables like, family independence, family achievement orientation,(experimental group); family intelligence orientation(control group); family conflict, family social orientation, family ethical complaints, family discipline, and total family interaction (in both experimental and control group) ; social competence (school competence, team organization in control group, peer social competence, and social cognition in experimental group, home related competence, social forethought and compassion, social emotional competence, and total social competence in both experimental and control group); and difficulties in emotion regulation (sub dimensions like lack of emotional awareness, lack of emotional clarity, difficulties in controlling impulsive behavior when distressed, limited access to emotional regulation strategies, and total difficulties in emotion regulation) .

Mann Whitney U Test

Mann Whitney U test is a non-parametric test, used to compare the difference between two independent samples, when the sample size is small ($n<30$), and when the sample distributions are not normally distributed. The test is used to find out whether the distribution of ranked responses between the two samples being compared is significantly different (Gaddis & Gaddis,1990). In some cases, the assumptions of normality and homogeneity of variance could not meet to follow independent sample t tests, then the Mann Whitney U test could be used to find out the group difference.

For the present study, some variables are found heterogeneous; the variables exhibit dissimilarity in their values or characteristics, and the sample size is less than 30, the researcher used Mann Whitney U test for comparing the group difference. Here, the researcher applied Mann Whitney U test for some of the mental health subdimensions of family interaction,(sub dimensions like family cohesion, family

intelligence orientation ;experimental group, family achievement orientation; control group), social competence (sub dimensions like, school competence and team organization in experimental group, and peer social competence and social cognition in experimental group); and difficulties in emotion regulation (sub dimensions like difficulties in engaging goal directed behavior when distressed, and non-acceptance of negative emotional response).

Univariate ANCOVA (Analysis of Covariance)

A covariate is called a concomitant and confound variable, which the investigator pursues to control (statistically subtract the effects) by using one of the methods is ANCOVA or Multiple regression analysis (Leech et al., 2005; Vogt, 1999). ANCOVA was originally developed by Fisher (1932) to reduce error variance in experimental studies. ANCOVA is a blend of analysis of variance and regression which is used to adjust the linear effect of variance of dependent variables (error) and make pure results as well as increase the analytical power. There are two assumptions of ANCOVA that is, the linearity of relationship and homogeneity of regression slopes. The ANCOVA adjustments will be biased if the connection is nonlinear. The extent of this bias depends on degree of deviation from linearity, especially when there are notable differences between groups regarding the covariate. Hence, besides conducting ANCOVA on the covariate, it is essential for the researcher to examine the relationship between the dependent variable and the covariate in initial analyses, typically by reviewing a scatter plot of the data points. Ensuring the assumption of homogeneity of regressions slopes or parallelism is also crucial when employing ANCOVA. If the regression slopes are not parallel to each other there is a chance of interaction effect with covariate and treatment effect. For the present study also, some variance has heterogeneous regression slopes, and are not normally distributed, comparison of

means of two groups, was done with paired sample *t* test (Zumbo & Jennings, 2002) with gained score (post-test- pretest).

For the present study researcher carried out ANCOVA for analyzing the post test results after intervention. For some variance the assumption of homogeneity of regression slopes or parallelism followed, since the sample sizes are equal in both groups the heterogeneity of regression slopes is ignored and continues with ANCOVA (Johnson, 1993). The power and effect size also computed. The effect size can be measured with *r* family and *d* family. The researcher used the *d* family effect size measure since it is pair wise comparison. Cohen's *d* is the most popular effect size measure (Cohen, 1988) used for finding the effect size for finding the strength of variables. The effect size in Cohen's d represents the difference between the groups in terms of their common standard deviation, and is used in single pre-post comparison groups (Lenhard & Lenhard 2017). The effect size is low when the value is 0.20, medium when it is 0.50 and large effect size when the value is 0.80 (Cohen, 1988).

Ethical Consideration

The present study was conducted among children with behavioral problems. The participants were selected based on the score on the DPCL checklist and parental information. There were 24 participants in the study, within the age range of 13-15 years. Before conducting the study, the researcher gets consent from parents and children. Also, the present study was ethically approved by the ethical committee of Prajyoti Niketan college, Pudukad.

Chapter Summary

Chapter two deals with the methods used in the study. Theis includes the phases description, the participants included in the study, the procedure for sample selection, and the measures used to collect data form the participants. The chapter also explains

about the training module prepared in the first phase and modifications done in the training module for the final phase. The chapter summarize with the description of statistical techniques used in the study**.**

The researcher undertook a comprehensive investigation into behavioral problems among children, analysing the various contributing factors and subsequently developing a multidimensional intervention program aimed at enhancing their mental health and addressing significant psychological variables. Thus, this chapter is focused on understanding behavioral issues, identifying the participant's socio-economic factors, and assessing the efficacy of the multidimensional program to enhance the mental well-being of children facing behavioral challenges. The study progressed through distinct phases, each separately outlined in its corresponding section.

Phase I: Pilot Study

The researcher conducted a pilot study in order to get an idea about the relevance of the present study among the group. The pilot study was conducted in two sections, in which section A of the study was conducted to know the occurrence of behavioral problems among school children. The youth self-report (YSR) was used to assess the frequency of behavioral problems among children. The study was conducted among 228 school children, within the age of 11-16 years of both boys and girls form Government, aided and unaided schools in Thrissur district. After the data collection, descriptive statistical analysis was done to know the frequency and percentage distribution of behavioral problems among children. The results and discussion of the study explained as a concerned section.

After recognizing the frequency distribution of behavioral issues among school children and their potential impact on mental health, the researcher focused on implementing an intervention plan to reduce these problems, which was assessed in the second section of phase 1. To test the effectiveness of the intervention, a trail experiment study was conducted by the researcher. For this purpose, the researcher selected children with behavioral issues, with the help of school counselors. The

researcher contacted the respective parents of children with behavioral problems with the help of a school counsellor. Several children with behavioral issues were selected based on a checklist; Developmental psychopathological checklist, completed by their parents. With consent from both parents and children, the intervention program began. Six children participated in the second section of pilot study, undergoing pre- and post-assessments using the checklist. The efficacy of the intervention program was determined through case summary and diagrams illustrating each participant's response.

Phase II: The Multidimensional Intervention Program

Following the promising results of the pilot study, the researcher identified key psychological variables—family interaction, social competence, and emotional regulation—as crucial for enhancing mental health and addressing behavioral problems in children. Although the pilot intervention was effective, certain modifications were found necessary to optimize its impact. Collaborating with psychology experts, the researcher modified the intervention program, resulting in a multidimensional approach.

Participants were selected based on their scores on the DPCL checklist and divided into experimental and control groups through random allocation, each comprising 12 participants, totalling 24 for the second phase. Pre-test and post-test assessments were conducted using the DPCL checklist along with evaluations of family interaction, social competence, and emotion regulation. Employing a pre-post control group design, the collected data analyzed using inferential statistics, including parametric and non-parametric tests, with results and discussions presented in respective sections.

Analysis of Phase I and Phase II

Phase I: Pilot Study

The pilot study was conducted in two sections. Each section wise analysis described in detail.

Section A: Frequency or Distribution of Behavioral Problems Among School Going Children

a). Analysis of Socio Demographic Details of Participants. In the first phase of the study, the researcher conducted a study to understand the frequency distribution of behavioral problems among children. The researcher approached different schools in Thrissur district, after getting approval from six school authorities, making rapport with students, the Youth self-report (YSR) was distributed among school students. The study was conducted among a total of 228 school student participants who were selected for the study. The participants were belonging to both boys and girls and were representing government, aided, and unaided schools. The descriptive analysis was done on the basis of different socio demographic details like gender, age, school type, income and parents.

Table 1

Socio Demographic Details of The Participants (N=228)

Variables	Groups	Frequency	Percentage
Age	11-13 years	162	(71%)
	14-16 years	66	(29%)
Gender	Boys	134	(58%)
	Girls	94	(41%)
School	Government	84	(37%)
	Aided	59	(26%)
	Un Aided	85	(37%)
Income	Low SES	104	(46%)
	Average	89	(39%)
	High SES	35	(15%)
Parents	Both parents	216	(95%)
	Single parent	12	(5%)

Table 1 indicates the sociodemographic details of the participants based on age, gender, type of school, income, and family details. Out of 228 samples, boys consist of 134 (59%) and girls 94 (41%), among them 71% belong to early adolescent age i.e., 11-13 years of age and 21% belong to middle adolescence (14-16 years) age. The distribution of students based on type of school as government (37%), aided (26%) and unaided (37%). Most of the students are from low socioeconomic status (46%), average (39%) and 15% are from high socioeconomic status. On the basis of family details 95% are having both parents, while 5% of the sample have single parents.

b). Analysis of Distribution of Behavioral Problems of Participants. The occurrence of behavioral problems among participants was analyzed using descriptive statistics. The distribution of behavioral problems was examined based on gender and age as follows.

Table 2

Distribution of Problem Behavior Based on Gender (N=228)

Problem behavior	Gender						Total
	Boys (*N=134*)			Girls (*N=94*)			
	Clinical	Borderline	Non clinical	Clinical	Borderline	Non clinical	
Internalized problem	7 (5%)	5 (3%)	31 (23%)	9 (9%)	8 (8%)	23(24%)	83
Externalized problem	12 (8%)	14 (10%)	49 (36%)	4 (4%)	3 (3%)	25(26%)	107
Other problem	3(2%)	3 (2%)	10 (7%)	4(4%)	3(3%)	15(15%)	38
Total	22	22	90	17	14	63	228

Table 2 represents the outcomes of the categorization of problem behavior into internalized, externalized, and other issues based on the youth self-report among the group. The problem behavior is categorized based on the severity of the problem presented among participants. There are three categories of problem behavior like,

internalized problem behavior, externalized problem behavior, and other problem behavior. Internalized problem behavior encompasses anxiety, depression, somatic complaints, and withdrawal. Within the group statistics, among boys (*n =134),* the clinical and borderline instances of internalizing problems were observed at 5% and 3%, respectively. Externalizing problems were identified at 8% in the clinical category and 10% in the borderline category, comprising rule-breaking and aggressive behavior. Attention problems, thought problems, and social problems (classified as "other problems") accounted for in the clinical category, and borderline category, are found to be 2% and 7% in the non-clinical category. When compared to the girls' statistics *(n =94),* the internalized problem reported as 9% and 8% for clinical and borderline category respectively, the externalized problem and other problem reported as 3% and 4% for clinical and borderline category respectively. The overall problem behavior result indicates that externalizing behavioral problems were reported as higher among boys (18%) than girls (7%), and internalized problem behavior was more prevalent among girls (17%) than boys (8%).

Table 3

Distribution of Problem Behavior Based on Age (N=228)

Problem behavior	Age						Total
	11-13 years (*N=162*)			14-16 years *(N=66)*			
	Clinical	Borderline	Non clinical	Clinical	Borderline	Non clinical	
Internalized problem	8(4%)	9(5%)	40(24%)	5(7%)	8(12%)	11(16%)	81
Externalized problem	12(7%)	14(8%)	50(30%)	4(6%)	6(9%)	21(31%)	107
Other problem	5(3%)	6(3%)	18(11%)	2(3%)	3(4%)	6(9%)	40
Total	25	29	108	11	17	38	228

Table 3 indicates the distribution of problem behavior based on age among participants. The two age groups representing the problem behavior, between the age of 11-13 years *(n =162),* and the age of 14-16 years *(n =66).* When compared to age wise distribution of problem behavior, the internalized problem behavior was more prevalent among the age group of 14-16 years (19%, including both clinical and borderline) than the age group of 11-13 years (9%). In the externalized problem behavior category, both the 11-13 years and 14-16 years age groups exhibit similar levels of behavioral issues, each comprising approximately 15% of the total. This underscores the prevalence of problem behavior during adolescence. Compared to other problem categories, both age groups report clinical and borderline behavioral issues at rates of 6% and 7%, respectively. Overall, the findings suggest that the 14-16 years age group demonstrates a higher prevalence of behavioral problems compared to the 11-13 years age group, indicating that age group is also a considerable factor for addressing behavioral problems among children. The study result shows a high frequency of externalizing problems among school aged children followed by other problems and internalized behavioral problems.

Section B: Trial study to find out the effectiveness of intervention strategies among children with behavioral problem

Following the identification of the occurrence of behavioral problems in children, it has become evident that these issues need to be addressed, prompting the necessity for an intervention strategy. Before implementing the final training program, a thorough evaluation of key topics to be discussed and administered in the concluding phase of training was essential. Therefore, section B of the present study is focused on conducting a trial study of an intervention program, aiming to assess the effectiveness of the training module for children experiencing behavioral problems.

To execute this phase, the researcher collaborated with school counselors, where they can get more access to get information regarding the child behavior, screening and selecting children exhibiting behavioral problems. After the initial analysis of the school counsellor, the researcher contacted parents of selected children with behavioral issues noted by the school counsellor. The parents get informed about the behavioral problems and the planning of introducing the intervention program to reduce the behavioral problem among children. After the introduction and consent from parents, six children participated in the study. They were screened by the scores obtained in the behavioral problem subscales of the Developmental Psychopathological Checklist. During the intervention stage, both parents and children underwent the intervention program. The total number of training sessions was about 12 sessions, among them 10 sessions are for children and six sessions were for parents, and two sessions were taken as pre and post assessment of the behavioral problem. The intervention package encompassed various components, including individual counselling, a daily routine chart, homework assignments, behavioral contracting, time management strategies, and relaxation techniques. The results presented were analyzed qualitatively as case summary and a comparison of pretest -post test scores were assessed. The response of each case was explained as tables and figures. The analysis of the response was recorded and presented as case summary of each participant and the diagrammatic representation of the behavioral problem presence and absence were analyzed individually and presented.

Case Summary

Case 1. Master SA.

Master S A, a 15-year-old student currently enrolled in the 10th standard, faces a challenging familial context as his parents are separated. He, along with his younger

brother, resides with his mother, who is employed on a daily wage basis. The family structure and economic circumstances contribute to the complexity of Master S A's upbringing.

The client sought intervention, accompanied by his mother, with a set of concerning issues. These included problematic alcohol and smoking habits, frequent bouts of anger resulting in destructive behavior, and a tendency to spend a significant amount of time with friends. Additionally, his academic progress reflected a concerning trend of poor performance. During the pre-assessment, the client has reported all the behavioral problems like, disobedience, stubbornness, disruptive, quarrelsome, aggression, temper tantrums, truancy and lying and stealing most of the time.

Both the client and his mother actively participated in the training sessions, indicating their commitment to addressing the behavioral challenges faced by Master S A. The collaborative effort between the client and his mother during the intervention process signifies a notable improvement in the overall well-being of Master S A. The presence of such familial support becomes crucial in resolving through the complex interplay of behavioral, academic, and personal challenges faced by the young student. The post assessment results indicate that the behavioral problems like stubbornness, disruptiveness, temper tantrums, truancy, lying and stealing have been reduced to minimum or absence in behavioral expression. Whereas the behavioral issues like disobedience, quarrelsome, aggression persisted without significant improvement in post assessment. The results are represented as table and figure below.

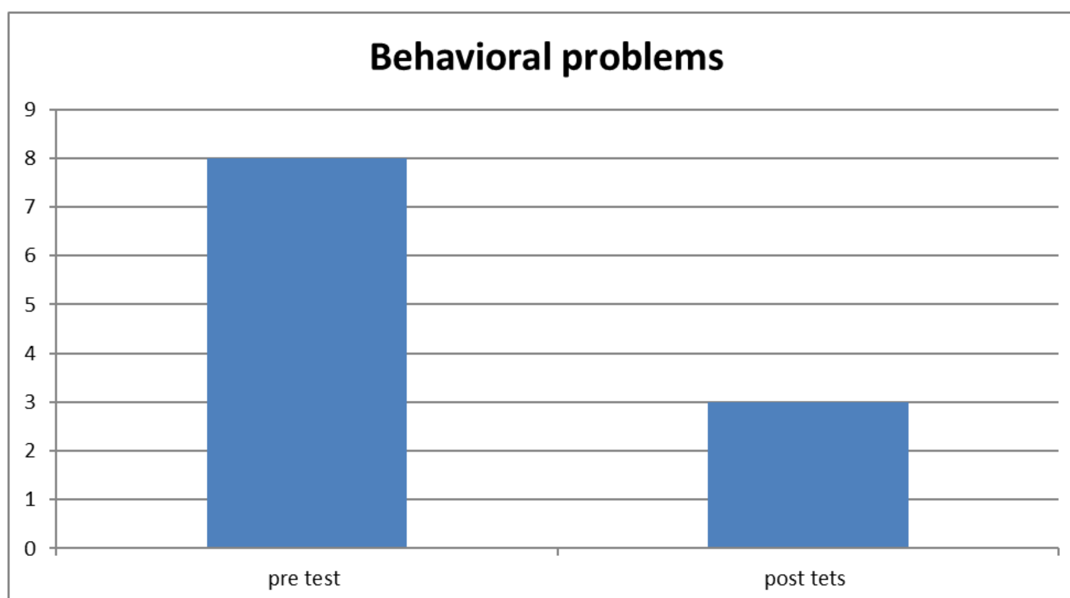
Table 4

Response of Presence or Absence of Behavior Problem Exhibited by Case 1

Behaviour	Pre test	Post test
1. Disobedience	Yes	Yes
2. Stubbornness	Yes	No
3. Disruptive	Yes	No
4. Quarrelsome	Yes	Yes
5. Aggression	Yes	Yes
6. Temper tantrums	Yes	No
7. Truancy	Yes	No
8. Lying and stealing	yes	No

Figure 2

Diagrammatic Representation of The Response of Presence or Absence of Behavior Problem Exhibited by Case 1.



The Table 4 and figure (Figure 2) serves as a visual representation of the scores obtained through the DPCL checklist, utilizing 'yes' to signify the presence of symptoms most of the time and 'no' to denote the absence or minimal occurrence of symptoms. The pre-test analysis demonstrates a prevalent manifestation of various

behavioral symptoms in the individuals under study, suggesting the depth of the challenges faced.

In contrast, the post-test assessment noted a significant reduction in the majority of these behavioral symptoms, indicating the positive impact of the intervention and alleviating the reported issues. This positive trend suggests that the intervention strategies employed were effective in addressing and reducing several problematic behaviors. Both the participant and parent were taught about behavioral problems. Parents were given support and assurance for interacting with the participant. The researcher helped the participant to improve study skills, the way to communicate with others, especially in school and home.

However, it's crucial to note that certain behavior, such as disobedience, quarrelsome conduct, and aggression, exhibited minimal change following the intervention program. Despite the overall effectiveness, this specific behavior did not show substantial improvement, highlighting that some modification was needed in behavioral interventions. This observation prompts a closer examination of the intervention strategies employed, emphasizing the need for personalized approaches to address and potentially modify persistent behavioral challenges. The acknowledgment that certain behavior may require additional attention underscores the ongoing nature of the therapeutic process and the importance of refining strategies to comprehensively address individual needs.

Case 2 JR

JR, a 14-year-old girl currently enrolled in the 9th standard, is part of a family comprising her father, mother, and a younger brother. The family dynamics are marked by significant challenges, including her father's struggle with alcoholism. Both of JR's

parents work as cooli workers, indicating a working-class background. Unfortunately, family discord is present, adding another layer of complexity to JR's environment.

JR joined in training sessions with concerns that encompassed poor academic performance, aggressive behavior, disobedience towards elders, and excessive use of her phone. Due to these behavioral issues, she was included in training sessions. The client has reported the behavioral problems in the pre assessment like, disobedience, stubbornness, quarrelsome, aggression, and temper tantrums. She shows interest in learning new skills and wants to reduce and change the behavioral issues.

Throughout the intervention, JR's mother was supportive and contributed to the effectiveness of the sessions. Her father did not attend the sessions, as he has to go for work daily. During the training session, researchers helped the participant to acknowledge the behavioral problems the participant has and taught skills which help in reducing aggressive behavior. Throughout the session, the participant's mother was cooperative with active participation. The post assessment of behavioral problems indicates that all the behavioral issues exhibited before the intervention have been reduced, except for aggression and temper tantrums.

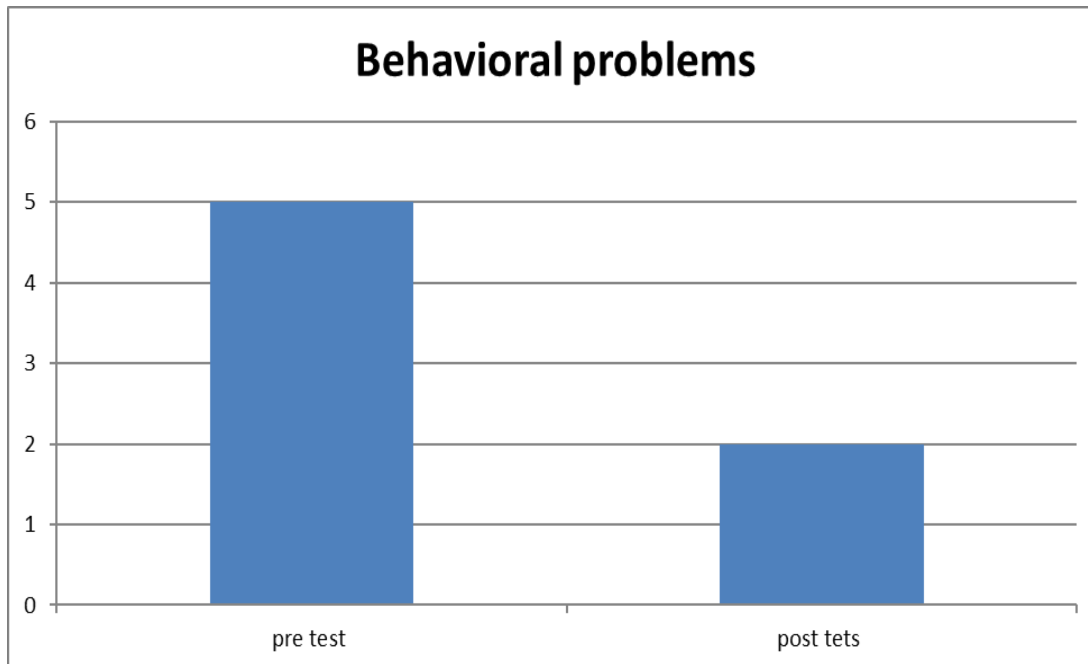
Table 5

Response of Presence or Absence of Behavior Problem Exhibited by Case 2

	Behaviour	Pre test	Post test
1.	Disobedience	Yes	No
2.	Stubbornness	Yes	No
3.	Disruptive	No	No
4.	Quarrelsome	Yes	No
5.	Aggression	Yes	Yes
6.	Temper tantrums	Yes	Yes
7.	Truancy	No	No
8.	Lying and stealing	No	No

Figure 3

Diagrammatic Representation of The Response of Presence or Absence of Behavior Problem Exhibited by Case 2



The tabulated results in the Table 5 and figure 3 indicate a comprehensive overview of the behavioral challenges observed in case 2. The initial assessment highlighted the notable presence of various behavioral problems in the individual, indicating the complexity of the issues. In response to these concerns, the post-test evaluation indicates positive outcomes, signifying the efficacy of the intervention in addressing and reducing some of the initially identified problems.

Despite the overall improvement, it is essential to note that certain behavior persisted without substantial reduction. Specifically, issues related to aggression and temper tantrums did not exhibit significant decreases following the completion of the training program.

The results highlight the importance of ongoing support and targeted strategies to comprehensively address the complexity of behavioral issues. It also emphasizes the

need for a holistic understanding of individual cases, recognizing that some aspects may require additional attention and specific intervention techniques for more profound and sustained improvements.

Case 3 S

Master S is a 15-year-old boy currently studying in the 10th standard. His family consists of his father, who works as a welder, his mother, employed as a nurse abroad, and a younger brother. Notably, the parents share a positive and stable relationship within the family unit, creating a supportive environment.

The primary reason for Master S's attendance in the training sessions revolves around behavioral issues that have been reported by parents. These include struggles with anger management, the use of abusive language, instances of lying and stealing, and concerns related to alcohol abuse. All the Behavioral problems like disobedience, stubbornness, disruptive, quarrelsome, aggression, temper tantrums, truancy and lying and stealing were reported as exhibited most of the time in the pre assessment.

Recognizing the need for intervention to address these challenges, Master S participated in all the training sessions. The participant's both parents have attended a few sessions. The parents were taught about the nature of behavior of participants, and were instructed to follow observing and noting down the behavior. They were also encouraged to have effective communication in the family. During the initial stages of training both parent and client were regularly active in completing the activities, but due to some reasons, the parent was not able to complete the rest of the sessions. Even though, parent was concerned about the clients training feedback and behavioral responses. The post assessment of behavioral problems indicates that the intervention was found effective to reduce or absence of behavior like disobedience, disruptive, quarrelsome, truancy, lying and stealing in the client.

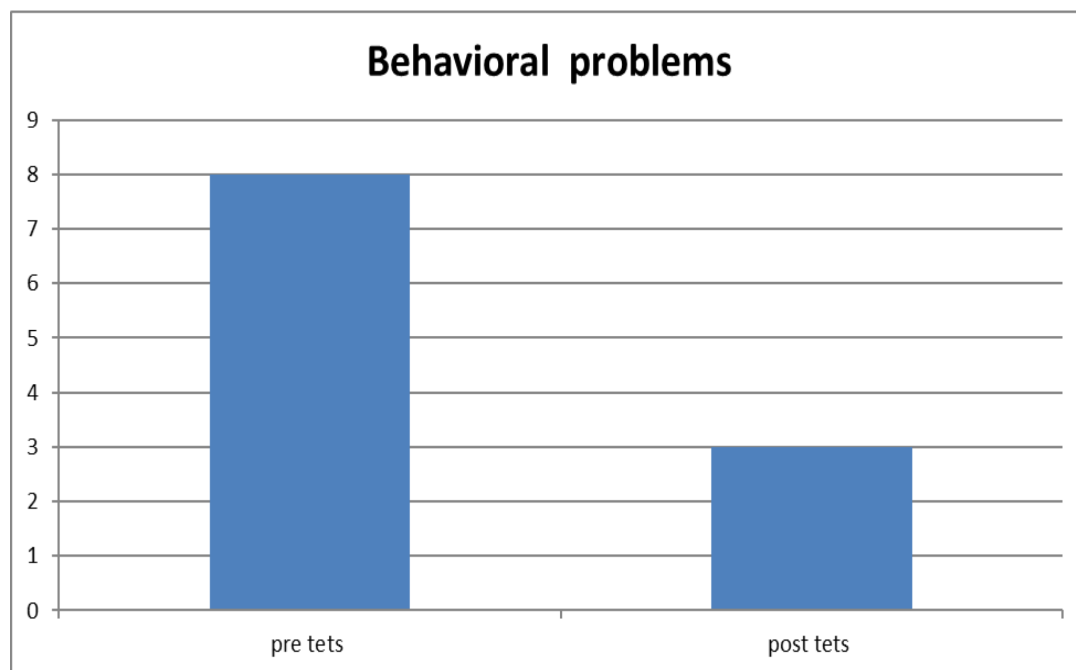
Table 6

Response of Presence or Absence of Behavior Problem Exhibited by Case 3

	Behaviour	Pre test	Post test
1.	Disobedience	Yes	No
2.	Stubbornness	Yes	Yes
3.	Disruptive	Yes	No
4.	Quarrelsome	Yes	No
5.	Aggression	Yes	Yes
6.	Temper tantrums	Yes	Yes
7.	Truancy	Yes	No
8.	Lying and stealing	Yes	No

Figure 4

Diagrammatic Representation of The Response of Presence or Absence of Behavior Problem Exhibited by Case 3



The Table 6 indicates the comprehensive analysis of the pretest and post-test responses for case 3, providing insights into the participant's behavioral dynamics. In the pretest phase, the participant reported experiencing all behavioral problems most of the time, indicating a considerable prevalence of these issues in their daily life.

The post-test results, however, show a noteworthy reduction in the majority of behavioral problems after the intervention program. This positive shift suggests that the intervention had a visible impact on reducing several problematic behaviors, fostering a more positive behavioral environment.

Despite these overall improvements, it is essential to highlight those certain behavioral aspects that persisted without significant change. Stubbornness, aggression, and temper tantrum behavior did not exhibit notable reductions following the intervention. This notable outcome suggests that while the intervention was successful in addressing some aspects of the behavioral issues, a more personalized or focused approach may be required to specifically target and reduce this persistent behavior. The results emphasize the complexity of behavioral interventions and the need for ongoing efforts to address the multifaceted nature of individual behavioral challenges. The diagrammatic representation of the result represented in as figure 4.

Case 4. S

Case 4 features Master S, a 14-year-old boy currently enrolled in the 9th standard. His family includes both parents, with his father being employed on a daily basis, while his mother works in a private firm. Unfortunately, the family context is marked by parental disharmony, adding an additional layer of complexity to the young boy's life.

The primary reasons for seeking intervention revolve around Master S's poor academic performance, behavioral issues, and engagement in alcohol and cigarette smoking. These concerns prompted his attendance in the training sessions, reflecting the family's commitment to addressing and resolving the challenges faced by their son. The pre-assessment of behavioral problems indicates that the client has reported all the behavioral problems most of the time.

During the initial session, Master S demonstrated a lack of cooperation, posing an initial challenge in the intervention process. However, his mother was supported during the first two sessions, indicating a source of encouragement within the family.

While both parents and the child attended all the subsequent sessions, it's notable that active participation from the child remained poor throughout the intervention program. This lack of active engagement may present a hurdle in the effectiveness of the intervention, underscoring the importance of addressing not only the presented issues but also fostering the active involvement and cooperation of the young individual in the therapeutic process. The post assessment indicates that the client has reported all the pre-assessed behavioral issues were persistent and not much change except in the truancy behavior.

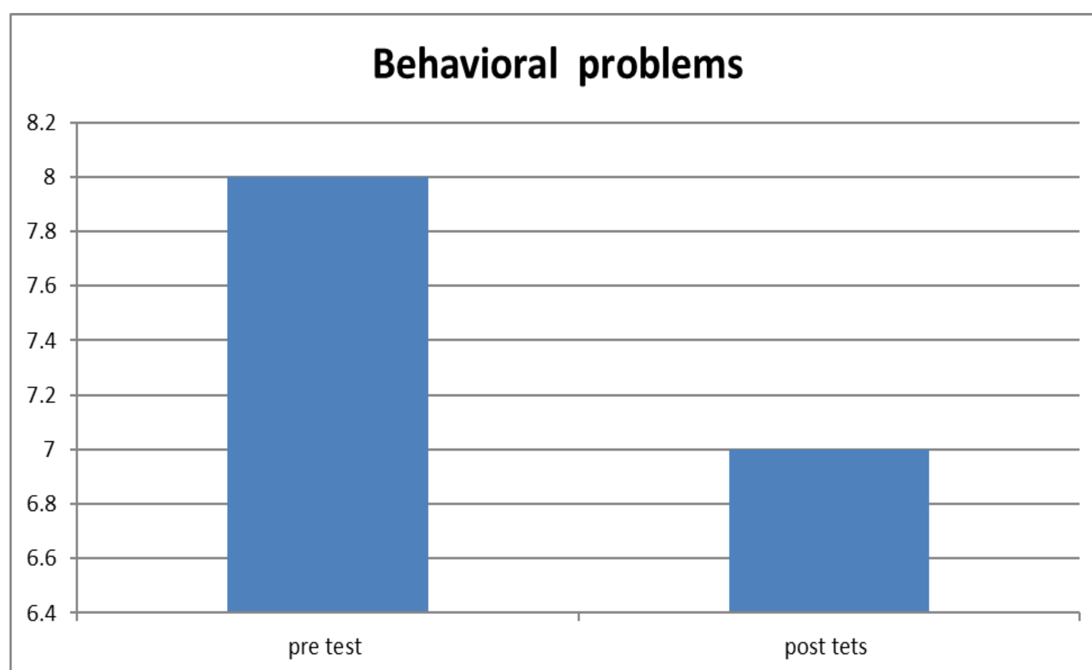
Table 7

Response of Presence or Absence of Behavior Problem Exhibited by Case 4

Behaviour	Pre test	Post test
1. Disobedience	Yes	Yes
2. Stubbornness	Yes	Yes
3. Disruptive	Yes	Yes
4. Quarrelsome	Yes	Yes
5. Aggression	Yes	Yes
6. Temper tantrums	Yes	Yes
7. Truancy	Yes	No
8. Lying and stealing	Yes	Yes

Figure 5

Diagrammatic Representation of The Response of Presence or Absence of Behavior Problem Exhibited by Case 4



The above results in Table 7 pertaining to case 4 highlight the responses recorded in both the pre-test and post-test assessments using the DPCL. In the pretest phase, the participant reported the presence of all issues outlined in the behavioral problem checklist. However, upon conducting the post-test analysis, it was observed that there was no notable change or reduction in the problematic behavior, with the exception of truancy.

