

Behavioral Problems of the Preschool and School Age Children: A Comparative Study

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ABSTRACT

Introduction Preschool and school age children with behavioural problems that no its solution are at risk for more serious behavioural problems in the future. The **aim** of the study was to compare behavioural problems in preschool age children versus school age children. **Subjects and methods:** A descriptive study was carried-out at outpatient clinics affiliated to the health insurance and ministry of health hospitals at Assuit governorate. **Sample:** Convenient sample of 100 children in the age group of 3-12 years were involved from the previously mentioned setting regardless their gender, rank, educational level and residence area. The study involved also the children's accompanying mothers regardless their characteristics. **Tools of data collection:** A pre-designed questionnaire sheet was used to assess characteristics of the studied children and their mother's knowledge about behavioural problems, while psychometric assessment scale e.g aggression, depression, anxiety, loneliness and self-esteem was performed to assess the behavioural problems of preschool and school age children namely (depression, anxiety, loneliness, aggression and self-esteem). **Results:** - the most common behavioural problem manifestations among preschool and school age children were stubbornness (72%) and lying (70%) respectively. Total knowledge of mothers about behavioural problems of both preschool and school age children was unsatisfactory. **Conclusion:** It can be concluded from the study findings that depression, anxiety, self-esteem and loneliness were the common behavioural problems of preschool age children, while aggression was the common behavioural problem in school age children. **Recommendations:** Counselling services regarding prevention, detection and management of behavioural problems in children should be available in health care settings in addition to hotlines, brochures, booklets, and educational media programs containing simple information about needs and problems of children.

Key words: behavioural problems, children, preschool, school, nursing, mothers.

Introduction

Preschool and school ages are times of great developmental changes. Children learn which behaviours are acceptable and which are not. Often behaviours that are perceived as problematic during these times are resolved without intervention. Preschool and

school age children with behavioural problems that no its solution are at risk for more serious behavioural problems in the future (Caspi, 2013).

Behavioural problems in preschool age children include elimination difficulties, sibling jealousy, lack of friends, self-destructive impulsiveness, multiple fears, nightmares, refusal to follow directions,

speech that is difficult to understand, and temper-tantrums (**Beharman, 2013**).

While behavioural problems in school age children include aggression, bedtime battles, biting, defiance, hair pulling, head banging, ignoring, interrupting, lying, masturbation, nail biting, nose picking, refusing to nap, resistance, sibling rivalry, talking back, tantrums, tattling, teasing, teeth grinding, thumb sucking and whining (**Davis, 2010**).

Nurses at the frontline of service delivery for children and young people are often best placed to recognize when the child or young person is experiencing difficulties. Nurses should be able to offer general advice and treatment for less severe problems; contribute towards mental health promotion; identify problems early in their development; and refer to more specialist services. Nurses will need to ensure that they are aware of local referral protocols to services, as services will vary in localities. With support and training, they will be able to provide screening and some simple interventions with young people and their families (**Ershadi et al., 2010**).

The causes of aggressive behavior in preschool and school children are poor parenting, trauma in the form of abuse or neglect, brain damage due to closed-head injury, lack of oxygen during the birth process, prenatal exposure to drugs, alcohol, or other toxins, etc., genetic abnormalities, other health problems, marital problems resulting in family instability and observation of aggressive peers. management aggressive child limit exposure to television and videos, practice alternatives to spanking, consistently apply empathy and logical consequences for aggressive behavior, neutralize arguments and power struggles and teach social skills and problem solving on a daily basis (**fay, 2016**).

Depression in preschool aged children between 3 and 6 years of age has recently become available, with prevalence rates very similar to that in school age children, estimated between 1–2%. Evidence for a specific and stable symptom constellation, discriminant validity from other early onset mental disorders, and greater family history of affective disorders in depressed preschoolers have been provided (**Shannon, 2011**).

