COMORBIDITY OF DEPRESSION AND ANXIETY WITH FUNCTIONAL IMPAIRMENT IN CHILDREN AND ADOLESCENTS WITH LOW ACADEMIC ACHIEVEMENT

By

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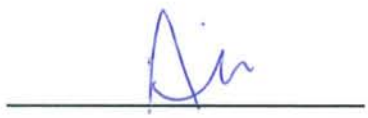

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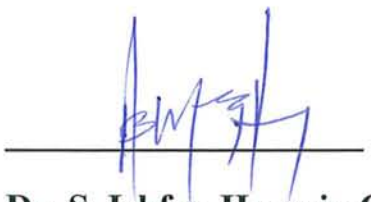

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MESSAGE TO PARENTS AND TEACHERS

- *"Every child's mental health is important.*
- *Many children have mental health problems.*
- *These problems are real and painful and can be severe.*
- *Mental health problems can be recognized and treated.*
- *Caring families and communities working together can help"*

"Save Your Youth Today Tomorrow it May be Too Late"

(International Associations of Educationists and Mental Health Practitioners)

DEDICATED
TO

All those needy children and adolescents who are at risk of being engulfed bySerious Emotional Disturbance

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To begin with the name of Almighty Allah who is the most beneficent and the most merciful". I offer extremes of my regards to Holy Prophet Muhammad (PBUH) and his Ahlulbait-e-Nabuwat, whose indomitable spirits have bestowed all the mercies of God like a shower over me and endowed me with potential, zest and ability to come out of blind alleys and accomplish this monstrous task successfully.

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ABSTRACT

The present research has been conducted to identify the comorbidity of depression, anxiety and functional impairment (FI) in children and adolescents with low academic achievement. Instruments used for the testing of hypothesis of the present research were Functional Impairment Assessment Scale (FIAS) newly constructed in the present study, Urdu Version of Depression and Anxiety in Youth Scale (DAYS, Phyllis et al., 1994) translated in the present research by the researcher, and Urdu Version Psychological Wellbeing Scale Affectometer-2 (Kammann & Flet, 1983) and translated in Urdu by Naheed (1997). The research has been carried out in three parts. Part I deals with the development of an indigenous scale named as Functional Impairment Assessment Scale (FIAS) for children and adolescents to be used in the main study. This part of the research was carried out in four steps by using independent sample (N=350) that includes: Generation of item pool for the scale; Content Validation and Categorization of items into specified categories; Selection of the final items for the scale; and Establishment of psychometric properties of the scale. Cronbach's alpha coefficient yielded a significantly positive correlation. All these reliability coefficients are also quite satisfactory. The FIAS also possesses satisfactory content and construct validity as well. The Part II of the present research has been planned to Translation of Depression and Anxiety in Youth Scale (DAYS) into Urdu to be used in present study and to confirm convergent and discriminant validities as well as to establish alpha coefficient reliability of the scale FIAS. Part III which is also main study deals with the hypotheses testing. Sample of the Main study consists of children and adolescents (N = 410) with age range 7-19 years both boys (N = 189) and girls (N = 221) studying in Federal Government Primary & Senior Schools and Model College for boys and girls of Rawalpindi and Islamabad cities. Whole the Sample was divided

into two main groups with respect to the academic achievement. Group 1: consisting of students (N = 205) showing low academic achievement and Group 2: consisting of students (N = 205) showing high level of academic achievement, All the students included in the sample were referred by the class teachers. It was also assumed that student with low academic achievement have high level of emotional disturbance (depression & anxiety) and functional impairment but have low level of psychological wellbeing and life satisfaction. To test these assumptions four types of analyses were applied to data. These analyses included: The reliability estimates of all the scales used in the study was conducted. A correlation matrix was computed in order to see the relationship among variables of depression, anxiety, psychological wellbeing, life satisfaction and functional impairment and low academic achievement. The purpose of the correlation matrix was to yield an initial insight into the pattern of relationships that might exist among the various variables. Since all the variables involved were continuous variables, therefore, Pearson Product Moment Correlation Coefficients were computed as indices of the magnitude and direction of relationship among various variables. Anova and t-test analysis for independent samples were computed to find the differences between low and high academic achievers on these variables as well as with respect to different demographic variables. Finally, Multiple Logistic Regression Analysis was carried out to study the combined effect of depression, anxiety, psychological wellbeing, life satisfaction and functional impairment on low academic achievement. It has been found that children and adolescents with low academic achievement have comorbidity of depression, anxiety and functional impairment. With respect to certain demographic variables it has been found that children and adolescents belonging to low socio-economical status and single parent families have shown significantly high level of emotional problems (depression and anxiety) and functional impairment as well as low academic achievement.

Chapter-I

INTRODUCTION

The present research has attempted to address the world wide current issue regarding children and adolescents who have emotional disability that unlike other physical disabilities remains unidentified.There is an international slogan of providing every child in need the proper interventions and effective special need services and first step towards it is to identify this needy young population at an early stage. DSM-IV (APA, 1994) recommends the incorporation of assessment of functional impairment for the diagnosis of emotional disturbance in children and adolescents.

Functional impairment (ranging from mild to severe) has been found in almost every childhood mental disorder and the presence of social, emotional and cognitive dysfunction is a signal of any underlying or commencing mental disorder which being unidentified may result in negative outcomes in the future. Many recent researches (Mieke, NeeltjeBatelaan, Harold, van Megen, Brenda, Penninx, et al., 2012; Ann Vander Stoep, Molly, Adrian, Isaac, Rhew, Elizabeth McCauley, Jerald, Herting, Helena, & Kraemer, 2012) document that without assessment of functional impairment diagnosis of psychopathology is not complete.

According to the Report of Surgeon General (U.S. Department of Health and Human Services, 1999), young peoples' mental health is very essential for their overall health and well-being. If they are mentally healthy they have good interpersonal, psychosocial, and communicative and effective coping as well as analylical skills. These are the positive emotions, which motivate them for the attainment of goals and help them sustain their interest in studies, drive them for

achievement of good marks and help them to maintain healthy relationships with peers, parents and also with teachers. Problems such as depression and anxiety may act as barriars to learning and can affect their psychosocial development, school performance and social relationships.

Recently, studies (Atkins, Frazier, Adil, & Talbott, 2003; Bishop et al., 2004; Libbey, 2004 & Wilson, 2004) has placed a good deal of emphasis on identification and inclusion of all those children and adolescents in special needs services who show symptoms of emotional disturbance not enough to fit into DSM-IV diagnostic criteria but which may escalate to become a major mental health problem in the near future. And a comprehensive programme involving schools and families can be he helpful. (Adelman & Taylor, 1999, 2000; Catalano, Haggerty, Oesterle, Fleming, & Hawkins, 2004; Klern & Connell, 2004;; McNeely & Falci, 2004; Paternite, & Johnston, 2005)

Children and adolescents with emotional problems can not enjoy a positive quality of life; can not function well at home, in school, and in their communities because due to low mental health they are unable to achieve the expected developmental cognitive, social, and emotional milestones. Many studies conducted in the past have tried to compare the emotional problems of children and adolescents with high / low academic achievement. In this connection Pieree (1961) studied 54 students of 10^{th} grade and 50 of 12^{th} grade boys with superior mental ability. The two groups were divided on the basis of their academic grade performance during the preceding year. The results indicated that students with high academic achievement had showed more favorable personality characteristics especially in responsibility, tolerance and emotional stability than the others with low academic achievement. It is a common belief among educators that child who does well in school is usually the

child who is emotionally well adjusted, while the child who achieves poorly is the one who either has a personality problem or creates problem (Kirkendall & Ismail, 1970).

According to Alexander, Natriello, and Pallas (1985), young children who are emotionally disturbed do not participate in classroom activities and are generally ignored by classmates and teachers. Even the preschool teachers pay less attention to such children and provide them less instruction and positive feedback. Being not accepted by their peers and teachers these children do not like schools, hence attend less, and as a consequence learn less. Therefore young children with psychosocial problems particularly depression and anxiety perform poorly on academic tasks and hence are at greater risk of dropping out from the shools and showing antisocial behavior in future.

The National Longitudinal Transition Study (NLTS) conducted in the early 1990s (Wagner, 1990; Wagner, Amico, Marder, Newman, & Blackorby, 1992) showed that children with emotional disturbance are at greater risk of poor academic performance. It was found that among other disabilities group the outcomes for youth in the primary disability category of emotional disturbance (ED) were not good including dropouts from schools, academic failure, poor social adjustment, and involvement in delinquent acts or criminal justice system. Wagnner (1995) found that serious emotional disturbance have a deep effect on school performance. Davis & Vander Stoep, (1997) also had similar findings with that of wagnner's which held that emotionally disturbed children and adolescents are at risk of negative outcomes such as absentiism, poor academic performance, dropping from schools, unemployment, and poor social relationships.

Prevalence

It has been found that approximately 20% of youth has been diagnosed of having emotional disturbance that are in need of mental health intervention plans (Committee on School Health, 2004; Goodman et al., 1997; Marsh, 2004). The prevalence rate might have increased to double if the unidentified youth who are "at risk" `are included (Dryfoos, 1990, 1994; Hodgkinson, 1989).

According to American Psychiatric Association, (1994) the mental health problems which are common in adolescents include learning and conduct disorders, anxiety, depression, substance abuse, and developmental disorders such as autism.

Depression in young people is a recurrent problem as it is in adults According to Lewinsohn, Clarke, & Seeley, (1994)) as in adults, episode of depression reccurs in children and adolescents but by the help of early diagnosis of depressive disorders and their effective intervention and treatment plans mental health in young population can be restored.

Brief Description of Key Concepts

Depression in children and adolescents. In DSM-III (APA, 1980) child and adolescent mental disorders were classified in a separate and distinct section but most investigators agree that mood disorders are fundamentally similar in children and in adults (Lewinsohn, Hops, Roberts, Seely, & Andrews, 1993). The same DSM criteria can be used to diagnose children and adolescents as to diagnose adults. However, some features of depression are more common in children and adolescents than in adults, notably, irritable mood.

There are some differences between children and adults with major depressive disorder (MDD) in the expression of various symptoms. Depressed appearance, separation anxiety, phobias, somatic complaints and behavioural problems occur more frequently in younger than older individuals. In contrast symptoms of anhidonia, psychomotor retardation, suicide attempts and impairment of functioning increase with age (Carlson, 1990). For most part, children and adults with MDD display similar symptoms and have a comparable rate of comorbidity and recurrence (Kovacs, 1997).

Though diagnostic criteria and key defining features of major depressive disorder in children and adolescents are the same as they are for adults the recognition and diagnosis of the disorder may be more difficult in youth for several reasons. Literature depicts that diagnosing and studying depression among adolescents have been difficult for three very different reasons.

First, depression during adolescence is often accompanied by other psychosocial or behavioral problems including anxiety, phobia, psychosomatic complaints and substance abuse (Brady & Kendall, 1992).

Second, many professionals have been tempted to attribute all observeable difficulties in adolescence to unseen depression. In the past, for example, the school phobia and anorexia nervosa were thought to hide the 'real' problem the depression. Now however it is widely recognized that not all adolescents with behavioral problems are necessarily depressed, but that depression and other problems are often co-morbid (Cantwell & Baker, 1991).

Third, the popular stereotype of adolescents as normally disturbed leads to many parents and teachers to fail to recognize the genuine psychological problems or child's underlying subjective negative moral (Wu, Kouzis, & Leaf, 1999). Childhood

is usually thought of as a happy and carefree time i.e., a period remote from worries, burdens and responsibilities of adulthood. Young people are perceived usually as positive and happy. They might encounter disappointment, disapproval or negative events in their daily life, yet their sadness, frustration and anger is expected to be temporary. That is, when children become sad, irritable or upset, parents often attribute such negative mood to temporary factors, such as lack of sleep or of not feeling well and expect the moods to pass. Thus for a long time it was thought that children did not get depressed, and when they did it would be short lived. This concept has been changed now. Research depicts that even three-month old baby can become depressed. Infants of depressed mothers display marked depressive behaviours (sad faces, slow movements, lack of responsiveness), even when interacting with a non-depressive adult (Field, 1986).

Signs and Clinical Characteristics of Depression in Children and Adolescents

The diagnostic criteria for mild depressive disorder (as cited in DSM-IV) are: depressed or irritable mood for most of the day or for at least one year; the poor appetite or overeating; insomnia or hypersomnia (sleeping too much); low energy or fatigue; low self esteem; poor concentration or difficulty making decisions; feelings of hopelessness.

The way symptoms are expressed varies with the developmental stage of the youngster (Geller & Luby, 1997; Brent, Perper, & Allman, 1991). In addition, children and young adolescents with depression may have difficulty in properly identifying and describing their internal emotional or mood states. For example, instead of communicating how bad they feel, they may act out and be irritable toward

others, which may be interpreted simply as misbehavior or disobedience. Research has found that parents are even less likely to identify major depression in their adolescents than are the adolescents themselves (Fleming & Offord, 1990). Therefore no "childhood" mood disorders in DSM-III-TR are specific to a developmental stage, unlike anxiety disorders. However it also seems clear that the "look" of depression changes with age. For example children three years of age might manifest depression by their facial expressions as well as by their eating, sleeping, and play behavior, quite differently from children between the ages of nine and twelve. Thesesymptoms cause clinically significant distress impairment in social, school or other important areas of functioning. A brief description of the expression of depression with respect to the age is being described in the next section.

Age difference. Depression in children may be expressed differently at different ages. An infant may show sadness by being passive and non-responsive; a preschooler may appear withdrawn and inhibited; a school aged child may be argumentative and combative; and a teenager may express feelings of guilt and hopelessness.

Infant. An infant may show sadness by being passive and non-responsive. They may are considered as crying baby.

Pre-schooler. Depression in children under age 7 tends to be diffused and less easily identified than depression in older children and adolescents (Cantwell, 1996). However it is important to be aware of depressive symptoms in young children, since less visible symptoms at a younger age may develop in to depressive disorder in late

childhood or early adolescence. Preschoolers who are depressed may appear extremely somber and tearful. They generally lack the exuberance, bounce, and enthusiasm in their play that characterize most preschoolers. They may display excessively clinging and whiny behaviour around their mothers as well as fear of separation or abandonment. Preschoolers who are depressed may also be irritable for no apparent reason. They may show negative and self destructive verbalization. Physical symptoms such as stomachache and vomiting are common in these children.

School aged. In addition to the symptoms of depression in preschoolers, school aged (5-10 yrs) children may display increasingly irritability, disruptive behaviour, temper tantrums, and combativeness. A parent may say "Nothing ever pleases may child-she hates herself and everything around her". School aged children may look sad but an often unwilling to talk about their sad feelings. Physical complaints may include weight loss, sleep disturbance and headache. Academic difficulties and peer problems are also common and may include frequent fighting's and may complaints of not having friends. Suicide threats may also begin to occur at this age.

Pre-teens. In addition to the symptoms of younger children the preteens (10 plus to 12 plus yrs) with depression show increased feeling ofself blame and expression of low self esteem, persistent sadness and social inhibition. A child may say "I am stupid" or "Nobody likes me". Feelings of isolation from family are also common pre-teens may experience an inability to sleep or may sleep too much.

Teenager. Teens may show an increased irritability with loss of feelings of pleasure in or interest, and worseningschool performance.Angry discussion with parents on parent teen issues is also more common than usual. Other symptoms at this age include negative body image, low self esteem and self consciousness. Around physical symptoms teens may experience excessive fatigue and energy loss. Teens with depression experience loneliness, self blame, guilt, feelings of worthlessness, suicidal thoughts and attempts. For some depressed teens, symptoms of irritability, aggression, and rage are more prominent. Since many of the behaviors and symptoms described above may also occasion children who are developing normally or in children with other disorder or conditions, the presence of sad mood, loss of interest, or irritability is essential for the diagnosis of depression. In addition whatever the child's age, the symptoms must reflect a change in behaviour, persist over time, and cause significant impairment in functioning. But a good rule of thumb is that an individual who displays three or more of the signs of depression for two weeks should probably consult a professional.

Gender Difference

With reference to the incidence of depressive disorders in children and adolecents it has been found that gender difference is not present among children aged 6 to 11 years, where depression is equally common in girls and boys. Gender differences begin between the ages of 13 and 15, when the rate rises for girls (Nolen-Hoeksema & Girgus, 1994).

The rate of depressive feelings at the time of puberty has been seen to increase to a marked extent. The depression is half as common during childhood as it is during

adolescence (Avenevoli & Steinberg, in press). Interestingly, where as depressive feelings are more common among boys than girls prior to adolescence depressive disorder are much more common among girls than boys after puberty (Cullinan, Osborne & Epstein, 2004).

The rising rate of depression in girls especially at the puberty period is more likely related to their biological tendency for developing depression. Hormones and sleep cycles, which can alter mood, differ dramatically between males and females (George, Conger, & Elder, 1996).

Depression can have a negative affect on adolescent's personality due to which most of the time they look sad, despair and aggressive. Depression effects on the functioning and adjustment of young people with in their social environment that persist long after the depressive episode is resolved. In adolescents there is also an increased risk for substance abuse and suicidal behavior (Birmaher, Ryan, & Williamson, 1996; Ryan, Puig-Antich, & Ambrosini, 1987; Weissman,Wolk, & Goldstein, 1999).

Effects of Depression on the Youth's Lives

It has been noted that many youngsters who just barely fail to meet diagnostic criteria for depressive disorder still show significant impairments in their social competence, cognitive attributions coping skills, family relations and experience of stress. They are also at great risk than often youth for the development of future depression and other disorders such as substance abuse (Lewinsohn, Gotlib, & Seeley, 1997).

Risk of suicidal behaviors in children and adolescents has neen seen to be increased with depression (Weissman, Wolk, & Goldstein, 1999; Shaffer, Gould, Fisher, & 1996). Adolescent boys may show more risk if the depression is comorbid with conduct disorder and alcohol or other substance abuse (Shaffer, Gould, & Fisher, 1996). In general, young female with depression show suicidal ideation and attempt suicide about a times more often than young males, by taking handful of sleeping pills or cutting their wrists being the most common means. However, since girls typically don't use guns, they are usually less successful in completing suicide than boys (Kovacs, 1997; Shaffer et al., 1996).

Although suicidal ideation (e.g., thinking about killing oneself) is common across many different types of disorders, actual suicide attempts seem to be specific to depression. In one 7-9 years follow-up of children with psychiatric disorders, 84% of all suicide attempts were found to occur for depressive disorders (Shaffer, et al., 1996). About 30% of youngsters who are clinically depressed attempt suicide by 17 years of age (Ryan et al., 1987). Unfortunately, about half of them eventually make further attempts (Kovacs, 1997). The suicide attempts of youngster with depression almost never occur during times when they are symptoms free e.g., 90% or more have depressive symptoms at the times of their suicidal episode.

Hoyert, Kochanek, and Murphy (1999) found that in 1997, suicide was the third leading cause of death in 10- to 24-year-olds. Up to 7 percent adolescents with major depressive disorder may commit suicide in the young adult years (Weissman, Wolk, & Goldstein, 1999).

Ages 13 and 14 are peak periods for a first suicide attempt by youngsters with depression, usually by drug ingestion. In adolescents with depression, suicide attempt double during the teen years, but show abrupt decline after age 17-18. It is possible

that as young people mature, they are better able to tolerate their negative mood states and acquire more resources for coping, thus making it less likely that they will attempt suicide during periods of sadness (Kovacs, Feinberg, & Crouse-Novac, 1984).

In short as depression in children was acknowledged, a popular view emerged that it was expressed completely differently in children than in adults, often in an indirect or hidden fashion. This idea came to be known as **masked depression**. It was through that virtually any known clinical symptoms in children including hyperactivity, learning problems aggression, bed wetting, separate anxiety and sleep problems and running away could be taken as the sign of an underlying but masked depression. Once popular, notion of masked depression now has been rejected. Depression in children isn't masked, but rather may simply be overlooked because it is mostly comorbid with other disorders, such as conduct problems and anxiety disorders (Carlson, 1990) and disruptive behavior, or substance abuse disorders (Angold & Costello, 1993) and with physical illnesses, such as diabetes (Kovacs, 1997).

Anxiety in Children and Adolescents

In children and adolescents anxiety disorders are the most common mental illnesses which occur mostly along with depression due to which the true picture of anxiety is very hard to study. So near some researchers anxiety is a mystery (Barlow, 2000, 2002; Barlow, Chorpita, & Turovsky, 1996). This is the reason that why a large number of young population remains unidentified and receives no help. As a result their anxiety disorder becomes chronic promoting high risk of other psychosocial

problems such as substance abuse, depression and even suicide (Rotberg, Schoen, & Zalsman, 2008).

Children may develop anxiety disorder when they encounter stressful life events, such as beginning school, or changing from primary to secondary school and the loss of a parent. Research has shown that if children with anxiety disorders do not receive intervention or proper treatment plan they perform poorly in school and are at high risk to develop some more serious problems. In childhood or adolescence the presenc of any anxiety disorder such as separation anxiety, phobias, generalized anxiety disorder and panic disorders is often associated with onset of anxiety disorder in adult life (Newmann, Marks, & Gamoran, 1996).

According to Pine (2007), generalized anxiety disorder in adolescence leads to the onset of major depression in adults but the exact relationship between the two disorders can not be established because symptoms of anxiety and depression are usually overlapping. Inspite of this unclear relationship the research evidence suggests that anxiety–depression has a worse early adult outcome than pure anxiety disorders (Pine, Cohen, Gurley et al., 1998).

History of child and adolescent anxiety disorder is strongly associated with substance abused, poor social relationships, depression and educational underachievement in adult life (Woodward, Fergusson, & Horwood, 2001).

Symptoms of Anxiety

Diagnosis of anxiety disorders in children and adolescents is very difficult for the reason that though they experience simmilar symptoms of anxiety as do adults yet their patteren of manifestation and expression of these symptoms is quite different.

Therefore is becomes hard to determine whether a child's behavior is his bad mood or a symptom of a disorder.

The symptoms of Anxiety Disorders as reported by Ginsburg, Riddle, and Davies (2006) occuring frequently in children and adolescents include intense fear and worry, sleeping problems, physical symptoms like headaches, restlessness, nausea or vomiting and stomach aches. They also found that children (age 12 and older) reported more physical symptoms than younger children whereas the boys and girls reported similar numbers of physical complaints.

Anxiety Disorders often come and go in unpredictable ways. They have a strong affect on everyday lives of young people due to which they can not function well in their school and home settings.

Anxiety disorders usually become chronic or long lasting and if left untreated in an early stage can lead to: school abscentisisum or an inability to finish school; impaired relations with peers; low self-esteem and alcohol or other drug use.

Different Anxiety Disorder in Children and Adolescents

Separation Anxiety Disorder. SAD is usually found in children younger than 18 years which lasts for at least 4 weeks (DSM-IV; APA, 1994).

Separation anxieties are quite normal among infants and toddlers but if older children or adolescents experience the same it may be attributed to symptoms of separation anxiety disorder. The diagnostic criteria for separation anxiety disorder holds that the anxiety or fear must cause distress or affect social, academic, or job functioning and must last at least 1 month (DSM-IV). Features of clinically significant symptoms of anxiety include: severe distress accompanied by unrealistic

fear about the safety of parents or loved ones, difficulty to fall asleep without being near parents especially mother or the maid to whome child has strong attachement, nightmares with separation-related themes, and homesickness (i.e., desire to return home or see the parents or primar caretaker when the child is in daycare centre or school). Older children and adolescents also show physical/somatic symptoms, such as dizziness, vertigo, nausea, vomiting, abdominal cramps, vomiting, palpitations and muscle aches. This may be so intence that present may become panic enough to seek medical treatment. Separation anxiety disorder leads to functional impairment in social situation (i.e., impaired ability to attend school or meet social responsibilities). Children with separation anxiety may fear that their parent may become ill or may have an accident, or child may loose them forever. Their excessive worry and fear that they or a family member might die compels them to stay close to their parent or home due to which it becomes really very difficult for them to attend school or stay anywhere away (DSM-IV; APA, 1994).

Separation anxiety also involves symptoms of depression, such as sadness, apathy, withdrawal, lack of interest in daily activities or difficulty in concentrating and is equally distributed between boys and girls (APA, 1994).

Burke and Silverman, (1987) reported that 5% of school-aged children refuse to attend school.

The Centers for Disease Control and Prevention (CDC) (2005) reported that about 40% of students who do not graduate high school have a diagnosable mental health disorder among those one half of individuals may have anxiety disorders such as posttraumatic stress disorder (PTSD), and school phobia.

Egger, Costello, and Angold (2003) reported that among children with anxious school refusal and truancy, as many as 88% had a psychiatric disorder. Such children had high rates of oppositional defiant disorder, depression, and conduct disorder which places a strong need of accurate diagnosis of comorbid conditions. McShane, Walter, and Rey (2001) reported that family history of psychiatric illness was found in one half of 192 adolescents with school refusal and those admitted for inpatient treatment were more likely to have a maternal history of psychiatric illness.

The remission rate of separation anxiety disorder is quite high and it persists even in adulthood. By the estimate of Keen, Fonseca, & Wintgens (2008) approximately 30-40% of individuals with this disorder have continued psychiatric symptoms into adulthood; as many as 65% in some studies have another comorbid anxiety disorder.

Adults with separation anxiety disorder may have difficulty moving or getting married and may in turn, worry about separation from their own children and partner (DSM-1V; APA, 1994).

The cause of separation anxiety disorder is not clear. Some risk factors have been identified such as joint family system, parental psychopathology, death or illness in the family, trauma, especially physical or sexual assault may bring on the disorder.

Carol & Watkin (2003) have postulated that early and traumatic separation from the loved one such as a prolonged stay away from the primary caregiver during the neonatal period, later sudden hospitalization, and early loss of attachments because of death or divorce as well as a family history of anxiety disorders or depression in first-degree relatives may increase the risk of developing separation anxiety disorder, school phobia, and depressive disorders in children and adolescents.

Mild form of separation anxiety is a sign of the development of healthy attachments to loved ones which usually stops within 3-4 minutes after the parent leaves. Factors that may contribute to separation anxiety as given by Carol and Watkin (2003) include divorce, death or illness and family changes such as birth of a sibling.

One of the mysteries faced by the psychopathologists is the apparent overlap of anxiety and depression. Several theorists have concluded that the two moods are more alike than different. However, we now know that almost everyone who is depressed, particularly to the extent of having a disorder, is also anxious (Barlow, 2002). The problem behavior has multiple and complex causes that vary from one individual to the next. The clustering of various problem behaviors is seen more often in some population than others. Generally it is seen more often in studies of adolescents than in studies of children or young adults (Gillmore, Hawkins, Catalano, Day, Moore, & Abbott, 1991; McGee & Newcomb, 1992).

Comorbidity of Depression and Anxiety in Children and Adolescents

Feinstein (1970) used the term "comorbidity" which refers to the presence of any additional coexisting ailment in a patient with a particular disorder. Uptill now different aspects of the phenomenon have been studied extensively. According to Lamers, Van Oppen , Cmjus, Smit, Johannes, Philip et al. (2011) the incidence of comorbidity of anxiety and depressive disorders is very high. Mieke, Neeltje, Batelaan, Harold, Van Megen, Brenda, Penninx et al. (2012) hold that anxiety–

anxiety comorbidity has an earlier age of onset and a more chronic course, whereas anxiety–depressive comorbidity leads to more treatment and impaired functioning.

Kashani et al. (1989) also found higher rates for Anxiety and Depression among girls than boys. Although co-variation among internalizing problems particularly depression and anxiety has been less extensively studied than co-variance among externalizing problems, it appears that there is a good deal of the co morbidity in depression and anxiety which tend to have in common the subjective state of distress. For example the depressed adolescents are more likely to experience anxiety, panic phobia, obsession thinking, suicidal ideation, eating disorders and various psychosomatic disturbances (i.e., physical problems that have psychological causes) (Attie & Brooks-Gunn, 1989; Brady & Kendall, 1992; Cantwell & Baker, 1991; Colten et al., 1991; Gerhardt, Compas, Connor, & Achenback, 1999; Hinden, Compas, Howell, & Achenbach, 1997; Kandelet al., 1991; Peterson et al., 1993).

. Symptoms of anxiety and depression may form a single indistinguishable dimension in younger children but are increasingly distinct in older children with at least one diagnosable disorder (Brown, 1996). As many as 70% of the youngsters with Major Depression Disorder (MDD) have comorbidity conduct problems, ADHD, and substance abuse are also common in clinic-referred youngsters with MDD (Birmaher et al., 1996).

Further, about 60% of the adolescents in community sample with MDD have a co morbid personality disorder. (Birmaher et al., 1996)

MDD in young people is more likely to occur after rather than before the onset of all other psychiatric problems except substance abuse, where MDD has been found to precede the onset of substance abuse by about 4 years.

Most co-occurring disorders are usually present before the MDD and are likely to persist even after the child is no longer depressed (Birmaher et al., 1996).

The presence of co morbid disorder with MDD not only increases the risk for recurrent depression but also decreases the youngster's response to treatment and is related to poor outcomes (Birmaher et al., 1996).

Just as various externalizing problems are hypothesized to reflect an underlying antisocial syndrome, various indicators of internalizing problems may be thought of as different manifestations of a common underlying factor. This factor is often referred to as negative affectively (Lonigon, Carey, & Finch, 1994).

Many people with depression also have symptoms of anxiety or panic. Research in the related field has identified symptoms that seem central to panic and anxiety. In panic the symptoms reflect primarily autonomic activation (excessive physiological symptoms such as heart palpitation and dizziness); muscle tension and apprehension (excessive worrying about the future) seems to reflect the essence of anxiety (Barlow, Chorpiter, & Turovsky, 1996).More important, a large number of symptoms help define both anxiety and depressive disorders. Because these symptoms are not specific to either kind of disorder, they are called symptoms of negative affect (Barlow, 2002).

According to Barlow (2002), identifying pure anxious or depressive symptoms as well as symptoms of negative affect that are common to both mood states, is an important step in creating the new diagnosis of mixed anxiety and depression. Other researchers have reported finding similar shared and discrete symptoms (e.g., Clark & Watson, 1991).

Symptoms of negative affect alone are often less severe than full blown anxiety or mood disorders, suggesting that these symptoms are on a continuum with major depression and anxiety disorders (Barlow, 2002).

Anxiety and Depression in Asia

Studies conducted during last 20 years in Asia revealed the evidence of high prevalence rate of depression and anxiety especially in India, Srilanka and Pakistan (Patel, Pereira, Coutinho, Fernandes, Fernandes, & Mann, 1998; Cheng, 1998; Mumford, Saeed, Ahmad, Latif, & Mubbashar, 1997). Though there is a large body of evidence which demonstrates the disabling effects of depression yet it is hardly acknowledged partly because of the stigma associated with these illnesses (Ormel, Von Korff, Ustun, Pini, Korten, & Oldehinkel, 1994; Murray & Lopez, 1996). Depression reduces the power of concentration and motivation impairing the ability to carry out everyday tasks damaging the relationship with family members as well as fellow or co-workers. The situation is worst when depressed people are living life under powerty because judgment and problem-solving abilities which are essential in order to deal with their circumstances become impaired due to depression. As depression can also lead to increase mortality rate in poor communities of the world there is an evidences of high suicidal rate in many developing countries, particularly amongst adolescents and young adults. In India, for example, the suicide rate increased by 6.2% per annum between 1980 and 1990 (Shah, 1996). Self infliction or self-harming behavior which does not lead to actual death has been found

to be the most common reason for emergency medical treatment in Sri Lanka (Eddleston, Sheriff, & Hawton, 1998).

It has been noted that many youngsters who just barely fail to meet diagnostic criteria for depressive disorder and anxiety disorder still show significant impairments in their social competence, cognitive attributions coping skills, family relations and experience of stress. They are also at great risk than often youth for the development of future depression and other disorders such as substance abuse (Herman-Stahl & Petersen, 1996).

There is a strong association between depression and functional impairment in children and adolescents in social situations such as in their homes, communities and schools (Barlow, 2002).

Functional Impairment and Comorbidity of Depression and Anxiety in Children and Adolescents

Most of the adolescents face difficulties due to transition i.e., when they enter in their middle or high school from small elementary schools. This transition involves changes in class room environment, teachers-student relationship as well as changes in student's academic performance, and interpersonal functioning in their social relationships (Barber & Olsen, 2004). These changes affect students' sense of psychological wellbeing, self-efficacy and social competence which may lead to some mental health difficulties such as anxiety and depression (Forgan & Vaughn, 2000) and presence of attention deficit and anxiety disorders inturn increase functional impairment in children and adolescents. It has been seen

that during this period, adolescents lose their personal competence, control, and self-confidence becoming more sensitive to social evaluation. The combined effect of their social and emotional dysfunction affects their perception related to their personal beliefs about competence and future goals hence lowering their school performance and academic achievement (Pintrich, 1999, 2003). Other factors which may contribute to impairment in children and adolescents include family factors such as low income, psychiatric illness in parents, their education and their marital status (divorce or remarriage) or other living arrangement. (Nagar, Sherer, Chen, and Aparasu, 2010)

Definitions

Functional impairment. Functional impairment refers to deficiet functioning of person (Guide to Social Security Law, 2010).

Functional impairment as demonstrated by children, with a serious emotional disturbance is the decreased ability over a long period of time to meet the challenges presented by day-to-day settings and interactions in school, home, and the community (DSM-IV; APA, 1994).

Functional impairment in school setting of the children as defined by (DSM-IV) is the child having significant problems at school with paying attention in class, with participating in group activities, with sustaining interpersonal relationships in peer group.

Near some researchers Functional Impairment in youngsters with depression and anxiety is referred as the deficits which they experience in their intellectual

performance and academic achievement, disturbance in self- perception, self- esteem and social problem solving (Kovacs, 1997).

In the recent years the measurement of functional impairment has been incorporated in the diagnosis of any psychopathology. DSM-IV criteria for all affective, anxiety, psychosocial, psychosomatic and personality disorders require the presence of functional impairment.

Serious Emotional Disturbance has been considered by Individuals with Disabilities Education Act (IDEA) as one of the major disability (a barriers to learning) in children with low academic performance which refers to as functional impairment in social, emotional and cognitive domains i.e., their inability to make and maintain interpersonal relationships with their age mates or teachers, an inappropriate types of behavior or feelings under normal circumstances.

Some mental health departments and psychometricians use functional impairment as the criteria or main dimension in the scales constructed for the identification of young population struggling with psychosocial problems.

Interest is now increasing in incorporation of functional impairment in valid and reliable assessment of emotional disturbance in terms of a decreased ability of young people to cope with everyday life situations in the school, the home, and the community over a long period of time (Mundt, Marks, Shear, & Greist, 2002).

The extensive review of literature reveals that more research regarding the psychometric properties of the existing scales as well as the development of some new scales encompassing the multiple domains of functioning of young populations is warranted. The important areas as revealed through literature review in which

impairment is usually rated are cognitive, social, and emotional functioning as well as Global learning behavior of children and adolescents.

Brief description of different domains of functional impairment of children and adolescents in home and school settings is as follows.

Impairment in Global Learning Behavior

Global learning behavioral dysfunction refer to child's deficits / impairment in all academic disciplines, in class as well as in extracurricular activities and sports including, lack of confidence, communication skills, punctuality, assertiveness, arts, culture, and social relationships with their families and peers (DSM–IV; APA, 1994). Youngsters with mental disorders perform more poorly than others in school, score lower on standardized achievement tests, are rated by their teachers as doing less well academically, and have lower levels of grade attainment (Cole, Martin, Powers, & Truglio, 1996). Poor concentration and thinking, psychomotor retardation or agitation, fatigue, insomnia, and somatic complaints of anxiety disorder many lead to grade repetition, being late for or skipping school; failure to complete homework, and dissatisfaction with or refusal of school (Lewinsohn et al., 1994). The overall intellectual potential of depressed and anxious youngsters is comparable to the potentially of these who are not depressed suggesting that association between severity of depression and children's overall intelligence is weak (Kovacs, 1997).

Literature review holds that as depression affects educational attainment (Berndt, Koran, Finkelstein, Gelenberg, Kornstein, Miller et al., 2000) it affects employment opportunities in future. The depressed employees cannot finish work in time as do other people (Druss, Rosenheck, & Sledge, 2000; Kessler et al., 1999;

Leon, Walkup, & Portera, 2002; Rice, 2009; Rost; Smith, & Dickinson, 2004; Collins et al.,2000; Stewart et al., 2003). Depressed workers are slow and give low productivity (Wang, 2004) and they do more errors (Greenberg et al., 2003). With the increase of depressive symptoms there is a decrease in work productivity (Thompson & Richardson, 1999) independent of comorbid medical conditions (Adler, McLaughlin, Rogers, Chang, Lapitsky, & Lerner, 2006). Depression has been found to have the highest negative impact on employee's performance than any other disorder (Collins et al., 2005). Depression basically impairs cognitive processing of individual more than any other psychological disorder (Burton, Conti, Chen, Schultz, & Edington, 1999) due to which his/her work productivity is reduced (Pardo, Pardo, Humes, & Posner, 2006). It also lowers down their memory (Bearden, Glahn, Monkul, Barrett, Najt, Villarrea et al., 2006; Rose & Ebmeier, 2006), attention and concentration (Zimmerman, McGlinchey, Young, & Chelminski, 2006; Levin, Heller, Mohanty, Herrington, & Miller, 2007), and energy levels (Christensen & Duncan,1995).

Cognitive disturbance. According to Barbara (1994), it is the good cognitive development which enables child to respond to new situations by the socially acceptible behaviors. They aquire these skills through social learning, from the social settings in which they live.

Cognitive processes involve many aspects such as thinking, memory, intelligence, creative thinking, critical thinking, language etc. (Santrock, 2006). Cognitive development is shown to be sensitive to environmental chaos. In emotionally disturbed individuals it is related to lower cognitive performance

(Gottfried, Fleming, & Gottfried, 1994), poor performance on reading tasks (Evans, Hygge, & Bullinger, 1995).

Many youngsters with depression and anxiety experience deficits and distortion in their thinking. Some cognitive disturbances, such as feelings of worthlessness, are part of the diagnosis of depression. Others, such as negative beliefs ("*I never do nothing right*") and attributions of failure ("*I am a total failure*") are not the part of diagnosis but typically accompany the disorder. Self critical automatic negative thoughts, such as "*I am no good*", "*I'm a real looser*", "*I'm ugly*", or "*I's gone fail*" are common.

Youngsters who are depressed frequently make inaccurate interpretations of their experiences. They attend to and focus narrowly on negative events for long periods of time, which is referred to as a depressive ruminative style (Nolen-Hoeksema, Girgus, & Seligmon, 1992). They misread situations, and may feel defeated, deprived, or rejected.

Normandean & Guay, (1998) found a positive relationship between better cognitive self-control and school achievement

Emotional dysfunction. Emotional Dysfunction refers to the symptoms of mixed anxiety and depression or negative affect characterized by a state of generalized feelings of fear and apprehension e.g., nervousness, irritability, anger, fear, discomfort, resentment cryingalong with pessimism, despair, helplessness, hopelessness, low self esteem, guilt, negative expectancy, and dread of impending disaster (Rawlins & Heacock, 1993).

Although minor fluctuations in the self esteem during adolescence are commonplace, it is not normal for adolescents or adults to feel a prolonged and intense sense of hopelessness, or frustration. Such young people are likely to be psychologically depressed and in need of professional help.

Unlike most children who bounce back quickly when they are sad, children who are depressed cannot seem to shake their sadness, and it begins to interfere their daily routines, social relationships, school performance and overall functioning. Depressed children often have accompanying problems, such as a anxiety or conduct disorders. Although we typically associate depression with feelings of sadness, there are often symptoms (e.g., irritability) which are important signs of the disturbance and sadness alone, without any other symptoms, may not indicate depression in the clinical sense of the term. Many youngsters with depression express these combined feelings of sadness and irritability. Besides sadness they may describe them as cranky, moody, short-fused, or easily upset. Irritability is one of the most common symptoms of depression, occurring in about 80% of clinic referred youngster with depression (Goodman, 1997).

Depression has emotion symptoms, including dejection, decreased enjoyment in the pleasurable activities and low self esteem. It also has the cognitive symptoms such as pessimism and hopelessness. Depression has motivation symptoms as well including apathy and boredom. Finally depression usually has physical symptoms such as a loss of appetite, loss of energy and sleep difficulties (Sheinberg, 2002). Thus, although clinical depression may resemble the normal emotional dips of childhood, for some youngsters it is pervasive disabling, long lasting and life threatening.

Keltner and Kring (1998) proposed an interpersonal theory according to which social interactions are guided by our emotions in the formation and maintenance of interpersonal relationships. As man is a social animal he struggles to form relationships with others and our emotions help us to maintain those relationships (Myers & Diener, 1995; Diener & Seligman, 2002). When there is disturbance in emotions, the guidance offered by them deteriorates and our social functioning is affected (Hatfield, Cacioppo, & Rapson, 1994; Joiner & Katz, 1999; Zauszniewski & Rong, 1999).

Leppnen (2006) gave the concept of information processing which suggests that depression results from an inability to process emotionally relevant social interaction cues. Abnormal cognitive and neural processing of emotional information may lead to major depression (Goeleven, Raedt, Baert, & Koster, 2006). If it is not so it may cause the social impairment (Hirschfeld, Dunner, Keitner, Klein, Koran, Kornstein, et al., 2002) and poor social functioning inturn lead to depression due to rejection (Coyne, 1976).

A recent study (Ardi & Kwartarini, 2012) aimed to explore what make teenagers happy. This study gave the insight that good relations with others,with their families,with friends, and events related to love and being loved all are source of their happiness and among all these thefamily-bond remains the most important in teen's life to keep them happy. It has been also concluded that all are nothing but social engagement.

Social dysfunction. Social dysfunction refers to child's inability to build and maintain social relationships such as initiating social conversations or making friends

and to perform group activity (Benard, 1993). Socially competent students take an active role in classroom as they possess the important social competence skills such as (i) Nigotiating, (ii) Making decisions, (iii) Listening carefully,(iv) Predicting the outcome of behavior, (v) Adapting action to certain circumstances, (vi) Empathizing with others, (vii) Answering question, (viii) Making choices, and (x)having fun (Miller,1998). Emotionally disturbed children and adolescents have a few close relationships, feel lonely and isolated and feel that others do not like them (which unfortunately often becomes a reality) and have few friends.Self management is essential factor of social competence that includes such abilities as self assessment, self planning, self direction, self monitoring, and self evaluation. In other words, self management is the ability to manage one's own behavior and life task (Alberto & Troutman, 1995; Martin & Pear, 1996). Self management has been shown by many as being extremely effective as behavior change and management tool (Perri & Richards, 1977; Stevenson & Fantuzzo, 1984). Emotionally disturbed children and adolescents have some of the greatest difficulties in adjusting to the demands of the school because of low social competence that creates problems in school adjustment and their academic performance.

Youngsters who even do recover from heir depression continue to experience some social impairment (Kovacs, 1997). Other than dysphoric mood, a social withdrawal is the symptom that distinguishes depression from that of other psychological disorders.

Chen (1997) found that children's academic achievement predicted their social competence. Children's social competence, aggression, leadership and peer acceptance contributed to their academic achievement. On the other hand peers

rejection leads to more aggression and interpersonal difficulties and declines in academic functioning over time (Lebolt, Rincon, & Freitas, 1998).

The outcome of Social dysfunction results in the form of peer problems, family problems.

Peer problems. It has been well established that problematic peer relationships are associated with a range of serious psychological and behaviour problems during adolescence and childhood. Individuals who are unpopular and who have poor peer relationships during adolescence are more likely than their socially accepted peers to be low achievers in school, to drop out of high school, to have a range of learning disabilities, to show a high rate of delinquent behaviour and to suffer from an array of emotional and mental health problems as adults (Berndt, 1982).

Depressed youngster spend significant amount of time alone, show little interest in seeing friends and engage in few activities. Their social withdrawal may reflect an inability to maintain social interactions possibility because of their negative, irritable, and aggressive behaviour towards others; deficits in social functioning, such as initiating social conversations or making friends and socially unskilled interpersonal behaviour. Thus youngsters with depression may fail to experience the social exchanges that lead to effective social skills and healthy social relationships (Kovacs, 1997).

Family problems. Youngsters with depression experience poor relations and conflicts with their parents and siblings.They report feeling socially isolated with their families and prefer to be alone rather than with them (Larson, 1990). Family

relationship difficulties have been found to persist even when children are no longer depressed. Youngsters with depression may be quite negative towards their parents when interacting and their parents in turn may respond in a negative, dismissing, or harsh manner. When repeated over time, these kinds of interaction may adversely affect the relationship between parent and child.

Emotionally disturbed children usually have conflicts and rivalary with their siblings as compared to their peers and these negative feelings increase as they mature from childhood to adolescents (Lempers & Clarklempers, 1992).

Psychosocial Internalizing Problems depression and anxiety in young people increase with the age. Although the précised reasons for the increase of depression are unknown, one factor that has been implicated is the transition in social environment; (family breakup, increased drug use, and change in job) which may create increasing level of stress for young people. These changes may also make children more vulnerable to stress due to a loss of protective factors such as a family support (Kovass, 1997).

Theoretical Explanation of Depression and Anxiety in Children and Adolescents

There are numerous theories that attempt to explain influence of various factors responsible for making children and adolescents vulnerable to depression and anxiety. A brief review is as follows.

Theorists (Barlow, 2002) have concluded that the two moods are more alike than different. However, we now know that almost everyone who is depressed,

particularly to the extent of having a disorder, is also anxious but not who is anxious is also depressed.

This is the biological vulnerability of the individual which brings changes in neurotransmitters in his brain while encountering stressful situations due to which he may become depressed. The biological vulnerability has been discussed as under.

Maternal mental health problem. Studies suggest that if mothers have depression their children are more likely to develop depression / anxiety disorder. The reason is that during their prenatal stage they are exposed to increased levels of ACTH (adrenocorticotropic a stress hormone) and due to hormonal influence they develop biological vulnerability which may result in depression / anxiety in the face of stressful situation (Herschkowitz, Kagan, & Zilles, 1997).

Genetic Influence. Researchers hold that genetic component cause biological vulnerability in individuals which may lead to develop depression and anxiety in any stage of their life. According to the theory of Gray and McNaughton, depression and anxiety is caused by the neurotransmitters released in brain during a stressful situation and partly by heritable personality traits such as neuroticism. While studying the co-morbidity of anxiety and depression in the perspective of genetic epidemiology Middeldorp, Cath, Van Dyck, and Boomsma (2005) reviewed twin and family studies and their results supported the theory of Gray and McNaughton that neuroticism is a shared risk factor for anxiety and depression.

Recent advance in the study of behavioral genetics have provided new insight into the issues addressing the impact of genes vs. environment on the development of

adolescent's psychopathology. Researchers conducted twin studies *to* examine this question by studying adolescents who are twins to see whether identical twins are more similar than fraternal twins (e.g., Elkins, McCue, & Iacono, 1997); by studying adolescents who have been adopted to see, which adopted adolescents are more like their biological parents than like their adaptive parents (e.g., Deater-Deckard & Plonin, 1999); and by studying adolescents and their siblings in step families, to see whether similarity between siblings varies with their biological relatedness (e.g., Hetherington, Reiss, & Plomin, 1994). In addition to examining whether and how much the given traits of adolescents are genetically versus environmentally determined. Researchers also ask how much these two set of factors interact (e.g., whether the same environment affects people with different genetic makeup in different ways (Collins et al., 2000).

While studying genetic versis environmental influence on adolescent researcher usually distinguishes two kinds of environmental influences. These are shared and non-shared environmental influences. The shared environmental influences are those in which the environmental factors are common to all the siblings and that may influence their personalities in a similar manner. The others are Non-shared environment influences which are the environmental factors that are not common to all the siblings and that may include factors within the family (e.g., two siblings being treated differently by their parents) as well as outside it (e.g., school experiences). Studies reveal that both genetic and non-shared environmental influence affects or influences the development of the individual very strongly. In contrast shared environmental influences such as parental personality a family's socioeconomic status and the neighborhood in which two siblings live are less

influential (McGue, Sharma, & Benson, 1996; Jennifer, Tackett, Irwin, Waldman, Carol, Van Hulle, Benjamin, & Lahey, 2011).

Franic, Middeldorp, Dolan, Ligthart, and Boomsma (2010) reviewed genetics studies and their results supported the role for genetic influence in the development of anxiety and depression in children but the intensity level increases with age as the child enters in his adolescence (Costello, Egger, & Angold, 2005). For Internalizing Problems, shared environment may become more important from early to middle childhood. Epidemiological studies have consistently documented a marked rise in the prevalence of depression occurring between the ages of 13 years and 15 years (e.g., Hankinet, Abramson, & Moffitt et al., 1998). Though there is an inevitable fact that biological and social changes occur in this period, yet behavioural genetic theory gives a profound explanation of this increases in adolescence. Rice, Harold, and Thapar (2002) reported larger grnrtic effects on adolescents than children. Scourfieldn, Rice, and Thapar, (2003) studied influence of 'Developmental' genes and O'Connoret al., (1998) as well as Silberget al., (1999) studied influence of environmental factors in adolescence but it remained unclear whether these influences emerged during the transition from childhood to adolescence or in the adolescence. Lau and Eley (2006) tried to clarify this by examining developmental changes in genetic and environmental and found that from adolescence to young adulthood, genetic factors contribute primarily towards stability of symptoms but also to change.

Gregory and Eley (2007) explored reasons for individual differences in levels of anxiety among children, by reviewing the genetic literature. They found that a

bundal of research to date has revealed that both genes and environmental influences play important roles in explaining differences in levels of anxiety among children.

Franic, Middeldorp, Dolan, Ligthart, and Boomsma (2010) explored the methodology of behavior genetics studies. The results demonstrated that genetic factors play a solid role in the etiology and temporal stability of individual differences in childhood anxiety and depression.

Genetic factors have been found to put strong influence over aggression, antisocial behaviour and delinquency (Eley, Lichenstein & Stevenson, 1999; Deater-Deckared & Plomin, 1999) and risk taking behavior in adolescence for suicide (Jacobson & Rowe, 1999; Blumenthol & Kupfer, 1988).

Eley and Stevenson, (2000) reported evidence for both genetic and environmental influences on depressive symptoms in adolescence. Biological vulnerability and environmental stress in adolescenst was also studied by Silberg, Rutter, Neale and Eaves (2001).Their is growing interest in developmental psychopathology research to explore genetic and environmental interactions associated with risk for high levels of depression symptoms in adolescence, emphasizing on loci implicated in the serotonin (5HT) system (Eley, Liang, Plomin, Sham, Sterne, Williamson, & Purcel, 2004).

Tackett, Waldman, Van Hulle, and Lahey (2011) investigated genetic influences on negative emotionality. Specifically, 19% of the variance in the major depressive disorder and conduct disorders was accounted for by genetic factors shared with negative emotionality in male twins. Although the full hypothesis could not be tested in female twins, 10% to 11% of the variance in the two disorders was also accounted for by genetic factors shared with negative emotionality. Common shared

environmental and non-shared environmental influences were found for major depressive disorder/conduct disorder comorbidity in male and female twins. This study revealed that Negative Emotionality represents an important dispositional trait that may explain genetic influences on depressive and conduct disorders comorbidity, at least for boys. Models of major depressive disorder/conduct disorder comorbidity must simultaneously measure common and specific genetic and environmental factors for a full understanding of this phenomenon. Gender differences require specific research attention in dispositional factors and developmental progression.

Research also found strong genetic influence on the adolescent's self image, and intelligence and moderate influence on scholastic, social and atheletic competence, (e.g., McGuire et al., 1994).

Individuals who are high in negative affectivity (who become distress easily) are at great risk for depression/ anxiety disorders and a wide range of internalizing problems (e.g., psychosomatic complaints, phobias and interpersonal problems). In fact, how much an individual is successful in coping with his negative affect depends largely on the social influences that include socioeconomic status and interpersonal relationships with family members and peers.

Social influence.

Peers. Today's teenagers spend more time in the exclusive company of their peers than their counterparts in the past. Hence the role of peers in shaping adolescent psychosocial development has become increasingly important.

Peers also play a crucial role in promoting (or hindering) normal psychosocial development. In the realm of identity, peers provide the sort of models and feedback

that adolescents cannot get from adults. The peer group may serve as a way station in the development of identity as adolescent begins to develop a separate sense of self that is differentiated from the family (Brown, Clasen, & Eicher, 1986).

Experience in the peer group also can be an important influence on adolescents self image and also is vital for the development and expression of autonomy. The process of developing more mature and more independent relationship with parents is accompanied by the establishment of more mature relationships with peers. In addition the peer group provides a contest for adolescent to test out decision making skills when there are not adults present to monitor and control their choices (Hill & Holmbeck, 1986).

Intimacy and sexuality, of course are much more common between peers than between adolescents and adults for a variety of reasons. Perhaps most critical is that both intimacy and sexuality require interaction between two individuals who are relative equals. It is therefore the adolescents peer group that generally plays an important role in socializing youngsters in appropriate sexual behaviour and in the development of the capacity for intimate friendship.

Finally, peers are an important influence on adolescent achievement. Students influence each other's academic performance. Although peers may play a less influential role than parents and teachers in influencing adolescent's long term educational and occupational plans, peers have a significant influence on adolescent's day to day school performance. For example, how much they effort and devote to their studies, and how well they perform in class (Epstein, 1983, Steinberg, 1990). The students whose friends do well in school are likely to achieve more than the students whose friends do not do as well (Epstem, 1983).

Popularity and Rejection in Adolescent Peer Groups

Researchers found that there are certain factors which determine which adolescents are popular and which ones are disliked withintheir peer groups.

The social skill plays an important role in determining popularity of adoloscents. Popular adolescents are skilled, and are confident in the eyes of their peers. Additionally they are friendly, cheerful good natured, humorous, and intelligent (Hartup, 1996; Hollingshead, 1949/1975). Popular adolescents have a significant social competence i.e., they have more knowledge about how to make friends and maintain friendship than adolescents who are less well accepted by their peers (Jarvinen & Nicholls, 1996).

Despite these broad generalizations about the determinant of popularity, it is important to note that there are many routes to popularity within adolescent peer groups. On a study of preadolescents and young adolescent boys indicate that there are two types of popular boys, at least at that age. One group, whom the researchers described as "Model" boys had the characteristics typically identified in studies of popular youth. .Second group of popular boys, whom the researchers described as "tough" was physically competent and extremely aggressive with lack of social and academic competence. This as well as several other studies indicate that, contrary to the notion that aggressive children are invariably rejected by their classmates, there are some youngsters both boys and girls who are aggressive and popular at the same time (Bowker, Bukowski, Hymel, & Sippola, 2000).

Compared with their less popular age mates, popular adolescents have got good social relationships with peers and participate well in extracurricular activities

which gives them more social recognition (such as being selected as the leader of the school organization) (Franzoi et al., 1994).

Social scientists have also shown an important disinclination among three types of unpopular or disliked adolescents (Bierman & Wargo, 1995; French, Conrod, & Turner, 1995; Hatzichristou & Hopf, 1996; Hymel, Bowker, & Woody, 1993; Parkhurst & Asher, 1992). Another unpopular group of adolescents is very aggressive; they have frequent fights with other students, are mostly involved in antisocial activities especially bulling.

A third group of unpopular youngsters are aggressive withdrawn. Like other aggressive adolescents, these children are unable to control their hostility; however like other withdrawn children, they become nervous while initiating friendship with other adolescents. Researchers point out that boy's exhibit more overt aggression than girls. A series of studies, however, indicates that girls also act aggressively toward peers, but that their emotional expression of aggression is often social, not physical (Crick & Grotpeter, 1995; Crick, Bigbee, & Howes, 1996). In particular, Crick has studied the use of **relational aggression** in which individuals adoapt the way to express their aggression and hostility in which instead of giving physical harm to others they try to damage their reputations by excluding them from social activities, or withdrawing attention and friendship.

Although relational aggression was first seen in girls, some studies hold that both genders use it but that girls are more distressed by it (Galen & Underwood, 1997). Although relational aggression is more covert than fighting or yelling the use of relationship aggression is nevertheless associated with rejection by peers (Crick, 1996). Being unpopular has negative consequences for adolescent's mental health and

psychological development. But studies show that consequences of peer rejection may differ among rejected youth who are aggressive versus those who are withdrawn. Aggressive children who are rejected are often likely to end up in peer groups with other aggressive youngsters, and they are at risk of conduct problems and involvement of antisocial activity (Feldman & Wentzel, 1995; French et al., 1995). In contrast, rejected withdrawn children appear to be at risk for depression as they feel severe lonliness, lack social skills and have low self-image (Hoza, Molina, Bukowski, & Sippola, 1995; Parkhurst & Asher, 1992).

Many psychologists believe that as unpopular adolescent lack some of the social skills and social understanding necessary to be popular with peers they misinterpret most of social situations. They feel that their peers are deliberately hostile whereas they actually are not (Crick & Dodge, 1994; Dodge & Coi, 1987) and their wrong and biased interpretation leads to their aggressive behavior (Astor, 1994; Crick & Dodge, 1994). A study of African American adolescents found that deficits in social information processing may characterize overly aggressive African American youngsters as well (Graham, 1993; Graham & Hudley, 1994).

So far as the social skill deficits of unpopular with drawn children is concerned research shows that these children are excessively anxious and uncertain, often having around this group, without knowing how to break into a conversation or activity. Their hesitancy, low self esteem and lack of confidence make other children feel uncomfortable or annoyance and their submissiveness makes them easy targets for bulling (Olweus, 1980). Many of these youngsters are especially sensitive to being rejected, a threat that may have its origins in early experience with parents (Downey, Ainsworth-Damell, & Dufur, 1998).

Unfortunately, the more these children are teased, rejected, and victimized the more hesitant they feel and more they blame themselves for their victimization, which only compounds their problem, creating a cycle of victimization (Graham & Juvonen, 1998; Hymel, Rubin, Rowden, & LaMare, 1990). For example, young adolescents who are victimized by their peers typically develop problems that lead to further peer rejection and victimizations. However, children who are victimized but who have a best friend are less likely to be caught in the cycle.

Some researchers have suggested that people with tendencies toward hopelessness, pessimisms and self-blame are more likely to interpret their daily life events in a negative way that leads to the development of depression (Gladstone & Kaslow, 1995; Lewinsohn et al., 1994). They attend and focus narrowly to the negative events for a long period of time (Depressive ruminant style) they misread the situations which leads to make them feel defeated, deprived and rejected.

The cognitive set, which may be linked to the ways in which children think they are viewed by their parents and later, by peers, developed during childhood are thought to trigger the commencing of depression in the adolescence (Cole & Jordan, 1995; Cole, Martin, & Powers, 1997; Garber, Weiss, & Shnley, 1993; Nolen-Hoeksema, Girgus, & Seligman, 1992). This kind of cognitive style is often referred to as negative affectivity (i.e., tendency to become distressed) (Lonigon, Carey, & Finch, 1994).

Current theoretical explanation of depression and other internalizing problems holds that basically it is the strong integeration between environmental and biological / genetical factors which is responsible for the development of psychopathology in youngsters. A main theory which holds this view has been discussed as under.

Diathesis-Stress Model of Depression

Today, most expert endorse a diathesis-stress model of depression (Hilsman & Garber, 1995) which suggests that when individuals who are predispose toward internalizing disorders (the term diathesis refers to this predisposition) encounter stressful events depression results. Individuals without diathesis (i.e., who are not predisposed toward depression) are able to with stand a great deal of stress, for instance, without developing any psychological disorder. On contrary individuals with strong diathesis those who are strongly predisposed towards depression) may become depressed on the face of stressful circumstances that most of us would consider to be quite normal (Nemade, Reiss, & Dombeck, 2007).

According to the model, if a person has greater vulnerability or susseptivity for depression, a little environmental stress will be enough to develop depression in him. On the contraroy strong environmental stress will be required to trigger the onset of depression in individual with low vulnerability. This is why people react differently in the face of a particular stressor. For instance a person while encountering the stressor like death, divorce, loss of job, business or relationship breakup may become depressive while the other may remain strong to react normally (Nemade, Reiss, & Dombeck, 2007).

This is how depression is thought to be a kind of complex mental state which can not be explained through a single factor rather a wholistic approach is required to get its true picture and same is true for its trearment plan i.e., treatment plan should cover both biological as well as psychological perspective if some one really wants to achieve a good prognostic level (Nemade, Reiss, & Dombeck, 2007).

The biological (glandular activity and hypothalamic impulsivity); psychological characteristics (temperament and personality traits) and family history including powerty, substance abuse and mental illness especially maternal depression and pregnancy complication which requires strong medication are considered to be diathesis factors which may or may not be permanent (Hankin & Abela, 2005).

In short, the diathesis-stress model gives a broad spectrum of factors including biological, environmental, and psychological perspegtives which are helpful in reducing the depressive symptoms as well as minimizing the frequency of reccurance of depression. (Scher, Ingram, & Segal, 2005)

Research has focused on both the 'diathesis' and 'stress' in order to identify the underlying causes of depression and other internalizing problems. Two categories of diathesis have received more attention. First is the biological. It is believed that diathesis or predisposition is related to the problematic pattern of neuronendocrine functioning (Neuroendocrine refers to the hormonal activity in the brain and nervous system). Researchers have focused in this respect on the regular activity of hypothalamic pituitary axes including those involving adrenal, thyroid, gonadol and somatotropic axes. Researchers who have been concerned with the stress component of the diathesis-stress model of depression (i.e., with the environmental influences on the depression) have focused on three broad sets of stressors (Aseltine, Gore, & Colten, 1994; Lewinsohn, Gotlib, & Seeley, 1997; Lewinsohn et al., 1994). First, depression is more common in the adolescents from the families characterized by high conflict and low cohesion, and it is higher among adolescents form divorced families. Second it is more common among adolescents who are unpopular or who have poor

peer relationship. Third, depressed individual report more chronic and acute stress than do non-depressed adolescents

Environmental Influence. These include stress (Lewinsohn, Rohde, & Seeley,1998); loss of a parent or loved one (Wells,Deykin, & Klerman, 1995); break-up of a romantic relationship (Monroe, Rohde, & Seeley, 1999); attentional, conduct or learning disorders (Spencer, Biederman, & Wilens, 1999); physical ailment such as diabetes (Kovacs, 1997);family problems such as parental psychopathology (Fendrich, Warner, & Weissman,1990), poverty or low SES (Beidel & Turner, 1997) abuse or neglect (Brown, Cohen, & Johnson, 1999); and other trauma, including natural disasters (Krug,Kresnow, & Peddicord, 1998). Stressful life events are particularly important for high levels of depression, (Eley,1997).

A brief review of various signs of risk factors in children and adolescents referred by literature as environmental influence responsible for the development of depression and anxiety disorder later on is as follows.

Lack of social supports. Literature review illuminates the fact that depression is directly proportional to the lack of social supports i.e., if a person lacks social supports he/she is nore likely to be disturbed. A person with low socioeconomic status may loose his self-esteem due to which he may avoid participating social activities. While working on social origins of depression Brown and Harris (1978) documented that low social support can increase depression. For instance, a young married women living far apart of her parents and her husband also lives away for most of the year certainly will have depressive symptoms.

Economic stress and poverty. According to an estimate a large number of adolescents grow up in poor families (i.e., families whose household income adjusted for family size is less than half of the national average and another 15 percent are classified as near poor. Approximately one third of adolescents live in middle class comfort, and another 30 percent enjoy very high family incomes (50 percent higher than average family income) (Hernandez, 1997). Reuters and Health, (2008) stated that children living in poverty were at greater risk of depression.

Although few scientific studies have been conducted on the homeless adolescents research suggests that these youngsters share many of the same problems with other youth who experience chronic poverty problems (Masten et al., 1993). About 5 percent of American adolescents experience at least one night of homelessness each year whereas in most Asian countries, the majority of the population belongs to the lower income group.There is a large body of research conducted in developed countries (Lewis, Bebbington, Br ugha, Farrell, Gill, Jenkins, & Meltzer,1998; Bruce, Takeuchi, & Leaf, 1991) as well as in less developed countries, (Todd, Patel,Simunyu,Gwanzura,Acuda, Winston, & Mann,1999) demonstrating the relationship between poverty and socioeconomic inequalities with depression.

Lack of resource. According to Patel, Araya, Lima, Ludermir, and Todd, (1999) it is really very hard and stressful for the people with low income to cope with household worries e.g., paying essential bills affording daily food and other grocery items in the face of inflationary pressures and above all job insecurity are the stressors strong enough to elicit the symptoms of depression and anxiety.

Unlike the developed and rich countries where divorece and remarriage is the leading risk factor for the childhood depression this relationship of low apportunity and depression can be well seen in an under developing country like Pakistan where there is high rate of unemployment large income inequality, no social support and welfare provision along with inflationary intensity resulting in feelings of frustration, hopelessness, anger and despair. Like divorce, low income is also found to be associated with disruptions in parenting due to which adolescents suffer from emotional problems, face academic difficulties and are indulged in delinquent acts (Conger, Conger, Mathew, & Elder, 1999; Kloep, 1995; Lempers, Clark-Lempers, & Simmons, 1989).

Although boys and girls alike are adversely affected by their family's economic problems, the pathways through which it occurs may differ between sexes. For girls it leads to increase their maturity and sense of responsibility to take over some of their mothers' duties while she works or looks for employment (Elder, 1974). For boys in contrast, disruption in families finances seen to lead more frequent conflicts, especially with father (Elder, Van Nguyen, & Caspi, 1986). The resulting disruption in family functioning increases irresponsibility and problem behaviour. Due to financial strain there remains conflict between parents and adolescents over money. These consequences, in turn, make parents more irritable which adversely affects the quality of their parenting. (McLoyd, 1990).

Family climate puts the adolescents at great risk for a wide range of problems. They are more like to become aggressive and depressed (Cumnings, Ballard, Elsheikh, & Lake, 1991).When the adolescents themselves are the recipients of aggressive parenting, they are likely to imitate this behaviour in their relationships

with siblings, and later, in their own marriages and with their children. The researchers have also studied the impact on adolescents of growing up a mid chronic economic disadvantage (Brody, Stoneman, & McCoy, 1994; Felner et al., 1995; McLoyd, Jayartne, Ceballo, & Borquez, Ceballo, & Borquez, 1994) especially those living in inner-city and rural communities.

In general persistent poverty, like temporary economic strain, undermines parental effectiveness making mothers and fathers harsher and depressed. These consequences all have negative effects on adolescent adjustment, which are manifested in increase in emotional as well as academic problems. (Conger, Patterson, & Ge, 1995). Poor children face violence, which is associated with higher rates of depression; school withdrawl (Felner et al., 1995); and high levels of stress (Felner et al., 1995; Masten, Miliotis, Graham-Bermann, Ramirez, & Neemann, 1993).

Impact of maternal education and employment. Lack of education has been found to be one of the leading risk factors of emotional disturbance in developing countries. Education might provide a means of escape from poverty or access to knowledge and other ways to resolve problems (Patel et al., 1999).

It has been found that educated parents tend to be more responsive and understanding and their involvement and responsiveness predicts social competence and psychosocial functioning (Weiss & Schwarz, 1996).Mother's lap is the first school for a child. If they are well educated they can play a tangible role in the cognitive development of their children. This concept has well been recognized by DePlanty, Coulter, and Duchane (2007) who stated that parents are first and the most important teachers of their children, and for their success in school they must

participate actively in their academic lives. Educators have also examined associations between parent-child relationship and adolescent's academic performance in that they have found that parental educational level was also related to the involvement and academic performance.

Although many researchers have focused their attention on the effects of maternal employment on the children's developmental recent years there has been an up surged interest in relation between parent's unemployment and children well-beingand in particular, in the ways in which adolescents mental health is affected by changes in their family's financial situation.

Childrenandadolescents whose mothers are educated and employed differ from those whose mothers are not in several respects. One important consequence of the rise in working women is that the father's role has begun to change. Rather than acting solely as head winner and disciplinarian men are now spending more time with their children and taking more responsibility for their upbringing–an arrangement that seem to benefit mother-child relationship as well as strengthening the father-child bond (Peterson, 1993).

A number of studies have found another interesting effect of mother's fulltime employment in the middle and upper-class families during high school performance among boys but not among girls (Bogenschneider & Steinberg, 1994; Bronfenbrenner & Crouter, 1982). It has been seen that in middle class families daugters usually get a positive effect of maternal employment during adolescents than sons (Bronfenbrenner & Croute, 1982). These middle class girls whose mothers work outside the home have higher careers aspirations than do girls whose mothers do not work because girls'

occupational plans are more influenced by having a mother work than are boy's plans (Hoffman, 1991).

Another explanation concerning the impact of maternal employment on parental monitoring in general is in relation to school in particular (Bogenschneider & Steinberg, 1994; Crouter, MacDermid, Mcltale, & Perry-Lenkins, 1990; Muller, 1995). It has been found that children who are monitored more carefully by their parents tend to do better in their school than their peers do (Steinberg, 1990). It may have more negative effect on boys than girls if both the parents have a full time employment but if parents manage to monitor their adolescents more carefully they do not seen to show special problems (Jacobson & Croekett, 2000).

Concerning the relationship of adolescents with their family when two parents are working at least one study finds that adolescents (especially boys) whose mothers work have more arguments with their mothers and siblings than do those whose mothers are not employed (Montensayor, 1984). If conflict at home depresses school performance, this may help explain why boys not girls whose mothers work a full time do less well in school.

Literature reveals that although financial support from father is associated with less problem behavior the financial standards of family might improve as a result of the increased income from the women's participation in work outside the home (Furstenberg, Morgan, & Allison, 1987).

and most adolescents have their mothers who work outside the home. Of the young people living in two parents families, a substantial number, close to 15 percent live with only one of their biological parents. And a shockingly high number of adolescents grow up under severe economic disadvantage (Hernandez, 1997).

According to demographers four of the most important changes that have occurred among American families with adolescents are: the increase in the rate of divorce, the increase in the prevalence of single parent household, the increased participation of mothers in the labour force, and the increase in the proportion of families living in poverty (e.g., Hernandez, 1997; Hetherington, Henderson, & Reiss, 1999), when youngsters live with only one of their natural parents either in single parent or in two parent households, it is nearly always with the mother, only 20 percent of children whose parents have been divorced live with their father (Hatherington et al., 1999).

Psychological Effect of Divorce and Single Parent Families on Adolescents

The importance of the parent-child relationship cannot be denied. Bleak home environment has detrimental effect on child's emotional health and progress in school. A Canadian research studied the effects of divorce on the school adjustment, educational achievement, self concept and school absenteeism of children. To examine these effects, data were collected on second to eighth-grade children from separated families.Teachers rated 50% of the children from separated families as achieving below grad placement compared to compare to 29% of their two-parents and peers. The results on Draw-A-Person Test identified 33% of the children from

separated families as being disturbed compared to 14% of the children from intact families. The teachers rated children from separated families with a significant difference between the two groups in acting-out behavior. Children from separated families show significantly more school-related problems than children from intact families (Hett, 1980).

Over the past 25 years, however researcher's ideas about the divorce and its impact on the adolescent have changed dramatically. First several longitudinal studies have indicated that adolescent's mental health is more affected by the process rather than the resulting divorce (e.g., Buchanan, Maccoby, & Dornbusch, 1996; Hetherington et al., 1998).

Southworth (1984) compared the academic achievement, classroom behavior, and emotional stability of 21 elementary school students from single parent families to that of 21 from intact, nuclear families. Behavior Checklists were used to ascertain classroom behavior and academic achievement was assessed through analysis of test scores on the educational Records Bureau Comprehensive Test. In addition, human figure drawings were studied to interpret the children's emotional status. Results showed statistically significant difference between single parent and intact or nuclear family children, with those from single-parent homes showing lower mathematics and reading achievement, poorer development in school in certain areas, and less emotional stability than their nuclear family classmates.

Another thing which is important to discuss is that adults who divorce are different from those who do not with respect to many traits that have strong genetic origins, such as anti-sociality, aggression, and predisposition to various sort of emotional and behavioural problems, such as depression, and anxiety, and these are

transferred to the children from their parents. At least apart from this reason that adolescent from divorced homes may have more problems than their peer is that they have inherited from their divorced parents some of the same traits that influenced their parents' divorce.

Second, research has linked the adverse consequences of divorce to a number of factors not specifically having a single parent or an absent father (see Hetherington et al., 1998 for a review). These include: the exposure of children to marital conflict (Amato & Keith, 1991; Forehand et al., 1994); disorganized and disrupted parenting (Fauber, Forehand, McCombs, & Wierson, 1990; Forehand, Thomas, Wierson, Brody, & Fauber, 1990; Hetherington et al., 1998); or excrssive stress experienced by the family (Hetherington et al., 1998).

Because 75 percent of divorced men and two-third of the divorced women remarry, most youngsters whose parents separate also experience living in a step family. And because the rate of divorce is higher for second marriages than first marriages (60 percent versus 50 percent) most youth whose parents remarry will experience yet a second divorce.

Moreover because divorce generally occurs faster in remarriages (one fourth happen within five years) many children confront a second divorce before they have finished adopting a step parent (Hetherington et al., 1999).

Remarriage. Remarriage itself icreases stress and problems if it did not occur during the early days of childhood. Such adolescents who grow with their step parents have more problems than their peers (Hetherington et al., 1999). For example youngster growing up in single parent household are more likely to be involved in

problem behaviour such as delinquency than those in intact homes, but the adolescents growing up in step families are even more at risk for this sort of problem behaviour then are adolescents in single parent families (Dornbusch et al., 1985).

Partly, this is because of the double dose of marital conflict arising from two marriages (i.e., one between parent and step parent and other between parent and ex-spouse) (Hansen, McLanahan, & Thomson, 1996; MacDonald & DeMaris, 1995; Hetherington et al., 1999).

