The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 4, DIP: 18.01.136/20170404
DOI: 10.25215/0404.136
http://www.ijip.in | July-September, 2017

The International Journal of INDIAN PSYCHOLOGY

Original Research Paper

Problem Behaviours and Associated Factors among Youth in Bangalore City, India

Mrs. Sudha A Rao[1]*, Dr. Komala M[2]

ABSTRACT

Youth is the significant phase of life, characterized by rapid and intense physical, physiological, psychological, behavioral changes with changing patterns of social interactions and relationships. The developmental changes that occur in the transitional period from adolescence to adulthood may cause varying degree of disturbances, resulting in problem behaviours (PB). A cross sectional study was conducted to assess the prevalence and association of socio-demographical factors with problem behaviours. The sample comprised of 800 youth both boys and girls of 18 to 24 years of age, drawn randomly from various educational institutions within Bangalore, a capital city of Karnataka state, India. Self-developed questionnaire was used to collect socio-demographical information and Achenbach System of Empirically Based Assessment-Adult Self-Report for ages 18-59 was administered to assess the problem behaviours. The findings revealed that the prevalence of internalizing problem behaviours (IPB) was found to be 59% whereas the prevalence of externalizing problem behaviours (EPB) was found to be 47% and the prevalence (inclusive of those in the borderline) of overall problem behaviours (OPB) was found to be 25% among youth in Bangalore city. Clinical IPB was most common in boys (43.5%) than girls (32.1%) and significant association was found between genders and internalizing problem behaviours among youth. Comparatively more boys (27.6%) than girls (25.7%) were found to in the clinical level of EPB, but no significant association was found between genders and EPB. Prevalence of clinical IPB, EPB and OPB in youth shows peak around 18-20 years of age (50.5%, 36.4% and 18.7%) followed by steady decline by 22-24 years of age (32.3%, 21.65% and 6.0%) respectively. Significant association between age groups and IPB, EPB, OPB was observed. Other socio-demographic factors like education, mother tongue, family monthly income were not found to be significantly associated with IPB, EPB and OPB among youth. There is a need for mental health care services to college students to handle the problem behaviours in more effective way and to enhance their quality of life. As preventive

[1] Research Scholar in Human Development, Department of Studies in Food Science and Nutrition, University of Mysore, Manasagangotri, Mysore, India
[2] Senior Assistant Professor of Human Development, Department of Studies in Food Science and Nutrition, University of Mysore, Manasagangotri, Mysore, India
*Responding Author

Received: August 12, 2017; Revision Received: September 22, 2017; Accepted: September 25, 2017

strategies, youth need educational awareness on problem behaviours and training in life skills education to understand the situation and to avoid further damage to the learning.

Keywords: *Youth, Internalizing Problem Behaviours, Externalizing Problem Behaviours*

In today's world, there are more youth than ever before and they are concentrated in developing countries. As per India's Census 2011, youth (15-24 years) constituted one-fifth (19.1%) of India's total population. It is expected that India will have 34.33% share of youth in total population by 2020 (Govt. of India, 2017). Youth is the significant phase of life, characterized by rapid and intense physical, physiological, psychological, behavioral changes with changing patterns of social interactions and relationships. The developmental changes that occur in the transitional period from adolescence to adulthood may cause varying degree of disturbances resulting in problem behaviours (PB). Several important problem behaviours either start or peak during adolescence and youth. As per WHO, an estimated 2.6 million young people aged 10 to 24 years die each year and a much greater number of young people suffer from illness 'behaviours' which hinder their ability to grow and develop to their full potential. Nearly two-thirds of premature deaths and one-third of the total disease burden in adults are associated with conditions or behaviours initiated in their youth (such as use of tobacco, physical inactivity, high risk sexual behaviours, injury and violence). The behavioural patterns established during this developmental phase determine their current health status and the risk for developing some chronic diseases in later years (Singh and Gopalkrishna, 2014).

Adolescence and youth generally is considered a time of experimentation and increased involvement in what have been called as problem behaviours (Biglan et.al. 2004). Problem behaviors (PB) are any behaviors that are seen by society as undesirable and usually causing some sort of negative response. Two broad indicators of PBs are internalizing and externalizing behaviours. *Internalizing Behaviours* are characterized by primary disturbance in mood and emotion, and include depression, anxiety, somatic complaints and withdrawal symptoms. *Externalizing Behaviours* are characterized primarily by disturbances in the regulation of behaviour and acting-out behaviours such as rule breaking, conduct problems and aggression.