Despite the limited improvement in the majority of behavioral problems, it is worth noting that the intervention program demonstrated effectiveness for the participant, particularly in addressing truancy. As the participant showed no interest to attend and complete the scheduled activities and was absent in most of the sessions. The figure 5 represent the diagrammatic representation of the result.

Case 5 S.S

Master S, a 14-year-old boy currently studying in the 9th standard, hails from a family where both parents work on a daily basis. His family includes his parents and a younger brother. Unfortunately, the family context is marked by parental conflicts, creating a challenging environment for the young boy. The client has reported the behavioral problems like, disobedience, stubbornness, disruptive, quarrelsome, aggression, temper tantrums, and truancy during the pre-assessment phase.

The reason for seeking intervention stems from behavioral and substance abuse issues exhibited by Master S. Both the client himself and his parents actively participated in all the intervention sessions, indicating their concern to addressing and resolving the challenges faced by the young boy. Even Though parental conflicts were there, the parents were supportive of the client’s intervention program, recognizing the importance of their involvement in fostering positive changes in their son's behavior and addressing the substance abuse concerns. The post assessment results indicate that most of the pre-assessed behavioral problems have been reduced to minimum or absent in most of the time, except for temper tantrums.

Table 8

Response of Presence or Absence of Behavior Problem Exhibited by Case 5

Behaviour	Pre test	Post test
1. Disobedience	Yes	No
2. Stubbornness	Yes	No
3. Disruptive	Yes	No
4. Quarrelsome	Yes	No
5. Aggression	Yes	No
6. Temper tantrums	Yes	Yes
7. Truancy	Yes	No
8. Lying and stealing	No	No

Figure 6

Diagrammatic Representation of The Response of Presence or Absence of Behavior Problem Exhibited by Case 5

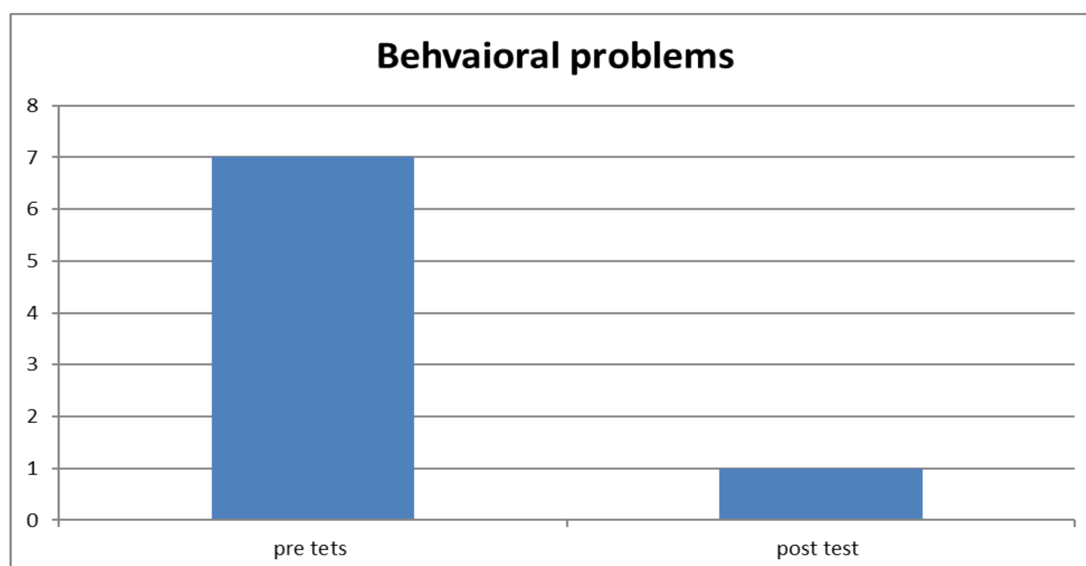


Table 8 represents whether case 5 exhibits behavioral issues or not. The comprehensive examination of the DPCL responses for case 5, offers insights into the participant's behavioral challenges. During the pretest phase, the participant acknowledged experiencing a range of behavioral problems, with the exception of lying and stealing, underscoring the pervasiveness of these issues in the individual's life. The diagrammatic representation of the case 5 represented in Figure 6.

When considering the post-test analysis, encouraging outcomes emerged. A notable reduction or absence of the majority of behavioral problems was observed, reflecting the positive impact of the intervention. This improvement indicates the efficacy of the strategies employed in addressing and reducing several behavioral problems identified initially.

However, a specific behavior, namely temper tantrums, demonstrated a notable persistence without experiencing a significant change or improvement following the training. The result highlights the complex nature of behavioral treatments,

emphasizing that while the overall impact is beneficial, certain behavior may require a more concentrated or personalized approach for significant change.

The findings emphasize the need of understanding the various variations within individual instances and designing intervention tactics to target specific behavior that may require extra attention. It confirms the premise that a complete customized strategy is required for comprehensive and long-term behavioral outcomes changes.

Case 6 A. P

Master AP, a 13-year-old boy currently enrolled in the 8th standard. He has a mother, father and a twin brother. His father is a driver and mother work on a daily basis.

The need for intervention arises due to the behavioral challenges experienced by Master AP. These include struggles with poor academic performance, manifestations of aggressive behavior, issues related to sibling interaction, and a tendency to engage in deceptive practices such as lying. Recognizing the different nature of these concerns, both the client and his parents actively participated in all the training sessions. During the pre-assessment the client has reported disobedience, stubbornness, disruptive, quarrelsome, aggression, and temper tantrums indicating the need of training.

Master AP and his parents were really committed and always showed up for the intervention sessions, which highlighted how they were all working together as a family to deal with the problems they were facing. The familial support plays an important role in the success of the intervention, fostering an environment where strategies can be implemented to improve academic performance, manage aggressive behavior, focus sibling relationships, and address deceptive practices. The acknowledgment of these challenges and the family's active involvement in the intervention process reflects a

collective dedication to the holistic well-being and development of Master AP. In the post-assessment, the client showed significant reductions in behavioral issues such as disobedience, stubbornness, quarrelsomeness, and temper tantrums, with these problems minimized or completely absent. This indicates the success of the intervention program.

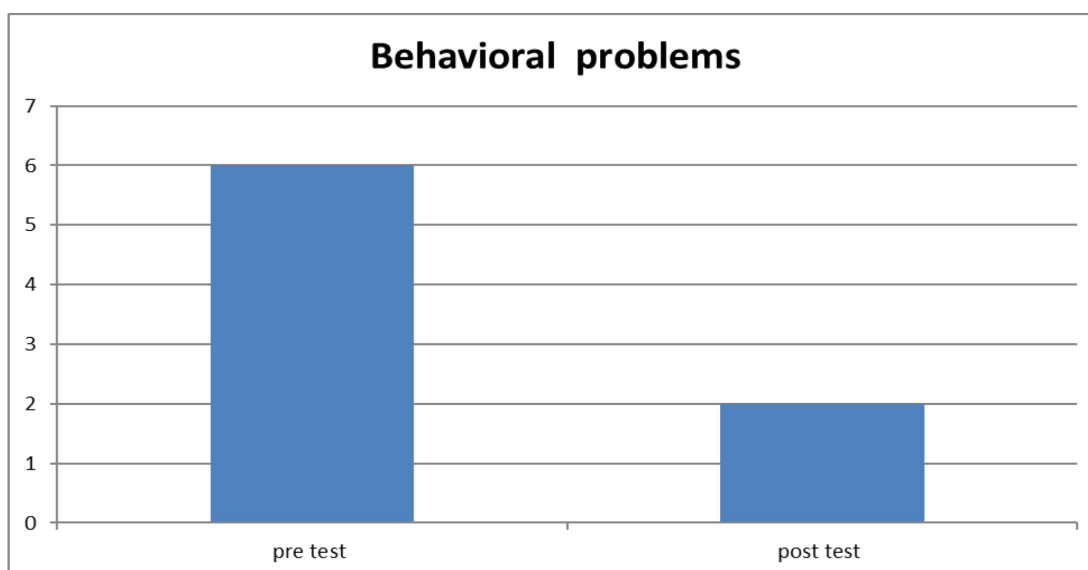
Table 9

Response of Presence or Absence of Behavior Problem Exhibited by Case 6

Behaviour	Pre test	Post test
1.Disobedience	Yes	No
2. Stubbornness	Yes	No
3. Disruptive	Yes	Yes
4. Quarrelsome	Yes	No
5. Aggression	Yes	Yes
6. Temper tantrums	Yes	No
7. Truancy	No	No
8. Lying and stealing	No	No

Figure 7

Diagrammatic Representation of The Response of Presence or Absence of Behavior Problem Exhibited by Case 6



The tabulated results in Table 9 provide a detailed overview of the DPCL responses for case 6, shedding light on the participant's behavioral dynamics. In the pretest analysis, a comprehensive assessment reveals that the participant reported a majority of behavioral problems, with the exceptions being truancy and lying and stealing.

Post-intervention, a positive shift is identified indicating substantial improvements or reductions in the behavioral problems reported prior to the intervention. This optimistic trend suggests the effectiveness of the training program in addressing and improving several problematic behaviors. Notably, the intervention demonstrated efficacy in reducing issues such as disobedience, stubbornness, quarrelsome behavior, and temper tantrums, reflecting positive strides in these areas. The diagrammatic representation of the results indicated in Figure 7.

However, it is crucial to note that a particular behavioral aspect, namely aggressive patterns, exhibited resistance to change and did not show significant improvement following the intervention. The results sound that more individualized and problem focused intervention strategies might be helpful for the children for reducing the behavioral problems.

The mixed results highlight the importance of recognizing the uniqueness within individual cases and adapting intervention strategies to comprehensively address specific behavior. Despite the challenges posed by the persistent aggressive pattern, the overall positive changes in other behavior emphasize the potential impact of targeted interventions in fostering behavioral improvements.

Phase II: The Multidimensional Intervention Program

In the final phase of the study, the researcher developed a training module based on the modified intervention process from phase I. The aim was to assess the impact of

the intervention program on psychological variables in children with behavioral problems. The pre-post control group design was used as a research design (Campbell & Stanley,1966), as the study is experimental in nature. The study involved two groups: an experimental group that received the training programs, and a control group which did not receive any training programs. By comparing the outcomes between these two groups, the effectiveness of the intervention program on psychological variables could be determined. For the analysis of variables, the researcher used Microsoft excel and statistical package for the social sciences (SPSS V.23) software for coding and analysing the data. The data were checked with the Shapiro-Wilk normality test to ensure the normal probability of sampling distribution. From the normality test it was found that some variables are normally distributed, while some are not normally distributed. The normally distributed variables are analyzed with parametric tests like independent sample t-test for comparing means. Non-parametric tests, including McNemar's chi-square test and the Mann-Whitney U test, were employed to analyze data for non-normally distributed variables. Additionally, Univariate ANCOVA was utilized to compare the effectiveness of the intervention between the experimental and control groups. Furthermore, gained scores were conducted to compare the mean differences between the experimental and control groups in the post-test.

The analysis in the second phase is described as a different section based on the type of analysis used. The sections are,

Section A: Analysis of socio demographic details among experimental and control group

Section B: Analysis of developmental psychopathological checklist among experimental and control group in pre and post assessment

Section C: Effectiveness of multidimensional intervention program on family interaction, social competence, and difficulties in emotion regulation with its dimensions between pre and post assessment among experimental and control group

Section A: Analysis of Socio Demographic Details Among Experimental and Control Group

This section deals with the analysis of socio demographic analysis like age, gender, sibling status, family status, and substance abuse of parents of participants in both experimental and control groups. The descriptive analysis like mean, frequency and percentage were used by the researcher to assess the data. Through this section, the researcher comprehensively analyzed the demographic characteristics of participants in both groups. Socio-demographic variables were summarized and presented, enabling researchers to identify potential differences or similarities between groups that could influence study outcomes. Additionally, this analysis provides contextual information and facilitates comparisons when interpreting the results of the intervention program.

Table 10

Mean Age of Participants / Experimental and Control Groups (N=24)

Groups / Age	***N***	***Mean***	***SD***
Experimental group	12	13.08	.79
Control group	12	14.42	.99

The result represented in Table 10 indicates the age group of participants. Total number of samples was 24 and among them 12 represented the experimental group and 12 belonged to the control group. The mean age of the experimental group was 13 years with SD value .79, and the mean age of the control group was 14 years with SD value .99.

Table 11

Frequency Distribution of Gender Among Experimental and Control Groups (N=24)

Groups	Gender	*f*	Percentage
Experimental group (*n=12*)	Boys	9	(75 %)
	Girls	3	(25 %)
Control group *(n=12)*	Boys	9	(75 %)
	Girls	3	(25 %)

The Table 11 represents the frequency distribution of participants in the experimental and control group, based on gender. The frequency distribution of gender showed both boys and girls participants were equally distributed in the experimental *(n = 12)* and control group (n = 12). The boys' participants were higher in both the experimental (f = 9) and control group (f = 9) than the girls' participants in the experimental (f = 3) and control group (f = 3). Hence, 75 % of participants belonged to the boy's category and 25% of participants were from the girls group.

Table 12

Frequency Distribution of Siblings Among Experimental and Control Groups (N=24)

Groups	Siblings	*f*	Percentage
Experimental group (N=12)	Yes	9	(75 %)
	No	3	(25 %)
Control group (N=12)	Yes	12	(100 %)
	No	0	(0 %)

The results in the Table 12 show the frequency distribution of siblings among participants (N = 24). Among the experimental group (n = 12), 9 participants have siblings and 3 were single born. And all the participants of the control group have siblings (f = 12).

Table 13

Frequency Distribution of Family Status/ Characteristics of Participants Among Experimental and Control Groups

Groups	Family status	*f*	Percentage
Experimental group *(n =12)*	Divorces	2	(17%)
	Parent abroad -Father	4	(33%)
	-Mother	-	-
	Single parent	-	-
	Separated	1	(8%)
	Staying with both parents	5	(42%)
	Total	12	(100%)
Control group *(n=12)*	Divorces	1	(8%)
	Parent Abroad - Father	1	(8%)
	Mother	1	(8%)
	Single parent	1	(8%)
	Separated	2	(18%)
	Staying with both parents	6	(50%)
	Total	12	(100%)

The frequency distribution of family status of parents of participants among experimental groups *(n = 12),* shows in Table 13 that five participants are staying with both parents, four participants' fathers were abroad, two participants' parents were divorced, and one participant's parents are separated. Most of the participants are staying with parents (42%). When considering the control group (*n = 12),* two participants' parents are separated, and each participant has divorced parents, father abroad, father only, and mother abroad, while 50% of participants are staying with both parents.

In the present section, parental involvement has considered for the understanding about the occurrence of behavioral problems among children.

Table 14

Frequency Distribution of Substance Abuse of Parents Among Experimental and Control Group

Groups	**Substance abuse**	***f***	**Percentage**
Experimental group *(n=12)*	No substance abuse	8	(67%)
	Alcoholic	4	(33%)
	Smoking	-	-
	Total	12	(100%)
Control group (*n=12)*	No substance abuse	7	(58%)
	Alcoholic	4	(33%)
	Smoking	1	(9%)
	Total	12	(100%)

The results in Table 14 represent the frequency distribution of parental substance abuse of participants from both experimental and control groups. When compared with the use of substance abuse of parents of participants, 67% parents from the experimental group and 58% parents from the control group are non-substance abusers. Although parental alcoholism was reported (33%) in both experimental and control groups. And, one participant's parents were using smoking as substance abuse in a control group.

Research in the field of mental health and child development presents several key findings. It suggests a manifestation of distinct behavioral tendencies between genders, with males demonstrating externalized problems like antisocial habits and aggression, while females often display internalized disorders such as anxiety and depression. Studies also point out that externalizing issues are more pronounced in boys, particularly when faced with stressful life events. Family composition, including factors like parental separation, divorce, or the presence of both biological parents, plays a significant role in children's well-being and behavioral outcomes. Additionally,

parental alcoholism is associated with children facing cognitive, emotional, and behavioral challenges, leading to mental health issues in adolescence and adulthood. Furthermore, number of siblings have been investigated in relation to behavioral problems, although the direct relationship remains inconclusive. It's important to note that socio-economic factors also play a role in mental health outcomes.

Even though, in the present study only few participants were belonging to families of parental alcoholism, separated or single parents, the consideration was taken to look after the parental or familial factors, as many research findings has collectively emphasized the complex interplay between family dynamics, parental behavior, and environmental factors in shaping the mental health and behavioral patterns of children. And the present section mentioned about frequency distribution of age, gender, and different socio economic status of participants.

Section B: Comparing Behavioral Problems Among Experimental and Control Group in Pre and Post Assessment Phases.

The analysis of the Developmental psychopathological checklist (DPCL) was conducted in the present section. The DPCL was used to assess the types of behavioral problems exhibited in both the participants of the experimental and control group. The behavioral problems like disobedience, stubbornness, disruptive, quarrelsome, aggression, temper tantrums, truancy, lying and stealing were assessed in pre and post stages, and the data were analyzed with Mc-Nemar's chi square test with continuity correction. The McNemar's test is one of the non-parametric tests used to assess paired nominal data. Specifically, the researcher used this test to determine if there was a substantial difference in the occurrence of behavioral problems between the pre- and post-assessment stages for both the experimental and control groups.

This analysis was utilized to investigate changes in the occurrence of various behavioral problems before and after the intervention among both the experimental and control groups. By employing McNemar's chi-square test with continuity correction, the researcher aimed to ascertain if there were statistically significant differences in the occurrence of these behavioral issues following the intervention.

The present section mainly focused on the study hypotheses of:

H1 & H2: There is a significant difference in the occurrence of behavioral problems in experimental and control group at pre test and post test phases of the intervention

Table 15

Comparing Occurrence of Behavioral Problems (DPCL) Among Children at Pre-test and Post-test Phases of The Intervention

Variables	Group	Before		After		χ^2_c	Sig.
		N	*%*	*N*	*%*		
1.Disobedience	Experimental	9	75.0	0	0	7.11	.004
	Control	12	100.0	12	100.0		
2.Stubbornness	Experimental	11	91.7	4	33.33	5.14	.016
	Control	4	33.33	4	33.33		
3.Disruptive	Experimental	8	66.7	2	16.7	4.17	.031
	Control	6	50.0	6	50.0		
4.Quarrelsome	Experimental	11	91.7	0	0	9.09	.001
	Control	6	50.0	6	50.0		
5. Aggression	Experimental	7	58.3	0	0	5.14	.016
	Control	8	66.7	8	66.7		
6.Temper tantrums	Experimental	7	58.3	0	0	5.14	.016
	Control	9	75.0	9	75.0		
7.Truancy	Experimental	3	25.0	0	00.0	1.33	.250
	Control	5	41.7	5	41.7		
8.Lying and Stealing	Experimental	4	33.33	0	0	2.25	.125
	Control	5	41.7	5	41.7		

χ^2_c: McNemar's test with continuity Correction

Table 15 indicate the pre post intervention score comparison with McNemer chi –square test. A noticeable disparity in various characteristic behavior between the experimental and control groups emerged following the intervention. Most of the behavioral problems like disobedience, stubbornness, disruptive behavior, quarrelsome, aggression, and temper tantrums show significant differences among experimental groups after the intervention program. Even though the behavior like truancy, lying and stealing are also reduced among experimental groups, the difference is not significant. Disobedience, a prevalent indicator of behavioral issues among children, demonstrated substantial decrease in the experimental group ($\chi^2 = 7.11$) post-intervention, with a significant level of $p<.004$, in contrast to the control group. In the initial assessment, both the experimental group (*n = 4)* and the control group (n =4) exhibited stubborn behavior. However, after the intervention, the post-test results revealed a significant reduction in stubbornness behavior ($\chi^2 = 5.14$, $p < .05$) within the experimental group, while that for the control group remains the same. Following the intervention program, the experimental group exhibited a better reduction in quarrelsome behavior compared to the control group ($\chi^2 = 9.09$), with a significance level of $p < .01$. As for aggressive behavior, at the pre-test, 15 children reported aggressive behavior, with 7 in the experimental group and 8 in the control group. In post-intervention, all children in the experimental group displayed minimal or no aggressive behavior, in contrast to the control group ($\chi^2 = 5.14$, $p < .01$). After the intervention program, temper tantrum behavior significantly decreased within the experimental group ($\chi^2 = 5.14$, $p < .05$), whereas the behavior remained stable in the control group. While there has been a decrease in behavior such as truancy, lying, and

stealing in the experimental group compared to the control group after the intervention program, this difference is not statistically significant (χ^2 = 1.33, 2.25, p >.05).

By the training program among parents and children, there is notable improvement in the behavioral aspects among children. Aggressive behavior has been reduced among children after the intervention. However, the training has been found to include strategies to deal more effectively with stealing, lying and truancy behavior among children. Parents of young children often encounter a common challenge in dealing with noncompliant or disobedient behavior, which involves a child intentionally refusing to follow instructions from a parent or another adult authority figure (Kalb & Loeber, 2003). Sundaram (2005) reported that children with behavioral problems aged 16 or younger have shown common symptoms like lying, initiating physical fights and stealing whereas fire setting, deviant sexual behavior, and running away from home are less frequently reported symptoms. The present results are supported by different researchers in various aspects of behavioral problems. The experimental group has significant decrease in behavioral problems than control groups, which has no changes in pre post assessment results. Hence, the intervention training was found to be effective for most of the problem behavior among experimental groups. Results indicate that there is significant difference in the occurrence of most of the behavioral problems at pre and post intervention in both experimental and control groups. The overall results indicates the effectiveness of the intervention programs and is similar to the findings of Greenberg, et al. (2001) that the utilization of multiple component for the preventive and treatment of behavioral issues among children was found satisfactory, and child focused cognitive behavior social training is found to be more effective for children with behavioral problems (Kazdin et al., 1992; Southam-

Gerow & Kendall, 1997; Webster –Stratton & Hammond, 1997; Webster-Stratton et al., 2004).

Hence, parenting interventions are highly supported in theory for preventing and addressing behavioral problems in young children. Substantial reviews highlight the effectiveness of interventions among parents, particularly in managing aggressive or oppositional behavior in typically evolving children (Kaminski et al., 2008; Kazdin 1997; Serketich & Dumas 1996). Elements within parenting interventions that constantly yield significant effects involve enhancing healthy parent-child interactions and communication skills, educating parents on utilizing strategies like time-outs and maintaining consistent disciplinary methods, and offering opportunities for parents to practice these new skills with their children during training sessions (Kaminski et al., 2008).

As mindfulness training has an effective role in reducing the behavioral problems among children, the result findings support with previous scientific research that mindfulness instruction promotes student happiness and concentration while reducing aggression and behavioral issues in the classroom. According to Keng et al., (2017), mindfulness is a useful technique for helping students regulate their emotions. Wang et al., (2017) also found in a study that, practicing mindfulness also enhances students' mental health, improves attention and concentration and is effective for better emotional awareness (Hill & Updegraff ,2011). Since mindfulness training encourages self-control and self-management, it may also be helpful for children who are violent. Additionally, children will learn how their minds operate and how to think by increasing their self-awareness and concentrating on themselves. This will help them better grasp their own experiences of the world, which they do not generally have (Fontana & Slack, 1997). Mindfulness training helps the children to become better self-

awareness and control their feelings, emotions, and thoughts thus helps in reducing behavioral problems. The findings also align with Weijer-Bergsma et al. (2012) and Bogels et al. (2008), indicating that mindfulness training has been effective in reducing externalized behavioral problems among children and adolescents. The post assessment results indicate the effectiveness of the training program, as most of the pre assessment behavioral problems have reduced to a minimal level during the post assessment evaluation.

Hence, the stated hypothesis H1 & H2: There is a significant difference in the occurrence of behavioral problems in experimental and control group at pretest and post test phases of the intervention is accepted for the behavior like disobedience, disruptive, stubbornness, aggression, temper tantrums, and quarrelsome. While the behavior like truancy, lying and stealing have found no significant difference between the group after the intervention, hence the stated hypothesis is rejected on this behavior.

***Section C*: Effectiveness of multidimensional intervention program on family interaction, social competence, and difficulties in emotion regulation with its dimensions between pre and post assessment among experimental and control group**

The present section deals with the effectiveness of multidimensional programs on family interaction, social competence, and difficulties in emotion regulation among the group. The effectiveness of multidimensional programs like parent management training, social skill training, and mindfulness training was assessed on the study variables and its dimensions. The data was checked with the Shapiro-Wilk test of normality, and for the variable family interaction, the dimensions like family independence, family achievement orientation (experimental group), family intelligent orientation (control group), family conflict, family social orientation, family ethical

complaints, family discipline, and total family interaction in both experimental and control groups are normally distributed. Whereas the variables like family cohesion, and family intelligence orientation in experimental group, and family achievement orientation in control group are not normally distributed.

In the social competence variable, the dimensions like school competence and team organization in the experimental group, and peer social competence and social cognition in the control group are not normally distributed. The other variables like school competence, and team organization in control group, peer social competence, social cognition in experimental group; home related competence, social forethought and compassion, social emotional competence, and total social competence in both experimental and control group are normally distributed. And also, social flexibility is not normally distributed in both experimental and control groups.

For the variable difficulties in emotion regulation, all the dimensions of difficulties in emotion regulation were normally distributed at the pretest phase of intervention. In the post test phase, the normality test score indicates that most of the variables in the emotion regulation are normally distributed, except difficulties in engaging goal directed behavior when distressed, and non-acceptance of negative emotional response.

The pre-test assessment of variables in the DPCL checklist of experimental and control groups was done with both parametric and non-parametric analysis. The normally distributed variables were analyzed with parametric tests like independent sample t test, and the non-parametric test like Mann Whitney U test (represented as *'a, b, c'* in pretest phase table) were used in the non-normally distributed variables. In the post-test analysis assessing the effectiveness of the intervention, the researcher compared family interaction scores between the control and experimental groups using

univariate ANCOVA, while controlling for pretest scores. The researcher ensured the reliability of the analysis by checking for normal distribution, consistent regression slopes, and even variance. Minor deviations from homogeneity of variance were disregarded due to the study's balanced design. The homoscedasticity is also confirmed through scatter plots of standardized residuals against predicted values. Through such analysis, the researcher is able to assess the effectiveness of intervention at a more empirical level.

Family Interaction and Its Dimensions

The hypothesis for the present section is:

H3: There is a significant difference in the family interaction and its dimensions in experimental and control group at pre-test phase of intervention

Table 16

Comparing Factors of Family Interaction Between Experimental Group (n =12) and Control Group (n =12) at Pre-test Phase of the Intervention

Family interactions	Group	*Mean*	*SD*	*w*	*t*	*Sig.*
1. Family Independence	Experimental	10.42	1.83	.91	0.23	.818
	Control	10.58	1.68	.94		
2. Family Cohesion	Experimental	11.00 [a]	2.12 [b]	.85*	57.00 [c]	.410
	Control	11.00 [a]	0.50 [b]	.86		
3. Family achievement Orientation	Experimental	11.50 [a]	1.75 [b]	.92	79.50 [c]	.671
	Control	12.00 [a]	2.25 [b]	.86*		
4. Family Intelligence Orientation	Experimental	9.00 [a]	0.50 [b]	.85*	102.00 [c]	.089
	Control	11.00 [a]	1.87 [b]	.89		
5. Family Conflict	Experimental	10.00	2.13	.94	2.19	.039
	Control	11.92	2.15	.95		
6. Family Social Orientation	Experimental	11.92	1.98	8..93	2.25	.035
	Control	10.33	1.44	.88		
7. Family Ethical Complaints	Experimental	10.75	1.96	.94	0.29	.774
	Control	10.50	2.24	.94		
8. Family Discipline	Experimental	9.58	1.73	.94	3.02	.006
	Control	11.58	1.51	.92		
9. Family Interaction	Experimental	86.00	5.88	.92	1.07	.298
	Control	88.58	5.99	.91		

Note. [a] Median; [b] QD; [c] Mann Whitney U test, * $p < .05$

Table 16 presents a summary of the Shapiro-Wilk test, indicating that scores for factors of family interaction are normally distributed within the groups (w = .91, .94, .86, .92, .89, .94, .95, .93, .88, .94, .94, .94, .92, .92, .91, $p > .05$) except family cohesion and family intelligence orientation in the experimental group (w = .85, .86, $p < .05$), family achievement orientation (w = .86, p<.05) in control group. Variances of Family cohesion and family intelligence orientation are heterogeneous (F = 7.88, 5.75, p < .01). As the sample size is smaller, a decision is made to compare the family cohesion, family achievement orientation and family intelligence orientation with Mann-Whitney U test; remaining factors are analyzed with independent sample t test.

Summary of independent sample test and Mann-Whitney U test indicate that factors of family interaction are similar among experimental and control group [t (22) = 0.23, 0.29, 1.07, $p > .05$; U = 57.00, .79.50, 102.00, $p > .05$], except family conflict [t (22) = 2.19, $p < .05$], family social orientation [t (22) = 2.25, $p < .05$] and family discipline [t (22) = 3.02, $p < .01$]. Family conflict and family discipline are higher among control groups compared to experimental groups; whereas family social orientation was higher among experimental group members.

Effectiveness of the intervention is tested by comparing post-test scores of family interaction between control group and experimental group after controlling scores at pre-test phase using univariate ANCOVA (Table 17). Major assumptions such as approximate normal distribution, homogeneity of regression slopes and homoscedasticity are performed to ensure the robustness of the statistical analysis. Small violation of the assumption of homogeneity of variance is ignored as the research design is balanced design (Johnson, 1993). Statement of homoscedasticity is tested by plotting a scatter plot of the standardized residuals against the predicted values (Field, 2015).

For analysing data statistically, the researcher verifies the data with normality; whether the data are normally distributed, homogeneity of regression slopes; whether the relationship between variables are consistent across different groups or conditions, and the homoscedasticity; the variability of data should be almost same across all levels of variables to be studied. Sometimes, there might be small deviations from these assumptions, but if the overall pattern is consistent and balanced, it's considered acceptable for statistical analysis. To check for homoscedasticity, researchers often plot the residuals (the differences between observed and predicted values) against the predicted values on a scatter plot to see if there's any pattern or systematic variation. If the points on the plot are randomly scattered and do not form any specific pattern, then the assumption of homoscedasticity is met.

Based on the pre test analysis, the stated hypothesis of H3 is accepted for the family interaction dimension like family conflict, family social orientation, and family discipline. While the other dimensions (family independence, family cohesion, family achievement orientation, family intellectual orientation, family ethical complaints, and overall family interaction) are rejected.

