CHAPTER – III

METHOD

3.1 Introduction:

The contents of this chapter illustrate the methods used to conduct this study. Introduction and purpose of the study, aim, Operational definitions of shyness, interpersonal relationship, and social conformity were offered to clarify the link between these constructs. Objectives, hypotheses and variables, Inclusion and exclusion criteria along with the sample size, assessment tools, and their scoring patterns, procedure used, statistics adopted and ethical considerations have been included.

3.2: Need for the Study:

The purpose of this study was to find the effect of behavioral problems and their relationship with shyness and Well-being among late childhood. Late childhood is a transition period, hence adjusting to the new demands and expectations leads to state of disequilibrium. As a formal schooling starts at this age, child may find it difficult to adjust to his/her school environment, teachers, and peers. In this process, they may face certain behavioral problems. It is argued that all children go through periods of behavior and emotional difficulty.

Late childhood phase is demanding for the children, parents, educators. Thus to understand the period of late childhood is vital. Till date limited research has happened in late childhood, therefore it motivated the researcher to study this period of Childhood. A significant need for early identification of behavioral problems in very
young children is highlighted by associations with delayed ability and disruptions in family life that may further contribute to risk for persistent behavior problems.

Previous studies has examined both contemporary & cumulative consequences of childhood problems, traits related to childhood problems such as bad temper, irritability, lack of self control etcetera may disrupt adult relationship and result in lower level of adult life (Moffit, 1993) so recognizing the childhood behavioral problems is important. These problems are among the most prevalent chronic conditions of childhood and often have serious negative consequences for a child’s academic achievement and social development (Merikangas, Brody, Fisher, Bourdon, Koretz, 2010).

Identifying behavioural problems in the early stages is beneficial for parents, teachers, and educators. Early identification of behavioural problems is critical to the wellbeing of children and their families. But little research has examined variation in externalizing and internalizing behaviours among children (O’Connor, Bureau, et al., 2011; Teti, 1999).

Policy discussions regarding the mental health needs of children and adolescents emphasize a lack of use of mental health services among youth and children. The authors conducted secondary data analyses in three nationally representative household surveys and found children are in need of mental health services, it is also revealed that most children in preschool who need a mental health evaluation do not receive services. The Child Behavior Checklist also assessed the association of unmet need with ethnicity (Kataoka, Zhang, Wells, 2002).

As a result, Prevention programs in elementary schools that target selected risk factors may be helpful in reducing future adolescent mental health problems, specifically
depressive symptoms (Mazza and Fleming, 2010). Child clinical problems may differ in their power to suggest clinic referral, and this "reliability" of problems may also differ with the gender or culture of the child who manifests them (Weisz, Weiss 1991).

Late childhood involves lots of interaction with peers, so shyness can inhibit socialization and also leads to other behavioral problems. Extreme shyness may lead to disturbances in psychological and physical health in children and also later stages of development. Therefore Shyness can change social world and impact emotional adjustment in a number of unconstructive ways (Guido, Lau, Yen, McCabe & Hough 2009).

Shy children, who have a strong desire to interact, tend to withdraw from to do as they are very anxious and socially fearful to approach (Crozier, 1995). Such children are at risk of adjustment difficulties, internalizing problems like loneliness, social anxiety, negative self-regard (Findlay, Coplan, & Bowker, 2009; Rubin, Chen, McDougall, Bowker, & McKinnon, 1995), peer rejection and exclusion (Coplan, Arbeau, & Armer, 2008; Gazelle & Ladd, 2003).

Today’s children indulge their leisure time using videogames, web surfing & another computer related miracle and that interfere with the time required seeking out direct contact with others for fun & friendship. Social time is replaced by the anonymous exchange of information within an externally imposed medium that promotes shyness in young people. So these children may not socialize as much in the homes of neighbors and friends (D’Souza, Urs & Jayaraju, 2008).