The prevalence of PB during adolescence and youth, and factors associated with PB has become more important in both research and clinical practices in health-related disciplines. WHO estimate shows that up to 20% adolescents have one or more mental or behavioural problems. Studies conducted in different parts of the world show that prevalence of behavioural and emotional problems in adolescents range from 16.5% to 40.8% and in India it is in the range of 13.7% to 50% (Pathak, et.al. 2011). According to Indian studies, the prevalence of conduct disorder was found to be 11.13% (Deivasigamani, 1990) and antisocial behaviour was found to be 7.1% (Sarkar, et.al. 1995). According to Muzammil, et.al. (2009), the overall prevalence of psychosocial problems among the adolescents was found to be 31.2%. The psychosocial problems were more in boys (34.77%) as compared to girls (27.6%). According to Rajiv Gandhi National Institute of Youth Movement Statistics on

youth, nearly 25% of people suffer from depression by the age of 24. According to a report from National Crime Records Bureau in 2009, 15 people committed suicide in the country every hour. As per Indian studies, 20% of teenagers are likely to be depressed and 40% admit to severe anxiety (Solomon, 2007). There are some reported studies on depression among the adolescents and youth population in India. Recent study by Jayanthi and Thirunavukarasu (2015) revealed that 25% school going adolescents suffer from depression and significant association between age and depression was found. A study by Nair et.al. (2004) indicated that 11.2% prevalence of severe and extreme grades of depression among school dropouts as against 3% among school going students. In community-based studies among adults, depressive symptoms have been evaluated to be around 61%, clinical depression around 16% to 34%, and anxiety around 7.5% to 30% in India. Other studies have however indicated that up to 25% of all young adults experienced a depressive episode by age 24 years, the highest incidence rate of any adult age-group. A study by Sahoo and Khess (2010) indicated that ranging from mild to extremely severe depressive symptoms were present in 18.5%, anxiety in 24.4%, and stress in 20% among college-going population in India. Clinical depression was present in 12.1% and generalized anxiety disorder in 19.0%. Comorbid anxiety and depression was high, with about 87% of those having depression also suffering from anxiety disorder. About 20.1 % boys and 17.9 % girls were suffering from high anxiety among adolescents of Kolkata city (Singh and Gopalakrishna, 2014). As per the report of NMHS 2015-16, the prevalence of morbidity amongst adolescents was 7.3% with a similar distribution between boys (7.5%) and girls (7.1%), but it was higher in urban metro areas. Current prevalence of anxiety disorder was 3.6%, and depressive disorder was 0.8% (Gururaj et.al.2016).

Though there has been worldwide research on PB, research studies conducted on this topic are limited, especially among the youth in Bangalore city that has emerged as the information technology hub of the country comprising people from various geographies and cultures across the world. In such a dynamic and populous city with multitudes of challenges, the psychological health of youth cannot be overlooked as they are the future leaders and citizens of the country. The present study was conceptualized considering the issues mentioned above. The objective of the study was to gauge the prevalence of problem behaviours among the youth in Bangalore city, and also to find the association between problem behaviours and socio-demographic factors such as gender, age, education, family income among youth.

MATERIALS AND METHODS

A cross sectional study was conducted to assess the prevalence and association of socio-demographical factors with problem behaviours. The sample comprised 800 youth both boys and girls of 18 to 24 years of age and they were drawn randomly from various educational institutions within Bangalore, a capital city of Karnataka state in India. Survey and questionnaire techniques were predominantly adopted to conduct the study. Self-developed questionnaire was used to collect socio-demographical information. Apart from collecting the socio-demographical information, the Achenbach System of Empirically Based Assessment-Adult Self-Report (ASEBA-ASR) for ages 18-59 was administered to assess the problem

