***Perspectives***

**Medical** – disturbed behaviour as 'disorders'. Emphasis on describing symptoms, diagnosis, treatment. Dominant model of mid C20. Can be criticised as emotional/behavioural difficulties are different to medical conditions. Even if a child is born with a disorder, the expression of it is in a social context – at home, school etc.

**Social Environment Model** – avoids putting labels on children like 'disturbed'. Cause is regarded as being in disturbed patterns of parental care – outside of the child. **Bowlby's** model of maternal deprivation is one illustration. Intervention would be in the form of support & training for parents; placement of children into therapy. Last resort intervention is to take children into care.

Neither model provides a satisfactory account of the development of disturbed behaviour ***by themselves***, as psychological development is a complex, continuous transaction between individuals and social processes. Understanding the interrelatedness of these factors is the key to understanding.

***Problem Behaviour***

**Herbert** argues that psychological abnormality is the inappropriate intensity, frequency and persistence of behavioural, cognitive and emotional responses that all children make – it's about drawing a line between atypical and typical development patterns. However, precise definitions are difficult/impossible, as it depends on factors like the age of the child concerned – bed wetting at age 1 is different to bed wetting at age 8. K-SADS (**Ambrosini**) specifies ages after which particular behaviours are inappropriate.

Child behaviour checklist (CBCL, **Achenbach**) measures 8 dimensions of behavioural difficulties (these are stable & broad in nature):

***Book 2 Chapter 2 –***
***Disturbed & Disturbing Behaviour***

- Withdrawn
- Somatic (body health) complaints
- Anxious/depressed
- Social problems
- Thought problems
- Attention problems
- Delinquent behaviour
- Aggressive behaviour

Dimensions make up two broad categories – internalising (often girls) & externalising (often boys) difficulties.

Rating of items reflects the expectations particular schools place on particular children and particular ages – in other words, no generic standards for behaviour and social integration exist. Normatively defined – therefore children have problems when they fall outside of this normal range (which may be wider or narrower depending on who is making the judgement.) Whose problem is it anyway - and where is it?

**Achenbach et al** – meta analysis of 100 studies of how children's problems are judged. Correlations are all weak:

0.24 between parents & mental health workers
0.27 between parents & teachers
0.34 between teachers and mental health workers

Correlations are even lower when taking the child's own judgements into account. This might be because of issues of reliability – procedures used insufficiently sensitive to identify problems. E.g. **Goodman et al** report info from parents better for detecting internalising disorders; from teacher, better for detecting externalising disorders. **Achenbach** argues it's the relationship between behaviour and social context – context-embedded - that is more relevant to explaining this.

- Different contexts mean that children may behave differently – e.g. home vs school
- Standards of behaviour expected differ between children (age, regulations, rituals)
- Those making the judgements vary in their expectations & tolerance of behaviours
- Relationship patterns differ in different contexts. Caregiver A + child A may produce harmony; Caregiver B + child A may produce discord.

'Goodness of fit' explanation – **Chess & Thomas**

Cross-cultural perspective – **Weisz et al;** study of 11-15 y.o. in Kenya/USA. US report children as being argumentative/disobedient; Kenyans report concerns on children's fears/anxieties. US children grow up in a permissive society; Kenyan children in more controlling environment.

Behaviour in one culture that is adaptive may be maladaptive in another – ***'ecological adaptiveness'*** **Bronfenbrenner & Morris** – social adjustment solutions vary at cultural, sub-cultural & individual levels.

Dunedin study reports 17% prevalence of disorders in children aged 11. From this, **White et al** found stability in anti-social behaviour from pre-school to adolescence. **Bates et al** found continuity in aggressive behaviours. Boys were not aggressive/highly aggressive/low level aggressive; Girls were either not aggressive or moderately aggressive, that declined over time.

Children may not therefore 'grow out' of their problems over time!

**Liu et al** – concept of ***'risk factors'*** – five key:

- Social background
- Parental attitudes
- Mother's mental state
- Father's behaviour
- Marital relationship

***Parents' roles in Problem Behaviour***

'I blame it on the parents' – draws attention away from the role children play in their problems (puritan innocence?) and from the collective responsibility of society. Has also become a foundation for some psychological theories on disturbed development.

**Kessen** – argues the influence in US of 'good mothering' and early experiences have combined with the idea that mother's are responsible for their children's welfare to produce a 'weapon of social control'. Beware ideologies that pretend to be psychological knowledge! Causal processes are more complex.

*Maternal Sensitivity*

**Murray & Stein** – experiment. 3 conditions. 1 natural perturbation – mother distracted; 2 unnatural perturbations – blank face and delayed reaction (video link). Condition 1 – child quiet; no distress. Condition 2 – strong reaction from child; try to engage then become self absorbed. Condition 3 – confusion, before become avoidant & self-absorbed, often distressed.

Demonstrates maternal responsiveness important; **Meins et al** criticise the idea of maternal sensitivity as ill-defined. Mind-mindedness more important.

*Mother's Attitudes*

Parties in a relationship ***think*** about each other, as well as express behaviour towards each other – they have an IWM of each other. Especially true for mother – trying to make sense out of her child's behaviour. The child also has expectations about their caregiver.

