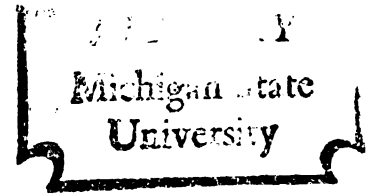




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## ABSTRACT

### THE AGREEMENT BETWEEN PARENTS IN PERCEIVING THE BEHAVIOR OF CLINIC AND NON-CLINIC CHILDREN

By

Lisa B. Partyka

The present study compared the agreement in perception between parents of clinic children and those of non-clinic children. It was hypothesized that parents of clinic children would exhibit significantly less agreement in the perception of their child's behavior than would parents of non-clinic children. More discrepancy and ambiguity of parental norms and expectations in clinic families was cited as the main reason supporting the first hypothesis. It was further hypothesized that no significant differences in parental agreement would be found as a function of the age or sex of the child. An attempt was made to differentiate those checklist items attributed to clinic children and those perceived as characteristic of non-clinic children.

The Children's Behavior Checklist was completed by the parents of 81 children referred to the Michigan State Psychological Clinic and by the parents of 96 children attending local elementary schools who had not been referred to a mental health agency. Statistical analyses demonstrated that adjustment, sex, or age alone did not produce significant differences in parental agreement. The adjustment-sex and adjustment-sex-age interactions, however, did have a significant effect on parental agreement. Parental agreement for 5-7 yr. old non-clinic males was significantly greater than parental agreement for 5-7 yr. old clinic males, 8-11 yr. old non-clinic males, and 5-7 yr. old non-clinic females. These results were attributed to age and sex-related differences in the parent-child relationship and to the greater definition and stereotyping of masculine behavior in our culture.

Further statistical analysis of the checklist revealed that items describing competence, control, and interpersonal skills were attributed to non-clinic children, while items concentrated in the areas of (low) impulse and motor control were perceived as characteristic of clinic children. The potential uses of the checklist as a research and clinical instrument were discussed. Recommendations for further research on the relation between parent's perception and other parent and child variables were proposed.



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PERCEIVING THE BEHAVIOR OF  
CLINIC AND NON-CLINIC  
CHILDREN

By

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A THESIS

Submitted to  
Michigan State University  
in partial fulfillment of the requirements  
for the degree of

MASTER OF ARTS

Department of Psychology

1971

GL1376

To Nana

With love and gratitude

## ACKNOWLEDGMENTS

Sincere appreciation is extended to Dr. Lucy Rau Ferguson, my Thesis Committee Chairman, for her invaluable guidance, encouragement, and suggestions throughout all phases of this research. Dr. Ellen Strommen and Dr. Lawrence Messe', the other two members of my committee, and Mr. Paul Wiesbord, a patient statistician, likewise deserve thanks for their assistance and participation.

Gratitude is also expressed to all those who took part in this research. The Parent-Teachers' Association of the Barnes Street Elementary School in Lansing, the Children's Cooperative Nursery School in East Lansing, and Mr. Craig, Principal of the Sycamore School in Holt, deserve special mention for their help in the collection of data.

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## CHAPTER I

### INTRODUCTION

#### Introduction

In an attempt to isolate parent correlates of child behavior, child development researchers have focused on either parental attitudes or parental behavior. Indirectly, they have tried to assess the parent-child interaction by relating particular parent attitudes and modes of parent behavior to type of child behavior. Another approach, which has greater potential than has been recognized, is a study of the parent's perception of a child.

That a person reacts to the stimulus he perceives is hardly a debatable point. Yet, researchers have tended to neglect this fact when investigating the determinants of parent and child behavior. They have thus short-circuited their paradigm and have neglected to question the parent stimuli the child is perceiving and the child stimuli the parent is perceiving. The present study attempted to expand the usual behavioral paradigm by including the intervening variable of perception. Specifically, the parent's perception of the child's behavior was the focus of investigation.

Perception is influenced by a multitude of variables.

The perceiver interprets the sensations he receives from a stimulus in light of his past experiences. Then he reacts according to the interpretation he gives to the stimulus, or stated differently, according to the meaning that the stimulus holds for him. So it is with the parent and child. The parent perceives and reacts to the child in terms of how he interprets the child's behavior. Likewise, the child's perception and reaction are dependent on the meaning that his parent's behavior has for him.

For present purposes, variables influencing parent perception are of importance. Lois Meek Stolz (1967), in discussing the factors operating on a parent in the parent-child interaction, summarized her ideas in the diagram below (p.279):

<u>Past</u>	<u>Present</u>	<u>Immediate</u>	
Childhood experiences	Personal characteristics	Parent's goals	
Adult experiences	Values	Parent's urges	
	Beliefs	Perception of child	Parent → Child behavior ↔ behavior
	Spouse interaction	Behavior setting	

Although Stolz does include the parent's perception of the child, she is referring to the parent's immediate perception when he attends to a child at any one point in time. The present study was concerned with parent's overall perception of a child which is created over time. Despite this difference in perspective, the past and present factors which are listed are appropriate for both considerations of perception. They influence perception at the



moment of interaction and at times when the parent is merely describing his child.

As is apparent in Stolz's diagram, a composite of variables influences a parent's behavior. Independent parent factors, as well as the stimulus properties of the child, interact to form the perception that determines parent behavior. A study of perception is useful in the sense that it reveals both the parent and child variables which have influenced the parent's behavior. By relating his perception of his child, a parent is actually describing his child as a stimulus to which he is reacting. He is pointing out behavior to which the parent is sensitive. He is giving his view on the development of the child and his opinion about other socializing influences on the child. He is showing acceptance or non-acceptance of the child's behavior. Stated succinctly, he is giving a full description of the effect that the child has on him.

Simultaneously, the parent is revealing his own needs, satisfactions, expectations, demands, likes, dislikes, etc. which he has imposed on the child. That is, he is indirectly revealing the parent factors which influenced his perception. One way of conceptualizing perception is as a global assessor of parent variables. It is formed as a result of the interaction of all the parent variables with the child variables.

Focusing on parent perception also has the potential of revealing the quality of the parent-child relationship.

The degree of involvement that the parent expresses, the position he gives his child in the family system, and the favorableness of his attitude toward his child, are indications of the type of relationship and interaction that exists between them.

Besides describing the child as a stimulus for the parent, parent's perception reveals the type of stimulus the parent provides for the child. The criticalness or sensitivity of the parent's comments, their child rearing attitudes with regard to this particular child, and the parental norms reveal the parent stimuli to which the child must respond. Obviously, no one study of parent perceptions can do all these things, but one may focus on one or the other determinant or outcome of parent perceptions, depending on the instrument used to assess them and the other variables included in the study.

#### Criticism of Research on Parent Attitudes

Voluminous studies have been directed toward correlating parent attitude with child behavior. Researchers had singled out attitude as a parent variable which had a significant effect on the quality of the parent-child interaction, and consequently on the behavioral development of the child. While parent attitude may very likely be one of the more significant parent variables correlated to child behavior, criticisms can be leveled toward an approach which merely assesses general child rearing

attitudes.

Medinnus & Curtis (1963) provide the first criticism when they stress that a parent's attitude toward a particular child must be considered along with general child rearing attitudes. Whether or not a parent acts in accordance with his professed child rearing attitudes depends on the parent's feelings for that particular child. What Medinnus & Curtis seem to be saying is that the child's personality traits or other characteristics (e.g. his sex), modify the parent's behavior. General parent attitude scales cannot detect such effects. In contrast, parent's perception measures the parent's attitude with regard to a particular child.

The first criticism leads directly into the second. That is, general parent attitude scales assess only one of the many parent variables which influence a child's behavioral development. The particular attitudes which Medinnus & Curtis speak of are just one of these other parent variables. A parent's attitude and behavior are modified according to the impact that the child's behavior has on the parent. Again, parent's perception may reflect precisely the child's impact on the parent.

The many contradictory findings for the correlation between parent attitude and child behavior can be explained partially by the limitations of studying just general parent attitudes. Before presenting drawbacks from methodological differences, a brief account of some



pertinent research on the correlation of parent attitudes with child's adjustment and behavior problems will be given.

Mark (1953) reported a correlation between maternal attitudes and son's behavior. From measures on the USC Parent Attitude Scale, Mark observed that mothers of schizophrenic males were more restrictive than mothers of non-schizophrenic males. In addition, the mothers of schizophrenic males exhibited an attitude of ambivalence by vacillating between excessive devotion and cool detachment toward their sons.

Paternal attitudes were found to be related to child's behavior problems by several researchers. Peterson, Becker, Luria, & Hellmer (1961) found that a strict, cold, aggressive attitude characterized the fathers of children with personality, conduct, and autistic problems. A positive correlation between paternal attitude on the authoritarian-control dimension of the PARI and adolescent hostility was reported by Chorost (1962).

Using the USC Parent Attitude Survey, Shoben (1949) was able to demonstrate a positive relationship between parent attitudes and child adjustment. Winder & Rau (1962) observed an attitudinal pattern of ambivalence, punitiveness, demands for aggression, restrictiveness and low maternal self-esteem to be characteristic of the parents of socially deviant preadolescent boys.

Several studies have found no correlation between

parent attitudes and child behavior. Brown (1942) found no significant differences between parent attitude scores of mothers of well adjusted and poorly adjusted children. Leyton (1958) likewise reported no difference in attitude between parents of well adjusted and maladjusted children. The PARI scores of mothers of schizophrenics were no different from the scores of control mothers in Zuckerman, Oltean, & Monashkin's study (1958).

It is quite probable that the contradictory findings of these few studies are related to differences in instruments used to assess both parent attitude and child behavior, and to the type and size of samples used for the studies. However, before a correlation between parent attitude and child behavior can be assumed, another question needs to be raised. What parent variables are the studies actually measuring?

Studies concerned with parent attitudes have been based on an assumption which researchers have begun to question. Although the focus has been on parent attitudes, many studies have assumed that parent attitude is an accurate reflection of parent behavior. The methodology used in these studies was designed according to the supposed validity of this assumption. That is, the self report measures of parents which have been used extensively in research concerned with parent-child relations, has assumed that professed attitude was predictive of actual behavior. Radke-Yarrow (1963) has questioned the validity of such

self-report instruments as the interview and questionnaire in reporting actual parental practices. Ferguson & Rowland (1969) have suggested that these same instruments do give valid measures of parent attitudes but not of parent behavior. Other studies, such as those of Crandall & Preston (1955), Gordon (1957), and Mannino, Kisiielewski, Kimbro, & Morgenstern (1968) have failed to demonstrate a direct relationship between expressed attitudes and observed behavior. The fallacy of the assumption is indicated by these findings.

Thus, while a correlation between parent behavior and child behavior may actually exist, many studies have lacked the proper design to assess such a relation. It is possible that the studies which did find this relation used instruments which accurately assessed parent behavior (even though this was labeled parent attitude) and that those that failed to demonstrate the correlation, employed measures which were inaccurate estimators of parent behavior. The methodological issue can be extended by suggesting that parent variables other than attitude and behavior could have been measured by the various instruments. Differences in results may be explained further by this suggestion.

#### Issues Involved in the Study of Parents' Perception

Having recognized the drawbacks of focusing on parent attitude alone as an estimator of the parent-child relationship, it can be suggested that a study of parent's

perception is a useful approach. A parent's perception of a child yields specific information about the child, the parent, and the relationship between them.

As has been previously mentioned, perception is influenced by many parent and child variables. Some parent variables which have been empirically investigated are reported by Sears, Maccoby, & Levin (1957). These researchers found such factors as high child rearing anxiety, low self esteem, dissatisfaction with current situation, low value for the mother role, low esteem for husband, and high disagreement with husband about child training matters to be related to a mother's perception of aggression in her child. Thus, it is apparent that variables independent of the child influence a mother's perception of her child and will consequently contribute to the type of interaction that exists between her and her child. The factors listed above can be considered parent attitude measures. However, it must be remembered that the researchers were studying mother's perception and not child's actual behavior. Therefore a relation between mother's attitude and child's behavior was not ascertained by this study.

When a parent is describing the behavior he perceives in his child, he is hampered by his lack of knowledge about behavioral norms for children. Cotler & Shoemaker (1969) found that mothers who rated their sons favorably on a Q sort and Self Esteem Picture Test did not make higher estimates of their son's performance on a Block Design

test than did mothers who held less favorable opinions of their sons. Instead, all mothers seemed to predict average performance for their child. When the mother was asked to describe her son's performance relative to other members of his own cultural subgroup, her account was accurate. When the mother was aware of a norm, she could then make an accurate judgment.

Sears, et al. (1957) also discuss the lack of "standard perspective" that characterizes mothers when they are asked to discuss their child's dependent behavior. What may be very dependent behavior to one mother, may be little or average to another. Both of these studies emphasize the "normless" quality of parents' perceptions. It must be remembered that a parent's perception is a description of the behavior as the parent sees it, and is not a direct and objective measure based on norms for all children.

The instruments used to measure parent perception have been mainly the Q Sort (Cotler & Shoemaker, 1969; Medinnus, 1961; Miller, 1964; Van Der Veen, Huebner, Jorgens, & Neja, 1964), the checklist (Griffiths, 1952; Peterson, Becker, Luria, & Hellmer, 1961; Wyer, 1965), and the interview (Clark & van Sommers, 1961; Eron, Banta, Walder, & Laulicht, 1961). The present study assessed parent's perception by using a Children's Behavior Checklist (constructed by Ferguson, Mac Kenzie, & Does). Both the content of the parent's perception and the agreement in perception exhibited by sets of parents were considered in different

phases of the study.

### Statement of Hypotheses

The first part of the present study concerned the amount of agreement in perceptions shown by parents of clinic children and parents of non-clinic children. Agreement was taken as a measure of the consistency of parental demands, expectations, needs, satisfactions, attitudes, etc. confronting the child. It was expected that parents of children referred to a clinic would show less agreement in perception of their child than parents of non-clinic children. This expectation was the first hypothesis tested.

In order to detect some of the child variables which influence parents' perception, a second hypothesis was posed. The influence of sex and age of the child were the child variables investigated. No significant differences in the agreement of parents' perception were expected (as a function) of sex or age of the child.

