

Emotional and Behavioral Problems of Primary School Children With and Without Learning Disabilities: A Comparative Study

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Abstract

The aim of this study was to investigate the behavioral and emotional problems of children with and without learning disabilities. The study sample consisted of 15 teachers and 424 primary school children with and without learning disabilities were selected from two governmental primary schools at Beni-Suef City, using case –control research design. Data were collected by the teachers using the Strengths and Difficulties Questionnaire (SDQ) for children and adolescents aged 4-16 years. The results conducted that the prevalence of total difficulties scores among primary school children with learning disabilities was 98.1% abnormal difficulties compared to 79.7% of normal children. Results also found that statistical significant differences were found between children with and without learning disability in all sub domains of emotional and behavioral disorders. This study documents that the high prevalence of difficulties among primary school children is an alarming condition that needs attention and early intervention. The study recommended that a periodic screening test should be provided for early detection of emotional and behavioral problems for children with learning disabilities.

Key words: Primary school children, learning disabilities, emotional and behavioral problems

Introduction

Learning disabilities are problems that affect the brain's ability to receive, process, analyze, or store information. These problems can make it difficult for children to learn as quickly as someone who isn't affected by learning disabilities; these children do not fall under other categories of handicap (Lyness, 2010). Learning disability constitutes one of the major health problems which affect the educational processes. Its prevalence is about 10-15% of the school age children (Robinson & Robertson, 2003). Currently, prevalence of learning disabilities was 7.66% among school-aged children in the United States (Boyle et al., 2011). In Egypt a study done by Ahmed et al. (2003) showed that the prevalence of learning disabilities (LD) among primary school children at Abbassia district was 15.7%, which increased among boys than girls.

Although the actual causes of learning disability can never be known, and this problem does not become evident until the child enters the primary grades, but a variety of suspected causes of learning disabilities have been proposed. The causes or influencing factors can be biomedical, developmental, behavioral, emotional, social, environmental and family issues. The problem may be in the area of reading, math, written expression, auditory perception and communication disorders (Nag & Snowling, 2012).

Students whose achievement lagged behind their intellectual potential present a serious problem to the parents, society and finally to the nation; instead of being the contributing members they turn out to be a social problem (Neill, 2008). Other possible outcomes for individuals with LD who have not received appropriate intervention or help are emotional and behavioral problems which include low self-esteem, suicide, family instability, substance abuse, depression, psychiatric problems and unemployment (Kemp et al., 2013).

Learning disabilities are lifelong. Individuals with learning disabilities can face unique challenges that are often pervasive throughout the lifespan. However, with appropriate cognitive/academic interventions they can overcome the effects of their disability (Neill, 2008; Nag & Snowling, 2012).

Teachers and paraprofessionals often are the first to recognize a student's lack of success with assignments, and his or her continuous problems with peer or adult relationships. While this fact may eventually result in a formal referral, a teacher's primary goal is to identify interfering behaviors and help students to overcome them. Teachers and paraprofessionals begin this process by analyzing the kinds of behavior that put students at risk (Quinn et al., 2000).

The community health nurses are in an excellent position to detect and support children with learning disabilities, usually in a multidisciplinary team, and concern with their clients' health in the widest context. They help clients of all ages to live their lives as fully and independently as possible, while respecting their rights and dignity (Slevin & Sines, 2005).

Significance of the study

Learning disabilities are noticed when children struggle with learning in their school years techniques. Eighty percent of children with learning disabilities, who have not been discovered and treated, have aggressive

behavior toward family and community. Thus, a child with poor academic performance has tendency to engage in criminal acts more than a child with higher school performance. Studying behavioral and emotional problems among those children will produce reliable information that creates a basis for early detection and intervention. Early detection allows time for follow up to occur before the child is expected to function in an advanced learning environment (**Hales, 2009**).

Epidemiological information about the prevalence of child behavior and emotional problems is essential to inform policy and public health practice. This information is weak in many developing countries and those in developmental transition. There have been few such studies in Arab countries as well as in Egypt (**Abd-Elhamid et al., 2009**).

Research question

What are the differences regarding behavioral and emotional problems among primary school children with and without learning disabilities?

Aim of the study

The aim of this study was to investigate the behavioral and emotional problems of children with and without learning disabilities.

Subjects and Methods

Research design: A case-control research design was utilized in this study to achieve the aim of the current study.

Setting: The study was conducted at two governmental primary schools, selected randomly representing two educational zones in Beni-Suef City; Abo Bakr El Sedek School represents West Zone and Madenat Beni-Suef Elgededa School represents East Zone.

Sample: The population of this study consisted of 15 teachers for helping in data collection, and 424 primary school age children residing in the study settings during the time of data collection. They were categorized into group (1) those who have a learning disability, including all available samples of 212 students with learning disabilities. They were recruited from the 4th (46), 5th (70) and 6th (96) grades of these schools. The second group consisted of (40) at 4th grade, (80) at 5th grade and (92) at 6th grade. The sample criteria included age range 10-12 years, free from chronic diseases, and the class teachers agreed to participate in the study.

