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# Caregivers' Perceptions About Their Children Identified as Having Atypical Behavior



**A Dissertation Presented**
**For the**
**Doctor of Philosophy Degree**
**University of Tennessee, Knoxville**

**Catherine Swanson Cain**
**December 2003**

*I would like to dedicate this dissertation to*
*Morgan I Cain, III*
*who lovingly sacrificed years of time,*
*emotional support, and finances to make my*
*dream of obtaining a PhD come true.*
*It's your turn, Baby…..*

*I would like to thank the members of my committee for their guidance, patience, and personal time. Thank you Dr. Susan Benner (chair), Dr. Amos Hatch, Dr. Sharon Judge and Dr. Priscilla Blanton.*

***"The self and social relationships are inseparable, forming yin and yang of the underlying gestalt of psychocultural processes" (Kitayama, 2000, p. 1145).***

# ABSTRACT

Past research on atypical behavior in young children has primarily focused on the caregiver and/or child, isolating characteristics such as the caregiver's parenting or the child's temperament (Deater-Deckard & O'Connor, 2000; Thomas & Clark, 1998). Current research has moved toward trying to build a more comprehensive and in-depth understanding of caregiver-child relationships (Bugental, 2000). One way of trying to understand caregiver-child relationships is to look at perceptions the caregiver has of the relationship (Stern & Smith, 1999). Caregiver perceptions include conscious reflections, what the caregiver knows and thinks about, and what the caregiver chooses to talk about (Bugental, 2000). Differences in family relationships, values and rules, history, the environment, practices of society, and cultural norms must also be considered (Grotevant, 1997; Hinde, 1991; Kitayama & Markus, 2000). The complexity of these many influential factors suggests the need to study caregiver relationships with their child in more detail (Baldwin, 1992; Berlin & Cassidy, 1999; Crittenden, 1988).

This qualitative study involves the exploration of caregivers' perceptions about their relationships with their children whom have been identified as having atypical behavior, taking into consideration the caregivers' perceptions of the many contextual factors that influence the relationship across time.

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## INTRODUCTION

He sat in the dirt at the edge of the playground rocking back and forth. Blonde hair and blue eyed, his rose colored cheeks were the hue of a healthy, robust child. Upon first glance he looked like any other typically developing four-year-old. But Adam was only semi-aware of the other children running around him in their super hero make-believe games. Even when a child nearly toppled over his outstretched legs he did not look up. His hands were clenched together and pressed between his plump thighs. His vacant eyes were locked on the area where hands met legs.

When I approached, he looked up and instantly forced a superficial smile. I asked him what he was doing and he said nothing for a moment, then without making eye contact he looked down and carefully lifted his dirt-streaked hands to show me the accomplishments of his play. In his hand was a small twig that had been sharpened to a point at one end. Adam had been using it to gouge the meaty flesh on the inside of his thigh and there was blood in several places. When I did not react, the superficially charming demeanor returned and he said in a cheery voice, "Oops, Adam accidentally cut himself again." Adam always addressed himself in the third person, as if he were on the outside looking in.

Adam had been referred to the mental health treatment facility I worked in by a local psychiatrist who had been treating him in the psychiatric ward of a nearby hospital. He had been admitted after his mother, Stephanie, found him trying to

suffocate his younger, eight-month-old sister with a pillow. Stephanie openly admitted needing help. What had gone wrong in her relationship with her child to make him do the things he did? She perceived herself to be at fault and had been openly criticized by others for having "caused" Adam's behavior. She wondered if his behavior was related to the fact that in the past, other family members had been diagnosed with mental health issues. She was fearful for both of their futures.

The development of atypical behavior in young children is increasingly becoming a focus for research (Fonagy, 1998; Kochanska, Murray, Jacques, Koenig, & Vandegeest, 1996). Karen (1994) suggests that there are least a million other children like Adam in New York City alone. It is estimated that as many as 5-10%, or, 3-6 million children nationwide, have behavior problems severe enough to be referred for special education services (Webster-Stratton, 1990).

According to Neisworth, Bagnato, Salvia, and Hunt (1999), atypical behavior refers to significant delays or dysfunctions in a child's behavior associated with neurobehavioral characteristics or a lag in developmental behavior. It is frequently associated with extreme temperamental styles and self-regulatory difficulty. It is also the number one reason children are referred to regional intervention programs across the country (Blair, Umbreit, & Boss, 1999; Carta, Sideridis, Rinkel, Guimaraes, Greenwood, Baggett, Peterson, Atwater, McEvory, & McConnell, 1994).

As is common in families where a child has been identified as having atypical behavior, Stephanie wondered if Adam's problems were her fault. In addition, she either spoke of actual accusations by others of being the cause of Adam's misbehavior, or at times, perceived others felt she was the cause of his problems. The perception of the caregiver being at fault is fostered by cultural beliefs and values, and societal practices. Therefore, past research on atypical behavior has focused primarily on characteristics of the caregiver and/or child, assuming a cause and effect relationship between those characteristics and the child's atypical behavior (Deater-Deckard & O'Connor, 2000; Thomas & Clark, 1998).

Rather than focusing on isolated characteristics of the caregiver or child many theorists suggest the need to study elements of the caregiver-child relationship (Bugental, 2000; Dunn, 1993; Hinde, 1987; Schaffer, 1991) that take into consideration the many contextual factors that surround the relationship, and in particular, the perceptions the caregiver has about those factors (Stern & Smith, 1999). Although caregivers may share common contextual factors, it is the perception of those factors that determines the effect the factors have on the caregiver-child relationship. For example, living in poverty may be a stressor for one caregiver and simply an accepted fact of life for another caregiver. This study will examine caregiver perceptions of the contextual factors surrounding them that influence their relationship with a child that has been identified as having atypical behavior.