The National Institute for Health and Care Excellence (NICE) has used the term ‘mental wellbeing’ in its work on children’s mental health. Its definition of mental wellbeing is
subdivided into three dimensions: emotional wellbeing, psychological wellbeing, and social wellbeing.

Emotional wellbeing includes happiness and confidence, and the opposite of depression/anxiety. Psychological wellbeing includes resilience, mastery, confidence, autonomy, attentiveness/involvement and the capacity to manage conflict and to problem solve.

Social wellbeing includes good relationships with others, and the opposite of conduct disorder, delinquency, interpersonal violence, and bullying. Wellbeing is generally understood as the quality of people’s lives. It is a dynamic state that is enhanced when people can fulfill their personal and social goals. It is understood both in relation to objective measures, such as household income, educational resources and health status; and subjective indicators such as happiness, perceptions of quality of life and life satisfaction.

In order to avoid imposing Western based notions of mental health, *culture-specific intervention model is required* (Nastasi, Moore, and Varjas’s 2004). There is also need to represent the child’s voice in research is to understand the psychological wellbeing of children (Nastasi, 2014).

### 3.3: Aim

The aim of the study was to assess the extent of behavioral problem during late childhood and their relationship with shyness and well-being.
3.4: Objectives:

- To assess behavioral problems in late childhood.
- To find out the relationship between behavioral problems and shyness.
- To find out the relationship between behavioral problems and well-being.
- To find out the influence of selected demographic variables on Shyness, Behavioral problems and Well-being.
- To find out the interaction effects between behavioral problems and area on shyness and wellbeing.

3.5: Hypotheses:

Following hypotheses have been formulated in the present study.

H1: Higher the level of behavioral problems more will be the shyness in late childhood.

H2: Higher the level of behavioral problems lesser will be the wellbeing in late childhood.

H3a – There will be significant difference between rural and urban school students in their behavior problems.

H3b – There will be a significant difference between rural and urban school students in their shyness.

H3c – There will be significant difference between rural and urban school students in their wellbeing.
H4a – There will be a significant difference between male and female children in their behavior problems.

H4b – There will be significant difference between male and female children in their shyness.

H4c – There will be significant difference between male and female children in their wellbeing.

H5a: there will be significant interaction effect between levels of behavioral problems and area on shyness

H5b: There will be significant interaction effect between levels of behavioral problems and area on wellbeing

H6a: There will be significant interaction effect between levels of behavioral problems and gender on shyness

H6b: There will be significant interaction effect between levels of behavioral problems and gender on wellbeing

3.6: Operational definitions of the variables

3.6.1: Behavioral problems

A problem behavior is the deviant behavior of a child which does not confirm to the expectations of the society is considered detrimental to the welfare of self, family, and society. Several clusters of problem behavior, not all of which are present in every student characterize the behaviorally disordered group. In turn, each of these problem behaviors is addressed by different interventions. The major clusters of problem
behavior that are commonly used to characterize behaviorally disordered students include:

a. Unsatisfactory academic achievement without evidence of sensory or cognitive disability.

b. Emotional disturbance.

c. Behavior excesses and deficits.

d. Disruptive behavior.

When the child shows at least one of the following criteria behaviors is considered problematic (Peshawar & Venkatesan, 1992)

3.6.2: Shyness

Shyness has been defined “as a feeling of discomfort or inhibition, awkwardness in social or interpersonal situations” (Buss, 1985). It is characterized by excessive self-focus, negative self-evaluation particularly in situations with unknown people that keeps one from reaching their goals, either in their academic or personal life (Durmuş, 2007; Pilkonis, 1977; Schölmerich, Broberg & Lamb, 2000).