It's normal for children to feel worried or anxious from time to time, such as when they're starting school or nursery, or moving to a new area. Anxiety is a feeling of unease, such as worry or fear it's an understandable reaction in children to change or a stressful event. But for some children, anxiety affects their behavior and thoughts on a daily basis, interfering with their school, home and social life. This is when you may need professional help to tackle it before it becomes a more serious issue. Anxiety disorders are estimated to affect 5-19% of all children and adolescents, and about 2-5% of children younger than 12. Some of the signs to look out for in child are finding it hard to concentrate ,not sleeping, or waking in the night with bad dreams , not eating properly , quickly getting angry or irritable, constantly worrying or having negative thoughts , feeling tense and fidgety, or using the toilet often ,always crying , being clingy all the time , complaining of tummy aches and feeling unwell (**pillitteri, 2010**).

Loneliness can be a distressing feeling reflecting perceptions of critical failure in achieving valued interpersonal connections. Most children experience occasional short-term loneliness as a normal result of routine social interactions. However, some children experience severe and/or chronic loneliness, which can lead to prolonged consequences in their development, overall well-being, and future mental health (**Margalit, 2010**).

Self-esteem comes from having a sense of belonging, believing to capable, and knowing the contributions that valued and worthwhile. Simple strategies to help boost your child's self-esteem: Give unconditional love, Teach limits, Support healthy risks Let mistakes happen, celebrate the positive, Listen well, Resist comparisons and Provide encouragement (Borba, 2013).

Significance of the study

Behavioural problems in preschool and school age children can result in problems later in life. Therefore, it was important to carry out this study to shed light on such problem with emphasis on pediatric nurse's role in its detection, prevention and management. 21% of children aged 2 to 5 years met criteria for a behavior disorder and 9% were rated as severe (Centerdiseass control CDC, 2010).

Aim of the study

This study aimed: to compare behavioral problems in preschool age children versus school age children.

Research questions:

What are the common behavioral problems among preschool and school age children?

Subjects and Methods

Research design:

A descriptive design was used to conduct this study.

A-Research Setting:

The study was carried-out at outpatient clinics affiliated to Health Insurance and Ministry of Health hospitals at Assiut Governorate.

B- Subjects:

A convenient sample of 100 children (50 preschools and 50 school age children) in the age group of 3-12 years were involved from the previously mentioned setting regardless their gender, rank, educational level and residence area. The study also involved the children accompanying mothers regardless their characteristics, also they were interviewed when necessary. Exclude children with chronic illness such as bronchial asthma and diabetes.

Tools for data collection:

Data were collected through using the following tools:

I.A. predesigned questionnaire sheet:

this tool was designed by the researcher and written in simple Arabic language based on scientific recent literature review to assess data about the following:

a. Characteristics of the studied children such as age, gender, rank, educational level, work and history of previous illness.

b. Characteristics of mothers of the studied children such as age, marital status, level of education, occupation, residence area and housing condition.

c. Mother's knowledge about behavioural problems in preschool and school age children such as definition, causes, factors affecting children's behavioural problems, types, manifestation and care.

2-Psychometric assessment To assess the presence of behavioural problems (Depression, Anxiety, Loneliness, Aggression and Self-esteem) of preschool & school age children.

II. Operational design:

The operational design for this study consisted of a preparatory phase, a pilot study and field work.

Preparatory phase:

This phase included reviewing of literature related to mothers' knowledge about behavioural problems using books, articles, journals, and the internet. This served also to develop the study tools for data collection.

Validity and reliability:

Validity of the study tools were ascertained by a group of experts (5) in the pediatric nursing field. The elicited suggestion were considered by the researcher then the final form of the questionnaire was formulated.

Pilot study:

A pilot study was carried out on 10% of children and their accompanying mothers from the previously mentioned settings to test the applicability, clarity and efficiency of the tools. The pilot study also served to estimate the time needed for each subject to fill in each study tool. The researcher excluded all children involved in the pilot study from the study sample.

Field work:

Data was collected in six months, from the first week of November 2014 till the end of April 2015.

The researcher first met the child and his/her accompanying mother in the previously mentioned settings, and explained the purpose of the study after introducing herself. The researcher was available 3 days/week at the morning shift. The tools of data collection were filled by researcher in 30

minutes, where each subject was individually interviewed.