## RATIONALE

Understanding caregiver perceptions is important to understanding how a caregiver-child relationship functions because of the influence those perceptions have on the relationship (Stern & Smith, 1999). For the purpose of this study, a caregiver is defined as either the biological or adoptive parent of the child. Perceptions include conscious reflections the caregiver makes, what the caregiver knows and thinks about, and what the caregiver chooses to talk about (Bugental, 2000).

Prior research on caregiver perceptions has followed various courses. Theorists have studied the cross generational transmission of perceived causes of child behavior (Burks & Parke, 1996), attributional biases of caregivers (Bugental, Blue, & Cruzcosa, 1989; Silvester, Bentovim, Stratton, & Hanks,1995: Smith & O'Leary, 1995) and the relationship of the caregiver's perceived locus of control of a child's behavior (Janssens, 1994; Roberts, Joe, & Rowe-Hallbert, 1992; Carton & Carton, 1998). Similar studies have focused on caregivers' beliefs about their own and their children's emotions (Gottman, Katz, & Hooven, 1996), as well as caregiver perceptions of self-efficacy (Coleman & Karraker, 1997; Johnston & Mash, 1989).

These studies add greatly to our understanding of how caregiver-child relationships function, but do not take into consideration the complexity of relationships in general. A caregiver-child relationship is not isolated, functioning in and of itself. Instead, relationships are greatly influenced by other relationships, by cultural values, practices, and rules, by past and present

experiences the caregiver and child have had, and by the type of environment the parent-child relationship is embedded in (Grotevant, 1997; Hinde, 1991; Kitayama & Markus, 2000). This complexity of influential factors suggests the need to study caregiver-child relationships in a comprehensive way that captures the many qualitative differences among relationships (Baldwin, 1992; Berlin & Cassidy, 1999; Crittenden, 1988).

Capturing the almost infinite ways in which these qualitative differences influence caregivers' perceptions, and how these perceptions influence the caregiver-child relationship, is nearly an impossible task. Yet, there is a current need to study these factors to better appreciate and understand the relevance of perceptions to psychosocial behavior in young children. Some researchers (Moffitt, 1990; White, Moffitt, Earls, Robins, & Silva, 1990) suggest there is a direct correlation between caregiver perceptions and child behavior. The intent of this study was not to look for cause and effect relationships between caregiver perceptions and atypical behavior in children. Rather, this study explored caregivers' perceptions about their interactions with their child without a linear, cause and effect format. To do this, I used an inductive approach in which I interviewed caregivers of children with atypical behavior, allowing caregivers to express and interpret their relationships with their children.

In addition, information about social, cultural, historical, and relational factors influencing the relationship was collected from forms the caregiver filled out when referring the child behavioral help through the Success By 6 program. Success By 6 (SB6) is an early intervention behavioral health resource for anyone working

with young children who have emotional, social, or behavioral health needs. In addition, caregivers completed the Temperament and Atypical Behavior Scale: Early Childhood Indicators of Developmental Dysfunction (TABS) (Neisworth, et al., 1999) twas filled out by the caregiver. The TABS is allows the caregiver to rate the child's behavior in four sub-categories, showing the type and intensity of atypical behavior within those categories.

## PURPOSE OF STUDY

Optimally, caregivers continuously assess what is going on with their child to determine why a child is behaving in a particular way. Caregivers also infer the needs, motives, and limitations of their child before deciding how they will respond to the child. How they respond, is in part, influenced by the perceptions the caregiver has of the child, the internal factors within the relationship, and external factors that have an effect on the caregiver-child relationship. The purpose of this study was to explore caregivers' perceptions about their children, about their relationship with their children, and about the factors that the caregiver felt influenced the relationship. The guiding research question, and sub-questions, were as follows:

## RESEARCH QUESTIONS

**What perceptions do primary caregivers of young children with atypical social/emotional behavior have about their relationship with their children?**

- **How do caregivers describe and make sense of their children's behavior?**
- **What factors do caregivers believe contribute to their children's behavior?**
- **What expectations do caregivers have for their children?**

Most prior research that has been conducted on caregiver-child relationships has been based on social-cognitive theoretical models. One of the guiding themes of this theory is that relationship behaviors become schematically, or cognitively, represented. These representations, or perceptions of reality, then guide future relationship behavior (Bargh, Chen, & Burrows, 1996; Bretherton, 1990; Bowlby, 1969, 1988). As a caregiver interacts with a child, the thought process the caregiver uses becomes memory-based and automatic (Bugental, Lewis, Lin, Lyon, & Kopeikin, 1999; Nix, Rinderhughes, Dodge, Bates, & Pettit, 1999). An analogy would be of a needle stuck in a groove of a record. The needle rides within a set groove, following the same pattern each time the record is played. Caregivers may also fall into set patterns, or "a groove in a record," even when those patterns of behavior are ineffective. How and why these ineffective interactions persist may largely depend upon the caregiver's perception of the child's behavior, of his or her own self, or of external factors surrounding the relationship.

# THEORETICAL FRAMEWORKS

## Introduction

Two theoretical frameworks guide this study: social-cognitive theory and family systems theory. My understanding of social-cognitive theory follows two complimentary, but varying, courses of research knowledge: the internal working model theory and symbolic interactionism. I chose to separate these theories because I believe the variation between the two was significant in explaining how caregiver-child relationships are constructed. Family systems theory was used to compliment the social cognition theories in that it supported the interconnectedness of relationships within relationships and over time.

## Internal Working Model

Bowlby (1969) was one of the first researchers to use the "internal working model" to study and understand caregiver-child relationships. The internal working model is not just a filter or lens from which the individual views the world, but rather a core, organizational structure, or blueprint, that may actually control an individual's behavior (Bretherton, 1990; Collins & Read, 1994).

