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Differences in the Perception of Behavior Problems in Pre-school Children among the Teachers and Parents

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***Abstract*—**Even the behavior problems in pre-school children might be considered as a transitional problem which may disappear by their transition into elementary school; it is an issue that needs a lot of attention because of the fact that the behavioral patterns are adopted in the children especially in this age. Common issue in the process of elimination of the behavior problems in the group of pre-school children is a difference in the perception of the importance and gravity of the symptoms. The underestimation of the children's problems by parents often result into conflicts with kindergarten teachers. Thus, the child does not get the support that his/her problems require and this might result into a school failure and can negatively influence his/her future school performance and success. The research sample consisted of 4 children with behavior problems, their teachers and parents. To determine the most problematic area in the child's behavior, Child Behavior Checklist (CBCL) filled by parents and Caregiver/Teacher Form (CTF-R) filled by teachers were used. Scores from the CBCL and the CTR-F were compared with Pearson correlation coefficient in order to find the differences in the perception of behavior problems in pre-school children.

***Keywords*—**Behavior problems, child behavior checklist, caregiver/teacher form, Pearson correlation coefficient, pre-school age.

I. Introduction

BEHAVIOUR problems in preschool children might be characterized as "any repeated pattern of behaviour, or perception of behaviour, that interferes with or is at risk of interfering with optimal learning or engagement in prosocial interactions with peers and adults." [1]. This kind of behaviour most often has the form of disrupted sleeping and eating habits, physical and oral aggression, property destruction, severe tantrums, self-injury, noncompliance, and withdrawal. For children of this age, challenging behaviour is always embedded in the context of child-caregiver relationships and interactions. [2]. Egger & Angold [3] indicate that if we want to understand an early onset of mental and emotional issues *"we cannot begin later than in a pre-school period"*. However, Diagnostic and statistical manual of mental disorders (DSM-V) [4] pays only little attention to the problem behaviour in pre-school children. In the classification the DSM-V focuses on the caution need in diagnosing the opposite defiant disorder in terms of the normative level of transitionally defiant behaviours. Although the maladaptive behaviours, outbursts of anger, and physical fights are usually demonstrated in children as a part of the autonomy development, such a behaviour is not typical and might be a reason for concerns if its frequency and intensity is high and if it is demonstrated also in comfortable situations and in a company of strange adults (e.g. when we ask child to clean up his toys) [5], [6]. A reluctance occurred among the researchers when it comes to diagnosing the behaviour difficulties in pre-school children. It is due to the concerns related the difficulties in defining exact diagnose in terms of rapid developmental changes which play an important role in infant and pre-school age; and to labelling young children with psychiatric diagnose and belief that the problems in early childhood are more functional relationship problems with parents and environment [3], [6].

Concerns related to exaggerated pathologisation of normal development are important; however, the research has shown that the problem behaviors might be consequently differed from normative symptoms of disruptive behavior in this age, already [7]. Pre-school years are the period of rapid developmental changes, especially in terms of regulation of emotions and behaviors management [8]. Although there exists a consensus among the theoretical knowledge in a meaning that the problem behavior occurs in a continuum of pre-school age [3]. Smaller consensus is found in terms of the problem behavior that represents clinically significant issues which might lead to diagnosing conduct disorder in a later age.

There is an opinion which says that the preschool behaviour problems are influenced both by biological and environmental factors, as manifest in individual differences in child characteristics (e.g., temperamental dimensions of activity, sociability, attention) and the quality of the caregiving environment. Genetic and prenatal environmental factors are influential in this age. Simultaneously, it is necessary to distinguish between *risk factors*, in the presence of which the probability of showing a disorder is raised; *precursors*, where there is continuity between an early problem (e.g., preschool disruptive problems) and a later one (e.g., conduct disorder); and the presence of formal *disorder*. Extremely difficult temperament is often viewed as a risk factor for later behaviour problems [9]. Although, at moderate levels of difficulty and without other indicators of child or family risk, such individual differences are likely to reflect developmentally normative patterns rather than necessarily implying risk for disorder. Furthermore, there has been

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increasing recognition of the multiple interacting factors that contribute to divergence in outcomes of infants who demonstrate early problems in feeding, emotionality, or disruptive behaviour [5]. This change was reflected in the work [10], which emphasized the goodness-of-fit between parent and child temperament, to Bell's [11] work on children's effects on parents, and Sameroff and Chandler's [12] transactional model of parent–child interaction. This might lead to an assumption that assessment and intervention efforts across problem behaviour types have focused on changing child behaviour, parent behaviour and resources, and the quality of parent–child interaction. As children under 5 years are so dependent on their caregiving environment, there is an emphasis on identifying risk factors in the family and the wider caregiving context (e.g., quality of a kindergarten) which moderate the course of early problem behaviour.

It is necessary to be aware of a fact that the isolated presence of problems related to aggression, noncompliance, and negative emotion does not mean diagnose, and we always need to consider the persistence, pervasiveness, and patterns of such behaviour [6]. While identifying problem behaviors, it is important to focus on a behaviour that is inappropriate (e.g. hitting adults), often and serious (e.g. destroying materials around), and inflexible (e.g. child keeps saying "no" automatically) which means that he indicates inability to regulate his/her emotional state [5], [6].