3.6.3: Well-being

Well-being refers to positive psychological perspective measuring positive aspects of wellbeing as opposed to a deficit based mental health model. The authors stated that their desired aim was to construct a scale that measured positive changes in children’s wellbeing based on positive psychology principles (Liddle & Carter, 2015).
3.7: Participants

Sample and sampling

The sample for the study was selected through Random sampling technique and then stratified random sampling technique was used to make sure that everyone in the sampling frame has an equal chance of being selected. Thus, considering external variables, such as diversity in social, economic and cultural backgrounds, a list of the sample schools were randomly selected from different parts of Mysore and the lot was taken to decide the schools be visited to collect the data. Lower and higher primary school students studying in 2nd to 4th and 5th and 7th class were selected for the purpose of the present study.

Once the schools were selected, the researcher approached the heads of institutions and concerned parents and submitted a letter seeking permission to collect data. The principals of school and parents were informed about the nature of the research. With the consent of concerned authorities and parents, the data for this study was collected.

Before administering the tests, the researcher developed a rapport with all students, parents who agreed to participate. Selected sample was administered the PBCL, SAT, SCWBS along with demographic information. The sample selected consisted of late childhood. They were studying in the schools in rural and urban areas of Mysore District in Karnataka.

The following schools from rural and urban areas were selected for the present study:

- Maharshi Public School, Vishveshwanagar, Mysuru
- St. Josephs Central School, Vijayanagar, Mysuru
- Excel Public School, Belvadi Post, Mysuru
- Pramati Hillview Academy, Kuvempunagar, Mysuru
- B.G.S. Central School, Kuvempunagar, Mysuru
- Sarkari Hiriya Prathamika shala, Belavadi, Mysuru
- Government Primary School, Hundi, Hinkal, Mysuru
- Government school, C.G. Koppalu, Mysuru

Table 3.1 showing distribution of the sample by Area and Gender

<table>
<thead>
<tr>
<th>Area/Gender</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kannada</td>
<td>English</td>
<td>Kannada</td>
</tr>
<tr>
<td>Urban</td>
<td>60</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Rural</td>
<td>60</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>120</td>
<td>120</td>
</tr>
</tbody>
</table>

3.8 Inclusion criteria:

1. Participants should be in their late Childhood.
2. The age of participants must range from 6-12 years.
3. Participants should be of both genders.
4. Participants should give consent to participate in the study.

3.9 Exclusion criteria:

1. Children from late childhood with cognitive abilities.
2. Children from late childhood under psychological intervention.
3. Children from late childhood who have taken similar tests earlier.
4. Children who are having developmental disorders, hyper activity disorder or substance used disorder.

3.10 Tools employed in the present study are

- Problem Behavior Check List (PBCL) - Veeraraghavan and Dogra (2000)
- Shyness Assessment Test (SAT) - D’Souza (2006)
- The Sterling Children’s Wellbeing Scale (SCWBS) - Liddle and carter (2004)

3.10.1 Socio-demographic Data Sheet

This semi-structured questionnaire consists of personal details like name of student, age, gender, place of birth, birth order, class, name of School, and academic achievement. It also includes parents’ qualification and their occupation, caste and religion.

3.10.2 Problem Behavior Check List (PBCL) Veeraraghavan and Dogra (2000)

Many children may suffer from emotional and behavioral problems. These could arise out of interactions or problems with other family members, or they may be reflection of the developmental stage of the child. When measuring the behaviors of children, it has often been noted that Self-reports. Several check lists that are meant to be rated by parents have been extensively studied.

The current checklist was devised using the following methodology:

i. The initial pool of 100 items was derived from behavioral descriptions based on ICD-10 diagnostic criteria for emotional, conduct and mixed disorders.

ii. They were given to 25 psychiatrists and 25 psychologists to rate.
iii. Only those items rated similarly by all 50 experts were included.

iv. The final pool of 58 items was administrated to 300 couples from normal population and to 200 couples from a psychiatric population to establish norms.

The Problem Behavior Check List (PBCL) consists of 58 items and requires the subject to indicate his / her feeling ticking most often, occasionally or never. The items in the test pertain to assess the level of children emotional and behavioral problems.