III. Administrative Design:

An official permission to conduct the study was obtained from the dean of faculty of nursing, Ain Shams University, by an issued letter to administrators of out-patient clinics affiliated to the Health Insurance and Ministry of Health Hospital, Assuit governorate. The researcher explained the purpose and expected outcomes of the study and confirmed their approval to conduct the study.

Ethical consideration:

The approval to carry out the study was obtained from the research ethics committee at the Faculty of Nursing, Ain Shams University. A verbal approval was obtained from each study subject before participation in the study. A clear and simple explanation was given according to their level of understanding and their physical and mental readiness. They were assured that all the gathered data was confidential and used for research purpose only.

The researcher clarified the aim of the study to the studied sample before starting. Mothers were informed that they could freely participate or not in the study and had the right to withdraw from the study at any time without giving any reasons.

IV. Statistical Design:

Data collected from the studied sample was revised, coded and computerized. Statistical analysis of the collected data was done using the statistical package for social sciences (SPSS) version 20.

Results

Table (1): Number and percentage distribution of the studied mothers according to their socio-demographic characteristics (n= 100) Regarding socio-demographic characteristics of the studied mothers, it was found that less than half of mothers of preschool age children (46.0%) were in the age group of 30<40 years with $\bar{X} \pm SD$ (38.13±10.31), and more than half of mothers of school age children (52.0%) were in age group 40<50 years with $\bar{X} \pm SD$ (41.06±9.89). It was found also that 98.0% and 84.0% of the mothers of preschool and school age children were married respectively. Also, it was clear that 40.0% and 32.0% of mothers of preschool and school age children respectively were highly educated (faculty education). A statistically significant difference (p<0.05) was found between preschool and school age children in relation to marital status of their mothers.

It is clear from **table (2)** that nearly three quarters (74.0% and 86.0%) of preschool and school age children's mothers were not working respectively. Also 62.0% of preschool age children's mothers had urban residences compared with 70.0% of school age children's mother who had rural residence. In addition, regarding the monthly income of the family, it was clear that 48.0% of mothers in both age groups were having 1500 < 2200 LE/month. There was a statistically significant difference (p<0.001) between preschool and school age children's mothers and their residence regarding to rural.

It is clear from **table (3)** that there was a statistically significant difference between preschool and school age children (p<0.001) in relation to age and educational level. 50% and 52% of preschool and school age children were females respectively. 96% and 54% of them were in the age groups of 3<6 and 9≤12 years with $\bar{X} \pm SD$ 4.7±1.8 and 8.11±2.91. 82% and 88% of preschool and

school age children were in kindergarten and primary education respectively. 34% and 50% were ranked as the fourth children in their families respectively. 100% and 96 % of preschool and school age children were not working. 62% and 54% of preschool and school age children reported previous history of illness due to diseases, and 64.5% and 55.6% of them were previously ill due to acute diseases respectively.

Figure (1): illustrated that more than half (58.0%) of the studied preschool children had severe depression, while half (50.0%) of the studied school age children had moderate depression, with highly statistically significant difference between preschool and school age children with χ^2 26.874 & p-value 0.001.

Figure (2) illustrated that nearly two thirds (62.0% and 64%) of the studied preschool and school age children had severe and moderate anxiety levels respectively with statistically significant difference between both groups with χ^2 13.950 & p- value 0.002

Figure (3) illustrated that nearly two thirds (64.0%) of the studied preschool age children had low self-esteem, while more than two thirds (68.0%) of the studied school age children had moderate self-esteem, with highly statistically significant difference between preschool and school age children with χ^2 42.320 & p-value 0.001.

Figure (4) illustrated that 58.0% and 82% of the studied preschool and school age children had negative aggression respectively with statistically significant difference between both groups with χ^2 8.057& p-value 0.045.

Figure (5) clarified that 66.0% and 58% of the studied preschool and school age children had mild loneliness respectively, with no statistically significant difference between both of them with χ^2 1.335 & p-value 0.513.

It is clear from table(4) that there was statistically significant difference ($p < 0.05$) between socio-demographic characteristics of the studied mothers namely, marital status, rural residence, and 1500<2200 income, and

their total knowledge regarding behavioural problems of preschool and school age children. While no statistically significant difference was observed in relation to the rest of mother's characteristics.