H4: There is a significant difference in the family interaction and its dimensions in experimental and control group at post test phase of intervention

Table 17

Scores of Family Interaction of Experimental Group (n =12) and Control Group (n=12) at Post-Test Phase of the Intervention

Family interactions	Group	*Mean*	*SD*	*w*
1. Family Independence	Experimental	19.42	3.85	.90
	Control	10.33	1.50	.94
2. Family Cohesion	Experimental	20.67	3.09	.95

Family interactions	Group	*Mean*	*SD*	*w*
	Control	10.50	1.00	.91
3. Family achievement orientation	Experimental	20.83	4.15	.92
	Control	11.50	1.83	.91
4. Family intelligence orientation	Experimental	17.75	2.77	.96
	Control	10.92	2.58	.91
5. Family Conflict	Experimental	20.17	2.95	.95
	Control	11.42	2.06	.98
6. Family Social Orientation	Experimental	21.00	2.00	.94
	Control	9.67	1.30	.92
7. Family Ethical Complains	Experimental	22.33	2.27	.95
	Control	10.17	2.08	.93
8. Family Discipline	Experimental	18.42	2.68	.90
	Control	11.00	1.35	.93
9. Family Interaction	Experimental	160.58	13.42	.92
	Control	85.50	7.03	.94

Table 17 indicates the summary of the of Shapiro-wilk test indicating, that the scores of family interaction in both groups (Experimental and control group) are normally distributed at post test phase of the intervention (w = .90, .94, .95, .91, .92, .91, .96, .91, .95, .98, .94, .92, .95, .93, .90, .93, .92, .94, $p > .05$).

Family Independence

Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.87, $p > .05$]. But, the variance of the scores of family independence between experimental and control groups are slightly heterogeneous [F (1,22) = 7.36, p = .013]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1993).

Table 18

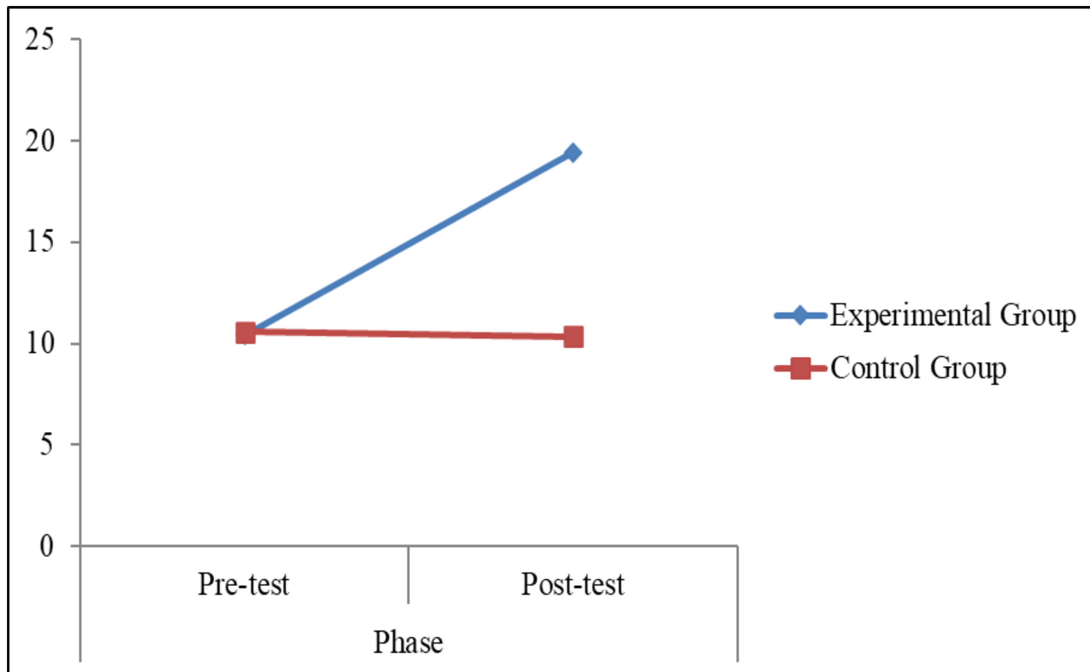
Comparing Family Independence Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	*MSS*	*F*	*Sig.*	η_p^2	Φ
Family Independence (Pre-test)	71.378	1	71.38	12.89	.002	.381	.93
Group	512.593	1	512.59	92.63	<.001	.815	1.00
Error	116.205	21	5.54				
Total	5993.000	24					

Table 18 represents the results of ANCOVA indicating, that the scores of family independence differ significantly between experimental group and control group, F (1,21) = 92.63, p <. 001.Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.00, p > .05]. But, the variance of the scores of family cohesion between experimental and control groups are slightly heterogeneous [F (1,22) = 5.66, p = .026]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1993). Score of family independence of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 81.5 percent (η_p^2= .815). The power of the statistics is high (*Φ* = 1.00). Changes in the scores of family independence are depicted in the figure 8.

Figure 8

Scores of Family Independence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Family Cohesion

Table 19

Comparing Family Cohesion Between Experimental Group and Control Group at Post-test Phase of the Intervention

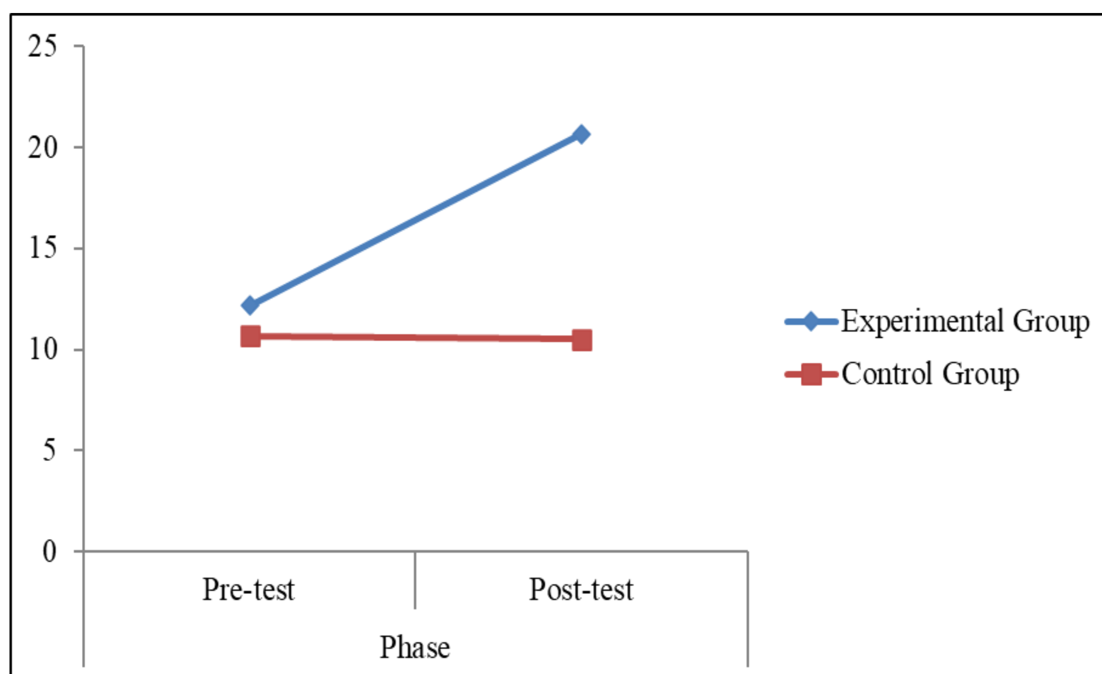
Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Family Cohesion (Pre-test)	67.20	1	67.20	29.11	.000	.58	.99
Group	443.06	1	443.06	191.96	.000	.90	1.00
Error	48.47	21	2.31				
Total	6564.00	24					

Results of ANCOVA presented in table 19 shows that scores of family cohesion differ significantly between experimental group and control group, F (1,21) = 191.96, p < .001. Score of family cohesion of members of the experimental group increased

significantly compared to the control group. Effect size of the intervention is 90 percent (η_p^2= .90). The power of the statistics is high (Φ = 1.00). Changes in the scores of family cohesion are depicted in the figure 9.

Figure 9

Scores of Family Cohesion of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Family Achievement Orientation

Table 20

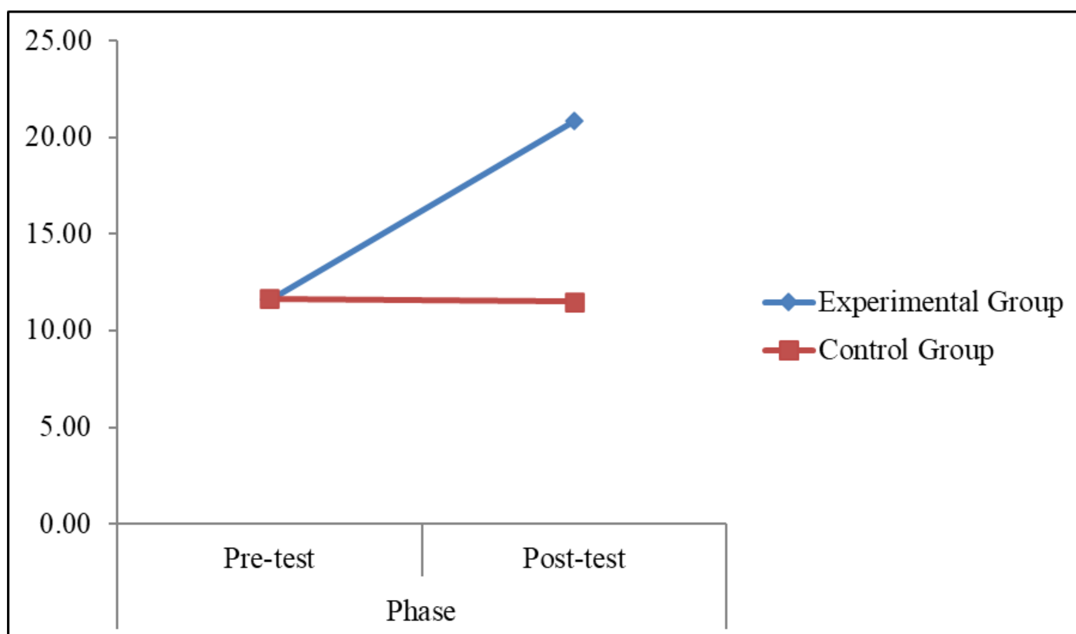
Comparing Family Achievement Orientation Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Family achievement orientation (Pre-test)	126.76	1	126.76	26.65	.000	.56	.99
Group	531.77	1	531.77	111.78	.000	.84	1.00
Error	99.90	21	4.76				
Total	7022.00	24					

Results of ANCOVA in table 20 indicate that scores of family achievement orientation differ significantly between experimental group and control group, $F\,(1{,}21) = 111.78$, $p < .001$. Score of family achievement orientation of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 84.2 percent ($\eta_p^2 = .84$). Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [$F\,(1{,}20) = 0.12$, $p > .05$]. But, the variance of the scores of family achievement orientation between experimental and control groups are heterogeneous [$F\,(1{,}22) = 16.75$, $p < .05$]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1993). The power of the statistics is high ($\Phi = 1.00$). Changes in the scores of family achievement orientation are depicted in figure 10.

Figure 10

Scores of Family Achievement Orientation of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Family Intelligence Orientation

Table 21 specifies the comparison of family intellectual orientation between experimental and control group at post test phase of intervention. Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.093, p > .05]. But, the variance of the scores of Family intelligence orientation between experimental and control groups are heterogeneous [F (1,22) = 22.792, p < .05]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1993).

Table 21

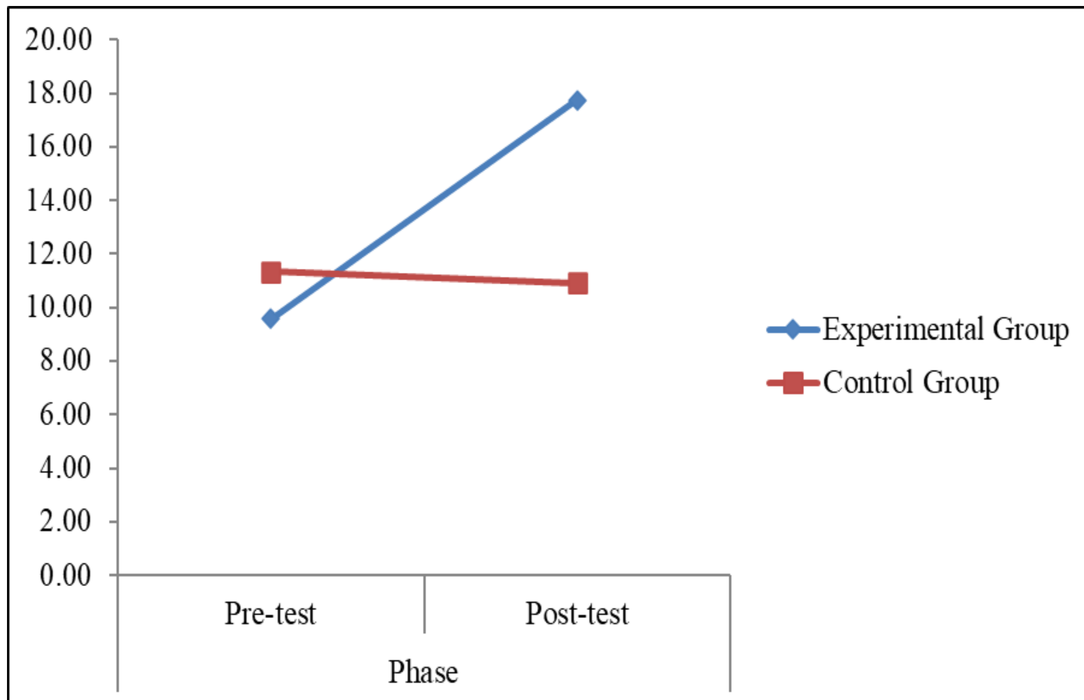
Comparing Family Intelligence Orientation Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Family intelligence orientation (Pre-test)	91.116	1	91.116	28.969	.000	.58	.99
Group	365.689	1	365.689	116.266	.000	.85	1.00
Error	66.051	21	3.145				
Total	5368.000	24					

The results of ANCOVA indicate that scores of Family intelligence orientation differ significantly between experimental group and control group, F (1,21) = 116.266, p < .001. Score of Family intelligence orientation of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 85 percent (η_p^2= .85). The power of the statistics is high (Φ = 1.00). Changes in the scores of family intelligence orientation are depicted in figure 11.

Figure 11

Scores of Family Intelligence Orientation of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Family Conflict

Table 22 represents the result of comparison in family conflict between experimental and control group at post test phase of intervention. The results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.049, $p > .05$]. But, the variance of the scores of Family Conflict between experimental and control groups are heterogeneous [F (1,22) = 8.347, $p < .05$]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1993).

Table 22

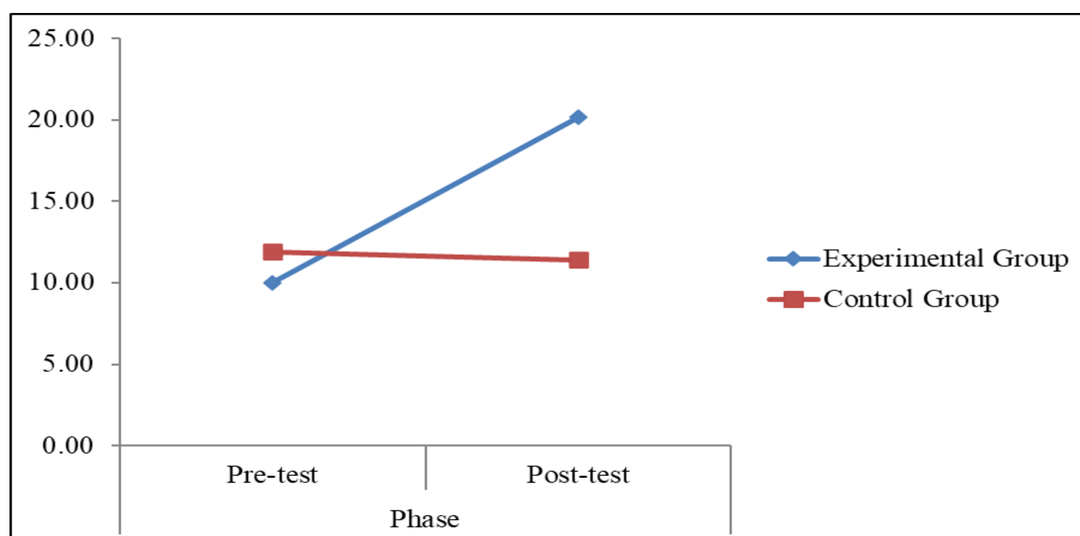
Comparing Family Conflict Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Family Conflict (Pre-test)	94.038	1	94.038	40.680	.000	.660	1.00
Group	553.329	1	553.329	239.362	.000	.919	1.00
Error	48.545	21	2.312				
Total	6587.000	24					

The results of ANCOVA indicate that scores of Family Conflict differ significantly between experimental group and control group, $F\ (1,21) = 239.362$, $p < .001$. Scores of Family Conflict of members of the experimental group improved significantly compared to the control group. Effect size of the intervention is 91.9 percent ($\eta_p^2 = .919$). The power of the statistics is high ($\Phi = 1.00$). Changes in the scores of Family Conflict are depicted in figure 12.

Figure 12

Scores of Family Conflict of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Family Social Orientation

Table 23 represents the post-test intervention analysis between experimental and control group in family social orientation dimension. The results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.37, p > .05]. But, variance of the scores of family's social orientation between experimental and control groups are heterogeneous [F (1,22) = 5.57, p < .05]. The decision is made to carry out ANCOVA because it's good at handling situations where the groups we're comparing have slightly different amounts of variation in their data. This is especially true when the groups have the same number of people. ANCOVA helps to adjust for any initial differences between the groups by considering additional factors that might affect the outcome that the researcher focused on. So, even if there are some small differences in how spread out the data is between groups, decision is made to perform ANCOVA (Johnson, 1993).

Table 23

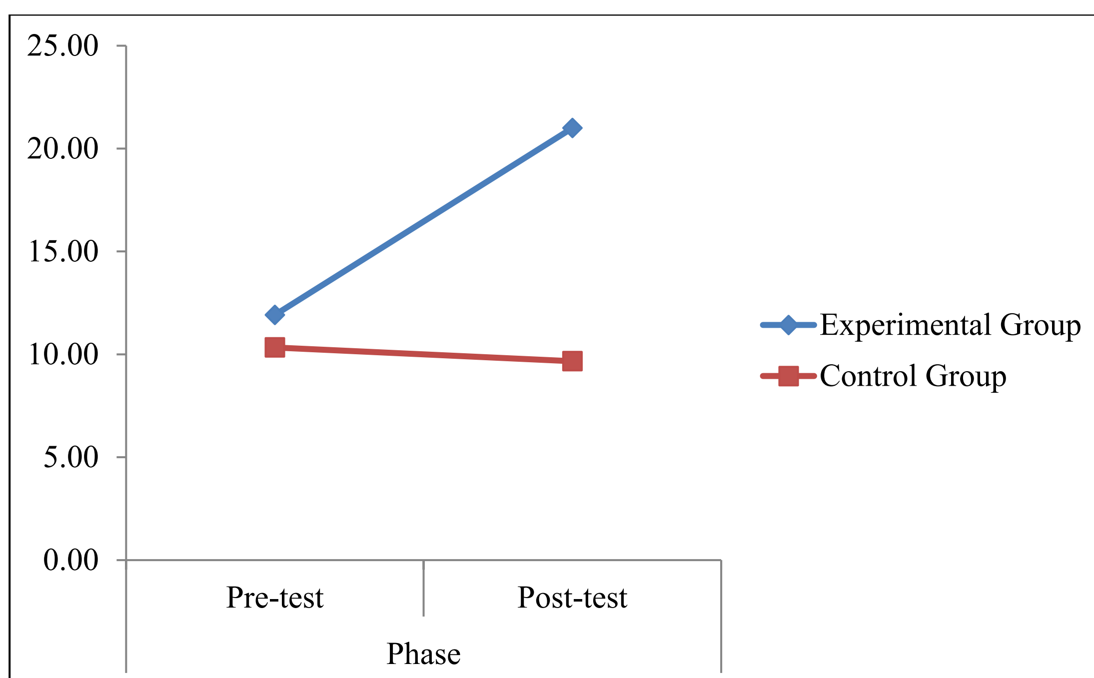
Comparing Family Social Orientation Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	*Φ*
Family Social Orientation (Pre-test)	17.974	1	17.974	8.445	.008	.287	.791
Group	538.544	1	538.544	253.047	.000	.923	1.00
Error	44.693	21	2.128				
Total	6476.000	24					

The results of ANCOVA indicate that scores of family social orientation differ significantly between experimental group and control group, F (1,21) = 253.047, $p < .001$. Scores of family social orientation of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 92.3 percent ($\eta_p^2 = .923$). The power of the statistics is high ($\Phi = 1.00$). Changes in the scores of family social orientation are depicted in figure 13.

Figure 13

Scores of Family Social Orientation of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Family Ethical Complains

The post test phase of intervention between experimental and control group on the family ethical complains dimension was represented in table 24. The results of statistical analyses carried out to test the assumptions of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.02, $p > .05$]. But, variance of the scores of

Family ethical complaints between experimental and control groups are heterogeneous [F (1,22) = 15.829, $p < .05$]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1993).

Table 24

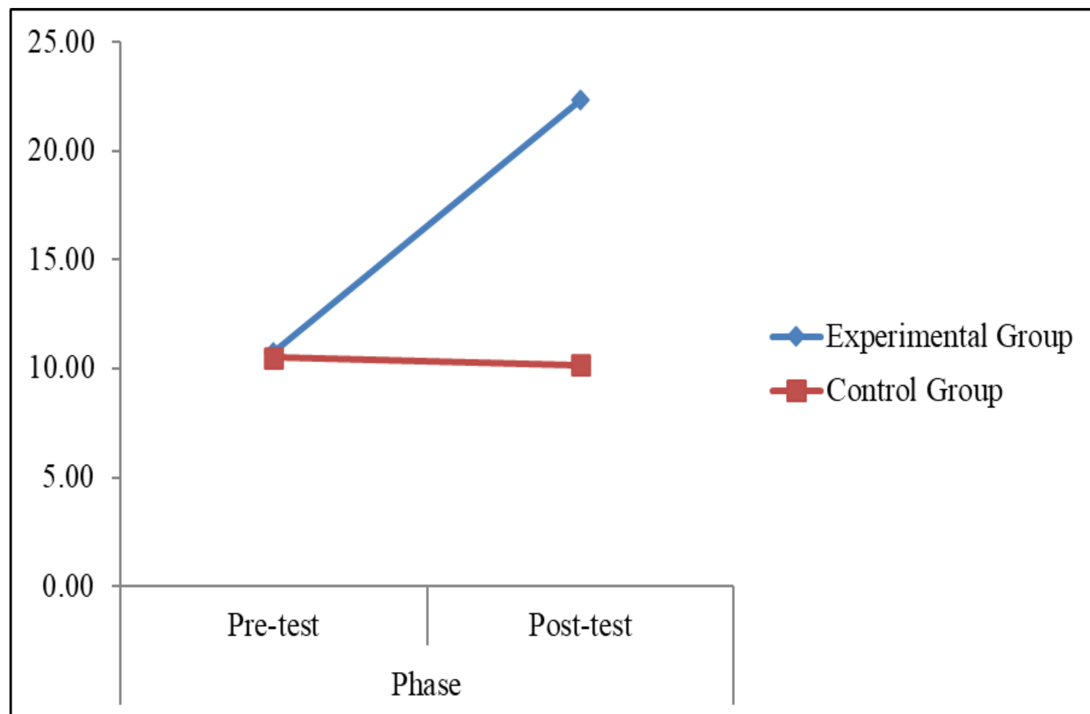
Comparing Family Ethical Complains Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Family Ethical Complains (Pre-test)	77.830	1	77.830	61.670	.000	.746	1.00
Group	852.526	1	852.526	675.511	.000	.970	1.00
Error	26.503	21	1.262				
Total	7330.000	24					

The results of ANCOVA indicate (Table 24) that scores of Family ethical complaints differ significantly between experimental group and control group, F (1,21) = 675.511, $p < .001$. Scores of Family ethical complaints of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 97 percent ($\eta_p^2 = .970$). The power of the statistics is high (Φ = 1.00). Changes in the scores of Family ethical complaints are depicted in the figure 14.

Figure 14

Scores of Family Ethical Complains of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Family Discipline

Table 25 illustrates the outcomes of the post-test intervention phase comparing the experimental and control groups in the family discipline dimension. Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 1.78, $p > .05$]. Variance of the scores of family discipline between experimental and control groups are homogeneous [F (1,22) = 3.601, $p > .05$]. Decision is made to carry out ANCOVA.

Table 25

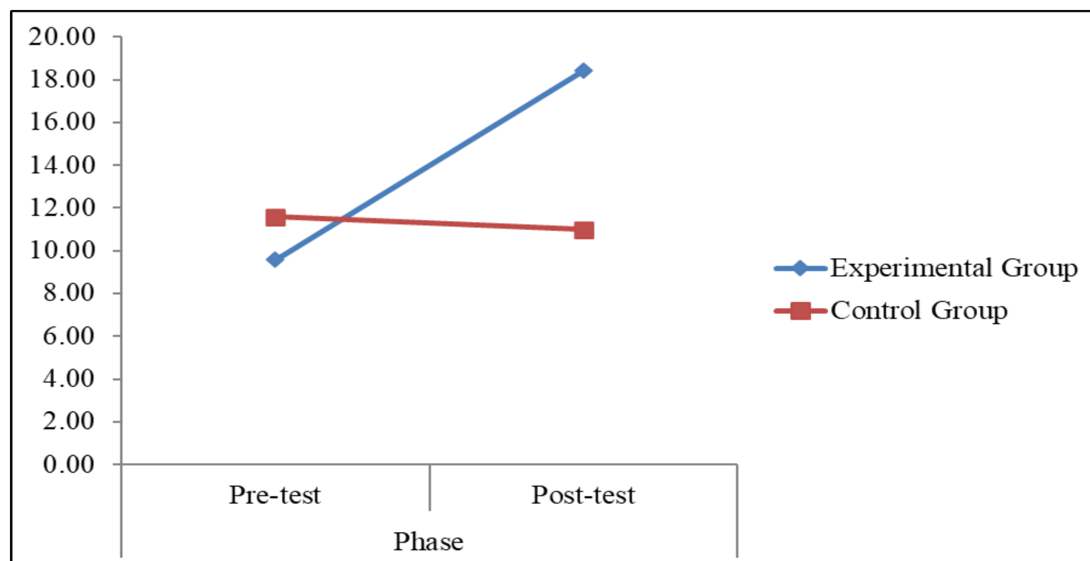
Comparing Family Discipline between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Family Discipline (Pre-test)	64.516	1	64.516	39.384	.000	.652	1.00
Group	385.034	1	385.034	235.045	.000	.918	1.00
Error	34.401	21	1.638				
Total	5621.000	24					

The results of ANCOVA indicate that scores of family discipline differ significantly between experimental group and control group, F (1,21) = 235.045, $p < .001$. Scores of family discipline of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 91.8 percent (η_p^2= .918). The power of the statistics is high (Φ = 1.00). Changes in the scores of family discipline are depicted in figure 15.

Figure 15

Scores of Family Discipline of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Family Interaction (Overall)

The results of overall score in family interaction in the post test phase of intervention between experimental and control group represented in table 26. The results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.40, $p > .05$]. But, the variance of the scores of family interaction between experimental and control groups are heterogeneous [F (1,22) = 11.685, $p < .05$]. The decision to conduct ANCOVA is based on the robustness of the test in cases where there is a violation of homogeneity of variance, especially when the sample size is equal (Johnson, 1993).

Table 26

Comparing Family Interaction Between Experimental Group and Control Group at Post-test Phase of the Intervention

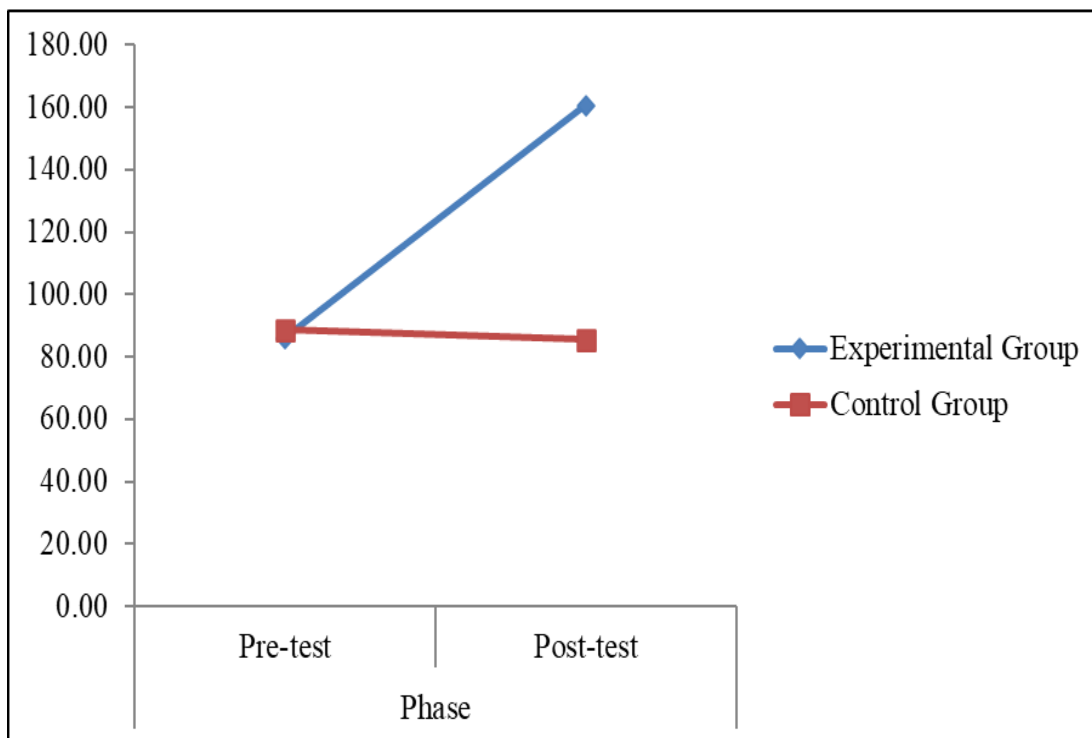
Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Family Interaction (Pre-test)	1289.171	1	1289.171	21.926	.000	.511	.994
Group	35081.092	1	35081.092	596.644	.000	.966	1.00
Error	1234.745	21	58.797				
Total	399691.000	24					

The results of ANCOVA indicate that scores of family interaction differ significantly between experimental group and control group, F (1,21) = 596.644, $p < .001$. Scores of family interaction of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 96.6 percent ($\eta_p^2 = .966$). The power of the statistics is high ($\Phi = 1.00$). Changes in the scores of family interaction are depicted in figure 16.

The results indicated that parental training has a positive impact on family interaction between parents and children. Proper communication with parents and children makes them feel and express the information more clearly and specifically and which in turn leads to a better understanding among them. All the sub dimensions of family interactions have a significant effect on intervention among experimental groups.

Figure 16

Scores of Family Interaction of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Family cohesion indicates the level of dedication, assistance and support that family members offer to each other (Asha, 1987). Quality time spent between parents and children, sharing and concern of more familial matters and relationships through parental training has been found effective to reduce family interactional problems among conduct symptoms. Through family cohesion a strong emotional bond and a

warm and supportive environment between family members can occur. The highest score obtained by the experimental group reveals that they received more help, commitment, and support from family members. Through supportive parental training among experimental groups, the family member was able to develop a competitive or achievement-oriented work in school as well as home. Interaction with children and parents through sharing, behavioral support enhanced intellectual and creative activities among children. The time spent with children made them feel more secure and expressive in their ideas and abilities. Family conflict denotes the extent of openly displayed anger, aggression, and discord or conflict among family members. A higher conflict score indicates lower communication problems between parents and children in the family. The experimental group children were provided with problem solving and anger management techniques to respond in a problem situation rationally rather than quickly. At the same time parental stress level is also monitored through relaxation techniques. Thus, children experience less conflict and express negative feelings of aggression and problems less to their family members. Through such intervention they were encouraged to share their difficulties among family and thus helped them to behave socially accepted ways of behavior patterns. The role of social skill training and active communication enhanced the empathetic understanding among the family members of the experimental group members. Hence interest in social activities were improved among the group. Ethical emphasis is related to the degree of emphasis on ethical and religious values among the family members. The ethical behaviour pattern develops within the family itself. By following simple rules and responsibilities, and participating in group activities, following social norms in the group through social skill training and empathy, ethical values have improved among the trained group. Discipline among family members indicates the extent of organization and structure in

managing family activities, and responsibilities, as well as the degree to which a set of rules and procedures govern family life. Family bonding maintains the family to be understandable, and considerable thus resulting in unity. A well cohesive family system has the skill to impart and maintain discipline in the family.