**Reliability and Validity:**

The index for test-retest reliability was found to be 0.85. Split half reliability was 0.81. Face validity was established through interviews with parents. Content validity was established through expert agreement on and diagnostic meaningfulness of items.

**Administration:**

The questionnaire is presented to the parents, teachers, guardians after rapports has been established and have been assured confidentiality. It is a self administering inventory. Both researcher and participants read the instructions on the first page. Any doubts raised can be cleared, and word meanings can be explained if required. There is no time limit.

**Description:**

The PBCL consists of 58 items that are presented in question format. For instance, ‘Does your child have resistance to authority?’ Each item must be rated on a three point scale of ‘Most often’, ‘Occasionally’, or ‘Never'.
‘Most often’ refers to high behavior problems. ‘Occasionally’ refers to average/moderate problem behavior. ‘Never’ represents no problem behavior.

All the 58 items selected were indicative of behavior problem in children. These were to be marked by respondents on a 1-3 point scale, as to what extent the behavior occurred ‘most often,’ ‘occasionally’, ‘never’. Thus the scores range from 58 and 174. These scores were divided into three categories based on the scores by the normal population (N=600) and the pathological population (N=200). The categories are as follows:

<table>
<thead>
<tr>
<th>Interpretation</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low problem behavior</td>
<td>58-96</td>
</tr>
<tr>
<td>Moderate problem behavior</td>
<td>97-135</td>
</tr>
<tr>
<td>High problem behavior</td>
<td>135-174</td>
</tr>
</tbody>
</table>

Table 3.2

Split-half and test-retest reliability values

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Index of reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Split-half</td>
<td>600</td>
<td>.81</td>
</tr>
<tr>
<td>Test-retest</td>
<td>600</td>
<td>.85</td>
</tr>
</tbody>
</table>

Scoring

Items indicative of high problem behavior were given 3; average and no problem behavior were assigned a score of 2 and 1 respectively. Total scores obtained ranged between 58-174, thus indicating that the higher the score, the higher the problem behavior of the child, and the lower the score problem behavior of the child.
3.10.3 Shyness Assessment Test (D’Souza, 2006).

The shyness assessment scale was developed by D’Souza (2006) of Maharaja’s College, University of Mysore. The scale consists of 54 items and asks a participant to respond by selecting Yes, or No, or cannot say. The items on the scale reflect three domains of shyness- cognitive/affective, physiological and action oriented. Item analysis of the scale using SPSS program resulted in Cronbach’s alpha coefficient of 0.735 for south Indian adolescents. Further, the scale had sufficiently high validity.

The reactions for shyness can occur at any or all of the following levels: cognitive, affective, physiological and behavioral, and may be triggered by a wide variety of arousal cues (Henderson & Zimbardo, 1998).

The physiological domain: Physiological manifestations of shyness may include: excessive perspiration, blushing, increased heart and pulse rate, dry mouth, trembling and uneasy feeling in the stomach.

The cognitive domain: At the cognitive domain, manifestations of shyness may include, fear of negative evaluation and rejection, self-consciousness, worry and rumination and self-blaming attributions.

The affective domain: Affective symptoms of shyness may include feelings of self-consciousness, embarrassment, insecurity and feelings of inferiority.

Behavioral component: It may include reticence, speech dysfluencies, passivity, reduced eye contact, maintaining physical distance, lack of appropriate responses and avoidance of situations.
Scoring: Responses were scored as 2 for ‘Yes’, 1 for ‘don’t know’, and ‘0’ for No. Depending on the scores the subjects were classified into three levels of shyness- High, Medium, Low. The scores for all the statements were cumulated and if the subject scored 80 and above he/she was considered as having high levels of shyness.

Shyness Assessment Test (SAT) was developed and tested exclusively on Indian adolescents by D’Souza (2006) by considering on the above points. The reliability index ascertained by split half (odd-even) method and Cronbach’s alpha coefficient for the scale as a whole were found to be 0.735 and 0.812 respectively. The reliability indices of the 3 domains were also calculated by split half method, which are as follows.