### Research Relevant to Present Study

Some disagreement in the perception of their child's behavior was expected for all parents. Differences in individual needs, satisfactions, expectations, and demands, and dissimilar opportunities to observe the child explain this disagreement. However, the disagreement between the parents of clinic children was expected to be exaggerated. The rationale for this greater amount of disagreement will

be given later in the paper.

Reasons for a certain amount of disagreement between parents are provided by several studies. Aberle & Naegle (1952) found that middle class fathers were more concerned with boys' behavior than with girls'. Girls were expected to just be sweet and nice, whereas the fathers wanted the boys to show competence, athletic ability, stability, self-restraint, and initiative. This finding suggests that a parent's increased attention to specific behaviors in a son or daughter could produce a difference in perception of that son or daughter.

Mothers' and fathers' differential reactions to sons and daughters were reported by Rothbart & Maccoby (1966). Using as a stimulus a young child's voice which was ambiguous as to sex, parents were asked to respond to different statements made by the child. The trend was for parents to demonstrate greater permissiveness for dependency and aggression when they were told that the child was of the sex opposite to theirs. The parents set different limits for these two types of behavior in each sex child, and thus, they would be expected to differ in the extent to which they considered the child's behavior dependent or aggressive. This study also demonstrates that the parent's reaction was based on his perception of the sex of the child.

Eron, et al. (1961) compared mother's and father's perceptions of their child's behavior and of their interactions with their child. Through administration of a



Guess-Who reputation measure to a population of third graders, the investigators chose a sample of 20 most aggressive children. Each group of 20 was evenly divided between males and females. The mothers' and fathers' perceptions were obtained in an extensive interview which was conducted independently for each parent. The investigators found that mothers and fathers did not agree to an appreciable extent in rating their child's behavior or their interactions with their children. They concluded: "...Thus, it is not that the parents cannot render reliable information, but perhaps mother and father each observes and reacts to children differently, and the observations and reactions of each must be taken into account to get a complete picture of parental socialization influences on child behavior" (p. 465). Although inconsistency between parents seemed to be the rule, an association was found between significant agreement in parent perceptions and type of behavior exhibited by the child. When mothers and fathers agreed that guilt was not denied by their child, low aggressive behavior usually characterized the child. Parents' agreement that guilt was denied was associated with high aggression in their child. Median aggression in the child was related to parents' disagreement on this matter.

Parents' Q sort descriptions of their five year old children were investigated by Medinnus (1961). Mothers and fathers each gave real and ideal sorts (or perceptions) of their child's traits. Interparent agreement was found to

be higher for the real rather than ideal sorts, thus indicating that parents agreed more in the way they perceived their child than in the goals they set for him. When compared to the high agreement found between groups of fathers and groups of mothers, interparent agreement between individual mothers and fathers was only moderate.

Miller (1964) studied the correlations between teachers, parents, and clinicians in Q sort ratings of normal children and children referred to a clinic. Generally, interjudge agreement on Q sort ratings (or perceptions) of a child's personality and interpersonal skills was low. However, agreement was higher for non-referred than for referred children. For the referred children, only parent-parent correlation reached significance.

#### Rationale for Greater Disagreement Between Parents of Clinic Children

Van Der Veen, et al. (1964) studied the relation of family adjustment to parents' agreement in perception by asking mothers and fathers independently to describe their family with the Family Concept Q Sort. Parents of the low adjustment families showed significantly less agreement in their perceptions than the parents of the high adjustment families. The investigators report: "...This result strongly supports the hypothesis that one aspect of family adjustment is the amount of agreement between the father and the mother on the way they perceive the family, and that less adequate family functioning is associated with less agreement

between the family concepts of the parents" (p. 52). In addition to this greater disagreement, the parents of the low adjusted families showed greater dissatisfaction with the family by having real sorts which were less like the ideal sort (arranged by a group of professional psychologists) than were the real sorts of parents of the high adjusted families. Marital dissatisfaction, measured by a Marital Questionnaire, was also found to be positively correlated with the amount of disagreement in parents' perceptions of the family. Since clinic children are more likely to come from poorly adjusted families than are non-clinic children, greater disagreement was expected between the parents of clinic children.

A possible explanation for discrepancies of perception between parents of clinic children is given by Wyer (1965). Basing his formulation on the view that a person's self-perception is partially derived from others' perceptions of that person, Wyer states that "a discrepancy between perceptions of their child by father and mother may create ambiguity in the child's perception of himself" (p. 311). He extends his theory by saying that a state of cognitive imbalance is created within the child faced with such ambiguity. Consequently, the child may either fail to develop behavior patterns that lead to positive self evaluation or he may be hindered from forming a realistic and acceptable self-perception, and thus be disposed to ineffective goal seeking. Related to the clinic child, Wyer's formulation

links the presence of maladaptive behavior in the child to the ambiguity that the parents create through their disagreements.

While it is possible that a child may not have learned adaptive behavior patterns in a family where parents are ambiguous in their attitudes and evaluations, it is also likely that the child could be acting out a parental conflict. If the parents do not come to some agreement about the norms they will set for the family in general and for the child in particular, it is quite plausible that the parents are in conflict themselves. Radke (1946) has suggested that a child's acting out behavior results from his sensitivity to moods and affectional relations within the family. Thus, the acting out behavior of clinic children could be indicative of the conflict and disagreement between parents.

Clark & van Sommers (1961) provide a third reason for expecting more disagreement between parents of clinic children. By studying the family relations of 20 children who were rated as maladjusted in school and who had a third adult living with their family, the investigators found that such children were subject to the contradictory demands of the parents. The entrance of a third adult to a family system often creates unsatisfactory relations between the parents. The child is caught in a power play and is used by one parent to undermine the other. Since the child is expected to show his allegiance to both parents, he is

beset with a conflict. His maladjusted behavior is reflective of this conflict. Although all clinic children do not have a third adult living in their families, parental contradictory demands may be operating to produce conflict in them.

The low interpersonal perceptivity that Ferreira (1964) found in abnormal families can be cited to support the expectation of greater disagreement between parents of clinic children. Normal and abnormal families composed of both parents and a child aged 10 or more participated in his study. Each member of the family was asked to color 11 flags which were then put in an envelope bearing the name of the member who colored them. Each member was then asked to guess how many of the flags would be disliked or "rejected" by each of the other members. Interpersonal perceptivity, as measured by the number of correct guesses, was found to be greater in children than in adults. Although no significant difference in amount of correct guesses was shown for members of both the normal and abnormal families, interpersonal perceptivity was found to be greatest for certain diads in the normal families. That is, members of the normal families tended to make the same type of guesses about each other's behavior. When one member of a diad would anticipate high or low rejecting behavior from the other member, the other member tended to predict the same behavior (i.e. high or low rejecting) for the first member. Ferreira concluded that interpersonal

perceptivity is a quality of a relationship rather than of an individual. It is the mutuality and reciprocity characteristic of normal families that heightens interpersonal perceptivity. In abnormal families, perceptivity is greatly reduced by the members' failure to communicate and promote an honest exchange of ideas and feelings. For the present research, it can be suggested that the low interpersonal perceptivity in families of clinic children will cause greater disagreement in parents' perceptions.

The research cited above provides four reasons for predicting greater disagreement in perception between the parents of clinic children, viz. ambiguous parental evaluation, parental conflict, contradictory demands placed on the child, and low interpersonal perceptivity among family members. A fifth reason can be found in the interpersonal relations in families with a maladjusted child. Frequently characteristic of such families is a pattern which shows the child allied with one of the parents, to the exclusion of the other. With such an arrangement, it is expected that the excluded parent would be more critical of the child's behavior, while the allied parent would be more favorably disposed.

#### Demonstrated Relation Between Parent Disagreement and Child's Behavior

Several studies report a direct correlation between parents' disagreement and child's behavior. Wyer (1965)

studied the interrelations of self-acceptance, discrepancy between parents' perceptions of their children, and academic effectiveness for 750 college men and women. By administering an adjective checklist to the students and their parents, Wyer measured the self-perception and self-acceptance of the students, and the parents' perception and acceptance of their children. Parent attitude concerning the purpose of college was also assessed. The discrepancy between parents' perceptions was related negatively to females' self-acceptance and to males' and females' academic effectiveness. Parent agreement as to the purpose of college was related to academic effectiveness in males. Thus, it is apparent that a child's goal seeking behavior and self-acceptance are affected by parents' disagreement in perception and attitude.

McCord, McCord, & Howard (1961) observed the families of 174 boys labeled either aggressive, assertive, or non-aggressive. The parents of the aggressive boys displayed much marital dissatisfaction and a high degree of disagreement concerning methods of child rearing. The investigators concluded that such homes instilled aggressive urges in the boy but gave him no model of control. Thus, it is likely that parents who disagree on issues may produce a confused and relatively uninhibited child.

Becker, Peterson, Hellmer, Shoemaker, & Quay's (1959) model for the origin of uncontrolled aggressive behavior in



a child is congruent with McCord, et al's. conclusion. According to this model it is the presence of a dictatorial mother and an ineffective father who give vent to unbridled emotion and who are inconsistent and arbitrary in their disciplinary practices that prompts the child to behave in an aggressive and uncontrollable manner.

A relation between areas of husband-wife conflict of parents of neurotic children and independent clinic ratings of corresponding problem areas in the child's behavior was found by Gasner & Murray (1969). Measures calculated from using the Revealed Difference Technique, showed that parental conflict in the areas of achievement, affiliation, and aggression were related to child's underachieving, withdrawing, and aggressive behavior. This specificity of parent conflict and child behavior suggests that the disagreement parents exhibit in their perception of certain behaviors or areas of behavior in the child could indicate the types of problems that the child is experiencing. Parental perception here has the potential of revealing the parent variables connected with specific behavior problems in the child.

The degree of disagreement parents exhibit may be indicative of the parents' own pathology. Liverant (1959) found that MMPI scores of parents of children showing deviant behavior reflected that the parents themselves were pathological. Although Rosenthal, Finkelstein, Ni, & Robertson (1959) observed only the mother-child interaction, they did find that the type of the mother-child relation was

related to particular behavior problems in their child. Thus, the quality of the interaction had specific effects on the behavior of the child.

The impact of the parents' disagreement on the child can be assessed most directly by looking at the child's perception. Serot & Teevan (1961) have suggested that a child's adjustment is related to his, rather than to his parents', perception of the parent-child relationship. If, for present purposes, the child perceives disagreement and dissatisfaction between his parents, then the likelihood of his becoming maladjusted is greater than if his parents were compatible.

Droppleman & Schaeffer (1963) reported that males do tend to perceive their mothers and fathers differently. The father is regarded as the source of authority, but the source of discipline is attributed to the same sex parent. Thus, children normally perceive some differences between their parents. However, to the clinic child, this difference is exaggerated. Vogel & Lauterbach (1963) found that behavior problem adolescents perceive more disparity between their parents than do normal adolescents. The problem adolescents regarded their father as rejecting and punitive, but they tended to idealize their mothers. This exaggerated difference in child's perception reveals that the parents' crucial effect on the child was precisely this disparity. The child experienced a difference, if not a contradiction or ambiguity, in parental characteristics.

### Behavior of Clinic and Non-Clinic Children

In order to gain some knowledge of the behavior perceived in clinic and non-clinic children, the second part of the present study attempted to label those behavior items which differentiated clinic children from non-clinic children. Objectively, this differentiation was aimed at classifying behavior. Subjectively, it detected those behaviors in the child to which the parent is most sensitive and to which the parent responds in interaction with his child.

The reliability of parents' judgments (or perceptions) about their child's behavior is supported by empirical data. Glidewell (1963) reported a positive correlation between a mother's description of her child's symptoms and a teacher's rating of the child's maladjustment. Comparing parents, teachers and clinicians, Miller (1964) found that parents consistently showed the greatest amount of Q sort agreement when describing their child's personality traits. Miller concluded that the time and attention parents give to a child accounts for the stability of their perceptions. A few other studies (Griffiths, 1952; Peterson, et al., 1961) have used parents' perceptions to diagnose a child's behavior problems.

To briefly summarize the hypotheses in light of the literature, it is expected that parents of clinic children

would exhibit significantly less agreement in the perception of their child's behavior than would parents of non-clinic children. In addition, no significant differences in parental agreement are expected as a function of the age or sex of the child. The Behavior Checklist items differentiating clinic from non-clinic children will also be investigated.

## CHAPTER II

### METHOD

#### Subjects

The total sample consisted of 177 children who were specified as members of either the clinic or the non-clinic group. The clinic group included 81 children who had been seen at the Michigan State Psychological Clinic. The 3:1 sex ratio of the 61 males and 20 females in the clinic group typifies the sex distribution found in the population of children exhibiting deviant behavior. The non-clinic group was composed of 96 children, coming from the same geographical area as the clinic children, but who had no record of being referred to a mental health agency. The 49 males and 47 females in the non-clinic group approximated a 1:1 sex ratio. The children ranged from 5 to 11 years of age, with the clinic children having a mean age of 8.60 and the non-clinic children a mean age of 8.36. Within each adjustment group, the children were placed into a 5-7 year or an 8-11 year age level. The numbers and mean ages of the children in each adjustment-sex-age group are summarized in Appendix A. The Children's Behavior Checklist and an identifying data sheet were completed by both parents for each child in the sample. SES scores, based on

Hollingshead's (1957) 5 level scale were computed to be 2.85 for the clinic group and 2.97 for the non-clinic group. Appendix A summarizes the distribution of SES scores for children within each of the adjustment-sex-age groups.

### Instrument

The instrument used to assess parental perception is a checklist of 154 interpersonal and symptomatic items referring to the behavior of children, compiled by Ferguson, MacKenzie, and Does at Michigan State University. The items for the behavior checklist were taken from parents' descriptions of children and from observations of children in play therapy and in classes for the emotionally disturbed. An attempt was made to include readily observable rather than inferential behavior items. The checklist contains two columns, one marked applicable and one characteristic. Since the terms applicable and characteristic are not defined by the checklist, it is assumed that there will be differences in the parents' own subjective judgments as to what these terms mean. The parent is asked to go through the checklist twice, the first time checking those behavior items which apply to his child and the second time marking those items which are also characteristic of the child's behavior. (A copy of the checklist is included in Appendix D.)