The effects of remarriages vary among children. In general girls show more difficulty in adjusting to remarriages than do boys, and older children have more difficultythan younger children (Hetherington, 1993; Lee, Barkham,Zimiles, & Ladewski, 1994; Needle, Su, & Doherty, 1990).Many adolescents find it difficult to adjust to a new authority figures moving into the house; especially that person has different ideas about rules and discipline (Buchanan et al., 1996; Hetherington et al., 1999). Adolescents in the step family may become stable when their stepparents are supportive and authoritative style of discipline (Henry & Lovelace, 1995; Hetherington et al., 1999).

Marrital conflict has been found to have an escalating effect on adolescent's mental health no matter it is between real parents or step parents.

The impact of marital conflict. Studies have documented that disputes between parents have more negative influence on their children than the separation /divorce between them (Kline, Johnston, & Tschann, 1991).

Although there is a significant difference between adolescents from divorced and non divorced families some of the differences have also been studied between

these groups before the parents were divorced (Cherlin et al., 1991) but not all researchers report this (e.g., Forehand, Armistead, & David, 1997). In one sample of British youngsters who were followed from birth into adulthood, 7-year-old whose parents eventually divorced had more educational and behaviour problems than did 7-years-olds whose parents did not divorce (Cherlin, Chase-Lansdale, & McRae, 1998; Elliott & Richards, 1991). One explanation for this is that the children in the households that later divorced were exposed to higher levels of marital disputes and stressed parent child relationships, both of which are known to increase children difficulties (Amato & Booth, 1996; Forehand, Neighbors, Devine, & Armistead, 1994). Although many young people show signs of difficulty, among them are problems in school, behavioral problems more anxiety and depression, immediately after their parents' divorce or remarry, most of these children become settled within two years and behave comparably to their peers whose biological parents remained married but have marital conflict (Hetherington et al., 1998).

Researchers studying why and how the parent's marriage affects their adolescent's mental health have made several conclusions.

First exposure to overt marital conflict and domestic violence has been linked to a wide range of adolescent's problems including, aggression, anti-sociality, delinquent and other types of acting out behaviour (Feldman & Wentzel, 1995; Harold & Conger, 1997; Harold & Conger, 1997; Krishna-Kumar & Buehler, 1996).

Second, parental disputes and conflicts arouse the feelings of insecurity, self-blame and threat. Adolescents who blame themselves for their parents marital conflicts, whose feelings of security are challenged are more likely to feel anxious, depressed and distressed (Davies & Cummings, 1994).

Finally, more adverse effect of marital conflict is seen when it ruins the parent child relationship. Due to their tension the mothers and fathers become more hostile, more irritable and less effective as parents (Davis & Cummings, 1994; Fine & Kurdek, 1995; Harold, Fincham, Usborne, & Conger, 1997). Adolescents who perceive their parents more hostile and uncaring, are more likely than their peers to report a wide range of emotional and behavioural problems.

So far as long term effects of divorce are concerned researches indicate that individual whose parents divorced during their childhood and adolescence years the diverse affect of the divorce may contain to have adjustment problem well into their thirties (Cherlin et al., 1998).

As functional impairement is thought to be an essential component of all the mental disorders (American Psychiatric Association, 1994) more attention has been laid upon the assessment of functional impairment rather than only symptoms which was a traditional approach (Mundt, Marks, Shear, & Greist, 2002).

Assessment of Emotional Disturbance (Depression & Anxiety) and Functional Impairment in Children and Adolescents with Low Academic Achievement

The existing literature review depicts that all emotionally disturbed children and adolescents show functional impairment in their social, emotional and cognitive domains (Cullinan & Epstein, 2001) including schizofrania (Brill, Levine, Reichenberg, Lubin, Weiser, & Rabinowitz, 2009) and bipolar disorder (Judd, Schettler, Akiskal, Maser, Coryell, Solomon, Endicott, & Keller, 2007).

The deficiet functioning is perspiquous even in the beginning of the illness. A marked impairment in psychosocial functioning appears in the initial stage of psychosis Mason, Startup, Halpin, Schall, Conrad & Carr, 2004; Niendam, Bearden, Zinberg, Johnson, O'Brien & Cannon, 2007; O'Brien, Zinberg, Rudd, Kopelowicz, Daley, Bearden, & Cannon, 2009; Prasad, Sahni, Rohm, & Keshavan, 2005; Cannon, 2009).

Although the functional impairment is an essential part of the psychiatric disorder and treatment needs, it is one that has not received the true focus of evaluations (Goldstein & Naglieri, 2009). The recent literature puts emphasis on considering symptoms and functional impairment separately in making a complete effective plan for diagnosis, treatment, and determination of improvement for future prognosis.

Literature review strongly favors the incorporation of functional impairment assessment along with other measures of mental health problems as it has many benefits. Among these one has been seen in determining prevalence rate of psychopathology in children and adolescents. Because an individual may have feeling of sadness, irritated mood or even desire to die but he/she cannot be labeled as having depression unless there is some functional impairment in their emotional, social, and cognitional functioning. Though there are very limited no of studies that incorporate the functional assessment along with other measures of emotional disturbance yet their affectivity has been well documented. For example in their studyRoberts, Lewinsohn, and Seeley (1991) reported that researchers has shown a big consensus concerning the use of functional impairment criteria along with the symptom or diagnostic criteria in determining the prevalence rate of psychopathology in children

and adolescents. They found that incorporating functional impairment into diagnostic algorithms substantially affects prevalence rates. In the two studies of 1990s (Jensen, Watanabe, Richters, Cortes, & Roper, 1995; Shaffer et al., 1996) the prevalence rate was found to be droped when assessment of functional impairement in any of the social situation (home or school) was included in the diagnostic criteria (i.e., from 13.6% to 8.8%)..

The other benefit of incorporating assessment of functional impairment (FI) along with other measures of mental health problems is that it provides the method of assessing severity of symptoms of the disorder. Literature places a good deal of emphasis on assessing severity of symptoms through assessing FI to fulfill the need for treatment. Literature reveals that besides DSM criteria definition of a case also involves the severity of the disorder, in terms of FI for the provision of treatment (Brandenburg, Friedman, & Silver, 1990; Jensen et al., 1995; Costello & Tweed, 1994) To provide a child in need proper treatment or effective services the severity level of the disorder must be determined. This can be well explained with an example of a medical specialist who is unable to adjust the doze of medicines to a fever patient unless he has taken the exact reading of degree of temperature through a thermometer. According to DSM-1V-TR, the measurement of Global Assessment of Functional Impairment must be incorporated along with other diagnostic measures of mental health problems as it is the systematic and empirical way which determines the severity level of the disorder.

Inclussion of FI in diagnostic criteria of DSM for psychopathology reduces the incidence rate of disoders by excluding 'false positives' (Spitzer & Wakefield, 1999).

Many states and federal agencies as well as manage care agencies in USA use functional impairment as eligibility criteria for services and defining of Serious Emotional Disturbance (SED).

The term emotionally disturbed is applied to the children usually who are inattentive, withdrawn, aggressive, un-conforming, disorganized, immature and unable to get along with others. The priming of the label "emotionally disturbed" on the given child depends on the nature of his maladaptive behaviour, its severity, and frequency of occurrence as perceived by a psychiatrist, psychologist, teacher, peer group and parents individually or in combination.

Actually there are at least four types of children who qualify for the label "*emotionally disturbed*" in school.

1. Those who become depressed and apathetic, with behaviour in marked contrast to the usual outgoing and enthusiastic classroom participation which preclude their learning anything in the class.
2. The second type of children are those like the one who when enter in the school on his first kindergarten day clinging his mothers skirts in terror as she might leave him (separate anxiety). During the next two years the same child enters school with great reluctance, screams and runs from other children when they approach him and frequently claims that he is ill in the morning in an attempt to avoid going to school. The maladaptive behaviour of such type of children becomes barrier to learning in school. Other children may have chronic emotional problems of a less seven nature. They are passive and pleasant in the school but become so anxious when a reading assignment is

presumed that he likes through, over, under and around the printed symbols but never directly at them and hence has a serious reading problem.

3. The third types of emotionally disturbed children is one with those having mental retardation with an IQ of 75 and are capable of acquiring certain basic academic skills in school. But their impulsivity and unwillingness to follow directions are constant limiting factors in their learning. By paying little attention to teacher's directions and quickly doing math's sums they make errors as compared to their other classmate who follow teachers instruction carefully and attentively and hence perform correctly. Although these third types of children with mental illness have mental retardation as their primary problem in school, but it is further complicated by a secondary problem of emotional disturbance.

4. The last category of children who qualify for the label "*emotionally disturbed*" is of those having other disabilities e.g., hearing impairment (deaf), and blinds. These children due to their disabilities cannot be remaining in a group of other children for more than a few minutes because of their extreme suspiciousness which courses them to strike out at one or more of them. They become violent at the slightest provocation from others because of their mistrust and hostility. Here an emotional disturbance constitutes their primary problem in learning and their physical disabilities as a problem of secondary importance.

In short words we can say that a teacher may be familiar of an 8 or 10 years old child who is unable to behave and learn. He seldom concentrates, has done no work has refused to conform and has been a constant source of harassment and at times just about to provide "*the last straw*" which will provoke his teacher to have

him exclude from school. He is an emotionally disturbed child with externalizing problem. His acting out behavior however puts him at the top of the class problem list.

Below him is another child may be an eight years old girl who cries at the slightest upset, and is immature, sits quietly with fingernail-biting. She is an emotionally disturbed child with "*internalizing problems*".

School Indicators of Emotional Disturbance

Research on developmental psychopathology has revealed that the impairment in the cognitive, emotional and social functioning may serve as the school indicator of the Internalizing problems (depression and anxiety) in the children and adolescents. But due to its co-occurrence it is often difficult to know whether cognitive and psychological deficits are an outcome or cause of depression (Cole, Martin, Posers, & Truglio, 1996).

Children with internalizing problem may be depressed and anxious, and may be in need to learn to pay attention, follow directions, and respond in an appropriate way so that they can be able to meet the goals of an effective education program.

Role of School Teachers in Assessing and Modifying Maladaptive Behavior

Teacher's referral of emotionally disturbed children and adolescents for the inclusion of special need services remained acknowlegable. Basically, teachers are the direct observers of the classroom behavior of children and are better able to identify

the children with emotional, social and academic problems with in their peer group. (Randy, Kamphaus, Thorpe, Winsor, Kroncke, Dowdy, & van Deventer, 2007).

Mental health practitioners and educationists have been trying to set different strategies to provide effective services to the children and adolescents with emotional disability by not only identifying the problem behaviors that inhibit the learning procedure in them but also to modify these maladaptive behaviors which inhibit the effective learning in school. These are actually the global learning behaviors or goals which a child must achieve or possess before starting the school.

The three major strategies have been utilized by the mental health practitioners and teachersof emotionally disturbed children which may help to achieve the above two main goals.

A brief description of these is as follows.

1. ***Psychodynamic interpersonal strategy***. In psychodynamic interpersonal strategy the problem behavior of emotionally disturbed child is seen as symptoms of psychic conflict. If the child is to function and learn in school, these symptoms must be thoroughly understood. In order to understand the psychological conflicts in childa tangible effort should be made to establish a positive and trusting relationship between teacher and child.
2. ***Sensory-Neurological Strategy.*** *'Sensory-Neurological Strategy'* deals with the organic causal factors related to maladaptive behavior, such asquestion often asked in special education in present time whether maladaptive behavior such as learning deficits, perceptual motor deficits, general coordination deficits, hyperactivity, impulsivity, emotional liability and short attention span and or distractibility.

3. ***Behavior Strategy.*** The Final approach is called the **behavior strategy** which aims to identify problem behavior which inhibits learning and to assist the child in developing more adaptive behavior.In summary we can say that psychodynamic interpersonal strategy ask '*why*' the child behaves as he does and focuses on the underlying psychological causal factors related to the problems presented in the classroom. The sensory neurological strategy is mostly concerned with "*how*" the child's behavior might be linked to the organic deficits. The behavior modification strategy focuses on "*what*" the child presents in the classroom which interferes his learning and what are the environmental factors that are controlled in modifying the child behavior, so that it falls in the line with standard required for learning.

All of these strategies have produced positive results for some emotionally disturbed children but each also has some limitations-which are as follows.

The psychodynamic interpersonal strategy has contributed significant goals in the field of education of emotionally disturbed children. Communicating acceptance, building positive relationships, allowing self-expressions, attempting to understand the child's behavior and remedying ego-defects are goals directed towards helping the child get ready for learning. However they are so global and difficult to define operationally that teachers of the disturbed may not clearly understand them.

But the most serious limitation of the strategy is in term of its implication of methodology in the classroom. In order to implement the goals effectively the teacher is dependent on low sensitive, intuitive, and psychologically sophisticated she is, rather than on her knowledge about the child development the learning process and educational practice. If teachers '*giftedness*' and '*artistry*' is the primary requisites for

success in teaching emotionally disturbed children, then a serious problem will arise in locating enough gifted teachers to work with the increasing number of emotionally disturbed children in the public schools.

The psychodynamic interpersonal strategy is probably the most suitable in the residential and special schools where a close working relationship exists between teacher and psychotherapist. Psychodynamic interpersonal strategy then is primarily relevant to education in terms of goals, even though they are difficult to define operationally, but seriously limited in terms of methodology it offers aver age teacher in the public schools.

In contrast, the sensory neurological strategy is strong in both goals and methodology. The educational goals of this strategy can be defined as observable acts (e.g., hand-eye coordination), rather than inferred psychological states (e.g., ego-functioning) and as such are more readily communicated to the teacher.

In addition, there are specific methodologies available to the teacher in accomplishing these goals and measurement techniques for assessing progress. The child, who has not established a right-left orientation can be identified fairly quickly, assigned a goal of laterality training and provided with a series of exercises and work sheets to assist him. His daily performance will give a ready indication of the progress he is making. Despite such specificity of both goals and methodology the sensory neurological strategy is limited because of the narrowness of its focus (i.e., specific to the students with physical disabilities). Rigid sensory-motor training procedures may minimize or overlook broaden socialization goals for children with emotional disability.

The behavior modification strategy offers (1) defining maladaptive behavior, (2) determining the environmental events which support the behavior, and (3) manipulating the environmental events to alter maladaptive behavior while these are general guidelines for the teacher they are totally lacking the developmental and educational implications.

Defining maladaptive behavior is left up to the teacher, and many teacher working with emotionally disturbed cannot "*see the trees for the forest*", and the task of accurately assessing the components of child's behavior which are interfering with successful adaptation in school is a difficult one.

In the school psychologist opinion both the goals and assessment methodologies must receive strong emphasis if the field of education of emotionally disturbed children is to develop and provide adequate programs in the public schools.

It has been stated that an effective educational strategy for the emotionally disturbed child is one which is equally effective for all other exceptional children. For from a discrete diagnostic category, "*emotional disturbance*" frequently appears in combination with other types of exceptionality.

A child with physical, sensory, intellectual, and neurological handicaps is often subjected to considerable stress, anxiety and depression. As a result maladaptive behavior patterns may develop which are sources of additional handicaps either on primary or secondary basis.

In dealing with this overlapping condition another category for exceptional children called the "*multiple handicapped*" has been emerged. The emergence of this new category has shifted the focus of the field from specialization to generalization.

The educational strategy which meets the current requirements in the field of education of exceptional children is the "*developmental strategy*" which has been originally devised as an approach to the education of children with emotional disturbance or maladaptive behavior. During the course of its development it becomes increasingly apparent that developmental strategy has generalist approach suitable for all exceptional children.

The developmental sequence describes behaviors which are educational and learning behaviors. It is a statement of developmental as well as many of the goals of other strategies (the psychodynamic interpersonal strategy, sensory neurological strategy and behaviour modification strategy) as mentioned above.

The developmental sequence of educational goals has been used as the basis for assessment and education of emotionally disturbed children.

Developmental Strategy

Developmental strategy was formulated by the staff of Neuropsychiatry Institute (NPI, UCLA). This is the institute which provides sources for research and training is the field of mental illness.

The developmental strategy provides a developmental framework describing the basic competencies without which children cannot successfully learn in school. These global learning behaviors are called the developmental sequence of educational goals.

Global learning behaviors: the core of developmental strategy (DS). The essential behaviors described in the DS are attention, responxe, order, exploratory, social, mastery and achievement. It is hypothesized that a child must possess these learning behaviors before getting admition in the school i.e., he must pay attention well to teachers, give peoper response and follow their instructions, explore the environment accurately and function appropriately in relation to others. The learning of these behaviours must occure from infancies to school age, and failure to learn any or all of them may indicate a warning signs that child may be developing serious emotional disturbance and may not be ready for school.

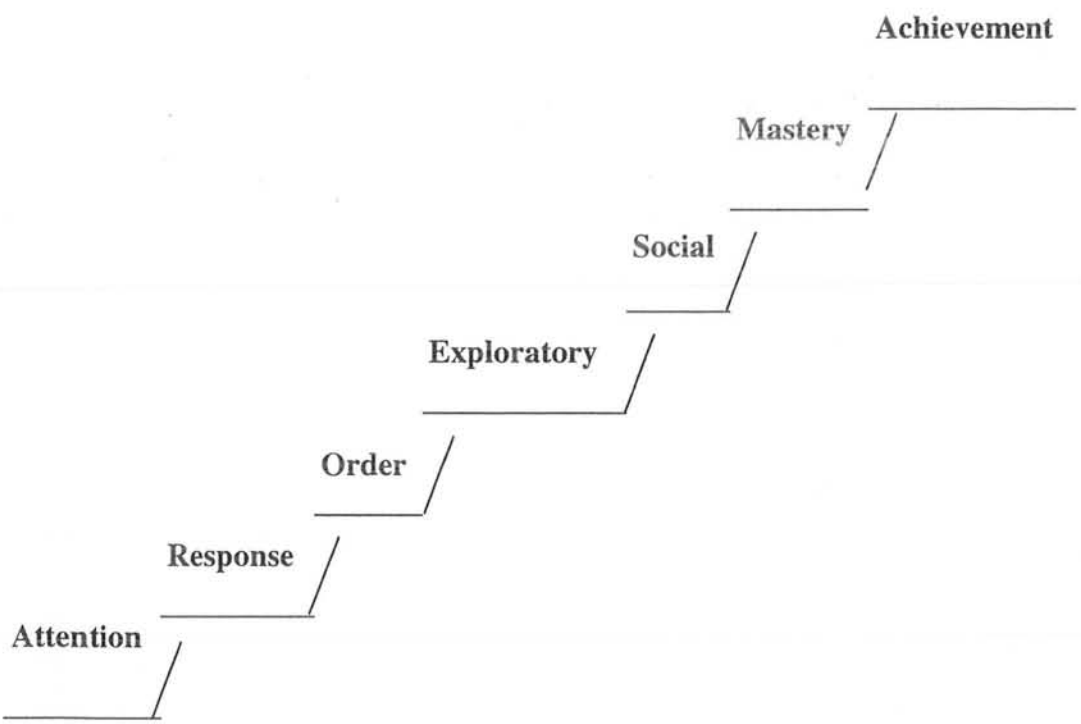

*Figure 1.*A developmental sequences of educational

The developmental sequence of education illustrated in the figure 'A' also includes mastery of self care and intellectual skills and achievement of self motivation in learning as the highest level goals.

While presented in hierarchal form, the behaviours described by the developmental sequence are not seen as discrete or as developing separately. They are, rather a part of a continuous sequences of development related to the learning process.It is just like climbing a ladder. Step by step, one often emotion where we cannot skip even a single step.

The developmental sequences of educational goals have been described as under.

Attention. The ability to focus on relevant cues in the environment is fundamental in all learning. The individual cannot learn if he does not pay attention. Before learning can begin the child must notice something. For example a child is taking part in a beginning reading lesson in school. In order to profit from the teachers instruction, he will have to look at the letter symbols being displayed rather than out the window. He will have to listen to the teacher as she points out differences between the letters and remember what she has said.

Response.While noticing something starts the learning process, the child next must do something that is making a response, in order to learn. Children, even from earliest infancy, are seldom unresponsive when the child enters school; active participation in learning is a must. For example the child undoubtedly is asked by the teacher to make a response during his reading lesson. He may be asked to read a

word. In order to learn to read he must first attend to the teacher and the learning even being provided and then become actively involved through responding. Such responses on his part will readily gain attention of teacher and the classmates. Noticing something (Attention) leads to do something (response) this is how learning procedure proceeds.

Order. Noticing something and doing something however does not guarantee that systematic learning will take place. The child must also follow directions and develop order in his attending and responding. Words are read from left to right (while reading English) hand side and once he finishes a line he starts the next one just below it on the left hand side of the page. The child will also learn that the stories being read have a beginning, middle, and end that a complete story must be read if he wants to gain all information. Once the child is attending and responding in an ordered manner his learning efficiency increases.

Exploratory.The more things the child notices the more he does, and the more systematic he is in attending and responding the more he learns about his environment that would is a fascinating place and the child finds through exploration that something are hot/cold some things are light/heavy, some dry and wet and some a sticky, some bitter/sweet, some bitter and some are soft. The multi-sensory explorations provide the child with raw material, the basic facts which he needs in learning. The children learn not only by looking and listening but also by touching, something and tasting. Art, music, and recreations are exploratory activities engaged in by the child periodically during his school career. In the present example the

reading will be a source of discovery and exploration for the child. The words themselves will convey the interesting new ideas and information to him.

Social. It is impossible to restrict the significance of child's relation with other to this fifth level, for at attention, response, order and exploratory levels, his experience were influenced by what he was given, shown and told by his parents, peers and other individuals.

Social relationships in the school are extremely important for the child. Working and playing successfully with other children and relating appropriately to teacher are essential for effective learning to take place. In the present example child's classmate may giggle aloud at his failure to read, or when he is the only one able to provide the answer to the teacher's question, nod their approval. Social tasks are inextricably woven into learning process and all children test and expand their knowledge and skills in a world of people.

Mastery. At mastery task level the child completes the learning process. The mastery task level is concerned with mastering of basic intellectual and adaptive skills and acquisition of a fund of knowledge or information about the environment which will enable the child to function independently and successfully within the limits of his abilities. Fundamental mastery skills such as speech and concept formation begin to develop in early childhood and continually develop, refined and expand during the process of growing up. Children also get mastery at early age to function independently of their parent such skills as eating, toileting, dressing and bathing on their own. In addition, they learn to tell time, stay out of the streets and obey the

safety rules away from home they become increasingly proficient at solving problems and mastering requirements of rules and games.

But the primary center in the child's life for undertaking mastery goals is school. In the classrooms he is supposed to become competent in reading, written language, and arithmetic. He will study science and social studies and will be concerned with accuracy and competition with peers.

During the course of the child's education he will be required to master the basic areas at increasingly complex level. In the present example the child at the mastery level will find him self actually able to read, understand and recall what he has read, do follow up assignments, and later receive good grades in reading on his report card.

Here important thing to be noticed is that the child reached at the mastery level of his reading skill through a series of proceeding readiness goals (attention, response, order, explanatory, social).

Achievement.The achievement level occupies the highest level on the developmental sequence. This is the enrichment level where self-motivations in learning develop, where pursuit for intellectual and adaptive skills in depth is important.

This is the level where children try to improve their learnt skills or their accomplished tasks when they improve they experience self-satisfaction and a desire for greater improvement. The more they improve the more their achievement motive becomes higher.

Once in school the achievement goals are given more importance. Block building and painting and later handwriting and reading are the skills consistently refined and improved. What is accomplished at one grade level is the raw material for the elaboration and further development at the next.

In the upper elementary grades the child who not only accomplishes his given assignments but also volunteers for extra work, and research out additional facts is the child working on achievement level. In our present example if the child reads a book about the deep sea diving may be so exciting and stimulating to him that he combs the library shelves for the additional material on this subject.

Unfortunately children with emotional problems unlike other physically disabled groups remain unidentified and a small number of students receive required mental health services. Only 11 percent of children in the United States have at least one significant mental illness that is accompanied by impairment in home, school or peer contexts (U. S. Department of Health and Human Services, 2001).

Current Emphasis on Assessment of Functional Impairment in Diagnosis of Psychopathology

People do become distress in their daily life and show many symptoms of emotional disturbance but they cannot be labbled for any mental disorder. In order to make differenciation between normal mood swings and mood disorders the developers of the DSM-IV have set a "clinical significance criterion" according to which if symptoms do not cause distress or impairment in social, occupational, or other important areas of functioning these cannot be labbled as a disorder (Spitzerand

Wakefield, 1999). Literature review, therefore, strongly favors the incorporation of functional impairment assessment along with other measures of mental health problems as it has two main benefits which are as follows.

1. Determining the prevalence rate. The incorporation of functional impairment (FI) among other diagnostic ragim has been found to affect markedly on the prevalence rate of psychopathology in children and adolescents. Because an individual may have feeling of sadness, irritated mood or even desire to die but he/she cannot be labeled as having depression unless there is some functional impairment in their emotional, social, and cognitional functioning (Jensen, Watanabe, Richters, Cortes, & Roper, 1995; Shaffer et al.,1996; Jensen, et al 1995; Shaffer et al., 1996; Costello & Tweed, 1994; Canino et al., 1987).

2. Determining the severity of symptoms. The other benefit of incorporating assessment of FI along with other measures of mental health problems is that it provides the method of assessing severity of symptoms of the disorder Treatment plan can better be fufilled if symptoms severity is determined and the best way to measure symptoms severity is through assesing functional impairment (see also, Mieke , Neeltje . Batelaan, Harold, van Megen, Brenda, Penninx et al., 2012).

According to DSM-1V-TR, the measurement of Global Assessment of Functional Impairment must be incorporated along with other diagnostic measures of mental health problems as it is the systematic and empirical way which determines the severity level of the disorder. Today many researchers seem to focus their studies in the assessment of functional impairment in a variety of ways.

The present research is the first of its kind in Pakistan in the sense that: it has attempted to incorporate the assessment of functional impairment along with the

measurement of Emotional Disturbance (depression & Anxiety) and has the privilege to be in line with the recent growing trend which recommends the use of functional impairment assessment into diagnostic algorithms. Further it provides an instruments for the assessment of the functional impairment in children and adolescents which possesses satisfactory psychometric properties The main advantage of newly developed Functional Impairment Assessment Scale (FIAS) lies in its efficacy in determining the intensity/severity level of the functional impairment which can help educators and the mental health practitioners making important decisions regarding prepare treatment and intervention plans or a complete system of cares for the child in need.

Though, growing interest in the field of developmental psychology has been seen in recent years among Pakistani young psychologists the present research is the first of its kind in Pakistan which has incorporated assessment of functional impairment in exploring level of emotional disturbance in children and adolescents with low academic achievement.

Many MPhil, and PhD Scholars National Institute of Psychology, Islamabad, and other cities of Pakistan have conducted researches regarding different aspects of developmental psychopathology and emotional/social competences in children and adolescents. A brief review is as under.

Pakistan Research in Developmental Psychology

Iqbal (2010) studied the possibility of maternal depression as a risk factor for Psychological development of infant. For this purpose 160 infants of mothers

diagnosed to have depressive disorder in the third trimester and 160 infants of mothers psychologically well in the third trimester from the rural community in Rawalpindi, Pakistan were followed up for one year. Bayley scales of infant development were administered to infants of both depressed and non-depressed mothers at the age of 12 months. Significantly lower developmental scores (bayley mental, behavior and motor rating scores) were found through univariate analyses in the infants at the 12 months age who were exposed to maternal depression.

Sara (2010) Studied the effects of parenting style and parent/peer attachment on disruptive behavior problems of adolescents and found that these is a significant role of parent/peer attachment as mediatory variable between authoritative parenting styles and disruptive behavior problems among adolescents.

Deeba (2002) documented that in Pakistan society child abuse and neglect was found to be prevalent in families with low socio-economic states as compared to the smaller families with same socio economic class.

Parental education especially of mother was found to be an important contributing factor as children of highly educated mothers reported less abuse (Deeba, 2002). Furthermore it has been found that fathers of the families with low socioeconomic status show more authoritarian attitude as compared to the other socioeconomic classes. Similarly highly educated fathers show less authoritarian attitude towards their children as compared to the fathers with low educational level (Deeba, 2002).

A study conducted by Saeed (2010) On Pakistani adolescents revealed that female were more stressed in the domains of academic and interpersonal relations and males were more stressed in socio-environmental domain. Interpersonal stressor were

reported equally by both genders. On the age specific variable Saeed (2010) document, though interpersonal stressors were reported equally by all age groups yet these were less in early adolescents and high in mid adolescents, similarly academic stressors were more prominent in early adolescents and less in older adolescents socio-environmental stressors however increased with age.

In her study Shafiq (2005) found that society religion dilemma education mass-media egoistic attitude operating at individual level and role of mother served as significant factors in formation transformation and maintenance of the concept of self and gender and several differences were found in these concepts prevailing in Pakistani culture against those presented in Western psychology.

Where studies hold that there is a negative relationship between comorbidity of internalizing problems and functional impairment and the academic achievement there are also studies demonstrating a positive relationship between self-esteem and psychological wellbeing and academic achievement.

Rubeela (2005) revealed that these students who scored high on self-esteem and playfulness scale also possessed high academic achievement.

Tasnim (2009) measured cognitive errors and anxiety among depressed and non-depressed adolescents with the sample a 240 (120 depressed 120 non-depressed) with the age range of 12 to 20 years. Three scales namely Urdu version of Children Negative Cognitive Error Questionnaire (CNCEQ), Taylor Manifest Anxiety Scale (TMAS) and Beck Depression Inventory (BDI) were used. Findings revealed significant differences between anxiety and cognitive errors of depressed and non-depressed adolescents. Depressed adolescent showed greater anxiety and more cognitive errors as compared to non-depressed adolescents. Findings also revealed

positive correlation between anxiety and cognitive errors. A similar trend of finding was found with respect to the different demographic variables (gender, age, socio-economic status etc) of depressed and non-depressed adolescents.

Shahzad (2002) studied the social and cognitive competences of adolescents in dual working families (where mother and father both work) and found that subjects who come from dual working families scored significantly high on cognitive and social competences scales as compared to their counterparts in single working families. Participants comprising both the groups were also matched in terms of maternal education (at least BA/ BSc). Single working parent has to face more economical burden due to which they cannot easily fulfill the needs and desires of their children so their children remain deprive of most the basic needs (both biological & psychological) due to which they may become frustrated or depressed.

. Besides, many other interesting concepts of developmental psychology were also studied in NIP. For example: Primary school education and children's understanding of science concepts regarding moon phenomenon in their cultural context (Masood, 2010); Short-term developmental outcomes and maternal support in infants with non-organic failure to Thrivel (Muhammad,2009); Emotional autonomy, self-efficacy and attachment among adolescents (Zafar, 2009); Development of social skills scale for children (Khan, 2005); Student life stress and its relationship with time management and adapted coping strategies (Akhtar,2005); Impact of parents marital conflicts on adolescents parental attachment and social competence (Azam, 2007) and Function of language in children in their family and social setting (Nawaz, 2007).

Different studies focusing on the comparison of emotional problems over high and low academic achievement have also been conducted in Pakistan. In this

connection. Shaamama (2010) examined the relationship between home chaos and cognitive ability, socio emotional adjustment, study skills, and academic achievement of school children. Results indicated significant positive relationship between home chaos and behavioral problems. A significant negative relationship was found between home chaos and cognitive ability and study skills as perceived by the parents and teachers. Children from chaos families exhibited significantly low academic achievement. Regression analysis revealed home chaos as a significant predictor of children's socio-emotional adjustment and study skills in books home and school settings. However home chaos was not significantly related to children's cognitive ability.

Boys were found to be more affected by home chaos than girls. Boys from chaotic families exhibited more behavior and adoptive problems as compared to the girls from same families.

Fatima (2007) studied Self-Efficacy,Self-Regulation, and Academic Performance of intermediate students with the sample of 200 (100 girls and 100 boys) and found that students with high academic performance show more self- efficacy and self-regulation than students with low academic performance in which boys showed more self- efficacy than girls whereas students with low academic performance show no gender difference on self-efficacy and self-regulation.

Ansari and Aftab (2007) studied the relationship between parenting style and academic performance with the sample of 53 adolescents of 15-17 years age and found authoritative parenting style and intrinsic motivations were significant predictors of high academic achievement.

Qauid and Farooq (2006) investigated the difference between high and low academic achievment with respect to their emotional problems. For this purpose they administered Human Figure Drawing (HFD) test on 180 enrolled students of gradethree and four of Government schools of Karachi. Their results revealed a significant difference in the emotional problems of high and low achievers.

Loona and Kamal (2004) studied academic performance and school success and school social behaviour of ADHD and non-ADHD with the sample of 468 children. They found a significant difference in primary and secondary children on total and sub-scale of Diagnostic Scale for Attention Deficit Hyperactivity Disorder (DS-ADHD).

Tahira, Khan, Anwar, and Mateen (2001) attempted to investigate the differences in the academic achievement of children studying in school situated in quiet and noisy areas. Results revealed that children studying in school situated in quiet had significantly better scores on reading, spelling and arithmetic tests as compared to children studying in school situated in noisy areas.

Riaz (1996) studied the intra family relationships, level of family adjustments, marital harmony of woman and academic achievement.The results demonstrate that subjects in excellent group have experienced a significantly higher level of family adjustment as compared to normal and average groups.

Ismail (1992) studied the relationship between self concept and academic performance of 60 Pakistani students. The result showed that self concept was positively correlated to academic performance showing consistency with the general assumption and rejection theory.

Some earlier studies conducted in Pakistan include: Ansari (1975) examined family environment and academic achievement. Positive correlation was found in female students coming from democratic homes as compared to non democratic environment.

In a subsequent study Ansari, Farooqi, Khan, Naheed, and Yasmin (1980) found achievement motivation to be significantly related to positive attitude towards female education. Age and income were found to be negatively correlated to the achievement motivation.

Moghni and Riaz (1984) studied a relationship between study habits, attitude, motives and academic problems among university students and that study attitudes and orientation was positively correlated with academic achievement.

Haque (1988) found that talented boys of higher secondary school Hyderabad perceived significantly more maternal warmth as compared to the low achieving boys.

The present research is unique among studies conducted on the academic achievement of children and adolescents in Pakistan in the sense that it has studied functional impairment along with other mental health problem in children and adolescents and its relationship with academic achievement. Measuring functional impairment in children and adolescents, according to the educational and developmental psychologists, is very important and preliminary step in making early identification of the developmental psychopathology in school children.

The main objective of current research is to examine the level of comorbidity of depression, anxiety and functional impairment in Pakistani children and adolescents with low academic achievement. Basically it attempts to explore the indicators of emotional disturbance and barriers to learning which make the academic

performance low primarily by studying Functional Impairment in terms of emotional, social, and cognitive dysfunction as well as the impairment in global learning behavior (low attention span, low concentration, low achievement motive etc.,) in children and adolescents.

Rationale of the Present Research

Serious Emotional Disturbance in children and adolescents can be identified by the assessment of functional impairment (Washington State Association of School Psychologists, 2000) which refers to the term which severely disrupts their daily functioning in home, school, or community.

The need of paying attention on the issue of preventing mental health difficulties in children and adolescents is being felt all over the world. It is being emphasized that every child's mental health is important. Though children's mental problems are common and even severe, but if early identification is made by the help of teachers and parents these can be treated (U.S Public Health Service, 2000).

Tension, stress, anxiety, depression and drug addiction which are the gifts of this modern era especially for the third world countries are enhancing suicidal rate among young adults. Today it is the main responsibility of school Psychologists, teachers and parents to identify the children with emotional disturbance and provide them intervention services.

In the third world country like Pakistan where literacy rate is very low and people are unaware of the silent killer (emotional disability) of their children and

young population there emerges a strong need to emphasize and highlight the hidden barriers to learning and acquisition of bright future of the youth of the day.

Being Pakistani psychologists it appears to be our main responsibility to do some tangible effort to prevent our children being suffering from bad outcomes in future (e.g., delinquency, dropout from schools, drug addiction, unemployment, depression and suicide).

More and more research work is required to provide the awareness of the current issue to the Pakistani families in understanding the mental problems of their children and helping them in planning effective intervention and treatment plans.

The rationale behind this research project was to introduce in Pakistan, the professional standards for identifying those needy students who have functional impairment and internalizing problems but remain unidentified, therefore, cannot receive special interventions and services in the school. And this is possible only if we have good screening instruments strong enough in their psychometric properties to identify the functional impairments in children and adolescents in early stage so that a complete comprehensive treatment plan can be planned for a growing population of students that have been misidentified and underserved in the past (Terluin, Brouwers, VanMarwijk, Verhaak, & van der Horst, 2009). So in order to achieve the goal of the present study it has been intended to provide teachers and school administration in Pakistan an indigenous screening scale (free from cultural and lingual biases) for the assessment of functional impairment, for early identification of the mental health difficulties in children and adolescents as well as for referral of these children to the special need or mental health services.

The rationale behind the construction of an indigenous Functional Impairment Assessment Scale (FIAS) is to identify the needy population of the Pakistani schools who are being treated badly by their school organizers, teachers, and classmates and even by their parents. Literature documents that these children, due to their low school performance and week social interaction are mostly ignored by the teacher and their peers. They occupy back seats of the class and sit alone as they usually have no friends. Their stress intensifies anxiety and thus negatively affects teacher performance as well. Eventually, the negative effect pervades the entire educational program. Therefore it is very important to identify all those students, who, due to their ED can affect the performance of their other classmates and also, create problems for their school administration. Once being identified, these students must be provided a special System of Care for their service with the help of teachers, parents and mental health professionals.

Researcher of the present study has strong feelings of sympathy towards young population of Pakistan who are suffering from severe emotional disturbance but are being overlooked by their parents, teachers and medical practitioners and has attempted to expresses her intrinsic desire and voice of her heart through this research project that,

"***Save Your Youth Today. Tomorrow it will be too late.***"

Chapter-II

RESEARCH DESIGN

The present research aims at determining the comorbidity of depression, anxiety, and Functional Impairment (FI) in terms of, emotional, social and cognitive dysfunction, as well as Impaired Global Learning Behavior in children and adolescents with low academic achievement.

The research also purports to identify the demographic risk factors in terms of gender, age, and socioeconomic status. Besides, marital conflict, family structure (single parent household may be divorced or died), and mother education have been explored also as demographic risk factors in the current study.

In order to get a more clear and vivid snapshot of the comorbidity of emotional disturbance (depression and anxiety) and functional impairment in children and adolescents with low academic achievement the current research attempts to make comparison of these students with those showing high academic achievement.

The present research consists of three parts. The details are as follows.

Part I: Development of an Indigenous Scale: Functional Impairment Assessment Scale (FIAS)

Being in line with the existing literature review the current study has got privilege to incorporate functional impairment assessment along with the other diagnostic measures while studying the level of comorbidity of depression, anxiety and psychological wellbeing in children and adolescents with low academic achievement.

An indigenous scale FIAS particularly in Urdu language has been planned to be developed in this part of the research for the assessment of the functional impairment in the young population with mental health and learning difficulties.

The main objectives of this part of research include:

1. To develop an indigenous scale Functional Impairment Assessment Scale (FIAS) for children and adolescents.
2. To determine the psychometric properties (reliability and validity) of the scale FIAS.

This part of the research was carried out in four steps by using independent samples. These are described as follows:

PhaseI: Generation of item pool for the scale.

Phase II: Content Validation and Categorization of items into specified categories.

Phase III: Selection of the final items for the scale

Phase IV: Establishment of psychometric properties of the scale

Part II: Translation of Depression and Anxiety in Youth Scale (DAYS) (Phyllis et al., 1994) into Urdu language and Validation of Functional Impairment Assessment Scale (FIAS)

The Part II of the present research has been planned to do translation of DAYS (Phyllis et al., 1994) to be used in the present study and also to confirm convergent and discriminant validities along with alpha coefficient reliability of the FIAS.

The objectives of this part of the research include:

1. Translation of DAYS (Phylis et al., 1994) into Urdu language to be used in present study
2. To establish the convergent validity of the FIAS with Urdu version of DAYS.
3. To determine the discriminant validity of FIAS with Urdu version of Psychological Well-being Scale (PWBS) Affectometer-2 (Kammann & Flet, 1983) translated by Naheed (1997) into Urdu.

Part III: Measurement of Comorbidity of Depression, Anxiety and Functional Impairment in Children and Adolescents with low Academic Achievement

Part III, the main study deals with the assessment of Depression, Anxiety and Functional Impairment (FI) in children and adolescents who manifest low academic performance by using newly constructed Functional Impairment Assessment Scale (FIAS) and Urdu version of DAYS (Phyllis e al., 1994) translated in Part II.

Objectives

Part III, the main study aims to measure the comorbidity of DEP, ANX and FI in children and adolescents who manifest low academic performance. In other words the research purports to identify the mental health difficulties or the barriers to the learning behavior in the young population, who attend school less, participate less in class as well as in school activities, have relationship problems with their peers and take low grades and show low academic achievement.

The main study was planned to assess the relationship of emotional disturbance (the hidden mental health difficulty) with the academic achievement of children and adolescents.

The specific objectives are as follows:

1. To find the comorbidity and relationship among the variables of the study, such as Functional Impairment (FI), Emotional Disturbance (DEP & ANX), psychological well-being (PWB) and life satisfaction (LS) in children and adolescents with low academic achievement.
2. To determine the difference of level of DEP, ANX, FI, PWB and LS in students with low and high academic achievement.
3. To find out the strength of the predictors of low academic achievement in terms of DEP, ANX, FI, low PWB and low LS. l as compared to those with high academic achievement.
4. To find the relationship of different demographic risk factors such as, socioeconomic status family structure, maternal education as well as age and gender of children and adolescents with the level of DEP, ANX, FI, PWB and LS.
5. To test the hypotheses formulated for the present research.

In addition to these, to further find out the reliability and validity of the newly constructed and translated instruments FIAS and DAYS-U respectively were also determined.

Main Hypotheses

Two main hypotheses formulated for the present research are:

1. There will be a comorbidity of DEP, ANX, and FI, in children and adolescents with low academic achievement.
2. Low academic achievement will be positively related to the DEP, ANX, and FI, but will be negatively related to the PWB and LS in children and adolescents.
3. FI will serve as the strongest predictor of low academic achievement among other variables such as DEP, ANX and low PWB.

In order to probe in-depth the relationship between low academic achievement and comorbidity of DEP, ANX, and FI, two sub-hypotheses were also originated from the main hypotheses.

Sub-Hypotheses

1. There will be difference in the scores of children and adolescents with high and low academic achievement on total and sub-scales of FIAS, DAYS-U, PWBS (Affectometer 2), and LSLS.
2. There will be difference in the scores of students with respect to their different age groups on total and sub-scales of FIAS, DAYS-U, and PWBS (Affectometer 2), and LSLS.

3. With respect to gender there will be a difference in the scores of boys and girls on total and sub-scales of FIAS, DAYS-U, and PWBS (Affectometer 2), and LSLS.
4. There will be difference in the scores of students belonging to the families with low, moderate or high socioeconomic status on total and sub-scales of FIAS, DAYS-U, and PWBS (Affectometer 2), LSLS.
5. There will be difference in the scores of students of uneducated and educated mothers on total and sub-scales of FIAS, DAYS-U, and PWBS (Affectometer 2), and LSLS.
6. Children and adolescents of discordant families have high level of Fl, DEP and ANX and have low sense of PWB and LS as compared to the students of harmonious families.

Operational Definitions

Comorbidity of Depression (DEP) and Anxiety (ANX). Comorbidity of DEP and ANX is a term which refers to the state of mixed depression and anxiety at the same time in the same person. (i.e., the occurrence of two or more disorders) (Nottelmann & Jensen, 1995; Clarkin, & Kendall, 1992; McGee, Feehan, Williams, Partridge, Silva, & Kelly, 1990). Because these symptoms are not specific to either kind of disorder, they are called symptoms of negative affect that are common to both mood states (Barlow, 2002). It has been evident through literature review that children with anxiety and depression have functional impairment in social situations (in homes, communities and schools) (Barlow, 2002)

In the present study symptoms of comorbidity of DEP and ANX has been adapted from (Barlow, 2002) which are: feelings of worthlessness; hopelessness; lack of motivations; kow concentration and loss of interest in daily activities and withdrawal to social situations or group activities.

Functional impairment. Functional Impairment in youngsters with mental health difficulties is referred as the deficits which they experience in their intellectual performance and academic achievement, disturbance in self- perception, self-esteem and social problem solving (Garber, Weiss & Shanley, 1993; Kovacs, 1997).

In the present study young population with FI were identified by their scores on the newly developed Functional Impairment Assessment Scale (FAS). This scale was developed indigenously in the context of Pakistani culture to measure the functional impairment through the domains of cognitive, social, and emotional dysfunctions. FIAS also measures the impairment in global learning behavior through its sub-scale LBDS.

Academic achievement. The aggregate of scores obtained by the student in the previous class annual examination were taken as the indicator of Academic achievement.

Low academic achievement. In the sample population of the present study children and adolescents with low academic achievement are those who have not passed their annual examinations of previous class successfully and are repeating the same class and their teachers rank them on the last five positions.

High academic achievement. In the present study children and adolescents with high academic achievement are those who stood at the first five positions with high Grades in their previous class annual examination.

Demographic risk factors. The research purports to identify the Demographic risk factors in terms of gender, age, socioeconomic status (low/high income), single (widow / divorced) parent household, and mother's education.

Age. Although there is some disagreement as to the ages that should be used to identify the boundaries of adolescence but the beginning of the puberty is widely accepted as marking the beginning of adolescence and the age of 19 years is commonly used as the beginning of adulthood. Therefore the extended period from 10 to 19 years of age is used as the definition of adolescence (Nutbeam & Booth, 1999).

From 6 to 19 years age children and adolescents have been included in the present research sample. As the main variable of the present research is academic achievement which has been assessed through report onannual examination result of the students so theage 7 was included because proper academic year with annual examinations starts from KG-1 Class.In Pakistani most of thechildren who get admission in KG-1 Class are of 6-7 years age and the students who are in BA usuaaly belong to 18-19 year age group. Hence for the present study classes from KG-1 to BA / BSC were included.

The whole sample has been divided into three groups with respect to age. Children from class KG-1 to KG- V were taken for the group 1 (i.e., 7-10 years of age) which was marked as Children, from class 6^{th} to 8^{th}(Middle) were recruited in

group II (i.e., 11-13years of age) as Early Adolescents and student of class 10th (Matric) to BA/BSc were included in group III (i.e., 14 – 19 years of age) as *Late Adolescents.*

Socioeconomic status. In the present research the term Socioeconomic Status has been referred as the level of monthly income. With respect to the perceived level of monthly income of majority of families of children studying in Rawalpindi and Islamabad FG and Model Colleges the sample has been divided into four groups.

a. Monthly income below 20,000 Rs has been referred as Low Socioeconomic Status.(LSS)

b. Income, ranging from 21,000 to 30,000 Rs as Low Middle Socioeconomic Status (LMS)

c. Income from 30,000 to 50,000 Rs. as Middle Socioeconomic Status (MSS)

d. Income from 51,000 Rs and above as High Socioeconomic Status (HSS)

Family structure. Family structure covers two categories: Children living with: both parents as intact families, and mother-only/ (divorced/ widow) as single parent families.

Mother's education. This variable covers three categories such as mothers with no schooling at all as ***Uneducated mothers***, from Matriculation to Graduation as ***Educated mothers***, Masters and above as ***Highly Educated Mothers.***

Marital conflict. Parents who have marital conflicts, disputes and other marital Problems which also break up in domestic violence have been included in the study. This variable will be measured by dividing the whole sample into two main groups: children from **Discordant Families** and children from **HarmoniousFamilies.**

Discordant families. It refers to the families where parents are living together but have frequent disputes and become violent to each other.

Harmonious families. It refers to the families where parents have no conflict with each other and have seldom disputes and are happily married.

Chapter-III

PART I: DEVELOPMENT OF FUNCTIONAL IMPAIRMENT ASSESSMENT SCALE (FIAS)

The Part-I of the present research has been conducted to develop an indigenous scale, Functional Impairment Assessment Scale (FIAS) to be used in the main study (Part-III). It was the requirement of the current research to use an indigenous scale particularly in Urdu language to measure the comorbidity of Depression (DEP), Anxiety (ANX) and Functional Impairment (FI) as an emotional disability in children and adolescents with low academic achievement with the age range of 6 to 19 years.

Objectives

1. To develop an indigenous Functional Impairment Assessment Scale (FIAS) for children and adolescent from 6 to 19 years age.
2. To determine the psychometric properties (reliabilities and validity) of the FIAS.

Development of Functional Impairment Assessment Scale (FIAS)

The need to develop FIAS emerged when no suitable scale was found which could meet the requirements of the present study. First of all search for the

appropriate scale was made within the country. There was no such instrument available in the country which could be used in the present research for the assessment of the FI or mental health difficulties in the children and adolescents. Then in order to find a suitable scale for the current study the existing foreign scales were explored through internet browsing. But unfortunately none of them could meet the criteria of selection for the current study on several points which has been discussed bellow for each scale separately.

The result of the literature review for finding an appropriate measure FI is as below.

Brief Review of Existing Scales of Functional Impairment

Child and Adolescent Functional Assessment Scale (CAFAS). CAFAS, (Hodges, 1994) measures general and specific areas of functioning. such as (1) The School/Work domain (2) The Home (3) The Community domain (4) The Behavior toward Others domain (5) The Moods/Emotions domain (6) The Self-harmful Behavior domain (7) The Substance Use domain and (8) The Thinking.

CAFAS was designed to be scored only by trained persons or mental health practitioners following a comprehensive interview and this is its main limitation because its ratings are based on the interviewer's judgements rather than self-reporting of individual due to which the findings may not be generalizeable. Further it is a time consuming procedure and requires a skilled interviewer (a psychologist or any other trained person). So this scale lost its attraction of being chosen by the researcher.

The Scale for Assessing Emotional Disturbance (SAED). SAED (Epstein & Cullinan, 1998) attempts to identify children and adolescents with emotional / behavioral difficulties in school and also measures student's progress.

Though this scale appeared to be very appropriate and fabulous to be used in the present study but unfortunately we could not select this scale due to two reasons:firstly, it uses Federal Criteria of United States for identifying the children and adolescents with severe emotional disturbance.In United States and the Individuals with Disabilities Education Act (IDEA) (P. L. 101-476) and the Education for All Handicapped Children Act (P.L. 94-142) of 1975 identified specific categories of disabilities under which children may be eligible for special education and related services. As defined by IDEA, serious emotional disturbance includes schizophrenia but does not apply to children who are socially maladjusted, unless it is determined that they have a serious emotional disturbance (Chris & Sam, 1993).

As Federal Definition does not include the element of social maladjustment due to which it is being encountered by severe criticism. Psychologists think that this definition must be reviewed.

The Devereux Behavior Rating Scale School Form. This 40 item scale has been developed to identify behaviours that may indicate severe emotional disturbance in children and adolescents.

This scale is also based on federal criteria which is as mentioned above not desirable by the researcher, because, Federal Definition has been used for identifying the children and adolescents with severe emotional disturbance. Hence this scale

which has been meant for the USA population does not seem to be appropriate for Pakistani population.

The Children's Global Assessment Scale (CGAS). The CGAS, (Schaffer et al., 1983) is a modification of the *Global Assessment Scale* (GAS) for adults (Endicott, Spitzer, Fleiss, & Cohen, 1976) which is commonly used for rating functioning in clinical population and was found to be sensitive to treatment effects in adolescents with depression (Mufson, Dorta, Wickramaratne, Nomura, Olfson, & Weissman,2004). As the sample of the present study consists of the school population and this scale is suitable for clinical population so researcher did not select this scale.

Global Assessment of Functioning Scale (GAF; Axis-V in DSM-IV). GAF is a scale that helps in identifying the individual who needs treatment and also is used in assessing the treatment effectiveness or change in behavior over time after treatment. .

An instrument developed to measure global functioning should encompass a wide range of functioning in almost every social setting and integrate information about multiple domains of functioning and the available scales like Global Assessment of Functional Impairment (GAS, DSM-IV; APA, 1994) does not provide information about psychosocial functioning in a specific role impairment (e.g., family / home and school functioning) that a multi dimensional instrument would supply. So this scale does not fulfill the requirement of the present study.

Vineland Adaptive Behavior Scales (VABS, Sparow, Balla, & Cichetti, 1984) which assess daily functioning of individuals who are mentally retarded or individuals with other disabilities can also be used in research investigating development and functioning of handicapped individuals. As VABS are the scales to be used only on handicaps and mentally retarded population these also could not pass the selection criteria for the current research.

The Brief Impairment Scale (BIS). The BIS (Birdet al., 2005) is a 23-item instrument that has high convergent and concurrent validity. The BIS is psychometrically sound, useful in assessments and as an outcome measure in clinical practice and research.

Literature review reveals that, though there are numerous global impairment tools available as mentioned above which are being used by mental health practitioners and researchers most of these are confound to measure a single aspect of functional impairment in clinical and symptomatic psychiatric patients. Some mix severe symptoms in functional impairment which require trained rators or clinicians for their scoring and some of these instruments are lengthy to administer and restricted to specific domains of functioning (See, Wagneret al., 2007),

Further, a need to develop new scale has also been felt strongly to achieve a culturally appropriate scale in order to cope with the cultural diversities. Due to prevailing joint family system in Pakisan the developmental, biological and cultural characteristics of children are inextricably interwoven in society. By the age five they have learned their home languages, developed social skills and established interpersonal relationships with their families and peers. So an indigenous scale like

FIAS in the native language (Urdu) was needed that could better reveal the subjective feelings and psychosocial phenomenon of the respondents. Hence it was decided by the researcher to develop a culturally and lingual appropriate indigenous scale that could measure impairment in global functioning of children and adolescents in the current study. Another rationale behind the development of the screener FIAS in the present research was to achieve an indigenous scale for school use to identify the children at-risk for problems behavior.

The development of FIAS makes the present study unique for providing school personnel in their hands an indigenous scale which has a primary goal to identify functional deficiets in the social, emotional and cognitive domains that interfere with acquisition academic achievement. It also aims to measure learning behavior competences necessary for every child to learn effectively. The Functional Impairment Assessment Scale (FIAS) basically tends to recognise the functions or behaviors responsible for the low school performance of students. Such information is of great use in making specific intervention plan.

The development of the Functional Impairment Assessment Scale (FIAS) for children and adolescents has been carried out into following four phases.

Phase I: Generation of item pool for the scale.

Phase II: Content Validation and Categorization of items into specified categories.

Phase III: Selection of the final items for the scale.

Phase IV: Establishment of psychometric properties of the scale.

Phase 1: Generation of Item Pool for Functional Impairment Assessment Scale (FIAS)

The main sources to generate an item pool for FIAS were:

1. Review of the existing literature.
2. Focus Group Discussion with teachers and parents.

Literature review and description of conceptual framework were used for the development of FIAS. In order to find the theoretical grounds of the scale under developed the existing literature on the said topic was extensively explored through browsing on internet and excessive exploration of books, researches, journals articles of the relevant areas from various sources.

The theoretical framework achieved through review of available literature on which the FIAS stems is given as under:

1. DSM-1V-TR Criteria of Mental Disorders.
2. Developmental Sequence of Educational Goals (Neuropsychiatry Institute, NPI).
3. Comorbid Model of Depression and Anxiety
4. Psychosocial Developmental Theories

1. DSM-1V-TR criteria of mental disorders. The theoretical basis on which the scale FIAS stems mainly is DSM-1V-TR Criteria of Mental Disorders. DSM-IV definition of functional impairment was mainly followed to develop FIAS. Functional impairment as demonstrated by children, with a serious emotional disturbance is the decreased ability over a long period of time to meet the challenges presented by day-

to-day settings and interactions in school, home, and the community (DSM-IV; APA, 1994).

DSM-1V defines Impairment in Global Learning behavior in school setting of the children as the child having significant problems with controlling behavior, with getting along with class fellows or peers due to emotional / social problems, and failing in some subjects or all. Example includes: changes in school performance, poor grades, poor attention span or lack of concentration, prolonged negative mood, social withdrawal, losing interest in friends or things usually enjoyed, growing inability to deal with daily problems and activities, marked personality change, feeling very sad, hopeless, or irritable. Beside DSM-1V-TR Criteria of Mental Disorders which describes the child'sfunctional deficits the conceptual frameworks given by other disciplines regarding assessment of mental health difficulties through functional impairment in school children and adolescents were also explored and followed while generating item pool of the scale under construction.

People such as educationists, neurologists, mental health practitioners and psychologists have identified certain global learning behaviors necessary for the effective learning and academic achievement. A brief review of work of these people is as follows.

*2. **Developmental strategy.*** The essential behaviors described in the developmental strategy are attention, responxe, order, exploratory, social, mastery and achievement. It is hypothesized that a child must possess these learning behaviors before getting admition in the school i.e., he must pay attention well to teachers, give

peoper response and follow their instructions, explore the environment accurately and function appropriately in relation to others.

All of these developmental levels or sequences of educational goals are woven together very strongly and if a child fails to cope at any level his learning will be impaired.

The developmental sequence does not represent the first attempt to describe learning in the classroom by mean of sequence or hierarchy of behaviours. Many others has tried to present this type of learning pattern e.g., the psychodynamic interpersonal strategy, sensory neurological strategy and behaviour modification strategy, but the developmental sequences of educational goal seem to be the most appropriate.

3. Comorbid model of depression and anxiety. Another source of theoretical underpinning of FIAS is the model of symptoms of mixed anxiety and depression. According to researchers (Barlow, 2002) identifying pure anxious or depressive symptoms as well as symptoms of negative affect that are common to both mood states is an important step in creating the new diagnosis of mixed anxiety and depression as these are not specific to either kind of disorder.Symptoms common to both anxiety and depressive states i.e., symptoms of negative affect (Zinbarg et al. 1994) such as excessive worry; irritability; crying; faigue; poor concentration; low memory; guilt; sense of worthlessness; hopelessness and sleeplessness have been also considered by the researcher in generating the item pool of under developed scale.

According to researchers (Barlow, 2002) Symptoms of negative affect alone are often less severe than full blown anxiety or mood disorders. Individuals with mixed ANX and DEP disorders frequently have functional impairment in social situations (in homes, communities and schools).

4. Psychosocial developmental theories. Another important source used to generate the item pool and to identify different domains of FIAS is the Psychosocial Developmental Theories. These theories also helped in identifying the demographic risk factors. A brief description is as under.

Social influence. Social factors such as socioeconomic status, parental support, interpersonal relationships, peer pressure, cultural and religious background all exert direct influence on the personality makeup of children.

Adolescents and their peers. Today's teenagers spend more time in the exclusive company of their peers than their counterparts in the past. Hence the role of peers in shaping adolescent psychosocial development has become increasingly important (Porown, Theobold, & Klute, in Prurs, Larson & Hem, 1993; Brown et al., 1986).

Experience in the peer group also can be an important influence on adolescents self image and also is vital for the development and expression of autonomy. In addition the peer group provides a contest for adolescent to test out decision making skills when there are not adults present to monitor and control their choices (Hill & Holmbeck, 1986).

Finally, peers are an important influence on adolescent achievement. Children and adolescents influence each other's academic performance. Although peers may play a less influential role than parents and teachers in influencing adolescent's long term educational and occupational plans, peers have a significant influence on adolescent's day to day school performance. For example, how well they perform in class and value the school (Epstein, 1983). The children and adolescents whose friends do well in school are likely to achieve more than the children and adolescents whose friends do not do as well (Epstem, 1983a). Similarly student whose friends are disruptive in school tend to become more disruptive. Basically this is the combination of aggression and poor emotional regulation that leads to problems with peers.

Popularity and rejection in adolescent peer groups. Researchers found that there are certain factors which determine which adolescents are popular and which ones are disliked within their peer groups.

Popular adolescents are skilled and confident in the eyes of their peers. Additionally they are friendly, cheerful good natured, humorous, and intelligent (Hollingshead, 1949/1975; Jarvinen & Nicholls, 1996).

Although many determinants of popularity are common across cultures, some differ: For example, shyness, which is clearly a social liability in American peers groups may be an asset among children in China (Cohen, Rubin & Li, 1995).

Social scientists have also shown an important disinclination among three types of unpopular or disliked adolescents (Bierman & Wargo, 1995; French, Conrod, & Turner, 1995; Hatzichristou & Hopf, 1996; Hymel, Bowker, & Woody, 1993; Parkhurst & Asher, 1992) which are as described under.

1. Overly aggressives. This group gets into fights with their peers, are involved in antisocial activities including bulling.
2. Withdrawns. This tends to be shy and avoid social gatherings and often become victoms of bulling.
3. Aggressive Withdrawns. These are aggressive and hostile towards their peers however like other withdrawn children they become nervous while initiating friendship with other adolescents. Researchers point out that boy's exhibit more overt aggression than girls (Crick, 1996; Crick, Bigbee, & Howes, 1996; Crick & Grotpeter, 1995).

Being unpopular has negative consequences for adolescent's mental health and psychological development. Peer rejection is associated with subsequent depression, behaviour and academic problems (DeRosier, Kupersmidt, & Patterson, 1994; Kupersmidt, Burchinal, & Patterson, 1995; Kupersmidt & Coie, 1990; Patterson & Stoolmie, 1991). Many psychologists believe that unpopular adolescent lack some of the social skills and social understanding necessary to be popular with peers (Crick & Dodge, 1994; Dodge & Coie, 1987).

So far as the social skill deficits of unpopular with drawn children is concerned research shows that these children are excessively anxious and uncertain, often having around this group, without knowing how to break into a conversation or activity. Their hesitancy, low self esteem and lack of confidence make other children feel uncomfortable or annoyance and their submissiveness makes them easy targets for bulling (Olweus, 1993; Salmivalli, 1998). Many of these youngsters are especially sensitive to being rejected; a threat that may have its origins in early experience with parents (Downey et al., 1998).

Demographic risk factor. Tthe risk factors include: Stress (Lewinsohn, Rohde & Seeley,1998); loss of a parent or loved one (Wells, Deykin & Klerman,1985); break-up of a romantic relationship (Monroe, Rohde & Seeley, 1999); attentional, conduct or learning disorders (Spencer, Biederman & Wilens, 1999); chronic illnesses (Kovacs, 1997); abuse or neglect (Brown, Cohen & Johnson, 1999); and other trauma, including natural disasters (Krug, Kresnow & Peddicord, 1998).

Besides, Economic Stress and Poverty (Hernandez, 1997; Conger, Conger, Mathew & Elder, 1999; Kloep, 1995; Lempers, Clark-Lempers, & Simmons, 1989); Impact of Maternal Education and Employment (Weiss & Schwarz, 1996; DePlanty, Jennifer; Coulter, Russell, Duchane, & Kim, 2007; Melby & Conger, 1996); Influence of Family Structure (Kellaghan et al., 1993; Coleman, 1991; Hatherington, 1999); Psychological Effect of Divorce and Single Parents Families on Adolescents (Hett, 1980, Southworth,1984). The Impact of Marital Conflict (Forehand, Armistead, & David, 1997; Cherlin, Chase-Lansdale, & McRae, 1998; Elliott & Richards, 1991; Amato & Booth, 1996; Forehand, Neighbors, Devine, & Armistead, 1994). All of these theories related to Patterns of Psychosocial Development and emotional disturbance in children and adolescents were carefully explored and studied to achieve the objective of this Phase (i.e., Generation of the Item Pool for FIAS) of Part 1 of the present study (See chapter I for more detail).

For the selection of names of sub-scales and general pattern of FIAS different existing instruments (previously mentioned) were also carefully reviewed.

Besides exploring literature review the other strategy which was adopted to attain feedback on the learning behavior, as well as the functioning deficits of children

and adolescents for the generation of item pool for the scale was focus group discussion technique.

Focus Group Discussions (FGD)

To generate the items for the identified areas, a series of FGD were conducted. Because the scale is indigenous and being developed in Urdu language according to the cultural and religious values for the Pakistani children and adolescents the researcher chose the FGD technique which appeared to be a direct way of obtaining perceptions, observations, and opinions of the core of the nation builders, the parents and teachers regarding the cognitive, emotional and social functioning of the children and adolescents with low academic achievements as compared to the high academic achievers. Further, it also provided a fast and easy way of approaching the target population.

After careful analysis of the situation the participants for the FGD were recruited from the Government and the Federal schools (FG), Islamabad Model Colleges for Girls/ Boys (IMCG & IMCB) and private schools of the city. All the participants were contacted through the Principals of schools. For the recruitment of parent participants their addresses and telephone numbers were obtained from school record sheets of children. Only parents of children with low academic achievementand of those with high academic achievement referred by teachers were recruited. The parents were provided with the brief written introduction of the research regarding the objectives of their inclusion in the focus group discussion.

Then the selected participants were also approached telephonically to confirm their participation in the FGD.

Participants. The FGD were carried out among trained teachers (with teaching qualification CT / B-AID orMA/MSC) with minimum experience of 5-years of primary and secondary schools of Federal Government (FG), Model colleges and private schools of Rawalpindi and Islamabad cities as well as among the parents with educational qualification of Matriculation to Master degree of children and adolescents with low / high academic achievement. The teacher participants were mostly English Science and Math teachers. Total participants were *N= 86*, including both the genders, males *N=40* and females *N=46*.

See Table 1 which shows the detail of the participants as well as various focus group arrangements.

Table 1

	Type of Groups	Date	Venue	Male	Female	Total Participants	AgeRange in Yrs
1	High School Teachers	4th September 2008	FG School for Girls, Islamabad	4	8	12	30-56
2	Primary School Teachers	5th September 2008	FG High School For Girls, Gualmandi, Rawalpindi.	5	6	11	26-47
3	High School Teachers	6th September 2008	IMCB, F/11, Islamabad	7	6	13	31-54
4	Primary School Teachers	8th September 2008	FG Primary Boys School, Islamabad	5	7	12	27-50
5	Parents of Children with Academic Problems	12th September 2008	IMCG, F6/2, Islamabad	6	6	12	30-55
6	Parents of Children with Good Academic Performance	13th September 2008	FG Primary Girls, School, Chaklala, Rawalpindi	7	7	14	32-48
7	Parents of children with low and high academicachievement	18th September 2008	School of Arts and Science,Islamabad	6	6	12	30-50
			Total	40	46	86	

Focus Group Participantsand Venue Details

Focus Group Guideline. For a carefully planned discussion, a Focus Group Guideline was prepared by the researcher (see Appendix A) so that opinions, ideas, perceptions and observation of the relevant expert people about the topic under consideration could be achieved. The Focus Group Guideline was prepared on the

basis of identified categories from the existing literature review and proper questions were made accordingly. The questions in the Guideline were made in such a way that these might cover all the aspects of the functional impairment which could be seen in children and adolescents with low academic achievement.

Flow of discussion was along the specified paths set in the questions of focus group guide lines which are as under:

1. What do you think about the Attention Span of students with low academic achievement?
2. Do the students with low academic performance take part in extra-curricular activities of school? Please give your remarks in this regard.
3. Please give your comments regarding the cognitive functioning (e.g., comprehending and analyzing the situations and responding accordingly) of children and adolescents with low and high academic performance.
4. What do you think about the social relationships of students with low academic achievement?
5. How is the emotional behavior of the children and adolescents with low academic achievement?
6. What will you say about the punctuality and rule obedience of the students with low and high academic achievement?

Procedure

Each Focus Group Discussion (FGD) of 90 minutes durations (average time) was arranged in the school's seminar halls or meeting rooms during school time with

independent sample. Formal consent of the teacher and parent participants was acquired (See Appendix "A1"). Before starting each focus group a brief introduction of the facilitator and participants were done to develop a rapport between them. In every focus group, the discussion opened with brief introduction of the main objectives of the research and participants were invited to comment on the school performance and social and emotional behavior of those children and adolescents who appear to have high and low academic achievement or those who have some perspicuous psychosocial problems with their school mates or school management. Every participant was encouraged to take part in the discussion and coordinator very skillfully, tried to keep the discussion well focused on the issue.

The group discussion was kept focused on a series of probing questions already set in focused group guide. Facilitator controlled the flow of discussion and ensured the equal participation of all the members through brain storming.Starting from the introduction of the research topic and general orientation of the study the questions were asked following the guideline. All the specified categories or areas were discussed in detail by giving the equal opportunities to all the participants to shed light of their opinion, observations and perceptions regarding the specified component of the topic under discussion. All participants enthusiastically participated in the discussion. They recognized the importance of assessing functional competences necessary for learning and identification of emotional and behavioral disturbance among children and adolescents who are weak in their studies. Parents especially mothers gave valuable information. Flow of discussion remained along the specified paths set in the questions of focus group guidelines. Facilitator kept on

seeking clarity and profound understanding throughout the discussion. Special attempt was made to make a smooth shift from one topic to the next.

Besides the tape-recorder used to record informations notes in the form of FGD transcripts were also taken so that information would be available immediately after the session for discussion.

Content analysis was made for the information obtained through the series of focus group discussion conducted with teachers as well as parents of children and adolescents with low as well as high academic performance. For this purpose on each question of the focus group guide, the maximum coding categories were generated by listening the recording carefully by the researcher. The new concepts from the information obtained through different focus group discussion were also taken to generate more coding categories. Incidents narrated by the participants were carefully and qualitatively analyzed and the relevant themes were picked up to make transcripts of each FGD.

Result

Responses of the participants of all the FGDs were jotted down systematically under each category in the form of FGD transcripts. These transcripts were interpreted with the help of deductive content analysis an approach used by Maring (2000) that is also explained by Hsieh and Shannon (2005) as directed content analysis where a theory or relevant research findings.are used as initial coding of content. In the present research the DSM-IV criteria of emotional disturbance as well as Developmental Sequence of Educational Goals given by Neuropsychiatry Institute

(NPI) for learning behavior was followed as the theoretical framework. By the deep contemplation in the data the researcher identified the themes emerging from the data which were also relevant to the conceptual framework of the scale.The following steps were involved in the interpretation of FGD data through deductive content analysis with the purpose of generating statements for the item pool of FIAS.

The first step in the process of deductive content analysis involves theoretical based definition of the aspect of analysis, main and sub categories (Hayring, 2000). Four main categories for the present content analysis were the four domains of functional impairment in which the cognitive dysfunction, emotional dysfunction, social dysfunction are based on the DSM-IV criteria, of mental disorder and definition of mixed anxiety and depression disorders (Barlow, 2002; Durand, & Stewart, 2006) and the fourth domain the Learning Behavior Dysfunction follows the *Global learning behavio*r defined by DSM-IV as well as *Developmental Sequence of Educational Goals (Neuropsychiatry Institute, NPI) which* describes the essential behaviors and competencies such as: attention: response, orders: exploratory; social: mastery and achievement.

The second step of content analysis involved data arrangement in the form of transcripts of FGDs in which only relevant questions from the FG Guide were transcribed. The data was further summarized to be used in the next step.

In the third step the summaries of the transcripts were analyzed thoroughly and variety of response patterns were observed and recorded while exploring the themes in the FGDs according to the commonality and predefined construct of functional impairment.

The fourth step of the process of content analysis was to draw and construct unit of analysis i.e., to draw specific response patterns from the response summary of FGD transcripts (Weber, 1990). On the basis of response summary the specific response patterns were identified before coding them into behavioral categories in the next step. The material of the FGDs transcripts was analyzed thoroughly step by step. All the responses were carefully examined and scrutinized by the researcher to evaluate their relevance to the represented the domains of functional impairment. The responses having frequencies less than 30 were not considered common behavior patterns.These responses were carefully analyzed, repeatedly scrutinized and finally coded as themes of specific behavioral pattern with in the process of content analysis. A variety of response patterns revealed by the participants of FGDs was identified and recorded along with the frequencies of their responses. These themes related to each domain of functional impairment are presented subsequently. The frequency of responses related to each theme and behavior pattern has been presented here in the parenthesis. The criterion for selecting a theme was of at least frequency of 30 responses i.e., if a response has occurred for at least 30 times or by half of different participants it would be tabulated for generating a specific statement of response category.

The following information was obtained from the primary and high school teachers and the parents of students with low and high academic achievement.

The summary and frequency of responses expressed by the participants of FGDs while exploring the question no.1 of Focus Group Guideline related to attention span.

The children and adolescents with low academic achievement show the following classroom behavior.

2. Do not pay attention to the teacher's instructions (f =73)
3. Due to lack of concentration they cannot finish their writing tasks or other assignments given to them (f =62).
4. Do not pay attention on the blackboard rather watches outside the window or door in the corridor (f =42).
5. Sit inattentively in class therefore if teacher asks them some question regarding the lesson being taught they appear to be blank minded (f =41).
6. Class Participation is very less. Due to inattentiveness they do not know what is being discussed in the class (f =40).
7. Cannot sit still on their seats (f =41).
8. Show repetitive behavior such as wandering in class, going to dustbin with the purpose of sharpening of pencils again and again, asking permission to go to the toilet for so many times (f =38).
9. Make frequent cuttings of words while writing and then rubbing or erasing it (f = 43).
10. Play with fingers or feet, continuously (f =32).
11. Do minor mistakes of spelling (f=57).

The summary and frequency of responses expressed by the participants of FGDs while exploring the question no.2 of Focus Group Guideline related to Extra-curricular Activities.

12. The children who are week in their studies or fail in their examinations are usually not good in extra-curricular activities (f =68)
13. The children and adolescents with high academic achievement take part in debates, drama, sports or other annual function of the term (f =63).
14. The children and adolescentswho are not good academically are less energetic, and are seldom seem in the sports ground (f =41).
15. The children and adolescents with low academic achievement do not participate in group activities of the class (f =48)
16. Student with academic problems do not take part in the decoration of their class room i.e., do not take part in making models or charts related to science or other subjects.(f = *36).*

The summary and frequency of responses expressed by the participants of FGDs while exploring the question no.3 of Focus Group Guideline related to cognitive functioning.

The children with academic problems:

17. Show a behavior that does not match with the current situation e.g., laughing when they are not supposed to laugh (f =69).
18. Become angry on minor things (f =74).
19. Ask irrelevant questions (f =62).
20. Cry easily some times for no apparent reason (f =45).
21. Do not follow the teacher's instruction (f =43).