behaviours (Achenbach and Rescorla, 2003). This is a 3-point scale that consisted of 126 items covering syndromes of internalizing, externalizing and other problem behaviours with objective type of answers, namely, 'very true or often true', 'somewhat or sometimes true' and 'not true'. The syndromes, namely, Anxious/Depressed, Withdrawn, Somatic Complaints are grouped under 'internalizing problem behaviours' (IPB); Aggressive Behavior, Rule-Breaking and Intrusive Behaviours are grouped under 'externalizing problem behaviours' (EPB); Thought and Attention Problems are grouped under 'other' problem behaviours. The overall problem behaviour (OPB) was assessed by considering all the syndromes of internalizing, externalizing and other problem behaviours. The collected data were subjected to scoring as suggested in the manual. The objective type of answers with 'very true or often true' was assigned with '2' score, 'somewhat or sometimes true' was assigned with '1' score and 'not true' was scored with '0'. The total scores under each dimension i.e. internalizing problem behaviours, externalizing problem behaviours and overall problem behaviours were taken as a base to identify the level of PB among youth. The score ranges from 0 to 78 for internalizing problem behaviours, 0 to 70 for externalizing problem behaviours and 0 to 240 for overall problem behaviours. Higher scores indicate high risk of PB while lower scores indicate no risk of PB. As illustrated in Table 1, the cut-off values and the corresponding interpretation for boys and girls was used to identify the normal, borderline and clinical level of problem behaviours under internalizing, externalizing and overall problem behaviours. The processed data was further subjected to statistical analysis using SPSS package 16 version for Windows. Chi-square test was adopted to find out the qualitative association between socio-demographic factors (gender, age, education, mother tongue and family income) and degree of problem behaviours among the study group. In ASEBA scale, there was no instruction whether borderline cut-off values or clinical cut-offs should be considered to identify the prevalence of problem behaviours. Hence in the present study, both borderline and clinical level samples were used to recognize the prevalence of problem behaviours among youth. Even though the individuals in the borderline level may not have the problem behaviours of clinical significance, the degree of problems are a cause for concern.

RESULTS

As per the personal details (table 2), higher percent of sample were girls (58.4%) than boys (41.6%). Majority of the sample were in 20-22 years (44.9%) of age followed by 41.8% in 22-24 years and 13.4% were in the age group of 18-20 years. Of the total sample, 67.4% of them were students pursuing Undergraduate programmes while 32.6% of them were students pursuing post-graduate programmes in various educational institutions in Bangalore city. Majority of youth were Hindus (91.1%) and rest were non-Hindus. Kannadigas[3] and non-Kannadigas were equally represented in the study group. As per family details, majority of them were from nuclear families (88.7%). The monthly family income was compiled in four different ranges where higher percent of sample were from families with monthly income of rupees ≤10,000/- (34.3%) while lowest percent of sample were from families with monthly

[3] Those who are from the state of Karnataka speak the native language called 'Kannada' as their mother tongue. They are referred as Kannadigas. Non-Kannadigas are those who don't speak Kannada as their mother tongue and would have migrated from other states of India.

income of rupees 20,001–30,000/- (15.6%). More than 25% sample were from families with monthly income of rupees >30,000/- (26.9%) and less than 25% sample were from families with monthly income of rupees 10,001–20,000/- (23.3%).

Internalizing problem behaviours (IPB) refers to primary disturbances in mood and emotion which includes syndromes of anxious/depressed, somatic complaints and withdrawn behaviours. The study samples were distributed under normal, borderline and clinical levels of internalizing problem behaviours (Figure 1). Of the total, 41% youth were observed under normal while 59% youth were observed under borderline (22%) and clinical (37%) level of internalizing behaviours. On the whole, prevalence of IPB was found to be 59% among youth of present study. Table 3 reveals the distribution of sample based on levels of IPB under study variables gender, age, education, mother tongue, family income. As per gender wise distribution, higher percent of girls were observed under normal (42.8%) and borderline levels than boys (38.1% and 18.3%) while higher percent of boys (43.5%) than girls (32.1%) were observed under clinical IPB. On whole, youth of present study were at risk of IPB and it was more prevalent among boys (61.9%) than girls (57.2%). The Chi-square test indicates that there was a highly significant association between genders and levels of IPB (χ^2 =11.888, d.f.=2) at P<0.003 level. Among different age groups, highest percent of youth in the age group of 18–20 years (50.5%) were observed under clinical level while highest percent of youth in the age group of 22-24 years (44.6%) were found in the normal range than their respective counterparts. Equal percent of youth in 20-22 years (23.1%) and 22-24 years (23.1%) of age groups were found under borderline level of IPB. On the whole, it was noticed that as the age increases the percent of youth under normal level also increased and younger (18 – 20 years) youth were at higher risk of IPB than their counterparts. The Chi-square test indicates that there was a highly significant association between age groups and levels of IPB (χ^2 =11.847, d.f.=4) at P<0.019 level. With regards to education and mother tongue, almost equal percent of samples were observed under normal, borderline and clinical IPB. No significant association was found between education, mother tongue and levels of IPB. As per monthly family income groups, 37 to 43% samples were observed under normal level, 19 to 25% of them observed under borderline and 33 to 40% sample were observed under clinical IPB. Though the percentage variation was observed, no significant association was found between monthly family income and levels of IPB.