Tools of data collection

One tool was used in this study, it consisted of two parts:

First part: concerned with personal data such as; age, sex, scholastic achievement, and grade.

Second part: The Strengths' and Difficulties' Questionnaire (SDQ) for children and adolescents aged 4-16 years were utilized in this study (**Goodman, 1999; Goodman & Scott, 1999; Mathai et al., 2002; Youth in Mind, 2005**). The SDQ has become one of the most widely used tools in child and adolescent children's emotional and behavioral symptoms across the globe. Although the SDQ was originally developed and validated within the UK, and its reliability and validity have been simulated in many countries, including Arab countries; important cross cultural issues have been raised (**Alyahri & Goodman, 2008**).

The SDQ consists of 25 items: emotional symptoms (5 items), conduct problems (5 items), hyperactivity/inattention (5 items), peer relationship problems (5 items) and prosocial behavior (5 items) (**Youth in Mind, 2005**).

Scoring system:

The SDQ comprises 25 items; 5 scales of 5 items each. The responses to items always being in the same way (as Somewhat True, Not True and Certainly True), but they are not all scored the same way. Standard values were used for coding item responses and summary scores. The standard values for coding individual item responses are 0 (Not True), 1 (Somewhat True), 2 (Certainly True); and the missing" values 7 (Unable to rate), 8 (Protocol exclusion) and 9 (Missing data) for all items except items 7, 11, 14, 21 and 25, these items are "reverse-scored", that is, the standard value is mapped to Item scores as follows: 0→2, 1→1, 2→0. SDQ scores also were classified as normal (0-11), borderline (12-15) and abnormal (16-40).

Summary scores were calculated if at least three of the five items have been completed (that is, coded 0, 1 or 2). Otherwise the summary score is set to missing. For the summary scores, the missing value used should be 99. The summary scores were computed using the equation shown below, with the result being rounded to the nearest whole number. In the first 25 SDQ questions, each summary scale is composed of five items.

Summary score= **Calculating the Total Difficulties scores**

Total Score = Emotional Scale + Conduct Scale + Hyperactivity Scale + Peer Problem Scale (but doesn't include the Pro-Social score). The total difficulties score ranges from 0-40 (**Youth in Mind, 2005**).

Other questions are NOT completed if respondents have answered "No" to Item 26, which asks for an overall opinion about the difficulties being present. In this case, all item responses for items 27 through 33 should be coded to "8" for "not applicable", and the impact score should be coded to zero. Item 27 is not

included in the impact Score, since it assesses the chronicity of the difficulties – the length of time they have been present. Item 33 is not included in the impact Score, since it assesses the burden on others rather than on the child/youth.

Ethical considerations:

Oral consent was taken from teachers of classes included in the study, they were informed that the data collected will be used for the research only, and confidentiality manner is assured.

Field work:

Official permission was obtained first from the Security Department, then the Ministry of Education, and from the directors of educational zones. Based on their approvals, permission was taken from the directors of the selected schools to collect the data.

The researcher started by explaining the purpose of the study briefly to the teachers of the selected classes. Then, the researchers started to meet the teachers of the classes to give an explanation for emotional and behavioral problems about each child. The duration ranged from 10 to 15 minutes. The researcher visited the schools from 9.00 a.m. to 1.00 p.m. two to three times per week, to give teacher's explanation and provide clarifications for any ambiguity in the questionnaire sheet and ensure accuracy of the data collected. The duration of data collection took about three months from beginning of October to the end of December, 2012.

Pilot study:

A pilot study was carried out on 10% of the studied sample (20 students) to test the content of the questionnaire, as well as to estimate the time needed for data collection. Those who shared in the pilot study were excluded from the main study sample.

Statistical design:

Pre-coded data were statistically analyzed using the Statistical Package of Social Science (SPSS) software program, version 21. Data were summarized using mean, standard deviation, median and interquartile range for quantitative variables and frequency and percentage for qualitative ones. Comparison between groups was done using independent sample t-test (if parametric) or Mann Whitney test (if non-parametric) for quantitative variables and Chi square test or Fisher's exact test for qualitative ones. Pvalues less than 0.05 were considered statistically significant and if less than 0.001, they were considered highly significant. Graphs were used to illustrate some information.

Results:

The current study results showed that the mean age of children with learning disabilities was 9.7 ± 1.8 compared to 9.8 ± 1.9 of normal children. Regarding children, gender, more than half of children with learning disabilities were males (54.2 %), compared to 47.6% of normal children.

Table (1): shows that highly statistically significant difference was found between both studied groups regarding pro-social sub domain. More than two fifths (44.3%) of children with learning disabilities compared to 26.9% of normal children were in abnormal line of preschool domain.

Table (2): reveals highly statistically significant difference was found between both studied groups regarding peer problems sub domain. The study results show that less than half of children with learning disabilities (47.2%) compared to less than one third (31.1%) of normal children were having abnormal peer relations.