22. Come in incomplete school uniform with usually unwashed face and hands, etc (f =32).
23. Are overly obedient and never disagree with the ideas or opinions of others. i.e., always give "yes Miss" type of response (f =38).
24. Try to perform better when parents promise them to give them a gift.(f =31)
25. Do not feel worry on the problems encountered by whole family (f =30)
26. Do not show sympathy for pets (f =31)
27. Do not take notice of parents advice (f =33)
28. Do not take advantage from others experiences rather learn by hard ways (f =31)
29. make sudden movements being unaware of its bad consequences or outcomes (f =42)
30. Receive too much fine from school (f =48)
31. Do not tolerate criticism (f =53).

The summary and frequency of responses expressed by the participants of FGDs while exploring the question no.4 of Focus Group Guideline related to Social Relationships.

Children and adolescents with low academic achievement:

32. Have very few friends (f =43).
33. Are shy and don't speak by themselves unless talked to them (f =42).
34. Always sit at the back benches or seat of the class (f =44).
35. Cannot do reading in loud voice in front of whole class (f =40).
36. Speak in such a low voice that it becomes very difficult to listen them (f =36).
37. Sit alone (f =35).

38. Have friends who are also weak in their studies and sit at the back seats of the class with them (f =44).
39. Talk too much and make noise in the class (f =32).
40. Have frequent disputes with their friends (f =42).
41. Do not share their rubber, pencils or other things with their desk mates (f =37).
42. Change their friends frequently (f =45).
43. After making new friends soon develop a conflict which finally ends in breakup (f =41).
44. Are not popular children and adolescents (f =52).
45. Are not selected a group leader (f =49).
46. Do not talk freely while sitting among family members / peer group.(f =46).
47. Do not play with their class mates (f =53).
48. Do not go in public gatherings (f =47).

The summary and frequency of responses expressed by the participants of FGDs while exploring the question no.6 of Focus Group Guideline related toEmotional Behavior.

Children and adolescents with low academic achievement:

49. Feel lack of confidence (f =66).
50. Do not make an eye contact while talking (f =38).
51. Mostly sit alone doing nothing (f =48).
52. Remain calm and appear lethargic (lack vital energy) (f =62).
53. Feel that they are ugly and nobody likes them (f =52).
54. Are very stubborn (f =54).

55. Are disobedient.(f =42).
56. Show aggression (f =55).
57. Become irritated on minor things (f =50).
58. Remain unhappy (f =59).
59. Do not take interest in any thing (f =39).
60. Do frequent physical complaints e.g., vomiting, stomach ache, pale face, and sweating (f =53).
61. Look quite and sad (f =43).
62. Most of the time remain passive and are usually victim ofbeliers (f =56).
63. Remain absent from the school (f =62).
64. Report that they could not sleep properly whole the night (f =52).
65. Boys spend more time out of home (f =32).
66. Cannot finish their school assignments in one sitting (f =52).
67. Cannot memorize their lesson (f =55).
68. Cry easily (f =51).
69. Become easily irritated on minor things (f =56).

***The summary and frequency of responses expressed by the participants of FGDs while exploring the question no.6 of Focus Group Guideline related to*punctual and responsible behavior.**

The children and adolescents with high academic achievement:

70. Have been found to be very responsible (f =68).
71. They complete the assignment given to them even if they are boring either from their teachers or parents in right time (f =72).

72. Donot waste their time going outside till late night (f =37).
73. Spend much time in their studies and seem to be involved in some constructive work (f = 56).
74. Never become absent from their school (f =53),
75. Never become late (f =51).
76. Have friends who are also good in studies and are position holder of the class (f =52).
77. Perform duties of head girl / boy in the school (f = 73).
78. Are recognized as the popular student of the school (f = 69).
79. Take care of their bodily health and hygiene (f =48).
80. Take care of their family members (f =31).
81. Do help to their parents in house hold jobs (f =33).
82. Do respect to the laws and rules of the home, community and school (f = 57).
83. Are very careful while doing home work and try to make perfection. Try to avoid even a single mistake (f =59).
84. Try to maintain their academic performance. If they lose their position in class they can't bear it and become so much depressed, cry and may stop eating or sleeping (f =52).
85. Prefer to work when there is no noise, no music or radio/TV is on (f = 73).

In the fifth and final step after determining the specific behavior pattern, the data was further summed up by drawing specific response categories on the basis of commonality and frequency of behavioral patterns for making interpretation more precise in order to facilitate the process of item generation. For example behavior

pattern such as *"Attention Span"*, *"Extra-curricular Activities", and "punctuality and responsibility"* were identified as single response categories on the basis of frequent responses of similar nature or representing different aspects of a single construct. All the response categories were carefully examined and scrutinized by the researcher to evaluate their conceptual relevance with the components of the functional impairment. As a result behavior patterns regarding *"Attention Span"*, *"Extra-curricular Activities" and "punctuality and responsibility"* were placed underthe category named as "Learning Behavior Dysfunction" andother behavior patterns interpreted according to conceptual framework of three more categories named as "Cognitive Dysfunction", "Social Dysfunction", and "Emotional Dysfunction".

Generation of Item Pool

At the end of the procedure a total number of 151 statements were extracted from FGDs data literature reviewto make an item pool in the first step of scale development (See Appendix "B" for list of item pool N=151). These statements were distributed between two forms: Form-P and Form-T by the researcher according to the response patterns which were appropriate for the child's functioning in different settings (home and school) along with the same dimensions or response categories.

Description of item pool. A total 79 statements for Parent Rating Scale (PRS) or Form- P (See Appendix B 1 for PRS, Form-P) amongst those 25 statements were representing "Cognitive Dysfunction" (CD), 18 were representing "Emotional Dysfunction" (ED), 17 statements were for "Social Dysfunction" (SD) and 19 were for " Learning behavior dysfunction" (LBD) (See Appendix B2 for domains /

categories of Form-P). The rest of 72 statements from total item pool of N=151 were assigned to Teachers Rating Scale (TRS) or Form-T of FIAS (See Appendix B3 for TRS, Form-T) amongst those 23 statements were representing "Cognitive Dysfunction" (CD), 12 were representing "Emotional Dysfunction" (ED), 16 statements were for "Social Dysfunction" (SD) and 21 were for " Learning behavior dysfunction" (LBD) (See Appendix B4 for domains / categories of Form-T)of FIAS.

All the items were phrased in simple and easy diction that are easily comprehendable to the people who were to answer them. Loaded and double-barreled items were avoided. .At last an item pool consisting of 79 items for the PRS and 72 items for the TRS of the scale FIAS was obtained.

Phase II: Content Validation and Categorization of Items

In this phase the content validity of both the Forms (P & T) was determined.. Generally two approaches comprising judgmental and statistical are available to determine content validity.

For the determination of content validity of FIAS the judgmental approach was adopted. The FIAS in its initial format was presented to experts or a panel of judges to seek their opinion for identifying the unclear inappropriate and double barrel statements and for rechecking of categorization into four domains of functional impairment as derived from conceptual framework of FIAS.

Experts. Though there is no fixed number of experts seen content validation studies (Cramer, Atwood, & Stoner, 2006) ten experts were taken because Haynes, Richard, and Kubany (1995) recmommend this number in order to get greater

confidence and reduce subjectivity. These ten experts were ten psychologists (five PhD scholars and five MPhil degree holders) who had insight into the research problem.

Procedure. For this purpose consensus among judges for categorization of items was taken regarding how essential a particular item is by rating it according to three categories such as: essential, useful but not essential and not necessary. The 79 item in Parent Rating Scale (PRS, Form-P) and 72 items in Teacher Rating Scale (TRS, Form-T) in the item pool were presented to the pannel of experts to measure the content validity of the items into four sub-scales namely: Cognitive Dysfunction Scale (CDS), Social Dysfunction Scale (CDS), Emotional Dysfunction Scale (EDS) and Learning Behavior Dysfunction Scale (LBDS) for children and adolescents.

Experts were provided with written instructions (See Appendix-B5) and were asked to categorize the items in the specified four dimensions, for both forms. For each item in the Form-P as well as Form-T the number of panelist stating that an item is essential, was noted. Only that item was selected for which more than half the panelist (i.e., at least 6 expects) stated that the item was essential for a particular category or sub-scale of the Form-P and Form-T of the scale FIAS.

Result. The outcome of expert's opinion revealed that some of the items needed to be discarded. They suggested that some of statements were required to be rephrased. According to the expert's evaluation of the item pool, the total number of the statements was reduced to 65 in each form. As a result in the item pool of 79 items,for the PRS (Form-P) the total 65 items were retained by discarding 14items (13, 14, 15,27,38, 40, 41, 44,46, 58,59,67,73,74) (See Appendix-B6).

A separate demographic Bio-Data Sheet was also prepared and was attached to the PRS (Form-P) (See Appendix-B7).These 65 items of Form-P were arranged in scale format with five response categories from "Never to Always" (SeeAppendix-B8).

Similarly in the item pool of 72 items, for the TRF (Form-T) the total 65 items were retained and 7 items were discarded (See Appendix-B9). These 65items of TRS (Form-T) were arranged in scale format with five response categories from "Never to Always" (See Appendix-B10).

Phase III: Selection of the Final Items for the Scale

The phase III of the present study Part-1 deals with the final selection of the items in the specified categories on the basis of Factor Analysis.

The item pool of 65 items for form-T and of 65 items for form- P of the Functional Impairment Assessment Scale (FIAS) was administered on an independent sample.

Sample. Two types of sample population were included referred as sample 1 and sample 2 independently for each part of the present research.

Sample 1: An independent sample consisting of 350 children and adolescents with age range 6-19 years (with the mean age M = 12.51, SD = 3.18) both, boys (n=*163*) and girls (n= *187*) was referred by the help of teachers.

The schools from which the sample population was gathered were randomly selected from the Islamabad Model College for girls and boys (IMCG, IMCB) as well as from Federal Government Primary and Senior Schools for boys and girls of Rawalpindi and Islamabad cities. The reason for choosing these schools was that a majority of children and adolescents of the city goes in these Fedral Government and Model colleges and schools. So these schools represent student population with the diversity of social and economic background.

Sample was also divided in two groups with respect to the high academic achievers (*n=162)* and to the low academic achievers (*n=188*). All the children and adolescents included in the sample were referred by the class teachers. The demographic information about the sample population regarding the family structure, mother education, marital conflict and socioeconomic status was collected through the Bio-data Sheet attached with Form-P (See Appendix-B7).It has been observed through the school record that student population of the FG and IMCG schools mostly belongs to the families where fathers are mostly Government employees with pay scales ranging from 11 to 21 grades.The families represented heterogeneous levels of income and parents had diverse levels of education ranging from uneducated, and matriculation to professionals.

Samlpe 2: The Informents. Information about the children was gathered by the two informants:

1. The class teacher (who knew the child for minimum of 6 months) *N*=35, both men (*n*=14) and women (*n*=19)

In this study the teachers played a big role in identifying the target population and providing information about the school functioning of the students.

2. Parents or family memberwho was able to provide the full information about the child's behavioral and psychological functioning. (*N*= 286, both mothers (*n*=168), fathers (*n*=83) and gardians (*n*=35).

Instrument. The item pool of 65 statements of PRS (Form-P) along with the Bio-data sheet (See Appendix- B7 & B8) and the item pool of 65 statements of TRS (Form-T) (Appendix-B10) was used as instrument for the purpose of Factor Analysis. The five response categories for each statement were rated according to the 5 points scale with anchors of "N*ever", "Rarely", "Sometimes", "Often", and "Always*" with the highest value of 5 for the response option of Always, 4 for Often, 3 for Sometime, 2 for Rarely and 1 for Never. The minimum possible score for PRF and TRF was 65 and the highest was 325. For scoring purpose reverse scoring was also done in both the forms by assigning the highest value of 5 to Never and the lowest value 1 to the response category of Always. In the Form-T all the statements are negatively worded except for 19 statements which are positively worded. These are: (7, 9, 14, 19, 20, 29, 32, 37, 43, 44, 47, 48, 51, 53, 54, 56, 57, 58, 59). These 19 items were re-coded as item (1=5)(2=4)(3=3)(4=2)(5=1).

In the Form-P all the statements are negatively worded except for 17 statements which are positively worded. These are: item 9, 19, 20, 25, 31, 32, 33, 41, 46, 47, 48, 49, 50, 51, 52, 55, 57. These 17 positively worded items were re-coded as item (1=5)(2=4)(3=3)(4=2)(5=1).

Procedure. Total 10academic institutes were contacted for the data collection. Among these, two were Islamabad Model College for Girls, two were Islamabad Model College for Boys along with their primary sections. Two were FG High School for Girls; two were FG High School for Boys and two were FG primary schools of Rawalpindi and Islamabad cities.Class teachers identified two Groups of children and adolescents (i.e., with low and high academic achievement) with the help of class records of the results of the annual examinations from all the schools. An informed consent was taken by the parents (See Appendix-AI). Children and adolescents who were not willing to participate or those who did not provide consent were not included in the study. There were 7 students whose families refused to participae. Besides there were 13 students whose parents were away and could not signed the informed conncent forms.

Information about the children was gathered by the two informants.The class teacher who knows the child for minimum of six months and parents or family members who are able to provide the full information about the child's behavioral and psychological functioning.

Firstly teachers were introduced with the main objectives of the research in which importance of the role of teachers in this context was also highlighted.After this teachers were instructed to fill the initially constructed item pool of TRS for the recruited two groups (students of high and low academic achievement). Then the other forms PRF (Form- P) along with bio-data sheet were sent home and collected back by the class teachers to be filled by parents (mostly mothers).

For the final selection of the items of FIAS for its two Forms (T & P) the data were subjected to statistical analysis.

Factor and reliability analysis of the scale FIAS (Farm T & Farm P) were conducted on combined data of children and adolescents with low and high academic achievement (N=350). The sample size was adequate to carry out factor analysis as Tabachnick and Fidell (2001) documented that it is good to have at least 300 cases for factor analysis. According to Comery and Lee (1992) number 300 is a good sample size, 100 poor and 1000 is excellent. Before conducting the FA data were checked for the suitability of the analysis. To see the adequacy of data Kaiser-Mayer-Olkin measure (KMO) was calculated. If the value is near zero it is the indicator of inadequate sample size and if it is near one it means sample size is good enough for running FA.

According to Kaiser (1974), values greater than .5 are acceptable, between .5 and .7 are satisfactory, between .7 and .8 are good, between .8 and .9 are great and above .9 as excellent. Among other preliminary test Bartlett's Test of Sphericity is also very important. It measures the relationship among variables and shows whether variables are fairly correlated with each other or not. In this test a null hypothesis stating that variables in the population matrix are uncorrelated. As variables are supposed to be correlated with each other result must prove the null hypothesis in order to show that variables are well correlated with each other. But if the variables are extremely correlated this makes the FA useless. To test whether the variables are extremely correlated to one another or not the determinant of correlation matrix is checked. If its value is greater than .00001 this means that variables are not highly correlated.

The numbers of factors retained in the present research were based on Eigen values which were greater than 1 and an item was kept in the scale if it was

theoretically relevant of the particular scale and if it had factor loading equal to or greater than .30.

Chronbach alpha was calculated to determine the internal consistency of the sub scales. Before computing factor analysis to obtain the sub- scales and validity of the Form-T and Form-P of scale FIAS the suitability of data size as well as the relationship among variables were assessed by using the procedures mentioned above.

The rotated extraction method was used to extract factors of Form-T and Form-P. Loading equal to or greater than .30 criteria was considered as significant. The Eigen values greater than 1 were taken as cut-off scores.

The selection of the rotation used in factor analysis depends upon whether the underlying factors are related or not. If factors are expected to be independent then orthogonal (e.g., varimax rotation) should be used. If there are theoretical grounds for supposing that factors might correlate then direct Oblimin should be selected. According to Guertin and Baily (1970) if all the items are highly correlated with each other and with the total score of the scale the 'The Direct Oblimin Method of Principle Component Factor Analysis is the best method to be applied. Moreover, Field (2005) considers the Direct Oblimin Method the most accurate for naturalistic data involving humans.

For the selection of the rotation used in factor analysis Item total correlation was also computed on the 65 item pool of Form-T and Form-P of FIAS to see whether underlying factors are related with each other and with the total score of the measure or not which showed that all the statements were correlated significantly with each other and with the total score of the measure the result is as follows.

Item total correlation. To determine the internal consistency of scale item-total correlation was computed on the 65 items for both the forms (P & T) before the factor analysis, so that the best suitable rotation could be selected to be used in the factor analysis.

Item Total Correlation was computed on the 65 items of Form-T and Form-P of FIAS before subjected to the factor analysis. All the items appeared significant at 0.01 levels in both the forms.

The magnitude of values resulting from the item total correlation of FIAS (Form-T) ranges from .41 to .78, which indicates the high level of relationship between the items and total scores of FIAS (Form-T). All the values are significant at the 0.01 level (Appendix- C1)

The result of the Item total correlation of PRF (Form-P) shows that all the items are significantly correlated with total score of the Form-P. The correlation coefficient ranges from .34 to .76 for all the 65 items of the FIAS which shows that all items are consistent with the total score of scale (See Appendix-C2).

As indicated from inter item correlations, all the 65 items of Form-T & P of FIAS were found to be positively correlated, it provided the strong basis for using the Direct Oblimin Method.

Factor analysis. For the factor analysis the Direct Oblimin rotation method was used for the selection of the final items and the identification of the number of factors for both the forms of FIAS.

Result

Teacher Rating Form (Form- T). The following Table 2 shows the KMO value which is above .9 which is quite greater than .60 i.e., the minimum value required to run the factor analysis.

Table 2

Kaiser-Meyer-OlkinMeasure and Bartlett's Test of Sphericity of Form-T of FIAS *(N=350)*

Kaiser-Meyer-Olkin Measure of Sample Adequacy	Bartlett's Test of Sphericity	*df*	*p*
	Approx. *Chi- Sq*		
.903	11858.036	2080	.000

This indicates the suitability of the data for the Principal Component Analysis.Bartlet test of Sphericity shows the variance-covariance matrix is proportional to an identity matrix and it is significant which indicates that the factors are not too much correlated.

Scree Plot

Scree plot supported four factors solution and accounted for 43% of the variance.Scree Plot graphically displays the Eigen values for each factors of Form-T which is presented in Figure 1.

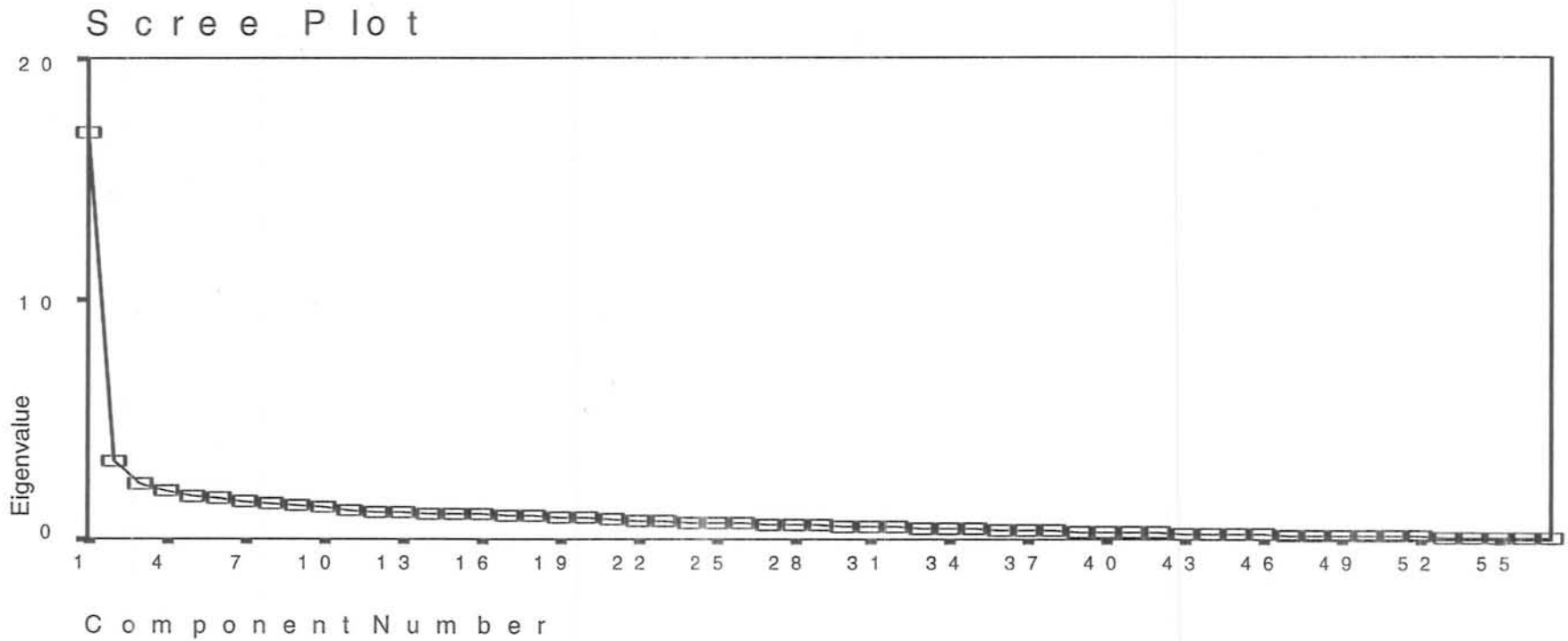

Figure 2: Scree Plot for Factor Matrix of 65 items of FIAS (*N=550*)

Scree plot shows the Eigen values which indicates the relative importance. The cut off point for the factors is at the point of inflexion of the curve. The point of inflexion on this scree plot shows fourfactors.

The Scree Plot in Figure 1 suggests that Factor 1 is a predominant factor and the other three are also displaying Eigen value greater than one (See Table 3 for detail)

Table 3

Eigen Values and Percentage Variance Explained By Four Extracted Factors for the Form-T of Functional Impairment Assessment Scale (FIAS)(N=350)

Factors	Eigen Values	% of Variance	Cumulative %
I	16.482	25.357	25.357
II	5.169	7.952	33.309
III	2.892	4.449	37.758
IV	2.504	3.852	41.611

The Table 3 illustrates the Eigen values and percentages of variance explained by four factors. Factor 1 has the highest Eigen value of 16.482 and explained 25.357% of the total of the variance. Factor II has Eigen value of 5.169 482 and explained 7.952% of the total of the variance. Factor III has Eigen value of 2.892 and explained 4.449 % of the total of the variance, and Factor IV has Eigen value of 2.504 and explained 3.852 % of the total of the variance. All other factors have an Eigen value less than 1.

Factor matrix (i.e., Structure matrix) of the 65 items for the Form-T of FIAS through Principle Component analysis by using Direct Oblimin Method is presented in Table 4.

Table 4

Factor matrix (i.e., Structure matrix) of the 62 items selected for the Form-T of FIAS through Principle Component analysis by using Direct Oblimin Method (N=350) (Item loadings ≥ .30)

	FI		F2		F3		F4	
S.No.	Item No	Factor Loading	Item No	Factor Loading	Item No	Factor Loading	Item No	Factor Loading
1	F2	.78	F3	,72	F34	.37	F54	.64
2	F53	.77	F6	.70	F31	.30	F32	.62
3	F61	.74	F15	.66	F38	.31	F19	.54
4	F51	.73	F17	.65	F42*	.31	F56	.53
5	F58	.71	F22	.61	F46	.30	F55	.46
6	F15	.71	F24	.60	F49*	.73	F18	.41
7	F23	.71	F39	.60	F45	.70	F44**	.58
8	F20*	.74	F41	.59	F50	.62	F47**	.47
9	F29	.67	F11	.58	F26	.60	F42*	.30
10	F7	.65	F40	.56	F33	.43	F49*	.37
11	F48	.62	F5	.54	F35	.41	F52*	.33
12	F37	.61	F4	.53	F28	.53	F20*	.43
13	F21	.61	F12*	.51	F27	.55		
14	F12*	.60	F8	.53				
15	F57	.60	F25	.53				

Continued...

	F1		F2		F3		F4	
S.No.	Item No	Factor Loading	Item No	Factor Loading	Item No	Factor Loading	Item No	Factor Loading
16	F60	.59	F16	.52				
17	F59	.57	F13	.50				
18	F62	.55	F52*	.49				
19	F43	.54						
20	F9	.52						
21	F10	.51						
22	F1	.51						
23	F36	.38						

Note: F stnds for factor. For the selection of items in a factor the loading criterion is .30 and above.

The Table 4 shows loadings of the selected items of Form-T of FIAS in four factors. According to their dimensions these factors F1, F2, F3, and F4were named as Learning Behavior Dysfunction (LBD), Cognitive Dysfunction (CD), Emotional Dysfunction (ED) and Social Dysfunction (SD) respectively.The loadings were obtained through Principle Component Analysis to determine the factor structure of the scale. The criterion for the selection of items was loading of .30 and above.

There are a few items represented with (*) in the Table 4 which occurred twice. e.g., F42* which states "***Is unable to work in group***" theoretically belongs to both emotional dysfunction as well as cognitive dysfunction domains. As this item

has factor loading more than, 30 in both of these factors so it has been decided to place this item in both of these domains. The item F20* which states*" Performs job responsibilities of academic group activates effectively"*also belongs theoretically to LBD and SD domains and also possesses satisfactory factor loading on both areas therefore it has been decided to place in both the domains. Another item is F49* which states ***"Sits alone".*** This statement is equally true for ED as well as SD domains. And as the factor loading of this item in both the domains is satisfactory therefore it has been decided to place this item in both of these categories. Similarly the item F52* which states ***"Becomes victim of bullies"*** also belong to CD and SD domains theoretically and has satisfactory factor loading in both the factors therefore it has been placed in both the subscales of Form-T. Item 12* which states that **"Does not take advantage of teachers instructions"** also bears the same situation and has been placed in both sub-scales i.e., LBD and CD (See the Table -4)

While selecting the final items in the four factors peculiar attention has been also given to the theoretical orientation of the items besides its value of factor loading. There are two items which have been selected preferably on the basis of their theoretical stems. These items have been represented with double satiric (**). For example though item f44** which states ***"Prefers to play with friends or class mates"*** has higher value of factor loading on factor III (ED) but has been placed in factor IV named as Social Dysfunction (SD) as it belongs more to this domain theoretically.Similarly item F47** which states *" **Makes friendship easily"*** has higher value of factor loading on factor III (ED) i.e.,.64 but it has been placed in factor IV (SD) where though its value is comparatively low (i.e., .42) but it has a strong theoretical ground for this domain.

A few items which had the values of factor loading less than .30 i.e., F14, F29, and F60 have been excluded from the Form-T of FIAS. Hence total 62 out of 65 items were retained in the Form-T of the scale FIAS.

Parent Rating Form (Form- P). The rotated extraction method was also used to extract factors of Form-P. Loading equal to or greater than .30 was considered as significant. The Eigen values greater than 1 were taken as cut-off scores. Scree plot supported four factors solution and accounted for 41% of the variance.

Table 5

Kaiser-Meyer-Olkin Measure and Bartlett's Test of Sphericity of Form-P of FIAS (N=350)

Kaiser-Meyer-Olkin Measure of Sample Adequacy	Bartlett's Test of Sphericity	*df*	*p*
	Approx. *Chi- Sq*		
.902	16178.311	2080	.000

Table 5 shows the KMO value which is above .9 that indicates the suitability of the data for the Principal Component Analysis. Bartlet test of Sphericity shows the variance-covariance matrix is proportional to an identity matrix and it is significant which indicates that the factors are independent.

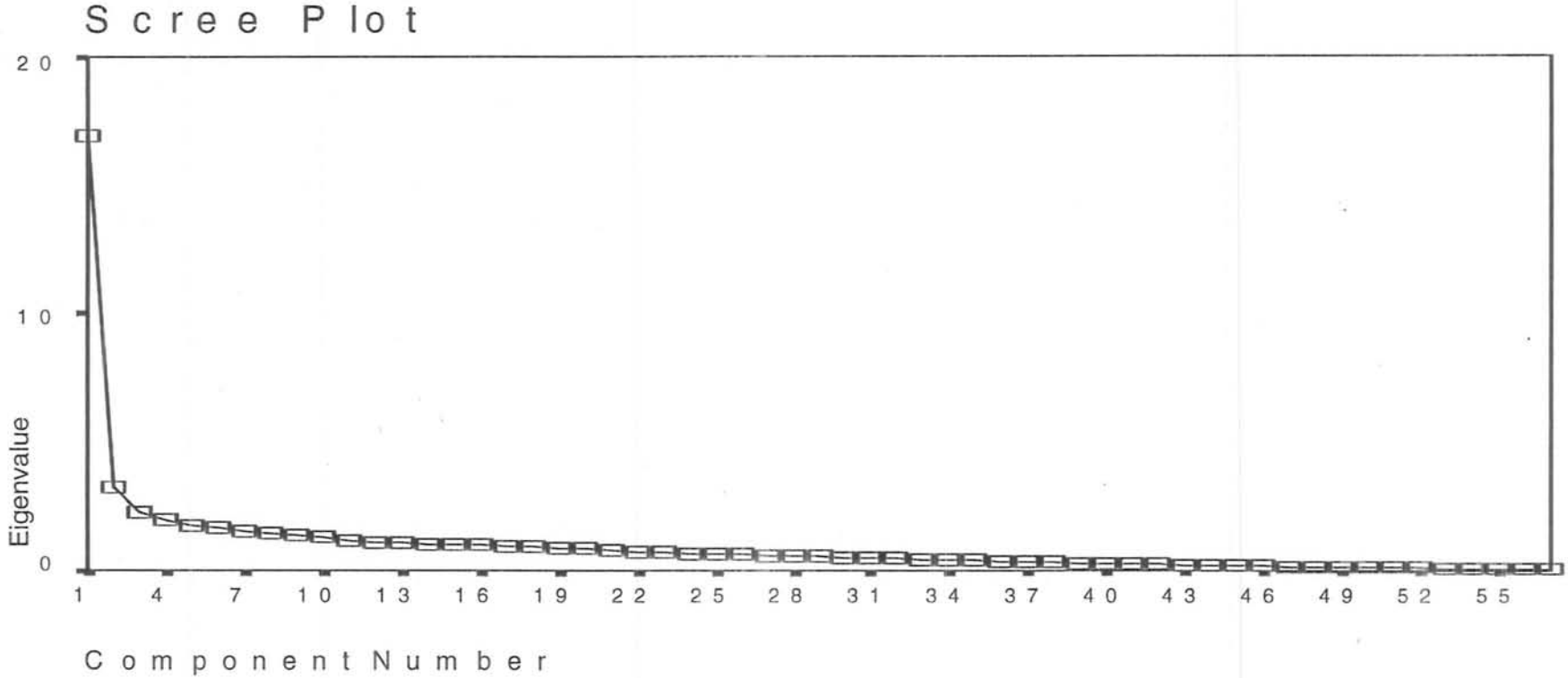

Figure 3. Scree Plot for extraction of factors of Form-P.

Scree plot shows the Eigen values which indicates the relative importance

The cut- off point for the factors is at the point of inflexion of the curve. The point of inflexion on this Scree plot shows four factors.

Table 6

Eigen Values and Percentage Variance Explained By Four Extracted Factors for the Form-P of Functional Impairment Assessment Scale (FIAS) (N=350)

Factors	Eigen Values	% of Variance	Cumulative %
I	16.482	25.357	25.357
II	5.169	7.952	33.309
III	2.892	4.449	37.758
IV	2.504	3.852	41.611

The Table 6 illustrates the Eigen values and percentages of variance explained by four factors. Factor 1 has the highest Eigen value of 16.482 and explained 25.357% of the total of the variance. Factor II has Eigen value of 5.169 482 and explained 7.952% of the total of the variance. Factor III has Eigen value of 2.892 and explained 4.449 % of the total of the variance, and Factor IV has Eigen value of 2.504 and explained 3.852 % of the total of the variance. All other factors have an Eigen value less than 1.

Table 7

Factor matrix (i.e., Structure matrix) of the 62 items selected for the TRS (Form-T) of FIAS through Principle Component analysis by using Direct Oblimin Method (N=350)(Item loadings ≥ .30)

	FI		F2		F3		F4	
S.No.	Item No	FL	Item No	FL	Item No	FL	Item No	FL
1	V54	.69	V22	.68	V58	.59	V52	.70
2	V45	.68	V26	.67	V34	.52	V46	.68
3	V60	.62	V14	.67	V24	.49	V41*	.67
4	V49	.56	V23	.62	V30	.48	V51	.62
5	V48*	.55	V27	.62	V59	.46	V31	.48
6	V36	.42	V1	.61	V29	.42	V25	.41
7	V53	.41	V6	.61	V44	.40	V2	.34
8	V57*	.34	V11	.60	V21	.39	V8	.32
9	V43	.33	V5	.60	V42	.37	V47*	.53
10	V32	.36	V10	.55	V17	.36	V9	.47
11	V35	.31	V39	.56	V2*	.34	V37	.47
12	V38	.36	V16	.54			V55	.44
13	V41*	.53	V15**	.43			V48	.32
14			V12	.53			V50*	.42

Continued...

	F1		F2		F3		F4	
S.No.	Item No	FL	Item No	FL	Item No	FL	Item No	FL
15			V20	.51			V57	.35
16			V28	.50				
17			V33	.48				
18			V13	.44				
19			V18	.43				
20			V4	.42				
21			V7	.41				
22			V2	.36				
23			V3	.44				

Note. The criterion for the selection of items was loading of .30 and above. F stands for 'Factor' and FL for 'Factor Loading'

The Table 7 shows loadings of the selected items of Form-P of FIAS in four factors. These four factors: F1, F2, F3, and F4 were named as Social Dysfunction (SD), Cognitive Dysfunction (CD), Emotional Dysfunction (ED) and Learning Behavior Dysfunction (LBD) respectively. The loadings were obtained through Principle Component Analysis to determine the factor structure of the scale. The criterion for the selection of items was loading of .30 and above.

There are a few items represented with (*) which occurred twice. e.g., **V2*** which states **"shows lack of attention while sitting among family members"**

theoretically this symptom belongs to both emotional dysfunction as well as cognitive dysfunction domains. As this item has factor loading more than, 30 in both of these factors so it has been decided to place this item in both of these domains. Another item is **V47*** which states **"Finishes the school home work in time"**. This statement is true for good cognitive functioning as well as learning behavior dysfunction. And as the factor loading of this item in both the domains is satisfactory therefore it has been decided to place this item in both of these categories with satisfactory value of factor loading (see the Table -6) Same is the case is for the **V48*** which theoretically belongs to SD and LBD and has satisfactory. Another item **V57***which states "**talks freely to everyone at home**' also belongs to SD as well as GLB domains theoreticallywhich are also known as the sub scales of the FIAS.

While selecting the final items in the four factors peculiar attention has been given to the theoretical orientation of the items other than its value of factor loading. There are a few items which have been selected preferably on the basis of their theoretical stems. These items have been represented with double satiric (**). For example item **V15**** which has higher value of factor loading on factor I has been placed in factor II named as Cognitive Dysfunction as it belongs more to this domain theoretically. Similarly item **V50**** has higher value of factor loading on factor 1 (SD) i.e., 64 but it has been placed in factor IV (LBD) where though its value is comparatively low (i.e., .42) but it has a strong theoretical ground for this domain.

A few items which had the values of factor loadingless than .30 i.e.,v18.v30, v33, v44, v53 have been excluded from the Form P of FIAS.Therefore, out of 65 items selected by judges these 60 items were retained and rest of 5 items were excluded from the scale which had the values of factor loading less than .30.

The Factor Analysis yielded 62 items in Form-T (See Appendix-C3) and 60 items in Form-P(Appendix- 4) which were found significantly correlated at $p< .05$

Sub- Scales of Teacher Rating Scale (TRS) (Form-T). In the final 62- item Form-T of FIAS, the distribution of items in its sub-scales were: Factor 1 the Learning Behavior Dysfunction Scale (LBDS) 23items(1, 2, 7, 9, 10, 12, 14, 20, 21, 23, 29, 36, 37, 43, 48, 51, 53, 57, 58, 59, 60, 61,\62), Factor II the Cognitive Dysfunction Scale (CDS) 18 items (3, 4, 5, 6, 8, 11,12, 13, 15, 16, 17, 22, 24, 25,39, 40, 41, 52); Factor III the Emotional Dysfunction Scale (EDS) 13 item (26,27,28, 31, 33, 34, 35, 38, 42, 45, 46, 49, 50) and Factor IV the Social Dysfunction Scale (SDS) 12 items(18,19, 20, 32,42, 44, 47, 49, , 52, 54, 55, 56,); (See Appendix-C5 for the list of sub-scales of TRS).

Sub- Scales of Parent Rating Form (Form-P). In the final Form-P of FIAS, the distribution of items in its sub-scales were: Social Dysfunction Scale (SDS) 13 items(32, 35, 36, 38,41, 43, 45, 48, 49,53, 54, 57, 60).;Cognitive Dysfunction Scale (CDS) 23 item (1, 2, 3, 4, 5, 6, 7, 10, 11, 12,13, 14, 15, 16, 18, 20, 22, 23, 26,27, 28,33,39,); Emotional Dysfunction Scale (EDS) 11 item (2, 17, 21,24, 29, 30, 34, 42, 44, 58, 59); Learning Behavior Dysfunction Scale (LBDS) 15 items (2, 8, 9, 25, 31,37, 41, 46, 47, 48, 50, 51, 52, 55,57) (See Appendix –C6 forthe fourSub-Scales of the Final 60-item PRS).

For the identification of the place value of items related to sub-scales scoring key has been prepared separately for the two forms. The scoring key also includes the

list of items to which reverse scoring has been assigned (See Appendix-7) for the scoring key of PRS & Appendix-8 for TRS).

The outcome of the factor analysis of Form-T and Form-P provided the empirical proof of the fact that the items were skilled fully distributed by the judges in the two forms of FIAS under the specified categories, as except a few items all the items emerged in their right or specified domains. Basically both the forms bear the same conceptual framework , therefore the sub-scale in PRS and TRS were given the same names as they measure the same construct and behavior of children and adolescents but in two different setting (i.e., home and school) by two respondents accordingly (i.e., parents and teachers). Both the Forms (T & P) consist of statements that measure the same construct but in two different settings (home & school). For example the item 11 of sub-scale Cognitive dysfunction Scale (CDS) of Form-P which states that "*Does not pay attention on parent's advice*" measures low attention of the child in home setting, but in Form-T the item 12 of CDS measures the low attention in school setting with the wording such as "*Does not take advantage of teacher's advice*". Similarly the item 23 of sub-scale Emotional dysfunction Scale (EDS) of Form-P which states that "Remains in continuous motion e.g., playing with fingers, shaking legs or taking a round again and again while doing studies" measures anxiety of the child in home setting, but in Form-T the item 24 of EDS measures the anxiety symptom in school setting with the wording such as "Cannot sit still in his/her seat while doing class work". See another example of an item 37 of Form-T of Learning Behavior Dysfunction Scale (LBDS) stating that ***"In order to assist the class teacher is usually elected monitor of the class"***is equivalent to the item 33 of

Form-P of Learning Behavior Dysfunction Scale (LBDS) stating **"Assists parents in the performance of important tasks at home".**

A detailed description of the four factors or the sub scales is presented in the next section.

Learning Behavior Dysfunction Scale (LBDS). Learning behavior dysfunction Scale measures child's deficits / impairment in allacademic disciplines, in class as well as in extracurricular activities and sports including, lack of confidence, communication skills, punctuality, assertiveness, arts, culture, and social relationships with their families. The LBDS measures the learning behavior dysfunction based on the DSM –IV criteria of Global learning behavioral deficits and Developmental Sequence of Educational Goals proposed by Neuropsychiatry Institute (NPI).On the basis of the definition, of Global learning behavior (DSM-IV, APA, 1994) children, who function well in their families and communities, are considered to be good learner in their schools as well.

After analyzing common themes manifested by the selected items in both the forms the factor one in the TRS and factor four in the PRS were named as Learning Behavior Dysfunction Scale (LBDS) for the present Functional Impairment Assessment Scale (FIAS). The 23 statements with high loadings clustered on factor one of TRS (Form-T) and 15 statements in the factor four of PRS (Form-P) were selected for the final inclusion and were arranged for the serial numbers of statements. The statement gathered on the Learning Behavior Dysfunction Scale (LBDS) 12 were positively and 3 were negatively and in the TRS 13 were positively worded and 10 were negatively worded (See, Appendix C4 & C6 for TRS & PRS respectively).The

negatively worded statements revealed lack of learning behavior competencies whereas positively worded statements reveal that child possesses a good deal of analytical and communicative and skills necessary for the adjustment in the school and for learning new tasks.

Emotional Dysfunction Scale (EDS). Emotional Dysfunction Scale (EDS) measures the symptoms of mixed anxiety and depression or negative affect characterized by a state of generalized feelings of fear and apprehension e.g., nervousness, irritability, anger, fear, discomfort, resentment crying along with pessimism, despair, helplessness, hopelessness, low self esteem, guilt, negative expectancy, and dread of impending disaster, (Rawlins & Heacock, 1993; Bootzin, Acocella, & Alloy).11 statements were clustered on the factor three of the PRS (Form-P) and 11 on the factor two of TRS conceptually representing emotional dysfunction which was named asEmotional Dysfunction Scale (EDS). There is no such statement which could bear the reverse scoring.

Social Dysfunction Scale (SDS). Social dysfunction Scale (SDS) measures child's inability to build and maintain social relationships such as initiating social conversations or making friends and to perform group activity (Kaslow et al., 1994). The total of 13 statements of this scale clustered on the factor four of TRS and 12 on the factor one of PRS. In the PRS there are 5 positively and 8 negatively worded statements and in the TRS there are 7 positively and 5 negatively worded statements. The positively worded statements indicating social competences bear reverse scoring.All the negative statements measure the deficits in social skills such as

impaired group functioning and mal- interpersonal relationships of children and adolescents with peers and other people present in their social environment. Therefore high score is an indicative of the lack of social or interpersonal skills.

Cognitive Dysfunction. Cognitive dysfunction Scale (CDS) measures poor mental function, associated with confusion, forgetfulness and difficulty. It also measures deficiency in ability to think perceive reason or remember loss of ability to attend to one's daily living needs, distortion in thinking, feelings of worthlessness, negative beliefs and self-critical negative thoughts.There are 23 statements in the sub scale CDS of Form- P (with only one statement that receives reverse scoring) and 19 statements in the Form-T clustered on also factor two of both Forms (T & P).

Scoring of FIAS. As FIAS consists of two forms both constructed on the format of five point Likert type scale with the anchors of *not at all, rarely, sometimes, often, always* with the scores 1, 2, 3, 4, 5 respectively. Both the forms were scored separately. The detailed description is as follows.

The Scoring of PRS (Form-P). The score range for the total scale PRF is between 60 to 300, and for its sub-scales Social Dysfunction Scale (SDS) (13 items) is from 13 to 65.; Cognitive Dysfunction Scale (CDS) (23 item) is from 23 to 115; Emotional Dysfunction Scale (EDS) (11 item) is from 11 to 55; Learning Behavior Dysfunction Scale (LBDS) (15 items) from 15 to 75.

In the Form-P all the statements are negatively worded except for 18 statements which are positively worded (9, 19, 20, 25, 31, 32, 33, 41, 46, 47, 48, 49,

50, 51, 52, 55, 56, 57). These 18 items were re-coded as (1=5)(2=4)(3=3)(4=2)(5=1) (See Appendix C7 for scoring Key of PRF).

The Scoring of TRF (Form-T). The score range for the total scale TRS is between 62 to 310 and for sub-scales it is: Learning Behavior Dysfunction Scale (LBDS) (23 to 115); Social Dysfunction Scale (SDS) (12 to 60); Cognitive Dysfunction Scale (CDS) (18 to 90) and Emotional Dysfunction Scale (EDS) (13 to 65). In the Form-T all the statements are negatively worded except for 19 statements which are positively worded (7, 9, 14, 19, 20, 29, 32, 37, 43, 44, 47, 48, 51, 53, 54, 56, 57, 58, 59).These 19 items were re-coded as (1=5)(2=4)(3=3)(4=2)(5=1)(See Appendix-C8).

The total score of FIAS is achieved by summing up of scores of two Forms T & P ranging from 122 to 6I0.

Interpretation of Scores of FIAS. Low score indicates that child has very mild signs of functional impairment which can be overcome if the class teacher and parent pay special attention to the child's needs. The scores falling in moderate range indicate significant functional impairment and the child needs further assessment for mental health disorders. The high score indicates the high level of functional impairment i.e.,that the child has severe level of dysfunction in cognitive, social and emotional domains and he / she has low learning behavior competences and child needs special services including proper treatment and intervention planes or a complete system of care.

Phase IV: Determination of Reliability of FIAS

For the determination of reliability of FIAS, Cronbach Alpha Coefficients, inter-scale correlation, and split-half reliability coefficients have been calculated for Form-T and Form-P and their sub-scales of FIAS.

Teacher Rating Form (TRF) (Form-T). *Cronbach's Alpha Coefficients of TRF.* Initial psychometric analysis, using Cronbach's Alpha Coefficient yielded an internal consistency coefficient of .91 for the entire TRS. For other sub-scales of TRF it ranged from .79 to .86. All these seem to be satisfactory reliabilities (See Table 8).

Table 8

The alpha reliability coefficients of total and sub-scales of Teacher Rating Scale (Form-T) (N = 350)

Sub-scales	No. of Items	Alpha Coefficients
LBDS	23	.81
SDS	12	.74
CDS	19	.86
ESD	11	.79
Total TRF (Form-T)	62	.91

Note. LBDS = Learning Behavior Dysfunction Scale, CDS = Cognitive Dysfunction Scale, SDS = Social Dysfunction Scale, EDS = Emotional Dysfunction Scale.

Interscale Correlation Coefficient of TRF. The Inter-scale correlations of all the subscales with each other and with total TRF have also been calculated (See Table 9).

Table 9

The Inter-Scale Correlation coefficients of total and sub-scales of Teacher Rating Form (Form-T) (N = 350)

	Sub-scales	I	II	III	IV	V
I	LBDS		.74***	.85***	58***	.57***
II	CDS			.84***	.82***	.94***
III	SDS				.76***	.90***
1V	EDS					.86***
V	TRF(Total)					-

*$p < .05$, **$p < .01$, ***$p < .000$

*Note.*LBDS = Learning Behavior Dysfunction Scale, CDS = Cognitive Dysfunction Scale, SDS = Social Dysfunction Scale, EDS = Emotional Dysfunction Scale.

The significantly positive correlation of the subscales of Learning Behavior Dysfunction, Cognitive Dysfunction, Emotional Dysfunction and Social Dysfunction with each other and with the total TRF (Form-T) shows the internal consistency of all these scales.

Split-half Reliability of TRF. For calculating the split-half reliability coefficient, TRF was divided into two parts. The alpha reliability coefficient of Part I and Part II was found to be .91 and .90 respectively, and Guttman split-half reliability coefficient was found to be .88 which is also quite satisfactory.

Note: *The reliability of TRF has also been reported in the main study.*

Parent Rating Form (PRF) (Form-P).

Cronbach's Alpha Coefficient of PRF. Cronbach's Alpha Coefficient yielded an internal consistency coefficient of .93 for the entire 60-item PRF. For other sub-scales of PRF it ranged from .76 to .87 (Table 10). All these seem to be satisfactory reliabilities.

Table 10

The alpha reliability coefficients of total and sub-scales of Parent Rating Scale (Form-P) (N = 350)

Sub-scales	No. of Items	Alpha Coefficients
LBDS	15	.83
SDS	12	.85
CDS	23	.78
EDS	11	.87
Total PRS (Form-P)	60	.93

Interscale Correlation Coefficient of PRF. The Inter scale correlation of all the subscales with each other and with total PRF have also been calculated (see Table 11).

Table 11

The Inter-Scale Correlation Coefficients of total and sub-scales of Parent Rating Form (Form-P) (N = 350)

Sub-scales	I	II	III	IV	V
I		.65***	.68***	.62***	.88***
II			.64***	.72***	.84***
III				.61***	.73***
IV					,76***
V PRS (Total)					

*$p < .05$, **$p < .01$, ***$p < .000$*

The significantly positive correlation of the subscales of, Cognitive Dysfunction, and Social Dysfunction, Emotional Dysfunction with each other and with the total PRS (Form-P) shows the internal consistency of all these scales.

Split-half Reliability of PRS. For calculating the split-half reliability coefficient, PRF was divided into two parts. The alpha reliability coefficient of Part I and Part II was found to be .91 and .90 respectively, and Guttman split-half reliability coefficient was found to be .88 which is also quite satisfactory.

Note. The reliability of PRF has also been obtained in the Part III of the present research which has been reported in the main study.

Discussion. The Part-1 of the present research has been conducted to develop an indigenous scale, Functional Impairment Assessment Scale (FIAS) to be used in the main study (Part-III). Literature review reveals that, in order to achieve a high degree of identification rate of functional impairment and emotional problems in children and adolescents, the culturally sensitive and linguistically appropriate assessment instruments must be used. Unfortunately there was no such scale available in the country particularly in Urdu language which could fulfill the needs of the present research. So in order to avoid the risk of cultural bias for the assessment of functional impairment and the level of the global learning behavior in Pakistani children and adolescents with low academic achievement an indigenous scalethe Functional Impairment Assessment Scale (FIAS) has been developed in this part of the research.

The rationale behind the construction of the scale is to achieve two goals: Firstly, to identify the functional impairments which may be the barriers to learning and the signs of some emotional disturbance and which may be used as the selection criteria for the inclusion of children in special need services. Secondly, to assess the progress in the modified behavior of emotionally disturbed children after the application of effective intervention and treatment plans.

The FIAS measures functional impairment in individuals beween 6-19 years age in different domains of their psychological functioning through its four sub scales which can be also used separately as domain-specific measures namely. Learning Behavior Dysfunction Scale (LBDS), Cognitive Dysfunction Scale (CDS), Emotional Dysfunction Scale (EDS), Social Dysfunction Scale. The FIAS measures several aspects of a child's functioning from two perspectives: parents, through Parent Rating

Scale (PRS), and teachers or other professional through Teacher Rating Scale (TRS) along with a Bio-Data Sheet.The FIAS consists of two forms: Form-T the Teacher Rating Scale (TRS) and Form-P the Parent Rating Scale (PRS).

The 62-item TRS has been constructed on the basis of the fact that teachers are the main source of children's referral to diagnostic, treatment and special needs services (Kamphaus, Thorpe, Winsor, Kroncke, Dowdy, & van Deventer, 2007).

TRS contains the items related to the functional impairments in terms of emotional, social and cognitive and learning behavior dysfunction of the children and adolescents in the school settings.In general TRS collects the global information regarding the class room behavior as well as learning behavior of the child which can be helpful in the early identification of any psychopathology which may be present in the child.

The 60-item Parent Rating Scale PRS (Form-P) was developed to get parental perceptions of basic problems for their children related to home and school functioning. PRS contained items covering cognitive, emotional and social dysfunction, as well as their learning behavior in home setting .e.g., items related to sleep, eating, temper, keeping friends, and concentration or attention problems in home and school. The PRS has also put an emphasis on emotional state of children such as irritability, hoplessness, sad or depressed mood and physical complaints. The information regarding the demographic variables (age, socio economic status, parental education, etc.) can be obtained through a Bio Data Sheet attached with the form-P.

The psychometric properties of the PRS and TRS forms as assessed by test-retest and inter-rater reliability have been found to be satisfactory. As both the forms are parallel measuring the same construct these provide the information through similar four domains but in two different environments (home and school). These

domains or four sub-scales are: (1) The Learning Behavior Dysfunction Scale (LBDS) that measures deficiets in learning ability to learn and progress and function satisfactorily in school (2) The Social Dysfunction Scale (SDS) that assesses the impairment in social skills necessary to make and maintain interpersonal relationships (3) The Emotional Dysfunction Scale (EDS) assesses emotional state in terms of depression and anxiety (4) The Cognitive Dysfunction Scale (CDS) that measures impairment in youth's ability to use rational thought processes. The scores of each domain are interpreted in terms of, mild, moderate and severe impairment.

The FIAS has been developed on strong theoretical stems extracted from DSM-IV criteria of emotional disturbance and Developmental strategy formulated by the staff of Neuropsychiatry Institute (NPI) which is the institute that provides sources for research and training is the field of mental illness. According to the developmental there are certain learning behaviors which are essential for all children to possess if they are to successfully learn in school.

The scale was developed in four steps. During the first step the item pool for the present measure was generated by using two sources: literature review and Focus Group Discussion. To determine the content validity of the item pool judgmental apreach was adapted that has been used as one of the primary methods to ascertain the content validity (see Hambleton, 1984; Lawshe, 1975; Martuza, 1974).

The second step involved the application of factor analysis. The selection of factor analysis method was made on the basis of the results of Item total correlation. As the result showed that all the statements were correlated significantly with each other at ($p<.05$ to $p<.01$) the Direct Oblimin Method of Principle Component was used to extract factors of Form-T & P. Loading equal to or greater than .30 criteria was considered as significant. The Eigen values greater than 1 were taken as cut-off

scores. Scree plot supported four factors solution and accounted for 43% of the variance.

According to their dimensions these factors F1, F2, F3, and F4 were named as Learning Behavior Dysfunction (LBD), Cognitive Dysfunction (CD), Emotional Dysfunction (ED) and Social Dysfunction (SD) respectively. The loadings were obtained through Principle Component Analysis to determine the factor structure of the scale. The criterion for the selection of items was loading of .30 and above.Three items which had the values of factor loading less than .30 i.e.,F14, F29, and F60 have been excluded from the Form-T of FIAS. Hence total 62 out of 65 items were retained in the Form-T of under developing scale FIAS. While selecting the final items in the four factors peculiar attention has been also given to the theoretical orientation of the items besides its value of factor loading. There are a few items which have been selected preferably on the basis of their theoretical stems. For example in Form-T though item F44** which states "*Prefers to play with friends or class mates*" has higher value of factor loading on factor III which has been labeled as Emotional Dysfunction (ED) but it was placed in factor IV named as Social Dysfunction (SD) as it belongs more to this domain theoretically. Similarly item F47**which states " *Makes friendship easily*" has higher value of factor loading on factor III (ED) i.e.,.64 but it has been placed in factor IV (SD) where though its value is comparatively low (i.e., .42) but it has a strong theoretical ground for this domain.

A similar procedure was adapted for Form-P and out of 65 items selected by experts 60 items were retained and rest of 5 items were excluded from the scale which had the values of factor loading less than .30. The items excluded were: 30, 33, 18.53, 44.

In the final Form-T of FIAS ($N = 62$), the distribution of items in its sub-scales was: Social Dysfunction Scale (SDS) 12 items; Cognitive Dysfunction Scale (CDS) 18 items; Emotional Dysfunction Scale (EDS) 13 item; Learning Behavior Dysfunction Scale (LBDS) 23 items. In the Form-T all the statements are negatively worded except for 19 statements which are positively worded. These are: (7, 9, 14, 19, 20, 29, 32, 37, 43, 44, 47, 48, 51, 53, 54, 56, 57, 58, 59). These 19 items were re-coded as item (1 = 5) (2 = 4) (3 = 3) (4 = 2) (5 = 1).

In the final Form-P ofFIAS, the distribution of items in its sub-scales was: Social Dysfunction Scale (SDS) 13 items; Cognitive Dysfunction Scale (CDS) 23 item; Emotional Dysfunction Scale (EDS) 11 item; Learning Behavior Dysfunction Scale (LBDS) 15 items. In the Form-P all the statements are negatively worded except for 17 statements which are positively worded. These items are: 9, 19, 20, 25, 31, 32, 33, 41, 46, 47, 48, 49, 50, 51, 52, 55, 57. These 17 positively worded items were re-coded as item (1 = 5) (2 = 4) (3 = 3) (4 = 2) (5 = 1).

The outcome of the factor analysis of Form-T and Form-P provided the empirical proof of the fact that the items were skilled fully distributed by the judges in the two forms of FIAS under the specified categories, as except a few items all the items emerged in their right or specified domains.

For the determination of reliability, Cronbach alpha coefficients, Inter-scale correlation, and split-half reliability coefficients have been calculated. Cronbach's alpha coefficient yielded an internal consistency coefficient of .91 for the total TRF (Form-T) and for its sub-scales it ranged from .74 to .84, which are quite satisfactory and .88 for PRF (Form-P) and for its sub-scales it ranged from .68 to .80 of FIAS. The Inter-scale correlation of all the subscales with each other and with total Form-T and Form-P of FIAS yielded a significantly positive correlation of the sub-scales of

Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction and Social Dysfunction with each other and with the total Form-T and Form-P of FIAS showing internal consistency of all these scales. This result is in accord with the findings that the overall intellectual potential of depressed and anxious youngsters is comparable to those who are not depressed suggesting that association between severity of depression and children's overall intelligence is weak (Kovacs, Feinberg, Crouse-Novak et al., 1984).

The split-half reliability coefficients have been found to be satisfactory which are .89 and .86 for Part I and Part II of TRF (Form-T) respectively and Guttman split-half reliability coefficient was found to be .91 and for the other form PRF the split-half reliability coefficients have been also found to be satisfactory which are .90 and .88 for Part I and Part II respectively and Guttman split-half reliability coefficient was found to be .93. All these reliability coefficients are also quite satisfactory.

When considering the validity of an instrument, three interrelated types of validity are often considered; content, criterion related, and construct. For the FIAS the content and construct validities were established.

During the construction of the FIAS the content validity was built into it through systematic and controlled item selection. When applied to the FIAS, the content validity issue is whether the items of the representative scales are representative of the symptoms of depression, anxiety, social dysfunction, cognitive dysfunction and whether the items measure the impairment in global learning behavior of the children and adolescents which is necessary for the academic achievement. This issue was addressed in both ways: logically and empirically.

The logical grounds of the content validity stem at the theoretical underpinning of the FIAS. Besides extensive browsing of literature review focus

group discussions were also conducted for this purpose. These professional sources helped to attest the validity of the content of the scale.

Further the expert's opinions were also sought during its development regarding how essential a particular item is by rating it according to three categories such as: *essential, useful but not essential and not necessary*. For this purpose consensus among judges for categorization of items was taken. Only that item was selected for which more than half the panelist stated that the item was essential for a particular category or sub-scale of the Form-P and Form-T of the scale FIAS. As a result in the item pool of 79 items, for the PRS Form-P the total 65 items were retained and 14 items were discarded and in the item pool of 72 items for the TRF total 65 items were retained and 7 items were discarded. This sort of professional input also placed a positive impact on the validity of the items.

Empirical evidence of the content validity of FIAS has been performed through Factor Analysis and item analysis. Through this procedure the items that did not discriminate well between the children and adolescents with/ without functional impairment were eliminated and as a result total 62- items for Form- T and 60-items for Form-P were retained.

Other validity which has been established for FIAS is the Construct Validity in terms of Discriminant and Convergent Validity. For the determination of the discriminant validity, the Urdu Version of Well-being Affectometer-2 and for convergent validity Depression and Anxiety in Youth Scale (DAYS; Phylis, 1994) has been used. For the purpose of validation of FIAS the DAYS was also translated in Urdu in Part-II of study (See the next section).

Chapter-IV

PART-II: TRANSLATION OF DEPRESSION AND ANXIETY IN YOUTH SCALE (DAYS) AND FURTHER VALIDATION OF THE FUNCTIONAL IMPAIRMENT ASSESSMENT SCALE (FIAS)

This part of the study has been conducted with the objective to determine the construct validity of the measure of functional impairment FIAS newly constructed in the Part I. Theorist regard construct validity as an umbrella which covers all the validities while some others regard it as the all-encompassing, unifying concept for all types of validity evidence (Anastasi & Urbina, 1997; Cronbach, 1988; Guion, 1980; Messick, 1992). The construct validation techniques involve determining it's convergent and discriminant validity.

Functional impairment has been found to be strongly associated with emotional disturbance. Depressive disorders put strong affects on the functioning and adjustment of young people in their community and school (Birmaher, Ryan, & Williamson, 1998; Ryan, Puig-Antich, & Ambrosini, 1987; Weissman, Wolk, & Goldstein, 1999). It has been found that students with serious emotional disturbance have poor performance and negative outcomes in school as well as less social skills (Wagner, 1990; Wagner, Amico, Marder, Newman, & Blackorby, 1992).

In order to test the convergent validity of FIAS it was hypothesized that children and adolescents who score high on functional impairment scale will also score high on the depression and anxiety scale.

Further, to determine the discriminant validity it was hypothesized that children and adolescents who have high level of psychological well-being will

perform well in their school and home environment. For this purpose DAYS (Phyllis, Newcorner, Enda, Barenbaum, Brain, & Bryant, 1994) was used to test the convergent validity of FIAS and Urdu version of Psychological Well-being Affectometer 2 (Kammann & Flet, 1983) translated by Naheed (1997) was used to establish the discriminant validity of FIAS .As FIAS is an indigenous scale constructed in Urdu Language for the Pakistani school population the DAYS was also translated into Urdu.

Objectives

The following objectives were achieved to in this part of study.

1. To translate the DAYS into Urdu.
2. To find the convergent validity between newly constructed Functional Impairment Assessment Scale (FIAS) and Urdu version of DAYS
3. To determine the discriminant validity between FIAS and Urdu version of Psychological Well-being Affectometer-2 (Kammann & Flet, 1983) translated by Naheed (1997) on the sample consisting of pre-adolescents and adolescents.
4. To determine the discriminant validity between FIAS and Life Satisfaction Ladder Scale (LSLS, Cantril, 1973) on the sample consisting of children (bellow 10 years age), pre-adolescents and adolescents.

Translation of Depression and Anxiety in Youth Scale (DAYS) into Urdu

DAYS was designed to assist practitioners, including school based personnel (e.g., psychologists, counselors and special education teachers), as well as mental health workers and members of the psychiatric community, with this initial step (identifying depression and anxiety in children and youth. The DAYS provides three sources of data pertaining to an individual's thoughts, feelings and behavior ratings from teachers (or teacher alternates), rating by parents (or parent surrogates), and students self- ratings. Information from varied perspectives sheds some light on child's internal world, and reveals the scope of the child's problems in the environment i.e., in school and at home. Because the DAYS can be easily administered, highly reliable, valid well standardized, and simple to score and interpret, professionals in both mental health settings and schools can use it with confidence.

The DAYS consists of three scales: Student self-Report (Scale S) with 22 items, Teachers Rating (Scale T) with 20 items, and Parents Rating (Scale P) with 28 items.

This scale is unique in that it consists of three rather than two dimensions. In addition to measuring depression and anxiety it assesses the children's social maladjustment. A total of 7 items comprise the social maladjustment, 13 items measure depressions and 8 items measure Anxiety. The internal consistency Reliability coefficients for DAYS Scales have been found to be quite satisfactory (i.e.,.89,.86, .87 for all three scales Scale S, Scale P and Scale T respectively).

In the present study DAYS has been planned to use for the validation of FIAS as well as to test the hypotheses of the main study. For this purpose a need was felt to translate the DAYS in Urdu because all other scales used in the current study are also in Urdu which is the national Language of Pakistan and most of the children living in Twin cities Rawalpindi and Islamabad speak Urdu at homes as their mother language.

Translation of DAYS (Phyllis e al., 1994) involved following three Steps:

Step I: Translation of DAYS Scale into Urdu by *Bilingual Translators*

Sample. The total 10 panelists (5 MPhil in psychology and 5 PhD scholars as well as degree holders in psychology) who were bilingual took part to translate all items of three Scales (Scale S, scale T, and Scale P) of DAYS (See Appendix-D 1.1 to D-1.3) into Urdu.

Procedure. The translators were directed to follow the guideline postulated by Brislin (1980). These guidelines suggest that translation should be done keeping following principles into considerations.

- To maximize the content similarity between the original test and the target language version.
- To maintain the relatively simple language level of the original test.
- To translate the test without substitution or elimination of any item.

The translators were asked to translate all the items of DAYS without substitution or elimination of any item. The DAYS profile / Record Form along with DAYS Scales was also translated into Urdu.They were also instructed to identify

those items which they think are not relevant to the Pakistani culture and to suggest best alternatives for them. As a result 10 transcripts of translations of DAYS were achieved. The translators found no discrepancy among the items of DAYS with respect to the Pakistani culture. The initial translation was then examined and evaluated by the committee of experts.

Step 2: Evaluation of the Translation

Second step involved committee approach in which four experts having minimum education of 16 years in relevant areas were invited to select the best Urdu translation of all the items present in the original scale.

Procedure. First of all a complete glossary of all the items of scale was prepared by the researcher from both English to English and English to Urdu dictionaries and then it was presented in front of committee of judges along with all the specimens of translations (N=10) done by the translators in Step 1 written under each item of the scale. The committee was requested to provide their consensus on the best translation for each item of the scale among the ten translations written under each item. By considering glossary as well Committee selected the best translation for each item of the scale.Each item was discussed at length and some items were re-phrased in simple diction. It has been observed by the committee during item review of translated items which was also pointed out by the initial translators that all the items of DAYS are relevant to the Pakistani culture and there is no any need to

replace these items according to the Pakistani culture (Appendix- D-2.1 to D-2.3 for the best translation).

Step 3: Back Translation

In order to get higher reliability (Berkanvoic (1980) the Urdu version of DAYS was back translated into English as a check on initial translation and to identify the points of equivalence or discrepancies between the two versions. The procedure followed in back translation is described as bellow.

Sample. The five Independent bilingual translators, who were not exposed to the items of the DAYS were provided with Urdu translation of DAYS having (See Appendix-D3) minimum education was 16 years, were selected for this purpose. Among these two were Pakistani British English teachers.

Procedure. The translated items selected by the committee in Step 2 were again given to 5 bilingual experts, to get back translation (in English) without showing them the original items of the scale. Then the committee again checked all the specimens ($N = 5$) of back translation for each the item to see whether the original scale was translated adequately or not. The items which yielded the best back translation (see Appendix-D3.1 to D3) were selected for the final Urdu version of the scale (DAYS).

The translated version of DAYS was used along with other instruments specified to be used for the determination of validity of FIAS as well as in the Study III the main study for the testing of the hypothesis.

Validation of Functional Impairment Assessment Scale (FIAS)

Basically Part- II deals with the determination of reliability and validity of the FIAS.All the scales to be used for the validation purpose were selected by the careful and detailed review of published literature and the electronic search was found to be the most relevant to be used in the present study.

Instruments

The following instruments were used in this part of the research.

1. Urdu version of Well-Being Scale (Affectometer 2) originally developed by Kammann and Flet (1983) and translated by Naheed (1997)
2. Life Satisfaction Ladder Scale (LSLS) devised by Cantril (as cited in Robinson & Shaver, 1973).
3. Urdu version of Depression and Anxiety in Youth Scale (DAYS-U, translated into Urdu in the present part)

Besides, a bio-data sheet attached to FIAS to record the information related to the age, gender, academic achievement, socio economic status, and mother'seducation was also used.

Well-being Scale Affectometer-2. Well-being Scale Affectometer-2 originally developed by Kammann and Flet (1983) and translated in Urdu by Naheed (1997) has been used for the children above 12 years of age. This scale is considered as a valid and reliable measure of well-being in terms of general happiness, based on negative and positive feelings. The scale consists of 39 items divided in two parts. Part I comprised of 19 statements and Part II had 20 objective items in it. In Part II item numbers 1 to 10 were positive items. Part I and Part II of well-being scale were also scored on 5-point Likert Type Scale. Giving the score of 1-5 i.e., 1 to "not at all", 2 to "occasionally", 3 to "some extent", 4 to "often", and 5 to "all of the times". This scoring was reversed for negative items of both the parts of well-being scale. Range of scores of well-being scale is in between 39 to 195. Split-half reliability of Urdu version of well-being scale (Affectometer-2) by Naheed (1997) had been found to be highly significant i.e., r - .75 (n = 72) between two parts, and alpha coefficient was 0.88 (n = 72) which is highly significant. In order to measure the psychological well-being in sechondary school students the Urdu Version Psychological Wellbeing ScaleAffectometer 2 was used whereas in primary school students especially those belonging to 6-8 years of age the life satisfaction lader scale was administered.The reasons behind not administering the Urdu Version of Psychological Wellbeing Scale Affectometer 2 on primary school students were two. Firstly it was found to be difficult for them to comprehend the constructs and concepts presented in the scale. Secondly, there was no any research evidence found in using Urdu Version of Psychological Wellbeing Scale Affectometer 2 on the children bellow 10 year age in Pakistan.

Life Satisfaction Ladder Scale (LSLS, Cantril, 1973). In the present study it has been measured through Life Satisfaction Ladder Scale devised by Cantril 1(as cited in Robinson & Shaver, 1973).

LSLS is a simple scale which presents intensity levels ranging from 1 to 9 placed in ascending order like a ladder where 1 stands for the lowest degree of un-satisfaction towards life whereas 9 represents the highest degree of life satisfaction

Urdu Version of Depression and Anxiety in Youth Scale (DAYS-U). DAYS-U translated in the present Part-II of study by the researcher has been used for the validation purpose in this part and for the testing of hypothesis of the present research in the main studyPart III. DAYS was designed to assist practitioners, including school based personnel (e.g., psychologists, counselors and special education teachers), as well as mental health workers and members of the psychiatric community, with this initial step (identifying depression and anxiety in children and youth).

Sample

Sample 1. An independent sample consisting of children and adolescents (N = 220) with age range 6-19 years (with mean M= 12.5 and SD =3.18) both boys (n = 110) and girls (n = 110) studying in Federal Government Primary & Senior Schools for boys and girls of Rawalpindi and Islamabad cities and Islamabad Model College for girls and boys (IMCG, IMCB) were included. The Sample was divided into two main groups with respect to the academic achievement.

Group1 consisting of students (n=115) showing low academic achievement who had been ranked on the last five positions in the final examination result sheet of their class. In this group there were 60 girls and 50 boys

Group 2 consisting of students (n = 105) showing high level of academic achievement, who acquire the first five positions in the final examination result sheet of their class.In this group there were 55 boys and 55 girls.

Sample 2: The Informants. Total 21 teachers (11women and 10 men), 176 parents (mostly mothers) and 23gardians participated in this part of the study.

All the students included in the sample were referred by the class teachers.The children who had difficulty getting along with others because of a physical disability e.g., deafness, blindness or mental retardation was not included in sample.

Procedure

Information about the children was gathered by the class teachers and parents/family member who is able to provide the full information about the child's behavioral and psychological functioning. For this purpose, the Federal Government (FG) schools for girls and boys of Rawalpindi (mainly Gualmandi and Chacklala) and Islamabad Model Colleges both for girls and boys (IMCG, IMCB) were selected. Teachers were introduced with the main objectives of the research by the researcher in which the importance of the role of teachers in this context was also highlighted. After taking informed consent (See, Appendix- A1) from the parents with the purpose of data collection were presented with scale in the form of booklet. Two booklets

were prepared: one for teachers consisting of newly constructed Teacher Rating Scale (TRS) (Form-T), and Scale-T of DAYS, and other one for parents and students consisting of Parent Rating Scale (PRS) the (form- P) along with bio-data sheet, the Scale-P of DAYS to be filled by the parents and, Scale-S, and Well-being Affectometer-2 to be filled by students. They were also provided with written instructions.The booklets prepared for parents were sent to their homes by children who were asked by their class teachers to take it at home carefully and after being filled bring these forms back and hand over to them.

By selecting the target population the teachers filled the booklet one of scales and sent the other one to the homes of the same students to be filled by the parents and students by themselves.

Parents and students were instructed also by the class teachers to read the instructions written for each scale carefully and try to attempt all the items and also fill the bio-data sheet by giving correct information.

Results

Concerning the validity of FIAS, the convergent validity i.e., the extent to which scales score correlate with other measures with which it should correlate theoretically, and the discriminant validity.i.e., the extent to which these scales scores show inverse relationship with other measures with which theoretically it should not correlate, or these scores show an inverse relationship when examined (Anastasi, 1982).

In order to determine the convergent validity of FIAS the Urdu version DAYS-U was used which was expected to be related to the newly developed Functional Impairment Assessment Scale (FIAS). On the other hand discriminant validity was expected to be determined by a negative correlation between FIAS and Well-being scale Affectometer-2.

Alpha reliability of the scales. The purpose of establishing reliability indices of the scales (i.e., Urdu versions of DAYS-U, PWB-Affectometer 2, & LSLS) being used in the Part II of the current study for the validation of FIAS was to ensure their suitability for indigenous populationand to get the initial insight into patterns of the relationships among variables of current investigation.

Reliability of DAYS-U. As DAYS-U has been used for the first time in Pakistan its psychometric soundness was warranted. It was necessary to ensure that all the items were significantly contributing in the measurement of their pertinent constructs.

In this Part- II of the current study DAYS-U has been used for the validation of FIAS therefore the reliability of DAYS-U has also been calculated. For this purpose alpha reliability coefficients and inter-scale correlation coefficient have been calculated.

The alpha reliability of the three sub-scales of the DAYS-U are: Scale S (.88); Scale T (.81) and Scale P (.84) which are very satisfactory.

The Alpha Reliability Coefficients of all the scales of DAYS –U have yielded satisfactory results. These coefficients show that this scale is quite reliable to be used for the validation of FIAS (See Table 12).

Table 12

Chronback's Alpha Reliability Coefficients OF DAYS-U Scales (N = 220)

Sub-Scal	No of Item	Alpha Reliability Coefficients
Scale-S	22	.88
Scale-T	20	.81
Scale- P	28	.84
DAYS-U	70	.91

Table 12 is showing the highest level of alpha coefficient for the sub-scale-S of DAYS-U i.e., $\alpha = .88$. For the rest of sub-scales the alpha coefficient also yielded satisfactory reliabilities. The alpha coefficient of the total DAYS-U i.e., $\alpha = .91$ has yielded an excellent reliability which indicates that the translated version of DAYS (Phyllis, 1994) is an appropriate measure of comorbidity of depression and anxiety for the indigenous population.