Parental management training has influenced positively among parents and children towards family interaction. The training has provided effective communication, which results in effective interaction and cohesion between parents and children. The close proximity of parents to their child enables consistent and responsive guidance, which is optimal for influencing and shaping the child's behavior. The present study findings are also supported with the previous research findings on effectiveness of parental training on family interaction. There are numerous programs which aim to improve parental skills, and children. Parent Management Training (PMT) rapidly gained popularity due to its time-limited nature, cost-effectiveness, and effectiveness as documented (Serketich & Dumas in 1996).2017

The current study results are related with the findings of previous research that children with behavioral problems exhibit negative or poor perception about components of family interactions. They perceive their parents as low in warmth, rejecting, caring, negligent pattern of object reward, inadequate support and excessive punishment. Behavioral parent training is most effectively worked among children with behavioral problem symptoms (Weisz et al., 2004). The techniques like building of positive parent-child relationship, use of rewards and praise for desirable behavior, giving clear rules and directions while communicating with children, practicing consistent and respectful behavior also improved the family interactions among the experimental group. In addition to those negative spirals in family interactions, blaming each other is also reduced.

Petzold (1998) asserts that examining family functioning is crucial in understanding children's behavior, given that the family plays a vital role in supporting, safeguarding, and directing children. The findings of the results indicate the efficacy of parents and family for molding the behavior of children. Children need fulfilling and healthy interactions with important people during their formative years, especially their parents. Families that prioritize moral and ethical considerations, intellectual stimulation, and social orientation as well as pleasant emotional engagement, a sense of belonging, and psychological safety aid in children's healthy development. Contrarily, parental deficiencies in terms of mental health issues, unfavourable attitudes, excessive emphasis on corporal punishment and control, as well as rejection and neglect of their charges, help to create undesirable behavioral patterns in children (Sayger et al., 1988; Dogra & Veeraraghavan,1994). Family independence explains about the degree of assertiveness, self-efficacy and ability to make one’s own decision. Since Families are not ready to seek other’s assistance to treat their children, it results in a sense of dependency and inefficiency among them (Walsh, 2014). A clear and supportive parenting and communication skills enhanced the experimental group of children with behavioral problems for having independence among family members. The children are able to feel independence, and are actively encouraged to openly express their feelings. The results are similar with the findings of Sood & Mishra (1995) stating that children from cordial and uncordial families exhibit problem behaviour in dramatically different ways. A child is more likely to develop pleasant feelings and avoid issues if family members, especially parents, have a friendly, accepting, and cooperative attitude towards one another and the child. This could aid in the development of healthy children. Behavioral problem symptoms are often related with the family context, that different family characteristics like poor parental supervision,

parental discord, mental illness among parents, and inadequate parental control lead to occurrence of behavioral problems among children (Sundaram, 2005; Wootton et al., 1997). Breitenstein et al., (2012); Gross et al., (2009, 2011) proposed that the parent training program yields a reduction in harsh disciplinary measures, enhancement of parenting skills, and broadening of parental social connections, thereby decreasing the frequency and intensity of their child's behavioral issues. Weekly handouts and assignments are provided to reinforce key concepts such as child-cantered time, the significance of routines, the value of positive reinforcement and support, the implementation of rewards, setting clear boundaries, and the consistent application of consequences. Additionally, parents are taught strategies like ignoring behavior, stress management techniques, time-outs, and problem-solving skills. According to reported outcomes, participation in the parent training resulted in a decrease in problematic behavior among children and marked improvements in parental self-confidence, more uniform disciplinary practices, reduced use of physical punishment, and increased warmth within the family dynamic. The components of FIS are positively related with the wellbeing of the family members. The current study lends support to the hypothesis made by Khatri, (1970), Robinson & Parkinson (1985), Patterson, (1982), Hetherington et al., (1989 which found that children from healthy families have fewer issues than those from distressed families. According to the findings, each parent (single parent and both parents) should strive to qualitatively improve their parenting skills for the benefit of their children. When we look up parental participation in the present study, most of the parents actively participated in the training sessions, which resulted in fulfilling the parental role in healthy interaction in the family with children.

Tipsord (2009) also noted that mindfulness training enhances interpersonal connection and relationship happiness; mindfulness promotes moral behavior (Ruedy

& Schweitzer, 2010), which is relatable to the present study findings that by practicing mindfulness the family interaction among children has improved among experimental groups. The social skill training enabled the children to behave well manners towards self and to others. The interpersonal relation skill helped them to interact with family members with respect and understanding. The conflict resolution skills among family members were found to be active cohesiveness in family interaction. The learning of social skills among children was found necessary as they are living and dealing with different social interactive processes like school, peer groups and other group entities. Hence, such learning or training in social interaction could be more effective when it deals with the most basic social learning source, the family. Research supported with the present study results indicates that individuals typically engage and maintain relationships with their family, friends, and intimate social circles. Possessing adequate social skills is essential for productive and successful engagement during this process. People that possess adequate social skills demonstrate a particular pattern of behavior, such as self-expression, empathy, and compassion, and as a result, their behavior is validated by other people's comments and interactions (Segrin, 2001).

Hence, the stated hypothesis H4: There is a significant difference in the family interaction and its dimensions in experimental and control group at post test phase of intervention is accepted. All the dimensions have found improved after the multidimensional intervention program among participants of experimental group than compared to control group.

Social Competence and its Dimensions

Hypotheses for analysing the present section is:

H5: There is a significant difference in the social competence with its sub dimensions in experimental and control group at pre-test phase of intervention.

Table 27

Comparing Factors of Adolescent Social Competence Between Experimental Group (n =12) and Control Group (n =12) at Pre-test Phase of the Intervention

Social Competence	Adolescent group	Median	QD	*w*	*U*	*Sig*
1.School competence	Experimental	9.50	1.75	.80*	59.50	.461
	Control	9.00	.88	.92		
2.Team organization	Experimental	9.50	1.25	.84*	61.50	.551
	Control	9.00	.88	.88		
3.Peer social competence	Experimental	9.50	1.38	.96	39.00	.060
	Control	9.00	.75	.77*		
4.Social cognition	Experimental	9.00	0.50	.90	52.00	.225
	Control	8.00	.88	.82*		
5.Home related competence	Experimental	11.08[a]	2.43[b]	.94	.921[c]	.750
	Control	10.33[a]	1.44[b]	.88		
6.Social forethought and compassion	Experimental	11.50[a]	2.75[b]	.98	2.348[c]	.028
	Control	9.42[a]	1.38[b]	.88		
7.SocialEmotional competence	Experimental	7.33[a]	1.88[b]	.96	3.099[c]	.005
	Control	9.58[a]	1.68[b]	.87		
8. Social flexibility	Experimental	9.50	1.25	.84*	67.00	.763
	Control	9.50	1.00	.79*		
9. Social competence	Experimental	78.67[a]	6.58[b]	.93	1.681[c]	.107
	Control	74.67[a]	4.96[b]	.96		

Note. [a] Mean; [b] SD; [c] independent sample *t* test * $p < .05$

The Summary of scores of adolescent social competences at the pretest phase of the intervention is presented in table 27. Results of the Shapiro-wilk test of normality

presented in the table indicate that scores of school competence and team organization are not normally distributed in the experimental group, $w = .80, .84, p < .05$. Similarly scores of peer social competence and social cognition are not normally distributed in the control group, $w = .77, .82, p < .05$. Scores of social flexibility are violated from the assumption of normality in both groups, $w = .84, .79, p < .05$. Thus, scores of school competence and team organization, peer social competence and social cognition, and social cognition between experimental group and control group at pretest phase are compared with Mann-Whitney U test. Scores of homes related competence, social forethought and compassion, social emotional competence and total score of social competence are compared with independent sample t test.

Summary of Mann-Whitney U test and independent sample t test presented in the table 27 indicate that factors of adolescent social competence are similar between experimental and control group at pretest phase of the intervention [U = 59.50, 61.50, 39.00, 52.00, 67.00, $p > .05$; t (22) = .921, 1.681, $p > .05$] except scores of social forethought and compassion [t (22) = 2.348, $p < .04$] and Social emotional competence, t (22) = 3.099, $p < .01$. Social forethought and compassion scores are higher in the experimental group whereas scores of Social emotional competences are higher at the control group, hence these scores are not normally distributed among experimental and control groups.

The pre test analysis shows that the hypothesis H5 is accepted for the dimensions of social competence like social forethought and compassion, and social emotional competence. While the other dimensions (school competence, team organization, peer social competence, home related competence, social flexibility, social cognition, and overall social competence) are found similar for between experimental and control group, hence rejected.

H6: There is a significant difference in the social competence with its sub dimensions in experimental and control group at post-test phase of intervention.

Table 28

Scores of Adolescent Social Competence Between Experimental Group (n =12) and Control Group (n =12) at Post-test Phase of the Intervention

Social Competence	Adolescent Group	Mean	SD	*w*
1. School competence	Experimental	17.00	2.76	.96
	Control	8.83	1.47	.89
2. Team organization	Experimental	17.42	3.23	.94
	Control	9.17	1.12	.90
3. Peer social competence	Experimental	20.50 [a]	.88 [b]	.80*
	Control	8.00 [a]	.38 [b]	.76*
4. Social cognition	Experimental	11.50 [a]	.38 [b]	.88
	Control	8.00 [a]	.88 [b]	.82*
5. Home related competence	Experimental	14.50	1.00	.91
	Control	9.92	1.24	.88
6. Social forethought and compassion	Experimental	15.75	1.29	.87
	Control	9.17	1.27	.94
7. Social emotional competence	Experimental	12.67	1.92	.92
	Control	9.25	1.82	.96
8. Social flexibility	Experimental	14.08	1.83	.96
	Control	9.50	1.31	.90
9. Social competence	Experimental	123.58	5.00	.98
	Control	72.00	4.51	.91

Note. [a] Median; [b] QD * $p < .05$

Summary of the scores of adolescent social competence at post test phase are presented in table 28. Results of the Shapiro wilk test of normality indicate that scores of peers' social competence is not normally distributed in both experimental and control groups, w = 80, .76, $p < .05$. Similarly, scores of social cognition are violated from the

assumption of normality in the control group, $w = .82$, $p < .05$. The scores of other variables of social competence suggest normal distribution among experimental and control groups.

School Competence

Table 29 represents the post test phase of intervention in school competence among experimental and control groups. Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.031, $p > .05$]. But, the variance of the scores of school competence between experimental and control groups are heterogeneous [F (1,22) = 6.718, $p < .05$]. The decision to conduct ANCOVA is made when the sample size is equal. ANCOVA is chosen for analysis because it is known to be reliable even in cases of homogeneity of variance violation (Johnson, 1993).

Table 29

Comparing School Competence Between Experimental Group and Control Group at Post-test Phase of the Intervention

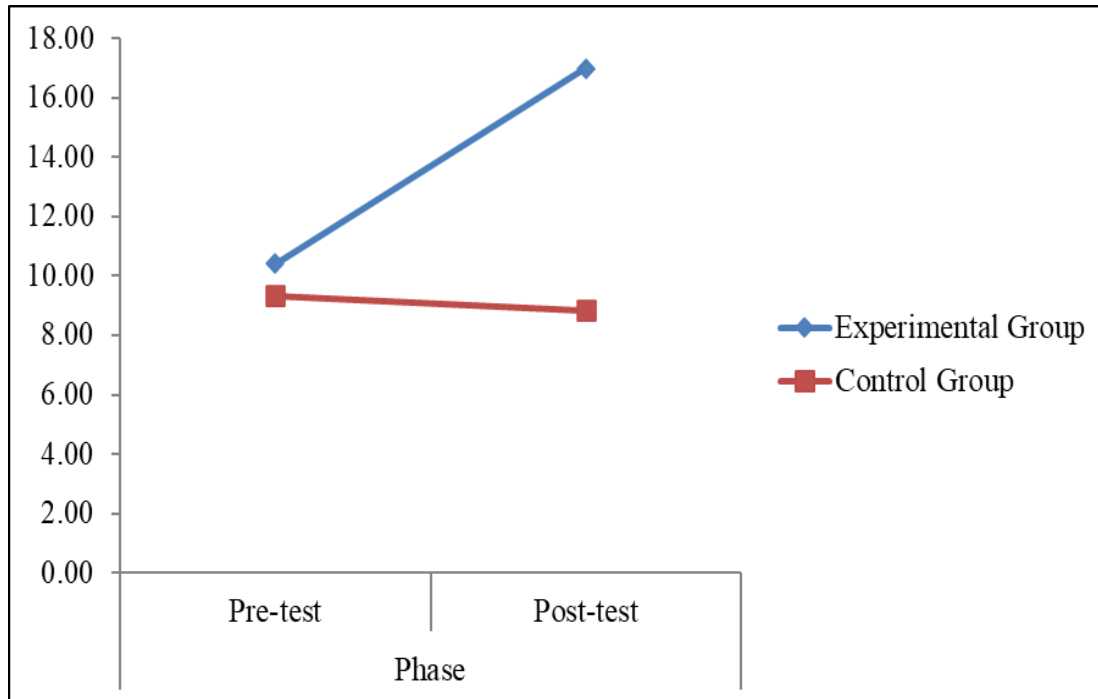
Sources of variance	**Sum of Squares**	***df***	**MSS**	***F***	***Sig.***	η_p^2	Φ
School Competence (Pre-test)	67.234	1	67.234	34.921	.000	.624	1.00
Group	306.473	1	306.473	159.178	.000	.883	1.00
Error	40.432	21	1.925				
Total	4512.000	24					

The results of ANCOVA indicate that scores of school competence differ significantly between experimental group and control group, F (1,21) = 159.178, $p < .001$. Scores of school competence of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 88.3

percent ($\eta_p{}^2$= .883). The power of the statistics is high (Φ = 1.00). Changes in the scores of school competence are depicted in the figure 17.

Figure 17

Scores of School Competence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Team organization

Table 30 indicates the results of the post test phase of intervention in team organization among the groups. Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.001, p > .05]. But, the variance of the scores of team organization between experimental and control groups are heterogeneous [F (1,22) = 40.987, p < .05]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1933).

Table 30

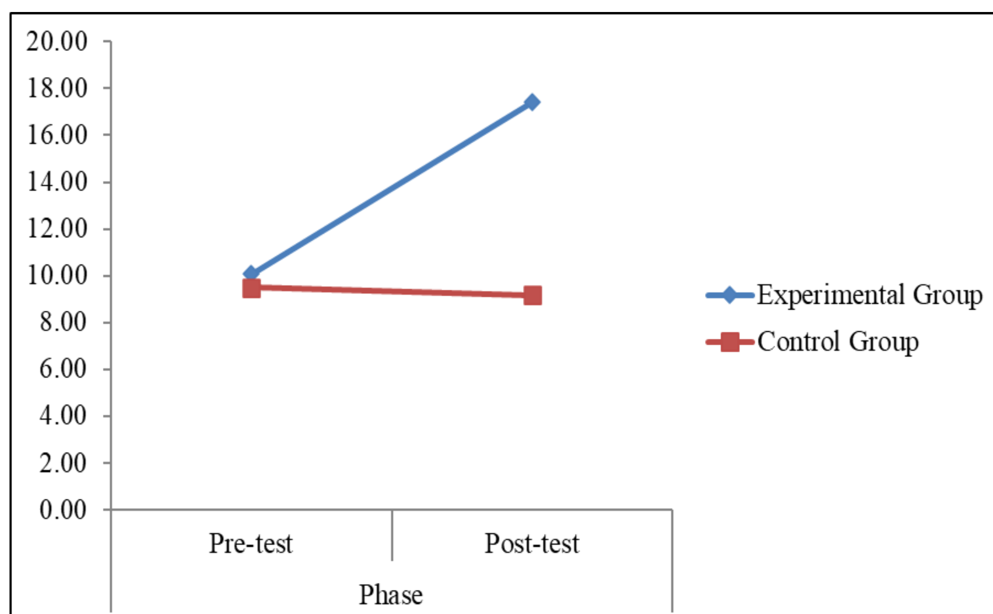
Comparing Team Organization between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Team organization (Pre-test)	35.163	1	35.163	7.904	.010	.273	.765
Group	357.993	1	357.993	80.474	.000	.793	1.00
Error	93.420	21	4.449				
Total	4777.000	24					

The results of ANCOVA indicate that scores of team organization differ significantly between experimental group and control group, F (1,21) = 80.474, $p < .001$. Scores of team organization of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 79.3percentage (η_p^2= .793). The power of the statistics is high (Φ = 1.00). Changes in the scores of team organization are depicted in figure 18.

Figure 18

Scores of Team Organization of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Peer Social Competence

Table 31 represents the results of peer social competence at the post test phase of intervention among the groups. The results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are heterogeneous indicating an interaction between covariate and independent variable [F (1,20) = 17.005, $p < .05$]. But, the variance of the scores of peer social competence between experimental and control groups are homogeneous [F (1,22) = 3.979, $p > .05$]. Scores of peer social competence are not normally distributed (w = .80, .76, $p < .05$, table 31). Thus, a decision is made to carry out gained score (Post test – Pretest) analysis considering violation of homogeneity of regression slopes as major violation among the assumptions of ANCOVA.

Table 31

Comparing Gained scores of Peers Social Competence Between Experimental Group and Control group.

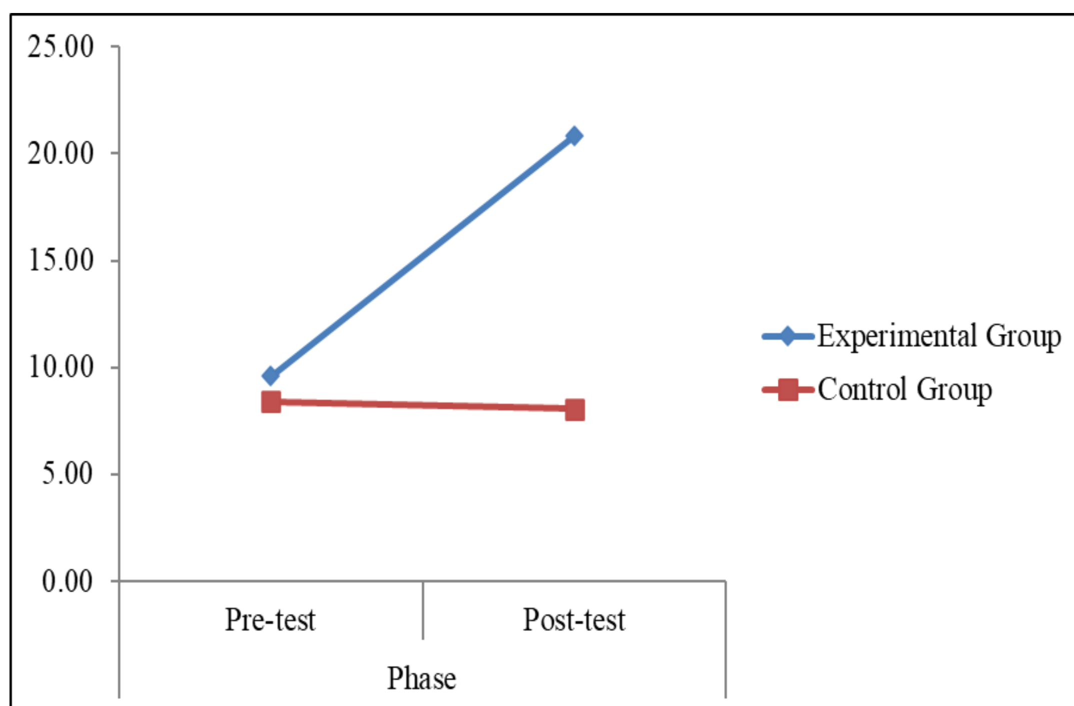
Group	Gained Scores (Post test- Pretest)		*w*	*U*	*Sig.*
	Median	QD			
Experimental	11	1.25	.87	.000	.000
Control	00	.38	.59*		

* $p < .05$

The table 31 indicate the results of the Shapiro-wilk test and the gained scores of peers' social competence are not normally distributed in the control group, w = .59, $p < .05$. Further assumption of homogeneity of variance is also violated, F (1,22) = 9.16, $p < .05$. Mann-Whitney U test has been carried out to compare the gained scores. Results indicate that gained scores are higher in the experimental group (Mean rank = 18.50) compared to the control group (Mean rank = 6.50), U = .00, Z = 4.28, $p < .001$. Effect size of the intervention is .87 ($r = Z/\sqrt{N}$; Rosenthal, 1994). Changes in the scores of peer social competence are depicted in figure 19.

Figure 19

Scores of Peer Social Competence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Social Cognition

The post test result of social cognition between experimental and control group represented in Table 32. Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are heterogeneous indicating an interaction between covariate and independent variable [F (1,20) = 6.67, p < .05]. The variance of the scores of social cognition between experimental and control groups are also heterogeneous [F (1,22) = 6.467, p > .05]. Scores of social cognition are violated from the assumption of normality in the control group, w = .82, p < .05, table 32. Decision is made to carry out gained score analysis (Post test - Pretest) considering violation of homogeneity of regression slopes as major violation among the assumptions of ANCOVA.

Table 32

Comparing Gained scores of Social Cognition Between Experimental Group and Control Group

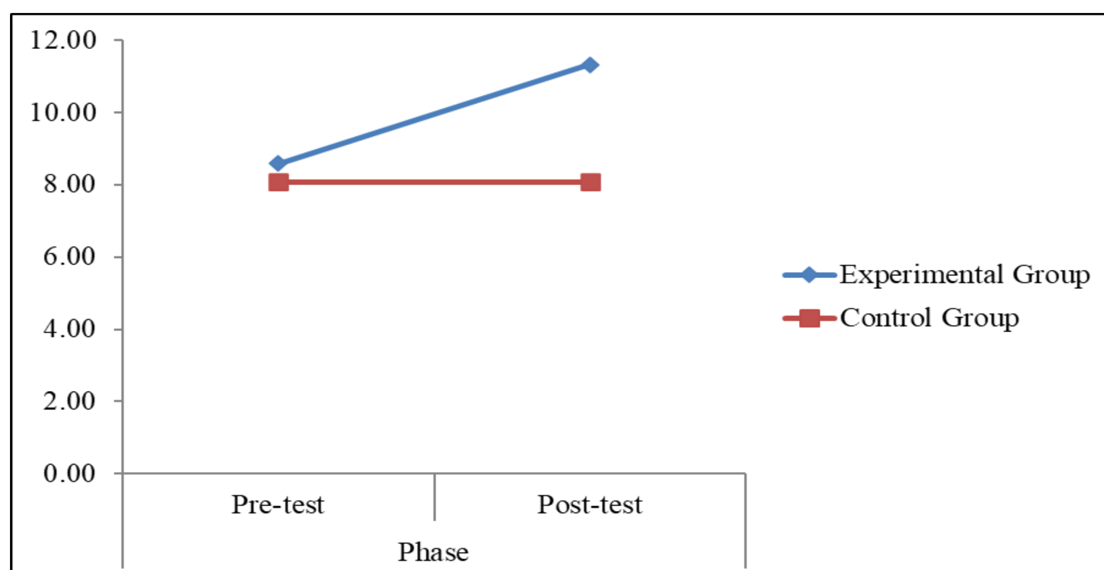
Group	Gained Scores (Post test- Pretest)		*w*	*U*	*Sig.*
	Median	QD			
Experimental	3.00	.88	.94	.000	.000
Control	.00	.00	--[a]		

Note. [Gained] scores are constant which is 0 in the control group.

The results of Shapiro-wilk test specify that scores gained scores of social cognitions is constant, thus does not follow normal distribution. Further, assumption of homogeneity of variance is also violated, F (1,22) = 23.18, $p < .05$. Mann-Whitney U test has been carried out to compare the gained scores. Results indicate that gained scores are higher in the experimental group (Mean rank = 18.50) compared to the control group (Mean rank = 6.50), $U = .00$, $Z = 4.46$, $p < .001$. Effect size of the intervention is .91 ($r = Z/\sqrt{N}$; Rosenthal, 1994). Changes in the scores of social cognitions are depicted in figure 20.

Figure 20

Scores of Social Cognition of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Home Related Competence

Table 33 shows the post-test intervention results in home related competence between groups. Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are heterogeneous indicating an interaction between covariate and independent variable [F (1,20) = 12.85, p < .05]. The variance of the scores of home related competence between experimental and control groups are homogeneous [F (1,22) = .148, p > .05]. Decision is made to carry out gained scores analysis (Post test – Pretest) considering violation of homogeneity of regression slopes as major violation among the assumptions of ANCOVA.

Table 33

Comparing Gained scores of Home Related Competence Between Experimental Group and Control Group

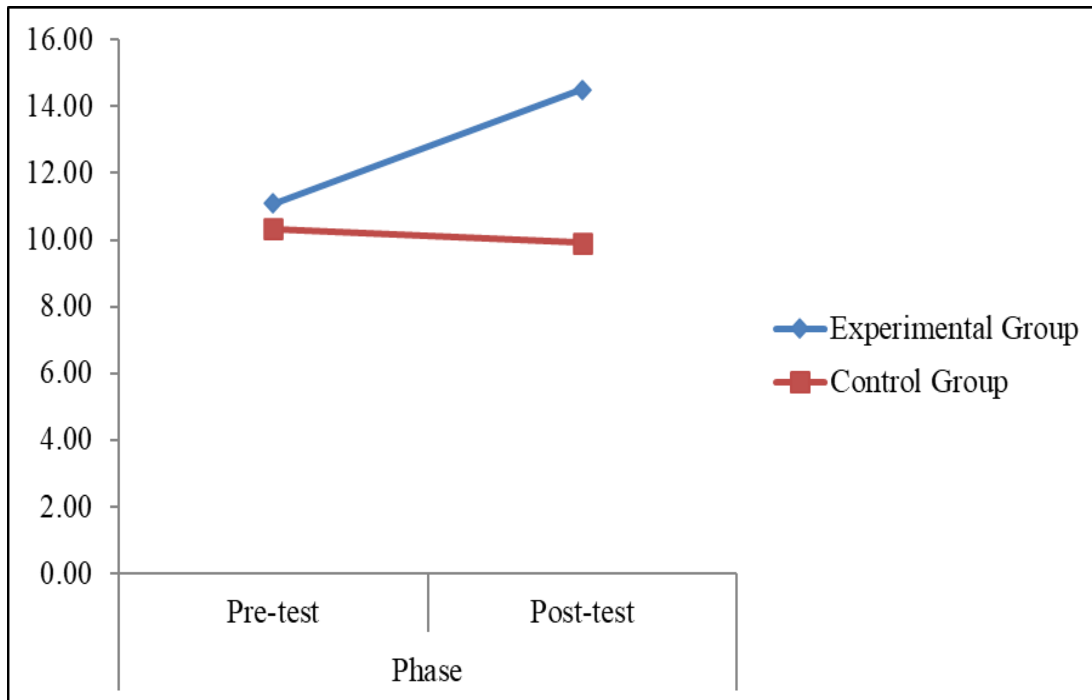
Group	Gained Scores (Post test- Pretest)		*w*	*U*	*Sig.*
	Median	QD			
Experimental	4.00	1.5	.89	.000	4.24
Control	0.00	.5	.64*		

* p < .05.

The results of the Shapiro-Wilk test indicate that scores gained scores of home related competence are not normally distributed in the control group, w = .64, p < .05. Further, assumption of homogeneity of variance is also violated, F (1,22) = 27.37, p < .05. Mann-Whitney U test has been carried out to compare the gained scores. Results indicate that gained scores are higher in the experimental group (Mean rank = 18.50) compared to the control group (Mean rank = 6.50), U = .00, Z = 4.24, p < .001. Effect size of the intervention is .86 ($r = Z/\sqrt{N}$; Rosenthal, 1994). Changes in the scores of home related competence are depicted in the figure 21.

Figure 21

Scores of Home Related Competence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Social Forethought and Compassion

Table 34 represents the result of post-test analysis in social forethought and compassion between experimental and control groups. The results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are heterogeneous indicating an interaction between covariate and independent variable [F (1,20) = 23.67, p < .05]. The variance of the scores of social forethought and compassion between experimental and control groups are homogeneous [F (1,22) = .623, p > .05]. Decision is made to carry out gained score analysis (Post test – Pretest) considering violation of homogeneity of regression slopes as major violation among the assumptions of ANCOVA.

Table 34

Comparing Gained Scores of Social Forethought and Compassion Between Experimental Group and Control Group

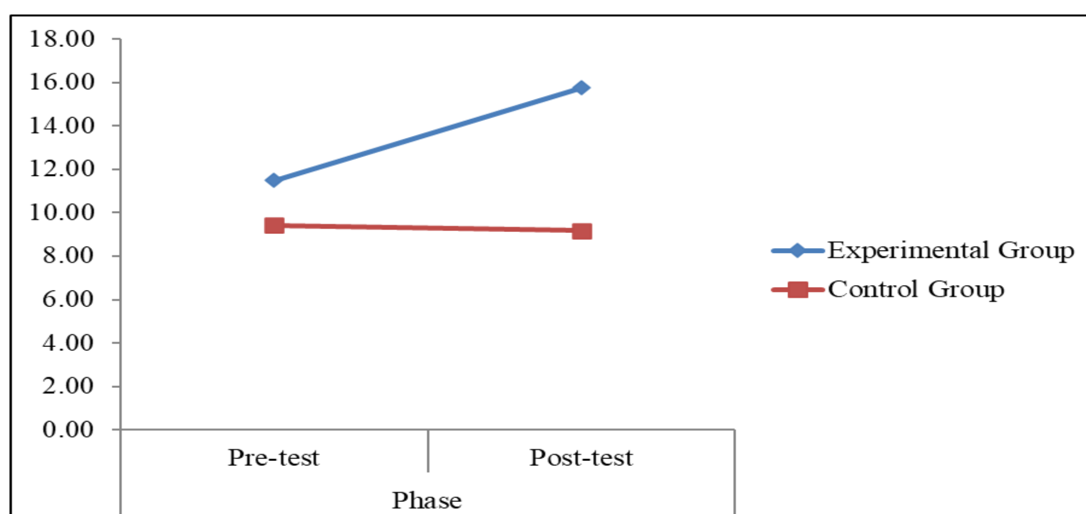
Group	Gained Scores (Post test- Pre test)		*w*	*U*	*Sig.*
	Median	QD			
Experimental	4.00	1.00	.91	.000	.000
Control	0.00	.38	.55*		

* $p < .05$.

The results of the Shapiro-Wilk test indicate that gained scores of social forethought and compassion are not normally distributed in the control group, $w = .55$, $p < .05$. Assumption of homogeneity of variance is also violated, $F(1,22) = 10.60$, $p < .05$. Mann-Whitney U test has been carried out to compare the gained scores. Results indicate that gained scores are higher in the experimental group (Mean rank = 18.50) compared to the control group (Mean rank = 6.50), $U = .00$, $Z = 4.28$, $p < .001$. Effect size of the intervention is .87 ($r = Z/\sqrt{N}$; Rosenthal, 1994). Changes in the scores of social forethought and compassion are depicted in the figure 22.