### Procedure

Behavior checklists for the clinic sample were collected at the Michigan State Psychological Clinic over a six year period. Each parent of a child referred to the clinic completed a checklist. Thus, behavior checklists were available from both the father and mother of most children. The demographic data of mother's and father's age, occupation, education, and the present family constellation were taken from information sheets filled out as part of clinic procedure for new referrals.

Behavior checklists for the non-clinic sample were obtained from parents of children attending school in the central Michigan area. The investigators distributed stamped, addressed envelopes to children in a public elementary school in Holt, Michigan, requesting that these envelopes be brought home to the child's parents. The envelopes contained a letter to the parents asking their cooperation in child development research, an information sheet requesting the demographic data necessary to compute SES score, and two checklists to be completed independently by each parent. (See Appendices B, C, and D.) The parents were asked to return the checklists and information sheets by mail in the envelope provided.

The investigators also distributed envelopes during PTA meetings to parents of children attending a public elementary school in Lansing, Michigan, and to parents of children attending a nursery school in East Lansing,

Michigan. The parents were likewise requested to return the checklists and information sheets by mail in the envelopes provided.

Approximately 20% of the total number of envelopes distributed were returned. 104 sets of parents responded by filling out and mailing back the two behavior checklists and the information sheet. This percentage of return suggests that the non-clinic sample cannot be considered representative of the total population of parents, but it does provide a reasonable contrast group for the clinic sample. Since sensitive and concerned parents would be more likely to participate in child development research, the results would presumably be biased in the well adjusted direction.

Although 104 sets of checklists were collected, only 96 were used for the non-clinic sample. Eight sets of checklists were eliminated on the suspicion that the parents may have consulted when completing the checklists. A criterion of 5 disagreements between parents was set in order for a child to be considered as part of either the clinic or non-clinic sample. Four subjects were eliminated from the clinic sample on this basis.

### Scoring

Since the first two hypotheses concerned amount of parental agreement characteristic of clinic and non-clinic children, and of the various age and sex groups, it was



necessary to derive measures of parental agreement. The behavior checklists completed by both parents for each child were considered in calculating the measure of parental agreement for that child. In analyzing the data, each child was assigned three scores, corresponding to the three indices used to measure percent agreement between parents. Because the parents were asked to describe their child by noting the characteristic items, the applicable items, and the non-applicable items (by not checking), the investigators wondered whether percent agreement differed as a function of the extent to which the parents described their child. That is, the question posed was how percent agreement differed when parents were asked to cite just characteristic items as opposed to citing characteristic and applicable items or citing characteristic, applicable, and non-applicable items. The parent's judgment about the salience of the behavior in the child's repertoire was also revealed by this method of scoring.

Index 1 considered only those items which had been checked as characteristic of the child. It was calculated by dividing the total number of items checked as characteristic by either parent into twice the number of items both parents agreed were characteristic. As in the other two agreement indices, this index score disregarded the content of the items. It merely represented overall agreement in the parents' perception of that child. Thus, Index 1 represented the percentage of agreement parents exhibited in

their choice of the items they regarded as characteristic of their child. Index 1 represented the parent's most subjective appraisal of the child since it selected those items which the parent considered as most significant in the child's behavior.

Index 2 considered those items which were checked in either the characteristic or applicable columns. It was calculated by dividing the total number of items checked as characteristic or applicable by either parent into twice the number of characteristic and applicable items that the parents agreed on. In other words, for Index 2, an item was not scored as an agreement if one parent considered it characteristic and the other merely applicable. This index allowed for a broader description of the child than did Index 1, since it accounted for behavior which was noticeable as well as characteristic. In a sense, however, it is a stricter index than index 1 since it measured the parents' agreement in choosing items which characterize the child and those which merely apply. It measured agreement among a wider range of behaviors.

Index 3 considered both checked and unchecked items. It was calculated by dividing the total number of items in the checklist into twice the number of items agreed on (considering all checked and unchecked items). Index 3 allowed for an indirect description of the child because it regarded agreement on unchecked items as an indication that the child did not exhibit the behavior described in that

item. Index 3 was thus a measure of the parents' agreement in both their direct and indirect descriptions of the child. Index 3 was the least precise of the three indices because it allowed for the possibility that omission (or not checking) was due to faulty knowledge rather than to agreement that the item was non-descriptive. Although the parent did have the opportunity to indicate those items about which he had no knowledge, it cannot be assumed that the parent omitted an item because it did not apply unless stated specifically.

The subjects were divided according to adjustment (clinic vs. non-clinic), sex, and age levels. A 2x2x2 analysis of variance design was used to compare parental perception as a function of the age, sex, and adjustment levels for each of the three indices.

#### Classification of Behavior Items

An attempt was made to classify those behavior items perceived in clinic children and those in non-clinic children. Because, in this study, the validity of the parent's perception was not tested against independent observations of the child's behavior, the classification dealt with perceived behavior rather than with actual behavior. Perceived behavior may very well be an accurate estimation of actual behavior, but this relation cannot be assumed without empirical investigation. Thus, the classification was aimed at differentiating those items which the

clinic parents perceived in their child from those items which the non-clinic parents perceived in their child.

Chi-square tests were performed on each of the 154 behavior items. By this analysis, it was possible to determine whether an item was perceived more in clinic children or in non-clinic children. The chi-square analysis tested the significance of the difference between the frequency of clinic parents who perceived that item in their child and the frequency of non-clinic parents who also perceived that item in their child.

The criterion for deciding whether a particular behavior (item) was perceived in a child, was the parents' checking of an item. If both parents of a child checked the item for their child, it was concluded that the item was perceived in the child. The difference between the characteristic and applicable columns in the checklist was disregarded for this calculation. One parent may have checked the item as characteristic and the other applicable, or both may have agreed that it was characteristic or applicable and checked it accordingly. However, these three conditions were considered to be equal. A check in either column by both parents satisfied the criterion. It was thought that a more objective view of the child's behavior could be obtained by simply considering the parents' checking, and by disregarding their judgments as to whether an item was characteristic or merely applicable to their child. When one or both of the parents failed to check an

item, it was concluded that the item was not perceived in a child.

The chi-square analysis performed on each item compared the frequency of parents who perceived the item in their child to the frequency of parents who did not perceive that item in their child, for both the clinic and non-clinic groups. By this comparison, it was possible to detect whether the proportion of parents who perceived the item in their child was significantly greater for the clinic group or for the non-clinic group. When an item was perceived to a significantly greater degree in one group than in the other, that item was classified as a behavior perceived in children who belonged to that adjustment group.

Since chi-square tests were able to isolate those items which were perceived as belonging to either the clinic group or to the non-clinic group, but not to both, those behavior items which were common to both groups could not be detected. In other words, if parents in both the clinic group and the non-clinic group perceived a behavior in their child to the same degree (even though this degree be extremely high for both groups), this behavior item would receive no classification from the chi-square analysis. A measure was derived for the purpose of detecting those items which could be classified in both the clinic and the non-clinic groups. Rather than distinguish clinic children from non-clinic children, such items would describe children in general.

The measure derived was labelled the mean agreement score. This score represented the degree to which parents in an adjustment group perceived an item in their child. Thus, each item received two scores; one for parents in the clinic group and one for parents in the non-clinic group. This score was called the mean agreement score because it was actually measuring the parents' agreement that a behavior item was descriptive of their child. This agreement was exhibited when both parents checked that item for their child.

The agreement between each set of parents in an adjustment group was considered when calculating the mean agreement score for that group. If both parents checked the item for their child (thereby expressing agreement), a score of 2 was recorded for those parents. If both parents failed to check the item, either by one or both leaving it unchecked, a score of 1 was recorded for those parents. Thus, a mean agreement score of 2 meant that all sets of parents in that behavior group perceived the item in their child, while a mean agreement score of 1 meant that no set of parents in that behavior group perceived the item in their child.

## CHAPTER III

### RESULTS

#### Hypotheses 1 & 2

Hypothesis 1 concerned the amount of agreement in parents' perceptions of clinic and non-clinic children. It was expected that the parents of clinic children would exhibit significantly less agreement in their perceptions of their child's behavior than the parents of non-clinic children.

Hypothesis 2 concerned the influence of sex and age of the child on the agreement of parents' perceptions. It was expected that no significant differences in parental agreement would be found as a function of the age or sex of the child.

Hypotheses 1 and 2 were tested by a 2x2x2 analysis of variance for unequal cell frequencies. Since the 3:1 ratio of males to females in the clinic group and the 1:1 ratio of males to females in the non-clinic group are characteristic of the distribution of sexes in both populations, a least squares solution was used (Winer, 1962, p. 292).

#### Effects of Adjustment, Sex, and Age

The first hypothesis predicted that, for all three indices, the parents of clinic children would exhibit less agreement in their perceptions of their child's behavior than

the parents of the non-clinic children. The analysis of variance results, presented in Tables 1, 2, and 3, are non-significant for the overall main effect of adjustment. The first hypothesis is not supported when the overall effect of adjustment irrespective of other factors in the design is considered.

The second hypothesis predicted that the age and sex of the child would not produce a significant difference in parental agreement for any of the three indices. The analysis of variance results, presented in Tables 1, 2, and 3, are non-significant for the overall main effects of sex and age.

**Table 1. Analysis of Variance for Per Cent Agreement Between Parents in the Perception of their Child's Behavior Considering Only Items Checked Characteristic. (Index 1)**

Source	SS	df	MS	F
Adjustment (A)	936.73	1	936.73	2.18
Sex (B)	81.09	1	81.09	.19
Age (C)	441.50	1	441.50	1.03
A X B	1073.64	1	1073.64	2.50
A X C	396.42	1	396.42	.92
B X C	9.05	1	9.05	.02
A X B X C	2125.27	1	2125.27	4.96*
Error	72438.51	169	428.63	

\*  $p \leq .05$



**Table 2. Analysis of Variance for Per Cent Agreement Between Parents in the Perception of their Child's Behavior Considering Items Checked Characteristic and Applicable. (Index 2)**

Source	SS	df	MS	F
Adjustment (A)	307.03	1	307.03	1.34
Sex (B)	33.81	1	33.81	.15
Age (C)	83.09	1	83.09	.36
A X B	1035.90	1	1035.90	4.52*
A X C	5.44	1	5.44	.02
B X C	257.80	1	257.80	1.12
A X B X C	917.63	1	917.63	4.01*
Error	38669.47	169	228.81	

\*  $p \leq .05$

The second hypothesis is supported when the overall effects of sex and age are considered independently and irrespectively of other factors in the design.

Although the overall main effects of adjustment, sex, and age were non-significant, inspection of the analysis of variance tables reveals that significant differences were obtained through interactions of these variables. (Appendix E lists the overall means for the analysis of variance tables for indices 1, 2, and 3.)

**Table 3. Analysis of Variance for Per Cent Agreement Between Parents in the Perception of their Child's Behavior Considering All Checked and Unchecked Items. (Index 3)**

Source	SS	df	MS	F
Adjustment (A)	695.77	1	695.77	2.36
Sex (B)	492.37	1	492.37	1.67
Age (C)	3.59	1	3.59	.01
A X B	1245.44	1	1245.44	4.23*
A X C	86.05	1	86.05	.29
B X C	181.29	1	181.29	.61
A X B X C	135.84	1	135.84	.46
Error	49741.13	169	294.33	

\*  $p \leq .05$

**Table 4. Means of Parents' Agreement Scores for the AB Interaction of Index 2.**

	Non-Clinic ( $A_1$ )	Clinic ( $A_2$ )
Males ( $B_1$ )	48.10	39.47
Females ( $B_2$ )	43.52	46.07

#### Adjustment X Sex Interaction

The interaction between the adjustment and sex variables was significant ( $p \leq .05$ ) for both indices 2 and 3. The mean Index 2 scores for the clinic and non-clinic males

**Table 5. Means of Parents' Agreement Scores for the AB Interaction of Index 3.**

	Non-Clinic ( $A_1$ )	Clinic ( $A_2$ )
<b>Males (<math>B_1</math>)</b>	72.65	65.69
<b>Females (<math>B_2</math>)</b>	71.17	72.18

**Table 6. Analysis of Variance for Simple Effects of Adjustment and Sex for Index 2.**

Source	SS	df	MS	F
<b>A for <math>B_1</math> (adjustment for males)</b>	1509.91	1	1509.91	6.60*
<b>A for <math>B_2</math> (adjustment for females)</b>	83.55	1	23.55	.10
<b>B for <math>A_1</math> (sex for non-clinic Ss)</b>	179.92	1	179.92	.78
<b>B for <math>A_2</math> (sex for clinic Ss)</b>	544.29	1	544.29	2.37
<b>Error</b>	38669.47	169	228.81	

\*  $p \leq .05$

and females are presented in Table 4. The mean Index 3 scores for the clinic and non-clinic males and females are presented in Table 5. The adjustment by sex interaction for Index 1 was non-significant (Table 1).

Analyses of variance for the simple effects of the adjustment by sex interaction were performed for indices 2 and 3. Table 6 shows that adjustment for males was significant ( $p \leq .05$ ) for Index 2. The means of the two groups of

**Table 7. Analysis of Variance for Simple Effects of Adjustment and Sex for Index 3.**

Source	SS	df	MS	F
A for B <sub>1</sub> (adjustment for males)	1390.52	1	1390.52	4.72*
A for B <sub>2</sub> (adjustment for females)	2.81	1	2.81	.01
B for A <sub>1</sub> (sex for non-clinic Ss)	16.47	1	16.47	.05
B for A <sub>2</sub> (sex for clinic Ss)	690.92	1	690.92	2.35
Error	49741.13	169	294.33	

\*  $p \leq .05$

males for Index 2 can be found in Table 4. Table 7 shows that the difference due to adjustment for males was again significant ( $p \leq .05$ ) for Index 3. The means of the adjustment groups for males for Index 3 can be found in Table 5.

For both indices 2 and 3, agreement between the parents of male subjects was found to be a function of their membership in the clinic or non-clinic group. Thus, it appears that hypothesis 1 is supported for male subjects only. Differences in parental agreement between clinic and non-clinic females were slightly in the wrong direction and non-significant.