Inter-scale correlation of DAYS-U. The inter-scale correlation for DAYS-U (Urdu version) has also been computed in the present study with *(N* = 220) (See Table 13).

Table 13

Inter-S-scale correlation of all the Scales of DAYS-U (N = 220)

	DAYS-U	1	2	3
1.	Scale S	-	.77***	.76***
2	Scale T	-	-	.86***
3	Scale-P	-	-	-

*$p < .05$, **$p < .01$, ***$p < .000$

The Table 13 shows a highly significant positive relationship at P≥.001 among the subscales as well as the total DAYS-U which is in desired direction.

Reliability of Urdu version Scale of Well-being Affectometer (2). As the Urdu version well-being affectometer-2 scale has been used for the validation of FIAS the reliability of well-being (Affectometer-2) has also been calculated with a sample of (N = 220) children and adolescents in the present study in which Chronbach'salpha reliability coefficients, and Inter-Scale Correlation Coefficient have been calculated.

The alpha reliability of the total (i.e., α = .93) as well as of Part I (i.e., α = .89) and Part II (i.e., α = .91) of the scales are quite satisfactory.These coefficients show that this scale is quite reliable to be used for the validation of FIAS (See Table 14).

Table 14

Chronback's Alpha Reliability Coefficients Of Urdu Version Wellbeing (Affectometer-2) Scale (N = 220)

Sub-Scales	No of Item	Alpha Coefficients
Part-I	19	.89
Part-II	20	..91
Total	39	.93

Inter-Scale Correlationof Well-being Affectometer-2 (Urdu version). The inter-scale correlation for Well-being Affectometer-2 (Urdu version) has also been computed in the present study with (N = 220) (See Table 15).

Table 15

Inter-scale correlation of Well-being (Affectometer-2) (N = 220)

Well-Being (Affectometer-2)	Part I	Part II	Total Well-Being
Part I	-	.67***	.86***
Part II	-	-	.96***
Well-Being (Affectometer-2)	-	-	-

*$p < .05$, **$p < .01$, ***$p < .000$

Reliability of FIAS. For the determination of reliability of FIAS, Cronbach Alpha Coefficients, and inter-scale correlation, coefficients have been calculated for its both forms (Form-T and Form-P) along with their sub-scales separately. The detail is given in the next section.

Cronbach's Alpha Coefficients of TRS. Cronbach's alpha coefficient yielded an internal consistency coefficient of .91 for the entire 62-item TRS. For other sub-scales of TRS it ranged from .79 to .90 (Table 16). All these seem to be satisfactory reliabilities.

Table 16

The alpha reliability coefficients of total and sub-scales of Teacher Rating Form (Form-T) (N = 220)

Sub-scales	No. of Items	Alpha Coefficients
LBDS	23	.90
SDS	12	.88
CDS	19	.84
EDS	11	.79
Total TRF (Form-T)	62	.93

*Note.*LBDS = Learning Behavior Dysfunction Scale, CDS = Cognitive Dysfunction Scale, SDS = Social Dysfunction Scale, EDS = Emotional Dysfunction Scale.

Table 16 is showing the highest level of alpha coefficient for the sub-scale of LBDS i.e., $\alpha = .90$. For the rest of sub-scales the alpha coefficient ranges from, 79 to .88 which also yielded satisfactory reliabilities. The alpha coefficient of the total i.e.,

α = .93 has yielded an excellent reliability which indicates that the TRS (Form-T) is an excellent indigenous measure of functional impairment and screening device for the school use for identifying children and adolescents with mental health difficulties.

Interscale Correlation Coefficient of TRS. The Interscale correlations of all the subscales with each other and with total TRS have also been calculated (See Table 17).

Table 17

The alpha reliability coefficients of total and sub-scales of Teacher Rating Form (Form-T) (N = 220)

	Sub-scales	I	II	III	IV	V
I	LBDS		.74***	.85***	58***	.57***
II	CDS			.84***	.82***	.94***
III	SDS				.76***	.90***
IV	EDS					.86***
V	TRS (Total)					-

Note. LBDS = Learning Behavior Dysfunction Scale, CDS = Cognitive Dysfunction Scale, SDS = Social Dysfunction Scale, EDS = Emotional Dysfunction Scale.

The significantly positive correlation of the subscales of Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction, and Social Dysfunction with each other and with the total TRS (Form-T) shows the internal consistency of all these scales. This is in accordance with what have been reported by Atkins, Frazier,

Adil, & Talbott, 2003; Libbey, 2004) that emotional dysfunction leads to the low academic functioning.

*Note.*The reliability of TRS has also been obtained in the Part III of the present research which has been reported in the main study.

Cronbach's Alpha Coefficient of PRS. Cronbach's Alpha Coefficient yielded an internal consistency coefficient of .94 for the entire 60-item PRS. For other sub-scales of PRS it ranged from .78 to .91 (Table 18). All these seem to be satisfactory reliabilities.

Table 18

The alpha reliability coefficients of total and sub-scales of Parent Rating Scale (Form-P) (N = 220)

Sub-scales	No. of Items	Alpha Coefficients
LBDS	15	.91
SDS	12	.90
CDS	23	.87
EDS	11	.78
Total PRS (Form-P)	60	..94

Note. LBDS = Learning Behavior Dysfunction Scale, CDS = Cognitive Dysfunction Scale, SDS = Social Dysfunction Scale, EDS = Emotional Dysfunction Scale.

Interscale Correlation Coefficient of PRS. The Inter scale correlation of all the subscales with each other and with total PRS have also been calculated (See Table 19).

Table 19

The alpha reliability coefficients of total and sub-scales of Parent Rating Scale (Form-P) (N = 220)

	Sub-scales	I	II	III	IV	V
I	LBDS		.65***	.68***	.62***	.88***
II	CDS			.64***	.72***	.84***
III	SDS				.61***	.73***
IV	EDS					.76***
V	TRS (Total)					

Note. LBDS = Learning Behavior Dysfunction Scale, CDS = Cognitive Dysfunction Scale, SDS = Social Dysfunction Scale, EDS = Emotional Dysfunction Scale.

The significantly positive correlation of the subscales of Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction, and Social Dysfunction with each other and with the total PRS (Form-P) shows the internal consistency of all these scales. The learning behavior impairment along with emotional, cognitive and social dysfunction indicates what is consistence with findings of Wagner (1995) who documented that students with serious emotional disturbance have a detrimental effect on school performance.

Note. The reliability of PRS has also been obtained in the Part III of the present research which has been reported in the main study.

Construct Validity. Construct validity of FIAS was established by computing convergent and discriminant validites.To find the convergent validity the scores of children and adolescents with low and high academic achievement on newly constructed Functional Impairment Assessment Scale (FIAS) and Urdu version of Depression and Anxiety in Youth Scale (DAYS, Phyllis, et al., 1994) were matched.

For determining the discriminant validity two scales were used, i.e., Urdu version of Psychological Well-being Affectometer-2 (Kammann & Flet, 1983) translated by Naheed (1997) was used for the sample consisting of only pre-adolescents and adolescents whereas the Life Satisfaction Ladder Scale (LSLS, Cantril, 1973) was used for the entire sample including also children (bellow 10 years age), along with pre-adolescents and adolescents.

Discriminant Validity. In order to establish the discriminant validities of FIAS, in the present research it has been hypothesized that children and adolescents with low academic achievement would show high scores on FIAS and its sub-scales but will score low on the Well-being Affectometer-2 scale (Urdu version) as well as on Life Satisfaction Ladder Scale (LSLS; Cantril, 1973). In other words there would be a negative correlation between Well-being Affectometer-2, Life Satisfaction Ladder Scale, and FIAS and its sub-scales.

For the confirmation of this hypothesis correlation coefficient between the total and the sub scales of FIAS in both the forms with Well-being Affectometer-2

scale (Urdu version) and its two parts as well as Life Satisfaction Ladder Scale (LSLS, Cantril, 1973)have been calculated (see Table 20).

Table 20

Correlation of scales of Well-being Affectometer-2 with total and sub-scales of Teacher Rating Scale (Form-T) (only pre-adolescents and adolescents, N = 150)

Sub-scales	Part I	Part II	Affectometer-2(Total)
EDS	-.31**	-.29***	-.32**
SDS	-.55***	-.79***	-.76***
CDS	-.44***	-.65***	-.63***
LBDS	-.49***	-.72***	-.69***
TRS (Total)	-.50***	-.71***	-.69***

$*p < .05$, $**p < .01$, $***p < .000$

Table 20 shows that there is negative correlation between the scores of Urdu version of Well-being Affectometer-2 and the total TRF (Form-T) of FIAS and its sub-scales Emotional Dysfunction, Cognitive Dysfunction and Social Dysfunction and Learning Behavior Dysfunction Scale i.e., the children and adolescents who got high scores on, FIAS and its sub-scales have scored low on Urdu-version of Affectometer-2 Well-being Scale.Therefore, the negative correlation between FIAS and its four-subscales with well-being affectometer-2 (total and parts I & II) shows discriminant validity of FIAS.

Table 21

Correlation of scales of Life Satisfaction Ladder Scale (LSLS with total and sub-scales of Teacher Rating Scale (Form-T) (N = 220)

Sub-scales	Life satisfactionLadderScale (LSLS)
EDS	-.61**
SDS	-.55***
CDS	-.74***
LBDS	-.79***
TRS (Total)	-.70***

$*p < .05$, $**p < .01$, $***p < .000$

Table 21 shows that there is negative correlation between the scores of Life Satisfaction Ladder Scale (LSLS) total TRF (Form-T) of FIAS and its sub-scales Emotional Dysfunction, Cognitive Dysfunction and Social Dysfunction and Learning Behavior Dysfunction Scale i.e., the children and adolescents who got high scores on, FIAS and its sub-scales have scored low on LSLS. Therefore, the negative correlation between FIAS and its four-subscales LSLS confirms discriminant validity of FIAS.

Discriminant validity of FIAS with Urdu-version of Well-being Scale Affectometer-2, and Life Satisfaction Ladder Scale (LSLS) has also been done in the Part III, the main study.

Convergent Validity. Depression and Anxiety in Youth Scale (DAYS-U) was used to establish the convergent validity of FIAS.For this purpose it has been hypothesized that the students who score high on FIAS will also score high on the DAYS and the students who score low on FIAS will also tend to score low on DAYS (see Table 22).

Table 22

Correlation of scales of DAYS-U with forms of FIAS the Total TRS (Form-T) and Total PRS(Form-P) (N = 220)

DAYS-U scales	Form-P	Form-T	FIAS (Total)
Scale-S	.64**	.69***	.72**
Scale T	.65***	.79***	.76***
Scale P	.44***	.65***	.63***
DAYS-U (Total)	..60***	..77***	..79***

***p < .01, ***p < .000*

Table 22 shows that correlation of the Urdu version of DAYS-U and its all the component scales (Scale-S, Scale-T, Scale-P) with the Teacher Rating Form (TRF) (Form-T) and Parent Rating Form (PRS) (Form-P) of the Functional Impairment Assessment Scale (FIAS) is positively correlated i.e., the children and adolescents who got high scores on, the two forms of FIAS also scored high on all the scales of DAYS-U. In order to see the relationship between the two scales in depth the correlation analysis among the sub-scales or the dimensions of both the scales (FIAS and DAYS-U) has also been explored which is as follows.

Teacher Rating Scale (TRS) (Form-T) and scales of DAYS-U. In order to see the relationship among the sub-scales or dimensions of the Form-T and the scales of DAYS-U the following correlation analysis were performed.

Correlation Analysis between Form-T of FIAS and Scale-S of DAYS-U

Table 23

Correlation of Sub-scales of Scale-S with total and sub-scales of Teacher Rating Scale (Form-T) (N =220)

Sub-scales	Anxiety	Depression	Total Scale-S
EDS	.61**	.59***	.72**
SDS	.55***	.76***	.77***
CDS	.44***	.55***	.59***
LBDS	.59***	.72***	.69***
TRS (Total)	.68***	.71***	.69***

$*p < .05$, $**p < .01$, $***p < .000$

Table 23 shows a positive correlation among the sub-scales of TRS such as Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction, and Social Dysfunction and Anxiety and Depression scales of the total Scale-S i.e., individuals who scored high on the FIAS have also scored high on Scale S of DAYS-U. This result is in desired direction.

Correlation Analysis between Form-T of FIAS and Scale-T of DAYS-U

Table 24

Corelational Analysis between the sub-scales of Form-T of FIAS and Sub scales of Scale-T of DAYS-U (N = 220)

Sub-scales	Anxiety	Depression	Total Scale-T
EDS	.69**	.59***	.73**
SDS	.56***	.76***	.71***
CDS	.64***	.55***	.69***
LBDS	.59***	.62***	.69***
TRS (Total)	.63***	.71***	.79***

$*p < .05$, $**p < .01$, $***p < .000$

Table 24 shows a positive correlation among the sub-scales of TRS such as, Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction, and Social Dysfunction and Anxiety and Depression scales of the Scale-T. This result also confirms the convergent validity of TRS of FIAS.

Correlation Analysis betweenSub-scales of Form-T of FIAS and Scale-P of DAYS-U

Table 25

Correlation of Sub-scales of Scale-P with total and sub-scales of Teacher Rating Form (Form-T) (N = 220)

Sub-scales	Social Malfunction	Anxiety	Depression	Total Scale-P
EDS	.57**	.64**	.69***	.73**
SDS	.73***	.66***	.73***	.75***
CDS	.59**	.54***	.45***	.69***
LBDS	.74***	.59***	.62***	.69***
TRS (Total)	77***	.63***	.71***	.79***

$*p < .05$, $**p < .01$, $***p < .000$

Table 25 shows a positive correlation among the sub-scales of TRS such as Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction, and Social Dysfunction and Anxiety and Depression scales of the Scale-P. This result is also in line with the previous result. i.e., it has once again confirmed the convergent validity of TRS of FIAS.

Parent Rating Form (PRF) (Form-P) and scales of DAYS-U. In order to see the relationship among the sub-scales or dimensions of the Form-P and the scales of DAYS-U the following correlation analysis were performed.

Correlation Analysis between the sub-scales of Form-P of FIAS and Scale-S of DAYS-U

Table 26

Correlation of Sub-scales of Scale-S with total and sub-scales of Parent Rating Scale (Form-P) (N = 220)

Sub-scales	Anxiety	Depression	Total Scale-S
EDS	.63**	.52***	.74**
SDS	.65***	.76***	.77***
CDS	.54***	.45***	.56***
LBDS	.58***	.62***	.59***
PRS (Total)	.63***	.61***	.73***

$*p < .05$, $**p < .01$, $***p < .000$

Table 26 shows a positive correlation among the sub-scales of PRS such asLearning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction, and Social Dysfunction and Anxiety and Depression scales of the Scale-S which is in desired direction.

Correlation Analysis between the sub-scales of Form-P of FIAS and Scale-T of DAYS-U

Table 27

Correlation of Sub-scales of Scale-T with total and sub-scales of Parent Rating Scale (PRS)(Form-P) (N = 220)

Sub-scales	Anxiety	Depression	Total Scale-T
EDS	.60**	.57***	.63**
SDS	.66***	.64***	.74***
CDS	.54***	.52***	.59***
LBDS	.60***	.59***	.62***
TRS (Total)	.66***	.61***	.73***

$*p < .05$, $**p < .01$, $***p < .000$

Table 27 shows a positive correlation among the sub-scales of PRF such as Learning Behavior Dysfunction, Cognitive Dysfunction, Emotional Dysfunction and Social Dysfunction and Anxiety and Depression scales of the total Scale-T. This result is also in line with the previous result. i.e., like TRS (Form-T) it has also confirmed the convergent validity of PRS of FIAS.

Correlation Analysis between the sub-scales of Form-P of FIAS and Scale-P of DAYS-U

Table 28

Correlation of Sub-scales of Scale-P with total and sub-scales of Parent Rating Scale (PRS) (Form-P) (N = 220)

Sub-scales	Social Malfunction	Anxiety	Depression	Total Scale-P
EDS	.61**	.71**	.69***	.73**
SDS	.68***	.60***	.72***	.76***
CDS	.57**	.64***	.55***	.62***
L*BDS*	.76***	.69***	.62***	.77***
TRF (Total)	.72***	.63***	.75***	.79***

**p < .05, **p < .01, ***p < .000*

Table 28 shows a positive correlation among the sub-scales of PRF such as Learning Behavior Dysfunction, Cognitive Dysfunction, Emotional Dysfunction and Social Dysfunction and Anxiety and Depression scales of the Scale-P.

Hence in the light of all the results shown in the Tables (20-28) it can be said that the hypotheses formulated for the validation purpose of the FIAS with DAYS-U (for convergent validity) and with Urdu version of well-being (Affectometer-2) (for discriminant validity) has been proved. This shows that FIAS has satisfactory validity. Further the measurement of functional impairment, Emotional Disturbance

(Depression and Anxiety) and the Psychological Well-being in children and adolescents as a function of different demographic variables (e.g., age, gender, family structure, socioeconomic status and academic achievement) were determined through the FIAS, DAYS-U and Well-being Affectometer-2 (Urdu version) in the main study which also confirmed the validity and reliability of FIAS.

Discussion

This part of the study has been conducted with the objective to determine the construct validity of the measure of functional impairment FIAS newly constructed in the Part I. Another main objective was also to translate the Depression and Anxiety in Youth Scale (DAYS) (Phyllis et al., 1994) in Urdu. The need to translate the DAYS in Urdu emerged due to two reasons. Firstly, the present research aimed to measure serious emotional disturbance (mixed depression and anxiety) along with its associated functional impairement so the requirement was of the two main instruments, one for measuring functional and other to assess the emotional disturbance in children and adolesnet (6-19 year age). For this purpose DAYS appeared the best which could meet the requirement os the study. Secondly DAYS also appeared the most suitable instrument which could be used for validation purpose of the newly constructed an indigenous Functional Impairment Assessment Scale (FIAS), As FIAS is in Urdu language therefore an Urdu version of DAYS could have served the purpose better. So the need to translate the DAYS emerged. Hence this segment the Part II of the research had been planed to perform translation of DAYS and to conduct validation of FIAS.

For the validation of newly constructed scale FIAS the technique of construct validity involving convergent and discriminant validity was adapted. Construct validity of FIAS was established by computing convergent and discriminant validities. To find the convergent validity the scores of children and adolescents with low and high academic achievement on newly FIAS and DAYS-U (Urdu version of DAYS) were matched.

For determining the discriminant validity two scales were used, i.e., Urdu version of Psychological Well-being Affectometer-2 (Kammann & Flet, 1983) translated by Naheed (1997) was used for the sample consisting of only pre-adolescents and adolescents whereas the Life Satisfaction Ladder Scale (LSLS; Cantril, 1973) was used for the entire sample including also children (bellow 10 years age),along with pre-adolescents and adolescents.

Literature review sheds the light on the comorbidity of depression and anxiety and their strong association with Functional impairment. It has been found that students with serious emotional disturbance have a detrimental effect on school performance to be at risk for a number of negative outcomes including poor academic performance, school dropout, unemployment, absenteeism, and poor social integration (Wagner, Amico, Marder, Newman, & Blackorby, 1992; Wagner, 1990).

Therefore, in order to test the convergent validity of FIAS it was hypothesized that children and adolescents who score high on functional impairment scale will also score high on the depression and anxiety scale. Further, to determine the discriminant validity it was hypothesized that children and adolescents who have high level of psychological well-being will perform well in their school and home environment. For this purpose DAYS was used to test the convergent validity of FIAS. Though

there were many other popular scales which were available in Pakistan with Urdu translation, the reason behind using DAYS was that, these other scales could not fulfill the requirements of the present study. For example we had Beck Depression Inventory which was in Urdu translation but we could not use it because of two reasons: firstly, as the sample of the present research includes children below twelve years age and BDI is only for the individuals with age twelve or onward. Further, it has not been used yet on the younger population who are under 12 years age. Secondly, BDI is basically a depression inventory and as the present research aimed to measure comorbidity of DEP and ANX for which a scale measuring the emotional disturbance (mixed symptoms of DEP and ANX) was needed. Hence DAYS appeared to be able to fullfill the needs of the present study.

In order to establish the discriminant validity of FIAS Urdu version of Psychological Well-being Affectometer (Kammann & Flet, 1983) translated by Naheed (1997) was used.

For the determination of discriminant and convergent validity of FIAS, the scores of the participants on FIAS were correlated with their scores on Urdu version Well-being Affectometer-2 Scale. For this it was hypothesized that the students who will show more functional impairment and emotional disturbance will show low sense of well-being.

The results suggest that FIAS possesses sufficient and promising discriminant and convergent validities. The results have established the discriminent validity as the total score of students on the two forms TRF and PRF of FIAS and scores on its sub-scales namely, Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction, and Social Dysfunction have shown significantly negative

correlation with the Life Satisfaction Ladder Scale and well-being affectometer-2. The scale used for validation purpose (Urdu version of Well-Being Affectometer-2 by Naheed, 1997) was constructed and developed in the Pakistan and in the same language (Urdu) so these findings are quite satisfactory.

For the determination of convergent validity of FIAS, the scores of the participants on FIAS were correlated with their scores on DAYS-U translated in the present study. For this it was hypothesized that the students who will score high on Functional Impairment Assessment Scale (FIAS) the newly developed in the present study will also show high score on the DAYS-U, because research on developmental psychopathology has revealed that the impairment in the cognitive, emotional and social functioning may serve as the school indicator of the emotional disturbance (depression and anxiety) in the children and adolescents. But due to its co-occurrence it is often difficult to know whether cognitive and psychological deficits are an outcome or cause of depression (Cole, Martin, Posers, & Truglio, 1996). The results suggest that FIAS possesses sufficient and satisfactory convergent validities as the total score on the two forms TRF and PRF of FIAS and scores on its sub-scales namely Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction, and Social Dysfunction have shown significantly positive correlation with the DAYS-U. These findings are also quite satisfactory.

Information from the FIAS is useful and extremely helpful in evaluating children for pre referral services, in placing children for specialized services, and in measuring the outcomes of services. The FIAS can identify child's learning behavior in school; his/her emotional/social/cognitive strengths and the areas in which

individual strengths need to be developed. The FIAS also has been designed to be widely used in several national studies of children with and without disabilities.

FIAS is the first scale of its kind in Pakistan constructed for the young population. It will be useful both in assessing the functional impairment and level of learning behavior dysfunction of young population with or without academic achievement in schools by teachers; in clinics by mental health practitioners and for the research purpose in the field of developmental psychology.

The internal consistency reliability and validity of the FIAS with respect to the different demographic or the risk factors such as age, socioeconomic status , parental education family structure and academic achievement will also be established with children with/without disabilities in part-2 or the main study of the present research project.

Conclusion

Overall, Functional Impairment Assessment Scale (FIAS) appears to be acceptable, with adequate content coverage, good reliability, and supportive validity evidence and can be used in the schools, and research institutes for finding the functional impairment in social, emotional, and cognitive functioning as well as the level of learning behavior dysfunction in Pakistani children and adolescents with low academic achievement.

Chapter-V

PART III: MAIN STUDY

MEASUREMENT OF COMORBIDITY OF DEPRESSION, ANXIETY AND FUNCTIONAL IMPAIRMENT IN CHILDREN AND ADOLESCENT WITH LOW ACADEMIC ACHIEVEMENT

The barriers to learning faced by students with academic problems are many and complex, and differ from student to student and often from day to day. Many have no visible disability rather they have emotional disturbance which serves as barrier to learning and can be difficult to identify. The present research has been planned to probe these hidden barriers to learning in the children and adolescents with low academic achievement which has received yet less attention in Pakistani society. In the light of literature review the researcher has identified certain important impairments in the domains of psychosocial functioning to be addressed for the present study. These are: Cognitive Dysfunction, Emotional Dysfunction, Social Dysfunction and impairment in Global Learning Behavior.

Objectives

Part III, the main study aims to measure the comorbidity of depression (DEP), anxiety (ANX) and functional impairment (FI) in children and adolescents who manifest low academic performance. In other words the research purports to identify the mental health difficulties or the barriers to the learning behavior in the young

population, who attend school less, participate less in class as well as in school activities, have relationship problems with their peers and take low grades and show low academic achievement.

The main study was planned to assess the relationship of emotional disturbance (the hidden mental health difficulty) with the academicachievement of children and adolescents.

The specific objectives are as follows:

1. To find the relationship among the comorbid variables of the study, such as depression (DEP), anxiety (ANX) and Functional Impairment (FI) with psychological well-being (PWB) and life satisfaction (LS) and academic achievement in children and adolescents.
2. To determine the difference of level of DEP, ANX, FI, low PWB and low LS in children and adolescents with low and high academic achievement.
3. To find out the strength of the predictors of low academic achievement in terms of DEP, ANX, FI, low PWB and low LS as compared to those with high academic achievement.
4. To find the relationship of different demographic risk factors such as, socioeconomic status family structure, maternal education as well as age and gender of children and adolescents with the level of DEP, ANX, FI, PWB and LS.
5. To test the hypotheses formulated for the present research.

In addition to these, to further find out the reliability and validity of the newly constructed and translated instruments FIAS and DAYS-U respectively were also determined.

Main hypotheses

Main hypotheses formulated for the present research are:

1. There will be a comorbidity of DEP, ANX and FI, in children and adolescents with low academic achievement.
2. Low academic achievement will be positively related to the DEP, ANX, and FI but will be negatively related to the psychological well-being and life satisfaction in children and adolescents.
3. Functional Impairment will serve as the strongest predictor of low academic achievement among other variables such as DEP, ANX and low PWB.

In order to probe in-depth the relationship between low academic achievement and comorbidity of DEP, ANX and FI two sub-hypotheses were also originated from the main hypotheses.

Sub-hypotheses

1. There will be difference in the scores of Children and adolescents with respect to their different age groups on total and sub-scales of FIAS, DAYS-U, and PWB (Affectometer 2), and life satisfaction (LSLS).
2. With respect to gender there will be a difference in the scores of boys and girls on total and sub-scales of FIAS, DAYS-U, and (PWB) (Affectometer 2), and life satisfaction (LSLS).
3. There will be difference in the scores of children and adolescents belonging to the families with low, moderate or high socioeconomic status on total and sub-

scales of FIAS, DAYS-U, and PWB (Affectometer 2), and life satisfaction (LSLS).

4. There will be difference in the scores of Children and adolescents of uneducated and educated mothers on total and sub-scales of FIAS, DAYS-U, and Psychological Well-being (PWB) (Affectometer 2), and life satisfaction (LSLS).
5. Children and adolescents of discordant families have high level of FI, DPR and ANX and have low sense of psychological well-being and life satisfaction as compared to the children and adolescents of harmonious families.
6. There will be difference in the scores of Children and adolescents with high and low academic achievement on total and sub-scales of FIAS, DAYS-U, and Psychological Well-being (Affectometer 2), and life satisfaction (LSLS).

Sample

Sample 1. The inclusion of the subjects was based on the teacher's referral.

Literature review has revealed the strong role of the school teachers in the process of referral of children for the special needs services.

In the current study recruitment of target population (students with low / high academic achievement) was accomplished by the help of the class teachers. They were asked to select the students on the basis of their performance on their annual examination held during the previous class. From every class 10 students were selected. Five were those who were ranked among first five positions and five who

ranked among last five positions on the annual examination result sheet prepared by the class teacher.

Teachers identified an independent sample of (N = 410) children and adolescents with the age range of 6-19 years (mean, M = 12.5, SD = 3.45) consisting of both boys (n = 189) and girls (n = 221) studying in Federal Government Primary & Senior Schools for boys and girls of Rawalpindi and Islamabad cities and Islamabad Model College for girls and boys (IMCG, IMCB) were included. The Sample was divided into two main groups with respect to the academic achievement.

Group I: consisting of children and adolescents (n = *205*) with low academic achievement. These were thosewhohad not passed their annual examinations successfully and were repeating the same class and their teachers rank them on the last five positions.

Group II: consisting of students (n = 205) with high level of academic achievement, were those who stood at the first five positions with high Grades in their annual examination.

Respondents

Information about the children was gathered by the two informants.The class teachers who know the child for minimum of six months and parents or family members who are able to provide the full information about the child's behavioral and psychological functioning.

Total (N = 52) both male (N = 23) and female (n = 29) class teachers, 278 mothers and 32 guardians participated. For this purpose, total 10 academic institutes

were contacted for the data collection. Among these, two were Islamabad Model College for Girl and two were Islamabad Model College for Boys along with their primary sections. In these Model Colleges of Islamabad city a large number of student populations come from the families with middle socioeconomic status and where parents are mostly educated. Two Private schools were contacted where mostly children of businessmen with high income (high SES) come. In order to include children of the families with low SES where parents are also less educated the FG schools (2 for girls and 2 for boys) mainly from Gualmandi and Chacklala regions of Rawalpindi were contacted because in these school most of the children come from families of Pakistan Army soldiures (Army Jawaans) and their qualification level is not more than matriculation and their wives are mostly uneducated or maximum schooling up to primary class.

An informed consent was taken by the parents (See Appendix-A). Those students whose parents did not respond to consent were not included in the study.

Firstly teachers were introduced with the main objectives of the research in which importance of the role of teachers in this context was also highlighted.. Besides, the written instructions including the definitions of the main construct were also provided to the teachers to help them identify the target population (See Appendix A-1).

After this teachers were instructed to fill the initially constructed item pool of TRS for the recruited two groups. Then the other forms PRF (Form- P) along with bio-data sheet were sent home and collected back by the class teachers to be filled by parents (mostly mother).

For data collection all the scales were presented in the form of booklets

Instruments

Instruments used for the testing of hypothesis of the main study or Part-III were:

1. Functional Impairment Assessment Scale (FIAS) developed in Part-I of the present study for the measurement of functional impairment.
2. Urdu Version of Depression and Anxiety in Youth Scale (DAYS, Phyllis et al., 1994) translated in the present study for the measurement of emotional disturbance
3. Urdu Version of Psychological Wellbeing Scale(Affectometer-2;Kammann & Flet, 1983) translated in Urdu by Naheed (1997)
4. Life Satisfaction Ladder Scale (LSLS) devised by Cantril (as cited in Robinson, & Shaver, 1973).

In addition a bio-data sheet for recording the information related to their age, sex, class, socioeconomic status and family structure had been attached with the FIAS. The detailed description of scales along with their reliabilities is as follows:

Functional Impairment Assessment Scale (FIAS). Newly constructed an indigenous scale FIAS is a unique scale of broad spectrum that measures the child's functional impairment and learning behavior from two perspectives: parents and teachers through TRS (Form-T with 60 items) for teachers and PRS (Form-P with 62 items) for parents along with a Bio-Data Sheet.

The underpinning need in the construction of FIAS was its use in the main study for the measurement of FI in Pakistani children and adolescents of ages 6

through 19. FIAS measures FI in different domains of their functioning both at home and school such as class room behavior, interaction with peers, emotional response (both psychological as well as physical), and their cognitive and personal strengths or competencies to learn in school through its four sub-scales namely. (1) Learning Behavior Dysfunction Scale (LBDS) (2) Cognitive Dysfunction Scale (CDS) (3) EmotionalDysfunction Scale (EDS) (4) Social Dysfunction Scale (SDS).

FIAS has been constructed on the format of five point Likert type scale with the anchors of *not at all, rarely, sometimes, often, always* with the scores 1,2,3,4,5 respectively:

For the determination of reliability of FIAS, Cronbach Alpha Coefficients, inter-scale correlation, and split-half reliability coefficients have been calculated for its both forms (Form-T and Form-P) separately which are quite satisfactory. Cronbach's Alpha Coefficient yielded an internal consistency coefficient of .94 for the entire 62-item TRS. For other sub-scales of TRS it ranged from .71 to .93 and the split-half reliability coefficient, of TRS of Part I and Part II was found to be .91 and .90 respectively.

For PRS (Form-P) Cronbach's Alpha Coefficient yielded an internal consistency coefficient of .92. For other sub-scales of PRS it ranged from .70 to .90. All these seem to be satisfactory reliabilities.

The results of Inter scale correlation of all the subscales with each other and with total scale of both the Forms: PRS (Form-P) and TRS (Form-T) have also been found to be satisfactory.

The alpha reliability coefficient of the FIAS has also been also determined in this part of the study with a sample of 410 students which are also quite satisfactory.

The second scale used for the measurement of DEP and ANX as well as to establish the convergent validity of the newly constructed scale FIAS was DAYS-U Originally developed by Phyllis, Newcorner, Enda, Barenbaum, Brain, and Bryant (1994) and translated in the Phase-I of the present research by the researcher.

DAYS was designed to assist practitioners, including school based personnel (e.g., psychologists, counselors and special education teachers), as well as mental health workers and members of the psychiatric community, with this initial step (identifying depression and anxiety in children and youth. The days provides three sources of data pertaining to an individual's thoughts, feelings and behavior ratings from teachers (or teacher alternates), rating by parents (or parent surrogates), and students self ratings. Information from varied perspectives sheds some light on child's internal world, and reveals the scope of the child's problems in the environment i.e., in school and at home. Because the DAYS is easily administered, highly reliable, valid well standardized, and simple to score and interpret, professionals in both mental health settings and schools can use it with confidence.

Well-being Affectometer-Urdu Version (2). Originally developed by Kammann and Flet (1983) and translated in Urdu by Naheed (1997) has been used for the children above 10 years of age. This scale is considered as a valid and reliable measure of well-being in terms of general happiness, based on negative and positive feelings.

The scale consists of 39 items divided in two parts. Part I comprised of 19 statements and Part II had 20 objective items in it. In Part II item no. 1 to 10 were positive items. Part I and Part II of well-being scale were also scored on 5-point Likert Type Scale. Giving the score of 1-5 i.e., 1 to "not at all", 2 to "occasionally", 3 to

"some extent", 4 to "often", and 5 to "all of the times". This scoring was reversed for negative items of both the parts of well-being scale. Range of scores of well-being scale is in between 39 to 195. Split-half reliability of Urdu version of well-being scale (Affectometer-2) by Naheed (1997) had been found to be highly significant i.e., r - .75 (n = 72) between two parts, and alpha coefficient was 0.88 (n = 72) which is highly significant.

The measurement of psychological wellbeing by using the scale the Urdu Version Psychological Wellbeing Scale Affectometer 2 was carried out on only secondary school students with the sample of N = 310 as the primary school students especially those belonging to 6-8 years of age were not given the scale to respond because it was found difficult for them to comprehend the constructs and concepts presented in Urdu Version of Psychological Wellbeing Scale Affectometer 2. Rather Life Satisfaction Ladder Scale was administered on these students. Another reason for not administering the WBS to children of age less than 10 years is that no research evidence has been found in using Urdu Version of Psychological Wellbeing Scale Affectometer 2 on this particular group in Pakistan.

Life Satisfaction Ladder Scale (LSLS). Life satisfaction gives a comprehensive picture of psychological wellbeing (Andrews & Withey, 1976; Diener et al., 1999; Herzog, Rogers, & Wood-Worth, 1982). In the present study it has been measured through Life Satisfaction Ladder Scale devised by Cantril (as cited in Robinson, & Shaver, 1973). LSLS is a simple scale which presents intensity levels ranging from 1 to 9 placed in ascending order like a ladder where 1 stands for the lowest degree of un-satisfaction towards life whereas 9 represents the highest degree of life satisfaction.

Demographic Information Sheet. Along with FIAS, DAYS-U, Psychological Well-being Affectometer-2 (Urdu Version) and LSLS a demographic information sheet was also administered to the subjects. It was presented in attached form with FIAS. It provided the demographic details of the sample regarding their age, gender, family structure, socioeconomicstatus, parent's educationand academic achievement.

Procedure

Information about the children was gathered by the class teachers and parents/family member who is able to provide the full information about the child's behavioral and psychological functioning. For this purpose, the Federal Government (FG) Schools for girls and boys of Islamabad and Rawalpindi (mainly Gualmandi and Chacklala) and Islamabad Model Colleges both for girls and boys (IMCG, IMCB) were selected. Teachers were introduced with the main objectives of the research by the researcher through a brief introductory Seminar in which the importance of the role of teachers in identifying students with emotional disability was alsohighlighted.For data collection all the scales were presented in the form of booklet. Two booklets along with written instructions were prepared: one for teachers consisting of Teacher Rating Scale (TRS) (Form-T), and Scale-T of DAYS, and the other for parents and students consisting ofParent Rating Scale (PRS) (Form- P) along with bio-data sheet, the Scale-P of DAYS Scale-S, LSLS and Psychological Wellbeing Scale Affectometer-2 to be filled by students and their parents/care takers. Informed consent was taken from the parents (See Appendix -C).

Teacher selected the students according to the rank order on the annual examination result sheets (i.e., lowest five and top five). After selecting the target population the teachers filled the booklet 1 and sent the booklet 2 to the homes of the same students to be filled by the parents and students by themselves.

Parents and students were instructed by the teachers to read the instructions written for each scale carefully and try to attempt all the items and also fill the bio-data sheet by giving correct information.

The present study has attempted to identify the hidden disabilities: DEP, ANX and FI in children and adolescents with low academic achievement by making comparison with those having high academic achievement and also to find the relationship of these mental health disabilities with different demographic variables.

Statistical Analysis Plan of the Main Study

The main objective of the present study was to measure the comorbidity of DEP, ANX and FI in children and adolescents as well as to determine the relationship among all these variables as predictors of low academic achievement. It was assumed that these variables predict low academic achievement in children and adolescents. It was also assumed that student with low academic achievement have high level of emotional disturbance (DEP, ANX and FI) with low level of psychological wellbeing (PWB) and life satisfaction (LS).

To test these assumptions four types of analyses were applied to data. These analyses included:

1. The reliability estimates of all the scales used in the study was conducted.

2. A correlation matrix was computed in order to see the relationship among variables: depression, anxiety, psychological wellbeing, life satisfaction and functional impairment and low academic achievement. The purpose of the correlation matrix was to yield an initial insight into the pattern of relationships that might exist among the various variables.
3. Since all the variables involved were continuous variables, therefore, Pearson Product Moment Correlation Coefficients were computed as indices of the magnitude and direction of relationship among various variables.
4. Anova and t-test analysis for independent samples were computed to find the differences between low and high academic achievers on these variables as well as with respect to different demographic variables.
5. Finally, Multiple Logistic Regression Analysis was carried out to study the combined effect of depression, anxiety, psychological wellbeing, life satisfaction and functional impairment on low academic achievemen.The results obtained are as follows.

Results

Reliability Analysis. Although the reliability of newly constructed FIAS and all other scales used in the present study have already been established in the earlier Part II of the study with the sample of (N = 350). In this Part III which is also the main study an attempt has also made to further ascertain the reliability of the scales on a larger independent sample (*i.e.*, N = 410). For this purpose Cronbach Alpha Coefficients, inter-scale correlation, and split-half reliability coefficients have been calculated for all the scales. The detailed result is given as under.

Reliability Analysis of Functional Impairment Assessment Scale (FIAS). For the determination of reliability of FIAS, Cronbach Alpha Coefficients, inter-scale correlation, and split-half reliability coefficients have been calculated for it's both forms (Form-T and Form-P) separately.

Reliability of Teacher Rating Scale (TRS) (Form-T).

Cronbach's Alpha Coefficients of TRS.. Cronbach's Alpha Coefficient yielded an internal consistency coefficient of .94 for the entire 62-item TRS. For other sub-scales of TRS it ranged from .84 to .92 (Table 29). All these seem to be satisfactory reliabilities.

Table 29

Cronbach's Alpha Coefficient for FIAS (Form T) and its Subscales (N = 410)

Sub-scales	No. of Items	Alpha Coefficients
LBDS	23	.93
CDS	19	.90
ESD	11	.71
SDS	12	.79
Total TRS (Form-T)	62	.94

*Note.*LBDS = Learning Behavior Dysfunction Scale; CDS = Cognitive Dysfunction Scale; EDS = Emotional Dysfunction Scale; SDS = Social Dysfunction Scale; TRS = Teacher Rating Scale.

The Table 29 displays the reliability of TRS (Form-T) (i.e., $\alpha = .94$) which is very high and satisfactory which is also in line with the previous finding of Part I of the study.

Inter-scale Correlation Coefficient of TRS. The Inter-scale correlations of all the subscales with each other and with total TRS have also been calculated (See Table 30).

Table 30

The Inter-scale correlation of total and sub-scales of TRS (Form-T) (N = 410)

Measures	LBD-T	CDS-T	ESD-T	SDS-T	TRS-Total
LBDS	-	.54***	,49***	.72***	.90***
CDS		-	.45***	.54***	.80***
EDS			-	.59***	.67***
SDS				-	.82***
TRS-Total					-

*Note.*LBDS = Learning Behavior Dysfunction Scale; CDS = Cognitive Dysfunction Scale; EDS = Emotional Dysfunction Scale; SDS = Social Dysfunction Scale; TRS = Teacher Rating *Scale.*

The significantly positive correlation of the subscales of GLBS, CDS, EDS and SDS with each other and with the total TRS (Form-T) shows the internal consistency of all these scales.

Split-half Reliability of TRS. For calculating the split-half reliability coefficient, TRS was divided into two parts with 31 items in each part. The alpha reliability coefficient of Part I and Part II was found to be .90 and .94 respectively,

and Guttman split-half reliability coefficient was found to be .91 which is also quite satisfactory.

Reliability ofParent Rating Scale (PRS) (Form-P).

Cronbach's Alpha Coefficient of PRS. Cronbach's Alpha Coefficient yielded an internal consistency coefficient of .92 for the entire 60-item PRS (Form-P). For other sub-scales of PRS it ranged from .70 to .89 (Table 31). All these seem to be satisfactory reliabilities.

Table 31

Cronbach's Alpha Coefficient for FIAS (Form T) and its Subscales (N = 410)

Sub-scales	No. of Items	Alpha Coefficients
SDS	12	.76
CDS	23	.89
ESD	11	.70
LBDS-	15	.81
Total TRS (Form-P)	62	.92

Note. SDS = Social Dysfunction Scale; CDS = Cognitive Dysfunction Scale; EDS = Emotional Dysfunction Scale; LBDS = Learning Behavior Dysfunction Scale; TRS = Teacher Rating Scale

The Table 30 displays the reliability of PRS (Form-P) (i.e.,α = .92) which is very high and satisfactory which is also in line with the previous finding of Part I of the study.

Inter-scale Correlation Coefficient of PRS (Form-P). The Inter-scale correlations of all the subscales with each other and with total PRShave also been calculated (See Table 32).

Table 32

The Inter-scale correlation of total and sub-scales of PRS (Form-P) (N = 410)

Measures	SDS-P	CDS-P	ESD-P	LBD-P	PRS-Total
SDS	-	.55***	.48***	.69***	.80***
CSD		-	.44***	.51***	.87***
EDS			-	.50**	.66***
LBDS				-	.80***
PRS-Total					-

*Note.*SDS = Social Dysfunction Scale; CDS = Cognitive Dysfunction Scale; EDS = Emotional Dysfunction Scale; LBDS = Learning Behavior Dysfunction Scale; PRS = Parent Rating Scale.

$*p < .05$, $**p < .01$, $***p < .000$

The significantly positive correlation of the subscales of SDS, CDS, EDS and LBD-P with each other and with the total PRS (Form-P) shows the internal consistency of all these scales.

Split-half Reliability of PRS. For calculating the split-half reliability coefficient, PRS was divided into two parts with 30 items in each part. The alpha

reliability coefficient of Part I and Part II was found to be .9I and .93 respectively, and Guttman split-half reliability coefficient was found to be .92 which is also quite satisfactory.

Reliability of DAYS-U. As the urdu version scale *DAYS-U* has been used for the validation of FIAS in the Part II the reliability of DAYS-U has also been calculated with a sample of (N = 350) children and adolescents. As DAYS-U has been used in this Part of the present study for the measurement of the Emotional Disturbances in terms of depression and anxiety its alpha coefficients, split-half reliability have been further calculated with an independent sample of $N = 410$.

The alpha reliability of the three scales of the DAYS-U are: Scale S (.88); Scale T (.81) and Scale P (.84) which are very satisfactory.

Split-half Reliability Coefficients. The split-half reliability coefficients of all the scales of DAYS –U have yielded satisfactory results. These coefficients show that this scale is quite reliable to be used for the validation of FIAS as well as for measuring emotional disturbance in children and adolescents included in the study (See Table 33).

Table 33

Split-half Reliability Coefficients OF DAYS-U Scales (N = 410)

DAYS SCALES	Part-1	Part-11	Guttman Splithalf Reliability Coefficient
Scale S	.73	.90	.89
Scale T	..78	.85.	.87
Scale P	.80	.88	.82

Inter-scale correlation. The inter-scale correlation for DAYS-U has also been computed in the present study with *(N* = 410) (See Table 34).

Table 34

Inter-scale correlation of all the Scales of DAYS-U (N = 410)

DAYS-U	Scale S	Scale T	Scale P
Scale S	-	.76***	.79***
Scale T	-	-	.82***
Scale P	-	-	-

**p < .05, **p < .01, ***p < .000*

Reliability of Urdu Version of Psychological Well-being Affectometer-2 Scale. The Urdu Version of Psychological Well-being Affectometer-2 scale has been also used in the previous part of the study (Part-II) for the validation of FIAS and the reliability of well-being (Affectometer-2) calculated with a sample of (*N*=350)

children and adolescents were found to be very satisfactory. In the part III (the main study) this scale has also been used to assess the psychological wellbeing of the sample population. So once again the reliability of the Urdu version Scale of Well-being Affectometer (2) has been calculated with the sample of 410 students which is as under.

Table 35

Chronback's Alpha Reliability Coefficients Of Urdu Version Wellbeing (Affectometer-2) Scale (N = 410)

Sub-Scales	No of Item	Alpha Coefficients
Part-I	19	.86
Part-II	20	..89
Total	39	.93

The alpha reliability Coefficient of Urdu Version Wellbeing (Affectometer-2) Scale computed on the smple (N=410) has been found to be quite satisfactory i.e., .86 and .89 for its part 1 and part II respectively and .93 for the total scale.

Split-half Reliability. The split-half reliability coefficient of Urdu version scale of well-being (Affectometer-2) has been found to be .81 and .90 respectively for part I and part II and the Guttman split half reliability coefficient was found to be .88 which is quite satisfactory. These coefficients show that this scale is quite reliable to be used to meet the objectives of the present study. The inter-scale correlation for well-being affectometer-2 (Urdu version) has also been computed.

Inter-Scale Correlationof Well-being Affectometer-2 (Urdu version). The inter-scale correlation for Well-being Affectometer-2 (Urdu version) has also been computed in the present study with (*N = 410*) which is showing that a positive correlation exists between the parts of the scale. (See Table 36)

Table 36

Inter-scale correlation of Well-being (Affectometer-2) (*N* = 410)

Well-Being (Affectometer-2)	Part I	Part II	Total Well-Being
Part I	-	.70***	.83***
Part II	-	-	.94***
Well-Being (Affectometer-2)	-	-	-

*$p < .05$, **$p < .01$, ***$p < .000$

Table 37.i

Correlation Analysis among the Variables of Study with Sample Population of Low Academic Achievers (N = 205)

	Form-T	DAYS-S	DAYS-P	DAYS-T	SDS-P	CDS-P	EDS-P	LBDS-P	SDS-T	CDS-T	EDS-T	LBDS-T	PWB-1	PWB-2	C.DAYS	C.FIAS	C.PWB	LSDS
Form-P	.22**	.57***	.49***	.06	.83***	.81***	.67***	.80***	.20	.12	.12	.12	-.10	.09	.60***	.80***	-.00	-.02
Form-T		.20**	.26***	.62***	.24**	.13	.10	.33***	.76***	.75***	.62***	.82***	-.08	.07	.45***	.76***	-.00	-.08
DAYS-S			.39**	.04	.44***	.49***	.46***	.45***	.19	.15*	.09	.18**	-.00	.20	.85***	.50***	-.13	-.01
DAYS-P				.16*	.40***	.37***	.38***	.50***	.19	.19	.04	.29***	-.11	-.00	.70***	.49***	-.06	-.11
DAYS-T					.13	.00	.01	.14*	.45***	.37***	.50***	.56***	-.15	-.07	.43***	.42***	-.13	-.08
SDS-P						.60***	.53***	.70***	.25**	.13	.13	.21*	-.10	.09	.50***	.70***	-.03	-.03
CDS-P							.43***	.54***	.11	.13	.12	.21*	-.10	.09	.60***	.80***	-.00	-.09
EDS-P								.54***	.07	.05	.04	.11	-.00	.18	.48***	.50***	.12	-.02
LBDS-P									.33***	.11	.27***	.36***	-.18	.03	.55***	.74***	-.08	-.06
SDS-T										.45***	.52***	.63***	-.05	-.01	.36***	.60***	-.02	-.02
CDS-T											.32***	.38***	-.04	-.14	.30***	.55***	-.06	-.11
EDS-T												.39***	-.09	-.04	.25***	.48***	-.08	-.01
LBDS-T													-.08	.04	.42***	.67***	-.02	-.03
PWB-1														.39***	-.00	.13	.81***	.70***
PWB-2															.11	.11	.85***	.81***
C.DAYS																.70***	.01	-.05
C.FIAS																	-.00	-.03
C.PWB																		.68***
LSDS																		-

Note. DAYS- S=; Student self-Report of DAYS; DAYS- P= Parent Rating Scale of DAYS; DAYS-T= Teacher Rating Scale of DAYS; SDS-P = Social Dysfunction Scale of Form-P; CDS-P = Cognitive Dysfunction Scale of Form-P; EDS-P = Emotional Dysfunction Scale of Form-P; LBDS-P = Learning Behavior Dysfunction Scale of Form-P; SDS-T = Social Dysfunction Scale of Form-T; CDS-T = Cognitive Dysfunction Scale of Form-T; EDS-T = Emotional Dysfunction Scale of Form-T; LBDS-T = Learning Behavior Dysfunction Scale of Form-T; PWB = Psychological Wellbeing; LSDS = Life Satisfaction Ladder Scale.

Table 37.ii

Correlation Analysis Among the Variables of Study with Sample Population of High Academic Achievers (N = 205).

	Form-T	DAYS-S	DAYS-P	DAYS-T	SDS-P	CDS-P	EDS-P	LBDS-P	SDS-T	CDS-T	EDS-T	LBDS-T	PWB-1	PWB-2	C.DAYS	C.FIAS	C.PWB	LSDS
Form-P	.25***	.45***	.43***	.15*	.78***	.86***	.65***	.77	.13	.26***	.05	.30	.13	.04	.52***	.74***	-.05	-.01
Form-T		.13	.23***	.71***	.25***	.13*	.19*	.32***	.84***	.84***	.70***	.92***	-.17*	-.08	.45***	.83***	-.13	-.05
DAYS-S			.43***	.03	.35***	.40***	.41***	.31***	.08	.15*	.00	.14*	-.11	-.24	.83***	.34***	-.19	.07
DAYS-P				.13*	.34***	.35***	.30***	.35***	.15*	.19*	.09	.26***	-.01	.04	.72***	.40***	.03	.33
DAYS-T					.14	.03	.16	.23***	.55***	.58***	.68***	.66***	-.01	-.04	.45***	.59***	-.01	-.11
SDS-P						.51	.44***	.67***	.14*	.22**	.07	.29***	-.09	.03	.42***	.62***	-.03	-.02
CDS-P							.46***	.46***	.05	.18*	.06	.17***	.12*	-.04	.41***	.59***	-.07	-.07
EDS-P								.44***	.13*	.16**	-.06	.17***	-.12	-.04	.41***	.56***	.72***	-.13
LBDS-P									.20**	.23***	.19*	.35***	-.06	.03	.43***	.86***	.66***	-.33
SDS-T										.61***	.62***	.75***	-.14	-.05	.32***	.67***	-.11	-.12
CDS-T											.51***	.64***	-.12	-.65	.39***	.72***	-.08	-.44
EDS-T												.51***	.09	-.03	.26***	-.09	.51***	-.08
LBDS-T													-.19	-.12	.44***	.80***	-.17	-.03
PWB-1														.62***	-.07	-.18	.89***	-.11
PWB-2															-.16	-.05	.93***	-.08
C.DAYS																.60***	-.11	-.03
C.FIAS																	-.16	-.07
C.PWB																		.68***
LSDS																		-

Note; DAYS-S=; Student self-Report of DAYS; DAYS-P= Parent Rating Scale of DAYS; DAYS-T= Teacher Rating Scale of DAYS; SDS-P = Social Dysfunction Scale of Form-P; CDS-P = Cognitive Dysfunction Scale of Form-P; EDS-P = Emotional Dysfunction Scale of Form-P; LBDS-P = Learning Behavior Dysfunction Scale of Form-P; SDS-T = Social Dysfunction Scale of Form-T; CDS-T = Cognitive Dysfunction Scale of Form-T; EDS-T = Emotional Dysfunction Scale of Form-T; LBDS-T = Learning Behavior Dysfunction Scale of Form-T; PWB = Psychological Wellbeing; LSDS = Life Satisfaction Ladder Scale.

Table 38 *Correlation Analysis Among the Variables of Study with Sample Population of Low and High Academic Achievers (N = 410).*

	Form-T	DAYS-S	DAYS-P	DAYS-T	SDS-P	CDS-P	EDS-P	GBDS-P	SDS-T	CDS-T	EDS-T	GBDS-T	PWB-1	PWB-2	DAYS	FIAS	PWB	LSDS
Form-P	.28***	.52***	,47***	.17**	.80***	.87***	..66***	.80***	.20***	.21***	.10*	.30***	-.07	.01	.42***	.74***	-.01	-.04
Form-T		.16**	.23**	.71***	.29***	.16*	.18***	.36***	.82***	.80***	.67***	.90***	-.11	-.06	.55***	.77***	-.11	-.05
DAYS-S			.42***	.05	.40***	.46***	.44***	.38***	.14*	.16*	.06	.15	.07	.18	.80***	.36***	-.16	.09
DAYS-P				.15*	.36***	.37***	.33***	.44***	.17**	.19***	.06	.24***	-.03	.00	.62***	.50***	.07	.31
DAYS-T					.21***	.06	.14	.25***	.55***	.51***	.56***	.66***	-.03	-.05	.45***	.62***	-.01	-.11
SDS-P						.55***	.48***	.70***	.28***	.20***	.15*	.30***	-.04	-.02	.43***	.66***	-.06	-.02
CDS-P							.44***	.51***	.10*	.17**	.00	.17	-.08	-.01	.41***	.59***	-.02	-.04
EDS-P								.50***	.01	.13**	.06	.20***	-.02	-.11	.44***	.57***	.75***	-.12
LBDS-P									.29***	.20***	.23***	.40***	-.06	-.01	.53***	.76***	.67***	-.37
SDS-T										.54***	.60***	.72***	-.10	-.05	.32***	.67***	-.11	-.12
CDS-T											.45***	.55***	-.09	-.01	.36***	.62***	-.08	-.33
EDS-T												.50***	-.08	-.04	.29***	-.04	.59***	-.18
LBDS-T													-.11	-.09	.55***	.70***	-.14	-.03
PWB-1														.60***	-.02	-.13	.90***	-.12
PWB-2															-.06	-.11	.93***	-.08
DAYS																.70***	-.11	-.01
FIAS																	-.06	-.06
PWB																		.68***
LSDS																		-

Note. DAYS-S=; Student self-Report of DAYS; DAYS-P= Parent Rating Scale of DAYS; DAYS-T= Teacher Rating Scale of DAYS; SDS-P = Social Dysfunction Scale of Form-P; CDS-P = Cognitive Dysfunction Scale of Form-P; EDS-P = Emotional Dysfunction Scale of Form-P; LBDS-P = Learning Behavior Dysfunction Scale of Form-P; SDS-T = Social Dysfunction Scale of Form-T; CDS-T = Cognitive Dysfunction Scale of Form-T; EDS-T = Emotional Dysfunction Scale of Form-T; LBDS-T = Learning Behavior Dysfunction Scale of Form-T; PWB = Psychological Wellbeing; LSDS = Life Satisfaction Ladder Scale.

Correlation Analysis

Correlations were computed between all the measures of the study to determine the relationship among variables of the study. Results are shown in the Tables 37 to 38. The result shows that among the sub-scales of Form-P the Social Dysfunction Scale (SDS) exhibited a high positive correlation with the total Form-P ($r = .83, p < .000$). Similarly this scale is also positively correlated with the Form-T the Teacher Rating Scale (TRS) but here the magnitude is low i.e., ($r = .24, p < .01$). This shows that though both the forms are inter-related and measure the same construct but in different situations i.e., school and home environment.

The difference in magnitude of the correlation value indicates that children and adolescents have different social behavior in the school environment. i.e., children are more shy, and quite and behave passively in school among their peers as compared to their home environment. Similarly the Learning Behavior Dysfunction Scale (LBDS) has exhibited a high positive correlation with the total Form-T ($r = .82$, $p < .000$) but the same scale has shown low correlation with Form-P ($r = .12, p < .05$) indicating the difference of learning behavior of children and adolescents with low academic achievement in classroom and home environment.

The two Forms (P & T) have exhibited negative correlation with Wellbeing and Life Satisfaction Scales i.e., (r =.-00, &.-02 with Form-P and r = -.00 & -.08 with Form-T respectively) indicating a zero or no relationship. This shows that individuals with functional impairment are not satisfied with their lives and possess very low psychological wellbeing.

The result has further confirmed the discriminent validity of the FIAS an indigenous scale newly developed in the Part-I of the present study. Same result has

been emerged for the other sub-scales e.g., EDS, and CDS of both the Forms which exhibited high correlation with the Forms to which these sub-scales belong but have negative or zero correlation with the Psychological wellbeing Affectometer-2 and with Life Satisfaction Ladder Scale (LSLS).

All sub-scales along with the total scales TRS and PRS are positively related to each other and with the DAYS-U. With DAYS-U (Urdu translation) FIAS (Functional Impairment Assessment Scale) has shown a positive relationship i.e., (r = .70, $p < .000$) which also has confirmed the convergent validity of FIAS with DAYS-U. The DAYS-U has also shown the negative or no correlation with the Wellbeing Affectometer-2 i.e., (r = -.08) and with Life Satisfaction Ladder Scale (LSLS) it is r = -.01 which is a desired direction. So far as the three scales of DAYS-U are concerned Scale-S has shown a positive relation with the Scale-P *i.e.,*(r = .39,$p < .000$) but it has shown no relationship *(i.e., r = .04)* with the Scale-T which is equivalent to zero.

The result indicates that in the sample population with high academic achievement (N = 205) there exists no relationship between the DAYS-T and DAYS-S i.e., r = *.03.* i.e., teacher's rating is different from that of student's self rating. This indicates that teachers did not rated high the individuals with high academic achievement on depression and anxiety scale.

A similar result has been found with the sample population with high and low academic achievement (N = 410). This result is exactly in line with the finding of authors (Phyllis, et al., 1994) of the scale DAYS who reported that students with Learning Disability perceive themselves as much depressed and anxious as do children without disabilities but their teachers rated them higher in depression. So the present results have confirmed our two main hypotheses stating:

1. There will be a comorbidity of emotional disturbance (DEP & ANX) and FI in children and adolescents with low academic achievement.
2. Low academic achievement will be positively related to the emotional disturbance (DEP & ANX) and FI but will be negatively related to the psychological well-being and life satisfaction in children and adolescents.

Difference between Children and Adolescents with High / Low Academic Achievement on Depression, Anxiety, Psychological Well-being, Life Satisfaction and Functional Impairment Scales. With respect to the academic achievement whole the sample was divided into two main groups namely Group I consisting of students (N = 205) showing low academic achievement and who had been failed or acquired the last five positions of their classes and *Group II* consisting of students (N = 205) showing high level of academic achievement, who usually become first in their class or acquire the first five positions in the class. All the students included in the sample were referred by the class teachers. Screening of mental health difficulties in the Group I was carried out with the help of instruments such as newly developed FIAS along with a bio-data sheet for the assessment of functional impairment, Urdu version of DAYS translated in the present study for the measurement of emotional problems and WBS Affectometer-2 for the measurement of the psychological well-being. In order to get a clear picture of mental health difficulties a comparison of Group I was made with the Group II with respect to the age, gender and other demographic risk factors such as Low socioeconomic status, maternal low education, marital discord and divorce in parents etc.

Functional Impairment and Academic Achievement. For the measurement of functional impairment boththe Forms of FIAS have been administered on the both the groups.The results obtained from the Form T and Form Pare as under:

Table 39

Academic Achievementwise difference on the total and sub-scales of (TRSForm-T) (N = 410)

	Academic Achievement					
	Group I (n = 205)		Group II (n = 205)			
	M	*SD*	*M*	*SD*	*t*	*p*
LBDS	71.48	17.64	55.87	20.08	-8.29	,001
CDS	43.15	13.85	37.43	13.22	-4.26	.543
EDS	24.70	7.15	22.70	6.93	-2.87	.686
SDS	45.88	7.01	42.86	8.12	-4.12	.012
TRS	170.40	34.40	144.50	40.14	-6.951	001

df = 408.

*Note.*LBDS = Learning Behavior Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, SDS= Social Dysfunction Scale,,TRS= Teacher Rating Scale.

The Table 39 shows that there is a significant difference *(t=-6.951, df = 408, p <.01)* among the two groups on the total and subscales of the Form T of FIAS. Further the table also shows that Group I has high mean score in the total Form-T (i.e., M = 170.40, SD = 3.40) as compared to Group II (i.e., M =144, SD =40.14) which means that Group I with low academic achievement has impaired learning behavior and functional impairment in the domains of emotional, social and cognitive functioning.The result from Form P has been shown in the following Table 40.

Table 40

Academic Achievementwise difference on the total and sub-scales of (PRS) (Form-P) ($N = 410$)

	Academic Achievement					
	Group I ($n = 205$)		Group II ($n = 205$)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
SDS	24.14	7.98	21.34	6.64	-3.862	.014
CDS	57.46	17.25	54.44	16.92	-1.783	.005
EDS	23.97	7.35	2I.98	6.41	-3.050	.050
LBDS	35.88	10.35	31.36	9.48	-4.454	.001
PRS	152.02	36.77	139.78	32.76	-3.562	.000

df = 408.

*Note.*SDS= Social Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, LBDS = Learning Behavior Dysfunction Scale,, PRS= Parent Rating Scale.

The Table 40 shows the same trend as shown by the Table 30 (i.e., of Form T) that there is a significant difference ***(t=-3.562, df = 408, p <.01)*** among the two groups on the total and subscales of Form Pof FIAS. Further the table shows that Group I has high mean score in the total Form-P (i.e., M =152.02, SD =36.77) as compared to Group II (M =139, SD =32.76). The same trend has been seen from Tables 30 to 31 in the mean scores of both the groups on the sub-scales of Form-T and Form-P of FIAS revealing that the students in Group I show low learning behavior and high emotional / social and cognitive dysfunction than the students in the Group II.

Emotional disturbance (DEP & ANX) and Academic Achievement. Emotional Disturbance with regard to the academic achievement of the Group I and Group II with the sample of ($N = 410$) were measured by DAYS-U.

Table 41

Academic Achievement wise difference on the total and sub-scales of Urdu version of DAYS ($N = 410$)

	Academic Achievement					
	Group I ($n = 205$)		Group II ($n = 205$)			
	M	*SD*	*M*	*SD*	*t*	*p*
Scale T						
Depression	5.23	2.01	3.06	1.10	4.56	.002
Anxiety	5.12	1.94	4.73	2.32	3.78	.031
Total	10.33	3.02	8.04	2.02	4.34	.073
Scale S						
Depression	13.02	5.22	11.03	3.20	6.41	.030
Anxiety	11.04	4.71	10.78	2.14	3.55	.022
Total	24.06	6.03	21.01	5.34	7.86	.031
Scale P						
Depression	5.32	1.66	3.12	2.21	3.63	.001
Anxiety	5.12	1.94	3.73	1.32	4.78	.014
Social Maladjustment	6.81	2.13	3.24	1.07	5.16	.011
Total	19.75	3.21	10.18	3.53	13.49	.021

Table 41 shows that there is asignificant differencein the t-test of Scale-S(t= 4.34, df = 408, p <..031), on Scale T (t= 7.86, df = 408, p <..003) and on Scale P (t=13.49, df = 408, p <..021) which means there is a difference in the level of DEP and ANX among students with low academic performance in their subjective rating

and in the perspective of their teachers and parents there is also a difference in the level of symptoms of depression and anxiety in both the groups. The mean score of the Group I was found to be higher than Group II on Scale P, Scale T and Scale S of DAYS-U (i.e., M =19.75, M =10.33, M =24.06 of Group I and M =10.18, M =8.04, M =21.01 of Group II respectively) which indicates that Group I is subjected to more co-existing Emotional / Social problems such as anxiety, depression and social maladjustment.

The same trend had been seen in previous Table 31 which shows that the mean scores of the Group I are higher than Group II on the subscales EDS and SDS of Form-T and Form-P of FIAS and there is also a significant difference in the t-scores. i.e., for Form-P (*t=--3.562, df = 408, p <.01)* and for Form-T *(t=-6.951, df= 408, p <.01).*

These results are in accordance with the early findings which state that youngsters with co-morbidity of DEP, ANX and FI perform more poorly than others in school, score lower on standard achievement tests, are rated by their teachers as doing less well academically, and have lower levels of grade attainment (Cole et al., 1996, See also Wagner, 1995). Further, overall intellectual potential of depressed and anxious youngsters is comparable to the potentially of those who are not depressed suggesting that association between severity of depression and children's overall intellectual performance is weak (Kovacs, Feinberg, Crouse-Novak, 1984; Kovacs, 1997).

The *t*-scores of DAYS-U on all of its scales have been found to be significant results on the basis of which our sub- hypothesis No 2 has been confirmed saying that

students with low academic achievement score high on DAYS-U as compared to their classmates with high academic achievement.

Hence according to T-test analysis on FIAS (see Tables 30) our main hypothesis has been confirmed which states:

"*Students with low academic achievement have comorbidity of emotional disturbance in terms of depression and anxiety and functional impairment as compared to their class mates with high academic achievement.*"

Further, since DAYS-U had been used to establish the convergent validity of newly constructed scale FIAS in Part II of the current study, here in the main study once again the attempt has been made to measure the construct validity of FIAS and in the light of means scores once again the results have established the convergent validity of FIAS total and its sub-scales Emotional Dysfunction Scale, Cognitive Dysfunction Scale, Social Dysfunction Scale and Learning Behavior Dysfunction Scale on the variable of academic achievement.

Psychological wellbeing and academic achievement. The measurement of psychological wellbeing in two groups Group 1 and Group IIwas carried out by using the scale the Urdu Version Psychological Wellbeing Scale Affectometer 2 on only secondary school students with the sample of $N = 350$ as the primary school students especially those belonging to 6-8 years of age were not given the scale to respond because it was found difficult for them to comprehend the constructs and conceptspresented in Urdu Version of Psychological Wellbeing Scale Affectometer 2. Rather Life Satisfaction Ladder Scale was administered on these students. See Table 42and 43 for primary students.

Table 42

Academic Achievement wise difference on Well-being Scale Affectometer-2 (Urdu version) ($N = 310$)

	Academic Achievement					
	Group I ($n = 155$)		Group II ($n = 155$)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
Part I	34.37	8.10	53.24	9.04	1.20	.051
Part II	46.43	13.11	54.12	13.12	.29	.033
Total	80.80	21.21	107.36	13.05	-1.24	.001

df = 308

Table 42 shows that there is a significant difference *(t=-1.04, df= 84, p <.01)* between the two groups The low mean score (M =80.80) of Group I illustrates that the students with low academic performance have low psychological wellbeing than Group II who's mean score is (M =107.36) which is quite higher. Along with psychological wellbeing life satisfaction scale was also administered on the whole sample including children less than 10 years of age. The result is as under.

Table 43

Academic Achievement wise difference on Life Satisfaction Ladder Scale (N = 410)

	Life Satisfaction Ladder Scale			
Academic Achievement	*M*	*SD*	*t*	*p*
Group I(n = 205)	5.40	2.13		
			9.123	.000
Group II(n = *205)*	7.02	1.45		

df = 408

Table 43 shows that the mean score of the Group I (M =5.40, SD =2.13) is lower than the Group II which is M =7.02, SD =1.45 on the Life Satisfaction Scale and there is a significant difference (t=-1.04,df= 84, p <.01)in t-scores. This means that children and adolescents with low academic achievement have less life satisfaction as compared to those who have high academic achievement.Therefore, in the light of the results shown in the Tables 33-34 our hypothesis regarding academic achievement nd psychological well-being has been confirmed which states: Students with low academic achievement have low sense of Psychological well-being and life satisfaction as compared to their classmates with high academic achievement.

Further, since these scales were basically used to establish the disceriminant validity of newly constructed scale FIAS in Part II of the current study, here in the main study once again the attempt has been made to measure the construct validity of FIAS and once again the results have established the discriminant validity of FIAS total and its sub-scales Emotional Dysfunction Scale, Cognitive Dysfunction Scale, Social Dysfunction Scale and Learning Behavior Dysfunction Scale on the variable of academic achievement.

The Difference between Children and Adolescents on the Comorbidity of Depression, Anxiety and Functional Impairment with Reference to Demographic Variables

The level of DEP, AXN, FI and PWB as a function of demographic variables such as age, gender, family structure, marital discord, socioeconomical status, and maternal education of the children and adolescents with/without academic achievement has also been examined. The detail of results is given bellow.

Age. Results regarding the relationship of Age with Functional Impairment, Emotional Disturbance (DEP & ANX) and Psychological Wellbeing in children and adolescents are as follows.

Functional Impairment and Age. In order to determine the level of Functional Impairment (FI) in different age groups the entire sample was divided into three categories such as from 6 to 10 years (children) (n = 120) and from 11 to 13 years (Pre-Adolescents) (n =135) and from 14 to 19 years (Adolescents) (n = *160*). For the determination of the difference between the three groups with respect to their Functional Impairment (FI) ANOVA was applied on the scores of total and sub-scales of both Form-T and Form-P of FIAS (See Table 44 to 43).

Table 44

Age wise difference on the total and sub-scales of (PRS)(Form-P) (N = 410)

	Age (in Years)					
	Children 7 to 10 years (n = 120)		Pre-Adolescents 11 to 13 years (n = 130)		Adolescents 14 to 19 years (n = 160)	
Subscales	*M*	*SD*	*M*	*SD*	*M*	*SD*
SDS	22.17	7.33	22.47	7.44	23.92	7.13
CDS	58.47	16.13	53.77	17.73	58.20	15.74
EDS	21.93	6.13	22.64	7.10	25.03	7.31
LBDS	31.19	10.11	33.33	9.85	37.06	9.34
PRS Total	144.01	35.29	143.12	35.88	154.72	31.32

*Note.*SDS= Social Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, LBDS = Learning Behavior Dysfunction Scale,, PRS= Parent Rating Scale.

Table 45

Age wise difference on the total and sub-scales of (PRS)(Form-P) (N = 410)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	2	7618.752	3809.376	3.122	.001
With Groups	407	1498131.09	1223.909		
Total	409	505749.82			

The results in the Tables (44-45) show that there is a significant difference $F,(2,409) = 3.112, p < .01$ among the three age groups on the total and subscales of the Form-P of FIAS. The mean scores of the three groups: Children, Pre-Adolescents, and Adolescent in the total Form-P are M =144.01, SD =35.29, M =143.12, SD =35.88,

and M =154.72, SD =31.32 respectively. It has been seen that the Adolescents with age range (14-19) years have the highest score which means that this group has high level of functional impairment and emotional disturbance. The information received from the teachers through TRS (Form-T) depicted the similar result, (see Tables 46-47).

Table 46

Age wise difference on the total and sub-scales of (TRS)(Form-T) (N = 410)

	Age (in Years)					
	Children 7 to 10 years (n = 120)		Pre-Adolescents 11 to 13 years (n = 130)		Adolescents 14 to 19 years (n = 160)	
Subscales	*M*	*SD*	*M*	*SD*	*M*	*SD*
SDS	43.21	8.48	44.37	7.67	45.90	6.56
CDS	40.28	14.96	39.83	13.54	40.44	12.64
EDS	23.56	7.06	23.45	7.39	24.26	7.05
LBDS	60.94	24.01	62.48	19.50	68.49	16.02
PRS Total	153.59	46.82	155.69	38.12	163.47	30.17

Note. SDS= Social Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, LBDS = Learning Behavior Dysfunction Scale,, PRS= Parent Rating Scale.

Table 47

Age wise difference on the total and sub-scales of (TRS)(Form-T) (N = 410)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	2	4657.370	2132.925	1.479	.000
With Groups	407	640759.73	1574.348		
Total	409	645417.10			

The results in the Tables (46-47) show that there is a significant difference $F,(2,409) = 1.479$, $p < .01$ among the three age groups on the total and subscales of the Form-T of FIAS. The mean scores of the three groups: Children, Pre-Adolescents, and Adolescents in the total Form-T are: M =153.59, SD =46.82, M =155.69, SD =38.12, and M =163.47, SD =30.17 respectively. Tables show that the mean scores of Adolescents are higher than the other two groups on the Forms-T total as well as on its sub-scales. This means that high school and college students have more functional impairment in the domains of social, emotional and cognitive functioning which in turn results in the impairment of their learning behavior due to which their academic performance becomes low. This result has been found to be in line with theearlier findings. For example, National Longitudinal Transition Study (NLTS) analysis showed a high rate of school dropout, failure in annual examination, lack of confidence and social skills, and involvement in delinquent behaviors among the high school youth (Wagner, Amico, Marder, New-man, & Blackorby, 1992).

According to One-way analysis (ANOVA),our hypothesis No. 1 from the sub hypothesis category of the main study that the Students within the age group of 14 to 15 years show high level of functional impairment and low learning behavior as compared to the students of other age groups has been confirmed.