Table (1): Number and percentage distribution of the studied mothers according to their socio-demographic characteristics (n= 100)

| Maternal socio-demographic characteristics | Preschool | | School | | Test of significance | |
|--|--------------------|-------------|-------------------|-------------|----------------------|---------|
| | No | % | No | % | χ^2 | p-value |
| Age (years): | | | | | | |
| 20 < 30 | 5 | 10.0 | 4 | 8.0 | 3.864 | 0.277 |
| 30 < 40 | 23 | 46.0 | 15 | 30.0 | | |
| 40 < 50 | 20 | 40.0 | 26 | 52.0 | | |
| 50 ≤ 60 | 2 | 4.0 | 5 | 10.0 | | |
| $\bar{X} \pm SD$ | 38.13±10.31 | | 41.06±9.89 | | | |
| Marital status: | | | | | | |
| Married. | 49 | 98.0 | 42 | 84.0 | 6.338 | 0.042* |
| Divorced. | 1 | 2.0 | 4 | 8.0 | | |
| Widowed. | 0 | 0.0 | 4 | 8.0 | | |
| Educational level: | | | | | | |
| Illiterate. | 5 | 10.0 | 6 | 12.0 | 8.046 | 0.154 |
| Read and write. | 8 | 16.0 | 11 | 22.0 | | |
| Primary. | 0 | 0.0 | 3 | 6.0 | | |
| Preparatory. | 4 | 8.0 | 0 | 0.0 | | |
| Secondary. | 13 | 26.0 | 14 | 28.0 | | |
| Faculty. | 20 | 40.0 | 16 | 32.0 | | |

*p-value <0.05 significant

Table (2): Number and percentage distribution of the studied mothers according to their work, residence and monthly income (n=100).

| Mothers' characteristics | Preschool | | School | | Test of significance | |
|------------------------------------|--------------------|-------------|--------------------|-------------|----------------------|---------------|
| | No | % | No | % | χ^2 | p-value |
| Work: | | | | | | |
| Working. | 13 | 26.0 | 7 | 14.0 | 2.250 | 0.134 |
| Not Working. | 37 | 74.0 | 43 | 86.0 | | |
| Type of work: | | | | | | |
| Technical. | 2 | 15.4 | 1 | 16.7 | 2.654 | 0.682 |
| Not technical. | 11 | 84.6 | 6 | 85.7 | | |
| Residence: | | | | | | |
| Rural. | 19 | 38.0 | 35 | 70.0 | 10.306 | 0.002* |
| Urban. | 31 | 62.0 | 15 | 30.0 | | |
| Family income/month (LE): | | | | | | |
| 800<1500 | 9 | 18.0 | 7 | 14.0 | 0.361 | 0.835 |
| 1500<2200 | 24 | 48.0 | 24 | 48.0 | | |
| 2200≤2900 | 17 | 34.0 | 19 | 38.0 | | |
| $\bar{X} \pm SD$ | 2604±415.92 | | 2751±227.31 | | | |

*p-value <0.05 significant; **p-value <0.001 highly significant.

Table (3): Number and percentage distribution of the studied children according to their characteristics n=100.