Over time, memories of social experiences become generalized and are no longer memories of actual events, but become abstract averages of many similar events (Zeanah & Anders, 1987). When new experiences occur, the internal working model is activated. Stored memories that are similar in content or nature come to surface, influencing how the individual responds in a new situation (Bretherton, 1990).

As the caregiver and child interact, they develop behavioral responses to each other that become increasingly coordinated and patterned over time (Bretherton, 1990; Sigel, McGillicuddy, & Goodnow, 1992; Stafford & Bayer, 1993). The caregiver learns what behaviors to expect from the child (e.g., colicky or easy to comfort) and the child learns what behaviors to expect from the caregiver (e.g., attempts to comfort or stop the crying). It is within the relational interaction that the child comes to know about him or herself, and about the caregiver (Winnicott, 1965). This knowledge, then, influences the child's relationship with others.

The internal working model theory attempts to explain the influence of relationships upon each other, including an individual's relationship with:

1) The self,
2) The other, and,
3) The self and the other (Bowlby, 1969, 1988; Crittenden, 1990).

The elements of the "self" can include traits, values, goals, needs, cultural practices, expectations, and stored memories (Rogers, Kuiper, & Kirker , 1977; Rogers, Rogers, & Kuiper, 1979). They might also include incentives, plans, and scripts for behavior (Markus & Wurf, 1987). The cognitive notion of the "self" is based on repeated categorizations of one's behavior by self and others (Kitayama & Markus, 1999). For example, if a newborn develops colic and thus experiences excessive periods of intense crying and the caregiver is unable to provide comfort to the child, the caregiver might experience feelings of helplessness or inadequacy. The caregiver might learn, over time, to anticipate

that each time the child cries, she or he will not be able to comfort the child. This type of repetitive interaction leads the caregiver to develop a relational schema, or internal working model, representing "helplessness" or "inadequacy" in relation to the child. Even after the colic passes, this schema may be activated each time the baby cries for other reasons, again, making the caregiver feel helpless.

Although the internal working model is believed to provide a means to organize behavioral actions systematically, it is not static. Fogel (1995) argues that the self is "a relational process that is continuously evolving" (p. 134). As humans experience new situations, new behavioral strategies are added to the internal working model structure, and previous strategies may be altered or replaced. These new experiences keep the internal working model in an ever changing state of adaptation that is constructed over time (Sroufe, 1988).

Pipp (1990) postulates two separate ways of knowing the self and the other: 1) through a sensorimotor internal working model, and 2) through a representational internal working model. In the first year and a half of life, the child experiences the caregiver through the senses of touch, taste, smell, sound, and sight. During this sensorimotor stage, the child is one with the caregiver, not understanding that he or she is a different entity (Harel, Oppenheim, Tirosh, & Ginni, 1999). By the age of two, the child has internalized extensive procedures and expectations regarding reciprocity and turn-taking within the relationship. An extensive repertoire of rules has been internalized, about where things belong, what is expected, and what should be done in particular circumstances (Kagan, 1981). This implies that in the absence of the caregiver, the child carries out the

caregiver's internalized rules, so that the rules are activated in a new social context and carried out autonomously (Emde, 1989).

Once the child shows an emerging capacity to initiate his or her own actions, he or she becomes less dependent upon the caregiver. As cognitive and language skills increase, the sensorimotor working model is replaced with a representational working model. The child begins to understand the informational content of the caregiver's communication, but remains limited in his or her ability to problem solve due to immature understanding and use of language (Mahler, 1979). The child attains the capacity for empathy, emotional arousal and comforting, helping, and sharing (Emde, 1989; Zahn-Waxler & Radke-Yarrow, 1982). The differences between self and caregiver knowledge disappears. The working model the child then uses is not just a replication of the caregiver's working model, but a blend of the child's own working model with the working model of the caregiver (Hoffman, Younblade, Coley, Fuligni, & Kovacs 1999; Pipp, 1990).

By the age of three, the need for caregiver support decreases as the child gradually learns to take over regulatory responsibilities through successful learning experiences with the caregiver. Thus, the child progresses from relying on others to assist in problem solving situations to the internalized skills acquired. This growing sense of identity, and the ability to recall the dictates of the caregiver, leads to the valuation of new behavioral and social skills in the child (Kopp, 1982; Landry, Smith, Swank, & Miller-Loncar, 2000).

## Symbolic Interactionism

Symbolic interactionism is a distinct theoretical approach within the social-cognition model that is not easily compared with other theories (Baldwin, 1992). It is often considered a conceptual framework rather than a specific theory (Blumer, 1969) and is deeply embedded in the philosophy of pragmatism and the work of Charles Darwin (Charon, 1989). Although Mead (1934) is most often credited with the founding base of symbolic interactionism, contributors such as Blumer (1969) and Cooley (1902) have also influenced my understanding of symbolic interactionism as it applies to this study. I have separated symbolic interactionism from the internal working model theory because, although these theories share many of the same theoretical concepts, they offer slightly different perspectives on one concept that is of particular interest.

Symbolic interactionism emphasizes the interrelationship between the individual and society, each as a product of the other. A critical aspect of symbolic interactionism is that humans live in a symbolic as well as a physical environment. Thus, to understand an individual's behavior, the symbols and values of the social group the individual lives in must also be studied. For example, the symbolic meaning a caregiver might assign to the birth of a new baby after trying to conceive for ten years would be different from the meaning of that birth to an overwhelmed caregiver with several children. Because symbolic meanings are shared with others through social interactions, understanding what meaning a social group assigns to a particular event is also important. Some cultures would give social approval to a family who was able to bring several

children into the world, while another culture might give social disapproval to the family of several children.

