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RESEARCH ARTICLE

BEHAVIORAL MODIFICATION THERAPY AND PARENTS POSITIVE ENROLMENT HELPS TO FIGHT AGAINST CHILDREN'S BEHAVIOR DIFFICULTIES

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ABSTRACT

The purpose of the study to examine the behavior problem and effect of behavior modification therapy, and parenting positive enrolment on school going children, and relation to their academic skills. Adolescence (boys and girls) who referred by doctors for behavior difficulties, and poor scholastic performance,(more than 6 months), referred at Shrivastavaclinic, chhindwara Madhya Pradesh were included in the study (N=156). An Analysis of variance showed that the F ratio is larger than the F crit value. The F crit is the critical value as extracted from the f-distribution in statistical tables based on two values of degrees of freedom df of 2 and 465. $p < 0.05$ significant (Means are different) different means say that there is an effect of level of parenting enrolment and behavior modification therapy help children with behavior difficulties and improve their academic skills. Study showed that positive parenting enrolment and behavior modification therapy program improves positive communication with children, healthy attachment, emotional adjustment, including intelligence, sustained attention, memory, or executive functions; affect activities, including increasing learning and applying knowledge and improving attending and completing tasks; or enhance participation, including moving across educational levels, succeeding in the educational program.

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INTRODUCTION

Most children have some behavior problem at some time or the other. Behaviour problem arise from conditions within the child or from external influences effects of which are often not noticed or understood by others. Behaviour problem range from extreme withdrawal to intense hostile aggression. Generally the stresses ae academic failure, school change, syllabus, teaching teacher change, non-acceptance by peer, illness, losing friend, fighting, changing of house and school. Behavioral problem can base on the criteria of abnormal behavior. Deviant to social norms of the particular culture of that society, behavior which is causing trouble to the person and others in the society and that behavior, which is present for a long time, is considered as abnormal behavior. But in case of behavioral problem in children one can define behavioral problems as such reactions (hitting, shouting, bulling, and abusing language) of a child which are not up to the expectations of the parents, teachers, members of the family, or members of the community.

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One can also say the behavior which is not fitting in with appropriate to age; sex and cultural background of the child can be termed as a problem. Behavior modification is the use of empirically demonstrated behavior change techniques to increase or decrease the frequency of behaviors, such as altering an individual's behaviors and reactions to stimuli through positive and negative reinforcement of adaptive behavior and/or the reduction of behavior through its extinction, punishment and/or satiation. The first use of the term behavior modification appears to have been by Edward Thorndike in 1911. His article Provisional Laws of Acquired Behavior or Learning makes frequent use of the term "modifying behavior". Through early research in the 1940s and the 1950s the term was used by Joseph Wolpe's research group. The experimental tradition in clinical psychology used it to refer to psycho-therapeutic techniques derived from empirical research. It has since come to refer mainly to techniques for increasing adaptive behavior through reinforcement and decreasing maladaptive behavior through extinction or punishment (with emphasis on the former). In recent years, the concept of punishment has had many critics, though these criticisms tend not to apply to negative punishment (time-outs) and usually apply to the addition of some aversive event. The use of positive punishment by board certified behavior analysts is restricted to extreme

circumstances when all other forms of treatment have failed and when the behavior to be modified is a danger to the person or to others (see professional practice of behavior analysis). In clinical settings positive punishment is usually restricted to using a spray bottle filled with water as an aversive event. When misused, more aversive punishment can lead to affective (emotional) disorders, as well as to the receiver of the punishment increasingly trying to avoid the punishment (i.e., "not get caught").