Concerning emotional symptoms domain, **table (3)** clarifies that highly statistically significant differences were found between both studied groups regarding emotional symptoms sub domain except for worry and depression. More than two fifths (43.9%) of children with learning disabilities compared 31.6% of normal children were having abnormal emotional symptoms.

Regarding to conduct problems sub scale between both groups, study results show a statistically significant difference in all sub domains except for often fights with other children, and 64.6% compared to 40.1% were categorized as abnormal (**table 4**)

Table (5): Points to statistically significant differences were found between both studied groups regarding all sub domains of hyperactivity except for restlessness.

Regarding details of questions concerned with difficulty type, 12.1% of children with learning disability were having extreme difficulties and regarding to its duration 34.3% of them was for more than 12 months.

Furthermore 41.1% of children with great learning disabilities compared to 37.7% of normal children their difficulties put the burden on the class as whole (**table 6**).

Figure (1): Illustrates that 98.1% of group 1 compared to 79.7% of group 2 had abnormal difficulties.

Table(1): Comparison between both groups in relation to Pro-social domain as reported by class teacher (n=424).

Pro-social Domain	Study Group		Control Group		Test value	P value
	n= 212		n= 212			
	N	%	N	%		
Considerate of other people's feelings						
Not true	85	40.1	70	33.0	X ² =9.4	0.009 HS
Somewhat true	89	42.0	77	36.3		
Certainly true	38	17.9	65	30.7		
Shares readily with other children						
Not true	62	29.2	35	16.5	X ² =36.2	<0.001 HS
Somewhat true	98	46.2	65	30.7		
Certainly true	52	24.5	112	52.8		
Helpful if someone is hurt, upset, feeling ill						
Not true	78	36.8	46	21.7	X ² =11.8	0.003 HS
Somewhat true	78	36.8	94	44.3		
Certainly true	56	26.4	72	34.0		
Kind to younger children						
Not true	41	19.3	31	14.6	X ² =10.2	0.006 HS
Somewhat true	104	49.1	82	38.7		
Certainly true	67	31.6	99	46.7		
Often volunteers to help others						
Not true	78	36.8	39	18.4	X ² =26.3	<0.001 HS
Somewhat true	79	37.3	73	34.4		
Certainly true	55	25.9	100	47.2		
Prosocial scale M ± SD	4.6 ± 2.4		6.1 ± 2.8		t=5.7	<0.001
Median (IQR)	5.0 (3.0 – 6.0)		6.0 (4.0 – 8.0)		Z=5.3	HS
Prosocial scale categories						
Normal	73	34.4	118	55.7	X ² =20.5	<0.001 HS
Borderline	45	21.2	37	17.5		
Abnormal	94	44.3	57	26.9		

Table (2): Comparison between both groups in relation to peer problems domain as reported by class teacher (n=424).

Peer Problems	Study Group		Control Group		Test value	P value
	n= 212		n= 212			
	no	%	no	%		
Rather solitary, prefers to play alone						
Not true	91	42.9	132	62.3	X ² =23.4	<0.001 HS
Somewhat true	69	32.5	61	28.8		
Certainly true	52	24.5	19	9.0		
Has at least one good friend						
Not true	57	26.9	33	15.6	X ² =30.7	<0.001 HS
Somewhat true	95	44.8	63	29.7		
Certainly true	60	28.3	116	54.7		
Generally liked by other children						
Not true	61	28.8	23	10.8	X ² =29.6	<0.001 HS
Somewhat true	97	45.8	92	43.4		
Certainly true	54	25.5	97	45.8		
Picked on or bullied by other children						
Not true	71	33.5	117	55.2	X ² =22.7	<0.001 HS
Somewhat true	96	45.3	55	25.9		
Certainly true	45	21.2	40	18.9		
Gets along better with adults than with other children						
Not true	65	30.7	46	21.7	X ² =33.7	<0.001 HS
Somewhat true	110	51.9	74	34.9		
Certainly true	37	17.5	92	43.4		
Peer problems scale M ± SD	4.6 ± 1.8		3.6 ± 1.7		t=5.8	<0.001
Median (IQR)	4.0 (3.3 – 6.0)		3.0 (2.0 – 5.0)		Z=5.7	HS
Peer problems scale categories						
Normal	53	25.0	116	54.7	X ² =39.9	<0.001 HS
Borderline	59	27.8	30	14.2		
Abnormal	100	47.2	66	31.1		

Table(3): Comparison between both groups in relation to emotional symptoms domain as reported by class teacher (n=424).