Blumer (1969) suggests that symbolic interactionism is based on three major premises:

1) Individuals act towards objects, including other people as objects, on the basis of the meaning these objects have for them.
2) The meaning of an object emerges from how the individual perceives that other people respond and act toward the object.
3) Individuals assign meaning to situations, other people, objects, and themselves through an interpretative process.

In the caregiver-child relationship, the interactions that take place between caregiver and child, and caregiver and others, eventually form mutually shared expectations and norms of practice. Over time and repetition, the caregiver begins to "expect" certain behaviors from the child just as the child "expects" certain behaviors from the caregiver. Likewise, both caregiver and child form mental representations, or perceptions, of each other. The function of perceptions and their meanings is important. Caregivers have a major role in the socializing of the child. How the caregiver "perceives" self and child steers the course of behavior within the caregiver-child relationship.

Whether or not a caregiver perceives him or herself to be in control of a misbehaving child will influence the process and outcome of a social interaction. A caregiver that feels powerless may react defensively, whereas a caregiver that feels in control might handle the same misbehavior with optimistic calm.

People actively interpret, and give meaning to, their every day life experiences based on their own attributes, thoughts, experiences, and attitudes (Kitayama & Markus, 1999, 2000). Using the last example, the caregiver who perceived him or herself to be powerless, and out of control, may have developed that feeling as a result of being criticized by a spouse or relative repeatedly. Or, the perception of powerlessness could have resulted simply because the caregiver thought the spouse or relative was critical of his or her ability to handle the child even if nothing was said. It is a caregiver's perception of how others see him or her that steers behavior and determines the course of action.

Within the internal working model framework, behavior is seen as being driven by instincts, forces, needs, drives, or built in motives (Burr, Leigh, Day, & Constantine, 1979). In contrast, within the symbolic interactionism framework, individuals are seen as social products that act as they think others expect them to act, and according to how they see others acting (Cooley, 1902; Mead, 1934). This acting is not an intra-psychological process as suggested by the internal working model theory, but is a social process that is fluent and ever changing, with the individual making choices about how to act or behave.

As people relate with other people, objects, or situations, they continue to re-evaluate and assign new symbolic meaning to their perceptions. A caregiver who has assigned the label of "difficult" or "defiant" to the misbehaving child and sees the child's behavior as deliberate, will interact differently than a caregiver who perceives the child as precocious or intellectually charming with the misbehavior being the result of an underchallenged mind. The caregiver's response to the

child's misbehavior is then based on these shared symbolic representations or perceptions (Stafford & Bayer, 1993). The first caregiver might chose to take the child to a therapist and request medication. The caregiver of the child who is perceived as being intelligent might opt to place the child in a high-quality child care setting that focuses on cognitive development. The child, in turn, acts according to the perceptions of how he or she thinks the caregiver, and society, expects him or her to act (Stafford & Bayer, 1993) creating a spiral of interactions that follow a circular, rather than a linear, cause and effect course.

As a caregiver-child relationship develops, the caregiver takes the role of "socializer," teaching the child rules that govern the relationship. These rules are determined through the interactions of the relationship, itself, and by the rules the caregiver has learned in other relationships. For example, a caregiver may have been spanked as a child, thus uses this behavior management technique to handle his or her own child's misbehavior. If through socializing the caregiver learns that time-out is more effective, the caregiver might use this behavior management technique instead.

With the increased development of motor, sensory, and language skills, the child becomes an active contributor to the relationship as well, influencing how the relationship develops (Stafford & Bayer, 1993). The child develops his or her own perceptions about objects, people, and events and assigns symbolic meaning to them based upon individual perceptions and the perceptions inherited from the caregiver. A child who perceives that others think he or she is difficult or defiant, might act in the manner expected. A child who perceives that

others see him or her as intelligent rather than disobedient or defiant, will most likely emulate scholarly-like behaviors. The relationship then becomes an act of adjusting and readjusting behavior on the part of both caregiver and child as both sets of perceptions, interpretations, and meanings are brought together in what Ekman (1972) calls social referencing.

Social referencing is the use of one's perception of another person's interpretation of the situation to form one's own understanding. "Symbiotic harmony" (Rothbaum, Pott, Azuma, Miyake, & Miyamoto, 2000), or "goodness of fit," occurs when certain characteristics of the child mesh with those of the caregiver creating a harmonious interactional relationship (Belsky & Vondra, 1985). If both the caregiver and child perceive the misbehavior to be a part of a desirable, or at least accepted, trait there will be less friction between caregiver and child.

Whereas the internal working model is based on a schematic, memory-based construct with the caregiver drawing upon interactional behaviors at an almost unconscious level, symbolic interactionism theorists suggest that the caregiver at times brings these constructs to the conscious before making a decision about how to interact. The meaning a caregiver assigns to an event is constantly changing as new interactions take place, both within, and out of the relationship. This differing factor is critical to understanding how a caregiver perceives their relationship with their child and is the reason for including both viewpoints as frameworks for this study.

## Family Systems Theory

The family systems theory compliments the theoretical social-cognition frameworks in that the caregiver-child relationship is viewed not only in and of itself, but also in the context of other relationships, within a family structure, and within greater society. The three key components of the family systems model that apply to this study are:

1) The family system has boundaries against the outside world and has its own dynamic character (Minuchin & Fishman, 1981).
2) The family system contains smaller subsystems that interact and are governed by the rules, patterns, and expectations of the family system (Nichols & Schwartz, 1998).
3) Dyadic relationships can exist even in the absence of interaction based on past memories, experiences, and future expectations (Hinde, 1987, 1988).