Emotional Disturbance (DEP & ANX) and Age. Emotional Disturbance with regard to the age with the sample of (N = 410) was measured by:

1. Urdu version of Depression and Anxiety in Youth Scale (DAYS-U)
2. Subscales especially DS, AS and SDS of the Functional Impairment Assessment scale (FIAS)

The previous Tables explain the existing trend for the incidence of the Emotional Disturbance in the children and adolescents with low academic achievement. The result shows that there is a significant difference in the mean scores of the Children, Pre-Adolescents and Adolescentson the subscales (DS, AS and the SDS) of Form-T and Form-P of FIAS. The same trend has been seen when measurement was made with the separate scale DAYS-U newly translated in to Urdu in the part one of the present study.

The DAYS-U results have also established the construct validity of FIAS in the main study for the second time. The DAYS-U results have been shown in the following Table 44.

Table 48

Age wise difference on the total and sub-scales of DAYS-U(N = 410)

	Age (in Years)					
	Children 7 to 10 years (n = 120)		Pre-Adolescents 11 to 13 years (n = 130)		Adolescents 14 to 19 years (n = 160)	
Subscales	*M*	*SD*	*M*	*SD*	*M*	*SD*
Scale T						
Depression	3.02	2.22	4.03	2.20	6.41*	5.47
Anxiety	5.04*	2.11	4.75	2.24	3.55	1.21
Total	7.06	2.77	8.78	2.83	9.96	2.80
Scale S						
Depression	12.22	3.21	13.43	3.38	15.98*	4.36
Anxiety	18.70*	4.38	17.47	5.11	16.14	3.32
Total	31.02	6.77	30.80	5.78	32.12	7.37
Scale P						
Depression	5.32	1.66	5.12	2.21	6.63*	1.67
Anxiety	5.12 *	1.94	4.73	2.32	4.78	2.10
Social	4.81	1.13	5.24	1.07	5.16	1.01
Maladjustment						
Total	12.75	3.21	14.18	3.53	15.49	3.37

Table 49

Age wise difference on the total and sub-scales of DAYS-U (N = 410)

Source	*df*	*SS*	*MS*	*F*	*p*
Scale S					
Between Groups	2	104.487	52.244	4.733	.001
Within Groups	407	3830.381	11.039		
Total	409	1910.899			
Scale T					
Between Groups	2	16.535	8.267	1.121	.327
Within Groups	407	2538.036	7.378		
Total	409	2554.571			
Scale P					
Between Groups	2	14.452	52.467	3.421	.253
Within Groups	407	3830.567			
Total	T409	3943.862			

Table 48 and 49 showthat there is a significant difference F,(2,409) = 4.733, p < .01 in the scale S of DAYS-U but there is no significant difference on the other two scale (P & T). This result is exactly in line with the earlier findings.

Another reason could be that in our South Asian society the adolescents especially girls do not share their subjective feeling of negative affect to their parents or teachers due to which they could not provide the exact information regarding the depressive symptoms of these children and adolescents. So far as the mean scores of

all the three groups regarding age of the sample population is concerned there is a big difference in that the mean scores of the Adolescents (14 to 19 years) were found to be high as compared to the other two groups. On Scale P the mean score for Children, Pre-Adolescents and Adolescents are$M$ =2.75, SD =3.21, M =14.18, SD =3.53, M =15.49, SD =3.37respectively. The same trend has been found in the results of the other two scales: Scale T (M = 7.06, SD = 2.77, M = 8.78, SD = 2.83, M = 9.96, SD = 2.80) and Scale S (M = 31.02, SD = 6.77, M = 30.80, SD = 5.78, M = 32.12, SD = 7.37) which indicates that adolescents are subjected to more psychosocial Emotional Disturbance. There areother interesting findings which are perspicuous in the mean scores of DAYS-U on its all scales regarding the age groups i.e., children have the highest mean scores on sub scale of anxiety (Anxiety Scale) whereas the adolescents scored higher on the sub scale of depression (Depression Scale) as compared to the other two groups on the three scale (Scale S, Scale T and Scale P) (see Table 34 with steric* on the values) .The early findings indicate that parents in many societies perceive that as the children grow they are more likely to feel depression but they show less inattentivness and hyperactivityr. These results are also in accordance with the DSM-1V according to which Anxiety Disorders are more common in childhood. Associated with more physiological symptoms and worry.

Hence in the light of the significant result on Scale S and the pattern of mean scores we can say that these results have confirmed our twosub hypothesis i.e., No.4 saying that "older adolescents within the age group of 14 to 19 years score high on the Depression and Anxiety scales as compared to the students of the 7 to 10 age groups" and No 5 which states that "The primary school students with age group (7 to 10 years) score high on the particularly Anxiety Scale whereas the high school / college

students score high on depression scale as compared to the students of other age groups."

Psychologica Wellbeing and Age. The measurement of psychological wellbeing in different age groups was carried out by using the scale the Urdu Version Psychological Wellbeing Scale Affectometer 2 and Life Satisfaction Ladder Scale. The results were also used to confirm the construct validity (Discriminent) of the FIAS for the second time (See Table 50).

Table 50

Age wise difference on Well-being Scale Affectometer-2 (Urdu version) ($N = 310$)

	Age (in Years)					
	Pre-Adolescents 11 to 13 years ($n = 160$)		Adolescents 14 to 19 years ($n = 150$)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
Part I	53.17	9.15	51.42	7.14	3.654	.002
Part II	54.32	10.13	52.41	11.46	4.421	.001
Total	107.49	19.28	103.83	8.30	6.351	.000

df =308

Table 51

Age wise difference on Life Satisfaction Ladder Scale ($N = 410$)

	Age (in Years)					
	Children 7 to 10 years ($n = 120$)		Pre-Adolescents 11 to 13 years ($n = 130$)		Adolescents 14 to 19 years ($n = 160$)	
Scale	*M*	*SD*	*M*	*SD*	*M*	*SD*
LSLS	6.96	1.67	6.08	1.94	5.08	1.9

Note. LSLS = Life Satisfaction Ladder Scale.

Table 52

Age wise difference on the Life Satisfaction Ladder Scale ($N = 410$)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	2	288179.41	144089.707	123.041	.000
Within Groups	407	406362.86	1171.075		
Total	409	694542.27			

Table 52 show that there is significant difference between the mean scores of two groups (pre-adolescents and adolescents) on Urdu version of Wellbeing Affectometer 2 *(t=6.351,df=408, p <,01). Similarly* Tables 47-48 also show a highly significant difference among the scores of the three groups (i.e., Children, pre-adolescents and adolescents) on Life Satisfaction Scale F,*(2,409) =123.041, p <.01.* However, the lower mean score for the Adolescents suggests that adolescents at the agebetween14 to 19 are more emotionally disturbed and feel low level of psychological wellbeing and also do not perceive their life satisfactory.In the light of

these results our sub- hypothesis No 9saying that"adolescents of 14 to 19 years will score low on psychological wellbeing and life satisfaction scale as compared to the students of other age groups"has been accepted. Further the result on Well-being Scale Affectometer-2 (Urdu version) and Life Satisfaction Ladder Scale has also established the discriminant validity of FIAS and its sub-scale of Cognitive Dysfunction (CD), and Social Dysfunction (SD), Emotional Dysfunction (ED) and Learning Behavior Dysfunction (LBD) on the demographic variable of age.

Gender. The determination of the Emotional Disturbance (DEP & ANX) and FI in yound population as a function of gender difference has also been performed. The results are as follows.

Functional impairment and gender. In order to determine the level of Functional Impairment (FI) with regard to the gender the whole sample was divided into two groups boys (n = 189) and girls (n = 221).T-test was applied on the scores of total and sub-scales of both Form-T and Form-P of FIAS (See Tables 53 to 54).

Table 53

Gender wise difference on the total and sub-scales of (PRS)(Form-P) (N = 410)

	Gender					
	Boys (n = 189)		Girls (n = 221)			
	M	*SD*	*M*	*SD*	*t*	*p*
SDS	24.77	7.56	21.74	7.17	3.839	.090
CDS	56.36	18.24	55.36	16.64	.402	.149
EDS	24.40	6.73	22.20	6.93	2.965	.968
LBDS	35.78	10.30	32.36	9.87	3.183	.523
PRS	153.07	36.34	142.21	34.21	2.877	.466

df=408

Note.SDS= Social Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, LBDS = Learning Behavior Dysfunction Scale,, PRS= Parent Rating Scale.

Table 54

Gender wise difference on the total and sub-scales of (TRS)(Form-T) (N = 410)

	Gender					
	Boys (n = 189)		Girls (n = 221)			
Sub-Scales	*M*	*SD*	*M*	*SD*	*t*	*p*
SDS	45.20	7.04	43.92	7.77	1.76	.727
CDS	42.18	12.82	39.18	14.1	2.23	.042
EDS	24.44	7.98	23.32	6.71	2.11	.047
LBDS	67.60	9.30	61.17	20.71	1.24	.040
Form-T	163.71	37.93	153.40	40.12	2.412	.432

df = 408.

Note. SDS= Social Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, LBDS = Learning Behavior Dysfunction Scale,, PRS= Parent Rating Scale.

The results in the Tables 53-54 portray the difference between the performances of the sample population on the Functional Impairment Assessment Scale (FIAS) Form P and Form T with respect to Gender. The results display a non significant difference. The same trend has been found in the sub scales of Form P and T which means that there is no effect of Gender on the school performance and functional impairment and its domains of social, emotional, and cognitive functioning. However the results show higher mean scores of boys on both the forms as compared to girls i.e., on Form-T boys have (*M* =*163.71*, *SD* =37.93) and girls (*M* =153.40, *SD* =40.12) and on Form-P boys have (*M* =153.07, *SD* =38.34) and girls have (142.21, *SD* = 34, 21).

Hence according to t-test analysis our hypothesis No 7 '*Adolescent boys show high level of Functional Impairment (FI) as compared to the girl students of their age mates.*' has not been confirmed. This means that there is no difference in the prevalence of functional impairment among girls and boys.

Emotional Disturbance (DEP & ANX) and Gender Difference. Comorbidity of Depression and Anxiety with regard to the gender with the sample of (*N* = 350) were measured by:

1. Urdu version Scale DAYS-U.
2. Subscales especially EDS and SDS of the Functional Impairment Assessment scale (FIAS) (Form P & Form T)

The following Table 51 portrays the difference between the performances of the sample population on the DAYS-U with respect to Gender.

Table 55

Gender wise difference on the total and sub-scales DAYS-U (N = 410)

Sub-Scales	Gender Girls (*n* = 221) *M*	*SD*	Boys (*n* = 189) *M*	*SD*	*t*	*p*
Scale T						
Depression	6.42*	2.67	5.03	2.20	6.41	3.47
Anxiety	3.04	1.71	4.78	1.14	3.55	1.21
Total	9.06	3.03	10.01	3.34	7.86	2.80
Scale S						
Depression	14.22*	4.21	13.43	3.38	14.08	4.36
Anxiety	13.30	4.38	15.47	5.11	16.14	3.32
Total	28.02	7.77	32.80	7.78	30.20	5.37
Scale P						
Depression	5.82*	1.66	5.12	1.21	6.63	1.67
Anxiety	3.12	2.04	3.73	3.32	4.78	2.10
Social Maladjustment	4.81	1.13	5.24	1.07	5.16	1.01
Total	12.75	3.21	14.18	3.53	13.49	3.37

According to t-score shown in Table 55 there is a non- significant difference in the mean scores of the two groups i.e., boys and girls on the performance of DAYS-U.

The same trend has been found in the all scales (S, T, & P) which means that there is no effect of Gender on the comorbidity of depression and anxiety or the presence of emotional disturbance i.e., there is no difference in the presence of

symptoms of depression and anxiety in girls and boys. .However the results showthat boys have high mean score in the total Scales (S, T, & P) of DAYS-U which indicates that adolescent boys are subjected to more negative affectivity when they pass from their primary school into secondary school. The same trend has been seen when measurement was made with the separate Form-T and Form-P of FIAS in which the boys scored higher on the subscales: emotional dysfunction (EDS) and social dysfunction SDS). But we have seen a different pattern of mean scores of boys and girls on the sub scale of depression (DS) of the three scales (S, T & P) of DAYS-U. Table show that girls have higher mean score on sub scale of depression on all the three scales as compared to boys (see satiric "*" on the mean scores of girls on all scales) which means girls experience more symptoms of depression whereas boys who have higher mean scores on the total three scales have more comorbidity of emotional problems in the domains of depression, anxiety and social maladjustment than girls. These results are in accordance with the early findings that level of comorbidity of different mental problems such as depression, anxiety, conduct or substance abuse disorders in adolescents is high (Angold & Costello, 1993) and that girls between 13-16 years age score higher on depressive disorders, whereas boys in score higher on emotional and behavioral problems. Hence in the light of the results of t-analysis we reject our sub-hypothesis No. 7 saying that "Adolescent boys exhibit signs of comorbidity of DEP, ANX and FI as compared to their age mate girls. This means that there is no difference in the incidence of comorbidity of emotional problems such as depression and anxiety with reference to gender among children and adolescents with academic problems. The current research holds that girls also show comorbidity of DEP, ANX and social maladjustment. The only difference that exists

is on the level or degree of severity of symptoms on the whole or on some specific areas i.e., DEP/ ANX. As results showed that girls scored higher on sub scale: depression scale (DS) of all the three scales of DAYS-U therefore in the light of results of present research and support of the existing literature review we accept our sub- hypothesis No. 8 which states that "Girls show significantly high level of symptoms of depression as compared to the boy students of their age mates."

Psychological Wellbeing and Gender. The measurement of psychological wellbeing in two groups (boys and girls) was carried out by using the scale the Urdu Version Psychological Wellbeing Scale Affectometer 2 (See Table 56).

Table 56

Gender wise difference on Well-being Scale Affectometer-2 (Urdu version) ($N = 410$)

	Gender					
	Boys Group ($n = 189$)		Girls Groups ($n = 221$)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
Part I	51.37	9.10	50.22	7.14	2.10	.038
Part II	53.33	10.11	52.12	8.16	1.29	.098
Total	105.00	19.21	102.44	15.30	-1.04	.000

df =308

Table 57

Gender wise difference on Life Satisfaction Ladder Scale ($N = 410$)

	Gender					
	Boys Groups ($n = 189$)		Girls ($n = 221$) Groups			
	M	*SD*	*M*	*SD*	*t*	*p*
LSLS	8.14	2.14	6.33	1.14	-3.124	.001

df =408

Table 56-57show that there is significant difference (t = -1.04, df =408, p <.01) on Wellbeing affectometer 2 and (t=3,214, df = 408,p<.01) on Life Satisfaction Scalebetween the scores of boys and girls. According to Table 41 there is difference between the mean scores of two genders. The girl students have lower mean score (M = 102.44, SD =15.30) than boys (M = 105.00, SD = 19.21).

Table 48 also exhibit the lower mean score for the girls on the life satisfaction scale.. This means that girls feel low level of psychological wellbeing and also do not perceive their life satisfactory. Studies reveal that psychological wellbeing is negatively correlated with depression. As girls usually show more depressive symptoms they also tend to report low level of psychological wellbeing (Fujita, Diener, & Sandvik, 1991).

Hence in the light of these results our sub- hypothesis No 9 saying that "Girls show significantly low psychological well being and life satisfaction as compared to the boy students of their age mates" has been accepted. Further the result on Well-being Scale Affectometer-2 (Urdu version) and Life Satisfaction Ladder Scale has also established the discriminant validity of FIAS and its sub-scale of Cognitive

Dysfunction (CD), and Social Dysfunction (SD), Emotional Dysfunction (ED) and Learning Behavior Dysfunction (LBD) on the demographic variable of age.

Socioeconomic status. Comorbidity of Emotional Disturbance ED, Functional Impairment FI and Psychological Wellbeing PWB has also been measured as a function of demographic variable such as socioeconomic status in children and adolescents with low academic achievement. In order to achieve the objective of the study the sample has been divided into four groups with respect to their monthly income as Low Socioeconomic Status (LS) (*N = 96*) with income up to 20,000 Rs, Low Middle (LMS) (*N =154*) with income from 21,000 to 30,000 Rs, High Middle (HMS) (*N = 129*) with income from 31,000 to 60,000 Rs, and High Socioeconomic Status (HS) (*N = 31*) with income more than 60,000 Rs.

Socioeconomic Status and Functional Impairment (FI). For the determination of the difference between the fourgroups with respect to their Functional Impairment (FI), ANOVA was applied on the scores of total and sub-scales of both Form-T and Form-P of FIAS. (See Table 58 to59)

Table 58

Socioeconomic Status wise difference on the total and sub-scales of (PRS)(Form-P) ($N = 410$)

	LS (n=96)		LM S (n=154)		HMS (n=129)		HS (n=31)	
Subscales	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
LBDS	35.55	10.13	34.15	10.35	31.57	10.01	31.32	9.09
CDS	59.57	18.01	55.78	17.94	53.40	15.80	52.62	15.65
EDS	24.47	6.82	23.43	7.95	21.60	6.10	21.62	5.26
SDS	24.57	7.88	22.92	8.00	21.39	6.60	21.60	5.83
PRS	155.23	37.02	147.24	38.28	138.48	30.18	138.44	28.95

*Note.*LS= Low Socioeconomic Status, LMS = Low MiddleScioeconomic Status, HMS = High Middle Scioeconomic Status, HS = High Scioeconomic Status., LBDS = Learning Behavior Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, SDS= Social Dysfunction Scale, PRS= Parent Rating Scale.

Table 59

Socioeconomic Status wise difference on the total and sub-scales of (PRS)(Form-P) ($N = 410$)

Source	*Df*	*SS*	*MS*	*F*	*p*
Between Groups	3	12581.956	4193.985	6.415	.000
Within Groups	406	226199.33	653.757		
Total	409	238791.84			

Table 60

Socioeconomic Status wise difference on the total and sub-scales of (TRS)(Form-T) ($N = 410$)

Subscales	LS (n=96)		LMS (n=154)		HMS (n=129)		HS (n=31)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
LBDS	68.46	20.02	65.16	19.82	6I.55	21.60	6I.23	21.02
CDS	42.41	14.27	41.00	13.40	38.09	13.38	38.77	15.27
EDS	24.47	7.95	23.99	6.68	22.45	8.90	22.21	6.34
SDS	45.15	7.71	44.48	7.50	43.34	8.05	42.76	7.56
TRS	166.00	40.00	160.05	37.78	147.79	39.44	143.64	38.45

Note. LS= Low Socioeconomic Status, LMS = Low Middle Scioeconomic Status, HMS = High Middle Scioeconomic Status, HS = High Scioeconomic Status., LBDS = Learning Behavior Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, SDS= Social Dysfunction Scale, PRS= Parent Rating Scale.

Table 61

Socioeconomic Status wise difference on the total and sub-scales of (TRS)(Form-T) ($N = 410$)

Source	*Df*	*SS*	*MS*	*F*	*p*
Between Groups	3	13798.024	4599.341	10.318	.000
Within Groups	407	152892.66	445.751		
Total	408	166690.69			

The results in the above Tables 58 to 61 show that there is a significant difference $F(3,408) = 10.318$, $p < .01$ on Form-T and $F(3,408) = 6.415$, $p < .01$ of FIAS

on Form-P among the socioeconomic status wisegroups with respect to the monthly income..Themean scores of LS, LMS, HMS, HS on PRS are: M = 155.23, SD =37.02, M =147.24, SD = 38.24, M =138.48, SD =30.18, M =138.44, SD = 28.95 respectively. Similarly the mean scores of LS, LMS, HMS, HS on TRS are: M = 166.00, SD =40.00, M =160.05, SD = 37.78, M =147.79, SD =39.44, M =143.64, SD =38.45 respectively.

The same trend has been seen in the mean scores of all the groups on the five sub-scales of Form-T and Form-P of FIAS.

This result is also in line with the evidence given by the literature which explains that children living in poverty manifest more symptoms of mental health problems as these become aggravated due to frustration, stress, and poor physical health (Conger, Conger, Mathew, & Elder, 1999; Kloep, 1995; Lempers, Clark-Lempers, & Simmons, 1989).

According to One-way (ANOVA) analysis our sub- hypothesis No.10 regarding the variable of socioeconomically status has been confirmed which states that: *There is comorbidity of DEP, ANX and FI in the children belonging to the families with low socioeconomic status as compared to the children belonging to the families with moderate or high socioeconomic status.*

Emotional disturbance (depression & anxiety) and socioeconomic status. Emotional disturbance with regard to the Socioeconomic Statuswith the sample of (N = 410) were measured by:

1. Urdu version of Depression and Anxiety in Youth Scale (DAYS-U)

2. Subscales especially EDS and SDS of both the forms of Functional Impairment Assessment scale (FIAS)

The result shown in the above Tables (58-61) reveals that there is a significant difference in the mean scores of the four groups of target population with respect to the socioeconomic status on the sub-scales (EDS and SDS) of Form-T and Form-P of FIAS. The same trend has been seen when measurement was made with the scale DAYS-U newly translated in to Urdu in the part one of the present study. The DAYS-U results have also established the construct validity of FIAS in the main study on the demographic variable of socioeconomic status of children and adolescents.

The DAYS-U results have been shown following.

Table 62

Socioeconomic Status wise difference on the total and sub-scales of DAYS-U (N = 410)

Sub-Scales	LS (n = 96)		LMS (n = 154)		HMS (n = 129)		HS (n = 31)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Scale S								
Depression	13.67	4.60	12.98	4.20	13.05	4.03	12.46	4.08
Anxiety	18.77	5.36	18.47	5.18	17.61	3.90	18.08	4.33
Total	32.45	9.20	31.46	8.40	30.66	6.95	29.10	6.31
Scale P								
Depression	5.73	1.69	5.20	1.74	4.84	1.38	4.84	1.12
Anxiety	3.24	2.23	3.30	2.11	2.72	2.07	2.93	1.87
Social Maladjustment	4.96	1.11	4.90	1.12	5.12	1.12	5.19	.93
Total	13.94	3.52	13.30	3.60	12.69	3.0	11.96	2.44
Scale T								
Depression	6.33	2.51	6.14	2.29	5.55	2.27	5.15	1.91
Anxiety	3.58	1.51	3.70	1.20	3.64	1.17	3.80	1.20
Total	9.91	2.85	9.84	2.72	9.19	2.64	8.96	2.32

Note. LS= Low Socioeconomic Status, LMS = Low Middle Scioeconomic Status, HMS = High Middle Scioeconomic Status, HS = High Scioeconomic Status.

Table 63

Socioeconomic status wise difference on the total and sub-scales of Urdu version of DAYS-U ($N = 350$)

Source	*df*	*SS*	*MS*	*F*	*p*
Scale S					
Between Groups	2	104.487	52.244	4.733	.001
Within Groups	325	3830.381	11.039		
Total	339	1910.899	8.267		
Scale T					
Between Groups	2	16.535	7.378	1.121	.000
Within Groups	344	2538.036	52.467		
Total	346	2554.571	13.243		
Scale P					
Between Groups	2	143.452		3.421	.000
Within Groups	347	830.567			
Total	349	3943.862			

Tables 62 and 63 show that there is a significant difference in the mean scores of all the groups on the variable of socioeconomically status. The mean scores on all the three scales of DAYS-Uare such as; on Scale-S mean scores of for four groups LS, LMS, HMS, HS are$M$ =32.45, M =31.46, M =30.66, and M =29.10 respectively on Scale P are M =13.94, M =13.30, M =12.96, M =11.29 respectively and on third subscale Scale T the mean scores are: M =9.91, M =9.84, M =9.19, M =8.96 respectivelyshowing the higher level of emotional disturbance in students from the families with low income group were as compared to the students belonging to others groups. These findings are also in line with the earlier findings which hold that the consequences of financial or economic strain, undermines all the negative effects on adolescent adjustment, which are manifested in increase in anxiety and depression, conduct problems and diminished school performance (Conger, Patterson, & Ge, 1995).

Psychological Wellbeing and Socioeconomic Status. The measurement of psychological wellbeing in the four groups regarding socioeconomic status was carried out by using the scale the Urdu Version of Psychological Wellbeing Scale Affectometer 2. The results were also used to confirm the construct validity (Discriminent) of the FIAS for the second time. (See Table 64)

Table 64

Socioeconomic Status wise difference on Well-being Scale Affectometer-2 (Urdu version) ($N = 310$)

Sub-Scales	LS (n=59)		LMS (n=98)		HM S (n=29)		HS (n=24)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Part I	52.63	10.36	53.68	10.30	52.43	10.43	55.33	6.41
Part II	54.32	11.12	54.96	10.14	53.80	10.03	55.42	8.59
Total	106.95	10,16	108.64	10.18	106.23	11.13	110.75	8.89

Note. LS= Low Socioeconomic Status, LMS = Low Middle Scioeconomic Status, HMS = High Middle Scioeconomic Status, HS = High Scioeconomic Status

Table 65

Socioeconomic Status wise difference on the total and sub-scales of Well-being Scale Affectometer-2 (Urdu version) ($N = 310$)

Source	*Df*	*SS*	*MS*	*F*	*p*
Between Groups	2	288179.41	144089.707	123.041	.002
Within Groups	407	406362.86	1171.075		
Total	408	694542.27			

Table 66

Socioeconomic Status wise difference on Life Satisfaction Ladder Scale ($N = 410$)

Measure	LS (n=96)		LMS (n=154)		HMS (n=129)		HS (n=31)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
LSLS	5.85	2.14	6.21	2.12	6.51	1.69	6.65	1.97

Note. LS= Low Socioeconomic Status, LMS = Low Middle Scioeconomic Status, HMS = High Middle Scioeconomic Status, HS = High Scioeconomic Status

Table 67

Socioeconomic wise difference on the Life Satisfaction Ladder Scale ($N = 410$)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	3	30.527	10.176	2.650	.000
Within Groups	406	1558.878	3.840		
Total	409	1589.405			

Tables 65-67 show that there is significant difference between the scores of the four groups on Well-being Scale Affectometer-2 (Urdu version) as well as on Life Satisfaction Ladder Scale. However, the lower value of mean scores (M =106.95, SD =10.16) on Well-being Scale Affectometer-2 (Urdu version) and (M =5.85, SD = 2,14) on LSLS for the LSES suggests that adolescents belonging to the families with low socioeconomic status (LS) have low sense of psychological well-being. Another interesting finding has also emerged from these tables that students belonging to High Middle Socioeconomic status have also low score almost equal to those pertaining to

the Low socioeconomic status (i.e., M =106.23, SD =11.13) on Well-being Scale Affectometer-2 (Urdu version). The reason with reference to our Pakistani society could be that people belonging to families with high middle socioeconomic status are mostly educated and do Government jobs and have more awareness and may also have their achievement motive very high but due to limited resources to satisfy their psychological needs they may have feelings of frustration or deprivation.

Further the result on *Well-being Scale Affectometer-2 (Urdu version)* has also established the discriminant validity of FIAS and its sub-scale, on the demographic variable of SES.

These results shown in Tables (65-67) with One-way (ANOVA) analysis have confirmed our Sub-hypothesis No. 11 which states that "*There is comorbidity of depression, anxiety, functional impairment and low level of psychological well-being in the children belonging to the families with low socioeconomic status as compared to the children belonging to the families with moderate or high socioeconomic status.*"

Academic Year (Class). Present research also purports to measure DEP, ANX and FI the in students regarding their acaemic year or class by using scales or instruments of the study such as FIAS, DAYS-U, Urdu version of PWB Affectometer-2, and LSLS.

In order to achieve the desired objective of the study whole sample was divided into three main academic groups of students namely Group-A(N = 103) consisting of students who are in 1 to 5 class with the age range of (6-10) years, Group-B (N = 135) consisting of students studding in class (6-8) with the age range of

(11-13) years, and Group-C(N = 172) consisting of students studding in class (9-14) with the age range of (14-19) years.

Results regarding the relationship of academic year with functional impairment, depression anxiety and psychological wellbeing in children and adolescents are as follows.

Functional Impairment and Academic Year. For the determination of the difference among the three groups (A, B, & C) with respect to their Functional Impairment (FI) ANOVA was applied on the scores of total and sub-scales of both Form-T and Form-P of FIAS (See Table 68-70).

Table 68

Academic Year wise difference on the total and sub-scales of (TRS) (Form-T) (N = 410)

	Academic Years					
	Groups-A (n = 103)		Group-B (n = 135)		Group-C (n = 172)	
Subscales	*M*	*SD*	*M*	*SD*	*M*	*SD*
SDS	43.51	8.51	44.49	7.70	45.28	6.15
CDS	40.28	15.04	40.04	13.44	39.70	12.48
EDS	23.51	6.71	23.63	6.40	24.62	7.47
LBDS	61.44	23.61	62.88	19.52	67.44	16.22
TRS	154.41	45.95	156.48	38.17	160.81	29.84

Note. SDS= Social Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, LBDS = Learning Behavior Dysfunction Scale,, TRS= Teacher Rating Form.

Table 69

One Way Analysis ANOVA of Academic Year wise difference on the (TRS) (Form-T) ($N = 410$)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	2	1611.080	805.540	.509	.601
Within Groups	407	643806,02	1581.833		
Total	409	645417.10			

Table 70

Academic Year wise difference on the total and sub-scales of (PRS)(Form-P) ($N = 410$)

	Academic Years					
	Groups-A ($n = 103$)		Group-B ($n = 135$)		Group-C ($n = 172$)	
Subscales	*M*	*SD*	*M*	*SD*	*M*	*SD*
SDS	22.61	7.68	22.28	7.32	24.07	7.101
CDS	58.53	17.27	35.36	17.13	59.61	15.32
EDS	22.44	6.87	22.47	6.85	25.85	6.96
LBDS	32.25	11.00	33.08	9.68	36.93	9.07
PRS	146.54	34.57	142.14	34.57	155.91	29.97

Note. SDS= Social Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, LBDS = Learning Behavior Dysfunction Scale,, PRS= Parent Rating Scale.

Table 71

One Way Analysis ANOVA of Academic Year wise difference on the total (PRS)(Form-P) (N = 410)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	2	8864.308	4432.151	3.630	.027
Within Groups	407	496885.54	675.839		
Total	409	505749.80			

The results in the Tables (68-71) show that there is a significant difference among the three groups on the total and subscales of PRS (Form-P) of FIAS i.e., $F(2,409) = 3.630$, $p < .05$. The mean scores of the Group A, B and C in the total Form-Pare: $M = 145.54$, $SD = 37.54$, $M = 142.14$, $SD = 34.57$ and $M = 155.91$, $SD = 29.97$ respectively. Table 64-65also show that there is a significant difference among the three groups on the total and subscales of TRS (Form-T) of FIAS i.e., $F(2,409) = 4.580$, $p < .05$. The mean scores of the students of the three groups in the total Form-T are: $M = 154.41$, $SD = 45.96$, $M = 156.48$, $SD = 38.17$ and $M = 160.81$, $SD = 29.84$ respectively. Table 66-67 show that the mean values occur in ascending fashion in which the mean scores of Group-C students are high as compared to other two groups on the TRS and PRS. This means that mental health difficulties developed in the early years and became severe later on and there emerged a gradual change associated with the functional impairment in the behavior and school performance as children reached in the higher classes which is also evident through the high mean scores of the high school and college students (Group-C).The same trend has been seen in the mean scores of all the groups on the sub-scales of Form-P and Form-T of

FIAS revealing that students of the High school show low learning behavior and have more emotional problems, have more cognitive dysfunction and also have more social or interpersonal problems.These results are in accordance with what literature review has demonstrated. For example the findings of Forgan and Vaughn (2000) state that the students show considerable amount of decline in their academic performance or grades. This means that as the child with mental health difficulty passes in to higher academic years his/her grades drop and his/her school performance decreases gradually.

According to One Way (ANOVA) analysis our sub- hypothesis No.11stating that" Incidence of level of comorbidity of functional impairment and emotional disturbance is high among High school Students" has been confirmed.

Level of Emotional Disturbance among children and adolescents of Group A, B and C with respect of their academic year was also measured on with the same sample of ($N = 410$) by: DAYS-U. Results have been described below.

Emotional Disturbance and Academic Year. Tables No's 69-72 explained the existing trend for the incidence of the comorbidity of Functional Impairment (FI) and Emotional Disturbance (ED) in the children and adolescents with respect to their academic years according to which there is a significant difference in the mean scores of the three groups (primary, middle and secondary) students on the subscales (EDS and SDS) of Form-T and Form-P of FIAS. The same trend has been seen when measurement was made with the separate scale DAYS-U newly translated in to Urdu in the part one of the present study. The results with DAYS-U have also established the construct validity of FIAS in the main study for the second time. For the

determination of the difference among the three groups with respect to their emotional disturbance in terms of depression and anxiety One Way Analysis ANOVA was applied on the scores of total and sub-scales of DAYS-U (Urdu version of DAYS). The results have been shown in the following Tables (73-74).

Table 73

Academic Year wise difference on the total and sub-scales of Urdu version of Depression and Anxiety in Youth Scale (DAYS-U) ($N = 410$)

	Academic Years					
	Groups-A ($n = 103$)		Group-B ($n = 135$)		Group-C ($n = 172$)	
Subscales	*M*	*SD*	*M*	*SD*	*M*	*SD*
Scale T						
Depression	5.88	2.24	6.04	2.47	6.41	2.47
Anxiety	4.65	1.33	3.78	2.24	4.55	1.21
Total	8.69	2.67	9.88	2.83	10.86	2.70
Scale S						
Depression	12.54	3.70	13.22	4.36	14.40	4.85
Anxiety	17.93	4.66	19.40	4.69	18.23	4.78
Total	30.75	7.75	31.61	7.91	33.86	8.44
Scale P						
Depression	5.15	1.65	6.10	2.21	6.89	2.67
Anxiety	4.12	1.99	5.13	2.32	4.55	2.10
Social Maladjustment	5.24	1.13	5.64	1.27	6.54	1.01
Total	12.15	3.19	13.41	3.76	14.56	3.35

Table 74

Academic Year wise difference on the total and sub-scales of Urdu version of Depression and Anxiety in Youth Scale (DAYS-U) (N = 410)

Source	*df*	*SS*	*MS*	*F*	*p*
Scale S					
Between Groups	2	331.680	165.840	2.590	.076
Within Groups	347	22219.017	64.032		
Total	349	22550.697			
Scale T					
Between Groups	2	16.704	8.352	1.132	.324
Within Groups	344	2537.867	7.378		
Total	346	2554.571			
Scale P					
Between Groups	2	73.921	36.961	3.322	.037
Within Groups	347	3860.947	11.127		
Total	349	3943.869			

Tables 73-74 show that there is a non-significant difference in the scores of all the three groups regarding academic year of the sample population on the three DAYS-U scales (S, T and P). This means that all the students with low academic achievement suffer from emotional disturbance regardless of their academic year or in which class they are studding. According to this result our Sub-hypothesis No.12 has been rejected which states that "High school students with academic problems have more emotional problems (depression & anxiety) than the primary school students with low academic achievement"

But we have noticed that there is a considerable difference in their means scores. i.e., on Scale- T the mean scores of Group-A, Group-B and Group-C are M =8.69,SD =2.64;M =9.88, SD = 2.83 and M =10.86, SD = 2.70 respectively. On the

Scale-S: *M* =30.75, *SD* =7.75; *M* =31.61, *SD* = 7.91 and*M* = 33.86, *SD* = 8.44 respectively and on Scale- P: *M* =12.15, *SD* = 3.19; *M* =13.41, *SD* = 3.76 and *M* =14.56, *SD* = 3.35 respectively.There is a similar trend in the results of all the scales Scale T and Scale S and Scale P which indicates that the mean scores of Group-C are high as compared to the other two groups. This means that students of high school and college are subjected to moreEmotional Disturbance i.e., are more anxious, have more depressive feelings and have more interpersonal or social problems. This result is in consensus with the early findings which state that most of the adolescents face difficulties due to transition i.e., when they enter in their high school.This transition involves major environmental changes for students which may lead to some mental health difficulties(Forgan & Vaughn,2000).

Psychological Well-being and Academic Year. The measurement of psychological wellbeing in students of year (8-14) with low / high academic performance were carried out by using the scale the Urdu Version Psychological Wellbeing Scale Affectometer 2 with the sample of *N = 310.* For the measurement of psychological wellbeing the primary school children under 10 years have not been included in this sample due to non availability of research evidence for Urdu Version Psychological Wellbeing Scale Affectometer 2 of being used on the primary school children. The measurement of psychological wellbeing in the primary school children has been carried out by using another scale the Life Satisfaction Ladder Scale (LSLS) (For results see the following section).

One Way Analysis of variance ANOVA has been computed on the Psychological Wellbeing Scale (Affectometer2) scores of target population. The

sample has been divided into three groups: Group-A (Year 6-8 students), Group-B (Year 8-12 students) and Group-C (Year 13-14 students). The results were also used to confirm the construct validity (Discriminent) of the FIAS for the second time. (See Tables , 75-78).

Table 75

Academic Year wise difference on Well-being Scale Affectometer-2 (Urdu version) (N = 310)

	Academic Years					
	Groups-A (n = 100)		Group-B (n = 110)		Group-C (n = 100)	
Subscales	*M*	*SD*	*M*	*SD*	*M*	*SD*
Part I	53.10	8.21	51.42	7.24	51.23	7.01
Part II	54.42	10.12	52.56	11.33	50.33	8.41
Total	106.52	20.35	102.67	8.30	103.41	12.70

Table 76

Academic Year wise difference on the total and sub-scales of Well-being Scale Affectometer-2 (Urdu version) (N = 310)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	2	277179.42	134088.705	123.043	.003
Within Groups	407	446362.61	1171.075		
Total	409	723542.03			

Table 77

Academic Year wise difference on Life Satisfaction Ladder Scale ($N = 410$)

	Academic Years					
	Groups-A ($n = 103$)		Group-B ($n = 135$)		Group-C ($n = 172$)	
Subscales	*M*	*SD*	*M*	*SD*	*M*	*SD*
LSLS	6.97	1.87	6.54	1.94	5.98	1.95

Note. LSLS = Life Satisfaction Ladder Scale

Table 78

*Academic Year wise difference on the*Life Satisfaction Ladder Scale ($N = 410$)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	2	83.142	41.571	11.233	.000
Within Groups	407	1506.263	3.701		
Total	409	1589.405			

Tables77-78 show that there is significant difference between the scores of the three groups on Well-being scale i.e., F (2,409) = 123.043, p <.05.. However, the low value of mean score for the students of secondary classes suggests that adolescents at the age between 11 to 15 years have low sense of psychological wellbeing.

The previous Tables also show the similar results with the Life Satisfaction Ladder Scale (LSLS) that there is a highly significant difference i.e., F (2,409) = 11.233, P <.01 among the scores of three groups on the LSLS. Table 77 shows that the mean score of the Group-C is the lowest one explaining that high school and

college students being more emotionally disturbed have low feelings of life satisfaction as compared to other groups.

This result is also in line with the early researches conducted on the high school students (as mentioned previously) according to which the rate of prevalence of emotional disturbance is very high among high school students. In the light of existing research evidence and the current results our sub-hypothesis No.13saying *"High school students report low sense on psychological wellbeing and life satisfaction as compared to the primary students or college student"*has been confirmed.

Further the result on *Well-being Scale Affectometer-2 (Urdu version)* has also established the discriminant validity of FIAS and its sub-scale on the demographic variable of academic year.

Maternal Education. The present study also attempts to measure the relationship of the maternal education with the emotional disturbance of the children and adolescents. For this purpose the sample has been grouped in four groups with regard to the maternal education i.e., group of uneducated mothers (n = 162) with no schooling, Less educated mothers (n = 121) who are up to matriculation Educated mothers (n = 85) who areGraduate and group of highly educated mothers (n = 42) who have Master degree or above.

For the determination of the difference among the three groups with respect to their Functional Impairment (FI) ANOVA was applied on the scores of total and sub-scales of both Form-T and Form-P of FIAS.

Table 79

Maternal Education wise difference on the total and sub-scales of (TRS)(Form-T) (N = 410)

	Maternal Education							
	Uneducated (n = 162)		Less Educated (n = 121)		Educated (n = 85)		High Educated (n = 42)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
LBDS	36.31	10.01	35.56	10.65	33.57	9.67	31.83	9.09
CDS	54.56	19.41	53.83	18.04	53.70	17.80	52.02	16.08
EDS	25.76	7.82	22.63	7.95	22.60	6.10	21.62	5.96
SDS	24.57	8.92	23.92	8.00	21.39	6.60	20.60	5.83
TRS	158.23	39.02	156.75	36.77	148.78	30.56	147.86	30.95

Note. LBDS = Learning Behavior Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, SDS= Social Dysfunction Scale, TRS= Teacher Rating Scale.

Table 80

Maternal Education wise difference on the total and sub-scales of (TRS)(Form-T) (N = 410)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	4	29147.968	7286.992	4.789	.001
Within Groups	407	616269.13	1521.652		
Total	409	645417.10			

The results in the Tables 80 shows that there is a significant difference i.e., $F(4,409) = 4.789$, $p < .01$ among the four groups of children and adolescents as a function of their maternal education on the Form-T of FIAS. Table 79 shows the mean scores and standard deviations of the four groups on the total Form-T which are: $M = 158.23$, $SD = 39.02$; $M = 156.75$, $SD = 36.77$; $M = 148.78$, $SD = 30.56$; M

=147.86, *SD* = 30.95. The highest mean score is of the children and adolescents of uneducated mothers which is *M* =158.23.

Table 81

Maternal Education wise difference on the total and sub-scales of (PRS)(Form-P) (N = 410)

	Maternal Education							
	Uneducated (n = 162)		Less Educated (n = 121)		Educated (n = 85)		High Educated (n = 42)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
LBDS	34.51	9.14	34.95	10.35	31.57	10.67	30.33	9.09
CDS	57.57	18.41	54.89	17.54	53.70	16.80	52.02	15.00
EDS	25.41	6.82	23.43	7.95	21.60	6.10	21.62	5.26
SDS	23.57	7.92	21.92	8.00	21.39	6.60	20.60	5.83
PRS	154.23	36.23	147.24	37.27	143.58	29.18	137.94	27.95

Note. LBDS = Learning Behavior Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, SDS= Social Dysfunction Scale, PRS= Parent Rating Scale.

Table 82

Maternal Education wise difference on the total and sub-scales of (PRS)(Form-P) (N 410)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	4	10321.559	2580.390	2.109	.001
Within Groups	405	495428.29	1223.280		
Total	409	505749.84			

The results in the Tables 82 shows that there is a significant difference i.e., $F(4.409) = 2.109$, $p < .0I$ among the four groups of children and adolescents as a function of their maternal education on the Form-P of FIAS. Table 81 shows the mean scores and standard deviations of the four groups on the total Form-P which are:$M = 154.23$, $SD = 36.23$; $M = 147.24$, $SD = 37.27$; $M = 143.58$, $SD = 29.18$; $M = 137.94$, $SD = 27.95$. The highest mean score is of the children and adolescents of uneducated mothers which is $M = 154.23$.

The high mean scores of the group 1 (uneducated mothers) indicate that children of the uneducated mothers have some deficits in their cognitive, social, emotional and academic functioning.

The same trend has been seen in the mean scores of all the groups on the five sub-scales of Form-T and Form-P of FIAS revealing that students in this group show low learning behavior. Whereas low mean scores of children pertaining to fourth group reveal that children of highly educated mothers have good learning behavior as compared to the children's of uneducated or low educated mothers.

These results are in accordance with what literature review that has demonstrated that educated parents especially mothers are the active participants in the development of psychosocial and cognitive competencies of their children. Parents are their children's first and most important teachers, and for students to succeed in school, parents must participate actively in their children's academic lives (DePlanty, Coulter-Kern, & Duchane, 2007).

According to One-way analysis (ANOVA), our sub- hypothesis No.14 stating that "Children of uneducated mothers have more signs of comorbidity of DEP, ANX and FI as compared to the children of educated mothers" has been confirmed.

Emotional Disturbance (DEP &ANX) and Maternal Education. Level of Emotional Disturbance in children and adolescents as a function of their maternal education was measured with the sample of (N = 410) byUrdu version of Depression and Anxiety in Youth Scale (DAYS-U).

The DAYS-U results have also established the construct validity of FIAS in the main study for the second time. (See Table 83)

Table 83

Maternal Education wise difference on the total and sub-scales of DAYS-U (N = 410)

	Maternal Education							
	Uneducated (n = 162)		Less Educated (n = 121)		Educated (n = 85)		High Educated (n = 42)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Scale T								
Depression	6.38	2.47	5.33	2.10	5.43	2.01	5.20	2.00
Anxiety	4.73	1.37	4.38	1.34	3.78	1.27	3.56	1.27
Total	10.19	2.74	9.88	2.63	9.21	2.37	8.45	1.98
Scale S								
Depression	13.54	4.10	13.22	4.31	13.01	4.13	12.46	3.68
Anxiety	18.93	4.70	18.78	5.09	17.23	4.76	17.07	4.64
Total	32.75	7.75	31.71	8.31	30.86	8.74	30.31	7.89
Scale P								
Depression	5.43	1.67	4.89	1.56	4.93	1.10	4.01	1.01
Anxiety	3.03	2.18	3.08	2.10	2.93	1.80	2.46	1.47
Social Maladjustment	5.98	1.13	4.94	1.08	4.54	1.17	4.31	1.12
Total	13.75	3.55	12.98	3.24	12.06	2.35	11.87	2.01

Table 84

Maternal Education wise difference on the total and sub-scales of DAYS-U (N = 410)

Source	*df*	*SS*	*MS*	*F*	*p*
Scale S					
Between Groups	2	29.653	14.315	.221	.802
Within Groups	347		64.905		
Total	349				
Scale T					
Between Groups	2	66.639	33.319	4.607	.511
Within Groups	344	2487.932	7.232		
Total	346	2554.571			
Scale P					
Between Groups	2	21.705	10852	.962	.383
Within Groups	347	3913.164	11.277		
Total	349	3934.869			

Table 84 explains that there is no significant difference in the scores of four groups on the Scales S (t = .221, df =409, p = .802), Scale- P (t= 4.607, df = 409, p =.511) & Scale- T (t = .962, df = 409, p = .383) of DAYS-U. It advocates that individual state of emotional disturbance is not affected by the mother's education.

Table 83 shows means scores and standard deviation of the four groupsas a function of maternal education. On Scale Tthe mean scores are:M =10.19, M =9.88,M =9.21 and M = 8.45respectively; on Scale S are: M =32.75, M =31.71,M =30.86 and M = 30.31 respectively; and on Scale P are: M =13.75, M =12.98,M =12.06 and M = 11.87 respectively. The mean scores of the Group 1 on all the scales of DAYS-U were found to be high as compared to the other two groups which indicate that children of uneducated mothers have more emotional problems as compared to other children of educated mothers. This result also shows the existing trend of the high mean scores of the group 1 indicating the incidence of the ED in the children and adolescents of

uneducated mothers.The same trend has been seen when measurement was made with the Subscales especially EDS, and SDS of the Functional Impairment Assessment scale (FIAS).

Further, once again the results on DAYS-U has appeared to establish the Convergent validity of FIAS and its sub-scale of on the demographic variable of maternal education.

Psychological wellbeing and maternal education. In order to test the hypothesis regarding the maternal education and PWB in children and adolescents the Urdu Version of Psychological Wellbeing Scale Affectometer 2 has been used. The results were also used to confirm the construct validity (Discriminent) of the FIAS for the second time (See Table 85).

Table 85

Maternal Education wise difference on Well-being Scale Affectometer-2 (Urdu version) ($N = 310$)

	Maternal Education							
	Uneducated ($n = 162$)		Less Educated ($n = 121$)		Educated ($n = 43$)		High Educated ($n = 21$)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Part I	50.86	13.06	51.75	8.91	53.09	9.98	54.73	9.67
Part II	52.24	10.88	53.77	8.57	54.39	10.16	55.62	8.18
Total	102.20	10.24	103. 59	11.12	104. 84	12.67	105.35	12.97

Table 86

Maternal Education wise difference on the total and sub-scales of Well-being Scale Affectometer-2 (Urdu version) ($N = 310$)

Source	*df*	*SS*	*MS*	*F*	*p*
Between Groups	2	377179.43	124089.705	113.043	.003
Within Groups	336	446362.61	1181.075		
Total	338	823542.04			

Table 85-86 show that there is significant difference between the scores of the four groups on Well-being scale. The mean scores of the children of uneducated, educated and highly educated are: M =102.20, M =103.59, M =104.84 and M =105.35 respectively. However, the lowest value of mean score of Group 1 suggests that Children and adolescents of uneducated mothers are more emotionally disturbedand hence possess low sense of psychological well-being.. Further the result on *Well-being Scale Affectometer-2 (Urdu version)* has also established the discriminant validity of FIAS and its sub-scale.of FIAS, on the demographic variable of maternal education..

Our findings on the variable of maternal education are in line with the existing research evidence which holds the view that children of uneducated mothers usually show symptoms of mental health difficulties and low sense of Psychological Well-being (PWB) whereas the children of educated mothers are well adaptive and show less emotional/behavioral, social and academic problems.

It has been found that in families where mothers are highly educated they usually work and provide financial support. Due to increased income from the women's participation the financial standards of family may improve which is also associated with less problem behavior in children and adolescents (Furstenberg, Morgan, & Allison, 1987).

In the light of these results our sub- hypothesis No 15 have confirmed which states that *Children of uneducated mothers are likely to have low sense of PWB as compared to the children of educated and highly eduated mothers.*

Family structure. The present study also attempts to measure the emotional disturbance of the children and adolescents as a function of their family structure. For this purpose the sample has been broken in to two categories: *children living in: Intact Family (N = 307)*, and Single or mother-only families (*N* = 103). This group consisted of mothers who were either divorced or their spouse had died.

Family Structure and Functional Impairment. For the determination of the difference among the two groups their on Functional Impairment (FI) T-test was applied on the scores of total and sub-scales of both Form-T and Form-P of FIAS (See Table 87 & 88).

Table 87

Family Structure wise difference on the total and sub-scales of (PRS)(Form-P) (N = 410)

	Family Structure					
	Single Parent Family (n = 103)		Intact Family (n = 307)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
LBDS	29.79	6.04	32.02	5.40	-2.49	.013
CDS	30.05	8.31	27.46	7.68	1.13	.043
EDS	29.44	7.98	27.32	7.23	2.19	.011
SDS	34.37	9.25	30.78	8.57	1.49	.032
Form-P	157.06	38.33	152.37	41.18	.620	.001

df = 408. Note. LBDS = Learning Behavior Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, SDS= Social Dysfunction Scale, PRS= Parent Rating Scale.

The results in the Tables 87 shows that there is a significant difference (t=-.620, df =408, p <.01) between the two groups on the total and subscales of Form-P and of FIAS. .Further the table show that children and adolescents from single parents families have high mean scores in the total as well as the sub-scales of Form-P, as compared to the children and adolescents from Intacts families which are M =157, SD =38.33; M =152.37, SD =41.18 respectively.

Table 88

Family Structure wise difference on the total and sub-scales of (TRS)(Form-T) (N = 410)

	Family Structure					
	Single Parent Family (n = 103)		Intact Family (n = 307)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
LBDS	30.16	6.24	33.36	4.25	4.13	.020
CDS	21.05	6.23	20.45	5.48	3.23	.056
EDS	24.44	6.98	23.32	6.71	4.11	.003
SDS	23.37	6.321	21.08	5.36	4.24	.012
Form-T	151,36	38.07	141.23	32.57	-2.952	.013

df = 408. Note. LBDS = Learning Behavior Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, SDS= Social Dysfunction Scale, PRS= Parent Rating Scale.

The results in the Tables 88 show that there is a significant difference (t = -2.952, df =408, p <.01) between the two groups on the total and subscales of Form-T and of FIAS .Further the tables show that children and adolescents from single parents families have high mean scores in the total as well as the sub-scales of Form-T, as compared to the children and adolescents from Intacts families which are M = 151.36, SD = 38.07 and M = 141.23, SD = 32.57 respectively which means that children and adolescents of single parent family show more functional impairment as compared to the others pertaining to the Intact Family. The same trend has been found in the five sub-scales of Form-T and Form-P of FIAS revealing that children and adolescents from single parent families show low learning behavior and high social dysfunction as well as cognitive dysfunction than others belonging to Intact Family.

Emotional Disturbance (DEP & ANX) and Family Structure. Emotional Disturbance in children and adolescents with regard to their family structure were measured with the sample of (N = 410) DAYS-U.

Emotional Disturbance especially depression and anxiety were measured on the two groups: Children of Single Parent Family (n = 103) and Intact Family (n = 307). Statistical analysis was performed by using T-Test which revealed that there is a significant difference in the mean scores of the both the groups. The results are as:.

Table 89

Family Structure wise difference on the total and sub-scales of DAYS-U (N = 410)

	Family Structure					
	Single Parent Family (n = 103)		Intact Family (n = 307)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
Scale T						
Depression	4.23	2.01	3.06	1.10	3.46	0.03
Anxiety	5.22	2.94	4.33	2.32	4.38	.110
Total	10.33	3.02	8.04	2.02	4.44	.011
Scale S						
Depression	13.42	5.72	12.13	3.20	5.41	.027
Anxiety	12.34	5.31	11.68	3.14	4.55	.138
Total	25.16	6.43	24.03	6.04	5.86	.052
Scale P						
Depression	5.32	1.66	4.12	2.01	4.63	.047
Anxiety	5.44	1.64	4.43	1.02	3.78	.024
Social Maladjustment	6.44	2.73	4.74	1.07	5.66	.011
Total	14.75	3.51	12.18	3.23	12.49	.053

df = 408

Table 89 shows that there is asignificant difference in the scores of the two groups (i.e.,on Scale S, t = 4.44, df = 408, p < .01 , on Scale T , t = 5.86, df = 408, p

< .05 and on Scale P, t = 12.49, df = 408, p < .05). The mean scores of the group belonging to single-parent families was found to be high as compared to the other Intact Family group on Scale S, Scale P and Scale T (See. on Scale-T for the two groups the mean scores are: M =10.33, and M =8.04 respectively; on Scale S are: M =25.16, and M =24.03 respectively; and on Scale-P are: M =14.75, and M =12.18 respectively)which indicatesthat single parent family structure do affect the level of depression and anxiety in children and adolescents. These results are in accordance with the early findings. According to Hetherington et al. (1998), many young people show signs of difficulty, among which are problems in school, behavioral and emotional problems immediately after their parents' divorce or remarry. Most of these children become settled within two years and behave comparably to their peers whose biological parents remained married (see also, Amato & Keith, 1991; Forehand, Armistead, & David, 1997; Hetherington, Henderson, & Reiss, 1999).

Hence according to T-test analysis our sub- hypothesis No. 16 has been accepted which states that *Children of single-parent families or mother only family score high on FI, as well as on DEP and ANX scales and low on PWB scales.*

Psychological Wellbeing and Family Structure.The measurement of psychological wellbeing in two groups was carried out by using the scale the Urdu Version Psychological Wellbeing Scale Affectometer 2 (See Table 90).

Table 90

Family Structure wise difference on Well-being Scale Affectometer-2 (Urdu version) ($N = 310$)

	Family Structure					
	Single Parent Family ($n = 72$)		Intact Family ($n = 238$)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
Part I	50.37	7.10	52.22	9.14	2.10	.020
Part II	52.33	9.11	53.12	10.16	2.29	.034
Total	102.60	16.21	105.34	19.30	-1.04	.035

df =409

Table 90 shows that there is a significant difference between the two groups (t =-1.06, df = 409, $p < .05$) on the scores of Well-*being Scale Affectometer-2 (Urdu Version).* The mean scores for children from Single-Parent Family and Intact Family are; M =102'60, and M =105.34 respectively indicating comparatively lower sense of psychological wellbeing in children of single parent families.

Table 91

Family Structure wise difference on Life Satisfaction Ladder Scale (N = 410)

	Life Satisfaction Ladder Scale			
	M	*SD*	*t*	*p*
DF(n = 103)	5.30	1.97	.926	.004
HF(n = 307)	6.02	1.45		

df= 408, *Note.*DF = Discordant Family and HF = Harmonious Family.

Table 91 shows that there is a significant difference between the two groups (t = .926, df = 408, $p < .05$) on the scores of *Life Satisfaction Ladder Scale*. The low

mean score children from Single-Parent Family (M =5.30, SD = 1.97) reveals that children of single parent families are less satisfied with their lives as compared to those of harmonious families.

In brief, Tables from 87 to 91 explain the existing trend of high level of FI, ED and low level of PWB and LS in the children and adolescents living with single parent (mostly mothers) as compared toIntact Family (father and mother). The result shows that there is a significant difference in the t-scores as well as in the mean scores of all the scales i.e., on the total and sub- scales of FIAS, DAYS-U and on Well-being Scale Affectometer-2 (Urdu version).

So far as the construct validity of FIAS is concerned, the result with DAYS-U has established the convergent validity of FIAS total and its sub-scales of Emotional Dysfunction Scale (EDS), Cognitive Dysfunction Scale (CDS), Social dysfunction Scale (SDS), and Learning Behavior Dysfunction Scale (LBDS) on the variable of family structure. The result withWell-*being Scale Affectometer-2 (Urdu version has confirmed the discriminant validity of FIAS and its sub scale* on the variable of family structure.

Marital conflict / dispute in parents. For the measurement of FI, ED, and PWB in children and adolescents with low academic achievement (N = 410) on the variable of marital conflict / dispute in parents the entire sample was divided into two groups: students of Discordant Families (n = *173*) and students of Harmonious Families (n = *237*).The term "Discordant" refers to the families where parents have frequent disputes with each other whereas the "Harmonious Families" refers to the families where parents have no disputes and are happily married.

Table 92

Marital conflict / Dispute wise difference on the total and sub-scales of (PRS)(Form-P) (N = 410)

	Marital Conflict/Dispute					
	Students of Harmonious Families (n = 237)		Students of Discordant Families (n = 173)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
LBDS	30.55	6.03	32.42	5.30	-2.46	.012
CDS	27.05	7.31	30.46	6.78	2.13	.043
EDS	27.44	7.98	29.32	6.23	2.19	.013
SDS	32.38	9.25	34.67	7.57	1.49	.032
PRS (Total)	142.64	29.33	151.37	25.37	3.33	.035

df= 406. *Note.* LBDS = Learning Behavior Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, SDS= Social Dysfunction Scale, PRS= Parent Rating Scale.

The result in the Tables 92 shows that there is a significant difference (t = 3.33, df = 406, p <..05) between the two groups of children and adolescents on the total and subscales of PRS of FIAS. Further the tables show that students of discordant family have high mean score M =156.23, SD = 38.23 in the total Form-T as compared to students of harmonious family which are M =152.16, SD = 32.03.

Table 93

Marital Conflict / dispute wise difference on the total and sub-scales of (TRS)(Form-T) (N = 410)

	Marital Conflict/Dispute					
	Students of Harmonious Families (n = 237)		Students of Discordant Families (n = 173)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
LBDS	31.26	7.24	33.36	5.25	3.43	. 042
CDS	21.55	6.03	22.25	5.58	3.33	.066
EDS	21.34	6.78	23.32	6.01	2.11	.043
SDS	41.37	7.36	44.51	8.30	4.24	.012
TRS Total	152.16	32.07	156.23	38.23	.623	.025

df= 406. *Note.* LBDS = Learning Behavior Dysfunction Scale, CDS= Cognitive Dysfunction Scale, EDS= Emotional Dysfunction Scale, SDS= Social Dysfunction Scale, PRS= Parent Rating Scale.

The Table 93 shows that there is a significant difference (t = .623, df = 406, p <.05) between the two groups of children and adolescents on the total and subscales of TRS of FIAS. Further the Table also shows that students of discordant family have high mean score M = 156.23, SD = 38.23 in the total Form-T as compared to students of harmonious family which are M = 152.16, SD = 32.03 which means that children of discordant families have significant deficits in social, emotional and school functioning. The same trend has been seen in the mean scores of the two groups on the five sub-scales of Form-T and Form-P of FIAS.

Emotional Disturbance (Depression & Anxiety) and Marital Conflict / Dispute. Emotional Disturbance (Depression & Anxiety) in children and adolescents of families with marital conflict were measured with the sample of (N = 410) by: DAYS-U.

Table 94

Marital Conflict / Dispute wise difference on the total and sub-scales of Urdu version of Depression and Anxiety in Youth Scale (DAYS-U) (N = 410)

	Domestic Violence					
	Students of Harmonious Families (n = 237)		Students of Discordant Families (n = 173)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
Scale T						
Depression	3.23	1.01	5.06	2.10	4.46	.013
Anxiety	3.32	2.34	4.33	2.92	3.38	.010
Total	8.63	3.02	10.04	2.02	4.44	.043
Scale S						
Depression	12.42	5.22	13.13	4.20	4.32	.047
Anxiety	11.34	5.31	12.68	3.14	4.55	.038
Total	24.16	6.43	25.03	6.04	5.86	.020
Scale P						
Depression	4.32	1.66	5.12	2.01	4.63	.026
Anxiety	4.44	1.64	5.43	1.02	3.78	.024
Social Maladjustment	4.44	2.73	5.74	1.07	5.66	.021
Total	12.75	3.51	14.18	3.23	12.49	.037

Table 94 shows that there is a significant difference in the scores of the two groups on Scale S (t = 4.44, df = 406, p <.o43), on Scale T (t = 5.86, df = 406, p < .020) and on Scale P (t = 12.49, df = 406, P < .037). The mean scores of the Students of Discordant Familieswere found to be high as compared to the Students of Harmonious Families i.e., M =14.18, SD = 3.32 and M =12.75, SD = 3.51 on Scale P, M =25.03, SD = 6,05 and M =24.16, SD = 6.43 on Scale S and on Scale S these are M =10.04, SD = 2.02 and M =8.04, SD = 3.02 respectively which indicates that students of discordant families are subjected to more psychosocial ED as compared to the students of harmonious families.

The measurement of ED in these groups had been also measured in the above section with FIAS (See Tables 82-83). The result showed that there was a significant difference in the t-scores as well as in the mean scores of the two groups on the subscales (EDS, and SDS) of Form-T and Form-P of FIAS. These results match with the early finding which document that there is a close relationship between the exposure of children to marital conflict (Amato & Keith, 1991; Forehand et al., 1991) disorganized and disrupted parenting (Fauber, Forehand, McCombs & Wierson, 1990; Forehand, Thomas, Wierson, Brody, & Fauber, 1990; Hetherington et al., 1998;) or marked increases in the degree of stress experienced by the household (Hetherington et al., 1998) with the bad outcome in the form of mental health problems, low psychological wellbeing and low academic performance.

Psychological wellbeing, life satisfaction and marital conflict /dispute in parents. The measurement of psychological wellbeing in two groups was carried out by using the scale the Urdu Version Psychological Wellbeing Scale Affectometer 2 and life satisfaction by the Life Satisfaction Ladder Scale (LSLS) See Table 90-91.

Table 95

Marital Conflict /Dispute wise difference on Well-being Scale Affectometer-2 (Urdu version) (N = 310)

	Students of HF (n = 193)		Students of DF (n = 117)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
Part I	55.47	9.10	49.82	7.35	2.37	.030
Part II	52.23	10.21	52.43	9.16	2.09	.041
Total	105.80	19.31	100.45	19.30	-1.03	.017

df =406 *Note*. DF = Discordant Family and HF = Harmonious Family

Table 95 shows that there is a significant difference (t = -1.03, df = 406, $p < .01$) between the scores oftwo groups on the Well-*being Scale Affectometer-2 (Urdu version)*. The lower mean score (M =100.45) of the students of discordant families indicates that they have low sense of psychological wellbeing than the students of harmonious families who scored greater (M = 105.80), on Well-*being* Scale Affectometer-2 (Urdu version). The variable of life satisfaction was measured by the Life Satisfaction Ladder Scale (LSLS) (See Table 96).

Table 96

Marital Conflict /Dispute wise difference on Life Satisfaction Ladder Scale (N = 410)

	Students of HF (n = 237)		Students of DF (n = 173)			
Subscales	*M*	*SD*	*M*	*SD*	*t*	*p*
LSLS	6.36	1.97	5.98	1.86	.704	.002

df= 408. *Note*.DF = Discordant Family and HF = Harmonious Family, LSLS = Life Satisfaction Ladder Scale

Result shown in Table 96 illustrates that there is a significant difference between the two groups on their scores on LSLS i.e., $t = .704$, $df = 408$, $p < .05$.

These results are also in line with the early findings which document that marital conflict enhances the depression and maladjustment of the child in the family largely indirectly through poorer mother-child relationships (Amato & Booth, 1996; Forehand, Neighbors, Devine, & Armistead, 1994; Kline, Johnston, & Tschann, 1991). Hence in the light of all the results shown in Tables and with the presence and support of research evidence mentioned above we accept our hypothesis regarding the demographic variable of marital conflict / dispute which states: *Children and adolescents of discordant families have high degree of Functional Impairment, Emotional Disturbance (DEP &ANX) and have low sense of PWB as compared to the children and adolescents of harmonious families.*

As this main part of the research also attempts to further establish the construct validity of FIAS, here once again proved it satisfactory on the variable of marital conflict / dispute i.e., the result with DAYS-U has established the convergent validity of FIAS total and its sub-scales. Similarly the results with Well-being Scale Affectometer-2 (Urdu version) and Life Satisfaction Ladder Scale (LSLS) has confirmed the discriminant validity of FIAS and its four sub-scales namely Emotional Dysfunction scale (EDS), Cognitive Dysfunction scale (CDS), social dysfunction scale (SDS) and Learning Behavior Dysfunction Scale (LBDS).

Determination of predictors of low academic achievement. The main objective of the present research was to explore relationships among depression, anxiety, psychological wellbeing and functional impairment as well as among

demographic risk factors as the predictors of low academic achievement. It was hypothesized that these variables predict low academic achievement in children and adolescents. It was also assumed that student with low academic achievement have high level of ED and FI but have low level of psychological wellbeing and life satisfaction. Further, so far as demographic risk factors are concerned, in the light of literature review it has been hypothesized that age, gender, income, maternal education, and family structure and family disputes have significant effect on academic achievement. To achieve this objective correlation coefficient was computed to see the relationships among variables and Logistic Multiple Regression analysis was conducted to find the magnitude of the of prediction. The reason behind the selection of the logistic multiple regression analysis was the fact that all the variables involved were continuous but the outcome variable (i.e., low academic achievement) was a categorical dichotomy. The logistic multiple regression analysis is the best regression analysis when the predictor variables are continuous or categorical but with an outcome variable that is categorical dichotomy (Field, 2005).

Result

The SPSS output of Logistic Regression analysis of Comorbidity of *DEP, ANX and FI*, and Psychological wellbeing, on the variable of academic achievement with (N = 410) produced a regression model for the variables in specified blocks. In block 1 model consists of depression and anxiety measured by DAYS and then produced a second model that contained the variables from both the Blocks (depression and anxiety from Block-1 and functional impairment measured by

Functional Impairment Assessment Scale, FIAS which was added in block 2). Then SPSS produced the Block-3 which contained all the variables of the upper two blocks by including the variable of psychological wellbeing measured by Urdu version of Psychological Wellbeing Scale Affectometer 2. To check the predictive strength of the environmental influence on the academic achievement data related to demographic risk factors (age, gender, income, etc.,) were also added in the model. SPSS produced further blocks up to block 8 in the way that each next block contained the contents of previous block. The output showed in the initial block 0 that out of 410 only 310 cases had been accepted in which there were 148 children and adolescents with low academic achievement whereas 162 were with high academic achievement. Overall the model correctly classified the 52.3 % of the children and adolescents. The block 0 which included only the constant in the equation also displayed a table for the variables not included in the equation. The bottom line of this table reported the value of Overall Statistics (residual Chi-square statistic) i.e., .877 which is significant *at* $p < .0001$ i.e., variables that are not made the part of the model have coefficients values that are significantly different from zero. This means if we add any of these variables in the model it will enhance its predictive power.

The dependent variable (i.e., academic achievement) was coded 0 and 1, (0 for low academic achiever and 1 for high academic achiever. In the analysis of block 1 only constant was forced to enter along with the first variable mixed state of depression and anxiety.

Table 97

Block 1: Logistic Multiple Regression Analysis of DAYS-U on the variable of academic achievement (N = 410)

	95% Cl for exp b				
	B (SE)	Wald (df)	Exp(B)	Lower	Upper
Inclusion					
Constant	,506 (.459)	1.214	1		
DAYS	.009 (.010)	.873(1)	0.991	0.972	1.010

Note. (*p <.01.**p <.001.***, p <.0001)

The important measure reported in Table 98-104 is the **Exp (B).** More crucial to the interpretation of the logistic regression is the value of (Exp) (B) in the SPSS output which is an indicator of the change in odds resulting from a unit change in the predictor. This proportionate change in odds is exp b, so we can interpret the exp b in terms of the change in odds. The value of exp b in the population could indicate either a positive (Exp (B) >I) or negative (Exp (B) <1) relationship: if the value is greater than 1 then it indicates that as predictor increases, the odds of the outcome occurring increase (positive relationship). Conversely a value less than 1 indicates that as the predictor increases the odds of occurring decrease (negative or inverse relationship. The SPSS version 12 displays a 95% confidence interval which is a usual statistic to have. If the confidence interval ranges from less than one to more than one then this would limit the generalizability of the findings.(Field, 2005).

The value of (Exp B) for depression and anxiety has been found to be .991 which is less than 1 revealing a negative relationship which means that if the depression and anxiety decreases academic achievement will improve. However the

confidence interval for these values cross 1(see, ranges from .972 to 1.010) which indicates that direction of this relationship may be unstable in this population as a whole. In addition depression and anxiety appear not to make a significant contribution to the prediction of academic achievement. Therefore we cannot be confident in generalizing that if the anxiety and depression decreases the academic achievement will improve in young population.

Table 98

Block 2: Logistic Multiple Regression Analysis of DAYS-U and Functional Impairment Assessment Scale (FIAS), on the variable of academic achievement (N = 410)

				95% Cl for exp b		
	B (SE)	Wald	*df*	Exp(B)	Lower	Upper
Inclusion						
Constant	2.844(.675)	17.769	1			
DAYS	.031*(.013)	5.709	1	0.982	0.972	0.994
FIAS	.014***(.003)	24.137	1	0.986	0.981	0.992

Note. (*p <.01.**p <.001.***, p <.0001)

In Block-2 where The Exp (B) value of functional impairment in the regression model in Block 2 (See Table 93) has been found to be Exp (B) =.986 which is less than 1 revealing a negative relationship which means that if the functional impairment increases the academic achievement will decrease in children and adolescents. The confidence interval for this value ranges from .981 to .992 which is also less than 1. Then we can be confident in generalizing that the relationship between functional impairment and academic achievement found in this study can be true of the whole the school population. The Block-2 has shown another interesting result that by the addition of the second predictor namely Function impairment in the

model the first predictor depression and anxiety has become a significant predictor of the outcome variable and its power of generalizability of has improved as the range of confidence interval has become less than 1 (see, .982-.994) which means that the depression and anxiety disorders alone are not a good predictors of academic achievement but when comorbid with Functional impairment then these disorder show an inverse relationship with academic achievement. (i.e., if the comorbidity of these disorder increases the academic achievement will decrease). Further we can be confident in generalizing that the relationship between comorbidity of depression and anxiety and functional impairment with academic achievement found in this study can be true of the whole the school population.

Table 99

Block 3:Logistic Multiple Regression Analysis of DAYS-U,and Functional Impairment Assessment Scale (FIAS) and ***Psychological Wellbeing Scale Affectometer 2 (Urdu version)*** *on the variable of academic achievement (N = 410).*

				95% Cl for exp b		
	B (SE)	Wald	df	Exp(B)	Lower	Upper
Inclusion						
Constant	4.439***(.675)	1.059	1	84.724		
DAYS	.036** (.013)	7.087	1	,960	.903	.994
FIAS	-.015*** .003)	26.108.	1	.986.	.980	.991
WBS	-.014***(.007)	4.028	1	1.010	1.000	1.020

Note. (*p <.01.**p <.001.***, p <.0001)

The Exp (B) value of the third predictor, the psychological wellbeing in the regression model in Block 3 (See Table 99) has been found to be Exp (B) =1.010 revealing a positive relationship which means that if the level of psychological

wellbeing increases then academic achievement will be also high. And as and the confidence interval for this value ranges from 1.000 to 1.020 which is more than 1revealing a positive relationship we can be confident that the relationship between psychological wellbeing and academic achievement found in this study can be true of the whole the school population.

Table 100

Block 4: Logistic Multiple Regression Analysis of DAYS-U, Functional Impairment Assessment Scale (FIAS), Psychological Wellbeing Scale Affectometer 2 (Urdu version) and Ageon the variable of academic achievement (N = 410).

				95% Cl for exp b	
	B (SE)	Wald	*df*	Exp(B)	Lower	Upper
Inclusion						
Constant	4.439*** (.675)					
DAYS	036** (.013)		1	,900	.879	.981
FIAS	-.015*** (.003)		1	.986	.980	.991
WBS	.014***(.007)		1	1.010	1.000	1.020
Age	.009* (.047)		1	.991	.904	.1000

Note (*p <.01.**p <.001.***, p <.0001)

In Block-4 where the Exp (B) value of AGE l (See Table 100) has been found to be.991 which is less than 1 revealing a negative relationship which means that if the age increases the academic achievement will decrease in children and adolescents who are emotionally disturbed. . However the confidence interval for these values cross 1(see, ranges from .904 to 1.002) which indicates that direction of this relationship may be unstable in this population as a whole. In addition variable of Age

appear not to make a significant contribution to the prediction of academic achievement. Therefore we cannot confidently generalize whether the age factor can improve or decrease the academic achievement in young population.