Emotional Symptoms	Study Group		Control Group		Test value	P value
	n= 212		n= 212			
	No	%	No	%		
Often complains of headaches, stomach- aches						
Not true	88	41.5	113	53.3	X ² =11.5	0.003 HS
Somewhat true	87	41.0	83	39.2		
Certainly true	37	17.5	16	7.5		
Many worries or often seems worried						
Not true	51	24.1	48	22.6	X ² =0.98	0.6 NS
Somewhat true	93	43.9	103	48.6		
Certainly true	68	32.1	61	28.8		
Often unhappy, depressed or tearful						
Not true	70	33.0	87	41.0	X ² =5.2	0.07 NS
Somewhat true	88	41.5	66	31.1		
Certainly true	54	25.5	59	27.8		
Nervous or, easily loses confidence						
Not true	61	28.8	120	56.6	X ² =33.8	< 0.001 HS
Somewhat true	80	37.7	52	24.5		
Certainly true	71	33.5	40	18.9		
Many fears, easily scared						
Not true	37	17.5	65	30.7	X ² =13.5	0.001 HS
Somewhat true	82	38.7	84	39.6		
Certainly true	93	43.9	63	29.7		
Emotional symptoms scale <i>M ± SD</i>						
	5.1 ± 2.1		4.1 ± 2.5		t=4.4	< 0.001
Median (IQR)						
	5.0 (4.0 – 6.0)		4.0 (2.0 – 6.0)		Z=4.1	HS
Emotional Symptoms scale categories						
Normal	76	35.8	112	52.8	X ² =12.4	0.002 HS
Borderline	43	20.3	33	15.6		
Abnormal	93	43.9	67	31.6		

Table (4): Comparison between both groups as regards conduct problem domain as reported by the class teacher (n=424).

Conduct Problems	Study Group		Control Group		Test value	P value
	n= 212		n= 212			
	N	%	N	%		
Often loses temper						
Not true	74	34.9	100	47.2	X ² =11.2	0.004 HS
Somewhat true	90	42.5	58	27.4		
Certainly true	48	22.6	54	25.5		
Generally well behaved,						
Not true	55	25.9	47	22.2	X ² =7.1	0.03 S
Somewhat true	96	45.3	78	36.8		
Certainly true	61	28.8	87	41.0		
Often fights with other children						
Not true	75	35.4	99	46.7	X ² =5.7	0.058 NS
Somewhat true	69	32.5	55	25.9		
Certainly true	68	32.1	58	27.4		
Often lies or cheats						
Not true	65	30.7	132	62.3	X ² =47.7	< 0.001 HS
Somewhat true	79	37.3	56	26.4		
Certainly true	68	32.1	24	11.3		
Steals from home, school or elsewhere						
Not true	128	60.4	172	81.1	X ² =22.5	< 0.001 HS
Somewhat true	58	27.4	30	14.2		
Certainly true	26	12.3	10	4.7		
Conduct problems scale <i>M ± SD</i>						
	4.4 ± 2.3		3.1 ± 2.5		t=5.3	< 0.001
Median (IQR)						
	4.0 (3.0 – 6.0)		3.0 (1.0 – 5.0)		Z=5.4	HS
Conduct problems scale categories						
Normal	49	23.1	99	46.7	X ² =29.2	< 0.001 HS
Borderline	26	12.3	28	13.2		
Abnormal	137	64.6	85	40.1		

Table (5): Comparison between both groups as regards hyperactivity domain as reported by the class teacher (n=424).

Hyperactivity Domain	Study Group		Control Group		Test value	P value
	n= 212		n= 212			
	N	%	N	%		
Restless, and overactive						
Not true	59	27.8	66	31.1	X ² =1.5	0.5 NS
Somewhat true	88	41.5	76	35.8		
Certainly true	65	30.7	70	33.0		
Constantly fidgeting or squirming						
Not true	66	31.1	92	43.4	X ² =14.4	0.001 HS
Somewhat true	94	44.3	57	26.9		
Certainly true	52	24.5	63	29.7		
Easily distracted, concentration wanders						
Not true	35	16.5	83	39.2	X ² =55.3	<0.001 HS
Somewhat true	55	25.9	80	37.7		
Certainly true	122	57.5	49	23.1		
Thinks things out before acting						
Not true	115	54.2	44	20.8	X ² =70.8	<0.001 HS
Somewhat true	74	34.9	79	37.3		
Certainly true	23	10.8	89	42.0		
Good attention span						
Not true	134	63.2	50	23.6	X ² =81.6	<0.001 HS
Somewhat true	46	21.7	52	24.5		
Certainly true	32	15.1	110	51.9		
Hyperactivity scale <i>M</i> ± <i>SD</i>	6.3 ± 2.0		4.2 ± 2.6		t=9.0	<0.001 HS
Median (<i>IQR</i>)	6.0 (5.0 – 8.0)		5.0 (2.0 – 6.0)		Z=8.2	
Hyperactivity scale categories						
Normal	63	29.7	141	66.5	X ² =58.0	<0.001 HS
Borderline	57	26.9	31	14.6		
Abnormal	92	43.4	40	18.9		

Table(6): Comparison between both groups regarding details of social difficulties as reported by class teacher (n=424).