Figure 22

Scores of Social Forethought and Compassion of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Social Emotional Competence

The results of post test phase of intervention in social emotional competence between experimental and control groups depicted in Table 35. The results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.657, $p > .05$]. Similarly, the variance of the scores of social emotional competence between experimental and control groups are homogeneous [F (1,22) = 1.036, $p > .05$]. Decision is made to carry out ANCOVA.

Table 35

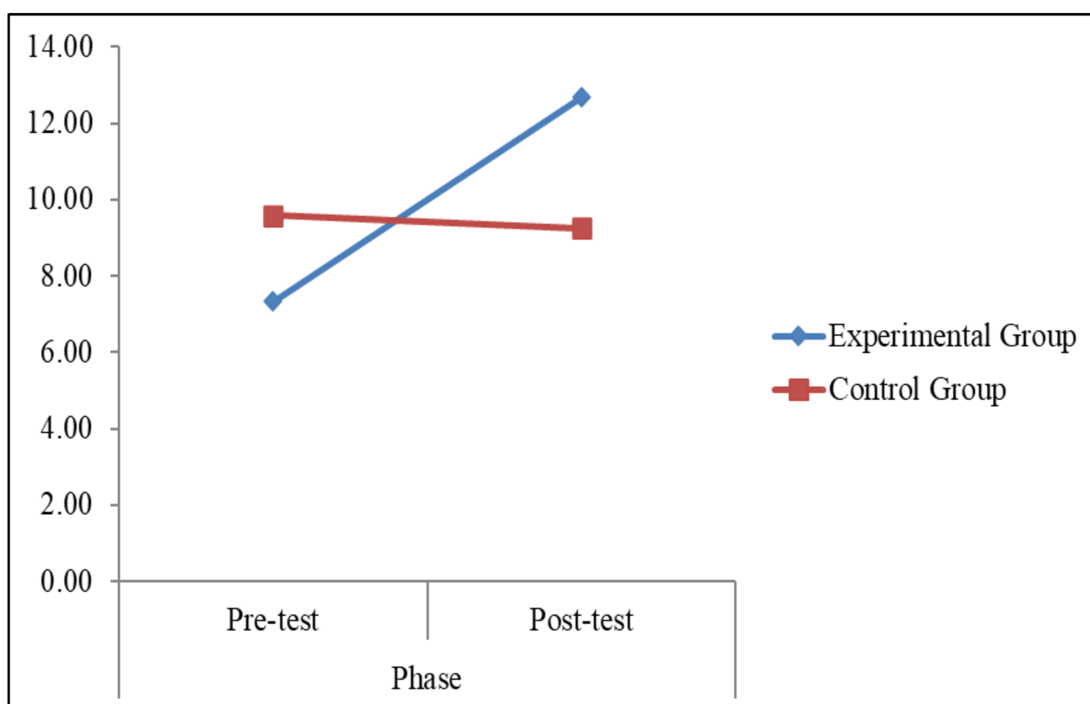
*Comparing Social Emotional Competence **B**etween Experimental Group and Control Group at Post-test Phase of the Intervention*

Sources of variance	**Sum of Squares**	***df***	**MSS**	***F***	***Sig.***	η_p^2	Φ
Social Emotional Competence (Pre-test)	46.012	1	46.012	31.266	.000	.598	1.000
Group	114.960	1	114.960	78.116	.000	.788	1.000
Error	30.905	21	1.472				
Total	3029.000	24					

The results of ANCOVA indicate that scores of social emotional competence differ significantly between experimental group and control group, F (1,21) = 78.116, $p < .001$. Scores of social emotional competence of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 78.8 percent ($\eta_p^2 = .788$). The power of the statistics is high ($\Phi = 1.00$). Changes in the scores of social emotional competence are depicted in figure 23.

Figure 23

Scores of Social Emotional Competence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Social Flexibility

Table 36 represents the scores of social flexibility among experimental and control groups at post-test analysis. The results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.30, $p > .05$]. Similarly, the variance of the scores of social flexibility between experimental and control groups are homogeneous [F(1,22) = .670, $p > .05$]. Decision is made to carry out ANCOVA.

Table 36

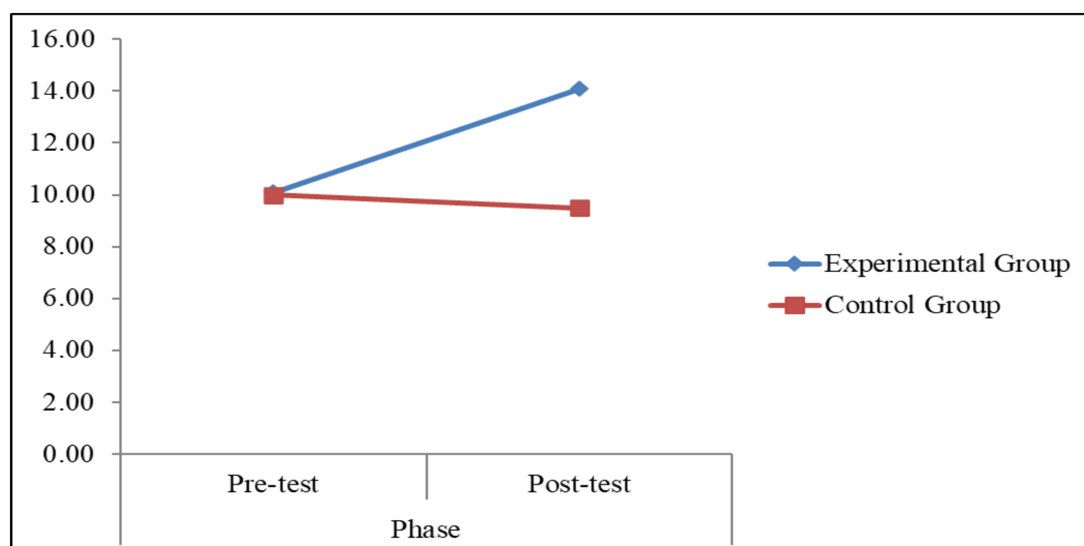
Comparing Social Flexibility Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Social Flexibility (Pre-test)	34.610	1	34.610	34.112	.000	.619	1.000
Group	122.527	1	122.527	120.765	.000	.852	1.000
Error	21.306	21	1.015				
Total	3519.000	24					

The results of ANCOVA indicate that scores of social flexibility differ significantly between experimental group and control group, F (1,21) = 120.765, $p <$ .001. Scores of social flexibility of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 85.2 percent (η_p^2= .852). The power of the statistics is high (Φ = 1.00). Changes in the scores of social flexibility are depicted in figure 24.

Figure 24

Scores of Social Flexibility of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Social Competence (overall)

Table 37 depicts the post test phase of analysis of overall scores of social competence in experimental and control groups. The results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.95, p > .05]. Similarly, the variance of the scores of social competence between experimental and control groups are homogeneous [F (1,22) = .743, p > .05]. Decision is made to carry out ANCOVA.

Table 37

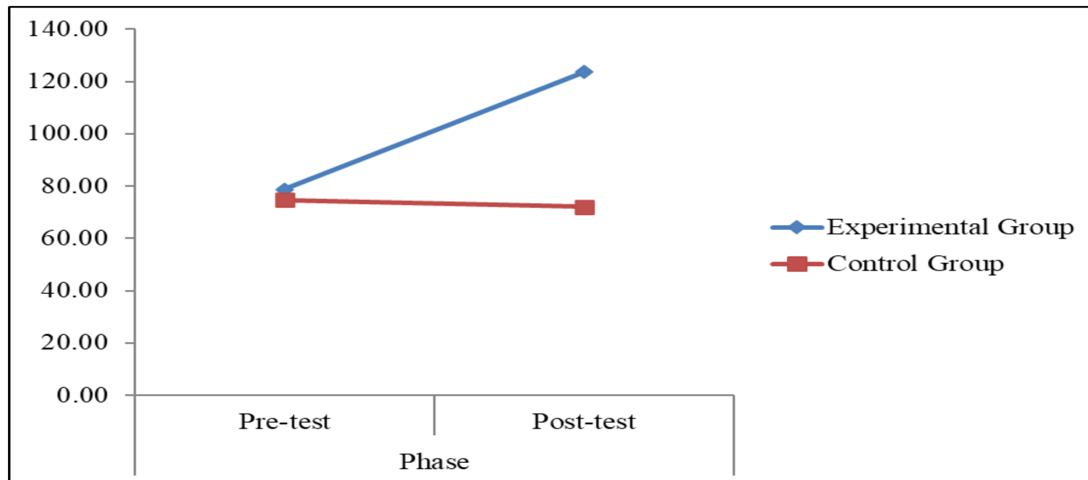
Comparing Social Competence (Overall) Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	**Sum of Squares**	***df***	**MSS**	***F***	***Sig.***	η_p^2	Φ
Social competence (Pre-test)	321.713	1	321.713	38.125	.000	.645	1.000
Group	12744.696	1	12744.696	1510.344	.000	.986	1.000
Error	177.204	21	8.438				
Total	245981.000	24					

The results of ANCOVA indicate that scores of social competence differ significantly between experimental group and control group, F (1,21) = 1510.344, p < .001. Scores of social competence of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 98.6 percent (η_p^2= .986). The power of the statistics is high (Φ = 1.00). Changes in the scores of social competence are depicted in figure 25

Figure 25

Scores of Social Competence of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



The results indicate that social competence among children with behavioral problems has improved after the multidimensional training program. The connection between social competence and behavioral issues has gained significant focus. It's become evident that fostering social competence in children and young people could serve as a viable standalone or additional approach to addressing and modifying these problems. Social competence is an adaptable quality that involves understanding others' perspectives, learning from past experiences, and applying this knowledge to focus social situations. It encompasses a child's awareness of how their actions impact their environment and their attentiveness to the needs of others (Clickeman, 2007). Group activities helped the group to have better interpersonal relationships, following social rules, initiating and working for common goals. Peer relations act as platforms for developing future interpersonal skills, offering children chances to understand reciprocity and intimacy. Working with disagreements and collaborating with peers and family members attained through problem solving techniques and conflict resolution strategies.

The present study focused on implementing effective parenting interaction skills, along with social skill training and mindfulness training to improve the social competency among the group. Through parent management training the children are able to improve better communication skills, following and accepting the rules of behavior, listening skills and so on. Studies supporting the present results Kazdin et al. (2018) reported that parent management training was found effective for reducing behavioral problems, improving social competence, and reducing aggressive behavior; increased social-emotional competence and decreased behavioral problems in young children after parent management training (Mason et al.,2016). These findings collectively supported to the current investigation results that parent management programs have effectively improved the social competence among children with behavioral problems.

The study results specify that social skill training enhances the social competency among children with behavioral problems. Social skill training like problem solving, conflict resolution, managing emotions and working with empathic understanding enabled the children to deal more effectively while they are in a group. Social skills refer to the capacity to effectively discern pertinent and valuable information within a social context. This ability enables individuals to focus opportunities for goal achievement and cultivate positive relationships with others. The study outcome could be interpreted as a deficiency in social skills, leading to children's challenges in effectively communicating their physical and emotional needs, collaborating with others, gaining acceptance from peer groups, accurately assessing social situations, and having insufficient knowledge of social rules and etiquette. Consequently, the social skills training program implemented in this study was specifically targeted as one of the remediation of children's deficits in social skills.

These training programs typically cover a wide range of skills, including aspects such as engaging in conversations, adhering to rules and instructions, demonstrating patience, working collaboratively, exhibiting playfulness, and taking on responsibilities. The development of these attributes is believed to contribute significantly to both social and behavioral success. The results were relatable with the findings of Sim et al. (2006) Seevers & Blank (2008) and Mannarino et al. (1982), that social skill training was found effective in social competences like self-control, decrease in aggressive behavior, and improvement in peer acceptance respectively.

The social skill training sessions were found effective among children with behavioral problems to improve cooperative interactions among groups. They were given opportunities to share their achievements, in which they were praised among group members. Group discussions helped the participants learn how to manage conflicts in a socially acceptable manner. The ability to integrate thoughts, feelings, and conduct in order to complete social tasks and produce social outcomes valued in the current environment and society is known as social competence. Children learn how to build and sustain meaningful relationships, avoid receiving unfair treatment from others, and interact with their parents through social skill training. Kazdin & Wassell (2000) found that parental training and social skill training was found effective for children with antisocial behavior.

Social skills encompass both cognitive and interpersonal facets, encompassing verbal and non-verbal elements essential for appropriate social behavior and fostering positive social interactions (Beauchamp & Anderson, 2010). Consistent with the findings of the current investigation, research conducted by Gresham et al. (2006) emphasizes that social skills training plays a crucial role in helping children initiate and sustain positive social relationships. It contributes to peer acceptance, facilitates the

development of friendships, promotes satisfactory school adjustment, and equips children to cope with the demands of the school environment. Other studies evaluating social skills programs suggest that intervening at an earlier stage increases the likelihood of positive outcomes and may prevent the emergence of problematic behavior (January et al., 2011).

Furthermore, assessments of the child component in Social Skills Training (SST) indicate reduced disruptive behavior, enhanced social competence and cognition, compared to control groups. There is also evidence of diminished aggressive behavior and Callous-Unemotional (CU) traits (Taylor et al., 2017). A pre-post study on children with disruptive behavior disorders showed a significant reduction in symptoms related to conduct problems through SST intervention (Aitken et al., 2018). The post intervention results of social competence indicates that the social skill training could help effectively for improving the social functioning among the children through effective interaction with others, problem solving abilities, understanding things from others perspectives and so on. In a meta-analysis conducted by Gresham et al. (2014), which reviewed six studies involving Social Skills Training (SST) for children with or at risk for emotional and behavioral disorders (EBD), the results indicated that SST proved to be an effective intervention. The study showed a 64% improvement rate relative to controls across a range of issues, including aggression, externalizing behavior, internalizing behavior, and antisocial behavior., which is relatable to the present finding with a high effect size in the intervention among experimental groups. This finding contrasts with Bullis et al. (2001), who suggested that SST may not effectively address the behavioral problems of extremely at-risk and antisocial children. This discrepancy could be attributed to factors such as small sample sizes or the lack of experienced therapists administering the intervention. In addition to the present results,

the mild forms of behavioral problem children were taken for the research purpose, which is consistent with most of the research reviews. Utilizing instructional strategies such as modelling, role-playing, positive reinforcement, and practice or rehearsal can aid children in fostering positive relationships with others, adapting effectively to behavioral expectations within specific settings, and communicating their needs and preferences appropriately (Seevers & Jones-Blank,2008).

Adults have been the primary focus of most mindfulness meditation research to date. On the other hand, as noted by Zoogman et al., in 2014, there has been a growing interest in children and adolescents more lately. Research in this new field shows that training in mindfulness meditation has positive effects on young people's psychological health, as shown by research by Biegel et al. (2009), Burke (2010), Flook et al. (2010), and Semple et al. (2010). Mindfulness has improved behavioral regulation (Flook et al., 2010), metacognition, and executive function; which has the primary role in the development of many behavioral disorders like attention problems, bullying, and delinquency (Hughes et al., 2000; Brocki & Bohlin, 2006). Consequently, mindfulness meditation is believed to contribute to improved focus and concentration, which, in turn, may have a beneficial effect on children’s behavioral regulation, socio-emotional development, and academic skills, as evidenced by studies conducted by Flook et al. (2010) Beauchemin et al. (2008) and Napoli et al. (2005). Valipour (2018) also states that mindfulness based cognitive therapy has significantly reduced the behavioral problems among children. The present investigation results relate with the earlier research findings that mindfulness helps the children to improve better self-awareness and emotional awareness, which serves as an effective method for interacting with the society or social functioning. Through mindfulness training the children could be

trained to increase mental awareness thus helping to reduce behavioral problems and improve social interaction.

The multidimensional intervention like parent management training, social skill training and mindfulness training have found effective to reduce behavioral problem and improve the social competence functioning among the experimental group. Hence, the hypothesis 6, stating that there is significant difference in social competence and its dimensions at post test phase intervention between experimental and control group is accepted.

Difficulties in Emotion Regulation and its Dimensions

The hypothesis under the present section is:

H7: There is a significant difference in the difficulties in emotion regulation and its dimensions in experimental and control group at pre-test phase of intervention.

Table 38

Comparing Factors of Difficulties in Emotion Regulation Between Experimental Group (n =12) and Control Group (n =12) at Pre-test Phase of the Intervention

Difficulties in emotion regulation	Group	Mean	SD	*w*	*t*	*Sig.*
1. Lack of emotional awareness	Experimental	22.75	1.77	.93	.640	.529
	Control	22.25	2.05	.95		
2. Lack of emotional clarity	Experimental	14.42	1.17	.87	5.444	.000
	Control	16.92	1.08	.94		
3. Difficulties in controlling impulsive behaviour when distressed	Experimental	20.00	1.71	.89	2.590	.017
	Control	21.75	1.60	.89		
4. Difficulties in engaging goal directed behaviour when distressed	Experimental	17.67	1.23	.87	4.603	.000
	Control	15.08	1.51	.92		
	Experimental	20.58	3.09	.88	5.449	.000

Difficulties in emotion regulation	Group	Mean	SD	*w*	*t*	*Sig.*
5. Non acceptance of negative emotional response	Control	27.58	3.20	.89		
6. Limited access to emotional regulation strategies	Experimental	12.08	1.24	.90	.363	.720
	Control	11.92	1.00	.88		
7. Difficulties in emotional regulation	Experimental	107.50	3.83	.91	4.619	.000
	Control	115.50	4.62	.94		

The summary of Shapiro wilk test indicate (Table 38) that scores of factors of difficulties in emotion regulation are normally distributed in both experimental and control group at pretest phase of the intervention, w = .93, .95, .87, .94, .89, .89, .87, .92, .88, .89, .90, .88, .91, .94, $p > .05$. Results of the independent sample t test indicate that scores of lack of emotional awareness and Limited access to emotional regulation strategies of control group and experimental group are similar before the intervention, t (22) = .640, .363, $p > .05$. Whereas Lack of emotional clarity, Difficulties in controlling impulsive behaviour when distressed, Difficulties in engaging goal directed behaviour when distressed, non-acceptance of negative emotional response, and total Difficulty in emotional regulation are different at the pretest phase of the intervention, t (22) = 5.444, 2.590, 4.603, 5.449, 4.619, $p < .05$.

Control group scored higher in lack of emotional clarity, difficulties in controlling impulsive behaviour when distressed, non-acceptance of negative emotional response, and overall difficulty in emotional regulation before the intervention. But, the average score of Difficulties in engaging goal directed behaviour when distressed are higher in the experimental group.

The stated hypothesis H7: There is a significant difference in the difficulties in emotion regulation and its dimensions in experimental and control group at pre-test

phase of intervention is accepted for the dimensions of lack of emotional clarity, difficulties in controlling impulsive behaviour when distressed, non-acceptance of negative emotional response, difficulties in engaging goal directed behaviour when distressed and overall difficulty in emotional regulation. While the dimensions like lack of emotional awareness, and limited access to emotion regulation strategies are found similar between groups, hence rejected the hypothesis.

H8: There is a significant difference in the difficulties in emotion regulation and its dimensions in experimental and control group at post-test phase of intervention.

Table 39

Scores of Factors of Difficulties in Emotion Regulation Between Experimental Group (n =12) and Control Group (n =12) at Post-test Phase of the Intervention

Difficulties in emotion regulation	Group	Mean	SD	*w*
1. Lack of emotional awareness	Experimental	12.00	3.22	.93
	Control	22.92	1.88	.94
2. Lack of emotional clarity	Experimental	9.92	3.26	.88
	Control	17.92	1.38	.93
3. Difficulties in controlling impulsive behaviour when distressed	Experimental	9.92	2.75	.88
	Control	22.25	1.42	.90
4. Difficulties in engaging goal directed behaviour when distressed	Experimental	9.00 [a]	0.75 [b]	.79*
	Control	15.00[a]	0.50[b]	.92
5. Non acceptance of negative emotional response	Experimental	10.50[a]	2.00[b]	.91
	Control	29.00[a]	1.38[b]	.80*
6. Limited access to emotional regulation strategies	Experimental	8.25	2.96	.93
	Control	12.25	0.75	.91
7. Difficulties in emotional regulation	Experimental	60.33	13.90	.89
	Control	118.58	4.78	.95

Note. [a] Median; [b] QD * $p < .05$

The scores of difficulties in engaging goal directed behaviour when distressed are not normally distributed in the experimental group (Table 39). Similarly scores of Non acceptance of negative emotional response are not normally distributed at the post test phase, $w = .79, .80, p < .05$, table 24.

Parental reinforcement and proper care towards children show a positive effect on their emotional regulations. A high score indicates low emotional regulation among individuals.

Lack of Emotional Awareness

Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [$F(1,20) = 1.51, p > .05$]. But, the variance of the scores of lack of emotional awareness between experimental and control groups are heterogeneous [$F(1,22) = 14.281, p < .05$]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1993).

Table 40

Comparing Lack of Emotional Awareness Between Experimental Group and Control Group at Post-test Phase of the Intervention

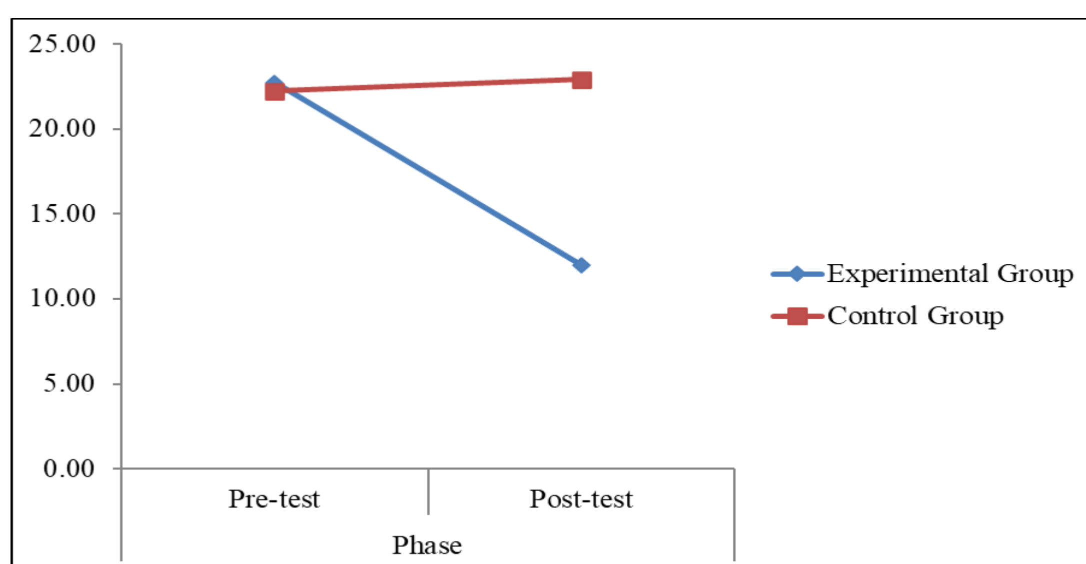
Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Lack of Emotional Awareness (Pre-test)	25.436	1	25.436	4.190	.053	.166	.497
Group	738.572	1	738.572	121.665	.000	.853	1.000
Error	127.481	21	6.071				
Total	8183.000	24					

The results of ANCOVA in table 40 indicate that scores of lack of emotional awareness differ significantly between experimental group and control group, $F(1,21)$

= 121.665, p < .001. Scores of lack of emotional awareness of members of the experimental group decreased significantly compared to the control group. Effect size of the intervention is 85.3 percent (η_p^2= .853). The power of the statistics is high (Φ = 1.00). Changes in the scores of lack of emotional awareness are depicted in figure 26.

Figure 26

Scores of Lack of Emotional Awareness of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Lack of Emotional Clarity

Table 41 represents the post-test analysis of lack of emotional clarity between experimental and control groups. The results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 1.128, p > .05]. But, the variance of the scores of lack of emotional clarity between experimental and control groups are heterogeneous [F (1,22) = 5.362, p < .05]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1993).

Table 41

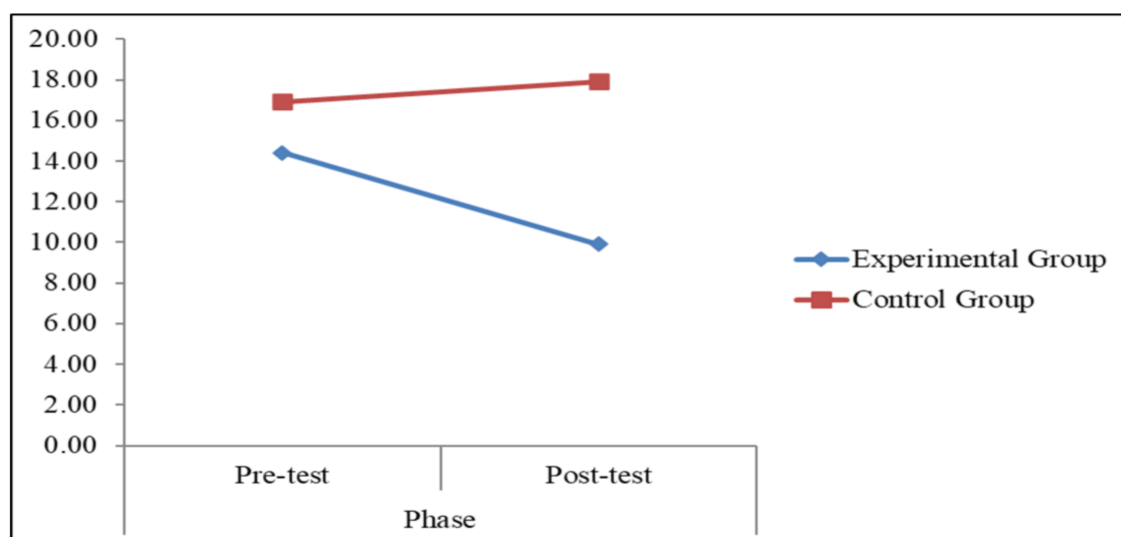
Comparing Lack of Emotional Clarity Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Lack of Emotional Clarity (Pre-test)	37.561	1	37.561	7.866	.011	.273	.763
Group	66.376	1	66.376	13.901	.001	.398	.944
Error	100.272	21	4.775				
Total	5170.000	24					

The results of ANCOVA indicate that scores of lack of emotional clarity differ significantly between experimental group and control group, F (1,21) = 253.047, $p < .001$. Scores of lack of emotional clarity of members of the experimental group increased significantly compared to the control group. Effect size of the intervention is 39.8percentage (η_p^2= .398). The power of the statistics is high (Φ = .944). Changes in the scores of lack of emotional clarity are depicted in figure 27.

Figure 27

Scores of Lack of Emotional Clarity of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Difficulties in Controlling Impulsive Behaviour When Distressed

Results of statistical analyses carried out to test the assumptions of indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 1.70, $p > .05$]. But, the variance of the scores of difficulties in controlling impulsive behaviour when distressed between experimental and control groups are heterogeneous [F (1,22) = 9.808, $p < .05$]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1993).

Table 42

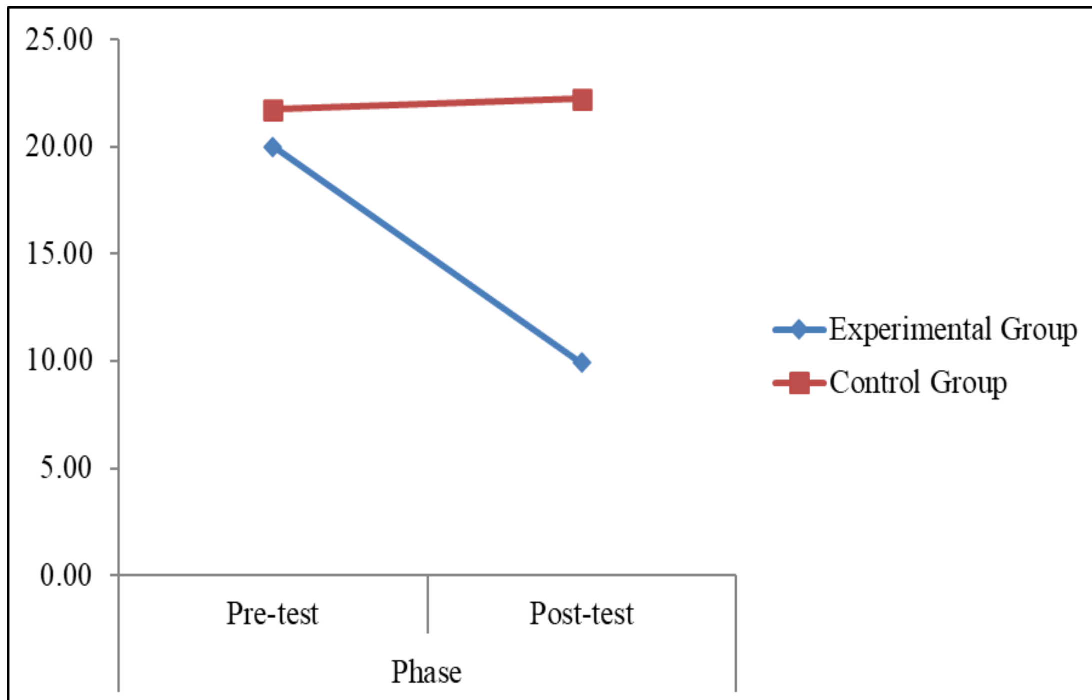
Comparing Difficulties in Controlling Impulsive Behaviour When Distressed Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Difficulties in Controlling Impulsive Behaviour When Distressed (Pre-test)	9.362	1	9.362	2.052	.167	.089	.277
Group	623.325	1	623.325	136.630	.000	.867	1.000
Error	95.805	21	4.562				
Total	7226.000	24					

The results of ANCOVA (Table 42) indicate that scores of difficulties in controlling impulsive behaviour when distressed differ significantly between experimental group and control group, F (1,21) = 253.047, $p < .001$. Scores of difficulties in controlling impulsive behaviour when distressed of members of an experimental group decreased significantly compared to the control group. Effect size of the intervention is 92.3 percent (η_p^2= .923). The power of the statistics is high (Φ = 1.00). Changes in the scores of difficulties in controlling impulsive behaviour when distressed are depicted in figure 28.

Figure 28

Scores of Difficulties in Controlling Impulsive Behaviour When Distressed of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Difficulties in Engaging Goal Directed Behaviour When Distressed

Results of statistical analyses carried out to test the assumptions of ANCOVA indicate that regression slopes are heterogeneous indicating an interaction between covariate and independent variable [F (1,20) = 25.68, $p < .05$]. But, variance of the scores of difficulties in engaging goal directed behaviour when distressed between experimental and control groups are homogeneous [F (1,22) = .488, $p > .05$]. Scores of Difficulties in engaging goal directed behaviour when distressed are not normally distributed in the experimental group, $w = .79$, $p < .05$, table 43. Decision is made to carry out gained score analysis (Post test – Pretest) considering violation of homogeneity of regression slopes as major violation among the assumptions of ANCOVA.