Behavior modification relies on the following

- Reinforcement (Positive and Negative)
- Punishment (Positive and Negative)
- Extinction
- Shaping
- Fading
- Chaining

Behavior therapy – also referred to as "behavioral therapy", "behavior modification" or "applied behavior analysis" – is a form of psychotherapy that involves reducing or eliminating behaviors and habits that are destructive, unhealthy, or undesirable and learning or increasing more appropriate behaviors. It is based on the premise that we are all shaped or "conditioned" by our environment. We learn to continue doing behaviors that are reinforced in some manner, and to stop doing those that aren't. In traditional behavior therapy, maladaptive or abnormal behaviors are believed to be the result of defective learning. For example, people learn to be anxious, compulsive, or inattentive. The goal of behavior therapy is to reduce or eliminate undesirable behaviors and teach or increase acceptable behaviors. This is accomplished through the use of behavioral techniques and strategies such as systematic desensitization, modeling, reinforcement, and aversive conditioning. Unlike psychoanalysis and other more psychodynamic approaches to therapy, behavior therapy relies on these conditioning techniques to help people make desired changes, rather than focusing on unconscious processes that may play a role in unhealthy or unwanted behaviors. Behavior therapy has been used to treat a variety of disorders and problems, including addictions, phobias, and behavioral problems in children

How does behaviour therapy help me and my child?

Negative interactions and behaviors in children. They may tend to misbehave and be punished more frequently than other children. This frequent punishment can have a negative effect on their self-image and cause problem behaviors to increase. Parents may find that their typical parenting strategies do not work very well. Parents can learn to manage the behavior of children who have behavior difficulties by receiving training in the use of behavioral techniques and work with caregivers (daycare providers, preschool teachers, and others) to help reduce these negative behaviors and interactions.

Aim and Objectives of the Study

The overall aims of the research were

- To examine children behavior problem and understand the level of difficulties.
- To examine whether parenting programmers work best for different types of family in terms of improving the child's behavior and/or attendance, for example: What type of attitudes (towards their child's behavior/attendance and to the course) do parents hold prior to the course? Which parents feel they have benefited most from parenting programmes? Is the type of behaviour and/or attendance problem a factor in the effectiveness of a parenting programme?
- The purpose of the study to examine the behavior problem and effect of behavior modification therapy, and parenting positive enrolment on school going children, and relation to their academic skills.

Hypotheses

Early diagnose, positive parenting enrolment and behavior modification therapy positively help school going children behavior problems, in relation to their academic skills.

MATERIAL AND METHODS

Place of Study: This study was conducted at **s**hrivastava clinic, chhindwara Madhya Pradesh

Period of Study: January 2017 to June 2018 (18months)

Inclusion Category

- Adolescence (boys and girls) (Age group 11 to 18 years)
- Adolescence (boys and girls) who referred by doctors for behaviour difficulties, and poor scholastic performance

Exclusion: Adolescence (boys and girls), (Parents complain about behavior, and poor scholastic performance, duration more than six months), at different schools from chhindwara (Madhya Pradesh).

Sample size: Adolescence (boys and girls) who referred by doctors for behaviour difficulties, and poor scholastic performance, (more than 6 months), referred at Shrivastava Clinic, chhindwara Madhya Pradesh were included in the study (N=156)

Study Design: Cross sectional study (Questionnaire based)

Tools

CBCL Testing

Child Behavior Checklist for Ages 6–18 (CBCL/6-18; Achenbach and Rescorla 2001) The 113 items on this measure are rated as Not True (0), somewhat or sometimes True (1), or Very True or Often True (2). Validity and reliability are excellent, and extensive normative data are available for children ranging from 6 to 18.

Procedure of Data collection

For collection of data from Shrivastavaclinic, chhindwara Madhya Pradesh was chosen. By keeping age and gender requirements in mind the subjects were selected more than the

required then the test of Child behavior checklist 6/18(CBCL) who referred by doctors for behavior difficulties, and poor scholastic performance,(more than 6 months), N 156 subjects have been selected randomly from different school going children's, which consists 156 school going students (boys 89 and67 Girls). First of all, checklist of trails was administered on the subjects to get their original viewpoint. The subjects were randomly selected sample in Shrivastavaclinic, chhindwara Madhya Pradesh, adolescence (boys 89 and 67 Girls) and done Child behavior checklist 6/18(CBCL), each subjects took about 40min to respond on the entire above tools. A period of eighteen months was devoted for the data collection.