| Children characteristic | Preschool | | School | | Test of significance | |
|-------------------------------------|----------------|--------------|------------------|-------------|----------------------|-------------------|
| | No | % | No | % | χ^2 | p-value |
| Gender: | | | | | | |
| Female. | 25 | 50.0 | 26 | 52.0 | 0.040 | 0.841 |
| Male. | 25 | 50.0 | 24 | 48.0 | | |
| Age (years): | | | | | | |
| 3<6 | 48 | 96.0 | 5 | 10.0 | 74.687 | < 0.001 ** |
| 6<9 | 2 | 4.0 | 18 | 36.0 | | |
| 9≤12 | 0 | 0.0 | 27 | 54.0 | | |
| $\bar{X} \pm SD$ | 4.7±1.8 | | 8.11±2.91 | | | |
| Education level: | | | | | | |
| Not yet enrolled. | 9 | 18.0 | 0 | 0.0 | 100.000 | < 0.001 ** |
| Kindergarten. | 41 | 82.0 | 0 | 0.0 | | |
| Primary. | 0 | 0.0 | 44 | 88.0 | | |
| Preparatory. | 0 | 0.0 | 6 | 12.0 | | |
| Rank: | | | | | | |
| First. | 12 | 24.0 | 4 | 8.0 | 5.635 | 0.131 |
| Second. | 7 | 14.0 | 6 | 12.0 | | |
| Third. | 14 | 28.0 | 15 | 30.0 | | |
| Fourth. | 17 | 34.0 | 25 | 50.0 | | |
| Work: | | | | | | |
| Yes. | 0 | 0.0 | 2 | 4.0 | 2.041 | 0.153 |
| No. | 50 | 100.0 | 48 | 96.0 | | |
| History of previous illness: | | | | | | |
| No. | 19 | 38.0 | 23 | 46.0 | 0.657 | 0.418 |
| Yes. | 31 | 62.0 | 27 | 54.0 | | |
| Cause of previous illness: | | | | | | |
| Acute disease. | 20 | 64.5 | 15 | 55.6 | 3.247 | 0.355 |
| Handicap. | 7 | 22.6 | 4 | 14.8 | | |
| Operation. | 4 | 12.9 | 8 | 29.6 | | |

**p-value <0.001 highly significant

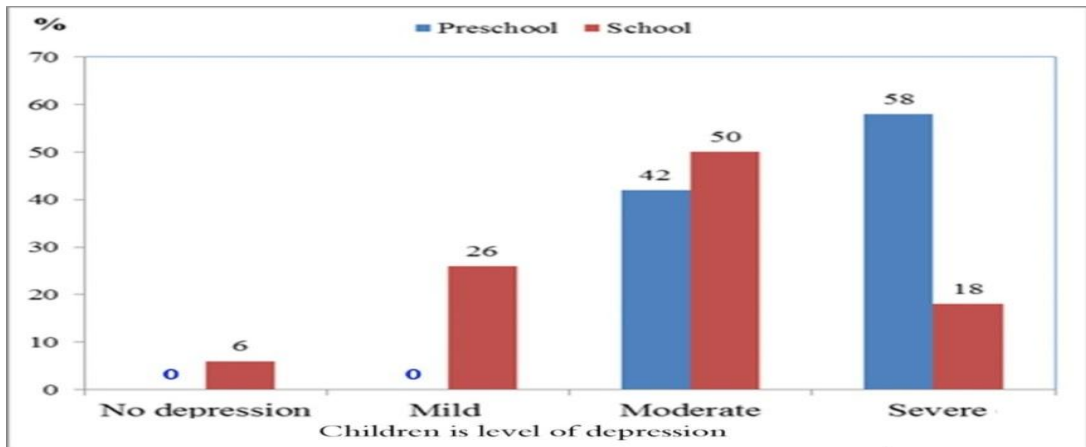


Figure (1): Number and percentage distribution of preschool and school age children according to their levels of depression n=100.

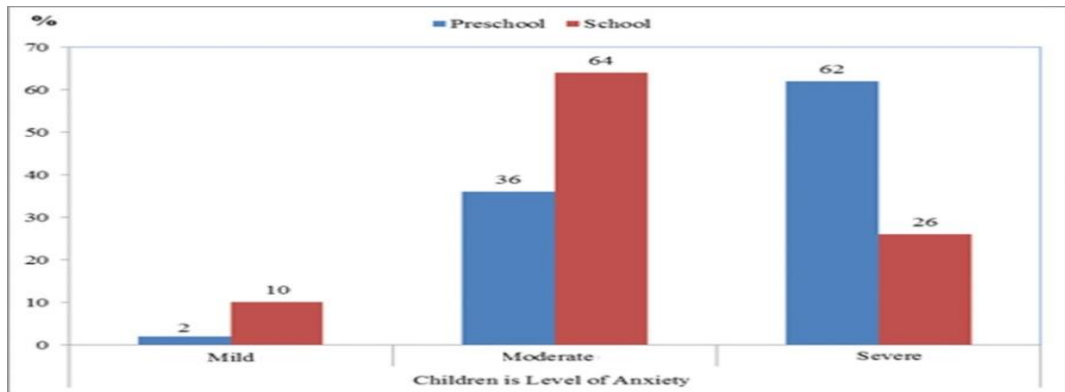


Figure (2): Number and percentage distribution of the studied Preschool and school age children according to their level of anxiety n=100.