The caregiver-child relationship cannot be understood in isolation from the family as a whole. Within the family, an organizational pattern of interactions exists among family members. Each family member's behavior influences each other family member's behavior in a circular, as opposed to a linear, connection. Rules and boundaries, whether overt or covert, influence the behavior and actions of all family members. Families tend to cling to these rules and boundaries, maintaining status quo. Minuchin and Fishman (1981) call this homeostasis.

How the caregiver perceives the caregiver-child relationship cannot be understood without understanding family rules, and the roles of each person

within the family (e.g., who does what, where, when, and how) (Hinde, 1987, 1989). For example, one family may have a rule, whether spoken or not, that family problems are not shared with anyone outside the family. Another family may be open to discussing family problems with others and would not see this as a violation of a family rule.

Each family member also performs certain roles within the family. For example, in some families, the mother is responsible for the care of the children while the father works. In other families, both parents may work and share the child care equally.

Although these roles and rules serve to perpetuate a status quo position that is resistant to change, events that occur over time, and experiences the family has, do change the way the family functions. Significant events, such as the death of a family member or moving to another part of the country will affect the interactions between family members and roles that family members play (Stafford & Bayer, 1993). For example, in the family where the father was the breadwinner and the mother stayed at home, the death of the father might require the mother to change her role. Winning the state lottery might mean to the father and mother who both worked, that neither would have to work in the future.

Families also interact differently during different stages of the life cycle (Carter & McGoldrick, 1999). A young, adolescent girl still living with her own parents might act and respond quite differently to the role of providing care to a child with atypical behavior than a mother in a traditional two-parent family in the child-

rearing years. Each stage of the life cycle has its own unique set of beliefs, values, needs, and stressors that are shared within families, and within greater society. These factors influence the caregiver's own perception about how they interact with their child.

Families are also composed of subsystems. A subsystem might consist of a mother and father, a caregiver and child, or a child and a non-primary caregiver living outside the home, as in the case of divorce. Subsystems also have boundaries and rules that guide them. The caregiver may have to set very different boundaries and rules for a child with typically developing behavior than a child with atypical behavior. For example, the child with typical behavior may instantly respond to a verbal direction given by the caregiver, while the child with atypical behavior may need physical assistance to comply. A caregiver might be experiencing difficulty in a marital relationship, adding stress to the challenge of meeting the demands of the child with atypical behavior, thus the caregiver's level of patience and tolerance of the child's behavior may be lowered.

The caregiver's perception of how the child is acting and how the child should act, also depends upon the social practices that others use. Communities have expectations about how young children should behave and about how a caregiver should interact should the child's behavior deviate from what is expected. People decide what actions to take based on individual perceptions, on how others are perceived to view the event, and on the symbolic meanings that have been assigned (Stafford & Bayer, 1993). Thus, culture, caregiving practices, social values, and beliefs guide how the caregiver perceives the child's

behavior and what responses the caregiver chooses (Fogel, 1993, 2000; LaRossa & Reitzes, 1994; Kitayama & Markus, 1999; Rothbaum, et al., 2000).

How one community responds to a child with atypical behavior might be different from how another community responds. For example, in some communities, the caregiver might be blamed for raising a child with differing behavior than is considered normal. This community might not offer support, adding tension and stress to the caregiver-child relationship. Another community might view the child's atypical behavior to be an externalization of violence on television, thus blaming the media and providing feelings of empathy and support for the caregiver.

## SUMMARY

Relationships are constructed, made meaningful, sustained, and evolve over time, within relational, social, and cultural contexts. Combining social-cognition theories with a family systems model provides a structural framework that takes into consideration the complicated inter-relatedness of relationships and the effect they have on caregivers' perceptions about their relationship with their child.

## DEFINITIONS

For the purpose of this study, the following definitions are given to these terms used in this paper. The definitions did not originate from any one given source, but rather, from multiple sources.

**Atypical Behavior**

Atypical behavior refers to significant delays or dysfunctions in a child's behavior associated with neurobehavioral characteristics or a lag in developmental behavior. It is frequently associated with extreme temperamental styles and self-regulatory behaviors.

**Caregiver**

A caregiver is defined as a biological or adoptive caregiver who has the primary responsibility of providing care to the child.

**Culture**

Culture is defined as the intergenerational transmission of various combinations of symbolic (e.g., ideas, beliefs, and values) and behavioral (e.g., rituals and practices) factors. Symbolic factors might include caregiver expectations, goals, aspirations, values, gender roles, approaches to disciplining, religious or spiritual values, and ideas and beliefs about health, illness, and disabilities. Behavioral factors might include "scripts" about everyday routines, such as sleeping, feeding, and playing. They also include language and socialization practices.

**Differentiation**

Differentiation is a term to describe an individual's process of developing autonomy and becoming less dependent on the family or origin. It also refers to the separation of thought from feeling.

**Homeostasis**

Homeostasis means maintaining balance. An individual or family that has been threatened or disrupted, will try to preserve equilibrium by acting in a manner that will cause events or behaviors of others to return to what is considered by the individual to be normal or expected.

**Parental Relationship**

A parental relationship is defined as a mother-father, mother-significant other, father-significant other, or adoptive parents who are sharing responsibilities of caring for a children of the caregivers in this study.

**Perceptions**

Perceptions include, but are not limited to, the descriptions, beliefs, expectations, and attributions the caregivers have about their children, although I use these four types of perceptions as structure for this study. Perceptions are influenced by many factors, including the caregiver's culture, family structure, and past experiences. They are also influenced by the caregiver's goals, needs, successes or failures with past relational and interactional strategies, as well as defenses, values and class identification of the caregiver.

**Relationship**

A relationship is defined as an emotional connection between two or more people, whether that be a connection be between the caregiver and child, the caregiver and a partner, or even the caregiver and a complete stranger who influenced how they thought and felt.