Table 101

Block 5: Logistic Multiple Regression Analysis of DAYS-U, Functional Impairment Assessment Scale (FIAS), Psychological Wellbeing Scale Affectometer 2 (Urdu version), Age and ***INCOME*** *on the variable of academic achievement (N = 410).*

				95% Cl for exp b		
	B (SE)	Wald	*df*	Exp(B)	Lower	Upper
Inclusion						
Constant	4.439*** (.675)					
DAYS	036** (.013)	8.034	1	,970	.901	.993
FIAS	-.015*** (.003)	25.190	1	.987	.900	.991
WBS	.014*(.007)	3.753	1	1.010	1.000	1.020
Age	.013(.047)	.082	1	.984	.902	.1011
Income	.003(.021)	2.203	1	1.011	,983	1.020

Note. (*p <.01.**p <.001.***, p <.0001)

The Exp (B) value of the fifth predictor, the **Income** in the regression model in Block 5 (See Table 101) has been found to be Exp (B) =1.000 and the confidence interval for this value ranges from .983 to 1.020 which is at one side less than one and on the other side it crosses 1 revealing no relationship with outcome variable. This means that income is not a significant predictor of the academic achievement and also we cannot be confident in generalizing that the relationship between psychological

wellbeing and academic achievement found in this study can be true of the whole the school population.

Table 102

Block 6: Logistic Multiple Regression Analysis DAYS-U, Functional Impairment Assessment Scale (FIAS), Psychological Wellbeing Scale Affectometer 2 (Urdu version), AGE, Income and ***Mother Education*** *on the variable of academic achievement (N = 410).*

		95% Cl for exp b		
	B (SE)	Lower	Exp(B)	Upper
Inclusion				
Constant	4.439*** (.675)			
DAYS	036** (.013)	.979	,990	.993
FIAS	-.015*** (.003)	.900	.987	.991
WBS	-.014***(.007)	1.000	1.010	1.020
Age	.013(.047)	.902	.984	.1000
Income	.003(.021)	.999	1.000	1.020
Mother Education	.374***(.09)	1.201	1.454	1.760

Note: (*p <.01.**p <.001.***, p <.0001)

The Exp (B) value of the sixth predictor, the Maternal Education in the regression model in Block 6 (See Table 102) has been found to be Exp (B) =1.454 and the confidence interval for this value ranges from 1,201 to 1.760 which is more than 1 revealing a positive relationship which means that children and adolescents of highly educated mothers will show high academic achievement. if the income increases then academic achievement will be also high. Then we can be confident that

the relationship between mother education and academic achievement found in this study can be true of the whole the school population.

Table 103

Block 7: Logistic Multiple Regression Analysis of DAYS-U, FIAS, PWB Scale Affectometer 2 (Urdu version), AGE, Income, Mother Education and ***Family Discard*** *on the variable of academic achievement (N = 410).*

95% Cl for exp b						
	B (SE)	Wald	df	Exp(B)	Lower	Upper
Inclusion						
Constant	4.439***(.675)	4.772	1			
DAYS	036** (.013)	6.363	1	,990	.979	.993
FIAS	-.015***(.003)	20.585	1	.987	.900	.991
WBS	-.014***(.007)	3.328	1	1.010	1.000	1.020
Age	.013*(.047)	.115	1	.984	.902	.1000
Income	.003**(.021)	1,387	1	1.000	1.000	1.000
Mother Education	.374***(.09)	14.863	1	1.454	1.201	1.760
Family Discard	-118**(259)	.208	1	.920	.889	.990

*Note. (*p <.01.** p <.001.***, p < .0001)*

BLOCK 7. The Exp (B) value of the seventh predictor, the Family Discard in the regression model in Block 7 has been found to be Exp (B) = .920 and the confidence interval for this value ranges from .889 to 990 which is less than 1 revealing a negative relationship which means that children and adolescents of discad family will show low academic achievement. if the family discard increases the

academic achievement will decrease. Then we can be confident that the relationship between family discard and academic achievement found in this study can be true of the whole the school population.

Table 104

Block 8: Logistic Multiple Regression Analysis of DAYS-U, FIAS, Psychological Wellbeing Scale Affectometer 2 (Urdu version), AGE, Income, Mother Education, Family Discard, and Gender on the variable of academic achievement (N = 410).

				95% Cl for exp b		
	B (SE)	Wald	df	Exp(B)	Lower	Upper
Inclusion						
Constant	4.439***(.675)	4.772	1			
DAYS	036** (.013)	6.363	1	,990	.979	.993
FIAS	-.015***(.003)	20.585	1	.987	.900	.991
WBS	-.014***(.007)	3.328	1	1.010	1.000	1.020
Age	.013*(.047)	.115	1	.984	.902	.1000
Income	.003**(.021)	1,387	1	1.000	1.000	1.000
Mother	.374***(.09)	14.863	1	1.454	1.201	1.760
Education						
Family Discard	-118**(259)	.208	1	.920	.889	.990
Gender-	-701*(.298)	5.533	1	.899	.887	.901

Note. (*p <.01.** p <.001.***, p < .0001)

In Block-8 where The Exp (B) value of 8th predictor (Gender) in the regression model (See Table 104) has been found to be Exp (B) =.899 which is significant at .05 level which reveals that variable of gender also contributes to the prediction of the academic achievement in children and adolescents.

In the above eight blocks **Wald statisticis** an important value also needs to be discussed. Wald statistic is a Chi-square distribution. If the coefficient is significantly different from zero then it is assumed that the predictor is making a significant contribution to the prediction of the outcome. In the Block 1 where we have forced SPSS to enter the scores of DAYS-U in the Regression model along with constant the Wald value has been found to be non-significant *(Wald (df) = .877 (1), P < ,350) documenting* that depression and anxiety is not a significant predictor of academic achievement. But in the next Blocks- 2 and 3 where functional impairment and psychological wellbeing had been added in the model its value became significant i.e., Wald (*df*) = 5.709* in block-2 and in block 3 Wald (*df*) = (1)7.087**, its significant level has further increased which means that depression and anxiety alone do not predict academic achievement but when comorbid with functional impairment and psychological wellbeing it becomes a significant predictor of the dependent variable (Academic achievement). Whereas the other variable functional impairment had been found to be highly significant *(Wald, (df) = 24.137***,(1), p < .000)* when forced to enter in the Block-2 revealing that functional impairment is the significant predictor of Academic achievement in children and adolescents.

Similarly psychological wellbeing when forced to enter in block-3 also proved to be a highly significant predictor of academic achievement (Wald, (*df*),= 17.767***,(1), $p < .000$). This trend has been seen in the rest of the blocks as well revealing that comorbidity of depression, anxiety functional impairment and psychological wellbeing as well as different risk factors significantly contributesin the prediction of academic achievement.

Logistic Regression Model also gives some other important values which have been shown in Table 105.

Table 105

Logistic Multiple Regression Analysis DAYS-U, FIAS, Psychological Wellbeing Scale Affectometer 2 (Urdu version), AGE, Income, Mother Education and ***Family Discard*** *on the variable of academic achievement (N = 410).*

Blocks	Model x^2 chi-square			2 Log Likelihood	Cox & Snell R square	Nagelkerke R square	Hosmen & Kemeshow	Overall %
	Df		Sig				*df* = 8 (Sig)	
Block 1 DAYS	1	878	.349	428.241	.003	.004	7.846 (.449)	52.3%
Block 2 FIAS	1	27.324	.000	400.917	.087	.116	8.923 (.349)	62.6%
Block 3 PWB	1	4.232	.040	396.685	.099	.133	6.596 (.581)	63.6%
Block 4 Age	1	.039	.844	396.647	.099	.133	6.486 (.432)	63.9%
Block 5 Income	1	3.438	.064	393.208	.109	.146	5.835 (.472)	65.2%
Block 6 MEdn	1	25.506	.000	377.702	.153	.204	6.321 (.371)	66.5%
Block 7 Discardant	1	208	.648	377.494	.153	.205	4.763 (.284)	67.5%
Block 8 Gender	1	5.713	.017	371.781	.169	.225	5.443 (.312)	67.8%

Table 105 shows the following values which need to be discussed.

Log-likelihood 2 LL. The value of -2LL should be less than the value when only the constant was included in the model because the lower values of 2LL indicate that the model is predicting the outcome variable more accurately (Field, 2005). The above Table 105 shows that value of 2LL has decreased in eight blocks gradually (428.241, 400.917, 396.685.... and so on). This reduction in the 2LL values tells us that the model is getting better and better at predicting academic achievement on adding more variables step by step.

Cox & Snell's Measure. SPSS gave us two other measures of R^2 the first is **Cox & Snell's** measure[4] and the second is **Nagelkerk s adjusted value**[4].In terms of interpretation they can be seen as similar to the R^2 in the linear regression in that they provide a gauge of the substantive significance of the model. Table 105 shows a substantial difference between the two values in every block revealing the effectively of the model in predicting the academic achievement.

Hosmer & Lemeshow s goodness of fit test. SPSS also produced **Hosmer & Lemeshow s goodness of fit test** in the Regression Analysis for the present study as it has more than one predictor that are continuous except for the dependent variable which is a categorical dichotomy. We have non- significant values here for the eight models (See the Table 105) which are the indicative of a model that is predicting the real world data fairly well.

In summary, the overall percentage of cases correctly classified cases in each block starting from the model in initial block 0 was found to be 52.3 % and when the first variable (depression & anxiety) was added in the model in block 1 no increase in the percentage of cases correctly classified was seen which indicates that inclusion of depression and anxiety has not improved our ability to predict whether academic achievement will be low or high in children and anxiety. But when variable of functional impairment was added in the model in the block 2 the percentage of cases correctly classified was raised to 62.6 %. The extra 10.3% percent shows a significant improvement in the model to predict the academic achievement. In the block 3 where variable of psychological wellbeing was added the percentage of cases correctly classified was raised to 63.2 %. So an extra 1.4% cases were correctly classified which is not a big deal of improvement in the model. Similarly age factor showed no improvement in the model as percentage of cases correctly classified was raised to 63.9 %. The difference is only of .3%. But in block 5 when the predictor variable of income was added the percentage of cases correctly classified was raised to 65.2 %. In block 6 when the predictor variable of mother education was added the percentage of cases correctly classified was raised to 66.5 % and the difference is of 1.3%. Similarly in block 7 where the predictor variable of discordant family was added the percentage of cases correctly classified was raised to 67.3 % and in block 8 where the predictor variable of gender was added the percentage of cases correctly classified was raised to 67.8 % and the difference was only of .5%.

In summary, we can see, though all the variables included in the model contribute to some extent in the prediction of the academic achievement in children and adolescents yet functional impairment has been weighted as a significant and

strong predictor and that depression and anxiety cannot predict academic achievement alone unless coexisting with functional impairment.

The results also indicated that demographic variables including age, gender, soscioeconomic status and family factors such as maternal depression, maternal education divorce or remarriage in parents lead to functional impairment in children and adolescents. These findings also match with other's work (e.g., Nagar, Sherer, Chen, Aparasu, 2010).

Discussion

The Part III of present research has attempted to assess the level of Comorbidity of Emotional Disturbance (DEP & ANX) and FI in Children and adolescents with low academic achievement. It has been found that students with low school performance usually have certain deficits in the domains of their psychosocial functioning both in their school and home settings which may be manifested in the form of low cognitive functioning, impaired emotional and social behavior.

Part III of the current research was carried out to achieve the main objectives of the study with an independent sample of N=410. The first objective was to re-establish the reliability and validity of the FIAS on a larger sample of school children and adolescents as a function of different demographic variables such as age, gender, family structure, marital conflict, socioeconomic status and maternal education. The results yielded high reliability and the significantly positive correlation of the subscales of LBDS, CDS, EDS, and SDS with each other and with the total TRF (Form-T) which shows the internal consistency of all these scales. The reliability of

PRS (Form-P) is also very high and satisfactory.For PRS (Form –P). There is also a significantly positive correlation of the subscales of SDS, CDS, EDS and LBD-P with each other and with the total PRS (Form-P) showing the internal consistency of all these scales. The construct validity performed on the larger and independent sample of part-III (i.e., these subjects did not participated in early parts (I & II) of the study which also proved to be very satisfactory. For the convergent validity the scores of the target population on Urdu version of DAYS were matched with that of FIAS and for Discriminant Validity the score on wellbeing Affectometer-2 (Urdu Version) were matched with scores of children and adolescents. The result has established very high and satisfactory construct validity.

The second main objective of the main study was to test the hypotheses formulated to answer the research questions regarding the assessment of the comorbidity of DP, ANX and FI in young population with low school performance by using newly developed (in PART-I) indigenous scale FIAS, Urdu version of DAYS (translated in part-II) an Urdu version of Psychological Well-Being (Affectometer-2) and Life Satisfaction Ladder Scale (LSLS). The results indicate that there is significantly positive relationship between low academic achievement and emotional disturbance. The negative correlation between the measures of emotional disturbance (DAYS-U) and functional impairment (FIAS) and the measures of psychological wellbeing (PWB-Affectometer-2) (Urdu Version) and Life Satisfaction scale (LSLS) indicates that the emotionally disturbed children and adolescents had low sense of life satisfaction and psychological wellbeing. The correlation analysis among all the scale total & subscales) shows that among the sub-scales of Form-P the Social Dysfunction Scale (SDS) exhibited a high positive correlation with the total Form-P (*r*

= .83, $p < .000$). Similarly this scale is also positively correlated with the Form-T the Teacher Rating Scale (TRS) but here the magnitude is low i.e., ($r = .24, p < .01$). This shows that though both the forms are inter-related and measure the same construct but in different situations i.e., school and home environment. The difference in magnitude of the correlation value indicates that children and adolescents have different social behavior in the school environment. i.e., children are more shy and quiet and behave passively in school among their peers as compared to their home environment. Similarly the Learning Behavior Dysfunction Scale (LBDS) has exhibited a high positive correlation with the total Form-T ($r = .82, p < .000$) but the same scale has shown low correlation with Form-P ($r = .12, p < .05$) indicating the difference of learning behavior of children and adolescents with low academic achievement in classroom and home environment. These two Form (P & T) have exhibited negative correlation with Wellbeing and Life Satisfaction Scales i.e., *(r =.-00, & .-02* with Form-P and *r = -.00 & -.08* with Form-T respectively) indicating a zero or no relationship. This shows that individuals with functional impairment are not satisfied with their lives and possess very low psychological wellbeing. This result has further confirmed the discriminent validity of the FIAS an indigenous scale newly developed in the Part-I of the present study. Same result has been emerged for the other sub-scales e.g., EDS, and CDS of both the Forms which exhibited high correlation with the Forms to which these sub-scales belong but have negative or zero correlation with the Psychological wellbeing Affectometer-2 and with Life Satisfaction Ladder Scale (LSLS). All sub-scales along with the total scales TRS and PRS are positively related to each other and with the DAYS-U. With DAYS-U (Urdu translation) FIAS has shown a positive relationship i.e., *(r = .70, p < .000)* which also has confirmed the

convergent validity of FIAS with DAYS-U. The DAYS-U has also shown the negative or no correlation with the Wellbeing Affectometer-2 i.e., (r = -.08) and with Life Satisfaction Ladder Scale (LSLS) it is r = -.01 which is a desired direction. So far as the three scales of DAYS-U are concerned Scale-S has shown a positive relation with the Scale-P *i.e.,(r = .39, p < .000)* but it has shown no relationship *(i.e., r = .04)* with the Scale-T which is equivalent to zero.

The results indicates that in the sample population with high academic achievement (N=205) there exists no relationship between the DAYS-T and DAYS-S i.e., *.r = .03.* i.e., teacher's rating is different from that of student's self-rating. This indicates that teachers did not rated high the individuals with high academic achievement on depression and anxiety scale.

A similar result has been found with the sample population with high and low academic achievement (N=410). This result is exactly in line with the finding of authors of the scale DAYS (Phyllis, et al., 1994) who reported that students with Learning Disability reported to have feelings of depression similar to children who had no disabilities but they were rated higher in depression by their teachers.

Further the difference in the level of depression, anxiety and functional impairment was evaluated on an independent sample (N=410, both girls and boys with age range of 6-19 years) by comparing the students with low academic achievement with control group of high academic achievers. The basic purpose of the study was to find out that how students with low academic performance differ in their performance on the above mentioned scales (on total and sub-scales) from those with high academic achievement. These scales were administered on two groups: ***Group I***: consisting of students (n = *205*) with low academic achievement who stood within the

last five positions on the annual examination result sheet prepared by their class teachers and ***Group II***: consisting of students *(n = 205)* with high level of academic achievement, who showed excellent performance in their annual examinations and who stood within the first five positions on the annual examination result sheet prepared by their class teachers. Information about the children was gathered by the class teachers and parents/family member who is able to provide the full information about the child's behavioral and psychological functioning. ANOVA and *t*-test analysis for independent samples were computed to find the differences between low and high academic achievers on these variables as well as with respect to different demographic variables. Finally, Multiple Logistic Regression Analysis was carried out to study the combined effect of depression, anxiety, psychological wellbeing, life satisfaction and functional impairment on low academic achievement.

The performance of both the groups on the total and sub-scales used in the part III: FIAS, DAYS-U, PWB (Affectometer-2, Urdu version) are discussed in detail in the following section.

Difference between Scores of Children and Adolescents with High / Low Academic Achievement on Functional Impairment Assessment Scale (FIAS). In the present study screening of FI in the Group I and Group II was carried out with the help of newly developed FIAS and its subscales through its two rating scales the Form T and Form P. It was assumed that students with low academic achievement will show higher level of FI on the FIAS and its sub-scales than Group II of high academic achievers. Our hypothesis confirmed at $p < .01$.These finding indicate that there is some relationship between functional impairment and low academic achievement and

can be considered as the risk factor of school failure. Many people during this decade have comment on this. For example, it has been found that the teachers judged the youth with academic problems as having lack of learning behavior and have more ED due to which they do not concentrate in class have low attention span have no interest in participating in group activities than those without disabilities (Cullinan & Sabornie, 2004).

The findings of the current study provide further support on the claim that there is positive relationship between FI and low academic achievement. The results are encouraging in assuming that the children and adolescents with low academic achievement have functional impairment ranging from mild to severe.

Difference between Scores of Children and Adolescents with High / Low Academic Achievement on Sub-scales of Functional Impairment Assessment Scale (FIAS). The analysis of scores of two groups (I & 2) on sub-scales of both the Forms (T & P) of FIAS through t-test were also carried out to compare the level of psychological functioning of children and adolescents with low / high academic achievement more precisely. The difference was found significant between two groups on the four domains of functioning four sub-scales namely: Learning Behavior Dysfunction Scale (LBDS), Emotional Dysfunction Scale (EDS), Social Dysfunction Scale (SDS), Cognitive Dysfunction Scale (CDS).The detail is given in the next section.

Learning Behavior Dysfunction Scale (LBDS). Learning behavior dysfunction Scale measures child's deficits / impairment in all academic disciplines,

in class as well as in extracurricular activities and sports including, lack of confidence, communication skills, punctuality, assertiveness, arts, culture, and social relationships with their families and peers. i.e., the sub-scale LBDS attempts to assess impairment in global learning behavior (a kind of student's class room or school behavior) which is thought to be necessary for their effective learning or academic achievement. The global learning behavior includes paying attention to the teacher's instruction, giving proper response i.e., class participation), taking part in school' extra-curricular activities (e.g., sports, drama or debates etc).

The results of the present study show that there is a significant difference between the scores of students with low and high academic achievement. In the present study it has been found that student who have low academic achievement scored high on Learning Behavior Dysfunction Scale (LBDS) that indicates that these students participate less in the class show lack of attention and do not concentrate, have no friends and are more irritable and do not follow the roles of schools and remain absent from the school. Our result regarding the global learning behavior in students is in line with the early research findings. It has been found earlier those students who manifest good learning behavior is usually good achievers and show good school performance. On the other hand students who have low learning behavior also show low academic achievement or are school runners. Eccles, Barber, Stone, and Hunt (2003) document that students who are good in extracurricular activities are also good in academic performance.

Emotional Dysfunction Scale (EDS). Emotional Dysfunction Scale (EDS) measures the symptoms of mixed anxiety and depression or negative affect

characterized by a state of generalized feelings of fear and apprehension e.g., nervousness, irritability, anger, fear, discomfort, resentment crying along with pessimism, despair, helplessness, hopelessness, low self-esteem, guilt, negative expectancy, and dread of impending disaster, (Rawlins & Heacock, 1993; Bootzin, Acocella, & Alloy). Our result on this sub-scale regarded the performance of students with low and high academic achievement showed that there is significant difference in two groups and that the mean scores of the students belonging to group I are higher than the group-II. These results are in accordance with the early findings which state that youngsters with co-morbidity of depression, anxiety and functional impairment perform more poorly than others in school, score lower on standard achievement tests, are rated by their teachers as doing less well academically, and have lower levels of grade attainment (Cole, 1990; Cole et al., 1996, See also Wagner, 1995)

. As EDS measures the symptoms of anxiety and depression the students who have scored higher on this scale have appeared demonstrate the physical complaints, inability to concentrate and restlessness. This further supports the documentation of Douglas et al. (2004) who depict that in depression the power of concentration of an individual is decreased due to which he / she mau feel it hard to pay attention on teacher's lectures or on reading a textbook. Similarly due to anxiety and irritability the student shows restlessness and therefore cannot sit on his/her seat for even a short period of time in the class. He must have to get up from his seat frequently. So our sub- hypothesis No 2 has been confirmed on $p< .01$ saying that students with low academic achievement manifest higher rate of emotional dysfunction as compared to their classmates with high academic achievement

Social dysfunction Scale (SDS). Social dysfunction Scale (SDS) measures child's inability to build and maintain social relationships such as initiating social conversations or making friends and to perform group activity (Kaslow et al., 1994). The positively worded statements of the scale indicate social competences the negative statements measure the deficits in social skills such as impaired group functioning and mal- interpersonal relationships of children and adolescents with peers and other people present in their social environment.

In the present study the Group I consisting of children and adolescents with low academic achievement have been found to have high mean score on the sub scale SDS as compared to the Group II with high academic achievement who scored less. Therefore high score is an indicative of the lack of social or interpersonal skills in youngsters with low academic achievement. Studies indicate that there is a close relationship among ED, academic and interpersonal social problems (Gresham, MacMillan, & Bocian, 1997).

Cognitive Dysfunction Scale (CDS). Cognitive dysfunction Scale (CDS) measures poor mental function, associated with confusion, forgetfulness and difficulty. It also measures deficiency in ability to think perceive reason or remember loss of ability to attend to one's daily living needs, distortion in thinking, feelings of worthlessness, negative beliefs and self-critical negative thoughts. The results on CDS revealed a significant difference between the scores of the two groups in that Group I has higher mean score. This is in accordance with the earlier findings which document that cognitive dysfunction in emotionally disturbed individuals is related to lower cognitive performance, poor performance on reading tasks, altered attentional patterns

and reduced use of communication to gain adult attention. It has been found that many youngsters with ED experience deficits and distortion in their thinking (Nolen-Hoeksema, Girgus, & Seligmon, 1992).

Difference between Scores of Children and Adolescents with High / Low Academic Achievement on Urdu Version Scale (DAYS-U). Emotional Disturbance with regard to the academic achievement of the Group I and Group II with the sample of (N = 410) were measured by DAYS-U. This scale possesses good reliability and validity. The reliability of DAYS-U has been calculated two times in the present study with independent sample. Once in Part II with the sample (N = *220*) and second in Part III with (N =*410*) and both times the result yielded satisfactory reliability. The alpha reliability of the three scales of the DAYS-U are: Scale S (.88); Scale T (.81) and Scale P (.84) which are very satisfactory. The inter-scale correlation for DAYS-U has also been computed in the present study with (N = 410) which yielded a satisfactory relationship among all the scales of DAYS-U.

The result of the present study shows that there is a significant difference in the t-test of all the scales of DAYS-U (Scale-S (p < .031), Scale T (p < .003) and on Scale P (p < .021) which means that there is a difference in the level of depression and anxiety among youngsters with low and high academic pfomance in their subjective rating. But in the perspective of their teachers and parents there is no difference in the level of symptoms of depression and anxiety in both the groups. However the mean score of the Group I was found to be higher than Group II on Scale P, Scale T and Scale S of DAYS-U which indicates that Group I is subjected to more co-existing Emotional / Social problems such as anxiety, depression, and social

maladjustment. These results are in accordance with the early findings which state that youngsters with co-morbidity of DEP, ANX and FI perform more poorly than others in school, score lower on standard achievement tests, are rated by their teachers as doing less well academically, and have lower levels of grade attainment (Cole, 1990; Cole et al., 1996, See also Wagner, 1995).

Further, overall intellectual potential of depressed and anxious youngsters is comparable to the potentially of those who are not depressed suggesting that association between severity of depression and children's overall intellectual performance is weak (Kovacs, Feinberg & Crouse-Novak, 1984; Kovacs, 1997). Since the result of *t*-scores of DAYS-U on all of its scales have been found to be significant our sub- hypothesis No 2 has been confirmed on $P < .05$ saying that students with low academic achievement score high on (Depression & Anxiety) scale as compared to their classmates with high academic achievement.

Besides measuring depression and anxiety of children and adolescents with low / high academic achievement in the main study DAYS-U has also been used for the validation of FIAS in the Part III for the second time. It has been seen that trend like that of DAYS-U existed in the mean scores of the Group I which is higher than Group II on the subscales LBDS, CDS, EDS, and SDS of Form-T and Form-P of FIAS and there is also a significant difference in the t-scores. i.e., for Form-P ($p < .01$) and for Form-T ($p < .01$) *and here* once again the results have established the convergent validity of FIAS total and its sub-scales on the variable of academic achievement.

Difference between Scores of Children and Adolescents with High / Low Academic Achievement on Urdu Version of Psychological Well-being Affectometer-2 Scale and Life Satisfaction Ladder Scale (LSLS). The Urdu Version of Psychological Well-being Affectometer-2 scale and Life Satisfaction Ladder Scale (LSLS) has been also used in the previous Part-II (with the sample of 220) of the study with the purpose of validation of the FIAS and in the Part III (with the sample of 410) it has been used for measuring psychological wellbeing in children and adolescents with low / high academic achievement. The reliability analysis of well-being (Affectometer-2) in both parts of the study calculated with independent sample was found to be satisfactory.

The Urdu Version Psychological Wellbeing Scale Affectometer 2 was administered on only secondary school students with the sample of $N = 350$ as the primary school students especially those belonging to 6-8 years of age were not included because (1) it appeared difficult for them to comprehend the constructs and concepts presented in Urdu Version of Psychological Wellbeing Scale Affectometer 2.(2) Another reason for not administering the WBS to children of age less than 10 years is that no research evidence has been found in using Urdu Version of Psychological Wellbeing Scale Affectometer 2 on this particular group in Pakistan.

Therefore Life Satisfaction Ladder Scale was administered on the primary students along with other students. It has been found in the present research that there is a significant difference between the two groups. The low mean score of Group I illustrates that the students with low academic performance have low psychological wellbeing than Group II who's mean score is quite higher. On the Life Satisfaction Scale the mean score of the Group I is low than the Group II and there is a significant

difference in *t*-scores. This means that children and adolescents with low academic achievement have less life satisfaction as compared to those who have high academic achievement. Therefore, in the light of the results shown in the Tables 33-34 our hypothesis regarding academic achievement and psychological well-being has been confirmed which states: Students with low academic achievement have low sense of Psychological well-being and life satisfaction as compared to their classmates with high academic achievement.

Further, since these scales were basically used to establish the discriminant validity of newly constructed scale FIAS in Part II of the current study, here in the main study once again the attempt has been made to measure the construct validity of FIAS and once again the results have established the discriminant validity of FIAS total and its sub-scales Emotional Dysfunction Scale (EDS), Cognitive Dysfunction Scale (CDS), Social Dysfunction Scale (SDS), and Learning Behavior Dysfunction Scale (LBDS) on the variable of academic achievement.

Co-morbidity of DEP, ANX and FI and the Academic Achievement. The present has attempted to measure the level of emotional disturbance and FI in young population with low academic achievement. For this purpose their performance on different measures were matched with control group (children and adolescents with low academic achievement). In the present research the performance of both the groups Group-I and Group II on the scales: FIAS and its sub-scales; DAYS-U and its three scales; PWS Affectometer-2 (Urdu version) and LSLS have yielded significant result on t-scores indicating that there is significant difference in the scores of the two group and mean scores of Group I on all these scales have been found to be high

revealing that children and adolescents with low academic achievement have higher level of FI and Emotional Disturbance (DEP & ANX) as compared to Group II of their age mates with high academic achievement. The studies indicate that among emotional and behavioral disorders the depression and anxiety are usually coexisting disorders seen in developmental psychopaology research which affect their academic performance in a variety of ways (e.g., Forness & Kavale, 2001; Forness, Kavale, & Lopez, 1993). A similar kind of result has been achieved in the present research. All the subjects who scored high on the DAYS-U also scored high on FIAS and its sub scales indicating that there is comorbidity of DEP, ANX and FI in the cognitive, social and emotional domains of children and teens with academic problems.

The findings of the comparative analysis between students with high and low academic achievement have confirmed the main hypothesis of the study *saying that* Students with low academic achievement have comorbidity of emotional disturbance in terms of DEP, ANX and FI as compared to their class mates with high academic achievement.

In order to find the relationship and strength of the predictors of academic achievement Multiple Logistic Regression Analysis was applied on the present data which revealed that in the model of block 1 when only DAYS score were added with constant it revealed that depression and anxiety do not predict academic achievement but when scores of Functional Impairment Assessment Scale (FIAS) were added in the block-2 then the overall percentage of predictive strength of the modal raised to a marked degree revealing that only comorbidity of DEP and ANX coupled with function impairment is associated with low academic achievement. This means that emotionally disturbed children and adolescents will show low academic achievement

only when they have functional impairment in the domains of their cognitive, social and learning behavior. In their study Douglas et al. (2004) also found a similar result. They documented that high school students with emotional disturbance have low level of overall competence, than their classmates who are free from emotional problems. In the next step it was found that Regression model improved further in the block 3 when the third variable of the study: the psychological wellbeing was added. These results are in line with the earlier findings. Researchers (Douglas et al., 2004) found that students with ED showed functional impairment such as inappropriate behavior, social maladjustment, relationship problems, physical problems and overall competences to a greater extent than students without ED due to a cognitive impairment which they have

Co-morbidity of Depression, Anxiety and Functional Impairment with Reference to Demographic Variables. Another objective of the present research was to explore level of academic achievement and comorbidity of ED, Psychological wellbeing and FI in children and adolescents as a function of different demoghraphic variables of age, gender, family structure (single / both parent families), maternal education and socioeconomic status. For this purpose sub hypotheses as the continuum or extension has been formulated. To test these hypotheses and to analyze the difference t-tets and Anova was computed.

Age. Recent research puts a profound emphasis on the need for early inter-vention for school age students with behavior problems (Kamps, Tankersley, Mancina, & Weidin[g]er, 1996) as well as inventing the standardized instruments to

measure mental disability in children and adolescents. Only early identification can lead to the early intervention planes and strategies effective enough to affect student classroom performance.

After the profound review of the existing literature the age range of the participants in the present study was decided to be from 6 to 19 years. Many longitudinal researches indicated that emotional disturbance and patterns of functional impairment begin at early age and if not treated timely continue up to adult life (Campbell, 1994; Walker et al., 1995).

The findings of the present research as a function of the age have confirmed the presence of mental health difficulties in the secondary school students. The results showed a comparatively high level of functional impairment and Emotional Disturbance especially depression within the age group from 12 to 15 years students and in children of age between 6 to 10 years a comorbidity of unhappy mood physical complaints and fear has been found to a greater extent. This result is in line with the early research findings For example, Douglas, Cullinan, Edward, and Sabornie (2004) found that among students who were provided special need services under the category of ED, about 65% were more than 12 years age. The popular age groups of students with ED are from 12 to 15-year-olds (Maag and Behrens, 1989).

The results of current study show that there is a significant difference in the mean scores of the (PSS) Primary School Students, (MSS) Middle School Students, and (HSS) High school students on the subscales (DS, AS and the SDS) of Form-T and Form-P of FIAS. The same trend has been seen when measurement was made with the separate scale DAYS-U newly translated in to Urdu in the part one of the present study.

The DAYS-U results have also established the construct validity of FIAS in the main study for the second time. This result is in line with the early research findings.

The measurement of psychological wellbeing in different age groups was carried out by using the scale the Urdu Version Psychological Wellbeing Scale Affectometer 2 and Life Satisfaction Ladder Scale. The results were also used to confirm the construct validity (Discriminent) of the FIAS for the second time. The results show that there is significant difference between the mean scores of two groups (adolescents and older adolescents) on Urdu version of Wellbeing Affectometer 2. And there is highly significant difference among the scores of the three groups (i.e., Children, adolescents and *(HSS) High school students*) on Life Satisfaction Scale. However, the lower mean score for the *(HSS) High school students* suggests that adolescents at the age between14 to 19 are more emotionally disturbed and feel low level of psychological wellbeing and also do not perceive their life satisfactory.

According to One-way analysis (ANOVA), our hypothesis No. 1, 4, 5, 6, 11, and 12 from the list of sub hypothesis of the main study that the Students within the age group of 12 to 15 years show high level of functional impairment and low learning behavior as compared to the students of other age groups; that students within the age group of 14 to 19 years ((HSS) High school students) score high on the Emotional Disturbance as compared to the students of the 7 to 10 age groups; that the primary school students with age group (7 to 10 years) score high on the particularly Anxiety Scale whereas the high school / college students score high on depression scale as compared to the students of other age groups and that a*dolescents of 14 to 19*

years will score low on psychological wellbeing and life satisfaction scales as compared to the students of other age groups, finally the incidence of level of comorbidity of functional impairment and emotional disturbance is high among High school Students; that high school students with academic problems have more emotional problems (depression & anxiety) than the primary school students with low academic achievement has been confirmed.

Gender. In childhood, boys and girls are at equal risk for depression; but during adolescence, girls have been found to be more susceptible of depression than boys (Birmaher, Ryan, & Williamson 1996; Steinhausen, Muller, and Metzke, 2008).

The results of the main study have revealed that the mean score of adolescent boys on FIAS and DAYS is greater than girls but adolescents girls have scored more on depression scale as compared to boys. The results display a non-significant difference. The same trend has been found in the sub scales of Form P and T which means that there is no effect of Gender on the school performance and functional impairment and its domains of social, emotional, and cognitive functioning. However the results show higher mean scores of boys on both the forms as compared to girls.

These findings are in accordance with the previous findings in which using a self-report instrument of suicide-related behavior, Miller (1994) found that adolescent girls with emotional disturbance reported more suicidal ideation and attempts than did boys.

In the cognitive dysfunction or inappropriate behavior subscale of FIAS both the genders showed high score. Cullinan, Epstein, and Kauffman (1984) while studying specific teacher-rated emotional and behavior problems among middle / high school students found that so far as cognitive dysfunction is concerned both girls and

boys with ED showed more inappropriate behavior than their peer without emotional problems.

Hence according to t-test analysis our hypothesis No 7, 8, and 9 that a*dolescent boys show high level of Functional Impairment (FI) as compared to the girl students of their age mates.*' has not been confirmed. This means that there is no difference in the prevalence of FI among girls and boys; that girls show significantly high level of symptoms of depression as compared to the boy students of their age mates and that girls show significantly low psychological well- being and life satisfaction as compared to the boy students of their age mates have been confirmed.

Socio-economical status. The present study has also explored the relationship of different demographic risk factors including family structure, domestic violence and low socio-economical status with the Emotional Disturbance, psychological wellbeing , life satisfaction and Functional Impairment in the children and adolescents with low academic achievement. The finding of the present research has confirmed the sub hypotheses No 10 *saying that t*here is comorbidity of DEP, ANX low PWB and FI in the children belonging to the families with low socioeconomic status as compared to the children belonging to the families with moderate or high socioeconomic status.

The results found are just in line with the previous findings regarding relationship of school failure in adolescence and demographic risk factors including low socioeconomic status, or lack of parental support for educational effort (e.g., Cairns & Neckerman, 1989; Felner, Brand, DuBois, Adan, Mulhall, & Evans, 1995) Hinshaw, 1992; Pungello, Kupersmidt, Burchinal, & Patterson, 1996; Rumberger,

1987; Rumberger, Ghatak, Poulos, Ritter, & Dornbusch, 1990; Stroup & Robins, 1972; Vallerand, Fortier, & Guay, 1997).

The literature states that children with lower socio-economic status are not supported by their parents or adult family members regarding basic biological as well as psychological needs, thus making them more frustrated and depressed. Due to the lack of family support they achieve less in their life.

Maternal education. The educational level of parents has been attributed to be an important aspect of socio-economic influence on school performance (Eva & Monica, 2009). The parents are the most influencial figure in the lives of their children's. Those children are successful in school whose parents take part actively in their academic activities (DePlanty, Coulter, & Duchane, 2007).

The present study has demonstrated that children whose mothers are educated have shown a high level of psychological well-being as compared to the other group. The high mean scores of the group 1indicated that children whose mothers are uneducated have some deficits in their cognitive, social, emotional and academic functioning.

The same trend has been seen in the mean scores of all the groups on the five sub-scales of Form-T and Form-P of FIAS revealing that students in this group show low learning behavior. Whereas low mean scores of children pertaining to fourth group reveal that children of highly educated mothers have good learning behavior as compared to the children's of uneducated mothers.

The significant result on t-test has confirmed sub hypothesis No 14, and 15 stating that children of uneducated mothers have more signs of comorbidity of

depression, anxiety and functional impairment as compared to the children of educated mothers; and that children of uneducated mothers have low sense of WBS as compared to the children of educated mothers. This is probably due to the fact that, most of the educated women like to work because it gives them more autonomy and satisfaction. They are economically as well as psychologically self-sufficient. Durrant & Sathar (2000) document that Pakistani women with higher status (educated and employed) are better able to make positive investment in their children. Being satisfied with themselves because of their financial contribution and more caring attitude they enhance psychological well-being in their children. Literature explains that mother's psychological well-being is strongly associated with mental health of their children. Mothers who are educated and do work (even part time) have good mental health. In an old study Gove and Tudor (1973) found that among married women, full time housewives seem to have more psychological problems than the working wives.

Single parent family. Family structure especially single parent family system has been found to put a strong influence on the psychological adjustment of adolescents (Savin-Williams & Berndt, 1990; Steinberg, 1990).

A number of researches illustrate that breakup in parental relationship or separation leads to the psychopathology in children. This study aims to find out the emotional disturbance in the children of single parent families (either divorced parent or one parent died).

The present research demonstrated that the children of single parent families (mostly mothers) following within two years of their mother's divorce or their father's

death have more depression and anxiety as well as functional impairment as compared to children of both parent families. The significant result has confirmed the sub hypotheses No 16 stating that children of single-parent families or mother only family score high on Functional Impairment, as well as on Depression and Anxiety scales and low on psychological well-being scales. This result is in consensus with the early findings which demonstrate that in first two years or so after divorce, children show more defiant behaviour, aggression, dependency, anxiety, depression and more difficulties in their social relationships and academic performance (Kurdek & Berg, 1983; Mitchell, Hammond, & Bee, 1983).

The higher level of ED and FI in children from single parent Pakistani families can be well explained under the cultural and religious values, in that, in Pakistan where the majority of population is Muslim there is no concept of unmarried mother. And the father has a very strong place and role in the family. The children who do not have their father (either died or divorced) find it very hard to fill the gap of their father and nobody else can take their place or compensate the loss of their real father. Therefore most of them become depressed and irritated. Literature also shows some kind of agreement that this issue is more or less culturally sensitive. In some ethnic groups the effect of family structure, showed little significant variation between married and unmarried families (Gibson-Davis & Gassman-Pines, 2009).

Marital conflict /domestic violence. Our results have demonstrated that children and adolescents from the discordant families have more symptoms of ED and low psychological well-being. The level of FI is high in this group as compared to the children and adolescents from harmonious families (where parents are happily

married). The significant result on this variable has confirmed our sub- hypotheses No 17 saying that Children and adolescents of discordant families have high degree of FI, DEP and ANX and have low sense of psychological well-being as compared to the children of harmonious families.

The literature review illustrates that the family role is to provide the child with a safe, secure, nurturing, loving and supportive environment that allows the children to have a happy and healthy youth which enables them to enter in adulthood safely.

Although divorce is generally associated with short term difficulties for the adolescent (Cherlin, Furstenberg, Jr., Chase-Lansdale, Kiernan, Robins, Morrison, & Teitler, 1991). One explanation for this is that the children in the households that later divorced were exposed to higher levels of marital unhappiness and conflicts which are known to increase children difficulties (Amato & Booth, 1996; Forehand, Neighbors, Devine, & Armistead, 1994).

Conclusion

The results of the present study revealed that children and adolescents with low academic achievement show significant comorbidity of DEP, ANX and FI . With respect to certain demographic variables it has been found that children and adolescents belonging to low socio-economic status and single parent families have shown significantly high level of emotional problems and functional impairment as well as low academic achievement. Logistic regression analysis showed that the depression and anxiety disorders alone are not good predictors of academic

achievement but when comorbid with FI then these disorders show an inverse relationship with academic achievement. Similarly among the demographic variables age and income have not found to be significant predictors whereas mother education and family discord has been found to be significant predictors of academic achievement in children and adolescents which is also in line of the earlier studies (see e.g., Masselam, Marcus, & Stunkard, 1990).

Chapter VI

GENERAL DISCUSSION

The present research has attempted to measure the level of comorbidity of DEP, ANX and FI in children and adolescents with low academic achievement. Unlike other physical disabilities ED as revealed by literature review is a kind of learning disability which remains unidentified and many students with low academic performance remain deprived of receiving effective services. The main reason is that the child screening studies regarding comorbid disorders and the extent of their related FI are very smsll in number because most studies are focused on screening for a particular problem with an instrument specifically developed for that disorder for example screening methods for attention-deficit/hyperactivity disorder (ADHD) (August, Realmuto, MacDonald, Nugent, & Crosby, 1996), Attention Deficit Disorder (Cantwell, 1996), and depression (Lewinsohn, Hops, Roberts, Secley, & Andrews, 1993) have been conducted on school population. Due to unidimentional screening many children remain unidentified who may have problems other than the target disorder.

The research on comorbidity of ED and the functional impairment across different aspects of behavior are very spars. Though every emotional disorder involves certain functional deficiets of individuals in different social activities including home and school settings (Nagar, Sherer, Chen, Aparasu, 2010) very little is known about the extent of functional impairment in children and adolescents with low academic achievement.

In Pakistan this is the first study of its kind which not only studies co-morbidity of depression and anxiety (ED) but also has attempted to juxtapose functional impairment which is considered to be a key symptom in assessing any developmental psychopathology in the children and adolescents. In recent years a need has been felt to place an emphasis on performing some tangible efforts in identifying emotional disability throygh the assessment of functional impairments in young population. For this purpose special screening devices are needed which are specifically mended for assessment of functional impairment. In the light of their most recent research findings Ann Vander Stoep, Molly, Adrian, Isaac, Rhew, Elizabeth, McCauley, Jerald, Herting, Helena, and Kraemer (2012) have suggest that when relying solely on DSM diagnostic criteria for comorbid depression and disruptive behavior disorders, many adolescents with significant impairment will be overlooked. Their findings also suggest that lower dimensional scale thresholds can be set when co-morbid conditions, rather than single forms of psychopathology, are being identified. Unfortunately there is no such measuring device available in Pakistan which can measure emotional disturbance through the assessment of the level of functional impairment. Here again this study has got a great opportunity to provide an indigenous scale in Urdu language to assess the level of functional impairment for school population which is another unique aspect of this study.

The newly developed Functional Impairment Assessment Scale (FIAS) covers all the domains such as social, emotional and cognitive functioning.

Following the conceptual framework the present study has measured the Functional Impairment in terms of five main categories of psychological functioning, namely, social dysfunction, cognitive dysfunction, emotional dysfunction and

impaired learning behavior involving lack of attention, concentration, response and interest in the classroom activity necessary for learning phenomena. These categories have strong theoretical and research stem. Literature has identified certain characteristics of adolescents with mental health difficulties in the academic, social, emotional and behavioral domains which are tangibly responsible for their elusive post school outcome.

The measurement of emotional disturbance (ED) and functional impairment (FI) in children and adolescents has been studied in home as well as in school setting with regard to their age, gender, academic achievement and class or academic year through parents and teacher rating forms.

As the basic objective of the present study was to identify the hidden barriers to leaning as well as to identify the primary mental disability (ED) in the children and adolescents who fail in the class, are low achievers and those who are school runners or simply refuse to come to school the assessment of functional impairment along with Emotional Disturbance (depression & anxiety) was planned to take into account. Four main questions addressed in the present study were:

6. To find the comorbidity and relationship among the variables of the study, such as FI, Emotional Disturbance (DEP & ANX), PWB, and life satisfaction (LS) in students with low academic achievement.
7. To determine the difference of level of Emotional Disturbance (DEP & ANX), FI, PWB and life satisfaction in students with low and high academic achievement.

8. To find out the strength of the predictors of low academic achievement in terms of emotional disturbance, functional impairment, low psychological well-being and low life satisfaction as compared to those with high academic achievement.

The current study was conducted in three parts with independent samples. Part I involved the development of an indigenous scale particularly in Urdu to be used as a research tool in the study. The results yielded an instrument with sufficient psychometric properties with the name of Functional Impairment Assessment Scale (FIAS). The Part II was conducted to perform validation of newly constructed FIAS and translation of Depression and Anxiety in Youth Scale (DAYS; Phyllis, Newcorner, Enda, Barenbaum, et al., 1994) in Urdu also to be used in the present research. (For details of part II please refer to the chapter-IV).

The third part of the research was carried out to address the research question through hypothesis testing formulated for this purpose in the main study: Part III of the current research. In order to test the hypotheses the instruments used were:

1. Functional impairment Assessment Scale (FIAS) an indigenous scale developed in the Part 1 of the study which was used for the measurement of the level of functional impairment;
2. DAYS (Phyllis e al., 1994) translated in the Part II of the study was used for the measurement of the Emotional Disturbance (DEP & ANX).
3. Urdu Version of Wellbeing Scale Affectometer 2 along with Life satisfaction Ladder Scale (LSLS) was used for the measurement of psychological wellbeing in the subjects or sample population and

In addition a bio-data sheet for recording the information related to their age, sex, class, socioeconomic status and family structure had been attached with the FIAS.

Reliability analysis of all the scales was also performed in the main study which yielded sufficient reliability, validity and internal consistency coefficients for all the scales indicating that the measures are reliable to use to achieve the objectives of the present research.

In the Part-1 of the present research an indigenous scale; Functional Impairment Assessment Scale (FIAS) has been developed to be used in the main study (Part-III). The rationale behind was to obtain a culturally free instrument which should be in Urdu language. Literature review reveals that, for the achievement of a high degree of identification rate of functional impairment and emotional problems in students, the culturally sensitive and linguistically appropriate assessment instruments must be used. Unfortunately there was no such scale available in the country particularly in Urdu language which could fulfill the needs of the present research. So in order to avoid the risk of cultural bias for the assessment of functional impairment and the level of the global learning behavior in Pakistani children and adolescents with low academic achievement an indigenous scalethe Functional Impairment Assessment Scale (FIAS) was developed in the Part I of the research.

In this context, the FIAS possesses the capacity to assess FI both in early / acute as well as in chronic / severe mental illness. The FIAS is a scale of broad spectrum which encompases all the main domains of functioning including social, emotional cognitive, and school or academic functioning. FIAS is a simple

instrument with easy administering and scoring method with strong psychometric properties.

The FIAS has been designed to be used for early identification of children and adolescents between 6 and 19 year age with emotional disturbance through the measurement of global impairment in different domains of their psychological functioning so that they could be provided with early intervention plan. In this sense this scale fulfills the recent diagnostic requirements recommended by DSM-IV criteria which state that all depressive disorders require the presence of functional impairment.

Assessment of FI in young population demands a multi assessment system that should include both home and school environment of the target population. In this regard parents and teachers have been found to be valid informants because the majority of students referred by teachers are found to have a disability.

Though teacher's ratings play a very important part in identifying emotionally disabled students these are restricted to certain behavioral aspects which a child depicts only in school. But there are so many other aspects of children's behavior which are related to home environment and which can only be reported by their parents. For example, children's social behavior in their peer groups or the learning behavior (attention span, carefulness and class participation) can better be perceived by their school teachers whereas parents especially mothers have better perception of their global functioning including emotional and behavioral problems at home environment. Therefore both the informants (parents and teachers) are of equal importance. Shemmassian and Lee (2012) also have found in their study that Parent ratings of ADHD optimally identified globally impaired children.

Functional Impairment Assessment Scale (FIAS) for Pakistani school population is a multi-modal assessment system that has been developed with strong theoretical stem which fulfills the requirements of new surging trends in the assessment of functional impairment of school population. The FIAS has been developed according to the DSM-IV criteria of emotionally disturbed and Developmental strategy formulated by the staff of Neuropsychiatry Institute (NPI) (UCLA) which is the institute that provides sources for research and training is the field of mental illness. Developmental strategy dscribes the behaviors or competencies that is necessary for all children to learn in school.

Functional Impairment Assessment Scale (FIAS) is the first scale of its kind in Pakistan constructed for the young population. It will be useful both in assessing the functional impairment and level of learning behavior of children and adolescents with or without academic achievement in schools by teachers; in clinics by mental health practitioners and for the research purpose in the field of developmental psychology.

FIAS measures the child's functioning and learning behavior in two different environments (home and school) from two perspectives: parents, through Parent Rating Form (PRF) along with a Bio-Data Sheet and teachers or other professional through Teacher Rating Form (TRF).

The 62- item Teacher Rating form (TRF) provides teachers in their hands a systematic way for identifying students at risk in which they can observe their classroom behavior directly regarding concentration or attention span, interpersonal relationship, and mood. TRS contains the items related to the functional impairments in terms of emotional, social and cognitive and learning behavior dysfunction of the children and adolescents in the school settings. In general TRS collects the global

information regarding the class room behavior and their problems with concentration or attention and learning behavior problems in school, etc.of the child that can be helpful in the early identification of any psychopathology which may be present in the child.

The 60-item Parent Rating Scale PRS (Form-P) was developed to acquire parental reports of the child's behavior at home regarding household activities, mood and social activities as well as his problems with eating, sleeping and interpersonal relationships The PRS contains items covering cognitive, emotional and social dysfunction. The PRS has also a group of items measuring emotional states such as anxiety and depression. The information regarding the demographic variables (age, socio economic status, parental education etc) can be obtained through a Bio Data Sheet attached with the form-P.

As both the forms measure the same construct these provide the information through similar four domains but in two different environments (home and school). These domains or four sub-scales are: (1) The Learning Behavior Dysfunction Scale (LBDS) assesses the problems with learning behavior in the class or other school places and the extent to which children obey school rules and performs age-appropriate tasks. (2) The Social Dysfunction Scale (SDS) measures the level of interpersonal skills of youngsters (3) The Emotional Dysfunction Scale (EDS) measures the level of depression, anxiety, and overall emotional state (4) The Cognitive Dysfunction Scale (CDS) assesses impairment in rational thought processes of youngsters. The scores of each domain are interpreted in terms of mild, moderate, and severe impairment.

The PRS and TRS possess good psychometric properties Good reliability of both the forms as assessed by test-retest and inter-rater reliability has been established. For the determination of reliability, Cronbach alpha coefficients, Inter-scale correlation, and split-half reliability coefficients have been calculated. Cronbach's alpha coefficient yielded an internal consistency coefficient of .91 for the total TRF (Form-T) and for its sub-scales it ranged from .74 to .84, which are quite satisfactory and .88 for PRF (Form-P) and for its sub-scales it ranged from .68 to .80 of FIAS. The Inter-scale correlation of all the subscales with each other and with total Form-T and Form-P of FIAS yielded a significantly positive correlation of the sub-scales of Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction and Social Dysfunction with each other and with the total Form-T and Form-P of FIAS showing internal consistency of all these scales. This result is in accord with the findings that the overall intellectual potential of depressed and anxious youngsters is comparable to those who are not depressed suggesting that association between severity of depression and children's overall intelligence is weak (Kovacs, Feinberg, Crouse-Novak, 1984). For the FIAS the content and construct validities were established which proved to be satisfactory.

For construct validity of newly constructed scale FIAS the Part II of the present study has been conducted specifically. For the determination of the discriminant validity, the Urdu Version of Well-being Affectometer-2 and for convergent validity the Urdu version of DAYS (Phylis et al., 1994) has been used which was translated in Urdu in Part-II of study. The need to translate the DAYS in Urdu emerged due to two reasons. Firstly, the present research aimed to use DAYS for validation of FIAS which is an indigenous scale constructed in Urdu Language for

the Pakistani school population and hence the Urdu version of DAYS could have served the purpose better. Secondly present research also planned to use the DAYS for the purpose of hypothesis testing in the main study therefore in order to cross the cultural and lingual barriers which could have ruin the data it was decided by the researcher to use the Urdu version of the DAYS in the current research. Though a well known scale named Beck Depression Inventory (BDI) is also available in Urdu language it has not been included in the present research, and the reason is that, it is used for the individuals of 12 years age and above whereas the age range of the sample included in the present research consists of individuals of 6 to 19 years age. Therefore, instead of BDI the DAYS (Phyllis e al., 1994) were included in the research as it has been designed for the children and adolescents of 6 to 19 years age. There is another scale namely Strength and Difficulties Questionnaire (SDQ) (Goodman, 1997) suggested by one of external analyst of the theses. Though this is very established and well known scale yet this also does not seem to meet the requirement of age range (6-19 years) of the sample population of the current study as SDQ is for 4-16 years age group. Further, SDQ measures more or less psychological constructs like prosoial, conduct, attention deficiet hyperactivity or externalizing disorders and present research aims to measure internalizing problems in children and adolescents. Hence DAYS appeared to be best suited to meet the demands of the current study.

For the determination of discriminant and convergent validity of FIAS, the scores of the participants on FIAS were correlated with their scores on Urdu version Well-being Affectometer-2 Scale. For this it was hypothesized that the students who will show more functional impairment and emotional disturbance will show low sense of well being.

The results suggest that FIAS possesses sufficient and promising discriminant and convergent validities as the total score on the two forms TRF and PRF of FIAS and scores on its sub-scales namely, Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction, and Social Dysfunction have shown significantly negative correlation with well-being affectometer-2. The scale used for validation purpose (Urdu version of Well-Being Affectometer-2 by Naheed, 1997) was constructed and developed in the Pakistan and in the same language (Urdu) so these findings are quite satisfactory.

For the determination of convergent validity of FIAS, the scores of the participants on FIAS were correlated with their scores on DAYS-U. For this it was hypothesized that the students who will score high on Functional Impairment Assessment Scale (FIAS) newly developed in the present study will also show high score on the DAYS-U, because research on developmental psychopathology has revealed that the impairment in the cognitive, emotional and social functioning may serve as the school indicator of the emotional disturbance in the children and adolescents. But due to its co-occurrence it is often difficult to know whether cognitive and psychological deficits are an outcome or cause of depression (Cole, Martin, Posers, & Truglio, 1996).

The results suggest that FIAS possesses sufficient and satisfactory convergent validities as the total score on the two forms TRF and PRF of FIAS and scores on its sub-scales namely Learning Behavior Dysfunction, Emotional Dysfunction, Cognitive Dysfunction, and Social Dysfunction have shown significantly positive correlation with the DAYS-U. These findings are also quite satisfactory.

The internal consistency reliability and validity of the FIAS with respect to the different demographic or the risk factors such as age, socioeconomic status , parental education family structure and academic achievement was established with children with / without disabilities in part-III, the main study of the present research project.

Part III the main study was carried out firstly to verify and establish the reliability and validity of the FIAS for second time on a new and a larger sample, of school children and adolescents as a function of different demographic variables such as age, gender, family structure, marital conflict, socioeconomic status and maternal education. The results have established very high and satisfactory reliability, content and construct validity.

Second major objective of the main study (Part-III) was to test the hypotheses formulated to answer the research questions regarding the assessment of the comorbidity and relationship among DEP, ANX and FI in school population with low academic performance with the sample of (N=410. For this purpose the correlation analysis among the variables of the study by using newly developed (in Part-I) indigenous scale FIAS, Urdu version of DAYS (translated in part-II) an Urdu version of Psychological Well-Being (Affectometer-2) and Life Satisfaction Ladder Scale (LSLS).

Another basic purpose of the study was to find out that how children and adolescents with low academic achievement differ in their performance on the above mentioned scales (on total and sub-scales) from the children and adolescents with high academic achievement. These scales were administered on two groups: ***Group I***: consisting of students (n=*205*) with low academic achievement who stood within the last five positions on the annual examination result sheet prepared by their class

teachers and ***Group II***: consisting of students *(n=205)* with high level of academic achievement, who showed excellent performance in their annual examinations and who stood within the first five positions on the annual examination result sheet prepared by their class teachers. Information about the children was gathered by the class teachers and parents/family member who is able to provide the full information about the child's behavioral and psychological functioning. ANOVA and *t*-test analysis for independent samples were computed to find the differences between low and high academic achievers on these variables as well as with respect to different demographic variables. Finally, Multiple Logistic Regression Analysis was carried out to study the combined effect of depression, anxiety, psychological wellbeing, life satisfaction and functional impairment on low academic achievement.

The findings of the present study indicate that there is a significant positive correlation between emotional disturbance and FI but there is a significant negative relationship between DAYS-U (Urdu translation), FIAS and PWB Affectometer-2 i.e., (r = -.08) and with Life Satisfaction Ladder Scale (LSLS) it is r = -.01 which is a desired direction.

The results of the main study also indicate that there is a significant difference between primary and high school students with low and high academic achievement with respect to ED and FI. It has been found that children and adolescents with academic problems display a comorbidity of, emotional, social and cognitive deficits. The current findings have confirmed the existing trend that children and adolescents with low academic performance have high level of ED and FI as compared to their age mates with high academic achievement. The high mean score of children and adolescents with low academic performance on FIAS and its subscales indicated that

this group may has some emotional disability in the cognitive social and emotional domains.

Effect of the impaired Global Learning Behavior on academic achievement was also explored. Our results showed that students with low academic performance posses low learning behavior. i.e., they do not concentrate in class have low attention span have no interest in participating in group activities, as compared to their age fellows without disabilities. It has been found that students who manifest good learning behavior, participate in extracurricular activities are usually good achievers and show good school performance and educational attainment. These findings are in accordance with the early findings that document that the teachers rated the youth with academic problems as having impaired learning behavior and emotional disturbance (Cullinan & Sabornie, 2004).

Level of Comorbidity of Functional Impairment (FI) and Emotional Disturbance (ED) with Respect to Demographic Variables

FI and ED were also studied with respect to certain demographic variables such as age, gender, socioeconomic status, single parent families, and maternal education and marital conflict.This study replicates other recent findings that the presence of comorbid depression in anxious youth is associated with severe anxiety and family dysfunction. (Guberman, & Manassis, 2011) and that Women, young people, and people earning low income are at high risk of comorbid anxiety and depressive disorders (Leray, Camara, Drapier, Riou, Bougeant, Pelissolo et al., 2011)

A brief description of associatin between comorbidity of Functional Impairment (FI) and Emotional Disturbance (ED) with respect to demographic variables is as follows.

Age. Recent research puts a profound emphasis on the need for early intervention for school age students with behavior problems (Kamps, Tankersley, Mancina, & Weidin[g]er, 1996) as well as inventing the standardized instruments to measure mental disability in children and adolescents. Only early identification can lead to the early intervention planes and strategies effective enough to affect student classroom performance.

The age range of the participants in the present study was decided to be from 6 to 19 years. Many longitudinal researches indicated that emotional disturbance and patterns of functional impairment begin at early age and if not treated timely continue up to adult life (Campbell, 1994; Walker et al., 1995).

The results of the present research as a function of the age showed a comparatively high level of FI and ED within the age group from 14 to 19 years (students of high school) and in children of age between 6 to 10 years a comorbidity of fear, sad and irritable mood, along with physical complaints has been found frequently. The senior students of high school or college students have been found to escalate in the depression scale scores as well. This result is in line with the early research findings. For example, Douglas, Cullinan, Edward, and Sabornie (2004) found that among students who were provided special need services under the category of ED, about 65% were more than 12 years age. The popular age groups of students with ED are 15-year-olds (Maag and Behrens, 1989).

The result shows that there is a significant difference in the mean scores of the (PSS) Primary School Students, (MSS) Middle School Students, and (HSS) High school students on the subscales (DS, AS and the SDS) of Form-T and Form-P of FIAS. The same trend has been seen when measurement was made with the separate scale DAYS-U newly translated in to Urdu in the part one of the present study.

The DAYS-U results have also established the construct validity of FIAS in the main study for the second time. This result is in line with the early research findings.

The measurement of psychological wellbeing in different age groups was carried out by using the scale the Urdu Version Psychological Wellbeing Scale Affectometer 2 and Life Satisfaction Ladder Scale. The results were also used to confirm the construct validity (Discriminent) of the FIAS for the second time. The results show that there is significant difference between the mean scores of two groups (Pre-adolescents and Adolescents) on Urdu version of Wellbeing Affectometer 2. And there is highly significant difference among the scores of the three groups (i.e., Children, adolescents and *(HSS) High school students*) on Life Satisfaction Scale. However, the lower mean score for the *(HSS) High school students* suggests that adolescents at the age between14 to 19 are more emotionally disturbed and feel low level of psychological wellbeing and also do not perceive their life satisfactory.

According to One-way analysis (ANOVA), our hypothesis No. 1, 4, 5, 6, 11, and 12 from the list of sub hypothesis of the main study that the Students within the age group of 12 to 15 years show high level of functional impairment and low learning behavior as compared to the students of other age groups; that students within the age group of 14 to 19 years ((HSS) High school students) score high on the

Emotional Disturbance as compared to the students of the 7 to 10 age groups; that the primary school students with age group (7 to 10 years) score high on the particularly Anxiety Scale whereas the high school / college students score high on depression scale as compared to the students of other age groups and that a*dolescents of 14 to 19 years will score low on psychological wellbeing and life satisfaction scales as compared to the students of other age groups*, finally the incidence of level of comorbidity of functional impairment and emotional disturbance is high among High school Students; that high school students with academic problems have more emotional problems (depression & anxiety) than the primary school students with low academic achievement has been confirmed.

Gender. In childhood, boys and girls are at equal risk for depression; but during adolescence, girls have been found to be more susceptible of depression than boys (Birmaher, Ryan, & Williamson 1996; Steinhausen, Muller, and Metzke, 2008).

FI and ED were also studied with respect to gender The results have revealed that the mean score of adolescent boys on FIAS and DAYS is greater than girls but adolescents girls have scored more on depression scale as compared to boys. These findings are in accordance with the previous findings in which using a self-report instrument of suicide-related behavior, Miller (1994) found that adolescent girls with emotional disturbance reported more suicidal ideation and attempts than did boys.

In the cognitive dysfunction or inappropriate behavior subscale of FIAS both the genders showed high score. A similar kind of result was obtained by Cullinan, Epstein, and Kauffman (1984) while studying specific teacher-rated emotional and behavior problems among middle / high school students found that so far as cognitive

dysfunction is concerned both girls and boys with ED showed more inappropriate behavior than their peer without emotional problems.

Hence according to t-test analysis our hypothesis No 7, 8, and 9 that a*dolescent boys show high level of Functional Impairment (FI) as compared to the girl students of their age mates.*' has not been confirmed. This means that there is no difference in the prevalence of FI among girls and boys; that girls show significantly high level of symptoms of depression as compared to the boy students of their age mates and that girls show significantly low psychological well- being and life satisfaction as compared to the boy students of their age mates have been confirmed.

Socio-economical Status. The present study has also explored the relationship of different demographic risk factors including family structure, domestic violence and low socio-economical status with the Emotional Disturbance, psychological wellbeing, life satisfaction and Functional Impairment in the children and adolescents with low academic performance. The finding of the present research has confirmed the sub hypotheses No 10 *saying that t*here is comorbidity of DEP, ANX low PWB and FI in the children belonging to the families with low socioeconomic status as compared to the children belonging to the families with moderate or high socioeconomic status.

The results found are just in line with the previous findings regarding relationship of school failure in adolescence and demographic risk factors including low socioeconomic status, or lack of parental support for educational effort (e.g., Cairns & Neckerman, 1989; Felner, Brand, DuBois, Adan, Mulhall, & Evans, 1995) Hinshaw, 1992; Pungello, Kupersmidt, Burchinal, & Patterson, 1996; Rumberger,

1987; Rumberger, Ghatak, Poulos, Ritter, & Dornbusch, 1990; Stroup & Robins, 1972; Vallerand, Fortier, & Guay, 1997).

The literature states that children with lower socio-economic status are not supported by their parents or adult family members for basic biological as well as psychological needs, which makes them more frustrated and depressed. Due to the lack of family support they achieve less in their life. Masselam, Marcus, and Stunkard (1990) found that family support is directly proportional to self-esteem but inversely proportion to the depressive symptoms over time..i.e., with the increase of family support self-esteem increases but depressive symptoms decrease.

Maternal Education. The educational level of parents has been attributed to be an important aspect of socio-economic influence on school performance (Eva & Monica, 2009). The parents are the most influencial figure in the lives of their children's. Those children are successful in school whose parents take part actively in their academic activities (DePlanty, Coulter, & Duchane, 2007).

The present study has demonstrated that children whose mothers are educated have shown a high level of psychological well-being as compared to the other group. The high mean scores of the group 1indicated that children whose mothers are less educated have some deficits in their cognitive, social, emotional and academic functioning.

The same trend has been seen in the mean scores of all the groups on the five sub-scales of Form-T and Form-P of FIAS revealing that students in this group show low learning behavior. Whereas low mean scores of children pertaining to fourth

group reveal that children of highly educated mothers have good learning behavior as compared to the children's of uneducated mothers.

The significant result on t-test has confirmed sub hypothesis No 14, and 15 stating that children of uneducated mothers have more signs of comorbidity of depression, anxiety and functional impairment as compared to the children of educated mothers; and that children of uneducated mothers have low sense of WBS as compared to the children of educated mothers. This is probably due to the fact that, most of the educated women like to work because it gives them more autonomy and satisfaction. They are economically as well as psychologically self-sufficient. Durrant and Sathar (2000) document that Pakistani women with higher status (educated and employed) are better able to make positive investment in their children. Being satisfied with themselves because of their financial contribution and more caring attitude they enhance psychological well-being in their children. Literature explains that mother's psychological well-being is strongly associated with mental health of their children. Mothers who are educated and do work (even part time) have good mental health. In an old study Gove and Tudor (1973) found that among married women, full time housewives seem to have more psychological problems than the working wives.

Single parent family. Family structure especially single parent family system has been found to put a strong influence on the psychological adjustment of adolescents (Savin-Williams & Berndt, 1990; Steinberg, 1990).

A number of researches illustrate that breakup in parental relationship or separation leads to the psychopathology in children. This study aims to find out the emotional disturbance in the children of single parent families (either divorced parent or one parent died).

The present research demonstrated that the children of single parent families (mostly mothers) following within two years of their mother's divorce or their father's death have more depression and anxiety as well as functional impairment as compared to children of both parent families. This result is in consensus with the early findings which demonstrate that in first two years or so after divorce, children show more defiant behaviour, aggression, dependency, anxiety, depression and more difficulties in their social relationships and academic performance (Kurdek & Berg, 1983; Mitchell, Hammond, & Bee, 1983).

The higher level of ED and FI in children from single parent Pakistani families can be well explained under the cultural and religious values, in that, in Pakistan where the majority of population is Muslim there is no concept of unmarried mother. And the father has a very strong place and role in the family. The children who do not have their father (either died or divorced) find it very hard to fill the gap of their father and nobody else can take their place or compensate the loss of their real father. Therefore most of them become depressed and irritated. Literature also shows some kind of agreement that this issue is more or less culturally sensitive. . In some ethnic groups the effect of family structure, showed little significant variation between married and unmarried families (Gibson-Davis, Christina; Gassman-Pines, & Anna, 2009).

Marital conflict /domestic violence. Our results have demonstrated that children and adolescents from the discordant families have more symptoms of ED and low psychological well-being. The level of FI is high in this group as compared to the children and adolescents from harmonious families (where parents are happily married).

The literature review illustrates that the family role is to provide the child with a safe, secure, nurturing, loving and supportive environment that allows the children to have a happy and healthy youth which enables them to enter in adulthood safely. But the marital conflict contributes to problematic emotional and behavioral child adjustment, largely indirectly through poorer mother-child relationships. Disputing spouses also have higher post separation conflict and children with more behavioral problems. Although divorce is generally associated with short term difficulties for the adolescent, several studies show that at least some of the differences between adolescents from divorced versus non divorced homes were present before the parent's divorce (Cherlin, Furstenberg, Chase-Lansdale, Kiernan, Robins, Morrison, & Teitler, 1991). One explanation for this is that the children in the households that later divorced were exposed to higher levels of marital unhappiness and conflict and strained parent child relationships, both of which are known to increase children difficulties (Amato & Booth, 1996; Forehand, Neighbors, Devine, & Armistead, 1994).

Determination of Strength of the Predictors of Academic Achievement

In order to find the relationship and strength of the predictors of academic achievement Multiple Logistic Regression Analysis was applied on the present data which revealed that that depression and anxiety do not predict academic achievement but only comorbidity of depression and anxiety coupled with function impairment is associated with low academic achievement. This means that emotionally disturbed children and adolescents will show low academic achievement only when they have functional impairment in the domains of their cognitive, social and learning behavior. In the next step it was found that Regression model improved further in the block 3 when the third variable of the study: the psychological wellbeing was added. These results are in line with the earlier findings. For example Researchers (Douglas et al., 2004) found that students with ED who had academic problems showed functional impairment in their cognitive thought processes, emotional and social behavior than other students without ED.

The overall percentage of cases correctly classified cases in each block starting from the model in initial block 0 was found to be 52.3 % and when the first variable (depression & anxiety) was added in the model in block 1 no increase in the percentage of cases correctly classified was seen which indicates that inclusion of depression and anxiety has not improved our ability to predict whether academic achievement will be low or high in children and anxiety. But when variable of functional impairment was added in the model in the block 2 the percentage of cases correctly classified was raised to 62.6 %. The extra 10.3% percent shows a significant improvement in the model to predict the academic achievement. In the block 3 where

variable of psychological wellbeing was added the percentage of cases correctly classified was raised to 63.2 %. So an extra 1.4% cases were correctly classified which is not a big deal of improvement in the model. So we can say that among the variables in the regression equation only functional impairment has been weighted as a significant predictor whereas psychological wellbeing has proved to be a week predictor of academic achievement and that depression and anxiety cannot predict academic achievement alone unless coexisting with functional impairment in children and adolescents. This means that emotionally disturbed children and adolescents will need special need services only when they have functional impairment in cognitive, social and emotional domains.

Conclusion

This is the first study of its kind conducted on the Pakistani school and college population that attempts in understanding the relationship between emotional disturbance and academic achievement. It also explores the influence of family structure, SES, marital conflict/ domestic violence, maternal education and other demographic variables including age, gender, academic year or class over the academic performance of children and adolescents.

Recently researchers (Mieke, NeeltjeBatelaan, Harold, van Megen, Brenda, Penninx, et al., 2012; Ann Vander Stoep, Molly, Adrian, Isaac, Rhew, Elizabeth McCauley, Jerald, Herting, Helena, & Kraemer, 2012) are highlighting the importance of incorporation of functional impairment in diagnosing ED and document that without assessment of functional impairment diagnosis of psychopathology is not complete. It has been found that presence of depression and anxiety symptoms alone

are not strong enough to predict low academic achievement rather it is the comorbidity of the functional impairment with depression and anxiety which actually leads to low acsdemic performance. i.e., presence of FI along with symptoms of DEP and ANX is the real barrier to learning.

Incorporation of functional impairment in the present research for identification of emotional disability in school or college students is an important aspect of the study which makes it unique in Pakistani research in the field of developmental psychology.

To identify functional impairment in the social, emotional, and cognitive domains is an important step of any intervention and treatment plan for students with emotional disturbance. The present results provided a very vivid picture of psychological functioning of children and adolescents with low/high academic achievement. Our Group 1 (students with low academic achievement) showed significant functional impairment and Emotional Disturbance (DEP & ANX) as compared to the control Group II (students with high academic achievement) that was found to be free from these symptoms. Interestingly all the results yielded the same trend established by the earlier findings. Conversely, students with comorbidity of depression, anxiety and FI showed a significant difference on Global Learning Behavior scale which measures overall competence required for effective learning.

So far as the age difference is concerned the high school students with low academic achievement showed more symptoms of ED and higher level of functional impairment than the primary and middle school students with low academic achievement.

Primary school students were found to be more likely to escalate in the anxiety, fear and physical complaints than their older peers whereas the secondary

school students were found to be more emotionally disturbed and manifested more social, emotional and cognitive dysfunction. Analysis on the basis of gender difference yielded that the secondary school boys were more likely to show co-morbidity of Emotional Disturbance and functional impairment than girls of their age mates who were found to score high on depression scales. Similarly children and adolescents pertaining to low socio-economical status, single parent family, discordant and of less educated parents showed high level of emotional disturbance, functional impairment and low academic achievement as compared to control group.

The results of this study have educational implications because understanding of hidden barriers to learning in students with low academic achievement is very necessary for making proper educational programs to improve their academic performance. The current research has not only attempted to give an insight on the issue of recognizing emotional disturbance that is referred as a hidden disability in school population but also has provided an effective instrument (FIAS) in the hands of teachers or school personel to identify the emotional disability in children and adolescents with low academic achievement. Another great contribution of the present research is the development of an indigenous Functional Impairment Assessment Scale (FIAS) which possesses satisfactory psychometric properties and that can be used with full confidence by teachers, researchers and psychologists in indentifying functional impairment in young population.