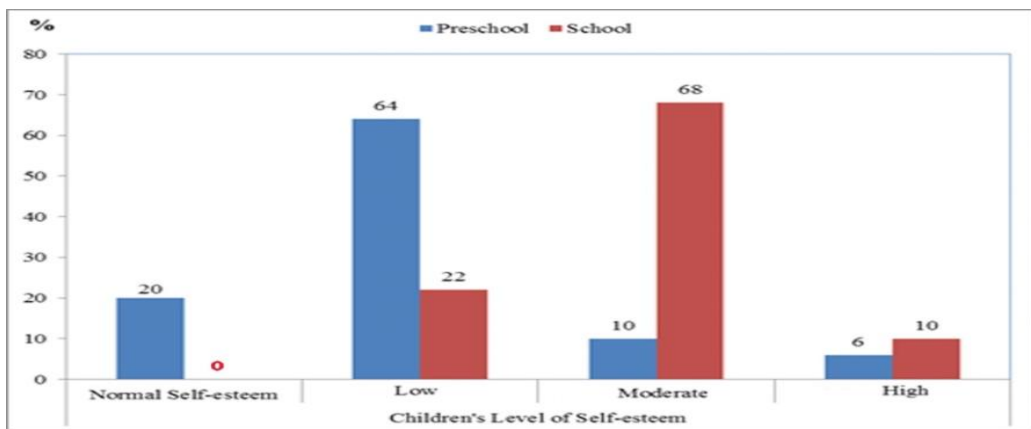
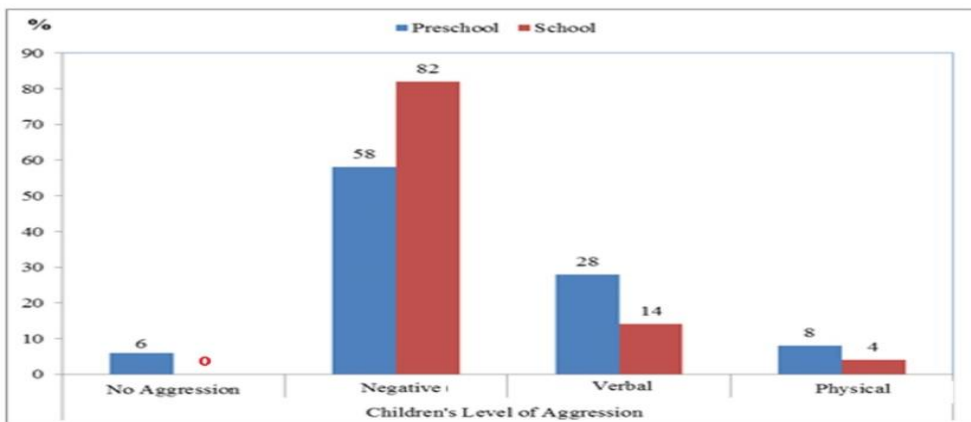


Figure (3): Number and percentage distribution of the studied preschool and school age children according to their levels of self-esteem n=100.

Figure (4): Number and percentage distribution of the studied preschool and school age children according to their levels of aggression n=100.



Nurses' Expectations toward Toxoplasmosis during Pregnancy

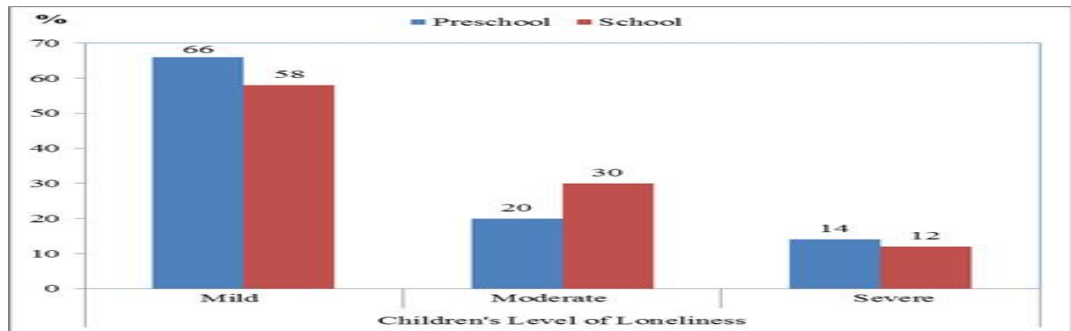


Figure (5): Number and percentage distribution of the studied preschool and school age children according to their levels of loneliness n= 100.