Table 43

Comparing Gained scores of Difficulties in Engaging Goal Directed Behaviour When Distressed Between Experimental Group and Control

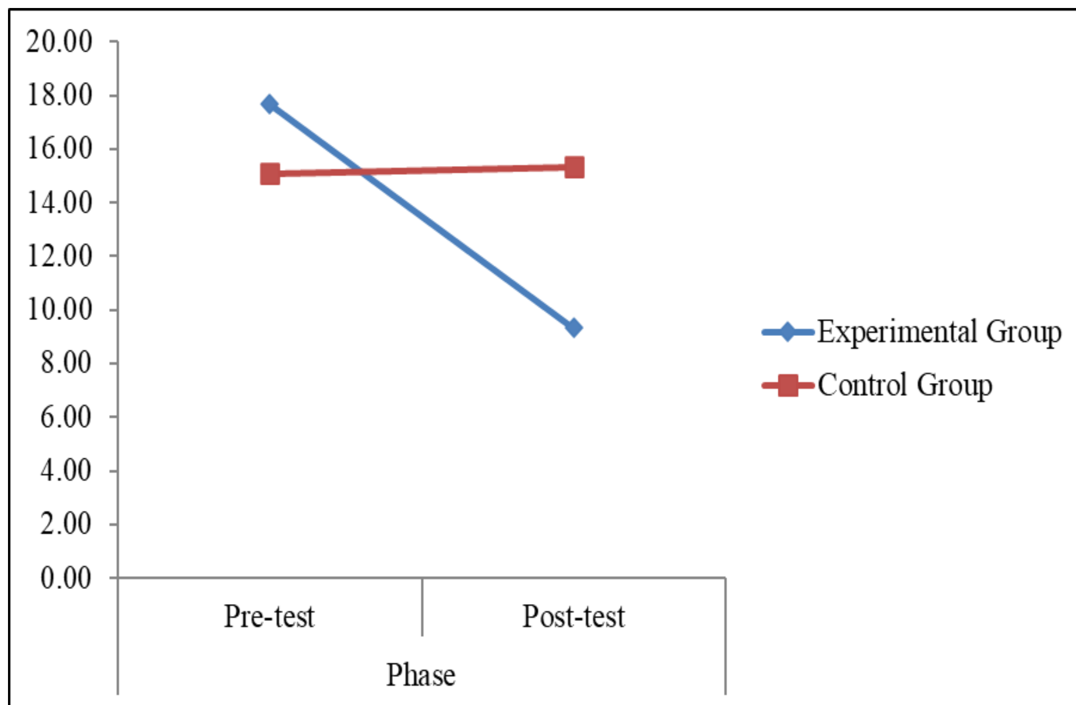
Group	**Gained Scores (Post test- Pretest)**		***w***	***U***	***Sig.***
	Median	QD			
Experimental	-10.00	2.65	.91	.000	.000
Control	0.00	.5	.66*		

* $p < .05$.

The results of the Shapiro-Wilk test indicate that scores gained scores of difficulties in engaging goal directed behaviour when distressed is not normally distributed in the control group, $w = .66$, $p < .05$. Further, assumption of homogeneity of variance is also violated, $F(1,22) = 14.92$, $p < .05$. Mann-Whitney U test has been carried out to compare the gained scores. Results indicate (Table 43) that gained scores are higher in the control group (Mean rank = 18.50) compared to the experimental group (Mean rank = 6.50), $U = .00$, $Z = 4.25$, $p < .001$. Effect size of the intervention is .87 ($r = Z/\sqrt{N}$; Rosenthal, 1994). Changes in the scores of difficulties in engaging goal directed behavior when distressed are depicted in the figure 29.

Figure 29

Scores of Difficulties in Engaging Goal Directed Behaviour When Distressed of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Non-Acceptance of Negative Emotional Response

The results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are heterogeneous indicating an interaction between covariate and independent variable [F (1,20) = 14.93, p < .05]. But, variance of the scores of non-acceptance of negative emotional response between experimental and control groups are homogeneous [F (1,22) = 3.807, p > .05]. Scores of Non acceptance of negative emotional response is not normally distributed at the post test phase, w = .80, p < .05, table 44. Decision is made to carry out gained score analysis (Post test – Pretest) considering violation of homogeneity of regression slopes as major violation among the assumptions of ANCOVA.

Table 44

Comparing Gained scores of Non-Acceptance of Negative Emotional Response Between Experimental Group and Control Group

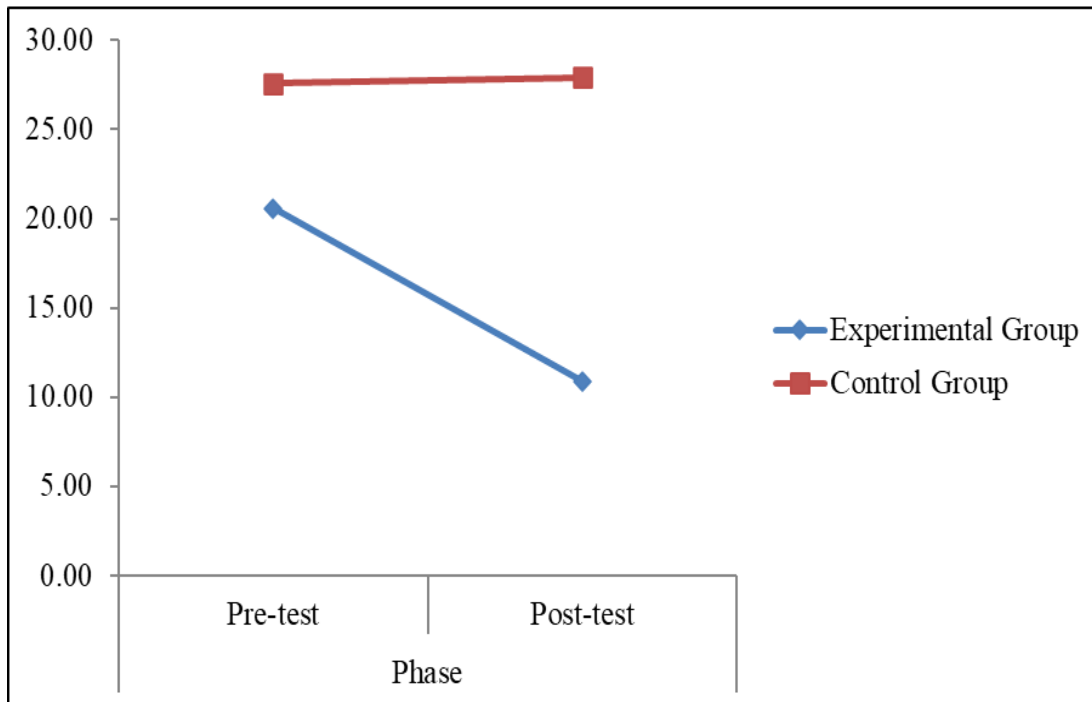
Group	Gained Scores (Post test- Pretest)		*w*	*U*	*Sig.*
	Median	QD			
Experimental	-.9.00	1.50	.78*	12.00	.000
Control	0.00	0.38	.55*		

* $p < .05$.

The results of the Shapiro-Wilk test indicate that gained scores of non-acceptance of negative emotional response are not normally distributed in the control group and experimental group, w = .78, .55, $p < .05$. Further, assumption of homogeneity of variance is also violated, F (1,22) = 6.03, $p < .05$. Mann-Whitney U test has been carried out to compare the gained scores. Results indicate (Table 44) that gained scores are higher in the control group (Mean rank = 17.50) compared to the experimental group (Mean rank = 7.50), U = 12.00, Z = 3.57, $p < .001$. Effect size of the intervention is .73 ($r = Z/\sqrt{N}$; Rosenthal, 1994). Changes in the scores of non-acceptance of negative emotional response are depicted in the figure 30.

Figure 30

Scores of Non-Acceptance of Negative Emotional Response of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Limited Access to Emotional Regulation Strategies

Table 45 directs the results of limited access to emotion regulation strategies in post test intervention between the groups. Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = .920, $p > .05$]. But, the variance of the scores of limited access to emotional regulation strategies between experimental and control groups are heterogeneous [F (1,22) = 7.729, $p < .05$]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1933).

Table 45

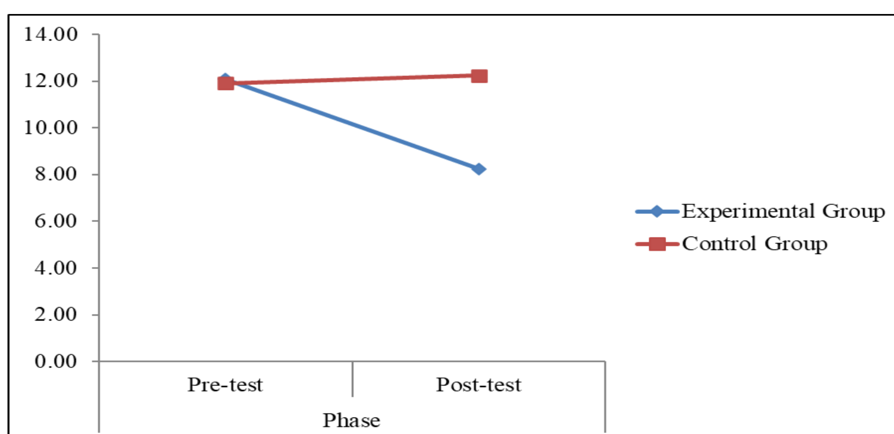
Comparing Limited Access to Emotional Regulation Strategies Between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
Limited Access to Emotional Regulation Strategies (Pre-test)	.144	1	.144	.029	.865	.001	.053
Group	96.001	1	96.001	19.696	.000	.484	.988
Error	102.356	21	4.874				
Total	2720.000	24					

The results of ANCOVA indicate that scores of limited accesses to emotional regulation strategies differ significantly between experimental group and control group, $F(1,21) = 19.696, p < .001$. Scores of limited accesses to emotional regulation strategies of members of the experimental group decreased significantly compared to the control group. Effect size of the intervention is 48.4 percent (η_p^2= .484). The power of the statistics is high (Φ = 1.00). Changes in the scores of limited accesses to emotional regulation strategies are depicted in the figure 31.

Figure 31

Scores of Limited Access to Emotional Regulation Strategies response of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



Difficulties in Emotion Regulation(Overall)

Results of statistical analyses carried out to test the assumption of ANCOVA indicate that regression slopes are homogeneous indicating absence of interaction between covariate and independent variable [F (1,20) = 0.01, $p > .05$]. But, the variance of the scores of difficulties in emotional regulation between experimental and control groups are heterogeneous [F (1,22) = 10.092, $p < .05$]. Decision is made to carry out ANCOVA as the test tends to be robust with the violation of homogeneity of variance if sample size is equal (Johnson, 1933).

Table 46

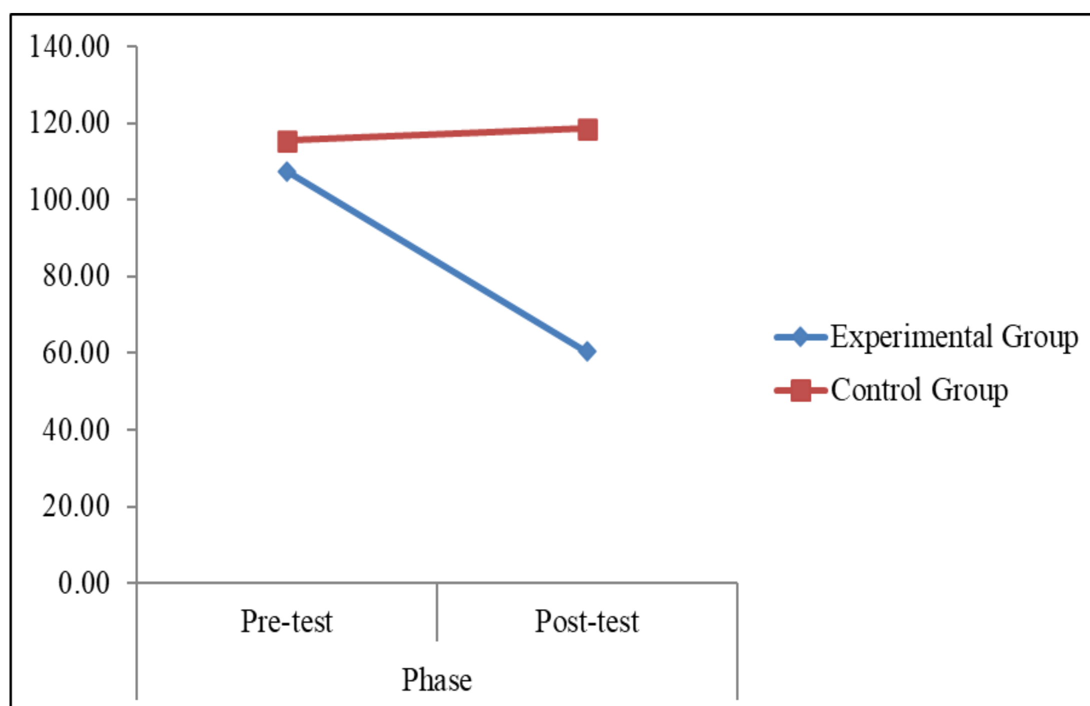
Comparing Difficulties in Emotion Regulation between Experimental Group and Control Group at Post-test Phase of the Intervention

Sources of variance	Sum of Squares	*df*	MSS	*F*	*Sig.*	η_p^2	Φ
DER_T (Pre-test)	320.940	1	320.940	3.277	.085	.135	.408
Group	7937.961	1	7937.961	81.053	.000	.794	1.000
Error	2056.643	21	97.935				
Total	214803.000	24					

The results of ANCOVA indicate that scores of difficulties in emotional regulation differ significantly between experimental group and control group, F (1,21) = 81.053, $p < .001$. Scores of difficulties in emotional regulation of members of the experimental group decreased significantly compared to the control group. Effect size of the intervention is 79.4 percent (η_p^2= .794). The power of the statistics is high (Φ = 1.00). Changes in the scores of difficulties in emotional regulation are depicted in figure 32.

Figure 32

Scores of Difficulties in Emotion Regulation of Control Group and Experimental Group at Pre-test and Post-test Phases of the Intervention



The multidimensional training program has improved the emotional regulation among experimental groups, as the participants in the experimental group showed improvement in all the dimensions of emotion regulation strategies. At the pretest level, the scores of difficulties in emotion regulation were high among both experimental and control groups. But after the intervention program, at the post test phase, there was a significant difference in the emotion regulation score between experimental and control group, indicating the efficacy of multidimensional training on emotion regulation skills. The multidimensional programs like parental management, social skill training, and mindfulness found to be effective in dealing with the emotional regulation difficulties among children with behavioral problems. In the last two decades, mindfulness has become more popular as a type of meditation practice and in psychological applications in therapeutic and educational contexts. Children were provided with the experience of

observing, listening to their own self and their surroundings. Such practices help them to understand their own emotions, accept and regulate their emotional expression in an effective manner. The results supported with the findings of (Hasha, 2009; Tipsord, 2009; Caldwell et al., 2010; Cash & Whittingham, 2010; Gold et al., 2010; Garland, et al., 2011) that mindfulness results in increase in positive emotions and reduction in negative emotions and stress and positive mental health. Mindfulness training has effective management techniques, which are linked with brain regions. There is an increase of grey matter in certain brain regions that are linked to memory, learning, and emotional regulation (Ekblad, 2009; Kishore, 2015), and empathy (Anderson et al., 2007; Tipsord, 2009). According to research, practicing mindfulness encourages people to help those in need and deepens their understanding of other people's suffering. It aids in the control of emotions. There is evidence that it may also increase self-compassion (Flook, Goldberg, Pinger, Bonus & Davidson, 2013). According to certain studies (Feldman et al., 2011; Keye & Pidgeon, 2013), mindfulness also aids in lowering emotional reactivity and enhances resilience.

In a recent study, a limited assessment of the Open Mind-Korea program involving preschool children (n=83) revealed that participants in the program exhibited enhanced emotion regulation, increased resilience, and demonstrated more prosocial behavior compared to their counterparts undergoing the standard curriculum, as reported by Kim et al. (2020) improved social emotional competence and behavioral regulation (Schonert-Reichl & Lawlor, 2010), and emotional regulation (Kim et al., 2020). According to Berkovits et al. (2017), among preschoolers, improved emotion regulation abilities were linked to higher social skills and fewer behavioral issues, whereas increased emotionality was linked to worse social skills and more behavioral issues. The research findings support the present results that social skill training has

improved the emotion regulation among experimental groups. The better the interaction with others facilitates to have improved communication, understanding and better self -regulation and fewer behavioral problems, as an indicator of better mental health. The results supported the findings of Martel et al., (2012), Mitchison et al. (2020) that they found a strong relationship with emotional dysregulation and externalizing behavioral problems. Mindfulness training helps in understanding emotional awareness, and emotional regulation skills and it will help the children to reduce emotional instability and adapt emotion regulation.

Parental training and social skill training has played an effective role in the regulation of emotional problems among intervention groups. The findings supported by Goertz-Dorten et al. (2019) that group based social skill training and cognitive behavior therapy in aggressive conduct has found significant decrease in behavioral problems, like rule breaking behavior and improvement in socially competent behavior. A moderate effect size change has been found in a treatment group of children with behavioral problems (Kazdin et al.,1989). Parent management training and social skill training has been found effective among children with antisocial behavior, and reduction in parental stress and depression (Kazdin & Wassell,2000).

The emotional expression of parents was also related to the development of behavioral problems among children. Peris & Barker (2000) states that parental negative emotional expression has a specific role for the occurrence of deviated forms of behavior. The present study focused on parent management with specification to understand the child and effective ways of interaction with the child both verbally and non-verbally. The results indicated that emotional regulation was found effective among intervention groups. Goertz- Dorten et al. (2019) has found similar results that parental negative expressed emotion was specifically reduced aggressive behavior

among children, indicating a potential positive impact on mental health outcomes. One of the elements through which the positive health effects of mindfulness meditation are believed to manifest is emotion regulation, as highlighted by Hölzel et al. (2011) and Malinowski (2013). In this context, the current study indirectly supports the notion that mindfulness meditation may enhance emotion awareness and regulation by improving the allocation of attentional resources and monitoring one's present-moment emotional experiences. According to this hypothesis, children participating in the mindfulness meditation training may develop a heightened ability to observe and accept emerging emotions, thereby reducing the likelihood of overreacting or avoiding them. However, while this explanation could elucidate the positive effects of Mindfulness-Oriented Meditation (MOM) training on children's internalizing and emotional issues, it may not fully account for the similar effects observed in the control group. But, Haydicky et al. (2017) supports the findings of the present results that mindfulness training enhances self-awareness and self-regulation which contributed to increased empathy, improved communications, and reductions in the intensity and duration of conflicts. Children with behavioral problems, also trained to have present-focused awareness which in turn contributes to improved self-monitoring and self-regulation of behavior and emotion.

Based on the findings of the study, the stated hypothesis is accepted that there found significant improvement in the emotion regulation among experimental group than the control group.

The current chapter investigates the findings and discussion of the research, highlighting the efficacy of a multidimensional program in mitigating behavioral issues among children and fostering overall well-being. Participants in the study included both parents and children. Numerous studies support the effectiveness of training programs in addressing behavioral problems. Given the COVID-19 protocols, the training was

conducted online. Meininger et al. (2022) suggest that online cognitive behavior intervention, such as teletherapy, was effective and well-received by children, adolescents, and their families during the pandemic. The prolonged social isolation caused by the pandemic, with children attending online classes and limited contact with peers, contributed to internalizing and externalizing problems, leading to poor mental health (Ng & Ng, 2022). The researcher initiated the intervention at a crucial time, as the conditions exacerbated feelings of social isolation and frustration, potentially resulting in heightened behavioral problems among children. The online nature of the sessions was facilitated by the availability and cooperation of parents, who were also coping with the challenges of the pandemic.

The results underline the program's effectiveness, possibly attributed to the children's sense of loneliness and lack of social interaction during the pandemic. The timely intervention provided a support system, enabling participants to connect with others, acquire new skills, and manifest notable improvements in both behavioral problems and mental health. The training served as a valuable resource for children experiencing the repercussions of social restrictions, offering them a means to cope and positively impact their overall well-being and mental health among the study group.

Chapter Summary

The present chapter deals with the analysis done in two phases. In the first phase (the pilot study), there was two sections and the section A focuses on the descriptive analysis to find the occurrence of the behavioral problem among participants. It was found that behavioral problems were more frequent among the group which rationale to the main study. The second section of phase I deals with the trial study which was analyzed with case summary of each participant. The response of participants for the occurrence of behavioral problem and the effect of intervention were also analyzed and

discussed. In the second phase of the study, the effect of a multidimensional intervention program was analyzed with independent sample t-test, and ANCOVA. The results of the effectiveness of intervention were discussed in different sections.

This chapter contains the resume of the study, method, major findings, tenability of the hypothesis, implications of the study, limitations and suggestions for future research.

Resume of The Study

The well-being and development of the young generation are paramount for a nation's future prosperity. The family and societal environment plays a crucial role in shaping children's potential, emphasizing the importance of societal responsibility, especially during adolescence. The evolution from viewing children as "miniature adults" to the "child study movement" highlights an understanding of distinct stages in their development. Diverse laws and policies influence the concept of childhood, with India defining a child as under 18 years. Childhood involves significant physical and mental changes, fostering self-awareness and interpersonal comprehension. Today's children exhibit heightened environmental adaptability, influenced by early educational experiences that impact psychological and cognitive abilities. Parenting, societal factors, and the environment collectively shape children's behavior, making early recognition and intervention for behavioral issues crucial for mental health. The overarching goal is to ensure children's well-being during this critical developmental stage, contributing to their future mental health and societal impact (David,2013). The key aspects in the mental development of children are the transition from normal behaviour to behavioral problems. Various contributing factors influence the emergence of these behavioral issues, prompting the implementation of diverse intervention strategies. In this particular study, the focus is on specific facets of mental health, namely family interaction, social competence, and emotion dysregulation. Additionally, the research incorporates a multimodal intervention program encompassing parental management, social skill training, and mindfulness training. The

aim is to enhance mental health and effectively reduce behavioral problems in children. The mental health among children is influenced by factors like family interaction, social competence, and emotion regulation. Family is the chief motivational factor to influence the personality of an individual. Healthy relationships in the family make a child well-adjusted and accepted. A healthy family climate may be helpful in making the best use of, even with the limited potentialities of teenagers.

Social competence entails the ability to focus social relations effectively, demonstrating adeptness in adhering to social norms and fostering healthy relationships. Emotional regulation involves adapting to emotional variations in a flexible manner. When children exhibit behavioral deviations in these aspects, intervention programs become essential to reduce severity and prevent further occurrence of problematic behavior, given its significant influence on children's mental health. Mental health in children is intricately connected to family, social, and emotional interactions, evolving over various developmental periods. The present study posits that family interaction, alongside social and emotional factors, plays a crucial role in a child's mental health. Consequently, the incorporation of parental training, social skill training, and mindfulness training has proven effective in addressing behavioral problems among children. This study anticipates contributing to a heightened awareness of mental health in young individuals, emphasizing the importance of multidimensional training programs for fostering better mental well-being. The present study has been entitled as' ' **EFFECTIVENESS OF MULTIDIMENSIONAL PROGRAM ON MENTAL HEALTH AMONG CHILDREN WITH BEHAVIORAL PROBLEM".**

The Major Objectives of The Study Were:

1. To examine whether there was any difference in behavioral problems among children who were undergone intervention and children who were not undergone intervention.
2. To evaluate the changes in family interaction, social competence, emotion dysregulation among children who underwent intervention and children who were not undergone intervention.

Method

Participants

The present study was conducted in two phases. Phase I comprises two sections: Section A investigates the frequency of behavioral problems among participants, while Section B examines the trial study on an intervention program for children with behavioral issues. In the initial pilot phase, a total of 228 school-going children were selected for the study. Among the participants were boys and girls aged between 11 and 16 years. They were selected randomly from six schools in Thrissur district. The second section of the pilot phase was the trial study session, which aimed to find out the utility of behavioral problems checklist, and also to find out the effectiveness of the intervention module. Six participants were selected based on the criteria met with the DPCL checklist. During the second and final phase of the study, the multidimensional intervention phase, a total of 24 participants were selected, and among them 12 participants were randomly allotted to the experimental group and another 12 participants were allotted to the control group. Among the participants, nine participants were boys, three participants were girls in both experimental and control groups, with the age of 13-15 years. After getting consent from school authorities, parents, and from participants, were given a brief description about the study and assurance were given regarding the confidentiality of the study. Only questionnaire measures were used in

the study, and all the questionnaires were given both through google form and social media platform. Both parental and children's participation is assured in the process of data collection and intervention process. Online training sessions were adopted for the main study.

Measures

Phase I

1. Socio demographic data, and
2. Youth self-report – (YSR, Achenbach,1991) for section A
3. Developmental Psychopathological Checklist (DPCL, Kapur et al., 1995))- for Section B

Phase II

1. Personal data sheet
2. Developmental pathological checklist - DPCL (Kapur et al.,1995)
3. Family interaction scale (Asha,1987)
4. Social Competence scale (Devassy & Raj, 2012)
5. Difficulties in Emotion regulation scale (Gratz & Roemer, 2004)

Statistical Analysis

The statistical analysis was carried out using the statistical software SPSS, 23. Microsoft Word and Microsoft Excel were used to generate tables. The obtained data were analyzed by using both parametric and non-parametric statistical techniques.

- Normality of data
- Mc Nemar's Chi- square test
- Descriptive statistics like frequency, percentage, mean, SD for normally distributed variables, and median, QD for non-normally distributed variables.

- Inferential statistics like independent sample t test for normally distributed variables, and Mann Whitney U, and Univariate ANCOVA test for non-normally distributed variables,

Major Findings

Major Findings of Phase I: The Pilot Study

- The behavioral problems like, externalized, internalized, and other problems were reported among school going children.
- Among the behavioral problems, externalized behavioral issues were more frequent than the internalized or other problem behavior among school children.
- The trial study was conducted among six school children, among them five boys and one girl participated in the study.
- Among the behavioral problems, the most reported issues are disobedience, quarrelsome, aggression, temper tantrums, and disruptive behavior and the least reported behavior are truancy, lying and stealing.
- After the intervention period, the behavior like disobedience, stubbornness, disruptive, quarrelsome, and truancy behavior has reduced among children.
- The training program has been found to be effective for reducing behavioral issues like lying and stealing but the difference found not significant.
- For behavior like aggression and temper tantrums, they are found less effective among children with behavioral problems, so they need more elaborate intervention to reduce this behavior.

Major Findings of Phase II

- The experimental group shows a notable decrease in obedience after the intervention. In the experimental group, nine participants reported disobedience

most of the time, and all of them reported minimum or no behavioral problems after the intervention program.

- The score of stubbornness has reduced significantly after the intervention among experimental groups. Among the experimental group, 11 participants reported stubborn behavior most of the time, but after the intervention it was noted that seven reported minimum or no behavioral problem.
- The disruptive behavior problem scores reduced significantly among children who were undergone intervention. In the experimental group, eight participants reported disruptive behavior most of the time, and the post intervention results indicate that six participants exhibited minimal or no such behavioral problem and two were persistent after the intervention.
- The experimental group shows a prominent significant difference in the behavioral issues like quarrelsome, aggression, and temper tantrums after the intervention. All the participants reported such behavior in pre intervention has reduced to minimal or no behavioral exhibition after the intervention, which signifies the efficacy of intervention.
- No statistically significant differences were observed in the scores related to lying, stealing, and truancy among children with behavioral problems, even following the completion of the training program.
- There is a significant difference in most of the behavioral problems, like disobedience, stubbornness, quarrelsome, disruptive, aggression, and temper tantrums between experimental and control groups after intervention.
- The results suggest that the intervention program has enhanced family interaction, including its dimensions (family achievement, family intelligence orientation, family conflict, family social orientation, family ethical concerns,

and family discipline) in children with behavioral problems in the experimental groups as opposed to the control group.

- The emotional dysregulation, and its dimensions (lack of emotional awareness, lack of emotional clarity, difficulties in controlling impulsive behavior when distressed, difficulties in engaging goal directed behavior when distressed, non-acceptance of negative emotional response, limited access to emotional regulation strategies) among children with behavioral problem has reduced significantly among experimental group, when compared with control group.
- The results indicates that the intervention program improved the social competence, with its dimensions (school competence, team organization, peer social competence, social cognition, home related competence, social forethought and compassion, social emotional competence, social flexibility) among children with behavioral problems of experimental group, compared to control group.
- Overall, the intervention program has found significant effectiveness for improving the mental health among children with behavioral problems.

Tenability of Hypotheses

Hypothesis 1 & 2

There is significant difference in pretest and post-test of behavior problems among children of intervention group and non-intervention group.

The results showed that there were significant differences in pretest scores of behavioral problems like, disobedience, temper tantrums, stubbornness, aggression, quarrelsome, disruptive behavior, lying and stealing, and truancy between experimental and control group, hence the stated hypothesis is accepted for the respective behavior.

While the behavior like truancy, lying and stealing have found no significant difference between the groups after the intervention, hence the stated hypothesis is rejected on this behavior.

Hypothesis 3

There is significant difference in family interaction and its dimensions in pretest among children of intervention group and non-intervention group.

The pretest analysis indicates that the dimensions of family interaction is found similar for family independence, family cohesion, family achievement orientation, family intellectual orientation, family ethical complaints, and overall family interaction, hence the stated hypothesis is rejected for these dimensions.

While the dimensions like family conflict, family social orientation, and family discipline are found significant difference between the group, hence hypothesis accepted for these dimensions.

Hypothesis 4-4.8

There is significant difference in family interaction and its dimensions in post-test among children of intervention group and non-intervention group.

The post test results indicate a significant difference in family interaction and its dimensions among experimental groups than control groups. Family independence, family cohesion, family achievement orientation, family intelligence orientation, family social orientation, family ethical complaints, and family discipline have improved, and family conflict among members reduced after the intervention program among experimental groups.

Hypothesis is accepted.

Hypothesis 5

There is significant difference in social competence and its dimensions in pretest among children of intervention group and non-intervention group.

The results showed that the dimensions of social competence like social forethought and compassion, social emotional competence are found significant difference, hence the hypothesis is accepted for these variables.

Although the dimensions of school competence, team organization, peer social competence, social cognition, social flexibility, home related competence, and over all social competence scores are found similar, hereafter the hypothesis is rejected for these variables.

Hypothesis 6-6.8

There is significant difference in social competence and its dimensions in post-test among children of intervention group and non-intervention group.

The results showed that there was significant difference in all the dimensions of social competence among experimental groups. The school competence, team organization, peer social competence, social cognition, home related competence, social forethought and compassion, social emotional competence. Social flexibility, and total social competence has improved among children who have undergone intervention programs.

Hypothesis is accepted.

Hypothesis 7

There is significant difference in difficulty in emotion regulation and its dimensions in pretest among children of intervention group and non-intervention group.

The results showed that the factors of difficulty in emotion regulation like lack of emotional awareness and limited access to emotional regulation strategies are found

similar between experimental and control groups, hence the hypothesis is rejected for these variables.

The emotion regulation variables like lack of emotional clarity, difficulties in controlling impulsive behavior when distressed, difficulties in engaging goal directed behavior when distressed, non-acceptance of negative emotional response, and total difficulty in emotion regulation are found difference, therefore the hypothesis is accepted for these variables.

Hypothesis 8-8.6

There is a significant difference in difficulty in emotion regulation with its sub dimensions in post-test among children of intervention group and non-intervention group.

The results showed a significant post-test difference in difficulty in emotion regulation with all its dimensions among experimental groups. There was significant improvement in the factors like emotional awareness, emotional clarity, controlling impulsive behavior when distressed, engaging goal directed behavior when distressed, acceptance of negative emotional response, access to emotional regulation strategies, and overall emotion regulation among experimental groups who were provided intervention programs.

The hypothesis is accepted.

Conclusion

The researcher acknowledges the limitations of the current study and hopes that the findings can prove beneficial to society, particularly for schools and parents. Identifying behavioral problems at early stages and employing multidimensional strategies among children may aid in managing and reducing these issues. This, in turn,

has the potential to enhance children's mental health and act as a preventive measure against the occurrence of more severe behavioral problems in the future.