Externalizing problem behaviours (EPB) refers to disturbances in the regulation of behaviours and acting-out behaviours such as rule breaking, conduct problems, aggression. Figure 2 indicates the distribution of study samples under levels of EPB. Of the total, 53% youth were in the normal range, 21% were in the borderline and 26% were in the clinical range of externalizing behaviours. On the whole, the EPB was prevalent among 47% of youth. Table 4 indicates the distribution of samples based on levels of externalizing problems under study variables. Gender-wise, 27.6% of boys alongside 25.7% girls were observed under clinical level of EPB while 23.3% girls beside 17.4% boys were observed under borderline level of EPB. On the whole, 45% of boys and 49% girls were at risk of EPB. But no significant association of gender with levels of EPB was observed. Among different age

groups, highest percent of youth in the age group of 18–20 years (36.4%) were observed under clinical level while highest percent of youth in the age group of 22-24 years (58.4%) were found in the normal range than their respective counterparts. Nearly equal percent of youth in all age groups (20-22%) were found under borderline level of EPB. On the whole, it was noticed that as the age increases the percentage of youth under normal level were also increased and on opposite side, young aged (18-20 years) youth were at higher risk of EPB than their counterparts. The Chi-square test indicates that there was a highly significant association between age groups and levels of EPB (χ^2 =12.087, d.f.=4) at P<0.017 level. With regards to education and mother tongue, almost equal percent of samples were observed under normal, borderline and clinical level of IPB. No significant association was found between education, mother tongue and levels of EPB. With reference to monthly family income, higher percent of sample from families with monthly income of rupees >30,000/- (30.2%) were observed under clinical level than their counterparts. Higher percent of sample from families with monthly income of rupees 10001to 20000/- (26.9%) were observed under borderline level than their counterparts. But no significant association was found between monthly family income and levels of EPB.

The overall problem behaviours (OPB) were assessed by considering internalizing, externalizing and other problem behaviours, collectively. Figure 3 indicates the distribution of sample based on levels of OPB under study variables. Of the total, 75% youth of present study were in normal range of behaviours while remaining 25% youth were observed under borderline (16%) and clinical (9%) levels. On the whole, 25% youth of present study had OPB. Table 5 indicates the distribution of sample based on levels of OPB under study variables. Among the girls, 14.8% were in the borderline and 8.8% were in clinical level. Among the boys, 18.6% were in the borderline and 8.4% were in clinical level. But the chi-square test indicates that there was no significant association between genders and levels of OPB. Among different age groups, it was observed that higher percentage of youth of 18-20 years of age (18.7%) were in the clinical range than their counterparts. Higher percentage of youth of 20-22 years of age (17%) were in borderline level of OPB than their corresponding groups. Higher percentage of youth of 22-24 years of age (78.1%) were observed under normal level of OPB. These findings clearly indicate that the OPB among youth reduce as the age increases. There was a highly significant association (χ^2 =17.290, d.f=4, P<0.002) between age groups and levels of OPB. Nearly equal percentage of samples of youth studying in UG and PG were observed under normal, borderline and clinical OPB. Similar results were also observed with reference to mother tongue. No significant association was observed between levels of OPB and education, mother tongue. With reference to monthly family income groups, comparatively higher percent of sample from families with monthly income of rupees <10,000/- (18.6%) were observed under borderline while comparatively higher percent of sample from families with monthly income of rupees 20,001 to 30,000/- (9.6%) were in clinical level than their respective counterparts. No significant association was found between levels of OPB and family monthly income.

DISCUSSION

The purpose of the present study was to explore the prevalence of problem behaviours, including internalizing and externalizing problem behaviours among youth. In the present study, the prevalence of IPB was found to be 59% whereas the prevalence of EPB was found to be 47% and the prevalence of OPB was found to be 25% among youth in Bangalore city. This clearly indicates that IPB was most common amongst them followed by EPB and OPB. The findings of the study are in consonance with the earlier studies where the authors reported that IPB are the common problem behaviours and the prevalence of emotional and behaviour problems in India range from 13.7% to 50% (Pathak, et.al. 2011, Muzammil, et.al. 2009). In the present study, the higher proportions of youth were seen beneath clinical level (37% and 26%) than borderline (22% and 21%) in both IPB and EPB respectively. This result indicates that youth of Bangalore city are at risk of problem behaviours and they need immediate mental health care services and counseling.