**Self-Regulation**

Self-regulation is defined as the ability to comply with a request, to initiate and cease activities according to situational demands, to modulate the intensity, frequency, and duration of verbal and motor acts in social settings, to postpone acting upon a desired object or goal, and to generate socially approved behavior in the absence of external monitors (Kopp, 1982).

**Social Referencing**

Social referencing is the use of one's perception of another person's interpretation of the situation to form one's own understanding

**Social Support**

Social support refers to support given by a parenting partner, family members, relatives, neighborhood, colleagues, or others in the community. The support might be emotionally based, financial, psychological, physical, or social.

**Socio-cultural**

For the purpose of this study, the term 'socio-cultural' refers to relationships, influences or factors in the caregiver's neighborhoods, churches, communities, and schools. It also refers to the influences and factors related to ethnicity and culture, whether that culture is something that is related to ethnicity or refers to the 'culture' of a particular group of individuals.

## Temperament

Temperament can be defined as dimensions of the personality that are innate or appear early and includes patterns of emotional expression, activity, and attending. Temperaments are biologically rooted, and fairly stable over time.

# CHAPTER II: LITERATURE REVIEW

## INTRODUCTION

Caregiver perceptions about their child's behavior, whether positive or negative, are linked to a child's socioemotional functioning. How they are linked, is not well understood (Isley, O'Neil, Clatelter, & Parke, 1999; Kendziora & O'Leary, 1998). A common belief has been that caregivers of children with atypical behavior have biased perceptions of their children that are negative. Some researchers (Kendziora & O'Leary, 1998) suggest the few empirical tests that have fostered this belief have lacked conceptual and/or methodological clarity and have yielded mixed results.

In this section of the paper I discuss perceptions and how they relate to the caregiver-child relationship. I also discuss how perceptions are influenced by contextual factors. Contextual factors include characteristics of the child and caregiver, the influence of other relationships, and the socio-cultural environment.

## THE CAREGIVER-CHILD RELATIONSHIP

A child's sense of self, as well as the child's self in relation to others, begins in the early years of life, primarily during the child's first relationship. This relationship is typically, but not necessarily, with the child's mother (Stern, 1989; Winnicott, 1965). It is during this relationship that children first learn social practices that later serve to govern their behavior.

A relationship is defined as an interconnection between the caregiver and child. Over time and with multiple interactions, caregivers develop perceptions about the children they care for. They also develop perceptions about themselves in relation to the child, and about the interactions that occur within the relationship (Aber, Slade, Belsky, & Cmic, 1999). These perceptions are influenced by many factors, including the caregiver's social environment and culture, family structure, and past experiences (Belsky, 1984; Sigel, McGillicuddy, & Goodnow, 1992). Perceptions are also influenced by goals, needs, values, and class identification (Medinnus, 1967).

Studies of caregiver-child relationships have a long history in developmental psychology and social learning. As early as the 1950s, a common research procedure was to interview parents, or to provide parents with questionnaires, about their disciplinary and socialization practices in order to understand how caregiver-child relationships function (Sigel, et al., 1992).

Throughout the 1980s and 1990s, research practices focused on the caregiver-child relationship specifically, typically studying the interactional patterns of a mother and child in isolation while ignoring the presence and dynamics of the family or the socio-cultural setting. The caregiver's control over the child, ability to supervise and discipline the child, amount of time spent with child, and personality and style, have all been proposed to be associated with child well-being. Therefore, an underlying assumption of most studies has been that there is a linear, or, cause-effect relationship, between caregiver behaviors and child outcome (Thomas & Clark, 1998).

Although caregiver behaviors have been linked to child behavior (O'Conner, Hetherington, & Reiss, 1998) found that atypical behavior and social responsibility vary among siblings within the same family structure and under the care of the same adult. Caregiver-child relationship difficulties, although characteristically problematic in certain family types, do not occur in all cases. For example, poverty is a known factor that influences negative behavior in a child because of the stressors that are associated with it. Overcrowded living conditions, lack of financial security and transportation, and frequent moves are all aspects of poverty that can impact the family in a negative way. Yet, not all families in poverty have children with atypical behavior and financial security does not guarantee a child will develop typical social skills. In addition, children in seemingly well-functioning families exhibit non-compliant and negative behavior (Kuczynski & Kochanska, 1990).

Some researchers resist assigning meaning to difficult behavior in young children; arguing that difficult behavior is a normal stage of child development. Achenbach & Edelbrock (1983) discovered in a large-scale study of 2,600 normally developing children between the ages of four and five, that disobedience and destruction of one's own things were reported by approximately 50% of the caregivers. Other behaviors, such as fighting, negativism, destructiveness, and lying are also relatively frequent at differing points of time in normal development (Kazdin, 1995).

This is because relationships are different between any two people. In other words, a caregiver's relationship with one child will be different than the

caregiver's relationship with a sibling. For every different relationship, then, there are differently constructed behaviors that are unique to that relationship that become natural and habitual over time (Kitzyama & Markus, 2000; Rothbaum, et al., 2000). Because these differences are qualitative in nature, many researchers suggest the need to study caregiver-child relationships from a different perspective. Consequently, recent research has focused on bringing understanding to the many factors that influence the caregiver-child relationship. One line of research has focused on perceptions the caregiver has of the child and about the relationship they share (Bugental, 2000; Goodnow, 1996; Wamboldt, 2000). In the next section of this paper, I will synthesize these factors with caregiver perceptions of these factors, describing how they influence the caregiver-child relationship.