II. Method

For gathering the data for two case-studies, we used Child Behaviour CheckList (CBCL) and Caregiver/teacher Reported Form (C-TFR) [14] to determine the most problematic area of the behaviour; semi-structured interview with parents and teachers of observed children, and structured observation in natural environment of the child – kindergarten. CBCL and CTR-F were filled up by the parents of examined child and his/her kindergarten teacher. According to the highest score, we determine the most problematic area of the behaviour. Subsequently, we compared the results from both parents, teacher, and the observer (author of the paper) with the Pearson correlation coefficient.

A. Participants

In the study we focused on two children with problem behaviors.

Daniel, boy, 5 years, 2 months

Daniel is cheerful and very communicative boy, but not very popular between peers in the classroom. Due to his impulsivity and over-activity, children did not like to play with him. Daniel also has a speech problem – dysarthria, and sometimes it is complicated to understand his words. Daniel has one older brother, mother is unemployed, and father works on constructions. Young family lives in a family house with father's parents and his grand-mother, so the household is shared by 4 generations. Daniel's grandmother works at the same school he is attending as a teacher's assistant. According to the interview with mother, grandmother's "will" to help with education and upbringing of her children, is very often the reason for fights with husband.

Tamara, girl, 4 years, 10 months

Tamara is very shy and quiet girl. During our first visit in the kindergarten, she was sitting alone at the table while other children were playing together. According to her teacher, Tamara did not talk to anyone in kindergarten first year of her attendance. After the teacher's urge, parents visited the speech therapist. However, parents found this visit as redundant and claimed that Tamara is very communicative at home. The agreed with cooperation, but did not cooperate much with us.

B. Measures

We used Child Behavior CheckList (CBCL 1 1/5 – 5) and Caregiver/teacher Reported Form (C-TRF).

Achenbach ASEBA Preschool Ages 1.5 - 5 years: ASEBA - Pre-School Module Ages 1.5-5 -The Child Behavior Checklist (CBCL/1.5-5) and the Caregiver-Teacher Report Form (C-TRF), revised in 2000, are a set of rating forms and profiles for the preschool-aged child. They replace the legacy (previous) editions of CBCL/2-3 and C-TRF/2-5. The profiles for the two instruments have the following 6 cross-informant syndromes: Emotionally Reactive, Anxious/Depressed, Somatic Complaints, Withdrawn, Attention Problems, and Aggressive Behavior. The CBCL/1.5-5 also has a Sleep Problems syndrome; while both forms have parallel Internalizing, Externalizing, and Total Problems scales. [13]

C. Procedure

The research took place in two kindergartens in Slovakia, in the eastern Prešov region in the school year 2014/2015. The boy was attending kindergarten in a village, and the girl was from the district city.

D. Data Analysis

The relations between respondents' answers were analysed by way of correlation analysis (the Pearson correlation coefficient used).

III. Results

In the case of Daniel the analysis of the CBCL and C-TFR completed by both parents, kindergarten teacher and the author (observer), shown that the most problematic area of Daniel´s behaviour was the problem with attention.

In view of the fact that all calculated correlation coefficients are positive, we can speak of positive linear relationship between variables. The lowest degree of correlation between each evaluation area, we observed between mother and observer (r = 0.468). This relationship can be evaluated as a mild degree of linkage. Significant correlation (i.e. stronger relationship) was recorded in the compared pairs "father x observer", "teacher x mother" and "father and mother" and comparatively well in a pair of "father x observer". The strongest correlation (resp. Relationship) was recorded between teacher and the observer.

TABLE I
CORRELATION OF ANSWERS IN DANIEL'S CASE

Analyzed couple	Correlation coefficient
Mother x Father	0,694653
Father x Teacher	0,703558
Father x Observer	0,562354
Mother x Teacher	0,614656
Mother x Observer	0,468249
Teacher x Observer	0,882784

In the case of Tamara, analysis of the CBCL and C-TFR completed by both parents, kindergarten teacher and the author, shown that the most problematic area of Tamara´s behaviour was the problem with her anxiety

TABLE II
CORRELATION OF ANSWERS IN TAMARA'S CASE

Analyzed couple	Correlation coefficient
Mother x Father	0,73970026
Father x Teacher	-0,24958211 (!)
Father x Observer	-0,49713208 (!)
Mother x Teacher	-0,18955638 (!)
Mother x Observer	-0,4201412 (!)
Teacher x Observer	0,39329559

Coefficients between father and teacher, father and observer, mother and teacher, and mother and observer were negative. Even coefficient between father and observer was on the border of mild correlation bond. A positive linear relationship was found between father and mother (with a significant level of correlation) and teachers and observers (with mild bonds).