Chapter Summary

In this chapter, the study's findings are synthesized and conclusions drawn. Firstly, an overview of the study's objectives and methodology is provided, offering a comprehensive understanding of the research process. Secondly, the key findings and results are summarized, providing insight into the main outcomes of the study. Thirdly, study's findings are discussed, focusing light on their significance and potential impact in relevant fields. Finally, the tenability of the hypotheses proposed at the outset of the research is evaluated based on the empirical evidence gathered

Recommendations

Based on the results of the study, several recommendations can be made to address the compromised mental health of children with behavioral problems. Firstly, integrated family intervention programs should be developed and implemented to target both parents and children, focusing on improving family dynamics, communication skills, problem-solving abilities, and emotional support. Additionally, parent management training should be provided to equip parents with effective strategies for managing their child's behavior and fostering positive parent-child interactions. The understanding of family interaction was found as an important skill between parents and children. When such intimacy or interaction develops there could develop a mutual understanding, low conflicts and disputes within family members. Because children learn such skills and behavior from the family itself. Social skills training should also be offered to enhance social interactions and relationship-building skills for both parents and children. Mindfulness training can be integrated into intervention programs to help develop emotional awareness, self-regulation skills, and stress management techniques. It's crucial to advocate for comprehensive intervention programs within school settings, collaborating with educators to integrate these programs into the curriculum or as supplementary support services. Encouraging and interacting efforts between parents, teachers, and students can further support the mental health and well-being of children with behavioral problems. Providing long-term support and follow-up services, as well as continuing research and evaluation, are essential for sustaining positive changes and improving intervention practices over time. By implementing these recommendations, parents, teachers, and researchers can create supportive environments conducive to positive development and promote the overall mental health of children with behavioral problems

Implications of The Study

The primary aim of the current research was to examine the mental health factors associated with behavioral problems in children and evaluate the effectiveness of various intervention programs in reducing these problems and enhancing mental well-being. While existing literature has examined different intervention strategies for addressing behavioral problems in children, this research uniquely concentrated on the mental health aspects of children with behavioral problems. The study sought to analyze the impact of parental management, social skill training, and mindfulness training on key variables, including family interaction, emotion regulation, and social competence. This research represents the inaugural effort to comprehensively examine the integrated effects of these variables on behavioral problems.

The early adolescent stage is characterized by rapid physical and psychological changes, with behavioral, emotional, and social transformations playing a key role in mental health development. Early identification of behavioral problems among children is crucial, necessitating timely intervention strategies. Several implications arise from the present study, including the observation that behavioral problems are more common among boys, and family characteristics such as parental alcoholism and issues like separated or divorced parents can adversely impact the development of problem behavior in children. So, it is necessary to screen for early diagnosis of behavioral problems, hence the severity and intensity of the symptoms may be reduced.

This study focuses on the factors contributing to the compromised mental health of children with behavioral problems. The family unit is regarded as the primary arena where individuals engage in interactions, communication, problem resolution, and the provision of care and support. The breakdown of these essential functions within a family adversely impacts the mental health of children. Effective emotional and social

competencies are crucial for fostering improved mental health among children. The study emphasizes these factors and advocates for a triarchic approach, emphasizing the interconnected processes of family dynamics, emotional well-being, and social relations as key elements influencing the mental health of children with behavioral problems.

Numerous intervention studies have been conducted to address behavioral issues in children. This current study concentrates on comprehensive programs targeting both parents and children, encompassing parent management, social skill training, and mindfulness training. The findings suggest the applicability of these programs within school settings, as many behavioral issues manifest during the school-age years. Through collaborative efforts involving parent-teacher-student interactions, the study implies that these programs contribute to the overall maintenance of a child's mental functioning.

Suggestions and Limitations of Research

- The current study exclusively drew samples from a single geographical area, and restricted number of participants, potentially limiting the generalizability of the results. Future studies could enhance reliability by including more diverse and inclusive samples.
- The use of various programs for both parents and children presented a challenge in determining the specific impact of each training program on children's mental health. To establish the distinct impacts of each program, future studies could consider incorporating two or more experimental groups.
- Better mental health promoting strategies could be applied at the primary level students itself, so such behavioral problems could be addressed at the earliest.

- Due to the limitations of the online training program, due to the COVID 19 pandemic condition, only a small group of children could participate, raising concerns about the generalizability of the findings. While online platforms were effective for different intervention programs, face-to-face offline training sessions were noted to provide a more interactive environment for participants and researchers to explore issues and solutions.
- In terms of mental health, the study primarily focused on the interactive role of family, emotion, and social aspects, neglecting various psychological factors that contribute to mental health and behavioral problems among children. Future studies could broaden their scope by considering different perspectives on mental health.
- The present study relied on self-reported questionnaires, potentially introducing subjective bias in responses. Future research may consider incorporating a variety of assessment methods to enhance the objectivity of data collection.

Chapter Summary

The chapter concludes by highlighting the recommendations drawn from the study's findings, and discussing on their potential implications. It also addresses the limitations encountered during the research process, which provide valuable insights into the study's scope and boundaries. Furthermore, the chapter offers suggestions for future research activities, identifying areas where further investigation could enhance understanding and address any gaps in knowledge.

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Appendix A

Personal data sheet

വ്യക്തി വിവരപ്പട്ടിക

Please tick (✓) or fill in the appropriate response where indicated. Kindly respond to all questions.

താഴെ കൊടുത്തിരിക്കുന്ന പ്രസ്താവനകൾ പൂരിപ്പിക്കുകയോ ശരിയടയാളം (✓) രേഖപ്പെടുത്തുകയോ ചെയ്യുക. ദയവായി എല്ലാ ചോദ്യങ്ങൾക്കും ഉത്തരം നൽകുക.

---

1. Name (not compulsory) :
   പേര് (നിർബന്ധമില്ല)

2. Age :
   വയസ്സ്

3. Gender : Boy/Girl
   ലിംഗം : ആൺ/പെൺ

4. Place of residence : Rural/Urban
   വാസസ്ഥലം : ഗ്രാമം/നഗരം

5. Religion : Hindu/Muslim/Christain :
   മതം : ഹിന്ദു /മുസ്ലിം/ ക്രിസ്ത്യൻ

6. Curriculam :School State CBSE ICSE
   പാഠ്യ പദ്ധതി : വിദ്യാലയം : സർക്കാർ: സി.ബി.എസ്.ഇ ഐ.സി.എസ്.ഇ

   - Govt. Aided Un-aided
     ഗവണ്മെന്റ് , എയ്ഡഡ്, അൺ എയ്ഡഡ്

   - Mixed School Boys only Girls only
     മിശ്ര വിദ്യാലയം ആൺകുട്ടികൾമാത്രം, പെൺകുട്ടികൾമാത്രം

7. Total marks obtained in the last annual exam:
   കഴിഞ്ഞ വർഷം പരീക്ഷക്കു ലഭിച്ച മൊത്തം മാർക്ക്:

8. Do you have close friends: : Yes/No; If Yes how many?
   നിങ്ങൾക്ക് ആത്മാർത്ഥ സുഹൃത്തുക്കൾ ഉണ്ടോ? : ഉണ്ട്/ഇല്ല: ഉണ്ടെങ്കിൽ എത്രപേർ?

9. Do you engage in extracurricular activities : Yes/No: If yes, Arts/ Sports/Any other (mention)
   പാഠ്യേതര പ്രവർത്തനങ്ങളിൽ പങ്കെടുത്തിട്ടുണ്ടോ: ഉണ്ട്/ഇല്ല: ഉണ്ടെങ്കിൽ കല/ കായികം/മറ്റിനങ്ങൾ (സൂചിപ്പിക്കുക)

10. Your hobbies :
    ഇഷ്ട വിനോദങ്ങൾ

11. Parents : Both parents/ Single parent/ Stepparents
    മാതാപിതാക്കൾ : അച്ഛനും അമ്മയും/ അമ്മ മാത്രം/അച്ഛൻ മാത്രം/ രണ്ടാനച്ഛൻ/ രണ്ടാനമ്മ

12. Are you staying with your parents? : Yes/No; if no, where do you stay?
    മാതാപിതാക്കളോടൊപ്പമാണോ താമസിക്കുന്നത്?: ആണ്/ അല്ല. അല്ലെങ്കിൽ എവിടെ യാണ് താമസം?

13. Type of family : Nuclear family/ Joint family
    കുടുംബം : അണു കുടുംബം/ കൂട്ടു കുടുംബം

14. Parents working : Both/Father only/Mother only
    ജോലി ചെയ്യുന്ന മാതാപിതാക്കൾ : രണ്ടു പേരും / പിതാവ് മാത്രം/ മാതാവ് മാത്രം

15. Occupation : Father - Mother-
    ജോലി : അച്ഛൻ അമ്മ

16. Annual family Income : Below one Lakh / 1-2 Lakh/ Above 3 Lakh
    കുടുംബത്തിന്റെ വാർഷിക വരുമാനം : ഒരു ലക്ഷത്തിൽ കുറവ്/ 1-2 ലക്ഷം/ 2-3 ലക്ഷം/ 3 ലക്ഷത്തിൽ കൂടുതൽ

17. Your Birth Order : Single Child/ First born/Second born/ Middle born/ Last born
    ജനനക്രമം: ഒറ്റകുട്ടി/ആദ്യകുട്ടി/രണ്ടാമത്തെകുട്ടി/മൂന്നാമത്തെ കുട്ടി/ അവസാനത്തെ കുട്ടി

18. Number of siblings : Brother : Sister :
    സഹോദരങ്ങളുടെ എണ്ണം : സഹോദരൻ : സഹോദരി :

19. Do you believe in God? : Yes/No
    ദൈവവിശ്വാസിയാണോ : ആണ്/ അല്ല

20. Do you Visit religious places? : Yes/No ; If Yes: Daily/ Weekends/ Rarely
    ആരാധനാലയങ്ങൾ സന്ദർശിക്കാറുണ്ടോ? : ഉവ്വ്/ഇല്ല/ദിവസവും/ ആഴ്ചയിൽ/വല്ലപ്പോഴും

Appendix B
Achenbach 1991

YOUTH SELF-REPORT FOR AGES 11–18

For office use only
ID #

Please Print

YOUR FULL NAME — FIRST — MIDDLE — LAST

YOUR SEX ☐ Boy ☐ Girl | YOUR AGE | ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Date ____ Yr. ____ | YOUR BIRTHDATE Mo. ____ Date ____ Yr. ____

GRADE IN SCHOOL ____

NOT ATTENDING SCHOOL ☐

IF YOU ARE WORKING, PLEASE STATE YOUR TYPE OF WORK:

PARENTS' USUAL TYPE OF WORK, even if not working now *(Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK: ____

MOTHER'S TYPE OF WORK ____

Please fill out this form to reflect *your* views, even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on pages 2 and 4.

I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of your age, about how much time do you spend in each?			Compared to others of your age, how well do you do each one?		
	Less Than Average	Average	More Than Average	Below Average	Average	Above Average
a. ____	☐	☐	☐	☐	☐	☐
b. ____	☐	☐	☐	☐	☐	☐
c. ____	☐	☐	☐	☐	☐	☐

II. **Please list your favorite hobbies, activities, and games, other than sports.** For example: cards, books, piano, cars, crafts, etc. (Do ***not*** include listening to radio or TV.)

☐ None

	Compared to others of your age, about how much time do you spend in each?			Compared to others of your age, how well do you do each one?		
	Less Than Average	Average	More Than Average	Below Average	Average	Above Average
a. ____	☐	☐	☐	☐	☐	☐
b. ____	☐	☐	☐	☐	☐	☐
c. ____	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams or groups you belong to.

☐ None

	Compared to others of your age, how active are you in each?		
	Less Active	Average	More Active
a. ____	☐	☐	☐
b. ____	☐	☐	☐
c. ____	☐	☐	☐

IV. **Please list any jobs or chores you have.** For example: paper route, babysitting, making bed, working in store, etc. (Include ***both*** paid and unpaid jobs and chores.)

☐ None

	Compared to others of your age, how well do you carry them out?		
	Below Average	Average	Above Average
a. ____	☐	☐	☐
b. ____	☐	☐	☐
c. ____	☐	☐	☐

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4-95 Edition

Please Print

V. 1. About how many close friends do you have? (Do *not* include brothers & sisters) ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week do you do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐ less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of your age, how well do you:

	Worse	About the same	Better	
a. Get along with your brothers & sisters?	☐	☐	☐	☐ I have no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Get along with your parents?	☐	☐	☐	
d. Do things by yourself?	☐	☐	☐	

VII. Performance in academic subjects. ☐ I do not attend school because __________

Check a box for each subject that you take

	Failing	Below Average	Average	Above Average
a. English or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. ________	☐	☐	☐	☐
f. ________	☐	☐	☐	☐
g. ________	☐	☐	☐	☐

Other academic subjects – for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., etc.

Do you have any illness, disability, or handicap? ☐ No ☐ Yes—please describe:

Please describe any concerns or problems you have about school:

Please describe any other concerns you have:

Please describe the best things about yourself:

PAGE 2

Below is a list of items that describe kids. For each item that describes you ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of you. Circle the ***1*** if the item is ***somewhat or sometimes true*** of you. If the item is ***not true*** of you, circle the ***0***.

Please Print **0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True**

0 1 2 1. I act too young for my age
0 1 2 2. I have an allergy (describe): ______
0 1 2 3. I argue a lot
0 1 2 4. I have asthma
0 1 2 5. I act like the opposite sex
0 1 2 6. I like animals
0 1 2 7. I brag
0 1 2 8. I have trouble concentrating or paying attention
0 1 2 9. I can't get my mind off certain thoughts (describe): ______
0 1 2 10. I have trouble sitting still
0 1 2 11. I'm too dependent on adults
0 1 2 12. I feel lonely
0 1 2 13. I feel confused or in a fog
0 1 2 14. I cry a lot
0 1 2 15. I am pretty honest
0 1 2 16. I am mean to others
0 1 2 17. I daydream a lot
0 1 2 18. I deliberately try to hurt or kill myself
0 1 2 19. I try to get a lot of attention
0 1 2 20. I destroy my own things
0 1 2 21. I destroy things belonging to others
0 1 2 22. I disobey my parents
0 1 2 23. I disobey at school
0 1 2 24. I don't eat as well as I should
0 1 2 25. I don't get along with other kids
0 1 2 26. I don't feel guilty after doing something I shouldn't
0 1 2 27. I am jealous of others
0 1 2 28. I am willing to help others when they need help
0 1 2 29. I am afraid of certain animals, situations, or places, other than school (describe): ______
0 1 2 30. I am afraid of going to school
0 1 2 31. I am afraid I might think or do something bad
0 1 2 32. I feel that I have to be perfect
0 1 2 33. I feel that no one loves me
0 1 2 34. I feel that others are out to get me
0 1 2 35. I feel worthless or inferior
0 1 2 36. I accidentally get hurt a lot
0 1 2 37. I get in many fights
0 1 2 38. I get teased a lot
0 1 2 39. I hang around with kids who get in trouble
0 1 2 40. I hear sounds or voices that other people think aren't there (describe): ______
0 1 2 41. I act without stopping to think
0 1 2 42. I would rather be alone than with others
0 1 2 43. I lie or cheat
0 1 2 44. I bite my fingernails
0 1 2 45. I am nervous or tense
0 1 2 46. Parts of my body twitch or make nervous movements (describe): ______
0 1 2 47. I have nightmares
0 1 2 48. I am not liked by other kids
0 1 2 49. I can do certain things better than most kids
0 1 2 50. I am too fearful or anxious
0 1 2 51. I feel dizzy
0 1 2 52. I feel too guilty
0 1 2 53. I eat too much
0 1 2 54. I feel overtired
0 1 2 55. I am overweight

56. Physical problems ***without known medical cause:***

0 1 2 a. Aches or pains (*not* stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feel sick
0 1 2 d. Problems with eyes (*not* if corrected by glasses) (describe): ______
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): ______

0 1 2 57. I physically attack people
0 1 2 58. I pick my skin or other parts of my body (describe): ______
0 1 2 59. I can be pretty friendly
0 1 2 60. I like to try new things
0 1 2 61. My school work is poor
0 1 2 62. I am poorly coordinated or clumsy
0 1 2 63. I would rather be with older kids than with kids my own age

PAGE 3

Please see other side

0 = Not True   1 = Somewhat or Sometimes True   2 = Very True or Often True

0 1 2 64. I would rather be with younger kids than with kids my own age
0 1 2 65. I refuse to talk
0 1 2 66. I repeat certain acts over and over (describe): ____________

____

____

0 1 2 67. I run away from home
0 1 2 68. I scream a lot
0 1 2 69. I am secretive or keep things to myself
0 1 2 70. I see things that other people think aren't there (describe): ____________

____

____

0 1 2 71. I am self-conscious or easily embarrassed
0 1 2 72. I set fires
0 1 2 73. I can work well with my hands
0 1 2 74. I show off or clown
0 1 2 75. I am shy
0 1 2 76. I sleep less than most kids
0 1 2 77. I sleep more than most kids during day and/or night (describe): ____________

____

____

0 1 2 78. I have a good imagination
0 1 2 79. I have a speech problem (describe): ____________

____

____

____

0 1 2 80. I stand up for my rights
0 1 2 81. I steal at home
0 1 2 82. I steal from places other than home

0 1 2 83. I store up things I don't need (describe):

____

____

0 1 2 84. I do things other people think are strange (describe): ____________

____

____

0 1 2 85. I have thoughts that other people would think are strange (describe): ____________

____

____

____

0 1 2 86. I am stubborn
0 1 2 87. My moods or feelings change suddenly
0 1 2 88. I enjoy being with other people
0 1 2 89. I am suspicious
0 1 2 90. I swear or use dirty language
0 1 2 91. I think about killing myself
0 1 2 92. I like to make others laugh
0 1 2 93. I talk too much
0 1 2 94. I tease others a lot
0 1 2 95. I have a hot temper
0 1 2 96. I think about sex too much
0 1 2 97. I threaten to hurt people
0 1 2 98. I like to help others
0 1 2 99. I am too concerned about being neat or clean
0 1 2 100. I have trouble sleeping (describe): ____________

____

____

0 1 2 101. I cut classes or skip school
0 1 2 102. I don't have much energy
0 1 2 103. I am unhappy, sad, or depressed
0 1 2 104. I am louder than other kids
0 1 2 105. I use alcohol or drugs for nonmedical purposes (describe): ____________

____

____

____

0 1 2 106. I try to be fair to others
0 1 2 107. I enjoy a good joke
0 1 2 108. I like to take life easy
0 1 2 109. I try to help other people when I can
0 1 2 110. I wish I were of the opposite sex
0 1 2 111. I keep from getting involved with others
0 1 2 112. I worry a lot

Please write down anything else that describes your feelings, behavior, or interests

____

PAGE 4   *PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS*

Appendix C

SCREENING TEST FOR TRAINING PROGRAM

Thank you for your registration for behavioral training program. For the training program we need a screening assessment of children for setting the goal of training session. parents please go through the questions and ensure your response.
Thank you .

താഴെ കൊടുത്തിരിക്കുന്നവയിൽ 6 - 12 മാസക്കാലമായി നിങ്ങളുടെ കുട്ടിയിൽ കാണപ്പെട്ട /കാണപ്പെടുന്ന ലക്ഷണങ്ങൾ അടയാളപ്പെടുത്തുക .

1. പലപ്പോഴും കോപം വരിക
2. നിസ്സാര കാര്യങ്ങൾക്ക് പോലും പെട്ടെന്ന് ദേഷ്യം വരിക
3. മുതിർന്നവരുമായി വാക്ക് തർക്കങ്ങളിൽ ഏ്വർപ്പെടുക
4. മുതിർന്നവർ പറയുന്നതു അനുസരിക്കാതിരിക്കുക
5. സ്വന്തം തെറ്റുകൾ മറ്റുള്ളവരിൽ ആരോപിക്കുക
6. പ്രതികാര മനോഭാവത്തോടുകൂടി പെരുമാറുക
7. ശാരീരികമായി മറ്റുള്ളവരെ ഉപദ്രവിക്കുക(മ്രഗങ്ങൾ,മനുഷ്യർ)
8. വീട്ടിലെ വസ്തുക്കൾ മനപൂർവം നശിപ്പികുക
9. നുണ പറയുക
10. ദേഷ്യം വന്നാൽ വീട് വിട്ടു പോകുക
11. നിയമങ്ങൾ അനുസരിക്കാതിരിക്കുക
12. മോഷ്ടിക്കുക
13. പഠനത്തിൽ തൽപര്യമില്ലാതിരിക്കുക
14. സഹാനുഭൂതി ഇല്ലാതിരിക്കുക
15. ചെയ്ത തെറ്റിന് കുറ്റബോധം തോന്നതിരിക്കുക

Appendix D

Personal data sheet

Please tick (   ) or fill in the appropriate responses where indicated. Kindly respond to all questions.

Name (optional):

Age:

Gender: Boy/ Girl

Place of residence: Rural / Urban

School:

Do you have: Both parents/ single parent/ stepparent

Are you staying with your parents? Yes/ No; if NO, where do you stay?

Type of family: Nuclear family/ Extended family/ Joint family

Parents working: Both / father only/ mother only

Annual family income: below one lakh/ 1-2 lakh/ 2-3 lakh/ above 3 lakhs

Appendix

Number of siblings:

Appendix E

സമ്മതപത്രം

ഞാൻ വന്ദന വി എസ് , എന്റെ പി എച്ച് ഡി പ്രബന്ധത്തിന്റെ പഠനത്തിൽ പങ്കെടുകുവാൻ നിങ്ങളെ ക്ഷണിക്കുന്നു. കുട്ടികളുടെ പെരുമാറ്റ വൈകല്യത്തെ കുറിച്ചും അതിനെ കൈകാര്യം ചെയ്യുന്ന രീതിയെ കുറിച്ചുമാണ് എന്റെ ഗവേഷണം. ഇതിലേക്കായി പെരുമാറ്റ വൈകല്യമുള്ള കുട്ടികളും അവരുടെ മാതാപിതാക്കളും പങ്കെടുക്കേണ്ടതായുണ്ട്. താങ്കൾ ഈ ഗവേഷണത്തിന്റെ ഭാഗമാകാൻ സമ്മതികുന്ന പക്ഷം താങ്കളുടെ പ്രശ്നങ്ങൾ വിലയിരുത്തുകയും ആവശ്യമെന്ന് കണ്ടാൽ പരിശീലനം നല്കുകയും ചെയ്യും.

ഗവേഷണത്തിന്റെ ഭാഗമായി നിങ്ങൾ പറയുന്ന വിവരങ്ങൾ പഠന ആവശ്യത്തിന് മാത്രമേ ഉപയോഗിക്കൂ.നിങ്ങളെ കുറിച്ചുള്ള വിവരങ്ങൾ വിശ്വസ്തമായി സൂക്ഷികുന്നതായിരിക്കും . നിങ്ങളുടെ അനുമതി കൂടാതെ നിങ്ങളെ സംബന്ധിക്കുന്ന ഒരു വിവരവും പുറത്താക്കുന്നതല്ല . ഗവേഷണത്തിൽ നിന്നു ഏത് ഘട്ടത്തിൽ വേണമെങ്കിലും നിങ്ങൾക്ക് പിൻമാറുകയും ചെയ്യാം.

ഗവേഷണ പഠനവുമായി ബന്ധപ്പെട്ട കാര്യങ്ങൾ മനസ്സിലാക്കുകയും, ഇതിൽ പങ്കെടുകൻ പൂർണസമ്മതമാണെന്ന് അറിയിക്കുകയും ചെയ്യുന്നു.

തിയ്യതി

കുട്ടി (ഒപ്പ്)

മാതാപിതാക്കൾ (ഒപ്പ്)

ഗവേഷക (ഒപ്പ്)

Appendix F

Developmental psychopathological checklist for children (DPCL)

Dr (Mrs.) Malavika Kapur

Department of Clinical Psychology

NIMHANS, Bangalore

C. PSYCHOPATHOLOGY

The items below are marked as being present only when they occur often or most of the but not when they occur sometimes)

Does the child have the problems of:

29	Poor attention	0	1
30	Distractibility- (if the child is doing a task and someone enters the room, or he hears a sound does he easily get distracted by this)	0	1
31	Inability to sit in a place	0	1
32	Acting without thinking	0	1
33	Stubbornness	0	1
34	Disobedience	0	1
35	Often interrupting others games, talk, being disruptive while playing, or breaking /throwing things frequently	0	1
36	Quarrelsomeness and fighting	0	1
37	Aggression as seen by hitting, biting, and pinching others (with/without provocation)	0	1
38	Getting very angry, crying a lot, rolling on the ground and continuing to be so for a long time, when his/her demands are not met.	0	1
39	Going to school and coming back on time, but actually does not attend the school	0	1
40	Indulging in lying and cheating	0	1
41	Refusing to go to school and staying back home for a duration of weeks or months	0	1
42	Poor school performance	0	1
43	Reading difficulty	0	1
44	Difficulty in writing	0	1
45	Difficulty in arithmetic	0	1

46	Forgetfulness or poor memory	0	1
47	Day dreaming	0	1
48	Being very quiet and reserved (withdrawn)	0	1
49	Talking very little even with family members	0	1
50	Worrying	0	1
51	Anxiousness and nervousness	0	1
52	Shyness and timidity	0	1
53	Fearful of animals /people/situation	0	1
54	Clinging	0	1
55	Crying easily	0	1
56	Goes on doing a particular thing over and over again, such as washing hands, or repeatedly saying certain numbers, or expressing that certain thoughts come to his/her mind repeatedly to the extend that if interferes with his/ her daily activities	0	1
57	Complaining of dizziness or giddiness	0	1
58	Complaining of aches and pains	0	1
59	Complaining of appearing to be always tired	0	1
60	Complaining of stomach ache	0	1
61	Fainting spells	0	1
62	Attacks of jerky movements and unconsciousness (fits or convulsions to be differentiated from epilepsy by a clinician)	0	1
63	Complaining of pulling sensation of the limbs	0	1
64	Chronic physical illness (specify, if present)	0	1
65	Physical handicaps (specify, if present)	0	1
*66	Of hearing voices and seeing things when no one was around	0	1
67	Of maintaining postures, being stiff, over long periods of time (if present, describe)	0	1
68	Of saying that he/she was a great person, or a bad person, or that he/she was being harmed by other people without a real basis for such beliefs.	0	1
69	Of talking and laughing to self	0	1

70	Of very poor appetite, sometimes leading to loss of weights	0	1
71	Of poor sleep/disturbed sleep	0	1
72	Of wetting and soiling during illness and was unaware of it	0	1
73	Of loss of interest in play and daily activities	0	1
74	Of moving and responding unusually slowly	0	1
75	Of being depressed, sad and dull	0	1
76	Of talking much more or faster than he/she normally used to	0	1
77	Of being irritable	0	1
*78	Of being unusually cheerful and happy (others, if any)	0	1

(*the items 66 to 78 are to be marked as present even if it has occurred more than once in the past or present)

Appendix G

Appendix

FAMILY INTERACTION SCALE

C B Asha (1987)

നിർദ്ദേശങ്ങൾ:

കുടുംബത്തെ കുറിച്ചുള്ള ചില പ്രസ്താവനകളാണ് താഴെ കൊടുത്തിരിക്കുന്നത്. ഒരോപ്രസ്താവനയും നിങ്ങളുടെ കുടുംബത്തെ സംബധിച്ചിടത്തോളം എത്രമാത്രം ശരിയാണ്എന്നു അടയാളപ്പെടുത്തുക. “എല്ലായ്പ്പോളും ശരിയാണ്”, “മിക്കവാറും ശരിയാണ്”, “ഇടക്കൊക്കെ ശരിയാണ്”, “അപൂർവമായി ശരിയാണ്”, “ശരിയല്ല” എന്നിങ്ങനെയുള്ള അഞ്ച് ഉത്തരങ്ങളിൽ നിന്നു ഒന്നു മാത്രമാണു ഓരോ പ്രസ്താവനക്കും നല്കേണ്ടത്. ഉത്തരങ്ങള് പ്രസ്താവനകൾകും നല്കേണ്ടത് . ഉത്തരങ്ങള് പ്രസ്താവനകൾക്ക് നേരെ കൊടുത്തിട്ടുള്ള ബ്രാക്കറ്റുകളിൽ ക്രോസ്സ് മാർക്ക് (‘X’) ഇട്ട് അടയാളപ്പെടുത്തുക.

ദയവായി എല്ലാ പ്രസ്താവനകൾക്കും ഉത്തരം നല്കുവാൻ ശ്രദ്ധിയ്ക്കുക .നിങ്ങളുടെ ഉത്തരങ്ങള് രഹസ്യമായി സൂക്ഷിക്കുന്നതാണ് .

നന്ദി

പ്രസ്താവനകൾ ഉത്തരങ്ങള്

		എല്ലായ്പ്പോളും ശരിയാണ്	മിക്കവാറും ശരിയാണ്	ഇടക്കൊക്കെ ശരിയാണ്	അപൂർവമായി ശരിയാണ്	ശരിയല്ല
A. 1	സ്വതന്ത്രമായി ഓരോന്നു ചെയ്യുന്നതിനുള്ള പ്രോൽസാഹനം വീട്ടിൽ നിന്നു എപ്പോളും ഞങ്ങൾക്ക് കിട്ടാറുണ്ട് .					
2	സ്വന്തം കാര്യങ്ങളെകുറിച്ച് അവനവൻ തന്നെ തീരുമാനമെടുക്കുകയാണ് വീട്ടിലെ പതിവ് .					
3	സ്വന്തം പ്രശ്നങ്ങൾ പരിഹരിക്കുന്നതിനായി ഓരോരുത്തരും മറ്റുള്ളവരെ ആശ്രയിക്കാറില്ല .					
4	ആവശ്യമുള്ളപ്പോളെല്ലാം പുറത്തുപോകാനുള്ള സ്വാതന്ത്ര്യം ഞങ്ങൾക്കുണ്ട് .					
5	പുസ്തകങ്ങളും വസ്ത്രങ്ങളും തെരഞ്ഞെടുക്കുവാനുള്ള സ്വാതന്ത്ര്യം വീട്ടിൽ ഞങ്ങൾക്കുണ്ട്.					
6	സ്വന്തം കാര്യങ്ങൾ തുറന്നു സംസാരിക്കാനുള്ള പ്രോത്സാഹനം വീട്ടിൽ ഞങ്ങൾക്ക് കിട്ടാറില്ല .					
7	എല്ലാ കാര്യത്തിലും സ്വാശ്രയശീലരാകനുള്ള					

	പരിശീലനം കുടുംബത്തിൽ ഞങ്ങൾക്ക് കിട്ടുന്നു.					
B.8	ഞങ്ങൾ ഒന്നാണ് എന്ന വിചാരം വീട്ടിലാർക്കും ഇല്ല .					
9	വീട്ടുകാര്യങ്ങളിലെല്ലാം ഞങ്ങൾ പരസ്പരം സഹായിക്കാറുണ്ട് .					
10	വീട്ടുജോലികൾ ചെയ്യുന്നതിന് ഞങ്ങൾ എല്ലാവരും സ്വമേധയാ തയ്യാറാകാറുണ്ട് .					
11	ഓരോരുത്തരും മറ്റുള്ളവർക്ക് തുണയാണ് എന്ന വിചാരം വീട്ടിലാർക്കും ഇല്ല.					
12	ഞങ്ങൾ വളരെ യോജിപ്പിലാണ് കഴിയുന്നത് .					
13	കുടുംബത്തിൽ ഓരോരുത്തർക്കും വേണ്ടത്ര ശ്രദ്ധയും പരിചരണവും കിട്ടാറുണ്ട്					
14	വിഷമാവസ്ഥയിൽ വീട്ടിൽ ഓരോരുത്തർക്കും മറ്റുള്ളവർ സഹായമാകാറുണ്ട് .					
C.15	ജീവിതത്തിൽ മുന്നേറുക എന്നത് ഞങ്ങളെ സാംബത്തിച്ചിടത്തോളം വളരെ പ്രധാനപ്പെട്ട ഒരു കാര്യമല്ല.					
16	ഞങ്ങൾ മത്സരത്തിൽ വിശ്വസിക്കുന്നു .					
17.	ചെയ്യുന്ന കാര്യങ്ങളെല്ലാം വളരെ നന്നായിട്ടു ചെയ്യണമെന്ന് ഞങ്ങൾ കരുതുന്നു.					
18	വിജയപ്രപ്തിക്കായ് ഞങ്ങളെല്ലാവരും കഠിനമായി പ്രയത്നിക്കാറുണ്ട് .					
19	ഉദ്യോഗകയറ്റം , ക്ലാസ്സിലെ റാങ്ക്/ഗ്രേഡ് എന്നിവയേകുറിച്ചോർത്തു ഞങ്ങൾ എപ്പോഴും വിഷമിക്കാറുണ്ട് .					
20	ഓരോ പ്രാവശ്യവും ഒന്നിനൊന്നു മെച്ചമായി കാര്യങ്ങൾ ചെയ്യുവാനാണ് ഞങ്ങൾ ശ്രമിക്കുന്നത് .					
21	ജോലിചെയ്യുക എന്നത് പരമപ്രധാനമായ ഒരു കടമയാണെന്ന് ഞങ്ങൾ കരുതുന്നു.					
D.22	ബുദ്ധിപരമായ പ്രവർത്തികൾക്ക് വിനോദത്തേക്കാൾ വളരെ പ്രധാന്യം ഞങ്ങൾ നൽകാറുണ്ട്.					
23	പുതിയതും വ്യതസ്തവുമായ കാര്യങ്ങളെകുറിച്ച് പഠിക്കുന്നതിന് ഞങ്ങൾക്ക് വീട്ടിൽ പ്രോൽത്സാഹനം കിട്ടാറുണ്ട് .					
24	ബുദ്ധിപരമായ ചർച്ചകളിൽ ഞങ്ങൾക്ക് തൽപര്യമില്ല .					
25	ടെലിവിഷൻ കാണുന്നതിനെക്കാൾ ഞങ്ങൾക്ക് തൽപര്യം ഗൌരവതരമായ വായനയിലാണ്.					
26.	ലിബ്രറിയിൽ പോയി വായിക്കുന്നതിൽ ഞങ്ങൾക്ക് തൽപര്യം ഇല്ല.					
27	പുതിയ ആശയങ്ങൾ പരീക്ഷിച്ചറിയുന്നതിന് ഞങ്ങൾക്ക് പ്രോൽത്സാഹനം ലഭിക്കാറുണ്ട് .					