Table (4): Relation between mother's total knowledge regarding behavioural problems of preschool and school age children and their socio-demographic data n= 100.

| Total knowledge Mother characteristics | Satisfactory | | Unsatisfactory | | Test of significance | |
|---|--------------|-------------|----------------|-------------|----------------------|---------------|
| | No | % | No | % | χ^2 | p-value |
| Age (years): | | | | | | |
| 20<30 | 7 | 18.9 | 2 | 3.2 | 7.210 | 0.066 |
| 30<40 | 12 | 32.4 | 26 | 41.3 | | |
| 40<50 | 16 | 43.2 | 30 | 47.6 | | |
| 50≤60 | 2 | 5.4 | 5 | 7.9 | | |
| Marital status: | | | | | | |
| Married. | 31 | 83.8 | 60 | 95.2 | 9.097 | 0.011* |
| Divorced. | 5 | 13.5 | 0 | 0.0 | | |
| Widowed. | 1 | 2.7 | 3 | 4.8 | | |
| Education level: | | | | | | |
| Illiterate. | 2 | 5.4 | 9 | 14.3 | 8.309 | 0.140 |
| Read and write. | 9 | 24.3 | 10 | 15.9 | | |
| Primary. | 3 | 8.1 | 0 | 0.0 | | |
| Preparatory. | 2 | 5.4 | 2 | 3.2 | | |
| Secondary. | 9 | 24.3 | 18 | 28.6 | | |
| Faculty. | 12 | 32.4 | 24 | 38.1 | | |
| Work: | | | | | | |
| No working. | 29 | 78.4 | 51 | 81.0 | 0.097 | 0.756 |
| Working. | 8 | 21.6 | 12 | 19.0 | | |
| Residence: | | | | | | |
| Rural. | 15 | 40.5 | 39 | 61.9 | 4.283 | 0.038* |
| Urban. | 22 | 59.5 | 24 | 38.1 | | |
| Income/month/LE: | | | | | | |
| 1500<2200 | 15 | 40.5 | 33 | 52.4 | 10.118 | 0.006* |
| 200<1500 | 2 | 5.4 | 14 | 22.2 | | |
| 2200≤2900 | 20 | 54.1 | 16 | 25.4 | | |
| Lives in an independent house: | | | | | | |
| No. | 9 | 24.3 | 11 | 17.5 | 0.686 | 0.407 |
| Yes. | 28 | 75.7 | 52 | 82.5 | | |

*p-value <0.05 significant.

Discussion:

Regarding characteristics of the studied mother's age, marital status, and educational level (**Table 1**). The study findings revealed that ($\bar{X} \pm SD$) of mothers' age was 38.13 ± 10.3 and 41.06 ± 9.89 for those of preschool and school age children respectively. This finding was not in an agreement with **Breaux (2013)**, who studied the role of parent psychopathology in the developmental trajectories of preschool children with behaviour problems, and found that mothers' average age was from 30-55 years old. The researcher thinks that this difference could be related to the differences in research aim and methodology

Regarding residence area of the studied mothers (**Table 2**), it was obvious that two thirds of mothers of preschool age children were from urban residence areas compared with three quarters of school age children's mothers who were from rural areas, this finding was highly supported by **Zenget al. (2009)**, who studied emotional, behavioural problems and related determinants among children aged 4 to 7 years in the rural areas of China, and mentioned that the prevalence of emotional and behavioural problems was high among children living in rural areas. But this result was not in an agreement with **Xiaoliet al. (2014)**, who studied prevalence of psychiatric disorders among children in Northeast China, and reported that rural children showed non-significantly lower prevalence of behavioural problems than urban ones. This may have been due to different life styles of rural children compared with urban ones.