In both cases, we can see significant differences in the perception of the behavior problems in children of pre-school age. Significance of the correlation is strongly connected with the parents' consideration of what is a "problem behavior". In Daniel's case, both parents agreed with cooperation and Daniel already visited clinician. Tamara's parents, as mentioned above, did not have any worries regarding her behavior. Also the correlation analysis has shown negative bonds with the teacher and observer. Another reason why Tamara's case was so controversial is that the quiet and shy children (those with internalizating problems) are very often over-looked and the teachers or parents do not see their isolation as a problem.

As outlined in these two case, many children with problems, especially young children who are not attending kindergarten, probably do not reach a professional support.

Children whose behavior is annoying to others are more likely to be sent to clinician than children whose behavior, even though equally disturbed, is calmer and less overt. It is the same with the children who are aggressive and overactive. They are more likely to be considered as a problem by parents or a kindergarten teacher than those quiet, withdrawn, and fearful children. Furthermore, it is likely that parents will seek help more readily if their child's challenging behavior is apparent outside the home as well. Thus the child who throws temper tantrums at home but is well behaved and cooperative around other adults will be less likely to be referred for help. But once a parent's concern is corroborated by the kindergarten teacher, help seeking is more likely. Similarly, when the behavior problems are accompanied by cognitive and/or language delays, parents may be more motivated to seek help in order to understand the severity of the cognitive problem and to obtain remedial intervention. Efficiently, it appears that cognitive and learning problems may be less threatening than behavioral ones or may be viewed by parents as more likely to require treatment [5].

Parents' previous experience with children, their implicit theories about the nature of development, their levels of tolerance for children's behavior, their developmental expectations, and their own definitions of "normality" will have an impact on their assessment of the need to seek help. Thus, for example, the parent who believes that early signs of disturbance are possible indicators of more serious, long-term problems (a continuity view) may be more likely to seek help than a parent who sees problematic behavior in preschoolers as merely a difficult phase of development (a discontinuity view). Similarly, parents with more limited tolerance for riotous and boisterous behavior may be more likely to seek a clinician than parents who are more child centered and tolerant of high levels of noise and activity [14].

IV. DISCUSSION

To understand the early onset and the early behavioral problems, and to prevent more serious conduct problems later in life, we cannot start later than in the pre-school period [3]. Although, specific personality factors play an important role in the development of problem behavior. Further child's personal performance in the school environment, family and environmental factor also contribute to the child's ability to regulate its emotions and behavior. It was found that the amount of family and environmental factors that are associated with the formation and development of problem behavior are very often the problems in the regulation of emotions in children of pre-school age (e.g. strict upbringing, substance abuse, mental illness of a parent, low socioeconomic status, exposure to domestic violence, etc.) [15]. Despite the fact that any of those factors alone is not a "red flag" (i.e. the presence one of the factors does not necessarily mean a diagnose of conduct disorder), aggregation, and accumulation of the risk factors are more likely associated with the onset and development of clinically significant problems in the behaviour of children.

Opinion that all children will grow up from their behaviour problems and overcome all the problems is not supported in the literature. Therefore, an attitude *"wait and see"* is not appropriate for the families with children with challenging behaviour.

Identification, intervention, and rehabilitation are the most important [16]. Both, early intervention and identification support positive outcomes in the elimination of the behaviour problems elimination. Early identification and rehabilitation has shown to be beneficial, in terms of the reaction of a child to an intervention prior to the fixation of the problem behavior's patterns into his brain and the subsequent

functioning in later life [17]. Early intervention offers an opportunity to intervene and thus influence the problem behaviors processes. Rehabilitation in a pre-school period is more than beneficial as the mastery of behaviour develops mainly in this period and thus provides a possibility to modify regulatory abilities [5]. Early detection and intervention of the problems in children plays an important role in a successful school adaptation. Whereas the lack of intervention might possibly negatively influence a child in various areas of his/her social and emotional functioning [18].

Increasing need for special-educational services and attention focused on the social and emotional development of children in pre-primary and primary education is obvious [19]. Therefore, there rises the necessity for consequent education of the pedagogical employees in a field of social and emotional problems, so the behaviour problems in preschool children. Education related to differentiation of typical and transient behaviour problems vs. long-term and serious behaviour problems, difficulties related to the emotional regulation and understanding of risk factors offers the pedagogical employees important information that might be helpful in identification of children and families who need intervention. When the children demonstrate, or when their parents notice such behaviour, a teacher has to recognize when there is a reason for concerns and when it is appropriate to seek for help in any other professional [20].

Early identification of children at risk for future conduct disorder id based on the idea that behaviour is predictable. Preventive and therapeutic interventions are based on the assumption that problems may persist in the absence of treatment. Maladaptive behaviour is often stable but, in the face of appropriate environmental interventions, change and transformation are possible. An extreme continuity view might lead to the conclusion that problems are likely to be outgrown in the absence of treatment, as part of a normal developmental transition. Whereas some behaviors, such aggression, appear to be relatively resistant to treatment, providing support for continuity position, some children at high risk for psychopathology appear to develop normally, providing support for the competing discontinuity view. Extreme adherence to either position, however, is probably an oversimplification. It seems to be clear that a more complex view that highlights the interaction among child characteristics and environmental factors, some stable and some changing, will be necessary to identify children at risk and to pinpoint directions for intervention. [5]

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