Social Difficulties	Study Group		Control Group		Test value	P value
	n= 212		n= 212			
	N	%	N	%		
Overall, do you think that your child has difficulties in any of the following areas: emotions, concentration, behavior or being able to get along with other people?						
No (total=140)	5	2.4	135	63.7	X ² =180.2	<0.001 HS
Yes (total=284)	207	97.6	77	36.3		
Difficulty type (n=284)						
Simple difficulties	102	49.3	58	75.3	X ² =16.6	<0.001 HS
Clear difficulties	80	38.6	17	22.1		
Extreme difficulties	25	12.1	2	2.6		
How long have these difficulties been present? (n=284)						
< 1 month	27	13.0	13	16.9	X ² =67.0	<0.001 HS
1-5 months	67	32.4	62	80.5		
6-12 months	42	20.3	2	2.6		
> 12 months	71	34.3	0	0.0		
Do the difficulties upset you (n=284)						
No	45	21.7	22	28.6	X ² =14.4	0.002 HS
Little	69	33.3	39	50.6		
Moderate	66	31.9	10	13.0		
Great	27	13.0	6	7.8		
Peer relationships (n=284)						
No	36	17.4	11	14.3	X ² =27.9	<0.001 HS
Little	53	25.6	44	57.1		
Moderate	68	32.9	17	22.1		
Great	50	24.2	5	6.5		
Class learning (n=284)						
No	5	2.4	14	18.2	X ² =51.1	<0.001 HS
Little	13	6.3	15	19.5		
Moderate	77	37.2	36	46.8		
Great	112	54.1	12	15.6		
Do the difficulties put a burden on the class as a whole? (n=284)						
No	8	3.9	0	0.0	X ² =44.7	<0.001 HS
Little	49	23.7	46	59.7		
Moderate	65	31.4	2	2.6		
Great	85	41.1	29	37.7		

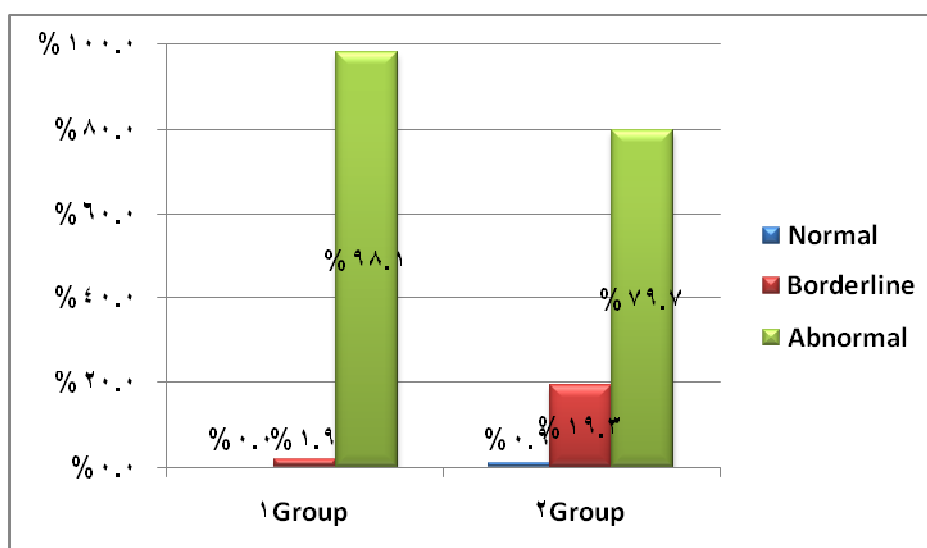


Figure (1): Total difficulty score between both groups

Discussion

A great attention has been given to the social emotional development of children with learning disabilities. Studies on this topic reveal that those with learning disabilities are at increased risk for mental health problems. Existing studies have focused on specific aspects of mental health such as stress, anxiety and

depression (**Wilson et al., 2009**). A multidisciplinary approach is essential for early recognition of learning disabilities.

Regarding gender of the studied sample, the current study result showed that more than half of children with learning disabilities were boys. The researchers have suggested that the prevalence of learning disabilities more among boys is due to their biological vulnerability. In the same line, **Mascheretti et al. (2013)** found that boys were more likely to have learning disabilities than girls. Similarly, **Giuliani and Bacon (2010)** found that boys outnumber girls by about three to one in the LD category

The prevalence of total difficulties was higher in the current study results than those reported in studies from other countries, the results of total difficulties indicated that almost all children with learning disabilities rated abnormal, compared to more than three quarters of the normal children. In a similar study, **Poblete et al. (2007)** found that more than half of the children with learning disability having abnormal behavioral and emotional difficulties. Recently, a study done among Libyan children by **Zeglam et al. (2011)** found that behavioral problems were more common among children with learning disability. On the other hand, **Syed et al. (2009)** stated that more than one third of children without learning disabilities are falling under abnormal difficulty category. Furthermore, a study done in Egypt by **Abd Elhamid et al. (2009)** who found that the total difficulties of children without learning disabilities were 20.6%.