Regarding age of the studied children, it was obvious that the mean age of the preschool children ($\bar{X} \pm SD$) was 4.7 ± 1.8 . This finding was highly supported by **Vahediet al. (2012)**, who studied social competence and behavioural problems in preschool children, and mentioned that their

age was from 3-6 years. On the other hand, the mean age of school age children's was ($\bar{X} \pm SD$) 8.11 ± 2.91 . This finding was in an agreement with **O'connoret al. (2012)**, who studied child's disruptive behaviour and parenting efficacy: Comparison of the effects of two models of insights, and mentioned that the age of the studied children was from 6-12 years. This may have been due to aim and methodology of the study.

In relation to psychometric assessment (**Figure 1**), more than half of the studied children had severe depression in preschool, this finding was in accordance with **Egger and Angold (2006)**, who studied common emotional and behavioural disorders in preschool children: Presentation, nosology, and epidemiology, and reported that there is increased rate of severe depression in preschool age children compared with moderate one in school age children. The researcher believes that occur due to parents not sharing their children's activities and respecting their rights.

It was clear that nearly two thirds of studied preschool children had severe anxiety; this was in agreement with **Vreekeet al. (2012)**, who studied the assessment of an inhibited, anxiety-prone temperament in a Dutch multi-ethnic population of preschool children, and mentioned that children in younger age group are more dependent physically and psychologically. On the other hand, regarding anxiety in preschool age, nearly two thirds of studied children had moderate anxiety. The researcher believes that separation of children from parents caused moderate to severe anxiety.

As observed there was highly statistically significant difference between preschool and school age children in relation to their self-esteem, where nearly two thirds of studied preschool age children had low self-esteem, this finding was in agreement with **Vahedi (2012)**, who studied social competence and behaviour problems in

preschool age children, and mentioned that preschool children's self-esteem compared with school age children's one was moderate. The researcher believes that the common method of punishment for children leads to children having low self-esteem. Parent not sharing their children in interesting hops create recreative events for them.

It was clear that more than half of studied preschool age children, had mild aggression, this finding was in agreement with **Raaijmakers (2008)**, who studied aggressive behaviour in preschool children, found that preschool age children had aggressive behaviour, showed impairments in inhibition, irrespective of attention problems. Compared with aggression in school age children, this finding was in agreement with **Sobhyet al. (2014)**, who studied emotional and behavioural problems of primary school children with and without learning disabilities: A comparative study, and mentioned that children in school age who had learning disabilities had higher scores on aggression. The researcher believes that the physical and verbal punishment for children and repeated frustration from parent leads to aggression child. Also watching T.V programs leads to aggression.

It was found that, more than two thirds of studied preschool children ,had mild loneliness, this finding was not in agreement with **Vahdi, (2012)**, who studied social competence and behaviour problems in preschool age children, and mentioned that preschool age children who had frequent emotional and behavioural problems, had also their social competence reduced gradually compared with school age children. The researcher believes that parents not encouraging children to cooperate and talk with peers may lead to loneliness in these children.

Regarding the relation between socio-demographic characteristic of the studied mothers and their total knowledge, it was clear that there was statistically significant

difference between marital status, rural residence, and income from 1500<2200 LE/month of the studied mothers and their total knowledge. This finding was in accordance with **Bornstein et al. (2010)**, who studied parenting knowledge: Experiential and socio-demographic factors in European American mothers of young children, and mentioned that there was positive relation between characteristics of the studied mothers and their total knowledge.

Conclusion:

It can be concluded from the study findings that depression, anxiety, self-esteem and loneliness were the common behavioural problems of preschool age children, while aggression was the common behavioural problem in school age children.

Recommendation

1. Counselling of parents and their children having behavioural problems at schools and pediatric health care settings when possible.
2. Counselling services regarding prevention, detection and management of behavioural problems in children should be available in health care settings in addition to hotlines, brochures, booklets, and educational media programs containing simple information about needs and problems of children.
3. Parents should be educated regarding the common behavioural problems during preschool and school age children.

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