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Disruptive Behaviour, Social Relating and Anxiety Problems of Children with Moderate Intellectual Disability

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Abstract: ***The present study is an attempt to find out the prevalence of disruptive behaviour, social relating and anxiety problems of children with moderate intellectual disability (IQ: 35-55, without additional severe physical or sensory deficits),). The sample comprised of 121 children (80 males and 41 females) randomly selected from 8 special schools for children with intellectual disability in Pondicherry (Mean 11.2 Years). Tools used were Binet Kamat test of intelligence (BKT) Vineland social maturity scale (VSMS) and Developmental behaviour checklist teacher version (DBC- T). Results reveal that birth order difference was significant in influencing the disruptive behaviour, whereas age and gender were not significant. Age was significant in influencing the social relating of children with moderate intellectual disability, whereas gender and birth order were not significant. Age was significant in influencing the anxiety problems, whereas gender and birth order were not significant.***
Keywords: Moderate Intellectual Disability, Disruptive, Social Relating, Anxiety, Special Schools

I. INTRODUCTION

Intellectual disability (ID) is an abnormality that has enormous psychosocial effects; it not only affects the people who suffer from it but also the family and society as a group. According to the World Health Organization (1994); approximately 156 million people or 3% of the world's population is intellectually disabled. The prevalence is calculated to be 1 to 3% in developed countries (Petterson & Bourke, 2007) and in India it is projected between 1 to 4% (Sharan & Bhargava, 2007). Individuals with mild intellectual disability represent the largest proportion (nearly 2.5% of the entire population); moderate intellectual disability involves around 0.4% of the population, and severe and profound levels collective data for about 0.1% (Cooke, 2003). Young people with intellectual disability has been found to have levels of psychopathology approximately 3 to 4 times higher than that of typically developing children (Dekker & Koot, 2002). Mental disorders are commonly experienced by people with intellectual disabilities-the point prevalence has been measured as 40 % (Cooper & Bailey, 2001). A person with intellectual disabilities is therefore considerably more likely to have additional mental disorders. As well as having all the risk factors that are relevant for the whole population, people with intellectual disabilities may have extra risk factors.

A. Materials And Method

The sample of the present study comprised of total 121 children, 80 boys and 41 girls with moderate intellectual disability in the age range of 6 to 15 years (Mean age = 11.2 years) randomly selected from 8 special schools for mentally retarded children among 12 special schools in Pondicherry (Union Territory). The children with severe additional physical deficits (like impairment of mobility or orthopaedic) or sensory deficits (like impairment of vision, hearing) were excluded in this study.

B. Tools Used

1) *Binet Kamat Test of Intelligence:* The Binet-Kamat Scale of intelligence is the Indian adaptation of the 1934 version of Stanford-Binet Scale of Intelligence. The original Stanford-Binet test was modified and standardized to measure general mental ability for the age group of 3-22 yrs. This Indian adaptation has items at each age level and yields a mental age and intelligence quotient.
2) *Vineland Social Maturity Scale Indian Adaptation:* An Indian adaptation of the Vineland Social Maturity Scale was used to assess children aged 0-16 years in the areas of self-help general, self-help dressing, self-help eating, self-direction, locomotion, communication, occupation and socialization. The scale yields a social age and a social quotient, which can be considered a proximate intelligence quotient. The Vineland Social Maturity Scale was originally devised by E. A. DOLL in 1935 and since then this test has been used in many parts of the world. It proved itself to be uniquely useful instrument in measuring Social maturity of children and young adults' normal children. This is a clear reflection of how social development and mental development are highly correlated.

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II. THE DEVELOPMENTAL BEHAVIOUR CHECKLIST-TEACHER VERSION (DBC-T)

The Developmental Behaviour Checklist (DBC) (Einfeld & Tonge, 1992, 2002) is a questionnaire which is completed by parents or other primary careers or teachers, reporting problems over a six-month period.