In the present study, it is surprising to note that clinical IPB was most common in boys (43.5%) than girls (32.1%) and significant association was found between genders and IPB among youth. This result is in dissonance with the results of earlier studies where the authors have mentioned that internalizing problems were commoner in girls than boys (Pathak, et.al. 2011, Hiremath, et.al. 2008). As per earlier studies, more boys than girls were found to have externalizing problems (Pathak, et.al. 2011, Hiremath, et.al. 2008). In the present study, comparatively more boys (27.6%) than girls (25.7%) were found in the clinical level of EPB while inverse results were noticed under borderline level. However, no significant association was found between genders and EPB in the present study. With reference to OPB, equal proportion of boys (8.40%) and girls (8.80%) were found in the clinical level of OPB whereas, slightly more percentage of boys (18.60%) than girls (14.80%) were found in the borderline level of OPB. Of the total, higher prevalence of OPB was observed in boys (27%) than girls (23.60%). This result is in dissonance with the results of earlier studies where the authors have mentioned that higher prevalence of behavioural/emotional problems was observed in girls as compared to boys (Pathak, 2011).

With regard to age groups, prevalence of clinical IPB, EPB and OPB in youth is at peak around 18-20 years of age (50.5%, 36.4% and 18.7%) followed by steady decline by 22-24 years of age (32.3%, 21.65% and 6.0%), respectively. Significant association between age groups and IPB, EPB, OPB was observed. Other socio-demographic factors like education, mother tongue, family monthly income were not found to be significantly associated with IPB, EPB and OPB among youth. As per the results of previous research, multiple factors were responsible for development of problem behaviours during adolescence and youth. Gender and age are the two important factors contribute to prevalence of problem behaviours among youth. As per the literature, gender difference in the problem behaviours may be due to various factors such as developmental trajectories and cultural factors (Hiremath, et.al. 2008). According to western studies, the rates of mental health problems rise steeply as age increase from mid to late adolescence and it doubles by 18-20 years (Mental Health

Foundation, 2015). Attending college, coping with academic pressure, family responsibilities may increase the risk for problem behaviours in college students (Pedrelli, et.al. 2015).

CONCLUSION

The clinical and borderline internalizing and externalizing problem behaviours are present in significant proportion of youth in the present study. There is an immediate need for mental health care services and counseling to these college students to handle the problem behaviours in more effective way and to enhance their quality of life. As preventive strategies, youth need educational awareness on problem behaviours and training in life skills education to understand the situation and to avoid further hindrance to learning. Faculty and administrators of educational institutions must be trained to identify the behavioral problems among college students and to give them suitable support and assistance. Health policy makers must recognize problem behaviours in youth as a disorder of public health significance and to implement college based mental health services so that problem behaviours in youth can be detected and treated at an early stage.

Acknowledgments

The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interests: The author declared no conflict of interests.

REFERENCES

Achenbach TM and Rescorla LA (2003) *'Manual for the ASEBA Adult Forms & Profiles', Burlington,* VT: University of Vermont, Research Center for Children, Youth, & Families.

Biglan A, Brennan PA, Foster SL and Holder HD (2004) *'Helping Adolescents at Risk: Prevention of Multiple Problem Behaviors'*, New York: Guilford Press

Deivasigamani TR (1990) 'Psychiatric Morbidity in Primary School Children: An Epidemiological Study', *Indian Journal Psychiatry*, 32: 235-40

Government of India (2017) *Youth in India-2017, Report by Social Statistics Division, Central Statistics Office,* Ministry of Statistics and Programme Implementation, Government of India, New Delhi. http://mospi.nic.in/sites/default/files/publication_reports/Youth_in_India-2017.pdf

Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, Mehta RY, Ram D, Shibukumar TM, Kokane A, Lenin Singh RK, Chavan BS, Sharma P, Ramasubramanian C, Dalal PK, Saha PK , Deuri SP, Giri AK, Kavishvar AB, Sinha VK, Thavody J, Chatterji R, Akoijam BS, Das S, Kashyap A, Ragavan VS, Singh SK, Misra R and NMHS collaborators group (2016), *National Mental Health Survey of India, 2015-16, Prevalence, Pattern and Outcomes, Bengaluru,* National Institute of Mental Health and Neuro Sciences, NIMHANS (129)

Hiremath Krupa, Hunshal Saraswati and Gaonkar Venkamma (2008) 'Behavioural Problems among Early Adolescents', *Karnataka Journal Agricultural Sciences*, 21(4): 557-560

Jayanthi P and Thirunavukarasu M (2015) 'Prevalence of Depression among School Going Adolescents in South India', *International Journal of Pharmaceutical and Clinical Research*, 7(1): 61-63

Mental Health Foundation (2015) *'Fundamental Facts About Mental Health 2015'*, London, Mental Health Foundation, https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf

Muzammil K, Kishore S and Semwal J (2009) 'Prevalence of Psychosocial Problems among Adolescents in District Dehradun, Uttarakhand', *Indian Journal of Public Health*, Jan-March; 53(1):18-21