Limitations and Suggestions

Though this study extends the understanding of student's'deficiets in different domains of functioning in home and school settings,.it also has certain limitations in

terms of different methods, techniques and its sources of information which are as follows:

Firstly, the main informants in this study were teachers and parents. Although in the assessment of developmental psychopathology parents and teachers play a very tangible role and are considered to be valid informants, the research evidence on how to match and combine their ratings in a systematic way is very sparce. Like prior investigations the present study has also this kind of limitation of being relying on teacher's referral or reports rather than direct observation. Because the teachers especially of Government schools of Pakistan have got the limited knowledge regarding the psychological behavior of the students as their class consists of a large number of students and it becomes hard for the teachers to observe each and every student very closely and keenly. Although in order to resolve this limitation parents were added as key informants to provide the information of the emotional state and functional impairment in their children and adolescents so that the overlooked aspects of student's psychological and learning behavior by the teachers could be compensated, yet the direct observations and in-depth interviews may be needed to unfold some more aspects. But unfortunately parents could not be contacted directly by the researcher due to limited resources and had to rely once again on class teachers who sent and received back the forms to be filled by parents in homes through their children. This was the most convenient way which could be adapted in order to collect the data as school children are usually used to of it because they always do this kind of duty. (e.g., taking the school circulars or report cards to home and returning back after signed by the parents to their class teachers)

Secondly, future research is needed to explore the class and school environments where a child spends five to seven hours during a day that may affect his psychological adjustment among adolescents. Similarly some extensive reseach

work is also required to explore the quality of community environment and neighborhood in which the adolescent resides and performs after-school activities so that the factors responsible for the child's school failure or drop out could be grasped.

Thirdly, future longitudinal studies are required to see the improvement or changes in functioning in students with low academic achievement as they age and enter into young adulthood so that in the light of this information professionals may adapt suitable strategies that have the potential to prepare the effective intervention and treatment plans for the needy adolescents.

At last, an indigenous screening device Functional Impairment Assessment Scale (FIAS) has been constructed in the current study. Though the newly developed FIAS possesses satisfactory psychometric properties further research regarding reliability and validity of the scale on clinical population will improve and enhance the confidence of its use in mental health clinics along with other diagnostic measures. Further, for some items which have been included in more than one sub-scale of FIAS on the basis of their theoretical orientation a thorough investigation is warranted in the future research.

Fourthly, the researchers feel the need for some greater discussion of the relationship between functional impairment and externalizing and/or internalizing behaviors, which are of key concern for children at school. As the present research could only address the internalizing problems it has been suggested to conduct a research encompassing externalizing behavior of school population in future as a PART 2 of the current research.

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APPENDICES

Focus Group Discussion
Guide Line

تعارف: محترم خواتین وحضرات السلام علیکم!

آج کے جس بحث ومباحثہ میں شرکت کے لیے آپ کو دعوت دی گئی ہے- اس کا مقصد آپ کی قیمتی آراء اور مشاہدات کو اکٹھا کرنا ہے تا کہ وہ تحقیقی کام میں کام آسکے۔اس تحقیق کا تعلق اُن بچوں کی ذہنی ونفسیاتی صلاحیتوں کو ناپنے سے ہے جو پڑھائی میں کمزور ہوتے ہیں۔ سکول میں ان کی کارکردگی اچھی نہیں ہوتی۔ یوں تو بظاہر اُن میں کوئی جسمانی معذوری یا نقص نہیں ہوتا، لیکن پھر بھی وہ پڑھائی میں اچھی کارکردگی نہیں دکھا پاتے اور رفتہ رفتہ وہ اپنے ساتھ کے باقی بچوں کی بہ نسبت پیچھے رہ جاتے ہیں اور پھر میٹرک بھی پاس نہیں کر پاتے۔

پاکستان کے قومی ادارۂ نفسیات، قائداعظم یونیورسٹی، اسلام آباد کے تحت ایسے بچوں کی ذہنی ونفسیاتی صلاحیتوں کو جانچنے کے لیے ایک سکیل بنایا جارہا ہے۔تا کہ ان کمزور بچوں کے ذہنی ونفسیاتی مسائل کا بروقت اندازہ لگایا جاسکے اور انہیں خصوصی توجہ اور سروسز دے کر کامیابی کی راہ پر گامزن کرایا جاسکے۔سکیل کی تعمیر کے سلسلے میں ہمیں آپ کی آراء اور مشاہدات کی جانکاری کرنی ہے، تا کہ یہ سکیل ہماری سماجی ومعاشرتی تقاضوں کو پورا کرسکے۔ہم آپ کو دعوت دیتے ہیں کہ سب باری باری اپنے خیالات کا اظہار کریں۔

سوالات

سوال نمبر 1 جو بچے پڑھائی میں کمزور ہوتے ہیں اُن کی کلاس میں توجہ کیسی ہوتی ہے؟

سوال نمبر 2 جو بچے پڑھائی میں کمزور ہوتے ہیں کیا وہ سکول کی دیگر تقاریب میں شرکت کرتے ہیں۔اپنے خیالات کا اظہار کیجئے۔

سوال نمبر 3 جو بچے پڑھائی میں کمزور ہوتے ہیں ان کی سمجھنے بوجھنے کی صلاحیت پر روشنی ڈالیے۔

سوال نمبر 4 فیل ہونے والے بچوں کی سماجی کارکردگی کے بارے میں آپ کیا جانتے ہیں؟

سوال نمبر 5 جو بچے پڑھائی میں کمزور ہوتے ہیں- بار بار فیل ہوتے ہیں، اُن کی نفسیاتی کیفیت کے بارے میں آپ کیا کہتے ہیں؟

سوال نمبر 6 پڑھائی میں کمزور بچے کیا وقت اور قانون کی پابندی کرتے ہیں؟

شکریہ!

اجازت نامہ

Informed Consent by Teachers & Parents

ہم قومی ادارہ نفسیات، قائداعظم یونیورسٹی، اسلام آباد کی جانب سے اُن بچوں کی ذہنی اور نفسیاتی صحت کے بارے میں تحقیق کر رہے ہیں جو پڑھائی میں کمزور ہوتے ہیں اور ایک یا ایک سے زیادہ مضامین میں اکثر فیل ہو جاتے ہیں۔ جوں جوں وہ بڑی کلاس میں جاتے ہیں ان کی تعلیمی کارکردگی میں بتدریج کمی واقع ہوتی جاتی ہے اور آخر کار وہ اپنے بڑے امتحانات (میٹرک، انٹرمیڈیٹ یا گریجویشن) پاس نہیں کر سکتے۔

محترم اساتذہ کرام، والدین اور ماہرین نفسیات کے مطابق ایسے بچوں کی ذہنی اور نفسیاتی صلاحیتوں اور کارکردگی میں کچھ کمی یا خلل (Functional Impairment) ہوتا ہے۔ جس کی وجہ سے وہ پڑھائی میں کمزور ہو جاتے ہیں اور ان میں ہیجانی کیفیت ڈپریشن Depression اور Anxiety پیدا ہو جاتی ہے۔

چونکہ یہ بچے جسمانی طور پر معذور (نابینا، بہرہ یا گونگے) نہیں ہوتے اس لیے ان کی ذہنی صحت اور نفسیاتی مسائل کی تشخیص پر زیادہ تر توجہ نہیں دی جاتی اور اس طرح یہ بروقت تشخیص اور امداد و علاج سے محروم رہ جاتے ہیں۔ بدقسمتی سے پاکستان میں ابھی تک ایسا کوئی پیمانہ یا سکیل موجود نہیں ہے۔ جس کے ذریعے پڑھائی میں کمزوریوں میں موجود Functional Impairment کی تشخیص کی جا سکے۔ مگر قومی ادارۂ نفسیات، ادارۂ امتیاز، قائداعظم یونیورسٹی، اسلام آباد کے زیر اہتمام آج کی اس اہم ضرورت کو محسوس کرتے ہوئے ایک اُردو زبان میں Functional Impairment Assessment Scale (FIAS) بنایا جا رہا ہے تا کہ ان بچوں کی بروقت تشخیص اور ان کا علاج کیا گیا ہے۔ اُن کی نشاندہی ٹیچرز نے ہی کی ہے یہی وجہ ہے کہ دنیا کے ترقی یافتہ ممالک میں ایسی باقاعدہ تعلیمی پالیسیاں مرتب کی گئی ہیں جن کی رو سے تمام اسکولز اور کالجز ان کمزور اور ضرورت مند بچوں کی نشاندہی کرتے ہوئے ان میں موجود ذہنی اور نفسیاتی خلل کی تشخیص میں حصہ لیں گے، تا کہ یہ بچے دوسرے بچوں سے پیچھے رہ کر قوم اور معاشرے پر بوجھ بن کر نہ رہ جائیں۔

ہم تمام ٹیچرز سے یہ درخواست کرتے ہیں کہ آپ (FIAS) سکیل کے بنانے میں ہمارے ساتھ تعاون کریں اور اپنے قیمتی تجربے اور آراء کی روشنی میں اپنی جماعت کے پڑھائی میں کمزور بچوں کے رویے اور ذہنی و نفسیاتی کارکردگی کے بارے میں معلومات فراہم کیجئے۔ آپ سے لی گئی معلومات صرف تحقیقی مقاصد کے لیے استعمال کی جائیں گی۔

(FIAS) سکیل مندرجہ ذیل دو فارمز پر مشتمل ہے۔

(1) Form-T جو ٹیچرز کے لیے ہے اس کی مدد سے ٹیچرز اپنی کلاس کے کمزور بچوں اور نفسیاتی کارکردگی میں خلل کی نشاندہی کریں گے۔

(2) Form-P جو والدین کے لیے ہے جس کے ذریعے والدین اپنے بچوں کی ذہنی اور نفسیاتی کارکردگی پر روشنی ڈالیں گے۔

نوٹ: تحقیق کے دوران اگر آپ کسی وجہ سے حصہ لینا جاری نہ رکھ سکیں تو آپ بغیر اطلاع کیے بھی چھوڑ کر جا سکتے ہیں۔

شکریہ!

دستخط ٹیچر.....

دستخط والدین.....

منجانب:

ثمینہ بخاری
پی۔ایچ۔ڈی اسکالر
قومی ادارۂ نفسیات
قائداعظم یونیورسٹی اسلام آباد

Permission Grant for the Translation of Depression and Anxiety in Youth Scale (DAYS)

From: kligon@proedinc.com
To: saminabukhari14@hotmail.com
Subject: RE: Requesting translation of DAYS - Urdu for PhD research
Date: Tue, 23 Sep 2008 16:31:49 -0500
Samina Bukhari
National Institute of Psychology
Quaid-i-Azam University
Islambad, Pakistan
(92) 3005-231101

Dear Samina Bukhari

PRO-ED, Inc. grants to you nonexclusive permission to translate the DAYS: Depression and Anxiety in Youth Scale (hereinafter called the "Translated Work") into Urdu for your research solely as described in your request below. The Translated Work is only for your own use and is not for commercial use or resale. You agree to give PRO-ED a copy of both the Translated Work along with a copy of your research.

This permission is non transferable and shall automatically expire upon the earlier of the completeness of your research or three (3) years from the date of this permission. PRO-ED makes no representation or warranty about the appropriateness, effectiveness, capability, or reliability in regards to your research and you agree to hold PRO-ED harmless from all claims that may occur as a result of your use of our product in your research.

We appreciate your interest in PRO-ED products.

Sincerely,
Kelly Ligon, Foreign Rights Editor
PRO-ED, Inc.
8700 Shoal Creek Boulevard
Austin, TX 78757 USA
(512) 451-3246 x682
(512) 451-6785 Fax
kligon@proedinc.com
www.PROEDInc.com

Thank you,
Darci Mundfrom

From: samina bukhari [mailto:saminabukhari14@hotmail.com]
Sent: Thursday, September 18, 2008 1:21 AM
To: Darci Mundfrom
Subject: Requesting permission for the translation of DAYS in Urdu for PhD research

Dear Darci Mundrom,
Hopefully you must have seen my email regarding getting permission for the translation of DAYS the Depression and Anxiety in Youth Scale (which you had granted me free for my PhD research) in urdu language.
I am writing to remind you that please grant me the permission as soon as possible.
and also i would like to get the email address of the author of the scale so that i could send him the translated version.
Hope to hear from you very soon.
Thank You.

From: saminabukhari14@hotmail.com
To: kligon@proedinc.com
Subject: RE: Please reply me - Requesting translation of DAYS - Urdu for PhD research
Date: Sat, 25 Oct 2008 13:53:16 +0500

Dear Kelly
Thank you very much for granting me the required permission. Further, I am sending you the back to English Translation of the Urdu version of the DAYS (plz. find the attachmentfile). I request you to match it with the original version of the DAYS and give me the feedback regarding your approval. Hope to receive a positive responce from your kind hands.
Thanx

From: kligon@proedinc.com
To: saminabukhari14@hotmail.com
CC: darci@proedinc.com
Subject: FW: Please reply me - Requesting translation of DAYS - Urdu for PhD research
Date: Tue, 21 Oct 2008 12:28:55 -0500

Dear Samina,

Darci Mundfrom forwarded your email that you have not received a reply regarding your usage of the DAYS. Attached is my email granting you permission in September. Please let me know if you need anything further.

Sincerely,
Kelly

Kelly Ligon, Foreign Rights Editor
PRO-ED, Inc.
kligon@proedinc.com

From: Darci Mundfrom [mailto:darci@proedinc.com]
Sent: Tuesday, October 21, 2008 9:54 AM
To: 'samina bukhari'
Cc: Kelly Ligon
Subject: RE: Please reply me on my request for getting permission to translate the scale.

Samina Bukhari,

From: samina bukhari [mailto:saminabukhari14@hotmail.com]
Sent: Thursday, September 18, 2008 1:21 AM
To: Darci Mundfrom
Subject: Requesting permission for the translation of DAYS in Urdu for PhD research

Dear Darci Mundrom,
Hopefully you must have seen my email regarding getting permission for the translation of DAYS the Depression and Anxiety in Youth Scale (which you had granted me free for my PhD research) in urdu language.
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and also i would like to get the email address of the author of the scale so that i could send him the translated version.
Hope to hear from you very soon.
Thank You.

--Forwarded Message Attachment--
From: kligon@proedinc.com
To: saminabukhari14@hotmail.com
Subject: RE: Requesting translation of DAYS - Urdu for PhD research
Date: Tue, 23 Sep 2008 16:31:49 -0500

Samina Bukhari, National Institute of Psychology
Quaid-i-Azam University, Islambad, Pakistan, (92) 3005-231101
Dear Samina Bukhari
PRO-ED, Inc. grants to you nonexclusive permission to translate the **DAYS: *Depression and Anxiety in Youth Scale*** (hereinafter called the 'Translated Work') into **Urdu** for your research solely as described in your request below. The Translated Work is only for your own use and is not for commercial use or resale. You agree to give PRO-ED a copy of both the Translated Work along with a copy of your research.
This permission is non transferable and shall automatically expire upon the earlier of the completeness of your research or three (3) years from the date of this permission. PRO-ED makes no representation or warranty about the appropriateness, effectiveness, capability, or reliability in regards to your research and you agree to hold PRO-ED harmless from all claims that may occur as a result of your use of our product in your research.
We appreciate your interest in PRO-ED products.
Sincerely,
Kelly Ligon, Foreign Rights Editor, *PRO-ED, Inc.*
8700 Shoal Creek Boulevard, Austin, TX 78757 USA
(512) 451-3246 x682, (512) 451-6785 Fax: kligon@proedinc.com, www.PROEDInc.com

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From: Darci Mundfrom [mailto:darci@proedinc.com]
Sent: Thursday, September 18, 2008 8:46 AM
To: 'samina bukhari'
Cc: Kelly Ligon
Subject: RE: Requesting permission for the translation of DAYS in Urdu for PhD research

Samina,
I will forward your email to Kelly Ligon whom is PRO-ED's contact regarding permissions to translate. You can also contact Kelly at kigon@proedinc.com.

Your message has been saved in the Drafts folder. Note that you will need to re-attach the files before you send the message.

saminabukhari14@hotmail.com . Show Cc

To:

Subject: FW: Please reply me - Requesting translation of DAYS - Urdu for PhD research

Insert: Attachments Photos . Emoticons

Total size: 13.3 KB of 10.0 MB

DAYS.docx (13.3 KB) Tahoma 10 B I U

From: saminabukhari14@hotmail.com
To: kligon@proedinc.com
Subject: RE: Please reply me - Requesting translation of DAYS - Urdu for PhD research
Date: Sat, 25 Oct 2008 13:53:16 +0500

Dear Kelly
Thank you very much for granting me the required permission. Further, I am sending you the back to English Translation of the Urdu version the DAYS (plz. find the attachmentfile). I request you to match it with the original version of the DAYS and give me the feedback regarding your approval. Hope to receive a positive responce from your kind hands.
Thanx

Item Pool of

Functional Impairment Assessment Scale (FIAS) (N = 151)

1- ہنسنے/رونے کا طرزِ عمل موقع محل کے برخلاف ہوتا ہے۔

2- معمولی بات پر شدید غصہ کا اظہار کرتا/ کرتی ہے۔

3- چھوٹی چھوٹی بات پر شدید ردِعمل کا اظہار کرتا/ کرتی ہے۔

4- ٹیچر کا کہنا نہیں مانتا/مانتی۔

5- اپنی جسمانی صفائی مثلاً (صاف یونیفارم میں آنا، ناخن اور بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔

6- اپنے اوپر تنقید برداشت نہیں کرتا/ کرتی۔

7- اُردو اور انگلش کی کتاب کی Reading شوق سے کرتی/ کرتا ہے۔

8- ریاضی کے سوال آسانی سے سمجھ لیتی/لیتا ہے۔

9- کسی کے پڑھانے کا کوئی فائدہ نہیں ہوتا۔

10- عام طرزِ عمل (Behavior) دوسرے بچوں سے مختلف ہوتا ہے۔

11- بچے کی کلاس میں کارکردگی ٹیچر کی توجہ / تعریف پر منحصر ہوتی ہے۔

12- موقع محل کے مطابق بات نہیں کرتا/ کرتی۔

13- دوسروں کی مرضی کے خلاف گفتگو میں مخل ہوتا/ہوتی ہے۔

14- اپنی غلطیوں سے سبق سیکھتا/ سیکھتی ہے۔

15- اپنے دلچسپ مشاغل کے انتخاب میں دوسروں سے مدد لیتی/لیتا ہے۔

16- بہت زیادہ تابعدار ہوتا/ہوتی ہے۔

17- کلاس میں اُٹھتے بیٹھتے وقت اکثر ٹھوکر لگتی ہے یا ہاتھ سے چیزیں گر جاتی ہیں۔

18- گروپ کی تعلیمی سرگرمیوں میں ذمہ داری سے اپنا رول نبھاتا/ نبھاتی ہے۔

19- کلاس فیلوز کے ساتھ اچھا برتاؤ کرتا/ کرتی ہے۔

20- سوالوں کے جواب غیر مناسب ہوتے ہیں۔

21- ایک ہی حرکت بار بار کرتا/ کرتی ہے جس سے ٹیچر کے پڑھانے میں خلل آتا ہے۔

22- ٹیچر کی ہدایات یا سمجھانے کا کوئی فائدہ نہیں لیتا/لیتی۔

23- کلاس میں بچے کی دلچسپی اور سوچ وقت کی مناسبت سے نہیں ہوتی۔

24- کلاس میں بے حسی یا تھلے پن کا مظاہرہ کرتا/ کرتی ہے۔

25- بغیر کسی ظاہری وجہ کے افسردہ اور چپ چپ نظر آتی/ آتا ہے۔

26- زیادہ دیر تک اپنی سیٹ پر بیٹھ کر کام نہیں کرسکتا/ سکتی۔

27- کلاس میں بغیر کسی وجہ کے چڑچڑے پن کا مظاہرہ کرتا/ کرتی ہے۔

28- کلاس میں بے چین یا مضطرب نظر آتا/ آتی ہے۔

29- چھوٹی سی بات پر آسانی سے رو پڑتی/ پڑتا ہے۔

30- بات نہایت دھیمی آواز میں کرتا/ کرتی ہے۔

31- بیماری کی شکایت مثلاً سر اور پیٹ درد، چکر وغیرہ) کرتا/ کرتی ہے۔

32- کلاس میں اونگھتا/ اونگھتی رہتی ہے۔

33- بات کرنے کے دوران نظریں نہیں ملاتا/ ملاتی۔

34- بہت تیز تیز اور اُونچی آواز میں بات کرتا/ کرتی ہے۔

35- کلاس میں اکیلا/ اکیلی بیٹھتی رہتی ہے۔

36- کلاس میں کھل کر بات کرتا/ کرتی ہے۔

37- کلاس کی پچھلی نشستوں پر بیٹھتا/ بیٹھتی ہے۔

38- گروپ میں انتشار پھیلاتی/ پھیلاتا ہے۔

39- دوستی آسانی سے کرتا/ کرتی ہے۔

40- کلاس فیلوز کے ساتھ مل کر کھیلتا/ کھیلتی ہے۔

41- دوسرے بچوں کے ساتھ مل کر بیٹھنا پسند نہیں کرتا/ کرتی۔

42- چھوٹی کلاس کے بچوں سے دوستی رکھتا/ رکھتی ہے۔

43- کلاس میں ٹیچر کا ہاتھ بٹانے کے لیے (Monitor) منتخب ہوتا/ ہوتی ہے۔

44- دوست بدلتے رہتے ہیں۔

45- گروپ میں کام نہیں کرسکتا/ کرسکتی۔

46- گروپ میں لڑائی ہوجاتی ہے۔

47- پڑھائی میں کمزور بچوں کے ساتھ دوستی رکھتا/ رکھتی ہے۔

48- ٹیچر کے ساتھ بات کرنے کے دوران زبان لڑکھڑاتی ہے۔

49- کلاس کے معروف بچوں میں شمار ہوتا ہے۔

50- کلاس فیلوز میں مذاق کا نشانہ بنتا/ بنتی ہے۔

51- کلاس فیلوز سے الگ تھلگ رہتا/ رہتی ہے۔

52- اسکول/ کالج کی سرگرمیوں میں شوق سے حصہ لیتا/ لیتی ہے۔

53- اسکول/ کالج سے غیر حاضر رہتا/ رہتی ہے۔

54- کلاس کا کام وقت پر کرتا/ کرتی ہے۔

55- اسکول/ کالج وقت پر پہنچتا/ پہنچتی ہے۔

56- اسکول/ کالج کے قائدے قانون پر پابندی کرتا/ کرتی ہے۔

57- کلاس کی سجاوٹ اور دیواروں پر چارٹس لگانے میں حصہ لیتا/لیتی ہے۔

58- بعض مضامین میں اچھی کارکردگی دکھاتا/دکھاتی ہے۔

59- کالج کے روزمرہ معمول کے مطابق نہیں چل سکتا/ سکتی۔

60- کلاس میں ٹیچر سے سزا ملتی ہے۔

61- بات کرنے پر خالی خالی نظروں سے دیکھتی/ دیکھتا رہتا ہے۔

62- کلاس میں متوجہ نہیں ہوتا/ ہوتی۔

63- میں نے نہیں سنا جسے جواب دیتا/دیتی۔

64- بلائے جانے پر جواب نہیں دیتا/دیتی۔

65- تختہ سیاہ پر نظریں مرکوز نہیں کرتا/ کرتی۔

66- ایک حرکت بار بار کرتا/ کرتی ہے جس سے ٹیچر کے پڑھانے میں خلل آتا ہے۔

67- ہجے (Spelling) کی غلطیاں بار بار کرتا/ کرتی ہے۔

68- اسکول کا کام کرتے ہوئے خوشخطی یا ترتیب کا خاص خیال رکھتی/رکھتا ہے۔

69- ٹیچر کی ہدایات یا سمجھانے کا کوئی فائدہ نہیں لیتا/لیتی۔

70- کلاس کا کام آسانی سے ختم کر لیتا/لیتی ہے۔

71- خیالی دنیا میں رہتا/رہتی ہے۔

72- کلاس میں بچے کی دلچسپی اور سوچ وقت کی مناسبت سے نہیں ہوتی۔

73- فیملی کے افراد کے درمیان بیٹھے ہوئے عدم توجہی کا اظہار کرتا/ کرتی ہے۔

74- میں نے نہیں سنا، جیسے جواب دیتا/دیتی ہے۔

75- بلائے جانے پر جواب نہیں دیتا/دیتی ہے۔

76- معمولی سی بات پر بہت زیادہ ہنسنے/رونے کا مظاہرہ کرتا/ کرتی ہے، جبکہ گھر کے دوسرے افراد ایسا نہیں کرتے۔

77- غصہ بہت جلد آجاتا ہے۔

78- معمولی سی فرمائش پوری نہ ہونے کی صورت پر بھی شدید منفی ردِعمل کا اظہار کرتا/ کرتی ہے۔

79- ماں باپ کا کہنا نہیں مانتا/مانتی۔

80- اپنی جسمانی صفائی (مثلاً غسل کرنا، صاف کپڑے پہننا، بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔

81- اگر کوئی نصیحت یا تنقید کی جائے، تو بُرا مان جاتا/جاتی ہے۔

82- اصل صورتِ حال سے بے خبر ہونے کی وجہ سے گفتگو میں حصہ نہیں لے سکتا/ سکتی۔

83- والدین کی نصیحت پر دھیان نہیں کرتا/ کرتی۔

84- گھر کی پریشانیوں کو محسوس نہیں کرتا/ کرتی۔

85- اپنے بہن بھائیوں سے حسد کرتا/ کرتی ہے۔

86- دوسروں کو شک کی نظر سے دیکھتا/دیکھتی ہے۔

87- خطرناک اور Risk والے کاموں میں حصہ لیتی/لیتا ہے۔

88- ماں باپ سے انعام یا کسی چیز کی لالچ میں اچھا کام کرنے کی کوشش کرتا/ کرتی ہے۔

89- موقع محل کے مطابق بات نہیں کرتا/ کرتی۔

90- دوسروں کی بات کاٹتی/ کاٹتا ہے۔

91- اپنے یا دوسروں کے تجربات سے فائدہ حاصل کرتا/ کرتی ہے۔

92- اپنی پسند کی چیزیں خریدتے وقت دوسروں پر انحصار کرتا/ کرتی ہے۔

93- اپنے کیے کی ذمہ داری جلد قبول کرتا/ کرتی ہے۔

94- بغیر سوچے سمجھے بات کرتا/ کرتی ہے۔

95- بعد میں رونما ہونے والے نتائج سے بے خبر بغیر اندازہ لگائے اچانک حرکت کرتا/ کرتی ہے۔ مثلاً جھٹکے سے اٹھنا، بات کا منہ سے نکل جانا وغیرہ۔

96- گھر کی سجاوٹ اور صفائی کا خیال رکھتی/رکھتا ہے۔

97- بہن بھائیوں اور ماں باپ سے پیار اور ہمدردی کا مظاہرہ کرتا/ کرتی ہے۔

98- سکول میں اچھی کارکردگی نہ دکھانے یا کلاس فیلوز کے برے رویے کی وجہ سے افسردہ حالت میں گھر لوٹتا/لوٹتی ہے۔

99- کم گو ہے صرف بلانے پر بولتا/بولتی ہے۔

100- مسلسل حرکت میں رہتا/رہتی ہے مثلاً ٹانگیں ہلانا، انگلیوں سے کھیلنا، بار بار پڑھائی کے دوران اٹھنا وغیرہ۔

101- چھوٹی چھوٹی بات پر بہن بھائیوں سے الجھ پڑتا/پڑتی ہے۔

102- بغیر کسی ظاہری وجہ سے بے چین رہتا/رہتی ہے۔

103- رونا بہت جلد آتا ہے۔

104- بہت کم آواز میں بات کرتا/ کرتی ہے۔

105- جسمانی شکایات (سر درد، پیٹ درد، متلی، چکر، غنودگی وغیرہ) کی وجہ سے سکول جانے سے انکار کرتا/ کرتی ہے۔

106- زیادہ سوتا/سوتی ہے۔

107- دوسروں کے سامنے بات کرنے کے دوران نظریں نیچی رکھتا/رکھتی ہے۔

108- بات تیز تیز اور اونچی آواز میں کرتا/ کرتی ہے۔

109- بھوک بہت کم یا زیادہ لگتی ہے۔

110- بھوک بہت زیادہ لگتی ہے۔

111- بے بسی اور ناامیدی کی بات کرتی/ کرتا ہے۔

112- افسوسناک واقعات اور موت کے بارے میں سوچتا سوچتی ہے۔

113- بیکار بیٹھ کر سوچتا/ سوچتی رہتی ہے۔

114- اپنی ذات پر تنقید کرتا/ کرتی ہے کہ میں ایسی ہوں/ میں ویسا ہوں۔

115- موت کی خواہش کرتا/ کرتی ہے۔

116- گھر میں سب سے کھل کر بات چیت کرتا/ کرتی ہے۔

117- دوست آسانی سے بناتا/ بناتی ہے، اور پھر اس کو قائم رکھنے کی کوشش کرتا/ کرتی ہے۔

118- دوسرے بچوں کے ساتھ مل کر کھیلتا/ کھیلتی ہے۔

119- دوسرے بچوں کے ساتھ گھل مل کر نہیں بیٹھتا/ بیٹھتی۔

120- اپنے سے کم عمر بچوں میں خوش رہتا/ رہتی ہے۔

121- گھر کے اہم کام سرانجام دینے میں ماں باپ کی مدد کرتا/ کرتی ہے۔

122- دوست بدلتے رہتے ہیں۔

123- گروپ میں کام نہیں کر سکتا/ سکتی۔

124- گروپ میں لڑائی ہو جاتی ہے۔

125- دوستی ان بچوں کے ساتھ ہوتی ہے جو پڑھائی میں نالائق ہوتے ہیں۔

126- بڑوں سے بات کرنے کے دوران زبان لڑکھڑاتی ہے۔

127- گروپ لیڈر بنتا/ بنتی ہے۔

128- دوسرے بچے بات بات پر مذاق اڑاتے ہیں۔

129- الگ تھلگ رہتا/ رہتی ہے۔

130- گھومنا پھرنا مفید ہوتا ہے۔

131- ٹیلیفون پر بات نہیں کرتا/ کرتی۔

132- گھر کے بحث و مباحثہ میں حصہ نہیں لیتا/ لیتی۔

133- سکول کی سرگرمیوں میں شوق سے حصہ لیتا/ لیتی ہے۔

134- سکول/ کالج سے غیر حاضر رہتا/ رہتی ہے۔

135- سکول/ کالج کا کام وقت پر کرتا/ کرتی ہے۔

136- سکول/ کالج کے لیے وقت پر تیار ہوتا/ ہوتی ہے۔

137- سکول/ کالج کی انتظامیہ کی طرف سے فائن/ جرمانے لگتے ہیں۔

138- سکول/ کالج کے قائدے وقانون پر پابندی کرتا/ کرتی ہے۔

139- کوئی کام پورا نہیں کرتا/ کرتی۔

140- کلاس کی سجاوٹ کے لیے چارٹس بناتی/ بناتا ہے۔

141- انگلش پڑھنے اور بولنے سی ہچکچاہتی/ ہچکچاتا ہے۔

142- بعض مضامین میں اچھی کارکردگی دکھاتا/دکھاتی ہے۔

143- سکول/ کالج جانے کے دنوں میں تھکاوٹ، جھنجھلاہٹ یا افسردگی کا مظاہرہ کرتا/ کرتی ہے۔

144- سکول/ کالج کی دیگر تقاریب میں شوق سے حصہ لیتا/لیتی ہے۔

145- ٹیچر کی طرف سے شکایات ملتی ہے۔

146- اسکول جانے سے گھبراتا/ گھبراتی ہے۔

147- پڑھائی کے یا کسی گھر کے کام کے دوران اپنی توجہ ایک جگہ پر مذکور نہیں کرتی/ کرتا۔

148- سکول کا/ گھر کا کام کرنے کے دوران بار بار اٹھتا/اٹھتی ہے۔

149- ٹیچر کی طرف سے لاپرواہی کی شکایت ملتی رہتی ہے۔

150- سکول کا کام کرنے کے دوران ربر کا استعمال بار بار کرتی/ کرتا ہے۔

151- سکول کا کام آسانی سے ختم کر لیتا/لیتی ہے۔

Item Pool of

Functional Impairment Assessment in Scale (FIAS)

Parents Rating Scale (PRS)

Form-P (N = 79)

1- فیملی کے افراد کے درمیان بیٹھے ہوئے عدم توجہی کا اظہار کرتا/ کرتی ہے۔

2- میں نے نہیں سنا جیسے جواب دیتا/دیتی ہے۔

3- بلائے جانے پر جواب دیتا/دیتی ہے۔

4- معمولی سے بات پر بہت زیادہ ہنسنے /رونے کا مظاہرہ کرتا/ کرتی ہے، جبکہ گھر کے دوسرے افراد ایسا نہیں کرتے۔

5- غصہ بہت جلد آجاتا ہے۔

6- معمولی سے فرمائش پوری نہ ہونے کی صورت پر بھی شدید منفی ردِعمل کا اظہار کرتا/ کرتی ہے۔

7- ماں باپ کا کہنا نہیں مانتا/مانتی۔

8- اپنی جسمانی صفائی (مثلاً غسل کرنا، صاف کپڑے پہننا، بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔

9- اگر کوئی نصیحت یا تنقید کی جائے تو برا مان جاتا/جاتی ہے۔

10- اصل صورت حال سے بے خبر ہونے کی وجہ سے گفتگو میں حصہ نہیں لے سکتا/سکتی۔

11- والدین کی نصیحت پر دھیان نہیں کرتا/ کرتی۔

12- گھر کی پریشانیوں کو محسوس نہیں کرتا/ کرتی۔

13- اپنے بہن بھائیوں سے حسد کرتا/ کرتی ہے۔

14- دوسروں کو شک کی نظر سے دیکھتا/دیکھتی ہے۔

15- خطرناک اور Risk والے کاموں میں حصہ لیتی/لیتا ہے۔

16- ماں باپ سے انعام یا کسی چیز کی لالچ میں اچھا کام کرنے کی کوشش کرتا/ کرتی ہے۔

17- موقع محل کے مطابق بات نہیں کرتا/ کرتی۔

18- دوسروں کی بات کاٹتی/ کاٹتا ہے۔

19- اپنے یا دوسروں کے تجربات سے فائدہ حاصل کرتا/ کرتی ہے۔

20- اپنی پسند کی چیزیں خریدتے وقت دوسروں پر انحصار کرتا/ کرتی ہے۔

21- اپنے کیے کی ذمہ داری جلد قبول کرتا/ کرتی ہے۔

22- بغیر سوچے سمجھے بات کرتا/ کرتی ہے۔

23- بعد میں رونما ہونے والے نتائج سے بے خبر بغیر اندازہ لگائے اچانک حرکت کرتا/ کرتی ہے۔ مثلاً جھٹکے سے اٹھنا، بات کا منہ سے نکل جانا وغیرہ۔

24- گھر کی سجاوٹ اور صفائی کا خیال رکھتی/رکھتا ہے۔

25- بہن بھائیوں اور ماں باپ سے پیار اور ہمدردی کا مظاہرہ کرتا/ کرتی ہے۔

26- سکول میں اچھی کارکردگی نہ دکھانے یا کلاس فیلوز کے برے رویے کی وجہ سے افسردہ حالت میں گھر لوٹتا/لوٹتی ہے۔

27- کم گو ہے صرف بلانے پر بولتا/بولتی ہے۔

28- مسلسل حرکت میں رہتا/رہتی ہے مثلاً ٹانگیں ہلانا، انگلیوں سے کھیلنا، بار بار پڑھائی کے دوران اٹھنا وغیرہ۔

29- چھوٹی چھوٹی بات پر بہن بھائیوں سے الجھ پڑتا/پڑتی ہے۔

30- بغیر کسی ظاہری وجہ سے بے چین رہتا/رہتی ہے۔

31- رونا بہت جلد آتا ہے۔

32- بہت کم آواز میں بات کرتا/ کرتی ہے۔

33- جسمانی شکایات (سر درد، پیٹ درد، متلی، چکر، غنودگی وغیرہ) کی وجہ سے سکول جانے سے انکار کرتا/ کرتی ہے۔

34- زیادہ سوتا/سوتی ہے۔

35- دوسروں کے سامنے بات کرنے کے دوران نظریں نیچی رکھتا/رکھتی ہے۔

36- بات تیز تیز اور اونچی آواز میں کرتا/ کرتی ہے۔

37- بھوک بہت کم لگتی ہے۔

38- بھوک بہت زیادہ لگتی ہے۔

39- بے بسی اور ناامیدی کی بات کرتی/ کرتا ہے۔

40- افسوسناک واقعات اور موت کے بارے میں سوچتا سوچتی ہے۔

41- بیکار بیٹھ کر سوچتا/سوچتی رہتی ہے۔

42- اپنی ذات پر تنقید کرتا/ کرتی ہے کہ میں ایسی ہوں/میں ویسا ہوں۔

43- موت کی خواہش کرتا/ کرتی ہے۔

44- گھر میں سب سے کھل کر بات چیت کرتا/ کرتی ہے۔

45- دوست آسانی سے بناتا/بناتی ہے، اور پھر اس کو قائم رکھنے کی کوشش کرتا/ کرتی ہے۔

46- دوسرے بچوں کے ساتھ ملکر کھیلتا/ کھیلتی ہے۔

47- دوسرے بچوں کے ساتھ گھل مل کر نہیں بیٹھتا/ بیٹھتی۔

48- اپنے سے کم عمر بچوں میں خوش رہتا/رہتی ہے۔

49- گھر کے اہم کام سرانجام دینے میں ماں باپ کی مدد کرتا/ کرتی ہے۔

50- دوست بدلتے رہتے ہیں۔

51- گروپ میں کام نہیں کرسکتا/ سکتی۔

52- گروپ میں لڑائی ہوجاتی ہے۔

53- دوستی ان بچوں کے ساتھ ہوتی ہے جو پڑھائی میں نالائق ہوتے ہیں۔

54- بڑوں سے بات کرنے کے دوران زبان لڑکھڑاتی ہے۔

55- گروپ لیڈر بنتا/ بنتی ہے۔

56- دوسرے بچے بات بات پر مذاق اڑاتے ہیں۔

56- الگ تھلگ رہتا/ رہتی ہے۔

58- گھومنا پھرنا پسند ہوتا ہے۔

59- ٹیلیفون پر بات نہیں کرتا/ کرتی۔

60- گھر کے بحث ومباحثہ میں حصہ لیتا/ لیتی ہے۔

61- سکول کی سرگرمیوں میں شوق سے حصہ لیتا/ لیتی ہے۔

62- سکول/ کالج سے غیر حاصر رہتا/ رہتی ہے۔

63- سکول/ کالج کا کام وقت پر کرتا/ کرتی ہے۔

64- سکول/ کالج کے لیے وقت پر تیار ہوتا/ ہوتی ہے۔

65- سکول/ کالج کی انتظامیہ کی طرف سے فائن/ جرمانے لگتے ہیں۔

66- سکول/ کالج کے قائدے وقانان پر پابندی کرتا/ کرتی ہے۔

67- کوئی کام پورا نہیں کرتا/ کرتی۔

68- کلاس کی سجاوٹ کے لیے چارٹس بناتی/ بناتا ہے۔

69- انگلش پڑھنے اور بولنے سے ہچکچاہتی/ ہچکچاتا ہے۔

70- بعض مضامین میں اچھی کارکردگی دکھاتا/ دکھاتی ہے۔

71- سکول/ کالج جانے کے دنوں میں تھکاوٹ، جھنجھلاہٹ یا افسردگی کا مظاہرہ کرتا/ کرتی ہے۔

72- سکول/ کالج کی دیگر تقاریب میں شوق سے حصہ لیتا/ لیتی ہے۔

73- ٹیچر کی طرف سے شکایات ملتی ہے۔

74- اسکول جانے سے گھبراتا/ گھبراتی ہے۔

75- پڑھائی کے یا کسی گھر کے کام کے دوران اپنی توجہ ایک جگہ پر مذکورہ نہیں کرتی/ کرتا۔

76- سکول کا/ گھر کا کام کرنے کے دوران بار بار اٹھتا/ اٹھتی ہے۔

77- ٹیچر کی طرف سے لاپرواہی کا شکایت ملتی رہتی ہے۔

78- سکول کا کام کرنے کے دوران ربر کا استعمال بار بار کرتی/ کرتا ہے۔

79- سکول کا کام آسانی سے ختم کرلیتا/ لیتی ہے۔

Item Pool of sub - Scale

Functional Impairment Assessment in Scale (FIAS)

Parents Rating Scale (PRS)

Form-P (N = 79)

Cognitive Dysfunction (n = 25)

1- فیملی کے افراد کے درمیان بیٹھے ہوئے عدم توجہی کا اظہار کرتا/ کرتی ہے۔

2- میں نے نہیں سنا جیسے جواب دیتا/دیتی ہے۔

3- بلائے جانے پر جواب نہیں دیتا/دیتی ہے۔

4- معمولی سے بات پر بہت زیادہ ہنسنے/رونے کا مظاہرہ کرتا/ کرتی ہے، جبکہ گھر کے دوسرے افراد ایسا نہیں کرتے۔

5- غصہ بہت جلد آجاتا ہے۔

6- معمولی سے فرمائش پوری نہ ہونے کی صورت پر بھی شدید منفی ردِعمل کا اظہار کرتا/ کرتی ہے۔

7- ماں باپ کا کہنا نہیں مانتا/مانتی۔

8- اپنی جسمانی صفائی (مثلاً غسل کرنا، صاف کپڑے پہننا، بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔

9- اگر کوئی نصیحت یا تنقید کی جائے، تو بُرا مان جاتا/جاتی ہے۔

10- اصل صورتِ حال سے بے خبر ہونے کی وجہ سے گفتگو میں حصہ نہیں لے سکتا/سکتی۔

11- والدین کی نصیحت پر دھیان نہیں کرتا/ کرتی۔

12- گھر کی پریشانیوں کو محسوس نہیں کرتا/ کرتی۔

13- اپنے بہن بھائیوں سے حسد کرتا/ کرتی ہے۔

14- دوسروں کو شک کی نظر سے دیکھتا/دیکھتی ہے۔

15- خطرناک اور Risk والے کاموں میں حصہ لیتی/لیتا ہے۔

16- ماں باپ سے انعام یا کسی چیز کی لالچ میں اچھا کام کرنے کی کوشش کرتا/ کرتی ہے۔

17- موقع محل کے مطابق بات نہیں کرتا/ کرتی۔

18- دوسروں کی بات کاٹتی/ کاٹتا ہے۔

19- اپنے یا دوسروں کے تجربات سے فائدہ حاصل کرتا/ کرتی ہے۔

20- اپنی پسند کی چیزیں خریدتے وقت دوسروں پر انحصار کرتا/ کرتی ہے۔

21- اپنے کیے کی ذمہ داری جلد قبول کرتا/ کرتی ہے۔

22- بغیر سوچے سمجھے بات کرتا/ کرتی ہے۔

-23 بعد میں رونما ہونے والے نتائج سے بے خبر بغیر اندازہ لگائے اچانک حرکت کرتا/ کرتی ہے۔ مثلاً جھٹکے سے اٹھنا، بات کا منہ سے نکل جانا وغیرہ۔

-24 گھر کی سجاوٹ اور صفائی کا خیال رکھتی/رکھتا ہے۔

-25 بہن بھائیوں اور ماں باپ سے پیار اور ہمدردی کا مظاہرہ کرتا/ کرتی ہے۔

Emotional Dysfunction (n = 18)

-26 سکول میں اچھی کارکردگی نہ دکھانے یا کلاس فیلوز کے برے رویے کی وجہ سے افسردہ حالت میں گھر لوٹتا/لوٹتی ہے۔

-27 کم گو ہے صرف بلانے پر بولتا/بولتی ہے۔

-28 مسلسل حرکت میں رہتا/رہتی ہے مثلاً ٹانگیں ہلانا، انگلیوں سے کھیلنا، بار بار پڑھائی کے دوران اٹھنا وغیرہ۔

-29 چھوٹی چھوٹی بات پر بہن بھائیوں سے الجھ پڑتا/پڑتی ہے۔

-30 بغیر کسی ظاہری وجہ سے بے چین رہتا/رہتی ہے۔

-31 رونا بہت جلد آتا ہے۔

-32 بہت کم آواز میں بات کرتا/ کرتی ہے۔

-33 جسمانی شکایات (سر درد، پیٹ درد، متلی، چکر، غنودگی وغیرہ) کی وجہ سے سکول جانے سے انکار کرتا/ کرتی ہے۔

-34 زیادہ سوتا/سوتی ہے۔

-35 دوسروں کے سامنے بات کرنے کے دوران نظریں نیچی رکھتا/رکھتی ہے۔

-36 بات تیز تیز اور اونچی آواز میں کرتا/ کرتی ہے۔

-37 بھوک بہت کم یا زیادہ لگتی ہے۔

-38 بھوک بہت زیادہ لگتی ہے۔

-39 بے بسی اور ناامیدی کی بات کرتی/ کرتا ہے۔

-40 افسوسناک واقعات اور موت کے بارے میں سوچتا سوچتی ہے۔

-41 بیکار بیٹھ کر سوچتا/سوچتی رہتی ہے۔

-42 اپنی ذات پر تنقید کرتا/ کرتی ہے کہ میں ایسی ہوں/میں ویسا ہوں۔

-43 موت کی خواہش کرتا/ کرتی ہے۔

Social Dysfunction (n = 17)

-44 گھر میں سب سے کھل کر بات چیت کرتا/ کرتی ہے۔

-45 دوست آسانی سے بناتا/بناتی ہے، اور پھر اس کو قائم رکھنے کی کوشش کرتا/ کرتی ہے۔

46- دوسرے بچوں کے ساتھ مل کر کھیلتا/ کھیلتی ہے۔

47- دوسرے بچوں کے ساتھ گھل مل کر نہیں بیٹھتا/ بیٹھتی۔

48- اپنے سے کم عمر بچوں میں خوش رہتا/رہتی ہے۔

49- گھر کے اہم کام سرانجام دینے میں ماں باپ کی مدد کرتا/ کرتی ہے۔

50- دوست بدلتے رہتے ہیں۔

51- گروپ میں کام نہیں کرسکتا/ سکتی۔

52- گروپ میں لڑائی ہوجاتی ہے۔

53- دوستی ان بچوں کے ساتھ ہوتی ہے جو پڑھائی میں نالائق ہوتے ہیں۔

54- بڑوں سے بات کرنے کے دوران زبان لڑکھڑاتی ہے۔

55- گروپ لیڈر بنتا/بنتی ہے۔

56- دوسرے بچے بات بات پر مذاق اڑاتے ہیں۔

57- الگ تھلگ رہتا/رہتی ہے۔

58- گھومنا پھرنا مفید ہوتا ہے۔

59- ٹیلیفون پر بات نہیں کرتا/ کرتی۔

60- گھر کے بحث ومباحثہ میں حصہ نہیں لیتا/لیتی۔

Learning Behavior Dysfunction (n = 19)

61- سکول کی سرگرمیوں میں شوق سے حصہ لیتا/لیتی ہے۔

62- سکول/ کالج سے غیر حاصر رہتا/رہتی ہے۔

63- سکول/ کالج کا کام وقت پر کرتا/ کرتی ہے۔

64- سکول/ کالج کے لیے وقت پر تیار ہوتا/ہوتی ہے۔

65- سکول/ کالج کی انتظامیہ کی طرف سے فائن/جرمانے لگتے ہیں۔

66- سکول/ کالج کے قائدے وقانون پر پابندی کرتا/ کرتی ہے۔

67- کوئی کام پورا نہیں کرتا/ کرتی۔

68- کلاس کی سجاوٹ کے لیے چارٹس بناتی/بناتا ہے۔

69- انگلش پڑھنے اور بولنے سے ہچکچاتی/ہچکچاتا ہے۔

70- بعض مضامین میں اچھی کارکردگی دکھاتا/دکھاتی ہے۔

71- سکول/ کالج جانے کے دنوں میں تھکاوٹ، جھنجھلاہٹ یا افسردگی کا مظاہرہ کرتا/ کرتی ہے۔

72- سکول/ کالج کی دیگر تقاریب میں شوق سے حصہ لیتا/لیتی ہے۔

73- ٹیچر کی طرف سے شکایات ملتی ہے۔

74- اسکول جانے سے گھبراتا/ گھبراتی ہے۔

75- پڑھائی کے یا کسی گھر کے کام کے دوران اپنی توجہ ایک جگہ پر مذکورہ نہیں کرتی/ کرتا۔

76- سکول کا/ گھر کا کام کرنے کے دوران بار بار اٹھتا/اٹھتی ہے۔

77- ٹیچر کی طرف سے لاپرواہی کا شکایت ملتی رہتی ہے۔

78- سکول کا کام کرنے کے دوران ربر کا استعمال بار بار کرتی/ کرتا ہے۔

79- سکول کا کام آسانی سے ختم کر لیتا/لیتی ہے۔

Item Pool of

Functional Impairment Assessment Scale (FIAS)

Teacher Rating Scale (TRS)

Form - T (N = 72)

1- ہنسنے/رونے کا طرزِ عمل موقع محل کے برخلاف ہوتا ہے۔

2- معمولی بات پر شدید غصہ کا اظہار کرتا/ کرتی ہے۔

3- چھوٹی چھوٹی بات پر شدید ردِ عمل کا اظہار کرتا/ کرتی ہے۔

4- ٹیچر کا کہنا نہیں مانتا/مانتی۔

5- اپنی جسمانی صفائی مثلاً (صاف یونیفارم میں آنا، ناخن اور بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔

6- اپنے اوپر تنقید برداشت نہیں کرتا/ کرتی۔

7- اُردو اور انگلش کی کتاب کی Reading شوق سے کرتا/کرتی ہے۔

8- ریاضی کے سوال آسانی سے سمجھ لیتا/لیتی ہے۔

9- کسی کے پڑھانے کا کوئی فائدہ نہیں ہوتا۔

10- عام طرزِ عمل (Behavior) دوسرے بچوں سے مختلف ہوتا ہے۔

11- بچے کی کلاس میں کارکردگی ٹیچر کی توجہ / تعریف پر منحصر ہوتی ہے۔

12- موقع محل کے مطابق بات نہیں کرتا/ کرتی۔

13- دوسروں کی مرضی کے خلاف گفتگو میں مخل ہوتا/ہوتی ہے۔

14- اپنی غلطیوں سے سبق سیکھتا/ سیکھتی ہے۔

15- اپنے دلچسپ مشاغل کے انتخاب میں دوسروں سے مدد لیتی/لیتا ہے۔

16- بہت زیادہ تابعدار ہوتا/ہوتی ہے۔

17- کلاس میں اُٹھتے بیٹھتے وقت اکثر ٹھوکر لگتی ہے یا ہاتھ سے چیزیں گر جاتی ہیں۔

18- گروپ کی تعلیمی سرگرمیوں میں ذمہ داری سے اپنا رول نبھاتا/نبھاتی ہے۔

19- کلاس فیلوز کے ساتھ اچھا برتاؤ کرتا/ کرتی ہے۔

20- سوالوں کے جواب غیر مناسب ہوتے ہیں۔

21- ایک ہی حرکت بار بار کرتا/ کرتی ہے جس سے ٹیچر کے پڑھانے میں خلل آتا ہے۔

22- ٹیچر کی ہدایات یا سمجھانے کا کوئی فائدہ نہیں لیتا/لیتی۔

23- کلاس میں بچے کی دلچسپی اور سوچ وقت کی مناسبت سے نہیں ہوتی۔

24- کلاس میں بے حسی یا تھکے پن کا مظاہرہ کرتا/ کرتی ہے۔

25- بغیر کسی ظاہری وجہ کے افسردہ اور چپ چپ نظر آتی/ آتا ہے۔

26- زیادہ دیر تک اپنی سیٹ پر بیٹھ کر کام نہیں کر سکتا/ سکتی۔

27- کلاس میں بغیر کسی وجہ کے چڑچڑے پن کا مظاہرہ کرتا/ کرتی ہے۔

28- کلاس میں بے چین یا مضطرب نظر آتا/ آتی ہے۔

29- چھوٹی سی بات پر آسانی سے رو پڑتی/ پڑتا ہے۔

30- بات نہایت دھیمی آواز میں کرتا/ کرتی ہے۔

31- بیماری کی شکایت مثلاً (سر اور پیٹ درد، چکر وغیرہ) کرتا/ کرتی ہے۔

32- کلاس میں اونگھتا/ اونگھتی رہتا/ رہتی ہے۔

33- بات کرنے کے دوران نظریں نہیں ملاتا/ ملاتی۔

34- بہت تیز تیز اور اُونچی آواز میں بات کرتا/ کرتی ہے۔

35- کلاس میں اکیلا/ اکیلی بیٹھا/ بیٹھی رہتا/ رہتی ہے۔

36- کلاس میں کھل کر بات کرتا/ کرتی ہے۔

37- کلاس کی پچھلی نشتوں پر بیٹھتا/ بیٹھتی ہے۔

38- گروپ میں انتشار پھیلاتا/ پھیلاتی ہے۔

39- دوستی آسانی سے کرتا/ کرتی ہے۔

40- کلاس فیلوز کے ساتھ مل کر کھیلتا/ کھیلتی ہے۔

41- دوسرے بچوں کے ساتھ مل کر بیٹھنا پسند نہیں کرتا/ کرتی۔

42- چھوٹی کلاس کے بچوں سے دوستی رکھتا/ رکھتی ہے۔

43- کلاس میں ٹیچر کا ہاتھ بٹانے کے لیے (Monitor) منتخب ہوتا/ ہوتی ہے۔

44- دوست بدلتے رہتے ہیں۔

45- گروپ میں کام نہیں کر سکتا/ کر سکتی۔

46- گروپ میں لڑائی ہو جاتی ہے۔

47- پڑھائی میں کمزور بچوں کے سا تھ دوستی رکھتا/ رکھتی ہے۔

48- ٹیچر کے ساتھ بات کرنے کے دوران زبان لڑکھڑاتی ہے۔

49- کلاس کے معروف بچوں میں شمار ہوتا ہے۔

50- کلاس فیلوز میں مذاق کا نشانہ بنتا/ بنتی ہے۔

51- کلاس فیلوز سے الگ تھلگ رہتا/ رہتی ہے۔

52- اسکول/ کالج کی سرگرمیوں میں شوق سے حصہ لیتا/ لیتی ہے۔

53- اسکول/ کالج سے غیر حاضر رہتا/ رہتی ہے۔

54- کلاس کا کام وقت پر کرتا/ کرتی ہے۔

55- اسکول/ کالج وقت پر پہنچتا/ پہنچتی ہے۔

56- اسکول/ کالج کے قائدے قانون پر پابندی کرتا/ کرتی ہے۔

57- کلاس کی سجاوٹ اور دیواروں پر چارٹس لگانے میں حصہ لیتا/لیتی ہے۔

58- بعض مضامین میں اچھی کارکردگی دکھاتا/دکھاتی ہے۔

59- کالج کے روزمرہ معمول کے مطابق نہیں چل سکتا/ سکتی۔

60- کلاس میں ٹیچر سے سزا ملتی ہے۔

61- بات کرنے پر خالی خالی نظروں سے دیکھتی/ دیکھتا رہتا ہے۔

62- کلاس میں متوجہ نہیں ہوتا/ ہوتی۔

63- میں نے نہیں سنا جیسے جواب دیتا/ دیتی۔

64- بلائے جانے پر جواب نہیں دیتا/ دیتی۔

65- تختہ سیاہ پر نظریں مرکوز نہیں کرتا/ کرتی۔

66- ایک ہر حرکت بار بار کرتا/ کرتی ہے جس سے ٹیچر کے پڑھانے میں خلل آتا ہے۔

67- ہجے (Spelling) کی غلطیاں بار بار کرتا/ کرتی ہے۔

68- اسکول کا کام کرتے ہوئے خوشخطی یا ترتیب کا خاص خیال رکھتی/ رکھتا ہے۔

69- ٹیچر کی ہدایات یا سمجھانے کا کوئی فائدہ نہیں لیتا/لیتی۔

70- کلاس کا کام آسانی سے ختم کر لیتا/لیتی ہے۔

71- خیالی دنیا میں رہتا/ رہتی ہے۔

72- کلاس میں بچے کی دلچسپی اور سوچ وقت کی مناسبت سے نہیں ہوتی۔

Item Pool of Sub - Scale of
functional Impairment Assessment Scale (FIAS)
Teacher Rating Scale (TRS)
Form - T (N = 72)

Cognitive Dysfunction (n = 23)

1- ہنسنے/رونے کا طرزِ عمل موقع محل کے برخلاف ہوتا ہے۔
2- معمولی بات پر شدید غصہ کا اظہار کرتا/ کرتی ہے۔
3- چھوٹی چھوٹی بات پر شدید ردِ عمل کا اظہار کرتا/ کرتی ہے۔
4- ٹیچر کا کہنا نہیں مانتا/مانتی۔
5- اپنی جسمانی صفائی مثلاً (صاف یونیفارم میں آنا، ناخن اور بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔
6- اپنے اوپر تنقید برداشت نہیں کرتا/ کرتی۔
7- اُردو اور انگلش کی کتاب کی Reading شوق سے کرتا/کرتی ہے۔
8- ریاضی کے سوال آسانی سے سمجھ لیتا/لیتی ہے۔
9- کسی کے پڑھانے کا کوئی فائدہ نہیں ہوتا۔
10- عام طرزِ عمل (Behavior) دوسرے بچوں سے مختلف ہوتا ہے۔
11- بچے کی کلاس میں کارکردگی ٹیچر کی توجہ / تعریف پر منحصر ہوتی ہے۔
12- موقع محل کے مطابق بات نہیں کرتا/ کرتی۔
13- دوسروں کی مرضی کے خلاف گفتگو میں مخل ہوتا/ہوتی ہے۔
14- اپنی غلطیوں سے سبق سیکھتا/ سیکھتی ہے۔
15- اپنے دلچسپ مشاغل کے انتخاب میں دوسروں سے مدد لیتی/لیتا ہے۔
16- بہت زیادہ تابعدار ہوتا/ہوتی ہے۔
17- کلاس میں اُٹھتے بیٹھتے وقت اکثر ٹھوکر لگتی ہے یا ہاتھ سے چیزیں گر جاتی ہیں۔
18- گروپ کی تعلیمی سرگرمیوں میں ذمہ داری سے اپنا رول نبھاتا/نبھاتی ہے۔
19- کلاس فیلوز کے ساتھ اچھا برتاؤ کرتا/ کرتی ہے۔
20- سوالوں کے جواب غیر مناسب ہوتے ہیں۔
21- ایک ہی حرکت بار بار کرتا/ کرتی ہے جس سے ٹیچر کے پڑھانے میں خلل آتا ہے۔

22- ٹیچر کی ہدایات یا سمجھانے کا کوئی فائدہ نہیں لیتا/لیتی۔

23- کلاس میں بچے کی دلچسپی اور سوچ وقت کی مناسبت سے نہیں ہوتی۔

Emotional Dysfunction (n = 12)

24- کلاس میں بے حسی یا تھکے پن کا مظاہرہ کرتا/ کرتی ہے۔

25- بغیر کسی ظاہری وجہ کے افسردہ اور چپ چپ نظر آتی/ آتا ہے۔

26- زیادہ دیر تک اپنی سیٹ پر بیٹھ کر کام نہیں کرسکتا/ سکتی۔

27- کلاس میں بغیر کسی وجہ کے چڑچڑے پن کا مظاہرہ کرتا/ کرتی ہے۔

28- کلاس میں بے چین یا مضطرب نظر آتا/ آتی ہے۔

29- چھوٹی سی بات پر آسانی سے رو پڑتی/پڑتا ہے۔

30- بات نہایت دھیمی آواز میں کرتا/ کرتی ہے۔

31- بیماری کی شکایت مثلاً (سر اور پیٹ درد، چکر وغیرہ) کرتا/ کرتی ہے۔

32- کلاس میں اونگھتا/اونگھتی رہتی ہے۔

33- بات کرنے کے دوران نظریں نہیں ملاتا/ملاتی۔

34- بہت تیز تیز اور اُونچی آواز میں بات کرتا/ کرتی ہے۔

35- کلاس میں اکیلا بیٹھا رہتا ہے/اکیلی بیٹھی رہتی ہے۔

Social Dysfunction (n = 16)

36- کلاس میں کھل کر بات کرتا/ کرتی ہے۔

37- کلاس کی پچھلی نشتوں پر بیٹھتا/ بیٹھتی ہے۔

38- گروپ میں انتشار پھیلاتا/پھیلاتی ہے۔

39- دوستی آسانی سے کرتا/ کرتی ہے۔

40- کلاس فیلوز کے ساتھ مل کر کھیلتا/ کھیلتی ہے۔

41- دوسرے بچوں کے ساتھ مل کر بیٹھنا پسند نہیں کرتا/ کرتی۔

42- چھوٹی کلاس کے بچوں سے دوستی رکھتا/رکھتی ہے۔

43- کلاس میں ٹیچر کا ہاتھ بٹانے کے لیے (Monitor) منتخب ہوتا/ہوتی ہے۔

44- دوست بدلتے رہتے ہیں۔

45- گروپ میں کام نہیں کرسکتا/ کرسکتی۔

46- گروپ میں لڑائی ہوجاتی ہے۔

47- پڑھائی میں کمزور بچوں کے ساتھ دوستی رکھتا/رکھتی ہے۔

48- ٹیچر کے ساتھ بات کرنے کے دوران زبان لڑکھڑاتی ہے۔

49- کلاس کے معروف بچوں میں شمار ہوتا ہے۔

50- کلاس فیلوز میں مذاق کا نشانہ بنتا/بنتی ہے۔

51- کلاس فیلوز سے الگ تھلگ رہتا/رہتی ہے۔

Learning Behavior Dysfunction (n = 21)

52- اسکول/کالج کی سرگرمیوں میں شوق سے حصہ لیتا/لیتی ہے۔

53- اسکول/کالج سے غیر حاضر رہتا/رہتی ہے۔

54- کلاس کا کام وقت پر کرتا/کرتی ہے۔

55- اسکول/کالج وقت پر پہنچتا/پہنچتی ہے۔

56- اسکول/کالج کے قائدے قانون پر پابندی کرتا/کرتی ہے۔

57- کلاس کی سجاوٹ اور دیواروں پر چارٹس لگانے میں حصہ لیتا/لیتی ہے۔

58- بعض مضامین میں اچھی کارکردگی دکھاتا/دکھاتی ہے۔

59- کالج کے روزمرہ معمول کے مطابق نہیں چل سکتا/سکتی۔

60- کلاس میں ٹیچر سے سزا ملتی ہے۔

61- بات کرنے پر خالی خالی نظروں سے دیکھتی/دیکھتا رہتا ہے۔

62- کلاس میں متوجہ نہیں ہوتا/ہوتی۔

63- میں نے نہیں سنا جیسے جواب دیتا/دیتی۔

64- بلائے جانے پر جواب نہیں دیتا/دیتی۔

65- تختہ سیاہ پر نظریں مرکوز نہیں کرتا/کرتی۔

66- ایک ہر حرکت بار بار کرتا/کرتی ہے جس سے ٹیچر کے پڑھانے میں خلل آتا ہے۔

67- ہجے (Spelling) کی غلطیاں بار بار کرتا/کرتی ہے۔

68- اسکول کا کام کرتے ہوئے خوشخطی یا ترتیب کا خاص خیال رکھتی/رکھتا ہے۔

69- ٹیچر کی ہدایات یا سمجھانے کا کوئی فائدہ نہیں لیتا/لیتی۔

70- کلاس کا کام آسانی سے ختم کر لیتا/لیتی ہے۔

71- خیالی دنیا میں رہتا/رہتی ہے۔

72- کلاس میں بچے کی دلچسپی اور سوچ وقت کی مناسبت سے نہیں ہوتی۔

Content Validation and Categorization of Items of FIAS

Instructions for Panelists (Judges)

Dear Participants.

An indigenous scale is being developed for the measurement of functional impairment in children and adolescents named as Functional Impairment Assessment Scale (FIAS) to be used in a PhD research project. For this purpose an item pool for (Form-T) and (Form-P) of FIAS are being presented to you in order to measure the content validity and to categorize the items into four sub-scales namely: Cognitive Dysfunction scale (CDS), Social Dysfunction Scale (CDS), Emotional Dysfunction Scale (EDS) and Learning Behavior Dysfunction Scale (LBDS) for children and adolescents. You are requested to read each item carefully and categories the item as how essential a particular item is by rating it according to three categories such as: ***essential, useful but not essential and not necessary*** by writing **just E / U/ NE** in front of every item written in the respective sub-scale.

Thank you for your cooperation.