## CAREGIVER PERCEPTIONS

Caregiver perceptions are the single most powerful correlate with outcomes of caregiving stress, family adjustment, and psychological distress (Frey, Greenberg, & Fewell, 1989). In other words, a caregiver may be faced with extreme illness, marital discord, or a child identified as having atypical behavior and still feel uplifted and in control depending upon how the caregiver perceives him or herself, the situation, and the child. If the caregiver perceives the situation as temporary, and perhaps, a test of religious strength, he or she will act differently than a caregiver who perceives the child is out of control or that God is punishing him or her. Although the child's behavior is the same, the perception

the caregiver has about the behavior is different, thus influencing how each caregiver handles the behavior.

Caregiver perceptions vary and may include: perceived causes of the child's behavior (Burks & Parke, 1996), attributional biases (Bugental, Blue, & Cruzcosa, 1989; Silvester, et al., 1995: Smith & O'Leary, 1995), perceived locus of control (Janssens, 1994; Roberts et al., 1992; Carton & Carton, 1998), beliefs about their own and their children's emotions (Gottman, Katz, & Hooven, 1996) and feelings of self-efficacy (Coleman & Karraker, 1997; Johnston & Mash, 1989). Bugental (2000) suggests that perceptions fall into one of four different categories: 1) descriptive, 2) analytical, 3) evaluative, or 4) efficacy.

**Descriptive Perceptions**

Descriptive perceptions include what the caregiver knows and thinks about, and what they chose to share with others. These include the symbolic meanings that caregivers assign to objects, events and people, and the way in which these meanings are shared with others through social interaction. For example, a caregiver might assign the symbolic word of "rowdy" or "revengeful" to their child's behavior. These descriptions have specific meanings, both to the caregiver and to others that have relationships with the caregiver. Descriptive beliefs about the child's behavior then influence the disciplinary practices of the caregiver and the course of the behavior patterns within the relationship (Bates, Maslin, & Frankel, 1985). For example, a behavior that is described as "revengeful" would be handled very differently than a behavior described as "developmentally normal."

The caregiver also assigns descriptive meanings to perceptions about other relationships and the environment (Parke & O'Neil, 1996). The caregiver may describe the family of origin as being "controlling" or "loving." The environment might be described as "unsafe" or "supportive." The descriptive meaning the caregiver assigns is not just based on current practices, but on past experiences, the beliefs and perceptions of others, personal values and beliefs, and hopes and expectations the caregiver has. Sameroff & Emde (1989) suggest the caregiver internalizes these descriptive perceptions and their meanings, with the meanings serving as a base of social understanding that then influences how the caregiver perceives and interacts with others.

If a caregiver internalized the perception that others think he or she is incapable of handing the child's behavior, the caregiver may harbor a perception of being incapable. The caregiver then reacts to the child in the way he or she perceives to be seen. In other words, because others think the caregiver is incapable, the caregiver acts with incapability, the beliefs of the others becoming part of what the caregiver believes about him or herself.

**Analytical Perceptions**

Analytical perceptions include what, or to whom, the caregiver assigns causality of the child's behavior. The child's behavior might be perceived as a result of something the caregiver did (i.e., being too lenient or strict), or causality might be assigned to someone else (i.e., an incompetent teacher, or rough playmates in the neighborhood). How the caregiver views causality greatly influences the caregiver's response to the behavior. Caregivers who assign

causality to be biological in nature, such as difficult behavior associated with a specific disability such as Down syndrome, tend to be more tolerant than if the behavior is believed to be the result of an external factor (Bugental, 2000; Reimers, Wacker, Derby, & Cooper, 1995).

Caregivers of children with atypical behavior often perceive themselves to be the blame for the child's problem (Collins & Collins, 1990). This assigning of blame is reinforced through socio-cultural perceptions about the causation of atypical behavior in children. The circular relationship between feeling blamed and being blamed by others reinforces the negative stigma of having a child with atypical behavior, and the belief that the caregiver is the cause of the behavior.

If the caregiver's perception is changed, and the caregiver perceives that he or she can positively influence the difficult behavior of the child, the caregiver typically will gain a greater sense of control (Lefcourt, Miller, Ware, & Sherk, 1981). A caregiver's perception of positive contribution and being in control has been shown to be associated with outcomes of better well-being and lower general stress for both caregiver and child. It also has been associated with a decrease of difficult behavior in the child (Early & Poermer, 1993). How caregivers develop feelings of control and how or if they feel as if they are positively affecting a child's behavior depends largely on the influence family, social, and formal contexts (McDonald, Donner, & Poertner, 1992).

## Evaluative Perceptions

Evaluative perceptions include caregiver attitudes and values, views of desirability of the child's behavior, and parenting practices (Holden & Edwards,

1989). If the caregiver values strict and unquestionable obedience from a young child, the way in which the caregiver disciplines and interacts with the child will most likely differ from a caregiver who values autonomy.

Evaluative perceptions of a child's noncompliance are strongly correlated with externalizing behavior in the child. In most cases, caregivers attribute the noncompliance as deliberate rejection and will try to counter balance with more forceful or coercive tactics (Olson, Bates, Sandy, & Lanthier, 2000). In cases where the child uses direct and aversive forms of noncompliance, which is often the result when the caregiver increases the forcefulness of the interaction, the child tends to use more coercive strategies in return. The interaction pattern then becomes a circular spiral of escalating behaviors from both caregiver and child (Carson & Parke, 1996).

On the positive side, children's positive behaviors may actually serve as reinforcers for caregivers (Tronick & Cohn, 1989). A child that is positive by nature will influence the caregiver to also become positive. Likewise, caregivers that use positive interactions, receive more positive interactions from their child.

Evaluative perceptions also include caregiver goals for the child and for the relationship (Dix, Ruble, Grusec, & Nixon, 1986). For example, one caregiver might perceive a son's aggressive behavior to be a necessary protection in a neighborhood where crime is high. Thus, the child's aggression is perceived as a desirable goal. Another caregiver might view aggressive behavior as something that will inhibit the child from getting along with others at school and may try to repress or correct the behavior. Caregiver goals for their children influence how

the caregiver feels about the behavior, and the disciplinary or interactional behaviors the caregiver uses to direct the behavior (Webster-Stratton, 1989).