The DBC-T is an instrument for the assessment of behavioural and emotional problems of young people aged 4-18 years with developmental and intellectual disabilities and is completed by teachers or teacher aides. It can be used in clinical practice in assessments and monitoring interventions, and in research studies.

This scale comprises of 94-items. Each behavioural description is scored on 0, 1, 2 rating where 0 = 'not true as far as you know', 1 = 'somewhat or sometimes true', and 2 = 'very true or often true'.

A. Reliability

The instrument has a high inter-rater reliability between parents and between teachers. Test re-test reliability and internal consistency are also high. The DBC-T has also been demonstrated to be sensitive to change over time.

B. Validity

High correlations between a total score on the checklist and two other measures of behaviour disturbance in children with intellectual, the AAMD Adaptive Behaviour Scales (Lambert & Wind miller, 1981) and the Scales of Independent Behaviour (Bruininks, Woodcock, Weatherman, & Hill, 1984) have been found. The total score on the DBC-T also correlates with child psychiatrists' ratings of severity of psychopathology using Rutter, Tigard and Whitmore's (1970) definition. The DBC-T instrument has high criterion group validity in distinguishing psychiatric cases from non-cases ($t = 7.8$, $p < .001$).

Table 1 Disruptive Behaviours, Social Relating and Anxiety problems based on Age

Variables	Age	Number	Mean	Std. Dev.	"t" value	Level of significance
Disruptive Behaviour	6-10	62	14.77	8.17	2.219	
	11-15	59	11.47	8.17		Not significant
Social Relating	6-10	62	6.08	2.67	3.926	Significant 0.01 level
	11-15	59	4.10	2.86		
Anxiety	6-10	62	5.31	2.82	3.746	Significant 0.01 level
	11-15	59	3.41	2.74		

Table 2 Disruptive behaviours, Social relating and Anxiety problems based on Gender

Variables	Gender	Number	Mean	Std. Dev.	"t" value	Level of significance
Disruptive Behaviour	Male	80	13.10	7.86	-0.120	Not significant
	Female	41	13.29	9.21		
Social Relating	Male	80	4.92	2.98	-0.999	Not significant
	Female	41	5.49	2.83		
Anxiety	Male	80	4.29	2.94	-0.483	Not significant
	Female	41	4.56	2.94		

Table 3 Disruptive behaviours, Social relating and Anxiety problems based on Birth Order

Variables	Birth Order	Number	Mean	Std. Dev.	"F" value	Level of significance
Disruptive Behaviour	First Born	62	10.97	7.00		
	Second Born	52	15.88	9.06	5.343	Significant 0.05 level
	Later Born	7	12.43	8.28		
Social Relating	First Born	62	4.66	2.95	2.562	Not significant
	Second Born	52	5.79	2.83		
	Later Born	7	4.14	2.79		
Anxiety	First Born	62	3.92	2.84	3.030	Not significant
	Second Born	52	5.10	2.96		
	Later Born	7	3.14	2.61		

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III. RESULTS

Table 1 shows that 3 dimensions of scales namely disruptive behaviours, social relating & anxiety problems can be inferred that "t" value (3.926) is significant for social relating at 0.01 level and "t" value (3.746) is significant for anxiety at 0.01 level. Finally, table 2 shows that "F" value (5.343) is significant for disruptive behaviour at 0.05 level. The present study supports the previous finding that anxiety, social relating & disruptive behaviours are common in children with moderate intellectual disability. The prevalence of social relating and anxiety were higher in younger children with moderate intellectual disability and the prevalence of disruptive behaviour is higher with second and later born children with moderate intellectual disability. This finding corroborates the ideas of Stores et al. (1998), who suggested that the young age children with intellectual disability reveal higher behaviour problems than the older children.

IV. CONCLUSION

Children with moderate intellectual disability are more influence major behavioural and emotional problems. Through proper diagnosis children with moderate intellectual disability can receive behavioural, emotional and psychiatric care. The implication of current research is it emphasized the need for developing diagnostic services, psychiatric services and education care for children with moderate intellectual disability. Therefore, it is recommended to provide multi-disciplinary teams in special education schools.