Nair MKC, Paul Mini K. and John Ramany (2004) 'Prevalence of Depression among Adolescents', *The Indian Journal of Pediatrics*, June; 71(6):523-524

Pathak R, Sharma RC, Parvan UC, Gupta BP, Ojha RK and Goel NK (2011) 'Behavioural and Emotional Problems in School Going Adolescents', *Australasian Medical Journal*, 4 (1): 15-21

Pedrelli Paola, Nyer Maren,Yeung Albert, Zulauf Courtney and Wilens Timothy (2015) 'College Students: Mental Health Problems and Treatment Considerations', *Academic Psychiatry*, October; 39(5): 503–511

Sahoo Saddichha and Khess Christoday RJ (2010) 'Prevalence of Depression, Anxiety, and Stress among Young Male Adults in India - A Dimensional and Categorical Diagnoses-Based Study', *The Journal of Nervous and Mental Disease*, December; 198 (12): 901–904

Sarkar AB, Kapur M and Kaliaperumal VG (1995) 'The Prevalence and Pattern of Psychological Disturbance in School Going Middle Childhood Children', *NIMHANS Journal*, January; 13: 33–41

Sharma MK and Marimuthu P (2014) 'Prevalence and Psychosocial Factors of Aggression among Youth', *Indian Journal of Psychological Medicine*, January-March; 36:48-53

Singh Sunitha and Gopalkrishna Gururaj (2014) 'Health behaviours and problems among young people in india: cause for concern & call for action', *Indian Journal of Medical Research*, August; 140: 185-208

Solomon RJ (2007) 'Adolescent Problem Behavior in Navi Mumbai: An Exploratory Study of Psychosocial Risk and Protection', *Journal of Indian Association of Child Adolescent Mental Health*, 3(4): 88-95.

Table 1: Cut-off levels and Interpretation for Levels of Problem Behaviours

Level of problem behaviours		Internalizing Problem Behaviours	Externalizing Problem Behaviours	Overall Problem Behaviours
Girls	Normal	0-19	0-16	0-67
	Borderline	20-24	17-21	68-81
	clinical	25-78	22-70	82-240
Boys	Normal	0-17	0-18	0-67
	Borderline	18-23	19-22	68-85
	clinical	24-78	23-70	86-240

Table 2: Profile of the Study Sample

Sl. No.	Personal and Socio-demographic details		N (%)
1	Gender	Females	467 (58.4)
		Males	333 (41.6)
2	Age in Years	18-20	107 (13.4)
		20-22	359 (44.9)
		22-24	334 (41.8)
3	Education	UG students	539 (67.4)
		PG students	261 (32.6)
4	Religion	Hindus	729 (91.1)
		Non-Hindus	71 (8.9)
5	Mother Tongue	Kannada	396 (49.5)
		Other than Kannada	404 (50.5)
6	Family Structure	Nuclear	710 (88.7)
		Joint	90 (11.3)
7	Family Income per Month	≤ 10000	274 (34.3)
		10001-20000	186 (23.3)
		20001-30000	125 (15.6)
		>30000	215 (26.9)

Figures in parentheses denote percentage.

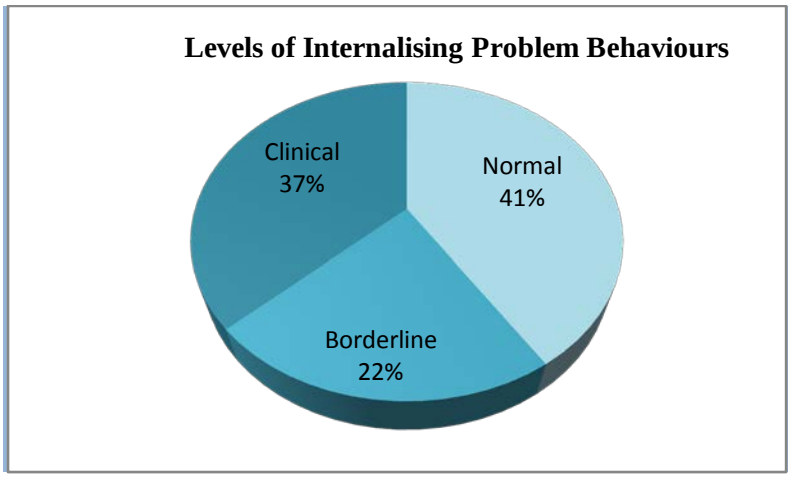

Figure 1: Distribution of Sample based on levels of Internalizing Problem Behaviours

Table 3: Distribution of Sample based on Levels of Internalizing Problem Behaviours under Study Variables