#### Adjustment X Sex X Age Interaction

The interaction between the adjustment, sex, and age variables was significant ( $p \leq .05$ ) for indices 1 and 2. The means relevant to this interaction for Index 1 are

Table 8. Means of Parents' Agreement Scores for the ABC Interaction of Index 1.

	Non-Clinic ( $A_1$ )	Clinic ( $A_2$ )
5-7 yr. old ( $C_1$ ) males ( $B_1$ )	59.31	43.77
8-11 yr. old ( $C_2$ ) males ( $B_1$ )	50.60	44.14
5-7 yr. old ( $C_1$ ) females ( $B_2$ )	46.67	58.50
8-11 yr. old ( $C_2$ ) females ( $B_2$ )	55.00	43.92

Table 9. Means of Parents' Agreement Scores for the ABC Interaction of Index 2.

	Non-Clinic ( $A_1$ )	Clinic ( $A_2$ )
5-7 yr. old ( $C_1$ ) males ( $B_1$ )	52.79	39.31
8-11 yr. old ( $C_2$ ) males ( $B_1$ )	43.57	39.79
5-7 yr. old ( $C_1$ ) females ( $B_2$ )	40.17	48.37
8-11 yr. old ( $C_2$ ) females ( $B_2$ )	47.03	43.92

presented in Table 8. The means representative of this interaction for Index 2 are presented in Table 9. The adjustment by sex by age interaction for Index 3 was non-significant (Table 3).

Analyses of variance for the simple effects of the adjustment by sex by age interaction were performed for indices 1 and 2. Table 10 shows that the difference between adjustment groups for 5-7 yr. old males was significant

**Table 10. Analysis of Variance for Simple Effects of Adjustment, Sex, and Age for Index 1.**

	Source	SS	df	MS	F
A for B <sub>1</sub> C <sub>1</sub>	(adjustment for 5-7 yr. old males)	1865.59	1	1865.59	4.35*
A for B <sub>1</sub> C <sub>2</sub>	(adjustment for 8-11 yr. old males)	769.04	1	769.04	1.79
A for B <sub>2</sub> C <sub>1</sub>	(adjustment for 5-7 yr. old females)	775.54	1	775.54	1.81
A for B <sub>2</sub> C <sub>2</sub>	(adjustment for 8-11 yr. old females)	1042.64	1	1042.64	2.43
B for A <sub>1</sub> C <sub>1</sub>	(sex for 5-7 yr. old non-clinic Ss)	1478.92	1	1478.92	3.45
B for A <sub>1</sub> C <sub>2</sub>	(sex for 8-11 yr. old non-clinic Ss)	285.48	1	285.48	.66
B for A <sub>2</sub> C <sub>1</sub>	(sex for 5-7 yr. old clinic Ss)	1074.64	1	1074.64	2.51
B for A <sub>2</sub> C <sub>2</sub>	(sex for 8-11 yr. old clinic Ss)	.50	1	.50	.001
C for A <sub>1</sub> B <sub>1</sub>	(age for non-clinic males)	883.67	1	883.67	2.06
C for A <sub>1</sub> B <sub>2</sub>	(age for non-clinic females)	771.28	1	771.28	1.79
C for A <sub>2</sub> B <sub>1</sub>	(age for clinic males)	1.45	1	1.45	.003
C for A <sub>2</sub> B <sub>2</sub>	(age for clinic females)	1020.83	1	1020.83	2.38
Error		72438.51	169	428.63	

\*p < .05

Table 11. Analysis of Variance for Simple Effects of Adjustment, Sex, and Age for Index 2.

	SS	df	MS	F
A for B <sub>1</sub> C <sub>1</sub> (adjustment for 5-7 yr. old males)	1402.95	1	1402.95	6.13*
A for B <sub>1</sub> C <sub>2</sub> (adjustment for 8-11 yr. old males)	263.09	1	263.09	1.15
A for B <sub>2</sub> C <sub>1</sub> (adjustment for 5-7 yr. old females)	373.16	1	373.16	1.63
A for B <sub>2</sub> C <sub>2</sub> (adjustment for 8-11 yr. old females)	82.51	1	82.51	.36
B for A <sub>1</sub> C <sub>1</sub> (sex for 5-7 yr. old non-clinic Ss)	1472.77	1	1472.77	6.44*
B for A <sub>1</sub> C <sub>2</sub> (sex for 8-11 yr. old non-clinic Ss)	177.33	1	177.33	.77
B for A <sub>2</sub> C <sub>1</sub> (sex for 5-7 yr. old clinic Ss)	407.16	1	407.16	1.78
B for A <sub>2</sub> C <sub>2</sub> (sex for 8-11 yr. old clinic Ss)	163.35	1	163.35	.71
C for A <sub>1</sub> B <sub>1</sub> (age for non-clinic males)	989.47	1	989.47	4.32*
C for A <sub>1</sub> B <sub>2</sub> (age for non-clinic females)	523.85	1	523.85	2.29
C for A <sub>2</sub> B <sub>1</sub> (age for clinic males)	184.04	1	184.04	.80
C for A <sub>2</sub> B <sub>2</sub> (age for clinic females)	95.41	1	95.41	.41
Error	38669.47	169	228.81	

\* p < .05

( $p \leq .05$ ) for Index 1. The means of the adjustment groups for 5-7 yr. old males can be found in Table 8. Table 11 shows that adjustment group for 5-7 yr. old males, sex for 5-7 yr. old non-clinic subjects, and age for non-clinic males were all significant ( $p \leq .05$ ) for Index 2. The means for the adjustment groups for 5-7 yr. old males, for the sex groups of 5-7 yr. old non-clinic subjects, and for the age groups for non-clinic males can be found in Table 9.

For both indices 1 and 2, agreement between the parents of 5-7 yr. old males was related to their membership in the clinic or non-clinic group. Hypothesis 1 is supported for 5-7 yr. old males only. Differences in parental agreement between 8-11 yr. old clinic and non-clinic males, and between 8-11 yr. old clinic and non-clinic females, were in the same direction, but they were non-significant. The differences in parental agreement for 5-7 yr. old clinic and non-clinic females were in the opposite direction. Although non-significant, greater parental agreement for 5-7 yr. old females was found to be a function of membership in the clinic rather than non-clinic group.

For Index 2 alone, agreement between the parents of 5-7 yr. old non-clinic children was found to be a function of the sex of the child. Thus, it appears that hypothesis 2 is not supported for 5-7 yr. old non-clinic children. Non-clinic males in the 5-7 age group had significantly greater agreement than 5-7 yr. old non-clinic females. Differences in parental agreement between 8-11 yr. old non-clinic



males and females, between 5-7 yr. old clinic males and females, and between 8-11 yr. old clinic males and females were all in the opposite direction and non-significant.

Agreement between the parents of non-clinic males was found to be related to age level for Index 2 alone. Thus, hypothesis 2 is not entirely supported for non-clinic males. Parents of 5-7 yr. old non-clinic males showed significantly greater agreement than parents of 8-11 yr. old non-clinic males. Differences in parental agreement between 5-7 yr. old and 8-11 yr. old clinic females were in the same direction but non-significant. Differences between 5-7 yr. old and 8-11 yr. old non-clinic females were in the opposite direction and non-significant. The 5-7 yr. old and 8-11 yr. old clinic males showed relatively no differences in parental agreement.

#### Chi-Square Analysis of the Checklist

Chi-square tests were performed on each of the 154 items of the Behavior Checklist. Table 12 lists 34 items which were found to yield significant chi-square values in the non-clinic direction (p values ranged from  $\angle .001$  to  $\angle .05$ ). Table 13 lists 32 items whose chi-square values were found to be significant in the clinic direction (p values ranged from  $\angle .001$  to  $\angle .05$ ). Appendix F lists the chi-square values of the remaining 88 items which did not reach significance in either direction. These items were not found to differentiate between behavior perceived in

clinic children as opposed to behavior perceived in non-clinic children.

**Table 12. Chi-Square Values of the Behavior Checklist Items Significantly Differentiating Clinic and Non-Clinic Children Which Were Characteristic of Non-Clinic Children.**

Item #	Item	$\chi^2$	p
3	Is concerned about feelings of others.	16.04	< .001
25	Handles small objects skillfully . . .	20.79	
31	Can be depended on to do what he (she) is supposed to do without reminders.	25.25	"
34	Activity is focussed on a particular purpose, seems to accomplish what he (she) set out to do. . . . .	20.82	"
39	Can accept new ideas without getting upset. . . . .	15.20	"
46	Shows pride in accomplishment. . . . .	16.38	"
50	Does what other adults ask him (her) to . . . . .	17.79	"
53	Moves gracefully - is well coordinated	11.60	"
55	Plays to win . . . . .	15.94	"
61	Others seem to want to be with him (her). . . . .	20.00	"
68	Makes friends quickly and easily . . .	14.77	"
75	Self-confident . . . . .	31.04	"
100	Polite and cooperative with others . .	17.66	"
114	Prefers competitive games. . . . .	14.73	"
121	Energetic. . . . .	12.53	"
125	Shows pleasure and involvement in most things he (she) does - enthusiastic.	11.31	"
136	Competes with other children . . . . .	16.25	"
139	Pitches in when things are to be done.	10.99	"
146	Learns quickly from others . . . . .	25.83	"
36	Likes to play with girls instead of boys . . . . .	8.14	< .005
48	Seems comfortable in new situations. .	9.31	
98	Able to stand up for himself (herself)	9.61	"
103	Careful in explanations - precise. . .	9.22	"
116	Shows appreciation when others help or do things for him (her). . . . .	8.34	"
145	Quick and clever . . . . .	10.14	"
2	Is tidy and neat, perhaps even a bit fussy about it . . . . .	7.27	< .01

Table 12 Continued

Item #	Item	$\chi^2$	p
113	Is curious about things. . . . .	7.70	"
150	Retains composure even when those a- round him (her) are acting in a boi- sterous way. . . . .	6.83	"
122	Asks sensible questions in new situa- tions. . . . .	5.82	$\angle$ .02
20	Feelings are apparent in facial ex- pression . . . . .	5.21	$\angle$ .025
101	Easily embarrassed . . . . .	5.22	"
57	Starts things off when with others . .	4.06	$\angle$ .05
83	Talks all the time . . . . .	4.25	"
151	Prefers playing with older or bigger children even when children of own age are around . . . . .	4.47	"

Table 13. Chi-Square Values of the Behavior Checklist Significantly Differentiating Clinic and Non-Clinic Children Which Were Characteristic of Clinic Children.

Item #	Item	$\chi^2$	p
5	Gets irritated or angry easily . . . . .	13.35	$\angle$ .001
8	Plays with toys in a rough way . . . . .	14.42	"
14	Doesn't pay attention to what grown- up says to him (her) . . . . .	17.49	"
18	Acts in ways that makes others not like him (her). . . . .	12.75	"
54	Seems to do things just to get others angry at him (her) . . . . .	21.24	$\angle$ .001
70	Quickly loses interest in an activity.	12.23	"
77	Plays mostly with younger or smaller children - even when children of own age are around . . . . .	12.68	"

Table 13 Continued

Item #	Item	$\chi^2$	p
90	Often has to be reminded of what he (she) can and cannot do. . . . .	14.80	"
95	Seems out of touch with what is going on around him (her) - off in his (her) own world. . . . .	11.05	"
110	When told to do something he (she) doesn't want to do, he (she) becomes very angry . . . . .	12.38	"
127	Doesn't seem to care about he (she) looks - often looks sloppy . . . . .	12.65	"
132	Blows up very easily when bothered by someone. . . . .	12.39	"
78	Seems sad and unhappy. . . . .	8.92	$\angle$ .005
80	Tends to go too far unless frequently reminded of rules. . . . .	8.29	"
94	Threatens to hit or hurt others. . . .	10.05	"
97	Has uncontrollable outbursts of temper	9.92	"
119	Will lie to get out of a tight spot. .	11.29	"
140	Fidgety and restless . . . . .	10.27	"
104	Often breaks the rules in games with others . . . . .	7.31	$\angle$ .01
142	Gets other children stirred up to mischief. . . . .	7.74	"
67	Has a characteristic mannerism or nervous habit . . . . .	5.61	$\angle$ .02
76	Bullies younger children . . . . .	5.65	"
112	Play is aimless, doesn't seem to make or accomplish anything . . . . .	6.14	"
126	Seems selfish, always wants own way. .	5.98	"
143	Acts as if everyone were against him .	6.36	"
29	Is left out and ignored by others. . .	5.02	$\angle$ .025
134	Prefers following others to taking the initiative . . . . .	5.09	"
4	Can't wait - must have things immediately. . . . .	4.81	$\angle$ .05
16	Looks awkward when he (she) moves around. . . . .	5.00	$\angle$ .05
43	Appears stiff in walking or moving about . . . . .	4.69	"

Table 13 Continued

Item #	Item	$\chi^2$	p
52	Has trouble finding the right words to say what he (she) means. . . . .	4.34	"
84	Will fight in a rough way where others could really get hurt. . . . .	3.74	"

In order to detect those items which could not differentiate the two adjustment groups, but which were common to both, a measure called the mean agreement score was derived. This measure represented the average of the agreement between sets of parents that an item was perceived in their child. A 2 was recorded for each set of parents that checked an item for their child and a 1 was recorded when one or both of the set failed to check the item. A mean agreement score for all parents of children in each adjustment group was calculated for an item. Thus, each item received two scores, corresponding to the mean agreement exhibited by parents of children in the clinic group and by parents of children in the non-clinic group.

Since a score of 2 represented agreement by all sets of parents and a score of 1, agreement (as here defined) by no set of parents, a score of 1.5 would mean that half the parents of children in that particular adjustment group agreed in perceiving that item in their child. Thus, 1.5 represents the criterion score above which there is

sufficient agreement to consider that item as descriptive of the behavior perceived in the child, and below which there is a great possibility that chance factors could have operated to determine the agreement score.