Statistical Analysis

The obtained data was statistically analyzed by applying descriptive (Mean, Standard Deviation, ANOVA) of significance of mean differences in term of various variable. We have entered all data and further Statistical Analysis was done with the help of IBM- SPSS-25 software.

RESULT

This study included two sets of participants: 1) school going adolescence; and 2) parents.

Analysis of variance showed On depression the F ratio 13.11 is larger than the F crit value 3.015 .The F crit (3.015) is the critical value as extracted from the f-distribution in statistical tables based on two values of degrees of freedom df of 2 and 465. $p < 0.05$ significant (Means are different) and as per the mean level of the First Face (CBCL 6/18-Depression scale) mean 10.88, is higher than that of the second phase (CBCL 6/18-Depression scale) mean 10.10, and Third Face (CBCL 6/18-Depression scale) mean9.27 .Different Means say that there is an effect of level of parenting counselling and Behavior modification therapy help children and improve their in depression issues. Out of 156 children 24%boys, and 51% girls scored high in depression (Enjoying little, cries, guilty, sleep less, lack of energy, sad, self- harm) . The National Institute of Mental Health (n.d.) has reported statistically significant differences across age and sex in the lifetime prevalence of mood disorders, including depression, for adolescents 13 to 18. Merikangas and colleagues (2010) found the lifetime prevalence of depression among female adolescents to be 15.9% while lifetime prevalence for males was 7.7%. Werner (1993) found that young people, who were at-risk because of perinatal stress, low socioeconomic status, or troubled family environment, could successfully overcome these risk factors to lead healthy lives. See table number 2. On Anxiety problem the F ratio 27.57 is larger than the F crit value 3.015 .The F crit (3.015) is the critical value as extracted from the f-distribution in statistical tables based on

Table 1. The prevalence of Behaviour difficulties in relation to thechild's age and sex

			Average	Percentage
Age	12-13 Years	Boys	18	20%
		Girls	14	21%
	14-15 Years	Boys	42	47%
		Girls	33	49%
	16-17 Years	Boys	22	25%
		Girls	17	25%
	17-18 Years	Boys	7	8%
		Girls	3	4%
Gender	Boys		89	57%
	Girls		67	43%

Table 2. DSM -the results of the ANOVA in that there appears to be an effect of level of parenting enrolment and Behavior modification therapy

Areas		Sum	Average	Variance	Source of variation	ss	df	MS	F	P-value	F- crit
Depression	1	1698	10.88	6.96	Between Group	201.97	2	100.98	13.11	0.000	3.015
	2	1576	10.10	8.73	Within group	3579.42	465	7.69			
	3	1447	9.27	7.38							
Anxiety	1	1303	8.35	7.18	Between Group	633.90	2	316.95	27.57	0.000	3.015
	2	940	6.02	14.61	Within group	5345.731	465	11.49			
	3	899	5.70	12.68							
Somatic	1	3782	24.24	29.47	Between Group	21714.2	2	10857.1	376.80	0.000	3.015
Problem	2	2023	12.96	30.45	Within group	13398.2	465	28.813			
	3	1241	7.955	26.50							
Attention	1	1629	10.44	3.33	Between Group	1540.89	2	770.44	74.08	0.000	3.01
Deficit	2	1001	6.85	18.08	Within group	4737.06	465	10.40			
	3	991	6.35	10.28							
Opposition	1	952	6.10	4.69	Between Group	222.22	2	111.11	15.47	0.000	3.015
al Defiant	2	743	4.79	7.89	Within group	3324.42	465	7.18			
problem	3	701	4.52	8.96							
Conduct	1	216	1.38	6.30	Between Group	47.74	2	23.87	5.685	0.004	3.015
Problem	2	150	0.97	5.39	Within group	1944.17	465	4.19			
	3	94	0.60	0.91							

The number of children selected at random who participated in this study were 180 however during the study twenty- four child was withdrawn by the parents leaving the sample size to be n = 156. The average age was 14 years (Table 1). Most of the participants were boys 89 (57%), and girls 67 (43%) (Table 1). st of the participants were middle class family .All participants exhibited command over Hindi language. An

two values of degrees of freedom df of 2 and 465. $p < 0.05$ significant (Means are different) and as per the mean level of the First Face (CBCL 6/18- Anxiety scale) mean 8.35, is higher than that of the second phase (CBCL 6/18- Anxiety scale) mean 6.02, and Third Face (CBCL 6/18- Anxiety scale) mean 5.76.