The present study result confirms previous reports that the children with LD have an enhanced likelihood of associated emotional, behavior, and social difficulties. The children with LD have significantly more than normal children in total pro-social scale and all of its sub items. In the same line, **Terras et al. (2009)** found that the rates of pro-social difficulties were significantly higher in population with learning disabilities than in the general population. **Pastor et al. (2012)** stated that children facing common social challenges at school identify concerns, they are often rejected by their peers and have poor self-concepts and were more likely to internalize the problem rather than trying to resolve it or asking for help. After reviewing 152 different studies, **Giuliani and Bacon (2010)** concluded that 75% of students with LD exhibit deficits in social skills. Studies of teacher ratings also suggested that students with learning disabilities have lower social status than other students.

Additionally, the current study results indicated that there was a statistically significant difference between children with and without LD regarding emotional difficulties, which nearly half of children with LD rated abnormal emotional symptoms compared to less than one third of normal children. This might be due to that some children showed excessive anxiety, and depression and not meeting the expected academic requirements. In agreement with the findings of the current study, **Dilshad (2006)** found that the children with and without learning difficulties show significant differences in emotional problems.

The current study results found no differences between both groups regarding depression and worry. On the contrary, **Mag and Reid (2006)** found that children with learning disabilities obtained statistically higher scores on measures of depression than their peers without learning disabilities. As well, these children appeared sad, gloomy, and showed hopelessness, great dissatisfaction with self and unhappiness than their counterparts. In this respect **Charles and Hellen (2003)** emphasized that children with learning disabilities (LD) often have problems that go far beyond those experienced in reading, writing, math, memory, or organization. For many, strong feelings of frustration, anger, sadness, or shame can lead to psychological difficulties such as anxiety, depression or low self-esteem, as well as behavioral problems such as substance abuse or juvenile delinquency. Consistently, **Wong et al (2006)** clarified that lack of self esteem experienced by students with learning disabilities might create feelings of inadequacy or inferiority which could be an impediment to establishing social relationships. In the same line, **Bevington and Wishart (2006)** emphasized a significant association between learning difficulties and emotional problems of children, whereas the difficulty level increased the level of problems also increased.

As regards to peer problems, the findings of this study revealed that nearly half of children with LD have peer problems compared to less than one third of children without LD. In accordance with these research findings, children with LD reported higher than their normal peers in solitary, having one good friend, bullied by other children. Children with learning difficulties appeared aloof and socially isolated and they described themselves as quiet and higher sense of loneliness when compared to their typical developing peers (**Al-Yagon & Mikulincer, 2004**). Recently, **Snyder (2013)** highlighted that LD children were not interested in any hobbies and solitary playing and bullying was obviously prevalent among them. Hence, surveys of 4th-6th graders in several states indicated that 25 percent of all children had been bullied at least several times. Further, **Essa (2010)** stated that the subjects claimed that they sometimes had been teased or bullied because of their reading and writing difficulties. So, the feeling of well-being had been significantly lower. In a similar study, **Peter (2011)** mentioned that children with learning disabilities have problems with family and peer relationships. This may be the result of processing problems which make it difficult for LD children to pick up social cues. When learning disabilities and behavioral problems appear together, it is important to identify whether the behavior is secondary to the learning disability or co-morbid. When the negative behavior is caused by the learning

disability, the solution to that behavior often lies in dealing with the learning disability. When it is co-morbid, the interventions become more complicated.

In relation to hyperactivity, the study results revealed that more than two fifths of children with LD reported hyperactivity. This finding was consistent with **Dockrell and Lindsay (2000)** who found that approximately 44% of children are having problems with hyper activities. Incongruent with this finding, **Abd Elhamid et al. (2009)** stated that the hyperactivity disorder was 0.7% of primary school children without learning disabilities. As well, the findings of the present study indicated that the children with learning difficulties showed poor concentration, short attention problems, fidgeting and not thinking before acting things more than their normal peer. In the same line, **Dilshad (2006)** showed stubborn, rebellious and uncooperative behaviors, easily excitable, impulsive, fidgety and restless behaviors were found more often in children with learning problems than their peers. Wherever the current findings stated there are no statistically significant differences in restless and over active between both groups, this might be due to the children's age group.

Concerning conduct problems, the current study results indicated that two thirds of children with LD compared to two fifths of children without LD had conduct problems. Similar rates of conduct difficulties among school children were found by **Syed et al. (2009)**. On the other hand, a study done in Egypt revealed that conduct disorder constituted 6.6% of primary school children without learning disabilities (**Abd Elhamid et al., 2009**). Children with learning difficulties tended to have frequent change of mood and act out their feelings, using verbal threats and physical aggression (**Pastor et al., 2012**). In this context, **Kavale and Frness (2000)** found that children who have learning disabilities had higher scores on aggression – conduct disorder scale than do other children with a difference of 1.02 points (scores of 2.29 & 1.27, respectively). However, **Statistics in Canada (2005)** reported that children with learning disabilities exhibit only slightly higher behavioral problems than other children.