**Table 3.2 showing reliability index and internal consistency for shyness scale**

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Domain</th>
<th>Reliability Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cognitive/Affective Domain</td>
<td>0.826</td>
</tr>
<tr>
<td>2</td>
<td>Physiological Domain</td>
<td>0.792</td>
</tr>
<tr>
<td>3</td>
<td>Action-oriented domain</td>
<td>0.725</td>
</tr>
</tbody>
</table>

**Internal consistency**

<table>
<thead>
<tr>
<th>Domains</th>
<th>Cognitive/Affective</th>
<th>Physiological</th>
<th>Action-oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive/Affective</td>
<td>-</td>
<td>0.51</td>
<td>0.53</td>
</tr>
<tr>
<td>Physiological</td>
<td>-</td>
<td>-</td>
<td>0.59</td>
</tr>
<tr>
<td>Action-oriented</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

All the obtained interrelations were found to be significant at the one percent level. In the present study SAT applied to children was based on the doctoral work done by Natesha (2011) on children.
3.10.4 The Sterling Children’s Wellbeing Scale (SCWBS):

The Stirling Children’s Wellbeing (SCWBS) was developed by Liddle and Carter (2004) and it’s a project initiated by the Educational Psychology Service with the objective of creating a holistic, positively worded scale measuring emotional and psychological Wellbeing in children aged of 7 to 15 years. The scale was developed and standardized by administering the questionnaire across 18 schools in the Stirling Council area with a population sample of 1800 children.

It consists of 15 items and requires the subject to indicate his/her response by ticking anyone, i.e., never, not much, some of the time, quite a lot of the time, all the time which best describes thoughts and feelings. The items in the test pertain to assess children wellbeing’s sub-component- positive Emotional state and Positive outlook.

Positive Emotional state and Positive outlook can be easily be interpreted as subjective (Hedonic) Wellbeing and psychological (Eudaimonic) Wellbeing.

Each item was rated on a Likert scale of 5 levels with the minimum score being 12 and the maximum score being 60. The scale covered areas of Wellbeing including optimism, cheerfulness, relaxation, satisfying interpersonal relationships, clear thinking, and competence. Overall this formed a single dimensioned scale with sub-components described as Positive Outlook and Positive Emotional State. The scale should provide a useful tool for education professionals to assess any changes in Wellbeing from a positive psychological perspective.

Scoring:

The SCWBS consist of 15 items measuring emotional Wellbeing and psychological Wellbeing. The scale consists of two sub-components consisting of 6 items each.
relating to emotional and psychological Wellbeing, namely positive Emotional state and Positive Outlook. The scale additionally includes a social desirability sub-scale in order to determine whether any participant’s scores have response set or predominantly socially desirable answers. The social desirability sub-scale consists of three items. All items on the scale are rated on a 5-point Likert based scale.

**Construct validity:**

Construct validity was tested by correlating the revised SCWBS with the DuBois self esteem scale and the WEMWBS using a Pearson’s Bivariate correlation. The total number of participants for the SCWBS was N = 204, DuBois Self-esteem scale N=176 and the WEMWBS N= 200. The discrepancy in the participant number was a result of children being withdrawn from class to attend other activities, keypads malfunctioning and one participant deciding to opt out of the study. There was strong significant positive correlation between the SCWBS and the WEMWBS (r =0.750, N= 200, p <0.01); a strong significant positive correlation between the SCWBS and the DuBois Self-esteem scale (r=0.647, N=176, p<0.01); and a strong significant positive correlation between the WEMWBS and the DuBois Self-esteem scale (r=0.646, N=176, p<0.01. This suggested good construct validity with a correlation above the r=0.7 benchmark between the WEMWBS and the SCWBS and as predicted, a strong but weaker correlation between the SCWBS and the DuBois Self Esteem Scale