Out of 156 children 49%boys and 45% girls scored high in anxiety (dependent,fear, school fear, nervous, nightmares, fearful, self-cones worries). Anxiety can have a negative effect on the information processing system. People with anxiety have difficulty storing and retrieving information (Nelson and Harwood, 2011). The term of anxiety is an instant, transitory emotion which can immediately impact on child cognition in specific condition and made them feeling worry, tightness and nervousness, all of these events can extremely impact on memory and learning process (Bigdeli, 2010; MacIntyre, 1995). Heimberg *et al*., (1993) found that people who experience high level of anxiety were less successful at encoding information and less effective at processing events, that's because that lots of their energy and attention wasted for managing anxiety, and fewer clues from the environment will be recognized by them; all of these will lead to losing considerable capacity of their working memory which can negatively impact their learning processes, and other study aim of Academic anxious students may be very silent, agreeing and willing to satisfy others (McLoone, Hudson, and Rapee, 2006). On Somatic problem the F ratio 376.80 is larger than the F crit value 3.015 .The F crit (3.015) is the critical value as extracted from the f-distribution in statistical tables based on two values of degrees of freedom df of 2 and 465. $p < 0.05$ significant (Means are different) and as per the mean level of the First Face (CBCL 6/18- Somatic scale) mean 24.24, is higher than that of the second phase (CBCL 6/18- Somatic scale) mean 12.96, and Third Face (CBCL 6/18- Somaticscale) mean 7.95 . Out of 156 children 70% boys, and 90% girls scored high in somatic problem like – aches pain, headaches, skin related issues, stomachaches, vomits. As per score girls are facing more psychological stressor as compared to boys. There are multiple socio-emotional factors associated with reports of somatic symptoms among elementary school-aged children (Garralda, 2010), including stress and reduced coping abilities (Walker *et al*., 2007). Children with chronic disease may have poor coping skills that may be related to somatic symptoms (Stewart *et al*., 2010). Another study found that children who were characterized as rejected or neglected by their peers reported high levels of social anxiety (Jellesma *et al*., 2008).