The present study outcomes suggested that school-age children with LD showed great difficulty in peer relationship than did their non LD peers. In the same way, **Al-Yangon and Mikulincer (2004)** found that the children with learning disability reported higher levels of avoidance and anxiety in the close relationship as compared to children with typical development. Whereas studies conducted among children with typical development, demonstration revealed inconsistent outcomes (**Arnold et al., 2005; Carroll & Illes, 2006**).

Results of the current study revealed a significant difference between children with and without learning difficulties regarding classroom learning behavior. Meanwhile, **Hernandez (2013)** mentioned that this result refers to their frequent changing mood, inattentiveness and lack of concentration and disinterest. In accordance with the previous results, **Mourad et al. (2006)** denoted that the children who are at risk for learning disabilities often tended to be less on-task and to exhibit more off-task behavior than their classmates.

Conclusion:

The conclusion which can be drawn from this study would be that the prevalence of total difficulties' scores among primary school children with learning disabilities was 98.1% abnormal difficulties compared to 79.7% of normal children. The results also revealed that statistically significant differences were found between children with and without learning disability in all sub domains of emotional and behavioral disorders. Furthermore, the results showed that 12.1% of children with learning disability were having extreme difficulties, and more than half of them (54.1%) compared to 37.7% of normal children their difficulties put the burden on the class as a whole. High prevalence of difficulties among primary school children is an alarming condition that needs attention and early intervention.

Recommendations:

- A periodic screening test should be provided for early detection of mental health problems for children with learning disabilities.
- There is a need for developing programs to train, sensitize and mobilize teachers regarding the child's mental health problems with learning disability.
- Further research with larger, more representative sample is necessary as understanding the factors that leading to mental health problems among school children is essential for development of effective prevention and intervention strategies.

References

- Abd - Elhamid, A., Howe, R., & Reading, R., (2009). Prevalence of emotional and behavioral problems among 6 – 12 year old children in Egypt. *Social Psychiatry and Psychiatric Epidemiology*; 44 (1), 8-14.
- Ahmed, H. A., Radwan, S.A., Saber, A.S., Shoeib, R.M., & El Shoubary, A.M. (2003). Learning Disabilities: Prevalence and its impact on primary school children, *The Egyptian Journal of Community Medicine*; 21(4), 31-52.
- Allender, A.J. & Walton, B. (2001). *Community health nursing concepts and practice*. 5th edition. New York: Spradley, p.550.

- Al-Yagon, M. & Mikulincer, M. (2004). Patterns of close relationships and socioemotional and academic adjustment among school age children with learning disabilities. *Learning disabilities research and practice*, 19(1), 12-19.
- Alyahri, A., & Goodman, R. (2008). The prevalence of DSM-IV psychiatric disorders among 7-10 year old Yemeni school children. *Soc Psychiatry Psychiatr Epidemiol*; 43: 224-230.
- Arnold, E., Goldston, D., Walsh, A., Reboussin, B., Daniel, S., Hickman, E., et al. (2005). Severity of emotional and behavioral problems among poor and typical readers. *Journal of Abnormal Child Psychology*; 33 (2), 205–217.
- Bevington, J., & Wishart, J.G. (2006). The influence of classroom peers on cognitive performance in children with behavioral problems. *British Journal of Educational Psychology*; 69, 19-32.
- Boyle, C.A., Boulet, S., Schieve, L., Cohen, R.A., Blumberg, S.J. Yeargin-Allsopp, M. Visser, S. Kogan M.D. (2011). Trends in the prevalence of developmental disabilities in US children, 1997–2008. *Pediatrics*. Available at: http://www.cdc.gov/features/dsdev_disabilities/index.html
- Carroll, J. M., & Iles, J.E. (2006). An assessment of anxiety level in dyslexic students in higher education. *British Journal of Educational Psychology*; 76 (3), 651–662.
- Charles & Helen (2003). Learning disabilities and psychological Problems. *The Journal of Learning Disabilities*; 29, 226-237.
- Dilshad, H.A. (2006). Prevalence of learning difficulties/disabilities among primary school children effect on emotional problems and academic achievement. Master thesis on human development; pp. 74- 83.
- Dockrell, J. & Lindsay, G. (2000). The behavior and self-esteem of children with specific speech and language difficulties. *British Journal of Educational Psychology*; 70, 583-601.
- Giuliani, P. G & Bacon, P. A. (2010). Social-Emotional Problems. Available at: <http://www.education.com/reference/article/social-emotional-problems/>
- Goodman, R. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *Journal of Child Psychology and Psychiatry*; 40(5), 791-799.
- Goodman, R., & Scott, S. (1999). Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: Is small beautiful? *Journal of Abnormal Child psychology*; 27(1), 17-24.
- Hales, G. (2009). The pattern of personality in Dyslexic children and Adults: The invisible symptoms and the effects they produce. Paper Presented at the Fifth International Conference of the British Dyslexia Association, York, UK.
- Hernandez, T. A. (2013). The behavioral and emotional impact of dyslexia. Available at: <https://suite101.com/a/the-behavioral-and-emotional-impact-of-dyslexia-a161374>
- Kavale, K.A., & Frnes, S.R. (2000). Social skills deficit and learning disabilities: A meta-analysis. *Journal of Learning Disabilities*; 29(3), 226-237.
- Kemp, M. A. , Smith, M. A., & Segal, J. (2013). Learning disabilities and disorders. Types of learning disabilities and learning disorders and their signs. Available at: http://www.helpguide.org/mental/learning_disabilities.htm
- Lyness, D. (2010). Learning disabilities. Available at: http://kidshealth.org/teen/diseases_conditions/learning/learning_disabilities.html
- Mag, J. W., Reid, R. (2006). Depression among students with learning disabilities. Assessing the risk. *Journal of Learning Disabilities*; 39 (1), 3-10.
- Mascheretti, S., Marino, C., Simone, D., & Quadrelli, E. (2013). Putative risk factors in developmental dyslexia: A case-control study of Italian children control study of Italian children. *Journal of learning disabilities*; 46 (5). Available at: <http://idx.sagepub.com/content/early/2013/06/10/0022219413492853.abstract>
- Mathai, J., Anderson, P., & Bourne, A. (2002). The Strengths and Difficulties Questionnaire (SDQ) as a screening measure prior to admission to a child and adolescent mental health service (CAMHS). *Australian e-Journal for the Advancement of Mental Health*; 1(3), 1446-7984.
- Mourad, A., Walead, E., & Ahmed, G. (2006). Computer and learning disabilities, theory and practice. Alexandria: Dar El Wafaa.
- Nag, S., Snowling, M.J. (2012). School underachievement and specific learning difficulties. Chapter.3. In: ReyJM (Ed), IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions.
- Neill, D. (2008). Family therapist. Available at: <http://www.familytherapy.org.uk/Leaflets/learningdisabili.html>
- Pastor, P.N., Cynthia, A. ,Reuben,C.A., & Catherine, R., Duran, C.R.(2012). Identifying emotional and behavioral problems in children aged 4–17 years: United States, 2001–2007. *National Health Statistics Reports*. Centers for Disease Control and Prevention National Center for Health Statistics. Number 48.
- Peter, C. (2011). Understanding and treating anxiety disorders: An integrative approach to healing the wounded self. Washington: DC.