28	വിജ്ഞാനപ്രദമായ സിനിമയാണ് വിനോദ പ്രധാന്യമുള്ളതിനെക്കാൾ ഞങ്ങളിഷ്ടപ്പെടുന്നത് .					
E.29	ഞങ്ങൾ പരസ്പരം കുറ്റപ്പെടുത്താറില്ല					
30	വീട്ടിൽ എപ്പോഴും സമാധാനം നിലനിർത്താൻ ഞങ്ങളെല്ലാവരും ശ്രമിക്കാറുണ്ട് .					
31	ബഹളം വെയ്ക്കുന്നതുകൊണ്ട് എന്തെങ്കിലും നേടാനാകുമെന്ന് ഞങ്ങൾ വിശ്വസിക്കുന്നില്ല.					
32	ഞങ്ങൾ ധാരളമായി വഴക്കു കൂടുന്ന സ്വഭാവക്കാരാണ്.					
33	മറ്റുള്ളവരെ വേദനിപ്പിച്ചിട്ട് സ്വന്തം കാര്യം കാണുന്നതിൽ ഞങ്ങൾക്കു തൽപര്യമില്ല					
34	വഴക്കുകൂടി ഞങ്ങൾ പലപ്പോഴും അടികലശത്തിൽ എത്താറുണ്ട്					
35	ദേഷ്യം തോന്നിയാൽ പരസ്പരം ചീത്ത വിളിക്കുന്നതിന് ഞങ്ങൽക്ക് മടിയില്ല					
36	മറ്റുള്ളവരെ സഹായിക്കേണ്ടത് കടമയാണെന്ന് ഞങ്ങൾ കരുതുന്നു					
37	സംഗീതകച്ചേരി , നാടകം , പ്രഭാഷണം തുടങ്ങിയ പൊതു പരിപാടികൾക്ക് ഞങ്ങൾ പോകാറുണ്ട്					
38	സാമൂഹികവും രാഷ്ട്രീയവുമായ കാര്യങ്ങളെകുറിച്ചു വീട്ടിൽ ഞങ്ങൾ ചർച്ചചെയ്യാറില്ല					
39	വിശ്രമ സമയം പങ്കിടനായി ഞങ്ങൾക്ക് ധാരാളം നല്ല സുഹൃത്തുക്കളുണ്ട്					
40	ഞങ്ങൾ മറ്റുള്ളവരുമായി ഇടപഴകാനിഷ്ടപ്പെടുന്നില്ല					
41	അവധി ദിവസങ്ങൾ മിക്കവരും ഞങ്ങൾ വീട്ടിൽത്തന്നെ കഴിച്ചുകൂട്ടുകയാണ് പതിവ്					
42	ഞങ്ങളെല്ലാവരും സാമൂഹ്യ സേവന പരിപാടികളിൽ പങ്കെടുക്കാറുണ്ട്					
43	നൻമ്മ ചെയ്യുക എന്നത് വളരെ പ്രധാനപ്പെട്ട ഒരു കാര്യമായാണ് ഞങ്ങൾ കരുതുന്നത്					
44	ചെയ്യുന്ന നല്ല പ്രവർത്തികൾക്കെല്ലാം അർഹിക്കുന്ന പ്രതിഫലം കിട്ടുമെന്ന് ഞങ്ങൾ വിശ്വസിക്കുന്നു					
45	വിശ്വാസത്തിന്റെ പേരിൽ ചില കാര്യങ്ങൾ ഞങ്ങൾ സ്വീകരിക്കാറുണ്ട്					
46	തെറ്റുകൾക്കെല്ലാം ശിക്ഷകൊടുക്കേണ്ടതാണെന്ന് ഞങ്ങൾ വിശ്വസിക്കുന്നു					
47	ശരിയും തെറ്റും എന്താണെന്നതിനെക്കുറിച്ച് ഞങ്ങൾക്ക് വ്യക്തമായ ധാരണയില്ല					
48	നല്ല സ്വഭാവ ഗുണങ്ങൾ കുടുംബത്തിന് ഒരു നേട്ടമാണെന്ന് ഞങ്ങൾ വിശ്വസിക്കുന്നു					

49	ആദ്യം കടമ ചെയ്യുക , പിന്നീടു പരാതി യാകാം എന്നതാണു ഞങ്ങളുടെ മുദ്രാവാക്യം					
H.50	വീട്ടിൽ സമയനിഷ്ഠക്ക് വലിയ പ്രാധാന്യമുണ്ട്					
51	കർശനങ്ങളായ നിയമങ്ങളാണ് ഞങ്ങളുടെ വീട്ടിലേത്					
52	ഞങ്ങളുടെ വീട്ടിൽ നിസ്സാരമായ കുറ്റങ്ങൾക്കുപോലും കഠിനമായ ശിക്ഷ ലഭിക്കാറുണ്ട്					
53	ഞങ്ങളെ സംബന്ധിച്ചു നിയമങ്ങൾ അനുസരിക്കുക എന്നത് വളരെ പ്രധാനപ്പെട്ട ഒരു കാര്യമാണ്					
54	വീട്ടിൽ മിക്കവരും വളരെ കർക്കശസ്വഭാവക്കാരാണ്					
55	ജീവിത വിജയത്തിനു അച്ചടക്കം വളരെ ആവശ്യമായ ഒന്നാണെന്ന് ഞങ്ങൾ വിശ്വസിക്കുന്നു					
56	വീട്ടിലെ കാര്യങ്ങൾ വളരെ ചിട്ടയായി കൈകാര്യം ചെയ്യുവാൻ ഞങ്ങൾ ശ്രമിക്കാറുണ്ട്					

Appendix H

Appendix

DIFFICULTY IN EMOTION REGULATION SCALE

Milu and Jayan (2018)

താഴെ പറയുന്ന പ്രസ്താവനകളിൽ താങ്കളെ പറ്റി ശരിയെന്ന് തോന്നുന്ന ഉത്തരത്തിന്റെ ക്രമനമ്പർ ഓരോ പ്രസ്താവനകൾക്ക് നേരെ (^) അടയാളപ്പെടുത്തുക .

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line besides each item.

1	2	3	4	5
വളരെ അപൂർവം Almost never (0-10%)	ചിലപ്പോൾ Sometimes (11- 35%)	പകുതിയോളം സമയം About half the time (36-65%)	പലപ്പോഴും Most of the time 66-90%)	മിക്കപ്പോഴും Almost always (91-100%)

1	I pay attention to how I feel എന്റെ വികാരങ്ങളെകുറിച്ച് ഞാൻ ശ്രദ്ധിക്കാറുണ്ട്	1	2	3	4	5
2	I experience my emotions as overwhelming and out of control എന്റെ വികാരങ്ങൾ നിയാന്ത്രണാതീതവും ആവശ്യത്തിലധികവുമായി എനിക്കു അനുഭവപ്പെടാറുണ്ട്	1	2	3	4	5
3	I have no idea how I am feeling എനിക്കു എന്തു തോന്നുന്നു എന്നതിനെ കുറിച്ച് എനിക്കു യാതൊരു ധാരണയുമില്ല	1	2	3	4	5
4	I have difficulty making sense out of my feelings. എന്റെ വികാരങ്ങളെ നിയന്ത്രിച്ചെടുക്കുമ്പോൾ എനിക്കു പ്രയാസം തോന്നാറുണ്ട്	1	2	3	4	5
5	I am confused about how I feel എന്റെ വികാരങ്ങളെ കുറിച്ച് എനിക്കു ആശയക്കുഴപ്പമുണ്ട്	1	2	3	4	5
6	When I am upset, I acknowledge my emotions എന്റെ അസ്വസ്ഥമായ അവസ്ഥകളെ എനിക്കു നന്നായി അറിയാം	1	2	3	4	5
7	When I am upset, I become angry with myself for feeling that way എന്റെ അസ്വസ്ഥതയെ കുറിച്ച് എനിക്കു എന്നോടു തന്നെ ദേഷ്യം തോന്നാറുണ്ട്	1	2	3	4	5
8	When I am upset, I become embarrassed for feeling that way എന്റെ അസ്വസ്ഥതയെ കുറിച്ച് എനിക്കു നാണക്കേട് തോന്നാറുണ്ട്	1	2	3	4	5
9	When I am upset, I have difficulty getting work done അസ്വസ്ഥമായിരിക്കുമ്പോൾ എനിക്കു ജോലി ചെയ്യാൻ ബുദ്ധിമുട്ട് അനുഭവപ്പെടാറുണ്ട്	1	2	3	4	5
10	When I am upset, I become out of control അസ്വസ്ഥമായിരിക്കുമ്പോൾ എനിക്കു എന്നെ നിയന്ത്രിക്കാനാകാറില്ല	1	2	3	4	5
11	When I am upset, I believe that I will remain that way for a long time		2	3	4	5

	അസ്വസ്ഥമാകുമ്പോഴെല്ലാം ഞാൻ ആ അവസ്ഥയിൽ കുറെ സമയമിരിക്കുമെന്ന് എനിക്കു തോന്നാറുണ്ട്					
12	When I am upset, I believe that I will end up feeling very depressed ഞാൻ അസ്വസ്ഥമാകുമ്പോഴെല്ലാം ഞാൻ തീർത്തും വിഷാദവസ്ഥയിലാണ്	1	2	3	4	5
13	When I am upset, I believe that feelings are valid and important എന്റെ വികാരങ്ങൾ പ്രധാനപ്പെട്ടതും പ്രസക്തവുമാണെന്ന് ഞാൻ വിശ്വസിക്കുന്നു	1	2	3	4	5
14	When I am upset, I have difficulty focusing on other things ഞാൻ അസ്വസ്ഥമാകുമ്പോഴെല്ലാം എനിക്ക് മറ്റ് കാര്യങ്ങളിൽ ശ്രദ്ധ ചെലുത്തുവാൻ ബുദ്ധിമുട്ട് തോന്നാറുണ്ട്	1	2	3	4	5
15	When I am upset, I feel out of control ഞാൻ അസ്വസ്ഥമാകുമ്പോഴെല്ലാം എനിക്ക് എന്നെ നിയന്ത്രിക്കാൻ സാധിക്കാറില്ല	1	2	3	4	5
16	When I am upset, I feel ashamed with myself for feeling that way ഞാൻ അസ്വസ്ഥമായിരിക്കുമ്പോൾ ആ അവസ്ഥയിൽ ആയതിൽ എനിക്ക് നാണക്കേട് തോന്നാറുണ്ട്	1	2	3	4	5
17	When I am upset, I feel like I am weak ഞാൻ അസ്വസ്ഥമായിരിക്കുമ്പോൾ എന്റെ ശക്തി ക്ഷയിക്കുന്നതായി തോന്നാറുണ്ട്	1	2	3	4	5
18	When I am upset, I feel guilty for feeling that way ഞാൻ അസ്വസ്ഥമായിരിക്കുമ്പോൾ അതിൽ എനിക്ക് കുറ്റബോധം തോന്നാറുണ്ട്	1	2	3	4	5
19	When I am upset, I have difficulty concentrating ഞാൻ അസ്വസ്ഥമായിരിക്കുമ്പോൾ എനിക്ക് ഒന്നിനും ഏകാഗ്രത ലഭിക്കാറില്ല	1	2	3	4	5
20	When I am upset, I have difficulty controlling behaviours അസ്വസ്ഥമായിരിക്കുമ്പോൾ എന്റെ പ്രവർത്തികളെ നിയന്ത്രിക്കുവാൻ എനിക്ക് ബുദ്ധിമുട്ടുണ്ടാകാറുണ്ട്	1	2	3	4	5
21	When I am upset, I believe that there is nothing I can do make myself feel better അസ്വസ്ഥമായിരിക്കുമ്പോൾ ഇനിയെന്തു ചെയ്താലും എന്റെ അവസ്ഥ മെച്ചപ്പെടില്ല എന്നു എനിക്ക് തോന്നാറുണ്ട്	1	2	3	4	5
22	When I am upset, I become irritated with myself for feeling that way അസ്വസ്ഥമായിരിക്കുമ്പോൾ എനിക്ക് ആ അവസ്ഥയെ കുറിച്ച് അലോസരം തോന്നാറുണ്ട്	1	2	3	4	5
23	When I am upset, I started to feel very bad about myself അസ്വസ്ഥമായിരിക്കുമ്പോൾ എനിക്ക് എന്നെ കുറിച്ച് മോശമായി തോന്നാറുണ്ട്	1	2	3	4	5
24	When I am upset, I believe that wallowing in it is all I can do അസ്വസ്ഥമായിരിക്കുമ്പോൾ അതിൽ ഊഴ്ന്നു കിടക്കാൻ മാത്രമേ എനിക്കു കഴിയൂ എന്നു തോന്നാറുണ്ട്	1	2	3	4	5
25	When I am upset, I lose control over my behaviours അസ്വസ്ഥമായിരിക്കുമ്പോൾ എന്റെ പ്രവർത്തികളുടെ മേൽ എനിക്കു നിയന്ത്രണമുണ്ടാകാറില്ല	1	2	3	4	5
26	When I am upset, I have difficulty thinking about anything else അസ്വസ്ഥമായിരിക്കുമ്പോൾ എനിക്കു മറ്റൊന്നിനെ കുറിച്ചും ചിന്തിക്കാൻ സാധിക്കാറില്ല	1	2	3	4	5

27	When I am upset, I take time to figure out what I am really feeling അസ്വസ്ഥമായിരിക്കുമ്പോൾ എന്റെ വികാരങ്ങളെ തിരിച്ചറിയുവാൻ എനിക്കു കുറെ സമയം വേണ്ടി വരാറുണ്ട്	1	2	3	4	5
28	When I am upset, it takes me a long time feel better അസ്വസ്ഥമായിരിക്കുമ്പോൾ അതിനെ തരണം ചെയ്യാൻ ഞാൻ കുറെ സമയം എടുക്കാറുണ്ട്	1	2	3	4	5
29	When I am upset, my emotions feel overwhelming അസ്വസ്ഥമായിരിക്കുമ്പോൾഎന്റെ വികാരങ്ങൾ ആവശ്യത്തിലധികമാകാറുണ്ട്	1	2	3	4	5

Appendix I

Appendix

SOCIAL COMPETENCE SCALE
Devassy and Raj (2012)

Instructions: The following are the statements related to the life of human behavior. Read them attentively and express your response by putting an X mark in the space provided against each of the statements as applicable to you. There is no right or wrong answers. So please mark the first response that comes to your mind.

നിർദേശങ്ങൾ:

ഒരോ വ്യക്തിയുടെയും പെരുമാറ്റങ്ങളുമായി ബന്ധപ്പെട്ടുകിടക്കുന്ന ഏതാനും പ്രസ്താവനകൾ താഴെ കൊടുത്തിരിക്കുന്നു.അവയെല്ലാം വളരെ ശ്രദയോടെ വായിച്ച് മനസ്സിലാക്കി നിങ്ങൾക്ക് അനുയോജ്യമെന്ന് തോന്നുന്ന അഞ്ചെണ്ണത്തിൽ ഏതെങ്കിലും ഒന്നിനുനേരെ (X) അടയാളപ്പെടുത്തുക.ഒന്നും തന്നെ വിട്ടുകളയാതെ മനസ്സിൽ ആദ്യം വരുന്ന ഉത്തരം ഏതാണോ അതുതന്നെ അടയാളപ്പെടുത്തുവാൻ ശ്രമിക്കുക.

5 Always എല്ലായ്പ്പോഴും	4 Often പലപ്പോഴും	3 Sometimes ചിലപ്പോൾ	2 Rarely അപൂർവമായി	1 Never ഒരിക്കലുമില്ല

Sl No	Items പ്രസ്താവനകൾ	5	4	3	2	1
1	I feel free to discuss personal issues with my parents എന്റെ മാതാപിതാക്കളുമായി വ്യക്തിപരമായ പ്രശ്നങ്ങൾ ചർച്ച ചെയ്യാൻ എനിക്കു സ്വാതന്ത്ര്യമുണ്ട്	5	4	3	2	1
2	I get along with others well എനിക്കു മറ്റുള്ളവരുമായി നന്നായി ഇടപെഴകാൻ സാധിക്കുന്നു	5	4	3	2	1
3	I take up leadership roles in my school/ college എന്റെ വിദാലയിലെ നേതൃതപാടവം/നായകസ്ഥാനം(leadership) ഞാൻ ഏറ്റെടുക്കാറുണ്ട്	5	4	3	2	1
4	I stand for social equality as it promotes growth of the society സമൂഹത്തിന്റെ വളർച്ചയെ	5	4	3	2	1

	പ്രോൽസാഹിപ്പികുന്നതിനുവേണ്ടിയുള്ള സാമൂഹിക സമത്വത്തിനായി ഞാൻ നിലകൊള്ളുന്നു					
5	I am interested in making friends and involve in social gatherings ചങ്ങാതിമാരെ ഉണ്ടാകുന്നതിനും ഒത്തുചേരുന്നതിനും എനിക്കു വളരെ താൽപര്യമാണ്	5	4	3	2	1
6	To respect the rights of others and of enemies is noble മറ്റുള്ളവരുടെയും, പ്രതേകിച്ച് ശത്രുക്കളുടേയും അവകാശങ്ങളെ ബഹുമാനിക്കുക എന്നത് ഉത്തമമാണ്	5	4	3	2	1
7	Forgiveness is the greatest virtue in my life ക്ഷമിയ്ക്കുക എന്നതാണു എന്റെ ജീവിതത്തിലെ ഏറ്റവും വലിയ പുണ്യം	5	4	3	2	1
8	I take leadership roles in common tasks പൊതുവായ ചുമതലകളിൽ ഞാൻ നേതൃപാടവം ഏറ്റെടുക്കുന്നു	5	4	3	2	1
9	I am disciplined and organised in life ഞാൻ വളരെ ചിട്ടയോടും ക്രമത്തോടെയും ജീവിക്കുന്നു	5	4	3	2	1
10	I succeed in team building and group identity ഒരു സമൂഹത്തെ വാർത്തെടുക്കുന്നതിലും അവരുടെ വ്യക്തിത്വത്തെ രൂപപ്പെടുത്തുന്നതിലും ഞാൻ വിജയിക്കാറുണ്ട്	5	4	3	2	1
11	I consider forgiveness and non- violence are the characteristics of great personalities ക്ഷമയും അഹിംസയും മികച്ച വ്യക്തിത്വങ്ങളുടെ സവിശേഷതകൾ ആയി ഞാൻ പരിഗണിക്കുന്നു	5	4	3	2	1
12	I prepare myself for the future at my school സ്കൂൾ വിദ്യാഭ്യാസ കാലഘട്ടത്തിൽതന്നെ ഞാൻ എന്റെ ഭാവിയെപ്പറ്റി ചിന്തിക്കാറുണ്ട്	5	4	3	2	1
13	I express myself anger appropriately without hurting others മറ്റുള്ളവരെ വേദനിപ്പിക്കാതെ ഞാൻ എന്റെ വേദനയും ദേഷ്യവും ഉചിതമായി പ്രകടിപ്പിക്കുവാൻ ശ്രമിക്കാറുണ്ട്	5	4	3	2	1
14	I enjoy my course of study ഞാനെന്റെ വിദ്യാഭ്യാസ കാലഘട്ടം വളരെയതികം ആസ്വദിക്കുന്നു	5	4	3	2	1

15	I manage my emotions effectively ഞാൻ എന്റെ വികാരങ്ങൾ നല്ല രീതിയിൽ കൈകാര്യം ചെയ്യുന്നു	5	4	3	2	1
16	I easily mingle in a group for work and play ഞാൻ ജോലി ചെയ്യുമ്പോളും , കളിക്കുമ്പോളും ,വളരെ വേഗത്തിൽ തന്നെ ഒരു സമൂഹവുമായി ഇടപെടാൻ സാധിക്കുന്നു	5	4	3	2	1
17	I am accepted by my group and am often asked to lead the group എന്റെ ഗ്രൂപ്പിൽ ഞാൻ സ്വീകാര്യനായതുകൊണ്ട് പലപ്പോളും ഗ്രൂപ്പിനെ നയിക്കുവാൻ എന്നോടു ആവശ്യപ്പെടാറുണ്ട്	5	4	3	2	1
18	I express emotions and feelings effectively without hurting the others മറ്റുള്ളവരെ വേദനിപ്പിക്കാതെ എനിക്കു എന്റെ വികാരങ്ങളെ പ്രകടിപ്പിക്കുവാൻ സാധിയ്ക്കും	5	4	3	2	1
19	I accept change smoothly ഓരോ മാറ്റത്തെയും എനിക്കു ഉൾക്കൊള്ളാൻ സാധിക്കാറുണ്ട്	5	4	3	2	1
20	I relate to my teachers well ഞാനെന്റെ അദ്ധ്യാപകരുമായി വളരെ നല്ല ബന്ധത്തിലാണ്	5	4	3	2	1
21	I am confident in organizing a group for a common cause or issue ഒരു പൊതു ആവശ്യത്തിന് വേണ്ടി നിലനിൽക്കേണ്ടിവരുമ്പോൾ അതിനു വേണ്ടി ഒരു സമൂഹത്തെ സംഘടിപ്പിക്കുന്നതിൽ എനിക് ആത്മവിശ്വാസമുണ്ട്	5	4	3	2	1
22	I make friends easily എനിക്കു വളരെ എളുപ്പത്തിൽ സുഹൃത്തുക്കളേ സമ്പാതിക്കാൻ പറ്റും	5	4	3	2	1
23	I adapt myself to change easily മാറ്റങ്ങളെ ഉൾകൊള്ളുവാൻ ഞാൻ എന്നെ തന്നെ പ്രാപ്തനക്കാറുണ്ട്	5	4	3	2	1
24	I use my free time effectively ഞാനെന്റെ ഒഴിവുസമയം ഫലപ്രദമായ രീതിയിൽ ഉപയോഗികാറുണ്ട്	5	4	3	2	1
25	I make compromises and negotiations easily without hurting my sense of self എന്റെ ആത്മബോധത്തെ വ്രണപ്പെടുത്താതെ ഞാൻ	5	4	3	2	1

	എളുപ്പത്തിൽ വിട്ടുവീഴ്ചകളും ചർച്ചകളും നടത്താറുണ്ട്					
26	I complete the assignments on time എന്റെ ഉത്തരവാദിത്വങ്ങൾ എല്ലാം ക്രത്യ സമയത്തുതന്നെ ചെയ്തുതീർക്കൻ സാധിക്കാറുണ്ട്	5	4	3	2	1
27	I make consensus when there is differences of opinion in my group എന്റെ ഗ്രൂപ്പിൽ അഭിപ്രായ വ്യത്യാസങ്ങൾ ഉണ്ടാകുമ്പോൾ എനിക്കു വളരെ സംയമനം പാലിച്ചുകൊണ്ട് അവ ഒത്തുതീർപ്പകൻ സാധിക്കാറുണ്ട്	5	4	3	2	1
28	I understand others and their needs ഞാൻ മറ്റുള്ളവരെയും അവരുടെ ആവശ്യങ്ങളെയും മനസിലാക്കാറുണ്ട്	5	4	3	2	1
29	I make use of the school time effectively ഞാൻ എന്റെ വിദ്യാഭ്യാസ കാലഘട്ടം കാര്യക്ഷമതയോടെ ഉപകാരപ്രദമായ വിധത്തിൽ ഉപയോഗിക്കാൻ കഴിയുന്നു ഉപയോഗികാറുണ്ട്	5	4	3	2	1
30	I consider respecting elders as a noble tradition of our culture മുതിർന്നവരെ ബഹുമാനികുന്നത് നമ്മുടെ സംസ്കാരത്തിന് ഉത്തമ പാരമ്പര്യമായി ഞാൻ കരുതുന്നു	5	4	3	2	1
31	I care about others and their success ഞാൻ മറ്റുള്ളവരെയും അവരുടെ വിജയത്തെയും പ്രോൽസാഹിപ്പിക്കാറുണ്ട്	5	4	3	2	1
32	I express my ideas and concerns at home freely എന്റെ ആശയങ്ങളും ആശങ്കകളും എനിക്കു വീട്ടിൽ സ്വതന്ത്രമായി പ്രകടിപ്പിക്കുവാൻ സാധിയ്ക്കും	5	4	3	2	1
33	I like making new friends പുതിയ ചങ്ങാതിമാരുമായുള്ള ബന്ധങ്ങൾ ഞാൻ വളരെയധികം ഇഷ്ട്ടപ്പെടുന്നു	5	4	3	2	1
34	I have good relationship with my siblings എന്റെ ബന്ധു ക്കളുമായി ഞാൻ വളരെ അടുപ്പത്തിലാണ്	5	4	3	2	1
35	I like my home atmosphere very much എന്റെ കുടുംബാന്തരീക്ഷം എനിക്കു വളരെയധികം ഇഷ്ടമാണ്	5	4	3	2	1
36	I listen carefully to my teachers instructions and advices എന്റെ അധ്യാപകരുടെ ഉപദേശങ്ങളും നിർദേശങ്ങളും വളരെ ശ്രദ്ധയോടെ ഞാൻ പാലിക്കാറുണ്ട്	5	4	3	2	1
37	Usually, I emerge as a leader among my friends സാധാരണയായി കൂട്ടുകാരുടെയിടയിൽ എന്നെ അവരുടെ	5	4	3	2	1
	തലവനായോ നേതാവായോ അവർ പരിഗണികാറുണ്ട്					

Appendix J

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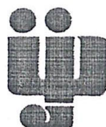

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METACOGNITION, SOCIAL COMPETENCE, AND MORAL VALUE AMONG CHILDREN

Vandana V S[1] and Soumya Starlet C T[2]

ABSTRACT

The metacognitive capacities and moral values along with social competence are regarded good mental health predictors. The purpose of this research was determining the mediating role between moral values metacognition and social competence among children. The participants were 171 schoolchildren who completed a questionnaire package that included the moral value scale, the metacognitive scale, and the social competence scale. Relationships between moral values, metacognition, and social competence were tested using the Pearson product-moment correlation coefficient and predictors of each variable were calculated with mediation Analysis, and process model. Findings show that metacognition, moral value and social competence were interrelated to each other. Mediation regression analysis results indicated that lying (moral value) partially mediated the relationship between social competence and metacognition.

INTRODUCTION

The psycho-social development during adolescence undergoes mounting from childhood to adulthood (Meeus 2016). The social judgment dimensions like morality, competence, and sociability have been shown as a basis of impression formation which modifies the social behavior among people, (Moscatelli, Kaniusonyte, Bannered, Zukauskiene,& Rubini 2018) and affect the individual relationship quality across multiple social contexts, as well as facilitating ample interpersonal interactions with individuals and demonstrates a higher psychological resilience (Gundersen, 2010).

Metacognition and moral values as core elements of social competence

Metacognitive skills and moral values have been developed as fundamental aspects of social competence thus helping the individual to have a better personal awareness of one's own behavior and to sensitize the needs of his surroundings .Metacognition means "thinking about one's thinking". Hacker (2009) defines metacognition as "...involves awareness of how they learn, and evaluation of their learning needs, generating strategies to meet these needs and then implementing strategies". Social domain theory implies (Kohlberg, 1969) that moral reasoning is connected to social information processing and subsequent behavior because of mediating the role of thought and action through the exercise of moral agency (Smetana, 2006).

METHOD

Participants

A sample of 171 participants (52 boys, and 119 girls) was randomly selected from two schools in Thrissur. The majority of the participants are high school students (N=134) and 34 students are from the middle school category.

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Hypotheses

(1) Metacognition has an interaction effect with social competence.

(2) Moral value mediates the association between metacognition and social competence.

Measures

Along with basic information about the participant like age and gender, the social competence scale (ASCS) by (Devassy & Raj, 2012) with a validity of .87 and a reliability of .93, metacognition scale by Saritha and Kaur (2018) with test-retest reliability of the test was found to be .69 and the test is of good content validity, and moral value scale by Singh and Gupta (1997) test-retest reliability and split-half reliability were found to be .86 and .87 respectively and the concurrent validity was also found to be .28, were used for collecting data.

RESULTS & DISCUSSION

Demographic information of the 171 participants and the Pearson correlations mean and SD between social competence, metacognition, and moral values are represented in Table 1. The results indicated a positive correlation between metacognition and social values ($r=.32$, $p<0.01$), moral value and social competence ($r= .17$, $p<0.05$), and a 0.01 significant relationship between moral value and metacognition($r=.40$), thus, H1 was supported. The result was supported with the findings of Mestre, Carlo, Samper, Malonda, & Mestre (2019) that moral reasoning is supported by cognitive, affective, and motivational processes that are grounded in social experience and culture

Table 2 presents results from the PROCESS models testing the mediating effect of lying (moral values) on the relationship between metacognition and social competence. Mediation regression analysis was executed to determine the interaction effect of lying on the predictive model of metacognition and social competence. The significance of the indirect effect was tested using nonparametric bootstrapping analysis with 5000 bootstrap samples.

The test concluded that lying (moral value) significantly mediates the effect of metacognition on social competence ($t= 2.85$: $p<0.01$). In model 1, lying was significantly associated with metacognition ($R2=.04$, $p<0.05$), therefore, H2 was partially supported. Metacognition is needed to reflect on cognitive processes and contributes to the way cognitive processes are used in everyday life, which directly affects social functioning (Cella, swan, Medin, Feeder, & Wykes 2014). Metacognition involves knowing the cognition and regulation of cognition, which indicates that better metacognitive skills result in well-balanced social skills and moral standards of living.

CONCLUSION

The correlational analysis addressed that metacognition, moral values, and social competence factors are positively related to each other with remarkable relation between moral value and social competence reported among school children, and metacognition and social competence demonstrated no difference

between them. Finally, clear direct evidence of metacognitive skills for social competence and the role of morality in terms of lying element mediated the social behavioral skill.

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