**External Reliability:**

The external reliability of the scale was tested using the test/re-test method. A Pearson correlation was run between the initial test scores and the re-test scores taken a week later. The analysis showed a strong correlation between the initial scores and the retest score (r=0.752, N=232, p<.01) showing that the scale had good external reliability.
The scale was founded on a positive psychological perspective measuring positive aspects of wellbeing as opposed to a deficit-based mental health model and also scale is not intended to be diagnostic purposes but with ongoing research, it may become useful indicator of poor mental health. The scale proved to be a reliable and valid measure of wellbeing meeting the benchmark criteria set out for standardizing measures. The resulting SCWBS consisted of 12 items measuring emotional and psychological wellbeing and 3 items forming a social desirability sub-scale. With further research, the scale’s sensitivity and discriminant validity can be established, and from which some diagnostic features may emerge. The scale is suitable for paper and pencil testing, though it is recommended that it be used electronically to increase accessibility for young children and children with reading difficulties. Overall the scale should provide educational professionals with a concise and robust measure of wellbeing that can assess the effectiveness of projects and interventions for children aged from 8 to 15 years.

A pilot test was done with 50 children for the suitability of the test in Mysuru and the same test was administered to the sample selected for the present study.

3.11 Procedure:

School Children aged between 06 to 12 years and their parents/teachers/guardians willing to participate in the research were administered scales of behavioural problems, shyness, and Wellbeing. Inclusion criteria and exclusion criteria was also considered. In the beginning rapport was established with the participants. They were given socio demographic sheets to be filled in by them. All participants received the same descriptions of the study and were told that all responses provided would be both confidential and anonymous.
This study was conducted in three sessions. Before administering the tests, the good rapport was established with the participants to encourage them to give an honest response. The participants were given a briefing about the purpose of the study and the importance of their participation and also participants were assured that their information will be kept confidential. After rapport is established, appropriate instructions were given to them and were allowed to fill in their personal information and answering the questionnaire. Interviews with the children were conducted in a quiet room and each lasted between and fifteen to thirty minutes.

Problem behavior check list was administered to the parents/teachers/guardians and shyness, Wellbeing scale was administered to the children. Sufficient time was given to them to respond to all items, maximum care was taken to see that no item was left unanswered. Data collection was done in three sessions and each session lasted for about 15-40 minutes.

3.11.1 Session: 1

In the first session, Problem Behavior Check List scale was administered to participants (parents/teachers/guardian) after establishing rapport with them. Participants read each item carefully and chose one of three possible responses (‘most often’, ‘occasionally’ or ‘never’) to show how much each statement is true about how they feel about the child in the described situations.

3.11.2 Session: 2

In the Second session, Shyness scale was given to children after establishing rapport with them. Participants were requested to read each item carefully and choose one of the three possible responses (yes, no and cannot say) to show how much each statement
is true about how they feel or do in the described situations. Participants were given assurance that all their information will be kept confidential.

3.11.3 Session: 3

In the third session, Wellbeing scale was administered to children after establishing rapport with them. Participants read each item carefully and chose one of five possible responses (‘never’, ‘not much’, ‘some of the time’, ‘quite a lot of the time’ and ‘all the time’) which best describes their thoughts and feelings in the described situations.

The statements on the SCWBS were read out with a pause after each statement to enable the children to mark the sheet as appropriate. The SCWBS administration procedure allowed efficient data collection from all participants and enabled children to ask questions and express any difficulties understanding words or phrases.

3.12 Statistical methods applied:

1. **Descriptive statistics** helps to summarize data and can only be used to describe the group that is being studied. The results cannot be generalized to any larger group. Any average, for example, is a descriptive statistic. Descriptive statistical techniques are Measures of central tendency and Measures of variability provide a means of describing the quantum of values and spread of scores in a distribution. These measures also indicate whether group under consideration is homogeneous or heterogeneous. The frequently used measures of variability are the range, standard deviation, and quartile deviation.