Samina Bukhari

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National Institute of Psychology (NIP)

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List of Redundant and Retained Items of

Functional Impairment Assessment in Scale (FIAS)

Parents Rating Scale (PRS)

Form-P (N = 79)

Redundant and Retained Items (n = 14)

-13 اپنے بہن بھائیوں سے حسد کرتا/ کرتی ہے۔

-14 دوسروں کو شک کی نظر سے دیکھتا/دیکھتی ہے۔

-15 خطرناک اور Risk والے کاموں میں حصہ لیتی/لیتا ہے۔

-27 کم گو ہے صرف بلانے پر بولتا/بولتی ہے۔

-38 بھوک بہت زیادہ لگتی ہے۔

-40 افسوسناک واقعات اور موت کے بارے میں سوچتا سوچتی ہے۔

-41 بیکار بیٹھ کر سوچتا/سوچتی رہتی ہے۔

-44 گھر میں سب سے کھل کر بات چیت کرتا/ کرتی ہے۔

-46 دوسرے بچوں کے ساتھ ملکر کھیلتا/ کھیلتی ہے۔

-58 گھومنا پھرنا پسند ہوتا ہے۔

-59 ٹیلیفون پر بات نہیں کرتا/ کرتی۔

-67 کوئی کام پورا نہیں کرتا/ کرتی۔

-73 ٹیچر کی طرف سے شکایات ملتی ہے۔

-74 اسکول جانے سے گھبراتا/ گھبراتی ہے۔

List of Retained Items (n = 65)

-1 فیملی کے افراد کے درمیان بیٹھے ہوئے عدم توجہی کا اظہار کرتا/ کرتی ہے۔

-2 میں نے نہیں سنا جیسے جواب دیتا/دیتی ہے۔

-3 بلائے جانے پر جواب دیتا/دیتی ہے۔

-4 معمولی سے بات پر بہت زیادہ ہنسنے /رونے کا مظاہرہ کرتا/ کرتی ہے، جبکہ گھر کے دوسرے افراد ایسا نہیں کرتے۔

-5 غصہ بہت جلد آجاتا ہے۔

6- معمولی سے فرمائش پوری نہ ہونے کی صورت پر بھی شدید منفی ردِعمل کا اظہار کرتا/ کرتی ہے۔

7- ماں باپ کا کہنا نہیں مانتا/مانتی۔

8- اپنی جسمانی صفائی (مثلاً غسل کرنا، صاف کپڑے پہننا، بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔

9- اگر کوئی نصیحت یا تنقید کی جائے تو برا مان جاتا/جاتی ہے۔

10- اصل صورت حال سے بے خبر ہونے کی وجہ سے گفتگو میں حصہ نہیں لے سکتا/سکتی۔

11- والدین کی نصیحت پر دھیان نہیں کرتا/ کرتی۔

12- گھر کی پریشانیوں کو محسوس نہیں کرتا/ کرتی۔

16- ماں باپ سے انعام یا کسی چیز کی لالچ میں اچھا کام کرنے کی کوشش کرتا/ کرتی ہے۔

17- موقع محل کے مطابق بات نہیں کرتا/ کرتی۔

18- دوسروں کی بات کاٹتی/ کاٹتا ہے۔

19- اپنے یا دوسروں کے تجربات سے فائدہ حاصل کرتا/ کرتی ہے۔

20- اپنی پسند کی چیزیں خریدتے وقت دوسروں پر انحصار کرتا/ کرتی ہے۔

21- اپنے کیے کی ذمہ داری جلد قبول کرتا/ کرتی ہے۔

22- بغیر سوچے سمجھے بات کرتا/ کرتی ہے۔

23- بعد میں رونما ہونے والے نتائج سے بے خبر بغیر اندازہ لگائے اچانک حرکت کرتا/ کرتی ہے۔ مثلاً جھٹکے سے اٹھنا، بات کا منہ سے نکل جانا وغیرہ۔

24- گھر کی سجاوٹ اور صفائی کا خیال رکھتی/رکھتا ہے۔

25- بہن بھائیوں اور ماں باپ سے پیار اور ہمدردی کا مظاہرہ کرتا/ کرتی ہے۔

26- سکول میں اچھی کارکردگی نہ دکھانے یا کلاس فیلوز کے برے رویے کی وجہ سے افسردہ حالت میں گھر لوٹتا/لوٹتی ہے۔

28- مسلسل حرکت میں رہتا/رہتی ہے مثلاً ٹانگیں ہلانا، انگلیوں سے کھیلنا، بار بار پڑھائی کے دوران اٹھنا وغیرہ۔

29- چھوٹی چھوٹی بات پر بہن بھائیوں سے الجھ پڑتا/پڑتی ہے۔

30- بغیر کسی ظاہری وجہ سے بے چین رہتا/رہتی ہے۔

31- رونا بہت جلد آتا ہے۔

32- بہت کم آواز میں بات کرتا/ کرتی ہے۔

33- جسمانی شکایات (سر درد، پیٹ درد، متلی، چکر، غنودگی وغیرہ) کی وجہ سے سکول جانے سے انکار کرتا/ کرتی ہے۔

34- زیادہ سوتا/سوتی ہے۔

35- دوسروں کے سامنے بات کرنے کے دوران نظریں نیچی رکھتا/رکھتی ہے۔

36- بات تیز تیز اور اونچی آواز میں کرتا/ کرتی ہے۔

37- بھوک بہت کم لگتی ہے۔

39- بے بسی اور نا امیدی کی بات کرتی/ کرتا ہے۔

42- اپنی ذات پر تنقید کرتا/ کرتی ہے کہ میں ایسی ہوں/ میں ویسا ہوں۔

43- موت کی خواہش کرتا/ کرتی ہے۔

45- دوست آسانی سے بناتا/ بناتی ہے، اور پھر اس کو قائم رکھنے کی کوشش کرتا/ کرتی ہے۔

47- دوسرے بچوں کے ساتھ گھل مل کر نہیں بیٹھتا/ بیٹھتی۔

48- اپنے سے کم عمر بچوں میں خوش رہتا/ رہتی ہے۔

49- گھر کے اہم کام سرانجام دینے میں ماں باپ کی مدد کرتا/ کرتی ہے۔

50- دوست بدلتے رہتے ہیں۔

51- گروپ میں کام نہیں کر سکتا/ سکتی۔

52- گروپ میں لڑائی ہو جاتی ہے۔

53- دوستی ان بچوں کے ساتھ ہوتی ہے جو پڑھائی میں نالائق ہوتے ہیں۔

54- بڑوں سے بات کرنے کے دوران زبان لڑکھڑاتی ہے۔

55- گروپ لیڈر بنتا/ بنتی ہے۔

56- دوسرے بچے بات بات پر مذاق اڑاتے ہیں۔

56- الگ تھلگ رہتا/ رہتی ہے۔

60- گھر کے بحث و مباحثہ میں حصہ لیتا/ لیتی ہے۔

61- سکول کی سرگرمیوں میں شوق سے حصہ لیتا/ لیتی ہے۔

62- سکول/ کالج سے غیر حاضر رہتا/ رہتی ہے۔

63- سکول/ کالج کا کام وقت پر کرتا/ کرتی ہے۔

64- سکول/ کالج کے لیے وقت پر تیار ہوتا/ ہوتی ہے۔

65- سکول/ کالج کی انتظامیہ کی طرف سے فائن/ جرمانے لگتے ہیں۔

66- سکول/ کالج کے قائدے وقانان پر پابندی کرتا/ کرتی ہے۔

68- کلاس کی سجاوٹ کے لیے چارٹس بناتی/ بناتا ہے۔

69- انگلش پڑھنے اور بولنے سے ہچکچاہتی/ ہچکچاتا ہے۔

70- بعض مضامین میں اچھی کارکردگی دکھاتا/ دکھاتی ہے۔

71- سکول/ کالج جانے کے دنوں میں تھکاوٹ، جھنجھلاہٹ یا افسردگی کا مظاہرہ کرتا/ کرتی ہے۔

72- سکول/ کالج کی دیگر تقاریب میں شوق سے حصہ لیتا/ لیتی ہے۔

75- پڑھائی کے یا کسی گھر کے کام کے دوران اپنی توجہ ایک جگہ پر مذکورہ نہیں کرتی/ کرتا۔

76- سکول کا/ گھر کا کام کرنے کے دوران بار بار اٹھتا/اٹھتی ہے۔

77- ٹیچر کی طرف سے لاپرواہی کا شکایت ملتی رہتی ہے۔

78- سکول کا کام کرنے کے دوران ربر کا استعمال بار بار کرتی/ کرتا ہے۔

79- سکول کا کام آسانی سے ختم کر لیتا/لیتی ہے۔

DEMOGRPAHIC DATA SHEET

ہدایات:

قومی ادارۂ نفسیات، قائداعظم یونیورسٹی کی جانب سے Parent's Rating Scale (PRS) سوالنامے کی صورت میں پیش کیا جارہا ہے جو آپ کے بچے کی ذہنی اور نفسیاتی کارکردگی اور اس کی ہیجانی کیفیت بیان کرتا ہے۔ ہر بیان کے سامنے 1 سے 5 تک نمبر درج ہیں جو اس بیان کے محسوس کرنے کے 5 درجوں یعنی کبھی نہیں، شاذ و نادر، کبھی کبھی، اکثر اور ہمیشہ کو ظاہر کرتے ہیں۔

آپ سے درخواست ہے کہ برائے مہربانی بچے کو مدِ نظر رکھتے ہوئے ہر بیان کو غور سے پڑھیں اور صرف اس نمبر پر دائرہ لگائیں جو آپ کے خیال میں بچے کی ذہنی اور نفسیاتی کارکردگی سے مطابقت رکھتا ہے۔ مثلاً بیان ہے کہ

'کلاس میں بچہ پڑھائی میں توجہ نہیں دیتا'

اگر آپ کے خیال میں ایسا کبھی نہیں کرتا، تو نمبر '1' پر دائرہ لگائیں اور اگر ہمیشہ ایسا ہی کرتا ہے، تو نمبر '5' پر دائرہ لگائیں وغیرہ وغیرہ۔

نوٹ: اگر آپ کے بچے کے ساتھ کوئی جسمانی معزوری (نابینا، بہرہ یا گونگا) ہے، تو برائے مہربانی سوالنامے کو پُر نہ کریں۔

ذاتی معلومات

بچے کا نام_____جنس_____ عمر_____

جماعت_____سکول/ کالج کا نام بمعہ ایڈریس_____

گھر کا پتہ_____باپ کی تعلیم اور پیشہ_____

گھر کی ماہانہ انکم_____ماں کی تعلیم اور پیشہ_____

بہن بھائیوں کی تعداد_____بہن بھائیوں میں بچے کا نمبر_____

مندرجہ ذیل کوائف کے "ہاں/نہیں" میں جواب دیں۔

1- کیا بچہ ماں باپ اور خاندان کے دیگر افراد (مثلاً دادی، دادا وغیرہ) کے ساتھ رہتا ہے------------------

2- کیا بچے کے ماں باپ دونوں زندہ ہیں------------ اگر نہیں، تو کون حیات ہے------------------

3- کیا بچے کے ماں باپ میں جھگڑا رہتا ہے------------------------------------

4- کیا ماں باپ میں طلاق ہو چکی ہے------------------------------------

5- آپ کے خیال میں کیا آپ کا بچہ شروع شروع میں اسکول میں اچھی کارکردگی دکھاتا تھا------------------
کیا آپ کا بچہ کسی کلاس میں فیل ہوا ہے------------------------------------

6- آپ کے خیال میں آپ کا بچہ کتنے عرصے میں اسکول کی کارکردگی میں کمی اور نفسیاتی مسائل کا مظاہرہ کر رہا ہے تفصیل لکھیں۔

Functional Impairment Assessment Scale (FIAS)

Parent Rating Scale (PRS) From-P (N = 65)

نمبر شمار	بیانات	کبھی نہیں	شاذ و نادر	کبھی کبھی	اکثر	ہمیشہ
-1	دوسروں کی بات کو کاٹتی ہے۔	1	2	3	4	5
-2	فیملی کے افراد کے درمیان بیٹھے ہوئے عدم توجہی کا اظہار کرتا/ کرتی ہے۔	1	2	3	4	5
-3	موقع محل کے مطابق بات نہیں کرتا/ کرتی۔	1	2	3	4	5
-4	ماں باپ سے انعام یا کسی چیز کی لالچ میں اچھا کام کرنے کی کوشش کرتا/ کرتی ہے۔	1	2	3	4	5
-5	میں نے نہیں سنا جیسے جواب دیتا/دیتی ہے۔	1	2	3	4	5
-6	اگر کوئی نصیحت یا تنقید کی جائے تو برا مان جاتا/جاتی ہے۔	1	2	3	4	5
-7	ماں باپ کا کہنا نہیں مانتا/مانتی۔	1	2	3	4	5
-8	گھر کی پریشانیوں کو محسوس کرتا/ کرتی۔	1	2	3	4	5
-9	سکول کا کام آسانی سے ختم کر لیتا/لیتی ہے۔	1	2	3	4	5
-10	معمولی سی فرمائش پوری نہ ہونے کی صورت پر بھی شدید منفی ردِ عمل کا اظہار کرتا/ کرتی ہوں۔	1	2	3	4	5
-11	والدین کی نصیحت پر دھیان نہیں کرتا/ کرتی۔	1	2	3	4	5
-12	غصہ بہت جلد آجاتا ہے۔	1	2	3	4	5
-13	سکول کا کام کرنے کے دوران ربر کا استعمال بار بار کرتی/ کرتا ہے۔	1	2	3	4	5
-14	معمولی سی بات پر بہت زیادہ ہنسنے /رونے کا مظاہرہ کرتا/ کرتی ہے، جبکہ گھر کے دوسرے افراد ایسا نہیں کرتے۔	1	2	3	4	5
-15	ٹیچر کی طرف سے لاپرواہی کی شکایت ملتی رہتی ہے۔	1	2	3	4	5
-16	سکول کا/ گھر کا کام کرنے کے دوران بار بار اٹھتی/اٹھتا ہے۔	1	2	3	4	5
-17	اصل صورت حال سے بے خبر ہونے کی وجہ سے گفتگو میں حصہ نہیں لے سکتا/سکتی۔	1	2	3	4	5
-18	بلائے جانے پر جواب دیتا/دیتی ہے۔	1	2	3	4	5
-19	پڑھائی کے یا کسی گھر کے کام کے دوران اپنی توجہ ایک جگہ پر مذکور نہیں کرتی/ کرتا۔	1	2	3	4	5

نمبر شمار	بیانات	کبھی نہیں	شاذونادر	کبھی کبھی	اکثر	ہمیشہ
-20	گھر کی سجاوٹ اور صفائی کا خیال رکھتی/رکھتا ہے۔	1	2	3	4	5
-21	اپنے کیے کی ذمہ داری جلد قبول کرتا/ کرتی ہے۔	1	2	3	4	5
-22	سکول میں اچھی کارکردگی نہ دکھانے یا کلاس فیلوز کے برے رویے کی وجہ سے افسردہ حالت میں گھر لوٹتا/لوٹتی ہے۔	1	2	3	4	5
-23	بغیر سوچے سمجھے بات کرتا/ کرتی ہے۔	1	2	3	4	5
-24	مسلسل حرکت میں رہتا/رہتی ہے مثلاً ٹانگیں ہلانا، انگلیوں سے کھیلنا، بار بار پڑھائی کے دوران اٹھنا وغیرہ۔	1	2	3	4	5
-25	بغیر کسی ظاہری وجہ سے بے چین رہتا/رہتی ہے۔	1	2	3	4	5
-26	اپنے یا دوسروں کے تجربات سے فائدہ حاصل کرتا/ کرتی ہے۔	1	2	3	4	5
-27	چھوٹی چھوٹی بات پر بہن بھائیوں سے الجھ پڑتا/پڑتی ہے۔	1	2	3	4	5
-28	بعد میں رونما ہونے والے نتائج سے بے خبر بجیر اندازہ لگائے اچانک حرکت کرتا/ کرتی ہے مثلاً جھٹکے سے اٹھنا، بات کا منہ سے نکل جانا وغیرہ۔	1	2	3	4	5
-29	رونا بہت جلد آتا ہے۔	1	2	3	4	5
-30	اپنی پسند کی چیزیں خریدتے وقت دوسروں پر انحصار کرتا/ کرتی ہے۔	1	2	3	4	5
-31	بے بسی اور ناامیدی کی باتیں کرتی ہے۔	1	2	3	4	5
-32	موت کی خواہش کرتا/ کرتی ہے، بھوک بہت زیادہ لگتی ہے۔	1	2	3	4	5
-33	بھوک بہت کم لگتی ہے۔	1	2	3	4	5
-34	اپنی ذات پر تنقید کرتا/کرتی ہے کہ میں ایسا/ایسی ہوں، میں ویسا/ویسی ہوں۔	1	2	3	4	5
-35	دوست آسانی سے بناتا/بناتی ہے، اور پھر اس کو قائم رکھنے کی کوشش کرتا/ کرتی ہے۔	1	2	3	4	5
-36	گھر کے اہم کام سرانجام دینے میں ماں باپ کی مدد کرتا/ کرتی ہے۔	1	2	3	4	5
-37	بہت کم آواز میں بات کرتا/ کرتی ہے۔	1	2	3	4	5
-38	گروپ میں کام نہیں کرسکتا/سکتی۔	1	2	3	4	5
-39	دوست بدلتے رہتے ہیں۔	1	2	3	4	5
-40	جسمانی شکایات (سر درد، پیٹ درد، متلی، چکر، غنودگی وغیرہ) کی وجہ سے سکول جانے سے انکار کرتا/ کرتی ہے۔	1	2	3	4	5
-41	گروپ میں لڑائی ہو جاتی ہے۔	1	2	3	4	5

نمبر شمار	بیانات	کبھی نہیں	شاذونادر	کبھی کبھی	اکثر	ہمیشہ
-42	بات تیز تیز اور اونچی آواز میں کرتا/ کرتی ہے۔	1	2	3	4	5
-43	دوستی ان بچوں کے ساتھ ہوتی ہے جو پڑھائی میں نالائق ہوتے ہیں۔	1	2	3	4	5
-44	زیادہ سوتا/ سوتی ہے۔	1	2	3	4	5
-45	گروپ لیڈر بنتا/ بنتی ہے۔	1	2	3	4	5
-46	دوسروں کے سامنے بات کرنے کے دوران نظریں نیچی رکھتا/ رکھتی ہے۔	1	2	3	4	5
-47	دوسرے بچے بات بات پر مذاق اڑاتے ہیں۔	1	2	3	4	5
-48	بڑوں سے بات کرنے کے دوران زبان لڑکھڑاتی ہے۔	1	2	3	4	5
-49	سکول/ کالج سے غیر حاضر رہتا/ رہتی ہے۔	1	2	3	4	5
-50	سکول کی سرگرمیوں میں شوق سے حصہ لیتا/ لیتی ہے۔	1	2	3	4	5
-51	سکول/ کالج کا کام وقت پر کرتا/ کرتی ہے۔	1	2	3	4	5
-52	سکول/ کالج کے قائدے قانون پر پابندی کرتا/ کرتی ہے۔	1	2	3	4	5
-53	انگلش پڑھنے اور بولنے سے ہچکچاتی/ ہچکچاتا ہے۔	1	2	3	4	5
-54	سکول/ کالج کے لئے وقت پر تیار ہوتا/ ہوتی ہے۔	1	2	3	4	5
-55	بعض مضامین میں اچھی کارکردگی دکھاتا/ دکھاتی ہے۔	1	2	3	4	5
-56	کلاس کی سجاوٹ کے لیے چارٹس بناتی/ بناتا ہے۔	1	2	3	4	5
-57	سکول/کالج کی دیگر تقریبات میں شوق سے حصہ لیتا/ لیتی ہے۔	1	2	3	4	5
-58	سکول/ کالج جانے کو دنوں میں تھکاوٹ، جھنجھلاہٹ یا افسردگی کا مظاہرہ کرتا/ کرتی ہے۔	1	2	3	4	5
-59	اپنے سے کم عمر کے بچوں سے کھیلتا/کھیلتی ہے۔	1	2	3	4	5
-60	اپنی جسمانی صفائی (مثلاً غسل کرنا، صاف کپڑے پہننا، بال تراشنا وغیرہ) پر توجہ دیتا/ دیتی ہے۔	1	2	3	4	5
-61	بہن بھائیوں اور ماں باپ سے پیار اور ہمدردی کا مظاہرہ کرتا/ کرتی ہے۔	1	2	3	4	5
-62	گھر کے بحث ومباحثہ میں حصہ لیتا/لیتی ہے۔	1	2	3	4	5
-63	الگ تھلگ رہتا/رہتی ہے۔	1	2	3	4	5
-64	دوسرے بچوں کے ساتھ گھل مل کر نہیں بیٹھتا/ بیٹھتی۔	1	2	3	4	5
-65	سکول/ کالج کی انتظامیہ کی طرف سے فائن/ جرمانے لگتے ہیں۔	1	2	3	4	5

Item Pool of

Functional Impairment Assessment Scale (FIAS)

Teacher Rating Scale (TRS)

Form - T (N = 72)

List of Redundant Items (n = 7)

-7 اُردواور انگلش کی کتاب کی Reading شوق سے کرتا/کرتی ہے۔

-8 ریاضی کے سوال آسانی سے سمجھ لیتا/لیتی ہے۔

-9 کسی کے پڑھانے کا کوئی فائدہ نہیں ہوتا۔

-17 کلاس میں اُٹھتے بیٹھتے وقت اکثر ٹھوکر لگتی ہے یا ہاتھ سے چیزیں گر جاتی ہیں۔

-26 زیادہ دیر تک اپنی سیٹ پر بیٹھ کر کام نہیں کر سکتا/ سکتی۔

-61 بات کرنے پر خالی خالی نظروں سے دیکھتی/ دیکھتا رہتا ہے۔

-71 خیالی دنیا میں رہتا/رہتی ہے۔

List of Retained Items (n = 65)

-1 ہنسنے/رونے کا طرزِ عمل موقع محل کے برخلاف ہوتا ہے۔

-2 معمولی بات پر شدید غصہ کا اظہار کرتا/ کرتی ہے۔

-3 چھوٹی چھوٹی بات پر شدید ردِ عمل کا اظہار کرتا/ کرتی ہے۔

-4 ٹیچر کا کہنا نہیں مانتا/مانتی۔

-5 اپنی جسمانی صفائی مثلاً (صاف یونیفارم میں آنا، ناخن اور بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔

-6 اپنے اوپر تنقید برداشت نہیں کرتا/ کرتی۔

-10 عام طرزِ عمل (Behavior) دوسرے بچوں سے مختلف ہوتا ہے۔

-11 بچے کی کلاس میں کارکردگی ٹیچر کی توجہ / تعریف پر منحصر ہوتی ہے۔

-12 موقع محل کے مطابق بات نہیں کرتا/ کرتی۔

-13 دوسروں کی مرضی کے خلاف گفتگو میں مخل ہوتا/ہوتی ہے۔

-14 اپنی غلطیوں سے سبق سیکھتا/ سیکھتی ہے۔

15- اپنے دلچسپ مشاغل کے انتخاب میں دوسروں سے مدد لیتی/لیتا ہے۔

16- بہت زیادہ تابعدار ہوتا/ ہوتی ہے۔

18- گروپ کی تعلیمی سرگرمیوں میں ذمہ داری سے اپنا رول نبھاتا/نبھاتی ہے۔

19- کلاس فیلوز کے ساتھ اچھا برتاؤ کرتا/ کرتی ہے۔

20- سوالوں کے جواب غیر مناسب ہوتے ہیں۔

21- ایک ہر حرکت بار بار کرتا/ کرتی ہے جس سے ٹیچر کے پڑھانے میں خلل آتا ہے۔

22- ٹیچر کی ہدایات یا سمجھانے کا کوئی فائدہ نہیں لیتا/لیتی۔

23- کلاس میں بچے کی دلچسپی اور سوچ وقت کی مناسبت سے نہیں ہوتی۔

24- کلاس میں بے حسی یا تھکے پن کا مظاہرہ کرتا/ کرتی ہے۔

25- بغیر کسی ظاہری وجہ کے افسردہ اور چپ چپ نظر آتی/ آتا ہے۔

27- کلاس میں بغیر کسی وجہ کے چڑچڑے پن کا مظاہرہ کرتا/ کرتی ہے۔

28- کلاس میں بے چین یا مضطرب نظر آتا/ آتی ہے۔

29- چھوٹی سی بات پر آسانی سے رو پڑتی/پڑتا ہے۔

30- بات نہایت دھیمی آواز میں کرتا/ کرتی ہے۔

31- بیماری کی شکایت مثلاً (سر اور پیٹ درد، چکر وغیرہ) کرتا/ کرتی ہے۔

32- کلاس میں اونگھتا/اونگھتی رہتا/رہتی ہے۔

33- بات کرنے کے دوران نظریں نہیں ملاتا/ملاتی۔

34- بہت تیز تیز اور اُونچی آواز میں بات کرتا/ کرتی ہے۔

35- کلاس میں اکیلا/اکیلی بیٹھا/بیٹھی رہتا/رہتی ہے۔

36- کلاس میں کھل کر بات کرتا/ کرتی ہے۔

37- کلاس کی پچھلی نشتوں پر بیٹھتا/ بیٹھتی ہے۔

38- گروپ میں انتشار پھیلاتا/پھیلاتی ہے۔

39- دوستی آسانی سے کرتا/ کرتی ہے۔

40- کلاس فیلوز کے ساتھ مل کر کھیلتا/ کھیلتی ہے۔

41- دوسرے بچوں کے ساتھ مل کر بیٹھنا پسند نہیں کرتا/ کرتی۔

42- چھوٹی کلاس کے بچوں سے دوستی رکھتا/رکھتی ہے۔

43- کلاس میں ٹیچر کا ہاتھ بٹانے کے لیے (Monitor) منتخب ہوتا/ہوتی ہے۔

44- دوست بدلتے رہتے ہیں۔

45- گروپ میں کام نہیں کرسکتا/ کرسکتی۔

46- گروپ میں لڑائی ہو جاتی ہے۔

47- پڑھائی میں کمزور بچوں کے ساتھ دوستی رکھتا/رکھتی ہے۔

48- ٹیچر کے ساتھ بات کرنے کے دوران زبان لڑکھڑاتی ہے۔

49- کلاس کے معروف بچوں میں شمار ہوتا ہے۔

50- کلاس فیلوز میں مذاق کا نشانہ بنتا/بنتی ہے۔

51- کلاس فیلوز سے الگ تھلگ رہتا/رہتی ہے۔

52- اسکول/ کالج کی سرگرمیوں میں شوق سے حصہ لیتا/لیتی ہے۔

53- اسکول/ کالج سے غیر حاضر رہتا/رہتی ہے۔

54- کلاس کا کام وقت پر کرتا/ کرتی ہے۔

55- اسکول/ کالج وقت پر پہنچتا/ پہنچتی ہے۔

56- اسکول/ کالج کے قائدے قانون پر پابندی کرتا/ کرتی ہے۔

57- کلاس کی سجاوٹ اور دیواروں پر چارٹس لگانے میں حصہ لیتا/لیتی ہے۔

58- بعض مضامین میں اچھی کارکردگی دکھاتا/دکھاتی ہے۔

59- کالج کے روزمرہ معمول کے مطابق نہیں چل سکتا/سکتی۔

60- کلاس میں ٹیچر سے سزا ملتی ہے۔

62- کلاس میں متوجہ نہیں ہوتا/ہوتی۔

63- میں نے نہیں سنا جیسے جواب دیتا/دیتی۔

64- بلائے جانے پر جواب نہیں دیتا/دیتی۔

65- تختہ سیاہ پر نظریں مرکوز نہیں کرتا/ کرتی۔

66- ایک ہر حرکت بار بار کرتا/ کرتی ہے جس سے ٹیچر کے پڑھانے میں خلل آتا ہے۔

67- ہجے (Spelling) کی غلطیاں بار بار کرتا/ کرتی ہے۔

68- اسکول کا کام کرتے ہوئے خوشخطی یا ترتیب کا خاص خیال رکھتی/رکھتا ہے۔

69- ٹیچر کی ہدایات یا سمجھانے کا کوئی فائدہ نہیں لیتا/لیتی۔

70- کلاس کا کام آسانی سے ختم کر لیتا/لیتی ہے۔

72- کلاس میں بچے کی دلچسپی اور سوچ وقت کی مناسبت سے نہیں ہوتی۔

Item Pool of

functional Impairment Assessment in Youth Scale (FIAYS)

Teacher's Rating scale (TRS)

Form-T

ہدایات:

قومی ادارۂ نفسیات، قائداعظم یونیورسٹی، اسلام آباد کی جانب سے Teacher's Rating Scale (TRS) سوالنامے کی صورت میں پیش کیا جارہا ہے جو بچے کی ذہنی اور نفسیاتی کارکردگی اور اس کی ہیجانی کیفیت بیان کرتا ہے۔ ہر بیان کے سامنے 1 سے 5 تک نمبر درج ہیں جو اس بیان کے محسوس کرنے کے 5 درجوں یعنی کبھی نہیں، کبھی کبھی، اکثر اور ہمیشہ کو ظاہر کرتے ہیں۔

آپ سے درخواست ہے کہ برائے مہربانی بچے کو مدِ نظر رکھتے ہوئے ہر بیان کو غور سے پڑھیں اور صرف اس نمبر پر دائرہ لگائیں جو آپ کے خیال میں بچے کی ذہنی اور نفسیاتی کارکردگی سے مطابقت تکھتا ہے۔ مثلاً بیان ہے کہ

'کلاس میں بچہ پڑھائی میں توجہ نہیں دیتا'

اگر آپ کے خیال میں ایسا کبھی نہیں کرتا تو نمبر '1' پر دائرہ لگائیں اور اگر ہمیشہ ایسا ہی کرتا ہے تو نمبر '5' پر دائرہ لگائیں وغیرہ وغیرہ۔

ذاتی معلومات

بچے کا نام_____جنس_____عمر_____

کلاس میں کارکردگی:_____

پہلے پانچ درجوں پر / آخری پانچ درجوں پر_____

ٹیچر کا نام_____جنس_____تعلیم_____

سکول کا نام_____

سکول کا پتہ_____

نمبر شمار	بیانات	کبھی نہیں	شاذ و نادر	کبھی کبھی	اکثر	ہمیشہ
-1	کلاس میں بچے کی دلچسپی اور سوچ وقت کی مناسبت سے نہیں ہوتی۔	1	2	3	4	5
-2	ہجے (Spelling) کی غلطیاں بار بار کرتا/ کرتی ہے۔	1	2	3	4	5
-3	معمولی بات پر شدید غصہ کا اظہار کرتا/ کرتی ہے۔	1	2	3	4	5
-4	ٹیچر کا کہا نہیں مانتا/مانتی۔	1	2	3	4	5
-5	بلائے جانے پر جواب نہیں دیتا/دیتی۔	1	2	3	4	5
-6	چھوٹی چھوٹی بات پر شدید ردِعمل کا اظہار کرتا/ کرتی ہے۔	1	2	3	4	5
-7	سکول کا کام کرتے ہوئے خوشخطی یا ترتیب کا خاص خیال رکھتی/رکھتا ہے۔	1	2	3	4	5
-8	تختہ سیاہ پر نظریں مرکوز نہیں کرتا/ کرتی۔	1	2	3	4	5
-9	اپنی جسمانی صفائی مثلاً (صاف یونیفارم میں، ناخن اور بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔	1	2	3	4	5
-10	کلاس میں متوجہ نہیں ہوتا/ہوتی۔	1	2	3	4	5
-11	اپنے اوپر تنقید برداشت نہیں کرتا/ کرتی۔	1	2	3	4	5
-12	ٹیچر کی ہدایات پر سمجھانے کا کوئی فائدہ نہیں لیتا/لیتی۔	1	2	3	4	5
-13	میں نے نہیں سنا جیسے جواب دیتا/دیتی۔	1	2	3	4	5
-14	بچے کی کلاس میں کارکردگی ٹیچر کی توجہ / تعریف پر منحصر ہوتی ہے۔	1	2	3	4	5
-15	کلاس کا کام آسانی سے ختم کر لیتا/لیتی ہے۔	1	2	3	4	5
-16	ایک حرکت بار بار کرتا/ کرتی ہے جس سے ٹیچر کے پڑھانے میں خلل آتا ہے۔	1	2	3	4	5
-17	خیالی دنیا میں رہتا/رہتی ہے۔	1	2	3	4	5
-18	ہنسنے/رونے کے طرزِ عمل موقع محل کے برخلاف ہوتا ہے۔	1	2	3	4	5
-19	کلاس میں اُٹھتے بیٹھتے وقت اکثر ٹھوکر لگتی ہے یا ہاتھ سے چیزیں گر جاتی ہیں۔	1	2	3	4	5
-20	کلاس فیلوز کے ساتھ اچھا برتاؤ کرتا/ کرتی ہے۔	1	2	3	4	5
-21	گروپ کی تعلیمی سرگرمیوں میں ذمہ داری سے اپنا رول نبھاتا/نبھاتی ہے۔	1	2	3	4	5
-22	کلاس میں بے حسی یا تھکے پن کا مظاہرہ کرتا/ کرتی ہے۔	1	2	3	4	5

نمبر شمار	بیانات	کبھی نہیں	شاذ و نادر	کبھی کبھی	اکثر	ہمیشہ
-23	دوسروں کی مرضی کے خلاف گفتگو میں مخل ہوتا/ ہوتی ہے۔	1	2	3	4	5
-24	سوالوں کے جواب غیر مناسب ہوتے ہیں	1	2	3	4	5
-25	زیادہ دیر تک اپنی سیٹ پر بیٹھ کر کام نہیں کر سکتا/ سکتی۔	1	2	3	4	5
-26	موقع محل کے مطابق بات نہیں کرتا/ کرتی۔	1	2	3	4	5
-27	بغیر کسی ظاہری وجہ کے افسردہ اور چپ چپ نظر آتی/ آتا ہے۔	1	2	3	4	5
-28	کلاس میں بے چین یا مضطرب نظر آتا/ آتی ہے۔	1	2	3	4	5
-29	اپنے دلچسپ مشاغل کے انتخاب میں دوسروں سے مدد لیتی/لیتا ہے۔	1	2	3	4	5
-30	کلاس میں بغیر کسی وجہ کے چڑچڑے پن کا مظاہرہ کرتا/ کرتی ہے۔	1	2	3	4	5
-31	اپنی غلطیوں سے سبق سیکھتا/ سیکھتی ہے۔	1	2	3	4	5
-32	چھوٹی سی بات پر آسانی سے رو پڑتی/ پڑتا ہے۔	1	2	3	4	5
-33	بات نہایت دھیمی آواز میں کرتا/ کرتی ہے۔	1	2	3	4	5
-34	بہت زیادہ تابعدار ہوتا/ ہوتی ہے۔	1	2	3	4	5
-35	کلاس میں اونگھتا/ اونگھتی رہتی ہے۔	1	2	3	4	5
-36	بیماری کی شکایات (مثلاً! سر اور پیٹ درد، چکر وغیرہ) کرتا/ کرتی ہے۔	1	2	3	4	5
-37	بات کرنے کے دوران نظریں نہیں ملاتا/ ملاتی۔	1	2	3	4	5
-38	پڑھائی میں کمزور بچوں کے ساتھ دوستی رکھتا/ رکھتی ہے۔	1	2	3	4	5
-39	کلاس میں ٹیچر کا ہاتھ بٹانے کیلئے (Monitor) منتخب ہوتا/ ہوتی ہے۔	1	2	3	4	5
-40	دوسرے بچوں کے ساتھ مل کر بیٹھنا پسند نہیں کرتا/ کرتی۔	1	2	3	4	5
-41	گروپ میں لڑائی ہو جاتی ہے۔	1	2	3	4	5
-42	دوست بدلتے رہتے ہیں۔	1	2	3	4	5
-43	بہت تیز تیز اور اُونچی آواز میں بات کرتا/ کرتی ہے۔	1	2	3	4	5
-44	گروپ میں کام نہیں کر سکتا/ سکتی۔	1	2	3	4	5
-45	کلاس میں کھل کر بات کرتا/ کرتی ہے۔	1	2	3	4	5
-46	کلاس فیلوز کے ساتھ مل کر کھیلتا/ کھیلتی ہے۔	1	2	3	4	5
-47	کلاس میں اکیلا/ اکیلی بیٹھی رہتی ہے۔	1	2	3	4	5

نمبر شمار	بیانات	کبھی نہیں	شاذونادر	کبھی کبھی	اکثر	ہمیشہ
-48	چھوٹی کلاس کے بچوں سے دوستی رکھتا/رکھتی ہے۔	1	2	3	4	5
-49	دوستی آسانی سے کرتا/ کرتی ہے۔	1	2	3	4	5
-50	سکول/کالج کی سرگرمیوں میں شوق سے حصہ لیتا/لیتی ہے۔	1	2	3	4	5
-51	کلاس فیلوز سے الگ تھلگ رہتا/رہتی ہے۔	1	2	3	4	5
-52	ٹیچر کے ساتھ بات کرنے کے دوران زبان لڑکھڑاتی ہے۔	1	2	3	4	5
-53	کلاس کا کام وقت پر کرتا/ کرتی ہے۔	1	2	3	4	5
-54	کلاس فیلوز میں مذاق کا نشانہ بنتا/بنتی ہے۔	1	2	3	4	5
-55	کلاس کے معروف بچوں میں شمار ہوتا ہے۔	1	2	3	4	5
-56	سکول/کالج وقت پر پہنچتا/ پہنچتی ہے۔	1	2	3	4	5
-57	سکول/کالج کی انتظامیہ کی طرف سے فائن/جرمانے لگتے ہیں۔	1	2	3	4	5
-58	سکول/کالج کے قائدے قانون پر پابندی کرتا/ کرتی ہے۔	1	2	3	4	5
-59	کلاس کی سجاوٹ اور دیواروں پر چارٹس لگانے میں حصہ لیتا/لیتی ہے۔	1	2	3	4	5
-60	انگلش پڑھنے اور بولنے سے ہچکچاتا/ ہچکچاتی ہے۔	1	2	3	4	5
-61	بعض مضامین میں اچھی کارکردگی دکھاتا/دکھاتی ہے۔	1	2	3	4	5
-62	سکول/کالج کی دیگر تقاریب مثلاً سپورٹس یا بزمِ ادب وغیرہ میں بڑے شوق سے حصہ لیتا/لیتی ہے۔	1	2	3	4	5
-63	کلاس میں ٹیچر سے سزا ملتی ہے۔	1	2	3	4	5
-64	کلاس کے روزمرہ معمول کے مطابق نہیں چل سکتا/سکتی۔	1	2	3	4	5
-65	سکول/کالج سے غیر حاضر رہتا/رہتی ہے۔	1	2	3	4	5

Item-total correlation of 65-item Form-T of FIAS (N = 350). Item loading ≥ .30

Item No.	Item Total Correlation	Item No.	Item Total Correlation
1	.49**	23	.60**
2	.78**	24	.47**
3	.52**	25	.51**
4	.49*	26	.67**
5	.57**	27	.45**
6	.52**	28	.61**
7	.66**	29	.60**
8	.50**	30	.51**
9	.53**	31	.61**
10	.53**	32	.51**
11	.49**	33	.54**
12	.44**	34	..71**
13	.54**	35	.64**
14	.42**	36	58**
15	.60**	37	.61**
16	55**	38	.59**
17	.47**	39	.52**
18	.68**	40	.53**
19	.72**	41	.47**
20	.59**	42	.57**
21	.57**	43	.58**
22	.60**	44	.41**

Continued C-1

Item no	Item-total Correlation	Item no	Item-total Correlation
45	.70**	56	.59**
46	.59**	57	.48**
47	.66**	58	.62**
48	.36**	59	.67**
49	.75**	60	.72**
50	.63**	61	.76**
51	.54**	62	.60**
52	.59**		
53	.48**		
54	.62**		
55	.67**		

**$p < .01$

Appendix-C 2

Item-total correlation of 65-item Form-P of FIAS (N = 350)). Item loading ≥ .30

Item no	Item-total Correlation	Item no	Item-total Correlation
1	.44**	20	.49**
2	.55**	21	.61**
3	.50**	22	.59**
4	.45**	23	.54**
5	.42**	24	.76**
6	.48**	25	.58**
7	.74**	26	.70**
8	.52**	27	.65**
9	.46**	28	.57**
10	.40**	29	.43**
11	.55**	30	.61**
12	.52**	31	.72**
13	.38**	32	.47**.
14	.54**	33	.52**
15	.57**	34	.49**
16	.34**	35	.66**
17	52**	36	.58**
18	.64**	37	.62**
19	.49**	38	.58**

Continued

Item no	Item-total Correlation	Item no	Item-total Correlation
39	.43**	54	.71**
40	.75**	55	.61**
41	.50**	56	.57**
42	.55**	57	.39**
43	.40**	58	.76**
44	.48**	59	.48**
45	.58**	60	.42**
46	.62**		
47	.36**		
48	.71**		
49	.61**		
50	.57**		
52	.46**		
53	.55**		

** $p < .01$

Final Scale
Functional Impairment Assessment in Scale (FIAS)
Teacher's Rating Scale (TRS)
Form-T (N = 62)

ہدایات:

قومی ادارۂ نفسیات، قائداعظم یونیورسٹی، اسلام آباد کی جانب سے Teacher's Rating Scale (TRS) سوالنامے کی صورت میں پیش کیا جارہا ہے جو بچے کی ذہنی اور نفسیاتی کارکردگی اور اس کی ہیجانی کیفیت بیان کرتا ہے۔ ہر بیان کے سامنے 1 سے 5 تک نمبر درج ہیں جو اس بیان کے محسوس کرنے کے 5 درجوں یعنی کبھی نہیں، کبھی کبھی، اکثر اور ہمیشہ کو ظاہر کرتے ہیں۔

آپ سے درخواست ہے کہ برائے مہربانی بچے کو مدِ نظر رکھتے ہوئے ہر بیان کو غور سے پڑھیں اور صرف اس نمبر پر دائرہ لگائیں جو آپ کے خیال میں بچے کی ذہنی اور نفسیاتی کارکردگی سے مطابقت تکھتا ہے۔ مثلاً بیان ہے کہ

'کلاس میں بچہ پڑھائی میں توجہ نہیں دیتا'

اگر آپ کے خیال میں ایسا کبھی نہیں کرتا تو نمبر '1' پر دائرہ لگائیں اور اگر ہمیشہ ایسا ہی کرتا ہے تو نمبر '5' پر دائرہ لگائیں وغیرہ وغیرہ۔

ذاتی معلومات

بچے کا نام_____جنس_____عمر_____

کلاس میں کارکردگی:_____

پہلے پانچ درجوں پر / آخری پانچ درجوں پر_____

ٹیچر کا نام_____جنس_____تعلیم_____

سکول کا نام_____

سکول کا پتہ_____

نمبر شمار	بیانات	کبھی نہیں	شاذ و نادر	کبھی کبھی	اکثر	ہمیشہ
-1	کلاس میں بچے کی دلچسپی اور سوچ وقت کی مناسبت سے نہیں ہوتی۔	1	2	3	4	5
-2	ہجے (Spelling) کی غلطیاں بار بار کرتا/ کرتی ہے۔	1	2	3	4	5
-3	معمولی بات پر شدید غصہ کا اظہار کرتا/ کرتی ہے۔	1	2	3	4	5
-4	ٹیچر کا کہا نہیں مانتا/مانتی۔	1	2	3	4	5
-5	بلائے جانے پر جواب نہیں دیتا/دیتی۔	1	2	3	4	5
-6	چھوٹی چھوٹی بات پر شدید ردِعمل کا اظہار کرتا/ کرتی ہے۔	1	2	3	4	5
-7	سکول کا کام کرتے ہوئے خوشخطی یا ترتیب کا خاص خیال رکھتی/رکھتا ہے۔	1	2	3	4	5
-8	تختہ سیاہ پر نظریں مرکوز نہیں کرتا/ کرتی۔	1	2	3	4	5
-9	اپنی جسمانی صفائی مثلاً (صاف یونیفارم میں، ناخن اور بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔	1	2	3	4	5
-10	کلاس میں متوجہ نہیں ہوتا/ہوتی۔	1	2	3	4	5
-11	اپنے اوپر تنقید برداشت نہیں کرتا/ کرتی۔	1	2	3	4	5
-12	ٹیچر کی ہدایات پر سمجھانے کا کوئی فائدہ نہیں لیتا/لیتی۔	1	2	3	4	5
-13	میں نے نہیں سنا، جیسے جواب دیتا/دیتی ہے۔	1	2	3	4	5
-14	کلاس کا کام آسانی سے ختم کر لیتا/لیتی ہے۔	1	2	3	4	5
-15	ایک حرکت بار بار کرتا/ کرتی ہے جس سے ٹیچر کے پڑھانے میں خلل آتا ہے۔	1	2	3	4	5
-16	خیالی دنیا میں رہتا/رہتی ہے۔	1	2	3	4	5
-17	ہنسنے/رونے کے طرزِ عمل موقع محل کے برخلاف ہوتا ہے۔	1	2	3	4	5
-18	کلاس میں اُٹھتے بیٹھتے وقت اکثر ٹھوکر لگتی ہے یا ہاتھ سے چیزیں گر جاتی ہیں۔	1	2	3	4	5
-19	کلاس فیلوز کے ساتھ اچھا برتاؤ کرتا/ کرتی ہے۔	1	2	3	4	5
-20	گروپ کی تعلیمی سرگرمیوں میں ذمہ داری سے اپنا رول نبھاتا/نبھاتی ہے۔	1	2	3	4	5
-21	کلاس میں بے حسی یا تھکے پن کا مظاہرہ کرتا/ کرتی ہے۔	1	2	3	4	5

نمبر شمار	بیانات	کبھی نہیں	شاذونادر	کبھی کبھی	اکثر	ہمیشہ
-22	دوسروں کی مرضی کے خلاف گفتگو میں مخل ہوتا/ ہوتی ہے۔					
-23	سوالوں کے جواب غیر مناسب ہوتے ہیں					
-24	زیادہ دیر تک اپنی سیٹ پر بیٹھ کر کام نہیں کر سکتا/ سکتی۔	1	2	3	4	5
-25	موقع محل کے مطابق بات نہیں کرتا/ کرتی۔	1	2	3	4	5
-26	بغیر کسی ظاہری وجہ کے افسردہ اور چپ چپ نظر آتی/ آتا ہے۔	1	2	3	4	5
-27	کلاس میں بے چین یا مضطرب نظر آتا/ آتی ہے۔	1	2	3	4	5
-28	کلاس میں بغیر کسی وجہ کے چڑچڑے پن کا مظاہرہ کرتا/ کرتی ہے۔	1	2	3	4	5
-29	اپنی غلطیوں سے سبق سیکھتا/ سیکھتی ہے۔	1	2	3	4	5
-30	چھوٹی سی بات پر آسانی سے رو پڑتی/ پڑتا ہے۔	1	2	3	4	5
-31	بات نہایت دھیمی آواز میں کرتا/ کرتی ہے۔	1	2	3	4	5
-32	بہت زیادہ تابعدار ہوتا/ ہوتی ہے۔	1	2	3	4	5
-33	کلاس میں اونگھتا/ اونگھتی رہتی ہے۔	1	2	3	4	5
-34	بیماری کی شکایات (مثلاً ! سر اور پیٹ درد، چکر وغیرہ) کرتا/ کرتی ہے۔	1	2	3	4	5
-35	بات کرنے کے دوران نظریں نہیں ملاتا/ ملاتی۔	1	2	3	4	5
-36	پڑھائی میں کمزور بچوں کے ساتھ دوستی رکھتا/ رکھتی ہے۔	1	2	3	4	5
-37	کلاس میں ٹیچر کا ہاتھ بٹانے کے لئے (Monitor) منتخب ہوتا/ ہوتی ہے۔	1	2	3	4	5
-38	دوسرے بچوں کے ساتھ مل کر بیٹھنا پسند نہیں کرتا/ کرتی۔	1	2	3	4	5
-39	گروپ میں لڑائی ہو جاتی ہے۔	1	2	3	4	5
-40	دوست بدلتے رہتے ہیں۔	1	2	3	4	5
-41	بہت تیز تیز اور اُونچی آواز میں بات کرتا/ کرتی ہے۔	1	2	3	4	5
-42	گروپ میں کام نہیں کر سکتا/ سکتی۔	1	2	3	4	5
-43	کلاس میں کھل کر بات کرتا/ کرتی ہے۔	1	2	3	4	5
-44	کلاس فیلوز کے ساتھ مل کر کھیلتا/ کھیلتی ہے۔	1	2	3	4	5

نمبر شمار	بیانات	کبھی نہیں	شاذونادر	کبھی کبھی	اکثر	ہمیشہ
-45	کلاس میں اکیلا/اکیلی بیٹھی رہتی ہے۔	1	2	3	4	5
-46	چھوٹی کلاس کے بچوں سے دوستی رکھتا/رکھتی ہے۔	1	2	3	4	5
-47	دوستی آسانی سے کرتا/ کرتی ہے۔	1	2	3	4	5
-48	سکول/ کالج کی سرگرمیوں میں شوق سے حصہ لیتا/لیتی ہے۔	1	2	3	4	5
-49	کلاس فیلوز سے الگ تھلگ رہتا/رہتی ہے۔	1	2	3	4	5
-50	ٹیچر کے ساتھ بات کرنے کے دوران زبان لڑکھڑاتی ہے۔	1	2	3	4	5
-51	کلاس کا کام وقت پر کرتا/ کرتی ہے۔	1	2	3	4	5
-52	کلاس فیلوز میں مذاق کا نشانہ بنتا/بنتی ہے۔	1	2	3	4	5
-53	کلاس کے معروف بچوں میں شمار ہوتا ہے۔	1	2	3	4	5
-54	سکول/ کالج وقت پر پہنچتا/ پہنچتی ہے۔	1	2	3	4	5
-55	سکول/ کالج کی انتظامیہ کی طرف سے فائن/جرمانے لگتے ہیں۔	1	2	3	4	5
-56	سکول/ کالج کے قائدے قانون پر پابندی کرتا/ کرتی ہے۔	1	2	3	4	5
-57	کلاس کی سجاوٹ اور دیواروں پر چارٹس لگانے میں حصہ لیتا/لیتی ہے۔	1	2	3	4	5
-58	بعض مضامین میں اچھی کارکردگی دکھاتا/دکھاتی ہے۔	1	2	3	4	5
-59	سکول/ کالج کی دیگر تقاریب مثلاً سپورٹس یا بزمِ ادب وغیرہ میں بڑے شوق سے حصہ لیتا/لیتی ہے۔	1	2	3	4	5
-60	کلاس میں ٹیچر سے سزا ملتی ہے۔	1	2	3	4	5
-61	کلاس کے روزمرہ معمول کے مطابق نہیں چل سکتا/سکتی۔	1	2	3	4	5
-62	سکول/ کالج سے غیر حاضر رہتا/رہتی ہے۔	1	2	3	4	5

Final Scale Functional Impairment Assessment Scale (FIAS)
Parent Rating Scale (PRS) From-P (N = 60)

نمبر شمار	بیانات	کبھی نہیں	شاذونادر	کبھی کبھی	اکثر	ہمیشہ
-1	دوسروں کی بات کو کاٹتی ہے۔	1	2	3	4	5
-2	فیملی کے افراد کے درمیان بیٹھے ہوئے عدم توجہی کا اظہار کرتا/ کرتی ہے۔	1	2	3	4	5
-3	موقع محل کے مطابق بات نہیں کرتا/ کرتی۔	1	2	3	4	5
-4	ماں باپ سے انعام یا کسی چیز کی لالچ میں اچھا کام کرنے کی کوشش کرتا/ کرتی ہے۔	1	2	3	4	5
-5	میں نے نہیں سنا، جیسے جواب دیتا/دیتی ہے۔	1	2	3	4	5
-6	اگر کوئی نصیحت یا تنقید کی جائے، تو برا مان جاتا/جاتی ہے۔	1	2	3	4	5
-7	ماں باپ کا کہنا نہیں مانتا/مانتی ہے۔	1	2	3	4	5
-8	گھر کی پریشانیوں کو محسوس کرتا/ کرتی ہے۔	1	2	3	4	5
-9	سکول کا کام آسانی سے ختم کر لیتا/لیتی ہے۔	1	2	3	4	5
-10	معمولی سی فرمائش پوری نہ ہونے کی صورت پر بھی شدید منفی ردِ عمل کا اظہار کرتا/ کرتی ہوں۔	1	2	3	4	5
-11	والدین کی نصیحت پر دھیان نہیں کرتا/ کرتی ہے۔	1	2	3	4	5
-12	غصہ بہت جلد آجاتا ہے۔	1	2	3	4	5
-13	سکول کا کام کرنے کے دوران ربر کا استعمال بار بار کرتی/ کرتا ہے۔	1	2	3	4	5
-14	معمولی سی بات پر بہت زیادہ ہنسنے/رونے کا مظاہرہ کرتا/ کرتی ہے، جبکہ گھر کے دوسرے افراد ایسا نہیں کرتے۔	1	2	3	4	5
-15	ٹیچر کی طرف سے لاپرواہی کی شکایت ملتی رہتی ہے۔	1	2	3	4	5
-16	سکول کا/ گھر کا کام کرنے کے دوران بار بار اٹھتی/اٹھتا ہے۔	1	2	3	4	5
-17	اصل صورت حال سے بے خبر ہونے کی وجہ سے گفتگو میں حصہ نہیں لے سکتا/ سکتی۔	1	2	3	4	5
-18	پڑھائی کے یا کسی گھر کے کام کے دوران اپنی توجہ ایک جگہ پر مذکور نہیں کرتی/ کرتا۔	1	2	3	4	5

نمبر شمار	بیانات	کبھی نہیں	شاذ و نادر	کبھی کبھی	اکثر	ہمیشہ
-19	گھر کی سجاوٹ اور صفائی کا خیال رکھتی / رکھتا ہے۔	1	2	3	4	5
-20	اپنے کئے کی ذمہ داری جلد قبول کرتا / کرتی ہے۔	1	2	3	4	5
-21	سکول میں اچھی کارکردگی نہ دکھانے یا کلاس فیلوز کے برے رویے کی وجہ سے افسردہ حالت میں گھر لوٹتا / لوٹتی ہے۔	1	2	3	4	5
-22	بغیر سوچے سمجھے بات کرتا / کرتی ہے۔	1	2	3	4	5
-23	مسلسل حرکت میں رہتا / رہتی ہے مثلاً ٹانگیں ہلانا، انگلیوں سے کھیلنا، بار بار پڑھائی کے دوران اٹھنا وغیرہ۔	1	2	3	4	5
-24	بغیر کسی ظاہری وجہ سے بے چین رہتا / رہتی ہے۔	1	2	3	4	5
-25	اپنے یا دوسروں کے تجربات سے فائدہ حاصل کرتا / کرتی ہے۔	1	2	3	4	5
-26	چھوٹی چھوٹی بات پر بہن بھائیوں سے الجھ پڑتا / پڑتی ہے۔	1	2	3	4	5
-27	بعد میں رونما ہونے والے نتائج سے بے خبر بغیر اندازہ لگائے اچانک حرکت کرتا / کرتی ہے مچلنا جھٹکے سے اٹھنا، بات کا منہ سے نکل جانا وغیرہ۔	1	2	3	4	5
-28	رونا بہت جلد آتا ہے۔	1	2	3	4	5
-29	بھوک بہت زیادہ لگتی ہے۔	1	2	3	4	5
-30	موت کی خواہش کرتا / کرتی ہے، بھوک بہت زیادہ لگتی ہے۔	1	2	3	4	5
-31	دوسرے بچوں کے ساتھ مل کر کھیلتا / کھیلتی ہے۔	1	2	3	4	5
-32	دوست آسانی سے بناتا / بناتی ہے، اور پھر اس کو قائم رکھنے کی کوشش کرتا / کرتی ہے۔	1	2	3	4	5
-33	گھر کے اہم کام سرانجام دینے میں ماں باپ کی مدد کرتا / کرتی ہے۔	1	2	3	4	5
-34	بہت کم آواز میں بات کرتا / کرتی ہے۔	1	2	3	4	5
-35	گروپ میں کام نہیں کر سکتا / سکتی۔	1	2	3	4	5
-36	دوست بدلتے رہتے ہیں۔	1	2	3	4	5
-37	جسمانی شکایات (سر درد، پیٹ درد، متلی، چکر، غنودگی وغیرہ) وجہ سے سکول جانے سے انکار کرتا / کرتی ہے۔	1	2	3	4	5
-38	گروپ میں لڑائی ہو جاتی ہے۔	1	2	3	4	5
-39	بات تیز تیز اور اونچی آواز میں کرتا / کرتی ہے۔	1	2	3	4	5
-40	دوستی ان بچوں کے ساتھ ہوتی ہے جو پڑھائی میں نالائق ہوتے ہیں۔	1	2	3	4	5

نمبر شمار	بیانات	کبھی نہیں	شاذونادر	کبھی کبھی	اکثر	ہمیشہ
-41	گروپ لیڈر بنتا/بنتی ہے۔					
-42	دوسروں کے سامنے بات کرنے کے دوران نظریں نیچی رکھتا/رکھتی ہے۔	1	2	3	4	5
-43	دوسرے بچے بات بات پر مذاق اڑاتے ہیں۔	1	2	3	4	5
-44	بڑوں سے بات کرنے کے دوران زبان لڑکھڑاتی ہے۔	1	2	3	4	5
-45	سکول/ کالج سے غیر حاضر رہتا/رہتی ہے۔	1	2	3	4	5
-46	سکول کی سرگرمیوں میں شوق سے حصہ لیتا/لیتی ہے۔	1	2	3	4	5
-47	سکول/ کالج کا کام وقت پر کرتا/ کرتی ہے۔	1	2	3	4	5
-48	سکول/ کالج کے قائدے وقانون پر پابندی کرتا/ کرتی ہے۔	1	2	3	4	5
-49	سکول/ کالج کے لئے وقت پر تیار ہوتا/ہوتی ہے۔	1	2	3	4	5
-50	بعض مضامین میں اچھی کارکردگی دکھاتا/دکھاتی ہے۔	1	2	3	4	5
-51	کلاس کی سجاوٹ کے لیے چارٹس بناتی/بناتا ہے۔	1	2	3	4	5
-52	سکول/کالج کی دیگر تقریبات میں شوق سے حصہ لیتا/لیتی ہے۔	1	2	3	4	5
-53	سکول / کالج جانے کو دنوں میں تھکاوٹ، جھنجلاہٹ یا افسردگی کا مظاہرہ کرتا/ کرتی ہے۔	1	2	3	4	5
-54	ٹیچر کی طرف سے شکایات ملتی رہتی ہیں۔	1	2	3	4	5
-55	اپنی جسمانی صفائی (مثلاً غسل کرنا، صاف کپڑے پہننا، بال تراشنا وغیرہ) پر توجہ دیتا/دیتی ہے۔	1	2	3	4	5
-56	بہن بھائیوں اور ماں باپ سے پیار اور ہمدردی کا مظاہرہ کرتا/ کرتی ہے۔	1	2	3	4	5
-57	گھر میں سب سے کھل کر بات چیت کرتا/ کرتی ہے۔	1	2	3	4	5
-58	الگ تھلگ رہتا/رہتی ہے۔	1	2	3	4	5
-59	دوسرے بچوں کے ساتھ گھل مل کر نہیں بیٹھتا/ بیٹھتی۔	1	2	3	4	5
-60	سکول/ کالج کی انتظامیہ کی طرف سے فائن/جرمانے لگتے ہیں۔	1	2	3	4	5

Appendix- C5

Sub-Scales of final TRS (Form-T) of FIAS (N=62)

1. **Social Dysfunction Scale (SDS) (12 items)**

   (18, 19*, 20*, 32*,42, 44*, 47*, 49, , 52, 54*, 55, 56*,)

   Positively worded items ((shown with satiric (*): (n = 7)

   Negatively worded items: (n = 5)

2. **Cognitive Dysfunction Scale (CDS) (18 items)**

   (3, 4, 5, 6, 8, 11, 12 13, 15, 16, 17, 22, 24, 25, 39, 40, 41, 52)

   Positively worded items (shown with satiric (*): n = 0

   Negatively worded items: n = 18

3. **Emotional Dysfunction Scale (EDS) (13- item)**

   (26, 27, 28, 31, 33, 34, 35, 38, 42, 45, 46, 49, 50)

   Positively worded items (shown with satiric (*): (n = 0)

   Negatively worded items: n = 13

4. **Learning Behavior Dysfunction Scale (LBDS) (23- items)**

   (1, 2, 7*, 9*, 10, 12, 14*, 20*, 21, 23, 29*, 36, 37*, 43*, 48,* 51*, 53*, 57*, 58*, 59*, 60, 61, 62)

   Positively worded items ((shown with satiric (*): n = 13

   Negatively worded items: (n = 10)

Note: In the Form-T all the statements are negatively worded except for 19 statements which are positively worded. These are: (7, 9, 14, 19, 20, 29, 32, 37, 43, 44, 47, 48, 51, 53, 54, 56, 57, 58, 59). These 19 items were re-coded as item (1=5)(2=4)(3=3)(4=2)(5=1).

Sub-Scales of PRS (Form-P) of FIAS

1. **Social Dysfunction Scale (SDS) (13 items)**

(32*, 35, 36, 38, 41*, 43, 45, 48*, 49*, 53, 54, 57*, 60)

Positively worded items ((shown with satiric (*): (n = 5)

Negatively worded items: (n = 8)

2. **Cognitive Dysfunction Scale (CDS) (23 item)**

(1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 18, 20, 22, 23, 26, 27, 28, 33*, 39)

Positively worded items (shown with satiric (*): n = 1

Negatively worded items: (n = 22)

3. **Emotional Dysfunction Scale (EDS) (11 item)**

(2, 17, 21, 24, 29, 30, 34, 42, 44, 58, 59)

Positively worded items ((shown with satiric (*): n = 0

Negatively worded items: (n = 11)

4. **Learning Behavior Dysfunction Scale (LBDS) (15 items)**

(2, 8, 9*, 25*, 31*, 33, 37, 41*, 46*, 47*, 48*, 50*, 51,* 52*, 55*, 57*)

Positively worded items ((shown with satiric (*): (n = 12)

Negatively worded items: (n = 3)

Note: In the Form-P all the statements are negatively worded except for 17 statements which are positively worded. These items are: 9, 19, 20, 25, 31, 32, 33, 41, 46, 47, 48, 49, 50, 51, 52, 55, 57.

These 17 positively worded items were re-coded as item (1=5)(2=4)(3=3)(4=2)(5=1).

Scoring Key of PRS (Form-P) of FIAS

Total Items: 60

Score Range: 60 -300

Note: In the Form-P all the statements are negatively worded except for 18 statements which are positively worded. These items are: 9, 19, 20, 25, 31, 32, 33, 41, 46, 47, 48, 49, 50, 51, 52, 55, 56,57.

These 18 positively worded items are re-coded as item (1=5)(2=4)(3=3)(4=2)(5=1).

Score range for Sub-scales of PRS

1. **Social Dysfunction Scale (SDS)**

   Total items = 13 Items (32*, 35, 36, 38, 41*, 43, 45, 48*, 49*, 53, 54, 57*, 60)

   Score Range: 13 to 65

   Positively worded items represented with satiric (*) were re-coded as: item (1=5)(2=4)(3=3)(4=2)(5=1).

2. **Cognitive Dysfunction Scale (CDS)**

   Total items: 23 Items (1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 18, 20, 22, 23, 26, 27, 28, 33*, 39)

   Score Range: 23 to 115

   Positively worded items represented with satiric (*) were re-coded as: Item (1=5)(2=4)(3=3)(4=2)(5=1).

3. **Emotional Dysfunction Scale (EDS)**

   Total Items: (11 item) (2, 17, 21, 24, 29, 30, 34, 42, 44, 58, 59)

   Positively worded items: None

   Score Range: 11 to 55

4. **Learning Behavior Dysfunction Scale (LBDS)**

   Total Items: 15 items (2, 8, 9*, 25*, 31*, 33, 37, 41*, 46*, 47*, 48*, 50*, 51,* 52*, 55*, 57*)

Positively worded items represented with satiric (*) were re-coded as: item

(1=5)(2=4)(3=3)(4=2)(5=1).

Score Range: 15 to 75

Scoring Key of TRS (Form-T) of FIAS

Total Items: 62

Score Range: 62 -310

Note: In the Form-T all the statements are negatively worded except for 19 statements which are positively worded. These are: (7, 9, 14, 19, 20, 29, 32, 37, 43, 44, 47, 48, 51, 53, 54, 56, 57, 58, 59). These 19 items were re-coded as item (1=5)(2=4)(3=3)(4=2)(5=1).

Score range for Sub-scales of TRS

1. **Social Dysfunction Scale (SDS)**

   Total items = 12 Items (18, 19*, 20*, 32*, 42, 44*, 47*, 49, 52, 54*, 55, 56*,)

   Score Range: 12 to 60

   Positively worded items represented with satiric (*) were re-coded as: item (1=5)(2=4)(3=3)(4=2)(5=1).

2. **Cognitive Dysfunction Scale (CDS)**

   Total items: 18 Items (3, 4, 5, 6, 8, 11, 12 13, 15, 16, 17, 22, 24, 25, 39, 40, 41, 52);

   Score Range: 18 to 90

   Positively worded items represented with satiric (*) were re-coded as: Item (1=5)(2=4)(3=3)(4=2)(5=1).

3. **Emotional Dysfunction Scale (EDS)**

   Total Items: (13 item) (26, 27, 28, 31, 33, 34, 35, 38, 42, 45, 46, 49, 50)

   Positively worded items: None

   Score Range: 13 to 65

4. **Learning Behavior Dysfunction Scale (LBDS)**

Total Items: 23 items (1, 2, 7*, 9*, 10, 12, 14*, 20*, 21, 23, 29*, 36, 37*, 43*, 48,* 51*, 53*, 57*, 58*, 59*, 60, 61, 62)

Score Range: 23 to 115

Positively worded items represented with satiric (*) were re-coded as: item (1=5)(2=4)(3=3)(4=2)(5=1).

(DAYS)

ORIGINAL VERSION STUDENT SELF REPORT (SCALE S)

Directions

Circle the number that best reflects your feelings. Choose the number that describes how much you believe in the statement applies to you.

1. I feel sad.
2. I have bad dreams.
3. I feel lonely.
4. I feel I am a bad person.
5. I feel sick.
6. I worry about dying.
7. I feel dumb.
8. I worry about keeping my friends.
9. I feel frightened.
10. I think I am ugly.
11. I think most people hate me.
12. I wish I could run away.
13. I feel like crying.
14. I have trouble sleeping.
15. Idon't feel like eating.
16. I have trouble getting along with.
17. I feel like killing myself.
18. I hate myself.
19. I feel that things do not matter anymore.
20. I cause problem for everybody.
21. I feel tired all the time.
22. I have nightmares.

PARENT RATING SCALE (SCALE P)

Directions

Please consider your child's behavior and circle True (T) or False (F) for each item.

1. Gets along well with other children.
2. Worries about other things.
3. Is frightened easily?
4. Has a good sense of humour.
5. Complains of feeling sick often.
6. Is good natured.
7. Cries easily.
8. Likes going to school
9. Has many close friends.
10. Usually obeys me.
11. Is out going.
12. Becomes upset easily.
13. Does not seem to enjoy life.
14. Has a clip on his shoulder.
15. Is nervous and edgy.
16. Works hard on school work.
17. Sulks a lot.
18. Thinks he/she is ugly.
19. Threatens to run away.
20. Is often moody.
21. Has threatened suicide.
22. Is cheerful.
23. Seems lonely.
24. Complains often.
25. Spends a lot of time sleeping or lying around.
26. Thinks others dislike him/her.
27. Wants to be the best at what he/she does.
28. Thinks he/she is failure

TEACHER'S RATING SCALE (SCALE T)

Directions

Please consider the child is question and circle true (T) or false (F) for each items.

1. Gets along well with other children.
2. Enjoys school.
3. Seems tired and listless often.
4. Is easily upset.
5. Gets down on himself/himself easily.
6. Is nervous and edgy.
7. Works hard in class.
8. Has few friends.
9. Seems unusually fearful.
10. Seems too serious minded.
11. Seems to enjoy life.
12. Whines and complains often.
13. Is sad very often.
14. Is sullen often.
15. Knows how to have good time.
16. Is moody.
17. Day drams often.
18. Is self confident?
19. Is dependent on others.
20. Can't sit still because of nervousness.

Days Student Self Report Scale (Scale S)

نام: _____ جماعت: _____

عمر: _____ مورخہ: _____

ہدایات: نیچے دیئے گئے ہر بیان کے سامنے 1 سے 4 تک نمبر درج ہیں۔ جو بیان جس درجے پر آپ سے مطابقت رکھتا ہے اس درجے کے نمبر پر دائرہ لگائیں۔

نمبر شمار	بیانات	کبھی نہیں	کبھی کبھی	اکثر	تقریباً ہر وقت
1	میں افسردہ رہتا/رہتی ہوں۔	1	2	3	4
2	مجھے بُرے خواب آتے ہیں۔	1	2	3	4
3	میں تنہائی محسوس کرتا/ کرتی ہوں۔	1	2	3	4
4	مجھے لگتا ہے کہ میں ایک بُرا انسان ہوں۔	1	2	3	4
5	میں بیمار لگتی/ لگتا ہوں۔	1	2	3	4
6	میں ڈرتا/ڈرتی ہوں کہ میں مر نہ جاؤں۔	1	2	3	4
7	مجھے لگتا ہے میں بے وقوف ہوں۔	1	2	3	4
8	میں فکرمند رہتا/رہتی ہوں کہ کہیں میرے دوست نہ چھوٹ جائیں۔	1	2	3	4
9	میں خوف زدہ رہتا/رہتی ہوں۔	1	2	3	4
10	میں سمجھتا/ سمجھتی ہوں کہ میں بدشکل ہوں۔	1	2	3	4
11	مجھے لگتا ہے کہ زیادہ تر لوگ مجھ سے نفرت کرتے ہیں۔	1	2	3	4
12	میری خواہش ہے کہ میں کہیں بھاگ جاؤں۔	1	2	3	4
13	میرا رونے کو جی چاہتا ہے۔	1	2	3	4
14	مجھے نیند ٹھیک سے نہیں آتی۔	1	2	3	4
15	مجھے بھوک ٹھیک سے نہیں لگتی۔	1	2	3	4
16	لوگوں کے ساتھ گھلنا ملنا مجھے دشوار لگتا ہے۔	1	2	3	4
17	مجھے لگتا ہے کہ میں اپنے آپ کو ختم کر دوں گا/ گی۔	1	2	3	4
18	مجھے اپنے آپ سے نفرت ہے۔	1	2	3	4
19	ایسا لگتا ہے کہ مجھے چیزوں کی کوئی پرواہ نہیں رہی۔	1	2	3	4
20	میں ہر کسی کے لئے تکلیف کا باعث بن جاتا/جاتی ہوں۔	1	2	3	4
22	میں رات کو ڈر جاتی/جاتا ہوں۔	1	2	3	4

DAYS Parent Rating Scale (Scale P)

نام:_____ جماعت:_____

عمر:_____ مورخہ:_____

ہدایات: نیچے دیئے گئے ہر بیان کے سامنے ص یعنی صحیح اور غ یعنی غلط پر دائرہ لگائیں۔

نمبر شمار	بیانات	صحیح	غلط
1	دوسرے بچوں کے ساتھ ٹھیک رہتا/رہتی ہے۔	ص	غ
2	چھوٹی چھوٹی باتوں کے لیے پریشان رہتی/رہتا ہوں۔	ص	غ
3	بہت جلد ڈر جاتا/جاتی ہے۔	ص	غ
4	حسِ مزاح اچھی ہے۔	ص	غ
5	اکثر بیماری کی شکایت رہتی ہے۔	ص	غ
6	اچھی طبیعت کا/کی مالک ہے۔	ص	غ
7	جلد رو پڑتا/پڑتی ہے۔	ص	غ
8	سکول جانا پسند کرتا/کرتی ہے۔	ص	غ
9	بہت سے قریبی/جگری دوست ہیں۔	ص	غ
10	عموماً میرا کہنا مانتا/مانتی ہے۔	ص	غ
11	باہر جانا گھومنا پھرنا اچھا لگتا ہے۔	ص	غ
12	بہت جلد گھبرا جاتا/جاتی ہے۔	ص	غ
13	زندگی کا مزا نہیں لیتا/لیتی۔	ص	غ
14	جلد ہار مان جاتا/جاتی ہے۔	ص	غ
15	ہر وقت بے چین اور مضطرب رہتا/رہتی ہے۔	ص	غ
16	سکول کا کام بڑی محنت سے کرتا/کرتی ہے۔	ص	غ
17	بہت زیادہ آزردہ یا ناراض رہتا/رہتی ہے۔	ص	غ
18	سوچتا/سوچتی ہے کہ میں بہت بدشکل ہوں۔	ص	غ
19	بھاگ جانے کی دھمکیاں دیتا/دیتی ہے۔	ص	غ
20	بہت موڈی ہے۔	ص	غ
21	خودکشی کرنے کی دھمکی دیتا/دیتی ہے۔	ص	غ
22	خوش مزاج ہے۔	ص	غ
23	تنہائی پسند ہے۔	ص	غ
24	کسی نہ کسی چیز کی شکایت رہتی ہے۔	ص	غ
25	زیادہ تر وقت سونے یا لیٹنے میں گزارتا/گزارتی ہے۔	ص	غ
26	سمجھتا/سمجھتی ہے کہ دوسرے اس سے ناپسند کرتے ہیں۔	ص	غ
27	جو بھی کام کرے اس میں اپنے آپ کو بہتر ثابت کرنا چاہتا/چاہتی ہے۔	ص	غ
28	سمجھتا/سمجھتی ہے کہ وہ ایک ناکام شخص ہے۔	ص	غ

DAYS TEACHER RATING SCALE (SCLAE T)

سٹوڈنٹ کا نام: _____ جماعت: _____

ہدایت: آپ سے درخواست ہے کہ بچے کو ذہن میں رکھتے ہوئے نیچے دی گئی ہر بیانات کے سامنے "ص" یعنی صحیح اور "غ" یعنی غلط پر دائرہ لگائیں۔

نمبر شمار	بیانات	صحیح	غلط
1	دوسرے بچوں کے ساتھ ٹھیک طرح سے رہتا/رہتی ہے۔	ص	غ
2	سکول میں خوش رہتا/رہتی ہے۔	ص	غ
3	اکثر سست سا نظر آتا/ آتی ہے۔	ص	غ
4	بہت جلد پریشان ہو جاتا/ جاتی ہے۔	ص	غ
5	اپنے آپ کو بہت جلد کم تر محسوس کرنے لگتا/ لگتی ہے۔	ص	غ
6	جلد بوکھلا جاتا/جاتی ہے۔	ص	غ
7	کلاس میں محنت سے کام کرتا/ کرتی ہے۔	ص	غ
8	دوست بہت کم ہیں۔	ص	غ
9	غیر معمولی حد تک ڈرا ہوا محسوس ہوتا/ہوتی ہے۔	ص	غ
10	بہت زیادہ سنجیدہ رہتا/رہتی ہے۔	ص	غ
11	زندگی کا مزہ لینا چاہتی/چاہتا ہے۔	ص	غ
12	اکثر شکایتیں کرتا/ کرتی ہے۔	ص	غ
13	اکثر افسردہ نظر آتا/ آتی ہے۔	ص	غ
14	اکثر ضد کر کے غصے میں بیٹھا رہتا/رہتی ہے۔	ص	غ
15	خوش وخرم رہنے کے طریقوں سے واقف ہے۔	ص	غ
16	موڈی ہے۔	ص	غ
17	دن میں خواب دیکھتی/دیکھتا ہے۔	ص	غ
18	خود اعتماد ہے۔	ص	غ
19	دوسروں پر انحصار کرتی/ کرتا ہے۔	ص	غ
20	مضطرب رہنے کی وجہ سے ایک جگہ ٹک کر نہیں بیٹھتا/ بیٹھتی۔	ص	غ

STUDENT SELF REPORT (SCALE S)

Back to English Translation

Choose and Circle the number given against each of the following statements that can reflect your feelings in a best way, and also is able to show how much the statement in your opinion applies to you.

1. I feel sad.
2. I have nightmares.
3. I feel lonely.
4. I feel I am a bad person.
5. I feel sick.
6. I am afraid of death.
7. I feel dumb.
8. I worry that I may not loose my friends.
9. I feel frightened.
10. I think I am ugly.
11. I feel most people hate me.
12. I feel like running away.
13. I feel like crying.
14. I feel it difficult to fall asleep.
15. I don't feel like eating.
16. I find it difficult to mix with people.
17. I feel like killing myself.
18. I hate myself.
19. I feel, now I don't bother about things.
20. I create problem for everyone.
21. I feel tired all the time.
22. I have nightmares.

PARENT RATING SCALE (SCALE P)

Back to English Translation

Please mark/circle the statements as True or False according to the behavior of your child.

1. Interacts well with other children.
2. Worries about unnecessary things.
3. Becomes frightened easily.
4. Has a good sense of humour.
5. Often complains of being sick.
6. Is good natured.
7. Cries easily.
8. Likes going to school.
9. Has many close friends.
10. Usually obeys me.
11. Is very social.
12. Easily upsets.
13. Does not enjoy life.
14. Gives up easily.
15. Seems to be nervous and irritable.
16. Works hard with school work.
17. Remains in bad mood.
18. Thinks he/she is ugly.
19. Threatens to run away.
20. Is often moody.
21. Has threatened to commit suicide.
22. Seems to be cheerful.
23. Seems lonely.
24. Complains often.
25. Spends most time in a day asleep or lying around.
26. Thinks other people dislike him/her
27. Wants to prove herself/himself the best in doing any work.

28. Thinks he/she is failure

Appendix "D-3.3"

TEACHER'S RATING SCALE (SCALE T)

Back to English Translation

Directions

For each statement please keep the child in mind and answer by circling either true or false.

1. Is able to interact well with other children.
2. Enjoys school.
3. Seems tired and empty minded.
4. Is easily upset.
5. Gets down on himself/herself easily.
6. Is nervous and becomes annoyed easily.
7. Works hard in class.
8. Has a few friends.
9. Seems unusually frightened.
10. Has a very serious disposition.
11. Enjoys life.
12. Cries peevishly and complains often.
13. Often appears sad.
14. Often sits stubborn and non-responsive.
15. Knows how to enjoy him/herself.
16. Is moody.
17. Often day dreams.
18. Is self confident
19. Is dependent on others.
20. Due to nervousness can't sit still.

Appendix-E

Urdu Version of Well-Being Affectometer-2 by Naheed (1997)

سوالنامہ 2

(حصہ الف)

ہدایات:

ہر شخص اپنی زندگی اور اپنی ذات کے بارے میں مخصوص سوچ اور رائے رکھتا ہے۔ اس سوال نامہ میں ایسے بیانات شامل ہیں۔ جو ہماری روزمرہ زندگی کے متعلق ہیں۔ ہر بیان کے سامنے جوابی کالم موجود ہے۔ آپ ان بیانات کو غور سے پڑھیں اور جو جوابی کال آپ کی رائے کو مکمل طور پر ظاہر کرتا ہو اس میں نشان ( ) لگائیں۔

مثال:

نمبر شمار	بیانات	بالکل نہیں	بہت کم	کبھی کبھی	زیادہ تر	ہمیشہ
1	میری زندگی مسائل سے بھری رہتی ہے۔	1	2	3	4	5

اگر درج بالا بیان آپ کے حالات سے بالکل مطابقت نہیں رکھتا تو کالم نمبر ایک میں نشان ( ) لگائیں اور اگر مکمل طور پر مطابقت رکھتا ہو تو آخری کالم میں نشان ( ) لگائیں۔ اسی طرح جو جوابی کالم متعلقہ بیان کے مطابق آپ کے حالات کی عکاسی کرتا ہو اسی کالم میں نشان لگائیں۔

یاد رہے کہ ہر بیان کے لئے صرف ایک کالم میں نشان لگائیں۔ کوئی بیان خالی نہ چھوڑیں۔ پہلے ایک بیان پر غور کر کے نشان لگا دیں۔ پھر دوسرے بیان کو پڑھیں تا کہ آپ کو فیصلہ کرنے میں آسانی رہے۔

نمبر شمار	بیانات	بالکل نہیں	بہت کم	کبھی کبھی	زیادہ تر	ہمیشہ
۱۔	میری زندگی صحیح طور پر بسر ہو رہی ہے۔	1	2	3	4	5
۲۔	کاش میں اپنی زندگی کا کچھ حصہ تبدیل کر سکتا/ سکتی۔	1	2	3	4	5
۳۔	مجھے اپنا مستقبل روشن دکھائی دیتا ہے۔	1	2	3	4	5
۴۔	ایسا لگتا ہے کہ جیسے میری زندگی کے بہترین سال گزر چکے ہیں۔	1	2	3	4	5
۵۔	میں خود کو پسند کرتا/ کرتی ہوں۔	1	2	3	4	5
۶۔	ایسا لگتا ہے کہ مجھ میں کچھ نہ کچھ خرابی ضرور ہے۔	1	2	3	4	5
۷۔	میں کسی بھی درپیش مسئلہ کو حل کر سکتا/ کر سکتی ہوں۔	1	2	3	4	5
۸۔	میں خود کو ایک ناکام انسان محسوس کرتا/ کرتی ہوں۔	1	2	3	4	5
۹۔	میں محسوس کرتا/ کرتی ہوں کہ لوگ مجھ سے محبت کرتے ہیں اور مجھ پر اعتبار کرتے ہیں۔	1	2	3	4	5
۱۰۔	ایسا لگتا ہے کہ جب مجھے ان کی ضرورت ہوتی ہے لوگ میرا ساتھ چھوڑ دیتے ہیں۔	1	2	3	4	5
۱۱۔	میں خود کو اپنے اردگرد کے لوگوں کے قریب محسوس کرتا/ کرتی ہوں۔	1	2	3	4	5
۱۲۔	مجھے دوسرے لوگوں میں کوئی دلچسپی نہیں رہی اور نہ ہی مجھے ان کی پرواہ ہے۔	1	2	3	4	5
۱۳۔	میرا خیال ہے کہ میں جو چاہوں کر سکتا/ کر سکتی ہوں۔	1	2	3	4	5
۱۴۔	میرے پاس اپنے کاموں سے زائد قوت ہے۔	1	2	3	4	5
۱۵۔	میں کچھ بھی کرنے کی پریشانی نہیں لے سکتا/ سکتی۔	1	2	3	4	5
۱۶۔	میں بہت زیادہ مسکراتا اور ہنستا رہتا/ رہتی ہوں۔	1	2	3	4	5
۱۷۔	ایسا لگتا ہے کہ میرے لئے کسی چیز میں کوئی لطف باقی نہیں رہا۔	1	2	3	4	5
۱۸۔	میں واضح اور تخلیقی انداز میں سوچتا/ سوچتی ہوں۔	1	2	3	4	5
۱۹۔	میں بے فائدہ سوچوں کے بھنور میں الجھا رہتا/ رہتی ہوں۔	1	2	3	4	5