On Attention deficit the F ratio 74.08 is larger than the F crit value 3.015. The F crit (3.015) is the critical value as extracted from the f-distribution in statistical tables based on two values of degrees of freedom df of 2 and 465. $p < 0.05$ significant (Means are different) and as per the mean level of the First Face (CBCL 6/18- Attention deficit scale) mean 10.44, is higher than that of the second phase (CBCL 6/18- Attention deficit scale) mean 6.85, and Third Face (CBCL 6/18- Attention deficit scale) mean 6.35. Out of 156 children 64% boys, and 66% girls scored high in attention deficit like – fails to finish, concentrate, sit still, impulsive, inattention, talk much, loud tone. The prevalence of ADHD in this sample was 11.8% for boys and 5.4% for girls and was not substantially less in older versus younger children. ADHD was found in 10.0% of subjects aged 8 to 11 years and in 7.5% of subjects aged 12 to 15 years (Froehlich *et al*. 2007). However, the condition persists into adulthood for the majority of boys and approximately one third of girls (Kessler, Adler, *et al*., 2005). Parents of children with ADHD experience increased levels of self-blame, social isolation, depression, and marital discord (Johnston and Mash, 2001). On Oppositional defiant problem the F ratio 15.47 is larger than the F crit value 3.015 .The F crit (3.015) is the critical value as extracted from the f-distribution in statistical tables based on two values of degrees of freedom df of 2 and 465. $p < 0.05$ significant (Means are different) and as per the mean level of the First Face (CBCL 6/18- Oppositional defiant scale) mean 6.10, is higher than that of the second phase (CBCL 6/18- Oppositional defiant scale) mean 4.79, and Third Face (CBCL 6/18- Oppositional defiant scale) mean 4.52. Out of 156 children 54% boys, and 52% girls scored high in Oppositional defiant problem (argues, disobey home/school, stubborn, temper). Involvement in bullying often is a sign that the child is at risk for aggression and violence Olweus D (1994).Other study indicates that some children develop the behavioral symptoms of ODD as a way to manage anxiety or uncertainty (Wilson J, Steiner H 2002). Present research showed that early-intervention and behavior modification and parenting enrolment programs therapy can help prevent Oppositional defiant problem. On Conduct problem the F ratio 5.685 is larger than the F crit value 3.015. The F crit (3.015) is the critical value as extracted from the f-distribution in statistical tables based on two values of degrees of freedom df of 2 and 465. $p < 0.05$ significant (Means are different) and as per the mean level of the First Face (CBCL 6/18- Conduct problem scale) mean 1.38, is higher than that of the second phase (CBCL 6/18- Conduct problem scale) mean 0.97, and Third Face (CBCL 6/18- Conduct problem scale) mean 0.60.

Out of 156 children 13% boys, and 4% girls scored high in conduct problem like cruel to animal, breaks rules, run away, swears, threaten, truant, attacks people, fights. The genetic literature on conduct/externalizing problems in children and adolescents is unusual insofar as more than any other behavioral trait, it has shown a significant effect of shared environment (Plomin RDeFries JCMcClearn GERutter M 1997). There is some evidence (Cadoret.*et al*. 1995; Ge Xrand et.al.1996). suggesting both gene environment interaction and correlation in conduct problems and related behaviors, and this may have contributed to the lack of any significant shared environmental influence in the present investigation. And 55(62%) boys, and 47 (70%) girls parents reported academic difficulties. A number of interventions (Jitendra, DuPaul, Soonneki, and Tresco, 2008; Raggi and Chronis, 2006; Trout, Lienemann, Reid, and Epstein, 2007) have been shown to be efficacious or promising for use with children with ADHD who have impaired academic achievement. It is also important to consider systemic changes to maximize the potential for benefit. These include ensuring smaller class sizes (Nye, Hedges, and Konstantopoulos, 2000), including sufficient exercise in students' days (Ridgway, Northup, Pellegrin, LaRue, and Hightshoe, 2003), and using software to promote task engagement (Ota and DuPaul, 2002).A variety of studies have shown that stimulants improve a number of cognitive/neuropsychological processes considered important for learning (Rhodes, Coghill and Matthews, 2006).

Conclusion

Compared to many other types of psychotherapy, one of the primary advantages of behavior modification therapy is that it's a relatively short-term treatment. As mentioned earlier, treatment goals can often be reached in several weeks, rather than several months or a few years. This makes it a more cost effective treatment approach than longer-term therapies. The techniques and strategies used in behavior modification therapy are also fairly straightforward and easy for most

parents and children to understand and learn. The Study conducted in Shrivastava clinic, chhindwara Madhya Pradesh showed that positive parenting enrolment and behavior modification therapy program improves positive communication with children, healthy attachment, emotional adjustment, including intelligence, sustained attention, memory, or executive functions; affect activities, including increasing learning and applying knowledge and improving attending and completing tasks; or enhance participation, including moving across educational levels, succeeding in the educational program.

Delimitation of the research

- Limited sample size
- Areas based research

Future research is required to further delineate and characterize the prevalence, frequency, and psychosocial correlates related to the behavior difficulties. Future prospect study should be developed in cooperating large sample size and mass study with appropriate methodology to capture the frequency and prevalence of positive parenting enrolment, behavior modification therapy effect on school gong children behavior and academic achievement.

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