In the present study descriptive statistics like frequencies, percentages, mean and S.D were employed to understand the late childhood’s level of behavioural problem, shyness and wellbeing in general.
2. **Independent samples t Test**: t-tests are used to compare two means or to find the significant difference between two mean scores. In the present study Independent samples t tests were employed to find out the influence of area (urban v rural) on behavioral problems, shyness and wellbeing. Also, t tests were employed to find out the influence of gender (male v female) on behavioral problems, shyness and wellbeing.

3. **Pearson product moment Correlation coefficient**: this analysis used to measure the strength of association between two variables. In other words, correlation coefficients measure extent of mutuality between 2 or more variables. In the present study Pearson product moment Correlation techniques were applied to find out the mutual relationship of behavioral problems with shyness and wellbeing scores of children in late childhood.

4. **ANOVA-2 way**: With Anova we can test the hypothesis, to compare two or more samples. The test result indicates the difference between two or more groups. One way was applied to verify the significance of the difference between respondents in different levels of Behavioral problems with Shyness and Wellbeing.

5. **Regression Analysis**:

Regression analysis is a statistical process for estimating the relationships among variables. It includes many techniques for modeling and analyzing several variables when the focus is on the relationship between a dependent variable and one or more independent variables (or 'predictors').

To find out the Joint Contribution of different components of Shyness and Wellbeing such as Cognitive Affective, Physiological and Action Oriented domains of shyness, Positive Outlook, Positive Emotional State and Social Desirability of wellbeing on
Behavioural problem of late childhood; the scores of behavioural problem and scores of components of shyness and Wellbeing were subjected to multiple correlation and regression analysis was done using ANOVA approach. This method is very much helpful to find out the exact Contribution each predictor variables which are related to the criterion variable and rate to the independent variables in order of their importance.

<table>
<thead>
<tr>
<th>Hypothesis no</th>
<th>Hypotheses</th>
<th>Statistical Test applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Higher the level of behavioral problems more will be shyness in late childhood.</td>
<td>Correlation</td>
</tr>
<tr>
<td>2</td>
<td>Higher the level of behavioral problems lowers the well-being in late Childhood.</td>
<td>Correlation</td>
</tr>
<tr>
<td>3a</td>
<td>There will be significant difference between rural and urban school students in their behavior problems</td>
<td>Independent samples t Test</td>
</tr>
<tr>
<td>3b</td>
<td>There will be significant difference between rural and urban school students in their shyness.</td>
<td>Independent samples t Test</td>
</tr>
<tr>
<td>3c</td>
<td>There will be significant difference between rural and urban school students in their wellbeing</td>
<td>Independent samples t Test</td>
</tr>
<tr>
<td>4a</td>
<td>Male and female late childhood children with different levels of behavioural problems differ significantly in their shyness and wellbeing</td>
<td>Independent samples t Test</td>
</tr>
</tbody>
</table>
There will be significant difference between male and female children in their shyness. **Independent samples t Test**

There will be significant difference between male and female children in their wellbeing. **Independent samples t Test**

There will be significant interaction effect between levels of behavioural problems and area on shyness **ANOVA-two-way**

There will be significant interaction effect between levels of behavioural problems and area on wellbeing **ANOVA-two-way**

There will be significant interaction effect between levels of behavioural problems and gender on shyness **ANOVA-two-way**

There will be significant interaction effect between levels of behavioural problems and gender on wellbeing **ANOVA-two-way**

### 3.13 Ethical considerations

Individuals identified with high level of behavioural problems, shyness and showing low Wellbeing were guided to seek help from professionals.

The participants were given a briefing about the purpose of the study and the importance of their participation and also participants were assured that their information will be kept confidential and anonymous.
Summary

The methodology that has been adopted includes the purpose of the study, operational definitions, objectives, and hypotheses. The sample size and procedure that was used to administer the test, the scoring pattern for each test, inclusion and exclusion criteria, and the statistical measures that have been used to assess the data were also included. Even ethical considerations were taken into account.