Variables		Internalizing Problem Behaviours			χ^2 Value (d.f.)	P value
		Normal (%)	Borderline (%)	Clinical (%)		
Gender	Females	200 (42.8)	117 (25.1)	150 (32.1)	11.888** (2)	0.003
	Males	127 (38.1)	61 (18.3)	145 (43.5)		
Age in years	18-20	35 (32.7)	18 (16.8)	54 (50.5)	11.847* (4)	0.019
	20-22	143 (39.8)	83 (23.1)	133 (37.0)		
	22-24	149 (44.6)	77 (23.1)	108 (32.3)		
Education	UG students	223 (41.4)	121 (22.4)	195 (36.2)	0.347NS (2)	0.841
	PG students	104 (39.8)	57 (21.8)	100 (38.3)		
Mother Tongue	Kannada	159 (40.2)	93 (23.5)	144 (36.4)	0.693NS (2)	0.707
	Other than Kannada	168 (41.6)	85 (21.0)	151 (37.4)		
Family Income	Rs. ≤ 10000	117 (42.7)	64 (23.4)	93 (33.9)	3.06NS (6)	0.801
	Rs. 10001-20000	75 (40.3)	36 (19.4)	75 (40.3)		
	Rs. 20001-30000	47 (37.6)	31 (24.8)	47 (37.6)		
	Rs. >30000	88 (40.9)	47 (21.9)	80 (37.2)		
Total		327 (40.9)	178 (22.3)	295 (36.9)		

*Figures in parenthesis denotes percentage; P=Probability; * indicates that p value is significant at 0.05 level;*
*** indicates highly significant at 0.001 level; NS indicates not significant.*

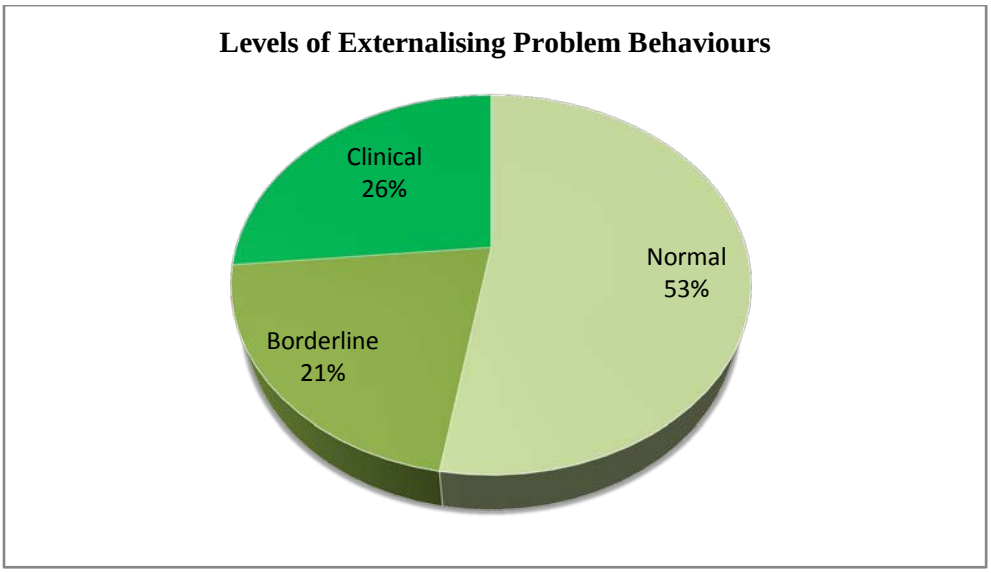

Figure 2: Distribution of Sample based on Levels of Externalizing Problem Behaviours

Table 4: Distribution of Sample based on Levels of Externalizing Problem Behaviours under study variables

Variables		Externalizing Problem Behaviours			χ^2 Value (d.f.)	P Value
		Normal (%)	Borderline (%)	Clinical (%)		
Gender	Females	238 (51.0)	109 (23.3)	120 (25.7)	4.129NS (2)	0.127
	Males	183 (55.0)	58 (17.4)	92 (27.6)		
Age in years	18-20	46 (43.0)	22 (20.6)	39 (36.4)	12.087* (4)	0.017
	20-22	180 (50.1)	78 (21.7)	101 (28.1)		
	22-24	195 (58.4)	67 (20.1)	72 (21.6)		
Education	UG students	289 (53.6)	109 (20.2)	141 (26.2)	0.719NS (2)	0.698
	PG students	132 (50.6)	58 (22.2)	71 (27.2)		
Mother Tongue	Kannada	209 (52.8)	78 (19.7)	109 (27.5)	0.836NS (2)	0.658
	Other than Kannada	212 (52.5)	89 (22.0)	103 (25.5)		
Family Income	Rs. ≤ 10000	149 (54.4)	54 (19.7)	71 (25.9)	7.739NS (6)	0.258
	Rs. 10001-20000	90 (48.4)	50 (26.9)	46 (24.7)		
	Rs. 20001-30000	68 (54.4)	27 (21.6)	30 (24.0)		
	Rs. >30000	114 (53.0)	36 (16.7)	65 (30.2)		
Total		421 (52.6)	167 (20.9)	212 (26.5)		