Table 14 lists those items which received a score of 1.5 or over for both adjustment groups. Although 8 of the 13 items were significantly more characteristic of non-clinic than clinic children by chi-square analysis, these same items received scores above 1.5 for the clinic group also. It is suggested that these 8 items, while measuring adjustive behavior, indicate that clinic children are not pervasively maladjusted. That is, clinic children do exhibit adjustment in various behavior areas. With the 8 items, the difference between the mean agreement scores for parents in both groups range from .17 to .28. In contrast, the differences between the mean agreement scores of the remaining 5 items (whose chi-square values do not reach significance in either direction) range from 0 to .08. The smaller difference in mean agreement scores for the 5 items shows that the 5 items are no more descriptive of one adjustment group than of the other. They can be considered items which are perceived equally in clinic and non-clinic children, i.e. they are seen as relatively characteristic of all children and can be thought of as child characteristics which are independent of adjustment. Appendix F lists the mean agreement scores for the remaining 141 items.

Table 14. Items For Which the Mean Agreement Scores Exceeded 1.5 for Both Adjustment Groups.

Item #		Means		$\chi^2$
		Non-Clinic	Clinic	
1	Is happy when he (she has done a "good" job. . . . .	1.99	1.94	3.65
3	Is concerned about feelings of others. . . . .	1.80	1.52	16.04*
20	Feelings are apparent in facial expression. . . . .	1.70	1.53	5.21 <sup>M</sup>
37	Hates to lose . . . . .	1.56	1.59	.16*
46	Shows pride in accomplishment . . . . .	1.98	1.79	16.38*
50	Does what other adults ask him (her) to. . . . .	1.84	1.56	17.79*
63	Feelings are easily hurt. . . . .	1.64	1.64	.008
73	Will interrupt someone else in order to state his (her) opinions . . . . .	1.50	1.51	.007
113	Is curious about things . . . . .	1.85	1.68	7.70**
121	Energetic . . . . .	1.81	1.57	12.53*
122	Asks sensible questions in new situations. . . . .	1.73	1.56	5.82 <sup>i</sup>
125	Shows pleasure and involvement in most things he (she) does - enthusiastic. . . . .	1.75	1.51	11.31*
149	Affectionate - enjoys being physically close to others. . . . .	1.65	1.57	1.12

\*p  $\angle$  .001 for non-clinic group  
 \*\*p  $\angle$  .01 for non-clinic group  
 i<sub>p</sub>  $\angle$  .02 for non-clinic group  
 m<sub>p</sub>  $\angle$  .025 for non-clinic group

## CHAPTER IV

### DISCUSSION

#### Effects of Adjustment Group, Sex and Age on Parental Agreement

The results for the two main hypotheses show that parents' agreement in the perception of their child's behavior was not affected by the adjustment, sex, or age of the child when these variables are considered independently. Hypotheses 1 predicted that parents of clinic children would exhibit significantly less agreement than parents of non-clinic children. This hypothesis was not supported for the overall effect of adjustment for any of the three indices. Hypothesis 2 predicted that the sex or age of the child would not produce significant differences in parental agreement. This second hypothesis was confirmed for all three indices when just the overall effect of sex and age was considered. Significant interactive effects were reported for the adjustment group and sex variables, and again for the adjustment group, sex, and age variables. The first part of the discussion will be concerned with an interpretation of the effects of these interactions on parental agreement.

In the introduction of this paper, ambiguous parental



evaluations, contradictory demands placed on the child, acting out of a parental conflict, low interpersonal perceptivity, and alliance with one parent to the exclusion of the other, were cited as possible underlying reasons for greater disagreement among parents of clinic subjects. It is possible that any one of these factors may have operated to produce the greater disagreement among the parents of clinic males which was observed in this study. Further insight, however, can be gained by focusing on male behavior itself.

In our culture, the masculine stereotype sets the norm for male behavior. The definition and limits of which behavior is considered masculine and which is labeled feminine is well articulated. Boys are expected to "act like men" and to inhibit all signs of feminine behavior. In contrast, the behavioral norms set for girls are not as stringent as they are for boys. It is permissible for girls to exhibit both masculine and feminine typed behavior. Consequently, female behavior is more variable and diffuse than is male behavior.

Because masculine behavior is so well defined, it is likely that parents' expectations of a son will be similar. Parents will tend to evaluate their son in a similar fashion. The high amount of agreement found for the parents of non-clinic males can be explained by this similarity of expectations. Non-clinic parents will perceive their son in light of the norms they set for him. Since these norms are

relatively the same, perceptions will be similar.

For the case of the clinic males, it may be the discrepancy in parental expectations that creates the low amount of agreement between parents. Because the male child is sensitive to the expectations transmitted by his parents, he is very susceptible to ambiguity and contradiction of expectations. The parents of clinic males showed the lowest agreement, and the parents of non-clinic males showed the highest agreement when scores of clinic and non-clinic, males and females were considered. The extremes of these scores suggest that disagreement does affect males to an appreciable degree.

Agreement between parents of males could also be indicative of the attention parents give to their sons. Non-clinic parents may be very concerned and aware of their son's behavior. Thus, they would perceive him similarly. Clinic parents, because they may pay less attention to their son will have a less adequate information base on which to describe him.

While there is a significant decrease in parental agreement across the non-clinic and clinic behavior groups for boys, there is a non-significant increase for girls. Parents of clinic females showed greater agreement than parents of non-clinic females. An interpretation of this trend reversal for females can be approached from two perspectives. First, why is agreement for parents of clinic females higher? Conversely, why is parental agreement lower

for non-clinic females?

The small sample of females in this study suggests that girls are less likely than boys to exhibit behavior which others consider to be maladjusted and which should be brought to the attention of a clinic. Perhaps then, a girl's maladjusted behavior would have to be very salient before her parents brought her into the clinic. In this context, salience refers to behavior which is atypical and commands attention. Such behavior may also be characteristic of clinic boys, but because of cultural expectations, it would be more noticeable in girls. If the maladjusted behavior is quite obvious, then parents may perceive their daughter similarly. Thus, the salience of the clinic females' behavior may explain the parents' high agreement.

Since females' behavior is not as defined as is male behavior, parental expectations may likewise be more variable and inconsistent for girls than for boys. Parents may tend to have more flexible and dissimilar norms for girls. Thus, parents' less defined expectations of girls whose adjustment is considered adequate, may create less agreement in perception.

The possibility remains, however, that females may not be as susceptible to discrepancies in parents' expectations as are males. Several studies (Chorost, 1962; McCord, et al., 1961; Mark, 1953; Peterson, et al., 1961; Winder & Rau, 1962) have found a relationship between parent factors and son's behavior. The present findings, along with

results attained by these studies, suggest that parent attitudes, behavior, and expectations may not affect girls in the same manner as they do boys.

By further analysis of the data, it was discovered that the effect of child's adjustment on parental agreement was limited to 5-7 yr. old males. The parents of 5-7 yr. old non-clinic males showed significantly greater agreement than the parents of 5-7 yr. old clinic males. Since reasons for the agreement between parents of males have already been discussed, a focus on the 5-7 age range would be helpful.

Between the ages of 5 and 7, the young boy is making the transition from home to school. He is expanding his world and consequently needs increased attention and concern to help him handle the conflicts which this new adventure entails. It would seem then that 5-7 is an age range during which children are particularly susceptible to parental and family influences. The agreement scores for parents of 5-7 yr. old males are congruent with this interpretation. The increased attention, concern, and similarity of expectations of parents of non-clinic males would produce high agreement in perceptions, while disinterest, conflict, and discrepancies in expectations of parents of clinic males would be reflected in low agreement scores.

Again, it is interesting to note the trends exhibited by parents of females. The parents of clinic females in the 5-7 yr. old range showed greater agreement than parents of non-clinic females in the same age range. Since only 8

subjects are included in the 5-7 yr. old clinic female group there is even more reason to believe that the mal-adjusted behavior of females must be very salient before parents bring them to the clinic. However, there is still the possibility that parents' disagreement may be unrelated to females' adjustment.

For the 8-11 yr. old range, the parents of non-clinic females showed greater agreement than the parents of clinic females. Perhaps 8-11 is an age range during which girls are susceptible to parental conflict and to discrepancies in parental expectations. When their daughter enters the preadolescent period, parents may begin to define their expectations for female behavior a little more rigidly. Also, the girls themselves may become more conscious of their behavior and of others' expectations of them.

The effect of sex of child on parental agreement was found to be significant for 5-7 yr. old non-clinic children. The parents of males in the 5-7 yr. old age range showed greater agreement than the parents of females in this same age range. A similar finding was reported by Medinnus (1961). By studying parents' Q sort descriptions of their five yr. old children, Medinnus found a trend toward higher inter-parent correlations for parents of boys than for parents of girls. This result was explained by greater inter-parent discussion of boy's behavior. In addition, the greater attention paid to males and the greater degree of similarity of parents' expectations for males can be cited for the

higher agreement of parents of males found in the two studies.

Although the effects of sex within the other adjustment group-age levels were non-significant, the trends will be discussed. For the non-clinic group within the 8-11 age range, parents of females showed greater agreement than parents of males. It is quite possible that 8-11 is a somewhat difficult age for all children, but that parents of non-clinic males are able to tolerate minor behavioral disturbances which occur. Within the clinic group, parents of 5-7 yr. old females showed greater agreement than parents of 5-7 yr. old males, while the parents of 8-11 yr. old males and females showed relatively the same agreement. The findings for 8-11 yr. olds show that both males and females are susceptible to parental disagreement during this age period.

Parental agreement for the sexes within the adjustment groups shows that non-clinic males had higher scores than non-clinic females, whereas clinic males had lower scores than clinic females. Again, the influence of the masculine stereotype in the non-clinic group and the salience of the behavior of clinic females could account for the respective differences in agreement.

Age was found significantly to affect parental agreement for non-clinic males. Parents of 5-7 yr. old non-clinic boys showed significantly greater agreement than parents of 8-11 yr. old non-clinic boys. There is a decrease

in parental agreement with the boy's increasing age. As a boy gets older, he usually spends more time away from home. This decreased opportunity for parents to observe boys' behavior could create differences in the parents' perception. Also, the greater variability that begins to characterize a boy's behavior as he grows older may account for the greater differences in perception at the 8-11 age level.

Parental agreement increased with the non-clinic female's increasing age. Whereas parental expectations for the 5-7 yr. old female may be variable and flexible, they may become more definite for the 8-11 yr. old female. Parents may begin to feel that their daughters should emit certain feminine behaviors. Consequently, their concern and greater definition of expectations would explain the greater agreement in perceptions.

No difference in parental agreement was found between 5-7 and 8-11 yr. old males in the clinic group. This finding suggests that boys are susceptible to conflict during both age ranges. They are aware of parents' expectations and are negatively affected by any discrepancies or disagreements between the parents. For clinic females, a decrease in parental agreement with increasing age was observed. Again, this trend highlights the females greater susceptibility to conflict during the 8-11 yr. old period. Also, it suggests that disagreement in parents' perceptions of girls does not affect the child's adjustment for 5-7 yr. olds, but may for 8-11 yr. olds.

### Relationships Between the Indices

Table 15 presents the means and standard deviations of the overall percentages of agreement derived from the three indices. They give some indication of the way in which the three indices may function to reflect parental perceptions.

Index 1 measured parents' agreement on the items they checked as characteristic of their child. Inspection of the table reveals a mean of 49.50. Although the mean per se indicates that parents agreed on about 50% of the items they marked as characteristic, the large standard deviation shows that percentage scores were widely distributed. Parents exhibited great variability in their agreement when checking items as characteristic. While some parents showed a great deal of agreement on selecting items which were characteristic, other parents disagreed on a high percentage of the items.

Adjustment was shown to be related to parents' agreement for 5-7 yr. old males for Index 1. Since Index 1 is a measure of items parents checked as characteristic, it can be concluded that parents of 5-7 yr. old non-clinic males expressed a great deal of agreement on items marked characteristic, while parents of 5-7 yr. old clinic males showed much disagreement on characteristic items. If Index 1 is regarded as a measure of the parents' most subjective appraisal of the child, and if it is influenced by parent variables to a greater extent than are the other indices, it



**Table 15. Means and Standard Deviations of Overall Percent Agreement for the Three Indices Used to Measure Perception.**

	Mean	Standard Deviation
Index 1	49.50	21.07
Index 2	43.68	15.44
Index 3	69.48	17.62

may be conjectured that there is much consistency of appraisal and of parent variables for the 5-7 yr. old non-clinic child. Conversely, the 5-7 yr. old clinic male child is faced with much inconsistency. Since this index shows the highest standard deviation, it may be the most sensitive to differences among families in parent-child relations.

Index 2 measured parents' agreement on the items checked as characteristic and applicable to their child. The mean for Index 2 is 43.68. Although the mean for Index 2 shows lower percentage of agreement than does the mean for Index 1, the standard deviation is likewise lower. This smaller standard deviation indicates that the pattern of parental agreement was less variable than it was for Index 1 even though the scores were still widely distributed.

Likewise for Index 2, adjustment was shown to be related to the percent agreement between the parents of 5-7 yr. old male subjects. When applicable items are considered

in addition to characteristic ones, the parents of 5-7 yr. old non-clinic males still exhibit a high percentage of agreement in comparison to the parents of 5-7 yr. old clinic males. Parents of well adjusted children seem to agree on the child's behavior which is characteristic (or obvious) and also on that which is applicable (or merely noticeable).

The adjustment group-sex-age interaction was found to be significant for both indices 1 and 2. However, the simple effects of sex for 5-7 yr. old non-clinic subjects and of age for non-clinic males were found to be significant only for Index 2. It would seem that the significance of these two variables for Index 2 is related to the difference in the manner of measuring perception. The parents of 5-7 yr. old non-clinic males showed greater agreement than both the parents of 5-7 yr. old non-clinic females and the parents of 8-11 yr. old non-clinic males. When only characteristic items were considered, this difference was not significant. When applicable items are included in the measurement, the difference becomes significant. Thus, it would seem that the parents of 5-7 yr. old non-clinic females and 8-11 yr. old non-clinic males showed relatively less agreement on applicable items than they had on characteristic items. The decrease in means for this adjustment group-sex-age level across the two indices attests to more disagreement with applicable items considered. Thus, it is possible that differences in the child's relationship

to the two parents or in the parents' opportunities to observe the child will be more evident when the noticeable as well as characteristic items are included.