**Bor et al** reported mothers who had a –ve attitude towards their child at 6mo.o reported behaviour problems at 5y.o. **Dadds et al** found abuse-risk mothers rated their child's behaviour more negatively across 3 scenarios - even when it was a +ve situation. They attributed –ve behaviour to internal factors when viewing their own and an unfamiliar child. Supports **Stratton & Swaffer** earlier research findings that abuse-risk mothers view –ve behaviour as arising in the child and +ve behaviour due to situational factors.

*Role of Fathers*

NICHD study reports father's caregiving activities predicted by factors:

- Associated with the father
- Martial relationship
- The child

Father – child rearing beliefs, working hours, personality, age predict caregiving activities – more done if younger with +ve personalities; had fewer working hours.

Relationship – marital intimacy meant greater caregiving

Children – age and gender – 6-15months father's caregiving increases; stable afterwards; more involvement with sons.

Absent fathers – **Jafee et al** – 1,116 twin pairs of 5y.o. – Environmental Longitudinal Risk Study in England & Wales. Absence beneficial if father is antisocial. Suggests quality of father's relationship (rather than quantity) is key to development.

***Children's roles in Problem Behaviour***

*Directions of effect in human processes*

Beliefs about family & parenting as the cause of behaviour problems reflect a 'social environment' perspective – *child as a passive victim of circumstances*. **Bell** challenged this view by criticising a study by **Sears et al** that argued that there were close links between parental style and aggressive behaviour in children. The original study argued that it was a combination of parent's permissiveness & punitiveness that caused children to become aggressive. **Bell** reinterpreted the evidence that it was the child's temperament that determined aggression and that parental discipline strategies were attempts to modify behaviour. Later research (**Rutter et al**) backs this interpretation up.

*Transactional Model*

**Sameroff** argues a complicated could make a calm mother more anxious; feeds back into the first few month's of a child's life; child develops inconsistent feeding/sleeping patterns because of this behaviour; child becomes difficult; mother spends less time with child; lack of interaction leads to poor language development …

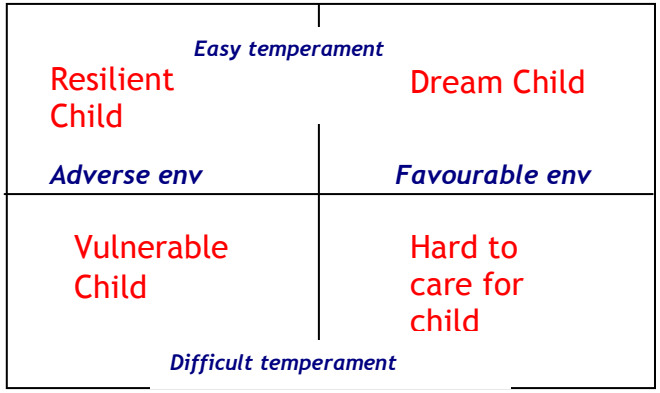
*Influence of temperament*

Controversial way of accounting for individual differences, according to **Oates & Stevenson**. Strong associations have been found between 'difficult' temperament at 4/5 y.o. and behavioural difficulties later on. Dunedin study shows differences in temperament were the only factor that distinguished between violent/non-violent offenders.

Evidence points to bi-directionality between parenting & temperament (**Gallagher**)

**Kochanska** – maternal behaviour and children's temperament interact in subtle ways. Fearful, inhibited children more compliant when low-power discipline used. In fearless children, attachment style more likely to determine compliance.

**Chess and Thomas** – 'goodness of fit' – the transactional relationship between child & environment. Results when child's capacities, motivations & temperament are well aligned to the demands, expectations and opportunities of the environment.




*Protective Factors*

For example – intelligence – **Tiet et al** – children at high risk of maladjustment mange to adjust well if they have a higher IQ. **Flouri & Buchanan** – boys with higher IQs protect against later criminality.

Interplay between risk & protective factors is dynamic. Different patterns of influence at different stages – e.g. starting nursery is often when a child's 'difficult' status is 'confirmed'.

*Temperament, attachment, maternal support*

Most studies into attachment suggest insecure attachment is due to mother's depressed mental state/unavailability/insensitivity/lack of reciprocity. However, **Waters et al** in a study of 100 infants found newborn irritability predicted an SST insecure attachment at age 1. **Crockenburg** extended this to show how infant characteristics interact with the environment in producing relationship difficulties. Found that more irritable infants less likely to attract responsive care, therefore more likely to show insecure attachment. Low irritable group formed secure attachments regardless of the amount of maternal support provided.

*Multiple pathways in developmental disorders*

Arguable that current research over emphasises the significance of the mother-child relationship. Discord between parents can be serious – **Hinde & Stevenson-Hinde** argue it is the complex system of relationships within families that should be the starting point for research.

Emotional/social problems don't always originate due to disturbance in social and emotional development. E.g, Language disorders linked to behaviour difficulties – **Ruttter & Casaer**.

*Gender*

Risk factors greater for boys than girls.

Gender may interact with parental attitudes/behaviour – e.g. **Berg-Nielsen et al** found low parental involvement caused more problems for boys. Father's lack of contact created more anger in sons than daughters.

Different (social) expectations of boys & girls also may have an impact.