*Figures in parenthesis denotes percentage; P=Probability; * indicates that p value is significant at 0.05 level;*
NS indicates not significant.

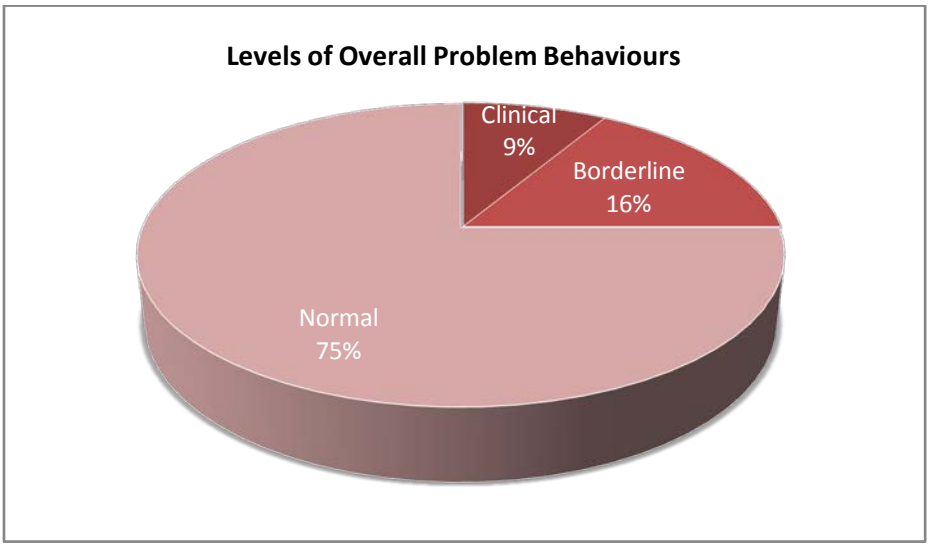

Figure 3: Distribution of Sample based on Levels of Overall Problem Behaviours

Table 5: Distribution of Sample based on Level of Overall Problem Behaviours under Study Variables

Variables		Overall Problem Behaviours			χ^2 value (d.f.)	P Value
		Normal (%)	Borderline (%)	Clinical (%)		
Gender	Females	357 (76.40)	69 (14.80)	41 (8.80)	2.097 (2)	0.350
	Males	243 (73.0)	62 (18.60)	28 (8.40)		
Age in years	18-20	70 (65.4)	17 (15.9)	20 (18.7)	17.290** (4)	0.002
	20-22	269 (74.9)	61 (17.0)	29 (8.1)		
	22-24	261 (78.1)	53 (15.9)	20 (6.0)		
Education	UG students	401 (74.4)	90 (16.7)	48 (8.9)	0.336NS (2)	0.845
	PG students	199 (76.2)	41 (15.7)	21 (8.0)		
Mother tongue	Kannada	290 (73.2)	68 (17.2)	38 (9.6)	1.488NS (2)	0.475
	Other than Kannada	310 (76.7)	63 (15.6)	31 (7.7)		
Family Income	Rs. ≤ 10000	201 (73.4)	51 (18.6)	22 (8.0)	3.052NS (6)	0.802
	Rs. 10001-20000	143 (76.9)	27 (14.5)	16 (8.6)		
	Rs. 20001-30000	90 (72.0)	23 (18.4)	12 (9.6)		
	Rs. >30000	166 (77.2)	30 (14.0)	19 (8.8)		
Total		600 (75.0)	131 (16.4)	69 (8.6)		

*Figures in parenthesis denotes percentage; P=Probability; * indicates that p value is significant at 0.05 level;*

*** indicates highly significant at 0.001 level; NS indicates not significant.*

How to cite this article: Rao S A & Komala A (2017). Problem Behaviours and Associated Factors among Youth in Bangalore City, India. *International Journal of Indian Psychology*, Vol. 4, (4), DIP:18.01.136/20170404, DOI:10.25215/0404.136