Index 3 measured parents' agreement on all checked and unchecked items. A mean of 69.48, recorded for Index 3, is greater than the means for indices 1 and 2. The standard deviation lies between the standard deviations for the other two indices, thus indicating that the distribution of scores is more variable than for Index 2 but less variable than for Index 1.

Since the behavior checklist contains 154 items, there is a great possibility that many items will not be characteristic nor applicable to a child, and will not be checked by either parent. The large mean for Index 3 reflects the increased probability that agreement will occur when unchecked items are included.

#### Classification of Checklist Items

Chi-square analysis of the data showed that 66 items differentiated the clinic and non-clinic groups. Thirty-four items were found to be significant in the non-clinic direction. Parents of non-clinic children perceived these items in their child to a significantly greater degree than did parents of clinic children.

Ferguson, MacKenzie, and Does, when compiling the checklist, rationally classified each item according to the area of behavior which the item may be presumed to

measure. Of the items found to be significant in the non-clinic direction, 10 were considered to reflect Competence-Mastery, 5 Nurturance-Dependency, 4 Authority-Control, 4 Motoric functioning, 4 Verbal behavior, 3 Closeness-Distance, 3 Expression of Affect, and 1 Aggression. Thirty of the 34 items were deemed desirable traits for children to possess. All of the areas of behavior included in the checklist are represented by these significant items. Appendix F lists these 34 items and their corresponding area of behavior. Based on the frequency count, parents of non-clinic children perceived in their child items which describe competence, control, and the skills necessary for developing satisfactory interpersonal relations.

Thirty-two items were found to have significant chi-square values in the clinic direction. These items were perceived by parents in clinic children to a greater extent than they were perceived in non-clinic children. Again, all of the areas of behavior were represented by these items. However, there was a difference in the number of items pertaining to each area of behavior. Nine of the significant items were judged to measure Aggression, whereas 5 measured Authority-Control, 5 Motoric functioning, 3 Competence-Mastery, 3 Closeness-Distance, 3 Expression of Affect, 1 Nurturance-Dependency, and 1 Verbal Behavior. All 32 items were considered undesirable traits for children. Appendix F lists the 32 items and their corresponding area of behavior. Only one of the items in the non-clinic

direction referred to aggression, whereas the greatest number of items significant in the clinic direction measured aggression. The items significant in the clinic direction appear to be mainly concentrated in the areas of impulse and motor control, and are related only slightly to behaviors representing interpersonal relations.

Since the chi-square analysis would not reflect items common to both adjustment groups, it was decided that mean agreement scores would be used to detect such behavior items. Thirteen items received a score of 1.50 or over for both behavior groups. Since 8 of the 13 items were found to be significant in the non-clinic direction, only the remaining 5 items could be considered as equally common to both behavior groups. It is interesting to note that, although 8 items were significant for non-clinic children, more than half of the clinic parents also perceived these items in their child. It is reasonable to conclude that some behaviors denoting adjustment will also be seen as characteristic of clinic children.

The pattern of agreement scores for those items which reached significance in either direction is likewise curious. Of the 34 items which were significant in the non-clinic direction, 23 had mean agreement scores greater than 1.5 for non-clinic parents. In contrast, only 2 of the 32 items which reached significance in the clinic direction had mean agreement scores greater than 1.5 for clinic parents.

The pattern for the significant non-clinic items suggests that there is a great deal of consistency for all non-clinic parents in perceiving a particular item in their child. For 23 of the 34 items, more than half of all the non-clinic parents observed this behavior in their child. Thus, it is reasonable to assume that adjusted children exhibit many of the same behaviors.

The pattern for the significant clinic items shows that there is little consistency among all clinic parents in perceiving particular items in their child. Out of 32 significant clinic items, only 2 were perceived in clinic children by at least half of their parents. The great variability of maladjusted behaviors is suggested by the pattern shown by clinic parents. While adjusted behaviors tend to be the same for all children, maladjusted behaviors vary with each particular child. Thus, clinicians must be cautious when evaluating maladjusted behavior. Rather than look for a common syndrome in order to consider a child maladjusted, they must focus on the particular behaviors that the child exhibits.

### Evaluation of the Checklist

The behavior checklist can be used for both research and clinic purposes. As a research tool, it provides information about parents' perceptions and child behavior. As a clinical instrument, it gathers information about a child's maladjusted behavior. The appropriateness of the checklist

as a clinical instrument is given some light by the present results.

In total, 66 items were found to differentiate clinic and non-clinic children in the sample. Although 34 items were said to characterize non-clinic children, it can be said that the absence of these 34 items in a child also describes a clinic (or maladjusted) child. Thus, the 32 items describe the clinic child directly and 34 describe him indirectly.

By looking at the direction of the non-significant chi-square values for the rest of the items, it is apparent that 63 of the 88 items were in the clinic direction. This trend for clinic parents to perceive these other items in their child suggests that the checklist tends to measure maladjusted rather than adjusted behavior. Perhaps the non-significance of these items highlights the variability of maladjusted behaviors among clinic children which was discussed previously. However, a question is raised as to the suitability of keeping items in the checklist which are not sensitive enough to pick up differences between the two behavior groups.

As a clinical instrument, the checklist organizes information about a child's behavior in a systematic and clear way. Filling out a checklist is a fast and efficient process. The information gained, however, tells something of the nature of a child's adjustment, but it does not provide an accurate measure of the degree of pathology or type

of pathology in the child. Norms would have to be included in the checklist before such a judgment is possible. Thus, this one drawback creates a limitation on the use of the checklist in the clinic. However, this drawback may not even be considered appropriate if the clinician using the checklist only wants to gather information about the child's behavior.

The information gained by the checklist could probably be gained in an extended interview with the parents. Thus, as a measure of children's behavior, the checklist can be superseded. But, there are some advantages to the efficiency, to comparing parents' ratings of their child's behavior, and to having the information on file to refer back to.

One way of testing the usefulness of the checklist in the clinic is to have therapists fill out the checklist after participating in a few sessions with a child. If the relation is such that the clinician is not given the opportunity to know how the child should be rated on particular behaviors, then the checklist definitely contributes to the clinician's information about and consequent understanding of the child.

A modification of the checklist which may be helpful for both research and clinic purposes is a shortening of the number of items of the checklist to the 66 which were found to differentiate the two adjustment groups. As a clinic instrument, this shortened checklist could more



accurately assess degree of maladjustment, since a child's behavior with regard to each item would more clearly reflect adjustment or maladjustment. This shortened checklist could then be adapted for use in the schools as a screening device to detect maladjusted children. A scale to measure the degree of maladjustment could be created and incorporated.

By shortening the checklist, however, the clinician may be losing information which is helpful, and maybe even vital, to his understanding of the child. For example, a particular behavior in a child may not be indicative of maladjustment by itself, but when it is seen in combination with other behaviors or with other family dynamics, it may be pathological. Knowing a child's behavior with regard to this item may increase the clinician's understanding of the child's own dynamics. Thus, it would seem that the appropriateness of the checklist as it is now depends on the purpose for which the clinician uses it. A shortened version may be more appropriate as a screening device and as an assessor of degree of maladjustment, whereas the present lengthy version gives helpful information about the individual child.

One of the advantages of the present checklist is the wording of the items. Most behaviors described are easily observed and do not require inferential judgments. The checklist is thereby understandable for most parents. In addition, parents tend to be less defensive when describing

their child apart from themselves. That is, they may be made less anxious by attributing behaviors to a child than by describing the child's behavior as related to the parent-child relationship. For this reason, the present checklist is less threatening to parents than are some other means of gathering information about the child.

#### Implications of Findings for Further Research

The present findings suggest several implications for further research with this particular checklist or with similar types. Since parental agreement was found to be related to adjustment for boys only, an effort can be made to detect behaviors which may similarly relate parental agreement and adjustment for girls. If such a relationship does exist for girls, perhaps this checklist was not sensitive enough to detect it for girls.

Another direction of research could look at the amount of agreement on the significant clinic and non-clinic items for each sex and age group. Such a procedure may reveal maladjusted items which are specific to males and females during certain stages of development. The checklist results suggest that undesirable items are characteristic of non-clinic children. Thus, undesirable behaviors which are characteristic of a developmental stage may be labeled as such and will be separated from those behaviors which are more general indicators of maladjustment.

An addition to the checklist which may provide

helpful information about the parents themselves, is a scale to measure the amount of disagreement in parents' perceptions of their child. This measure of disagreement may be indicative of the conflict between the parents and may suggest that the focus of family therapy be directed more toward the marital relationship than was previously planned.

In using the Children's Behavior Checklist, it must be remembered that this instrument was developed relative to a middle class population. Therefore, the differentiating items are appropriate for middle class children. Further research with the instrument is necessary before generalizing the present results, if possible, to lower class children.

A property of the Children's Behavior Checklist suggests a direction for the future study of parent perceptions. With this behavior checklist, parents were free to describe their child only within certain limits. They were able to choose the items which described their child, yet they were restricted to the items listed. In addition to this instrument variable, the checklist was influenced by the parents' judgment of what characteristic and applicable means to them. Individual differences in the parent's manner of describing his child were not taken into account. Thus, characteristics of the instruments used to assess perception and the parent variables which influence the parent's response need to be accounted for when interpreting the results of future research on parental perception.

Ferreira (1964) found that perceptivity in a family depended upon the relationships that existed between its members. The results for the present study suggest indirectly that where family harmony is greater, perceptivity is increased. Further research may be focused on studying perceptivity in the parent-child dyad itself. Disagreement between parents may have been caused by low perceptivity between one parent and the child. If this is true, the agreement of parents' perceptions may prove to be an effective measure for revealing latent or overt conflict in a family.

The trends found in agreement scores for parents of children across the two adjustment groups suggest that the quality of the parent-child relationship changes with age and is different for the two sexes. This is an area open to further investigation.

The correlation of parents' agreement in perception with their agreement in attitudes is another area open to further research. Such studies would more accurately assess the plausibility of regarding perception as a potent source of information about the parent-child interaction and about the family.

Gasner & Murray (1969) found that areas of parental conflict were related to corresponding problem areas of a child's behavior. Future research could be directed toward studying a possible correlation between parents' discrepancies in the perception of their child and the child's

maladjusted behavior.

The parent's perception of the child's behavior and the child's actual behavior as rated by independent observers is another interesting approach to the study of parent influences. Discrepancies in these two methods of behavior measurement may provide insight into variables which influence a parent's relation to a child.

Lastly, the relation of parent's perception to such other measures as parent's perceived similarity to the child and child's perceived similarity to the parent may be indicative of the strength and nature of the identification process between the parent and child. In turn, the assessment of this relation may give an estimation of the degree of impact that parents and child have on each other.

## CHAPTER V

### SUMMARY

This study was concerned with the agreement in perception between parents of clinic and of non-clinic children. The first hypothesis predicted that parents of clinic children would exhibit significantly less agreement than parents of non-clinic children. The second hypothesis predicted that age or sex of the child would not produce significant differences in parental agreement.

Subjects were 49 males and 47 females in the non-clinic group and 61 males and 20 males in the clinic group. The subjects were divided into two age groups: 5-7 yr. olds and 8-11 yr. olds. To test parental agreement, each subject was assigned three scores, corresponding to the three different indices used to measure parents' agreement in perceiving the behavior of that subject.

A 2x2x2 analysis of variance (least squares solution) was performed to discover significant differences in parental agreement related to the adjustment, sex, or age of the child. The results demonstrated that adjustment, sex, or age alone did not produce significant differences in parental agreement. The adjustment-sex and adjustment-sex-age interactions, however, did have a significant effect on

parental agreement. Parental agreement for 5-7 yr. old non-clinic males was significantly greater than parental agreement for 5-7 yr. old clinic males, 8-11 yr. old non-clinic males, and 5-7 yr. old non-clinic females. These results were attributed to the parent-child relationship and to the greater definition and stereotyping of masculine behavior in our culture.

Chi-square analysis of the checklist revealed that items describing competence, control, and interpersonal skills were more often perceived in non-clinic children, while negative items concentrated in the areas of impulse and motor control were perceived in clinic children. The potential uses of the checklist as a research and clinical instrument were discussed. Recommendations for further research on the relation between parent's perception and other parent and child variables were proposed.

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## REFERENCES

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## **APPENDICES**

- APPENDIX A    Numbers, Mean Ages, and SES Scores of  
                 Children for Each Adjustment-Sex-  
                 Group**
- APPENDIX B    Letter to Parents**
- APPENDIX C    Information Sheet**
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- APPENDIX E    Overall Means for the Analysis of  
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# APPENDIX A

Numbers, Mean Ages, and SES Scores of Children for Each  
Adjustment-Sex-Age Group.

	<u>Non-Clinic</u>			<u>Clinic</u>		
	Mean Age	Number	SES	Mean Age	Number	SES
Males	5-7	19	2.74	6.30	13	2.50 (1)*
	8-11	30	3.03	9.46	48	2.90 (5)
Females	5-7	18	3.28	6.00	8	2.86 (1)
	8-11	29	2.93	8.58	12	3.00 (1)
Overall means of adjustment groups	8.36		2.97	8.60		2.85

\*Due to lack of information, SES score was not computed for number of subjects in the parentheses.

## APPENDIX B

MICHIGAN STATE UNIVERSITY . East Lansing

Department of Psychology . Olds Hall

Dear Parents:

The field of child psychology has taught us much about the development of children's behavior. We, as members of the Psychology Department at Michigan State University, are interested in studying the behavior of school-age children. Since we believe that parents know more about their children's behavior than anyone else, we are asking you to help us gather data for our study.

Enclosed you will find two copies of the Children's Behavior Checklist - one to be completed by each parent - and a short family Information Sheet. After choosing one of your children between the ages of 5 and 11 who is presently attending school (kindergarten included), we would appreciate your filling out the checklist with respect to this child. Instructions are included on the first page of the checklist.

We realize mothers and fathers have had different opportunities to observe their child, so we would prefer your filling out the checklists independently and without consultation. After both checklists have been completed, we would appreciate your placing them and the information sheet in the enclosed pre-addressed and stamped envelope and mailing the envelope at your earliest convenience.