- Poblete, X., Clark, E., Marina, D., & Becky, C. (2007). School children's perception of learning problems, bullying and break up of friendship. *Arch Dis Child*, 92(Suppl1), A50–A52. PMID: PMC2066101.
- Quinn, M., Osher, D., Warger, C., Hanley, T., Bader, B., Tate, R., & Hoffman, C. (2000). Educational strategies for children with emotional and behavioral problems Published by Center for Effective Collaboration and Practice, American Institutes for Research, Washington, DC
- Robinson, M.D., & Robertson, D.M. (2003). Behavior and mental health needs in childhood. *practical pediatric*, 1st ed, Churchill, Leoengston, Toronto:
- Slevin, E. & Sines, D. (2005). The role of community nurses for people with learning disabilities: working with people who challenge. *International Journal of Nursing Studies*; 42(4), 415–427.
- Snyder, M. (2013). Understanding bullying and its impact on kids with learning disabilities or AD/HD. Available at: <http://www.greatschools.org/special-education/health/823-understanding-bullying-and-its-impact-on-kids-with-learning-disabilities-or-ad-hd.gs>.
- Statistics in Canada (2005). National longitudinal survey of children and youth: Home environment, income and child behavior *The Daily*, February 21.
- Syed, E.U, Hussein, S.A., & Haidry, S.E. (2009). Prevalence of emotional and behavioral problems among primary school children in Karachi, Pakistan--multi informant survey. *Indian J Pediatr*. [Serial online]. Jun, (Cited 2010 Oct 26). Available at: URL: <http://www.ncbi.nlm.nih.gov/pubmed/19390811>
- Terras, M. L., Thompson, L.C., & Minnis, H. (2009). Dyslexia and psycho-social functioning: An exploratory study of the role of self-esteem and understanding. *Dyslexia*; 15, 304–327.
- Wilson, D., Armstrong, C., Furrrie, A., & Walcott, E. (2009). The mental health of Canadians with self-reported learning disabilities. *Journal of Learning Disabilities*; 42, 1. Available at: <http://journaloflearningdisabilities.sagepub.com> hosted at <http://online.sagepub.com>. Accessed on 3-5 2010.
- Wong, I., Milan, A., & Hou, F. (2006). Learning disabilities and child altruism, anxiety and aggression. *Learning Disabilities Association of Canada*. Available at: "www.idac-tacc.ca" Accessed on: 20 – 2 - 2012.
- Youth in Mind (2005). SDQ: Information for researchers and professionals about the Strengths and Difficulties Questionnaire. Retrieved 5 November 2005. Available at: <http://www.sdqinfo.com>
- Zeglam, A.M., Abou-Riana, F.M., & Al-Hmadi, S.A. (2011). Prevalence of behavioral problems among nursery children in Tripoli. *Middle East Journal of Family Medicine*;9(3), 3-7.s