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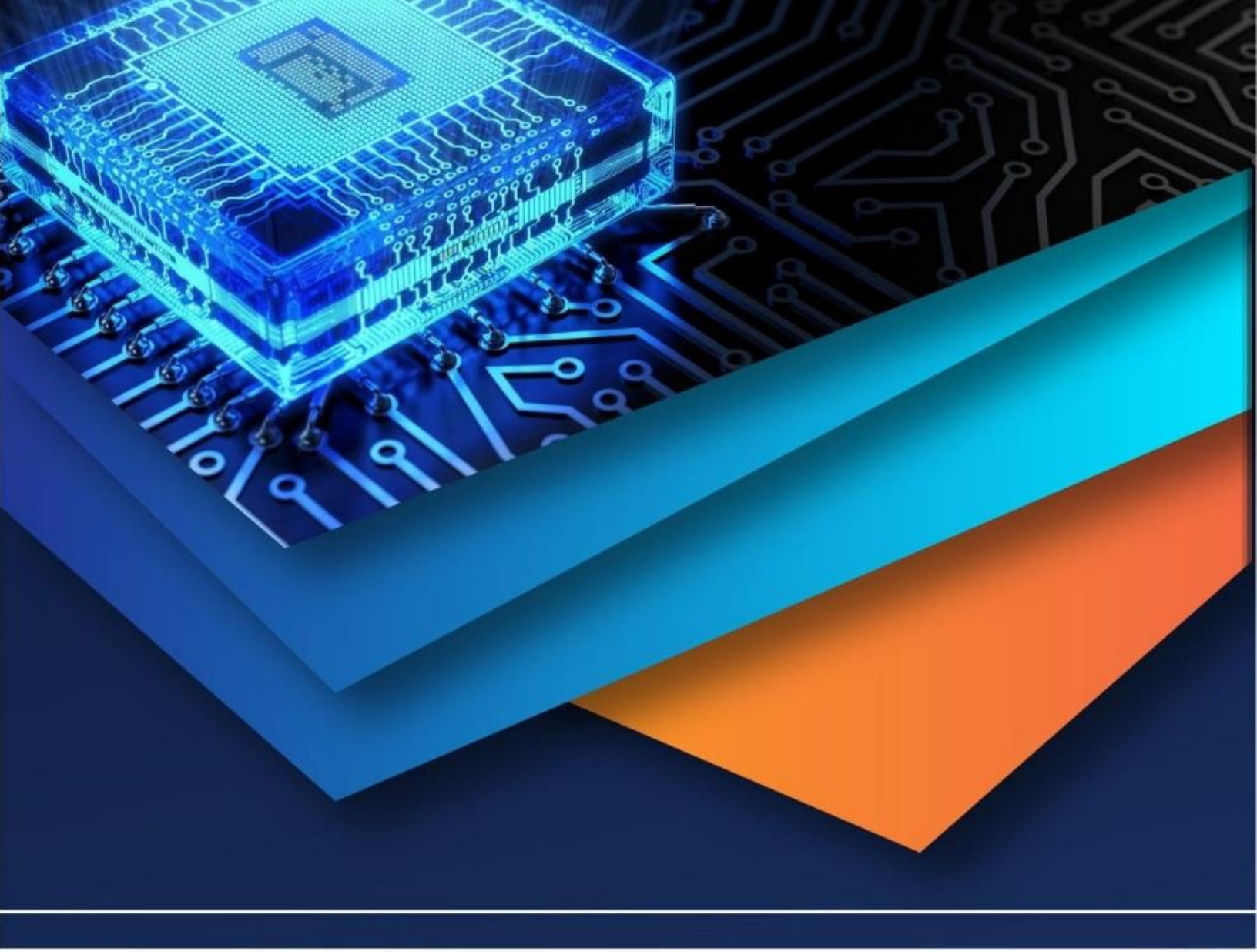

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