Thank you for your cooperation. We will send you a brief report of our findings when the study is completed.

Lucy R. Ferguson, Ph.D.

*Lucy R. Ferguson*

Barry Lester

*Barry Lester*

Lisa Partyka

*Lisa Partyka*

LRF:mc

Enc.

**APPENDIX C**

**INFORMATION SHEET**

Name of child to be described: \_\_\_\_\_

Sex: \_\_\_\_\_

Age of child: \_\_\_\_\_

Other children in family - ages: \_\_\_\_\_

Sexes: \_\_\_\_\_

Name of mother: \_\_\_\_\_

Education: \_\_\_\_\_

Occupation: \_\_\_\_\_

Name of father: \_\_\_\_\_

Education: \_\_\_\_\_

Occupation: \_\_\_\_\_



CHILDREN'S BEHAVIOR CHECKLIST

Name of child: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Name of person filling out checklist: \_\_\_\_\_

Relationship to child (mother, father, teacher, clinician, etc.): \_\_\_\_\_

Situation in which child has been observed (home, school, clinic, etc.): \_\_\_\_\_

This is a list of items describing many aspects of children's behavior--things that children do or ways they have been described by others. Not all of the items will apply to the particular child you are describing, but quite a few of them will. First, go through the list and put a checkmark (✓) in the first column by each item which applies to this child. If there are some items which you do not check because you do not know whether they apply or not, or have never had the opportunity to observe them (for instance, "He (she) is a finicky eater," if you see this child only in school and don't know anything about his (her) eating habits), put an (0) in the first column.

After you have gone through the list, please go back through those items you have checked and put another checkmark (✓) in the second column opposite those that are now most characteristic of this child, that describe how he (she) is most of the time.

	Does this apply at all?	Is it char- acteristic?
1. Is happy when he (she) has done a "good job."	_____	_____
2. Is tidy and neat, perhaps even a little bit fussy about it.	_____	_____
3. Is concerned about feelings of others	_____	_____
4. Can't wait - must have things immediately.	_____	_____
5. Gets irritated or angry easily.	_____	_____
6. Is a finicky eater.	_____	_____
7. Makes strange or distorted faces.	_____	_____
8. Plays with toys in a rough way.	_____	_____
9. Sometimes makes meaningless or strange noises	_____	_____
10. Doesn't go out of his (her) way to make friends.	_____	_____
11. Hurts self when angry.	_____	_____
12. Often wakes up crying in the middle of the night--complains of nightmares.	_____	_____
13. Wants very much to be approved of.	_____	_____

	Does this apply at all?	Is it char- acteristic?
14. Doesn't pay attention to what grown-up says to him (her).	_____	_____
15. Pouts and becomes sullen when refused help.	_____	_____
16. Looks awkward when he (she) moves around.	_____	_____
17. Sometimes says odd things.	_____	_____
18. Acts in ways that makes others not like him (her).	_____	_____
19. Doesn't pay much attention to others, seems more involved with himself (herself).	_____	_____
20. Feelings are apparent in facial expression.	_____	_____
21. Has trouble falling asleep at night.	_____	_____
22. Acts helpless to get attention.	_____	_____
23. Rebels when routine is upset.	_____	_____
24. Becomes embarrassed when praised for doing something well.	_____	_____
25. Handles small objects skillfully.	_____	_____
26. Memory seems poor, forgets what he (she) is trying to say or forgets things that have just happened.	_____	_____
27. Never goes out of the way to help others, even when asked.	_____	_____
28. Seldom laughs or smiles.	_____	_____
29. Is left out of things and ignored by others.	_____	_____
30. Seldom satisfied with what others do for him (her) - unappreciative.	_____	_____
31. Can be depended on to do what he (she) is supposed to do without reminders.	_____	_____
32. Never gets excited about anything, even when you would expect him (her) to be pleased with something.	_____	_____
33. Often giggles or smiles for no apparent reason.	_____	_____
34. Activity is focused on a particular purpose, seems to accomplish what he (she) sets out to do.	_____	_____
35. Asks many silly questions	_____	_____
36. Likes to play with girls instead of boys.	_____	_____
37. Hates to lose.	_____	_____

	Does this apply at all?	Is it char- acteristic?
38. Doesn't fight back when other people attack him (her).	_____	_____
39. Can accept new ideas without getting upset.	_____	_____
40. Asks for help on tasks that he (she) can very well do on his (her) own.	_____	_____
41. Seems unable to change ways of doing things.	_____	_____
42. Moods often change for no apparent reason.	_____	_____
43. Appears stiff in walking or moving about.	_____	_____
44. Doesn't start a conversation, others must begin first.	_____	_____
45. Acts angry when adult shows attention to other children.	_____	_____
46. Shows pride in accomplishment.	_____	_____
47. Breaks down and cries for no apparent reason.	_____	_____
48. Seems comfortable in new situations.	_____	_____
49. Comes to others for protection, even when it is not necessary	_____	_____
50. Does what other adults ask him (her) to.	_____	_____
51. Blames himself (herself) when he (she) has done nothing wrong.	_____	_____
52. Has trouble finding the right words to say what he (she) means.	_____	_____
53. Moves gracefully - is well coordinated.	_____	_____
54. Seems to do things just to get others angry at him (her).	_____	_____
55. Plays to win.	_____	_____
56. Is a "copycat" - always imitating others.	_____	_____
57. Starts things off when with others.	_____	_____
58. Spends most of time sitting and watching - doesn't play and do things with others.	_____	_____
59. Very critical of others - always telling others what is wrong with them.	_____	_____
60. Gets carried away by his (her) feelings, acts on them right away.	_____	_____

	Does this apply at all?	Is it char- acteristic?
61. Others seem to want to be with him (her).	_____	_____
62. Seems distrustful of others; doesn't think he (she) can rely on others or believe their promises.	_____	_____
63. Feelings are easily hurt.	_____	_____
64. Talks in a funny way (e.g. stutter, lisp).	_____	_____
65. Asks the same question over and over again.	_____	_____
66. Seems quiet when around other children.	_____	_____
67. Has a characteristic mannerism or nervous habit. Specify: _____	_____	_____
68. Makes friends quickly and easily.	_____	_____
69. Lacks pep and complains of being tired.	_____	_____
70. Quickly loses interest in an activity.	_____	_____
71. Sucks thumb.	_____	_____
72. Very moody - sad one minute and happy the next.	_____	_____
73. Will interrupt someone else in order to state his (her) opinions.	_____	_____
74. Talks or mutters to self as if conversing with self.	_____	_____
75. Self confident.	_____	_____
76. Bullies younger children.	_____	_____
77. Plays mostly with younger or smaller children - even when children of own age are around.	_____	_____
78. Seems sad and unhappy.	_____	_____
79. Uses "baby talk."	_____	_____
80. Tends to go too far unless frequently reminded of rules.	_____	_____
81. Often becomes so stuck on one idea that he (she) can't stop thinking or talking about it.	_____	_____
82. Does not wait for others to approach but seeks others out.	_____	_____
83. Talks all the time.	_____	_____
84. Will fight in a rough way where others could really get hurt.	_____	_____

	Does this apply at all?	Is it char- acteristics?
85. Refuses to share things with others.	_____	_____
86. Brags about what he (she) can do.	_____	_____
87. Holds a grudge.	_____	_____
88. Often tries to do more than he (she) can handle on his (her) own.	_____	_____
89. Prefers standing by adults when other children are present.	_____	_____
90. Often has to be reminded of what he (she) can and cannot do.	_____	_____
91. Is frightened of being alone.	_____	_____
92. Uses mostly gestures or movements to express or communicate feelings.	_____	_____
93. Avoids talking about himself (herself).	_____	_____
94. Threatens to hit or hurt others.	_____	_____
95. Seems out of touch with what is going on around him (her) - off in his (her) own world.	_____	_____
96. Often seems angry for no particular reason, expresses it in many different ways.	_____	_____
97. Has uncontrollable outbursts of temper.	_____	_____
98. Able to stand up for himself (herself).	_____	_____
99. Likes to perform for company.	_____	_____
100. Polite and cooperative with others.	_____	_____
101. Easily embarrassed.	_____	_____
102. Body often looks tense, as if expecting a fight.	_____	_____
103. Careful in explanations - precise.	_____	_____
104. Often breaks the rules in games with others.	_____	_____
105. Avoids physical contact with others.	_____	_____
106. Easily scared.	_____	_____
107. Doesn't like to let others know how he (she) feels.	_____	_____
108. Frequently disappointed.	_____	_____
109. A new situation seems to bring out the show-off in him (her).	_____	_____

	Does this apply at all?	Is it char- acteristic?
110. When told to do something he (she) doesn't want to do, he (she) becomes very angry.	_____	_____
111. Often acts silly.	_____	_____
112. Play is aimless, doesn't seem to make or accomplish anything.	_____	_____
113. Is curious about things.	_____	_____
114. Prefers competitive games.	_____	_____
115. Likes to play with boys instead of girls.	_____	_____
116. Shows appreciation when others help or do things for him (her).	_____	_____
117. Seems afraid to try anything new.	_____	_____
118. Doesn't like to ask others for help.	_____	_____
119. Will lie to get out of a tight spot.	_____	_____
120. Nothing seems to interest him (her).	_____	_____
121. Energetic.	_____	_____
122. Asks sensible questions in new situation.	_____	_____
123. Aggressive and overpowering with other children.	_____	_____
124. Likes to do things well so others will notice him (her).	_____	_____
125. Shows pleasure and involvement in most things he (she) does - enthusiastic.	_____	_____
126. Seems selfish, always wants own way.	_____	_____
127. Doesn't seem to care about how he (she) looks - often looks sloppy.	_____	_____
128. Bossy with others.	_____	_____
129. Makes faces and acts "silly."	_____	_____
130. Tires easily in activities.	_____	_____
131. Speech often seems unrelated to what is going on.	_____	_____
132. Blows up very easily when bothered by someone.	_____	_____
133. Stays to self during games.	_____	_____
134. Prefers following others to taking the initiative.	_____	_____

	Does this apply at all?	Is it char- acteristic?
135. Says he (she) is not as good as others - feels bad about himself (herself).	_____	_____
136. Competes with other children.	_____	_____
137. Does what is expected to do, but grumbles about it.	_____	_____
138. When he (she) likes someone, he (she) tells them so.	_____	_____
139. Pitches in when things are to be done.	_____	_____
140. Fidgety and restless.	_____	_____
141.. Speaks only in response to direct questioning.	_____	_____
142. Gets other children stirred up to mischief.	_____	_____
143. Acts as if everyone were against him.	_____	_____
144. Makes rules for others.	_____	_____
145. Quick and clever.	_____	_____
146. Learns quickly from others.	_____	_____
147. Once he (she) makes up his (her) mind about something, it's hard for him (her) to change.	_____	_____
148. Shows delight when hurting others.	_____	_____
149. Affectionate - enjoys being physically close to others.	_____	_____
150. Retains composure even when those around him (her) are acting in a boisterous way.	_____	_____
151. Prefers playing with older or bigger children even when child of own age are around.	_____	_____
152. Often tattles on others.	_____	_____
153. Speaks so rapidly he (she) is difficult to understand.	_____	_____
154. Quickly moves from one activity to the next.	_____	_____

After completing this checklist, you may think of some other descriptions which you feel characterize this child but are not included in the checklist. Please write any such items or comments in the space below.

# APPENDIX E

## Overall Means for Analysis of Variance for Index 1

	Non-Clinic	Clinic
5-7 yr. old males	59.31	43.77
8-11 yr. old males	50.60	44.14
5-7 yr. old females	46.67	58.50
8-11 yr. old females	55.00	43.92

## Overall Means for Analysis of Variance for Index 2

	Non-Clinic	Clinic
5-7 yr. old males	52.79	39.31
8-11 yr. old males	43.57	39.79
5-7 yr. old females	40.17	48.37
8-11 yr. old females	47.03	43.92

## Overall Means for Analysis of Variance for Index 3

	Non-Clinic	Clinic
5-7 yr. old males	73.75	66.53
8-11 yr. old males	71.75	65.07
5-7 yr. old females	69.44	72.80
8-11 yr. old females	73.11	71.75



# APPENDIX F

## Chi-Square Values, Mean Agreement Scores, and Areas of Behavior for the Checklist Items\*

Item	CS		MAS		AB	D
	V	D	NC	C		
#1. Is happy when he (she) has done a "good job."	3.53	NC	1.99	1.94	A	d
2. Is tidy and neat, perhaps even a little bit fussy about it.	7.27*	NC	1.43	1.23	C-M	d
#3. Is concerned about feelings of others	16.04*	NC	1.80	1.52	N-D	d
4. Can't wait - must have things immediately.	4.01*	C	1.43	1.59	A-C	u
5. Gets irritated or angry easily.	13.35*	C	1.35	1.63	A	u
6. Is a finicky eater.	.06	C	1.29	1.31	C-M	u
7. Makes strange or distorted faces.	1.77	C	1.10	1.17	M	u
8. Plays with toys in a rough way.	14.42*	C	1.06	1.27	Agg	u
9. Sometimes makes meaningless or strange noises	.49	C	1.15	1.19	V	u
10. Doesn't go out of his (her) way to make friends.	1.28	C	1.17	1.28	C-D	u
11. Hurts self when angry.	.54	C	1.01	1.02	A	u
12. Often wakes up crying in the middle of the night--complains of nightmares.	.77	C	1.08	1.12	A	u
13. Wants very much to be approved of.	.15	NC	1.72	1.69	N-D	u
14. Doesn't pay attention to what grown-up says to him (her).	17.49*	C	1.18	1.47	A-C	u
15. Pouts and becomes sullen when refused help.	.16	C	1.28	1.31	A	u
16. Looks awkward when he (she) moves around.	5.00*	C	1.02	1.10	M	u
17. Sometimes says odd things.	.11	C	1.07	1.09	V	u

\*The explanations for all abbreviations used in the table are given after Appendix F.

## Appendix F Continued

Item	CS		MAS		AB	D
	V	D	NC	C		
18. Acts in ways that makes others not like him (her).	12.75*	C	1.10	1.32	Agg	u
19. Doesn't pay much attention to others, seems more involved with himself (herself).	.77	C	1.09	1.14	C-D	u
#20. Feelings are apparent in facial expression.	5.21*	NC	1.70	1.53	A	d
21. Has trouble falling asleep at night.	.09	C	1.16	1.17	C-M	u
22. Acts helpless to get attention.	.79	C	1.06	1.10	N-D	u
23. Rebels when routine is upset.	2.50	C	1.08	1.16	A-C	u
24. Becomes embarrassed when praised for doing something well.	.42	NC	1.07	1.05	A	u
25. Handles small objects skillfully.	20.79*	NC	1.68	1.33	M	d
26. Memory seems poor, forgets what he (she) is trying to say or forgets things that have just happened.	3.06	C	1.10	1.20	V	u
27. Never goes out of the way to help others, even when asked.	1.51	C	1.04	1.09	C-D	u
28. Seldom laughs or smiles.	.01	C	1.01	1.01	A	u
29. Is left out of things and ignored by others.	5.02*	C	1.04	1.14	C-M	u
30. Seldom satisfied with what others do for him (her) - unappreciative.	1.22	C	1.11	1.17	N-D	u
31. Can be depended on to do what he (she) is supposed to do without reminders.	25.25*	NC	1.46	1.11	A-C	d
32. Never gets excited about anything, even when you would expect him (her) to be pleased with something.	1.09	C	1.02	1.05	A	u
33. Often giggles or smiles for no apparent reason.	2.41	NC	1.11	1.05	A	u
34. Activity is focused on a particular purpose, seems to accomplish what he (she) sets out to do.	.22	NC	1.61	1.27	M	d

## Appendix F Continued

	Item	CS		MAS		AB	D
		V	D	NC	C		
35.	Asks many silly questions.	.22	NC	1.09	1.07	V	u
36.	Likes to play with girls instead of boys.	8.14*	NC	1.25	1.09	C-D	u
#37.	Hates to lose.	.16	C	1.56	1.59	C-M	d
38.	Doesn't fight back when other people attack him (her).	.20	C	1.13	1.15	A	u
39.	Can accept new ideas without getting upset.	15.20*	NC	1.69	1.40	C-M	d
40.	Asks for help on tasks that he (she) can very well do on his (her) own.	2.05	C	1.28	1.38	N-D	u
41.	Seems unable to change ways of doing things.	.38	C	1.03	1.05	A-C	u
42.	Moods often change for no apparent reason.	.02	C	1.10	1.11	A	u
43.	Appears stiff in walking or moving about.	4.69*	C	1.01	1.07	M	u
44.	Doesn't start a conversation, others must begin first.	3.45	NC	1.04	1.00	V	u
45.	Acts angry when adult shows attention to other children.	1.41	C	1.05	1.10	Agg	u
#46.	Shows pride in accomplishment.	16.38*	NC	1.98	1.79	C-M	d
47.	Breaks down and cries for no apparent reason.	.38	C	1.03	1.05	A	u
48.	Seems comfortable in new situations.	9.31*	NC	1.63	1.40	C-M	d
49.	Comes to others for protection, even when it is not necessary.	.04	C	1.03	1.04	N-D	u
50.	Does what other adults ask him (her) to.	17.79*	NC	1.84	1.56	A-C	d
51.	Blames himself (herself) when he (she) has done nothing wrong.	.08	C	1.05	1.06	A	u
52.	Has trouble finding the right words to say what he (she) means.	4.34*	C	1.14	1.26	V	u
53.	Moves gracefully - is well coordinated.	11.60*	NC	1.70	1.44	M	d
54.	Seems to do things just to get others angry at him (her).	21.24*	C	1.06	1.33	Agg	u

## Appendix F Continued

Item	CS		MAS		AB	D
	V	D	NC	C		
55. Plays to win.	15.94*	NC	1.76	1.47	C-M	d
56. Is a "copycat" - always imitating others.	1.26	C	1.08	1.14	N-D	u
57. Starts things off when with others.	4.06*	NC	1.42	1.27	C-M	d
58. Spends most of time sitting and watching - doesn't play and do things with others.	1.09	C	1.02	1.05	C-D	u
59. Very critical of others - always telling others what is wrong with them.	1.75	C	1.11	1.19	Agg	u
60. Gets carried away by his (her) feelings, acts on them right away.	2.01	C	1.27	1.37	A	u
61. Others seem to want to be with him (her).	20.00*	NC	1.74	1.41	C-M	d
62. Seems distrustful of others; doesn't think he (she) can rely on others or believe their promises.	2.51	C	1.03	1.09	C-D	u
#63. Feelings are easily hurt.	.008	C	1.64	1.64	A	u
64. Talks in a funny way (e.g. stutter, lisp).	.007	NC	1.05	1.05	V	u
65. Asks the same question over and over again.	1.26	C	1.08	1.14	N-D	u
66. Seems quiet when around other children.	3.45	NC	1.04	1.00	C-D	u
67. Has a characteristic mannerism or nervous habit. Specify: _____	5.61*	C	1.09	1.22	M	
68. Makes friends quickly and easily.	14.77*	NC	1.74	1.46	C-D	d
69. Lacks pep and complains of being tired.	1.38	NC	1.04	1.01	M	u
70. Quickly loses interest in an activity.	12.23*	C	1.13	1.35	A-C	u
71. Sucks thumb.	.38	C	1.07	1.10	M	u
72. Very moody - sad one minute and happy the next.	1.90	C	1.07	1.14	A	u
#73. Will interrupt someone else in order to state his (her) opinions.	.007	C	1.50	1.51	A-C	u
74. Talks or mutters to self as if conversing with self.	1.41	C	1.05	1.10	V	u

## Appendix F Continued

Item	CS		MAS		AB	D
	V	D	NC	C		
75. Self confident.	31.04*	NC	1.67	1.25	C-M	d
76. Bullies younger children.	5.65*	C	1.05	1.16	Agg	u
77. Plays mostly with younger or smaller children - even when children of own age are around.	12.68*	C	1.03	1.20	C-D	u
78. Seems sad and unhappy.	8.92*	C	1.03	1.16	A	u
79. Uses "baby talk."	.37	C	1.04	1.06	N-D	u
80. Tends to go too far unless frequently reminded of rules.	8.29*	C	1.23	1.43	A-C	u
81. Often becomes so stuck on one idea that he (she) can't stop thinking or talking about it.	2.87	C	1.18	1.28	A	u
82. Does not wait for others to approach but seeks others out.	1.55	NC	1.29	1.21	C-D	d
83. Talks all the time.	4.25*	NC	1.29	1.16	V	u
84. Will fight in a rough way where others could really get hurt.	3.74*	C	1.05	1.14	Agg	u
85. Refuses to share things with others.	2.59	C	1.07	1.15	C-D	u
86. Brags about what he (she) can do.	.19	NC	1.25	1.22	C-M	d
87. Holds a grudge.	1.34	C	1.06	1.11	A	u
88. Often tries to do more than he (she) can handle on his (her) own.	.03	C	1.19	1.20	C-M	u
89. Prefers standing by adults when other children are present.	.08	C	1.05	1.06	N-D	u
90. Often has to be reminded of what he (she) can and cannot do.	14.80*	C	1.20	1.47	A-C	u
91. Is frightened of being alone.	.38	NC	1.11	1.09	A	u
92. Uses mostly gestures or movements to express or communicate feelings.	1.45	NC	1.06	1.02	M	u
93. Avoids talking about himself (herself).	.14	NC	1.06	1.05	V	u
94. Threatens to hit or hurt others.	10.05*	C	1.05	1.21	Agg	u

## Appendix F Continued

Item	CS		MAS		AB	D
	V	D	NC	C		
95. Seems out of touch with what is going on around him (her) - off in his (her) own world.	11.05*	C	1.02	1.16	C-D	u
96. Often seems angry for no particular reason, expresses it in many different ways.	.09	C	1.06	1.07	A	u
97. Has uncontrollable outbursts of temper.	9.92*	C	1.08	1.26	A	u
98. Able to stand up for himself (herself).	9.61*	NC	1.69	1.46	C-M	d
99. Likes to perform for company.	1.81	NC	1.31	1.22	N-D	d
100. Polite and cooperative with others.	17.66*	NC	1.70	1.38	A-C	d
101. Easily embarrassed.	5.22*	NC	1.32	1.17	A	u
102. Body often looks tense, as if expecting a fight.	1.93	C	1.02	1.06	M	u
103. Careful in explanations - precise.	9.22*	NC	1.28	1.10	V	d
104. Often breaks the rules in games with others.	7.31*	C	1.10	1.26	Agg	u
105. Avoids physical contact with others.	.23	NC	1.05	1.04	C-D	u
106. Easily scared.	.76	NC	1.16	1.11	C-M	u
107. Doesn't like to let others know how he (she) feels.	.56	NC	1.18	1.14	A	u
108. Frequently disappointed.	2.28	C	1.18	1.27	C-M	u
109. A new situation seems to bring out the show-off in him (her).	.44	C	1.11	1.15	N-D	u
110. When told to do something he (she) doesn't want to do, he (she) becomes very angry.	12.38*	C	1.23	1.48	A-C	u
111. Often acts silly.	.28	C	1.26	1.30	A	u
112. Play is aimless, doesn't seem to make or accomplish anything.	6.14*	C	1.02	1.11	M	u
#113. Is curious about things.	7.70*	NC	1.85	1.68	V	d
114. Prefers competitive games.	14.73*	NC	1.43	1.16	Agg	
115. Likes to play with boys instead of girls.	.31	C	1.35	1.40	C-D	u

## Appendix F Continued

Item	CS		MAS		AB	D
	V	D	NC	C		
116. Shows appreciation when others help or do things for him (her).	8.34*	NC	1.63	1.41	N-D	d
117. Seems afraid to try anything new.	2.10	C	1.05	1.11	C-M	u
118. Doesn't like to ask others for help.	.03	NC	1.09	1.09	N-D	u
119. Will lie to get out of a tight spot.	11.29*	C	1.24	1.48	A-C	u
120. Nothing seems to interest him (her).	3.53	C	1.01	1.06	A	u
#121. Energetic.	12.53*	NC	1.81	1.57	M	d
#122. Asks sensible questions in new situation.	5.82*	NC	1.73	1.56	V	d
123. Aggressive and overpowering with other children.	2.43	C	1.09	1.17	Agg	u
124. Likes to do things well so others will notice him (her).	2.61	NC	1.54	1.42	N-D	d
#125. Shows pleasure and involvement in most things he (she) does - enthusiastic.	11.31*	NC	1.75	1.51	A	d
126. Seems selfish, always wants own way.	5.98*	C	1.14	1.28	N-D	u
127. Doesn't seem to care about how he (she) looks - often looks sloppy.	12.65*	C	1.07	1.27	C-M	u
128. Bossy with others.	2.05	C	1.28	1.38	A-C	u
129. Makes faces and acts "silly."	.80	C	1.13	1.17	M	u
130. Tires easily in activities.	1.09	C	1.02	1.05	M	u
131. Speech often seems unrelated to what is going on.	3.53	C	1.01	1.06	V	u
132. Blows up very easily when bothered by someone.	12.39*	C	1.22	1.47	Agg	u
133. Stays to self during games.	.03	NC	1.04	1.04	C-D	u
134. Prefers following others to taking the initiative.	5.09*	C	1.07	1.19	C-M	u
135. Says he (she) is not as good as others - feels bad about himself (herself).	2.31	C	1.13	1.21	C-M	u
136. Competes with other children.	16.25*	NC	1.63	1.32	N-D	d
137. Does what is expected to do, but grumbles about it.	1.33	NC	1.47	1.38	A-C	d

## Appendix F Continued

Item	CS		MAS		AB	D
	V	D	NC	C		
138. When he (she) likes someone, he (she) tells them so.	.92	NC	1.36	1.30	A	d
139. Pitches in when things are to be done.	10.99*	NC	1.49	1.25	N-D	d
140. Fidgety and restless.	10.27*	C	1.21	1.43	M	u
141. Speaks only in response to direct questioning.	.23	NC	1.05	1.04	V	u
142. Gets other children stirred up to mischief.	7.74*	C	1.03	1.15	Agg	u
143. Acts as if everyone were against him.	6.36*	C	1.10	1.25	C-D	u
144. Makes rules for others.	1.34	C	1.20	1.27	C-M	d
145. Quick and clever.	10.14*	NC	1.57	1.33	C-M	d
146. Learns quickly from others.	25.83*	NC	1.79	1.42	N-D	d
147. Once he (she) makes up his (her) mind about something, it's hard for him (her) to change.	.69	C	1.32	1.38	A-C	u
148. Shows delight when hurting others.	.54	C	1.01	1.02	A	u
#149. Affectionate - enjoys being physically close to others.	1.12	NC	1.65	1.57	A	d
150. Retains composure even when those around him (her) are acting in a boisterous way.	6.83*	NC	1.16	1.04	A-D	d
151. Prefers playing with older or bigger children even when child of own age are around.	4.47*	NC	1.15	1.05	C-D	u
152. Often tattles on others.	.04	C	1.27	1.28	Agg	u
153. Speaks so rapidly he (she) is difficult to understand.	2.24	NC	1.09	1.04	V	u
154. Quickly moves from one activity to the next.	.85	C	1.28	1.35	M	u



## **Abbreviations used in Appendix F**

### **Table Headings**

CS = Chi-Square  
V = Value  
D = Direction (Clinic or Non-Clinic)  
  
MAS = Mean Agreement Score  
NC = Score for Non-Clinic Group  
C = Score for Clinic Group  
  
AB = Area of Behavior  
D = Desirability of Trait (desirable or undesirable)

### **Insertions in Table**

\* = Attained significance at  $p \leq .05$   
# = Mean agreement scores are above 1.5 for both adjustment groups  
d = Desirable trait  
u = Undesirable trait

### **Areas of Behavior**

A = Expression of Affect  
A-C = Authority - Control  
Agg = Aggression  
C-D = Closeness - Distance  
C-M = Competence - Mastery  
M = Motoric functioning  
N-D = Nurturance - Dependency  
V = Verbal behavior

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