### Efficacy Perceptions

Perceptions of efficacy may include the connection between how the caregiver perceives "actual self" and the caregiver's desired reality, or the "ought to be self" (Bandura, 1989; Higgins, Fazio, Rohan, Zanna, 1998). For example, if a critical mother-in-law suggests that the disciplinary practices the caregiver uses are ineffective and the caregiver "ought" to do what another family member does, the caregiver may perceive the "actual self" as less desirable than the "ought to be self."

Some researchers question whether perceptions are self-aware acts, as suggested through a symbolic interactionist framework, or whether they are memory based and automatic, as might be concluded from an internal working model framework (Bugental, et al., 1997; Nix, et al., 1999). Because we cannot access internal processing in the caregiver, but can only study external behavior that might be associated with internal processing, this is a difficult question to answer.

## FACTORS INFLUENCING CAREGIVER PERCEPTIONS

Many contextual factors that are multi-faceted have influence on caregiver perceptions. These include characteristics of the child and caregiver; influences of relationships; as well as factors in the environment, society, and culture. Although I will address each of these factors separately, it is important to

remember that no one factor can be separated out from the other. They are all interconnected and have a multi-directional influence on each other.

## Child Factors

Child development researchers agree that one of the first developmental tasks for an infant is to establish a relationship with a primary caregiver (Keller, 2000). The infant may actually be born with built-in skills for initiating, maintaining, and terminating social interactions with others (Brazelton & Als, 1979; Stern, 1977). Even very young infants are aware of their environment and the people within it. By a few weeks of age, the infant can engage in social interactions with the caregiver. As motor and sensory capabilities develop, infants become increasingly more able to interpret the social meaning of the actions of those around them and to initiate interactions of their own. Some researchers believe the child may actually have an increased sensitivity to social interactions during this time to enable them to learn social skills better (Perry & Marcellus, 1997; Belsky & MacKinnon, 1994). The capability to make an internal representation of the external world is the basis for learning and acting (Main, Kaplan, & Cassidy, 1985; Slade & Aber, 1992).

For many years, it was believed that the infant was a passive member of the caregiver-child relationship, with the caregiver having sole responsibility of the socialization and interactional behaviors the dyad used. This implies a one-way social learning influence. Current researchers suggest that the child is not only an active participant in the relationship, but may also serve as a catalyst. The child influences the caregiver, and the relationship, in the same way that the

caregiver influences the child (George & Solomon, 1996; Mosier & Rogoff, 1994; Stafford & Bayer, 1993).

The idea that a child has equal influence on the relationship makes sense when watching a caregiver interact with two different children. One child might easily be engaged into interaction, while another may be resistive to the exact same initiation made by the caregiver. How the child responds (i.e., easily engaged or resistive) influences how the caregiver reacts in response. Over time, the caregiver then develops cognitive perceptions of the child based on these experiences. One child may be perceived as "friendly" or "agreeable" and the other as "difficult" or "resistive." The strategies the caregiver uses to discipline or interact will vary between the two children based on these beliefs. There are three main factors pertaining to the child that have the most influence on the caregiver-child relationship: physiological state, temperament, and the evolution of self control (Zahn-Waxler, & Radke-Yarrow, 1982).

**Physiological State**

Children with various forms of disabilities may require the caregiver to meet the physical needs of the child first and the socioemotional needs of child and self second. Often, caregivers raising a child with a disability feel low levels of emotional reserve, making the task of forming a relationship challenging (Mullen, 1998). Wasserman, Allen, & Solomon (1985), found that young children with physical disabilities performed poorly in measures of focused play, language production, social initiation, and affective expression. They tended to be easily

distracted, clingy, and noncompliant. These factors hinder a caregiver's ability to interact with the child.

The type of disability the child has, and the intensity or nature of the disability, can interfere with how the child's interacts and how the caregiver perceives the child to interact. These perceptions then become part of the interactional process of caregiver and child.

**Temperament**

Child temperament also plays a significant role in the functioning of the caregiver-child relationship. According to Bates (1980), temperament can be defined as the repertoire of traits that are innate in a child or appear very early in life, and include patterns of emotional expression, activity, and attending.

The first longitudinal studies on temperament began in the 1950s by Thomas and Chess (1991). They found that temperament was one of the most significant factors children have that influence their own development and the caregiver-child relationship. Because individual differences in temperament appear early in life, it is difficult to know whether behavior guides temperament or temperament guides behavior.

Temperament is thought to be fairly stable over time. It can, however, be modified through social interaction. For example, a shy child might become more outgoing with consistent encouragement from a caregiver, or an impulsive child might become less impetuous through efforts of the caregiver to change the impulsivity of the child. Still, the core style of temperament is fairly stable.

Although temperament influences how a child acts, it is not predictive of atypical behavior (Rothbart & Bates, 1998). Even in a case where a child has a difficult temperamental personality, given the right care, the child can acquire socially appropriate behavior. Just as readily, children with easy temperaments, if provided with insensitive care, may develop difficult behaviors (Belsky, Fish, & Isabella, 1991; Crockenberg, 1981; Fish, Stiffer, & Belsky, 1991). The role temperament plays in the caregiver-child relationship is often thought to be dependent upon the child's ability to self-regulate.

**Self-Regulation**

Self-regulation has been defined as the ability to comply with a request, to initiate and cease activities according to the given situation, to control the intensity, frequency, and duration of verbal and motor acts. It also refers to being able to postpone an act, and to generate socially approved behavior in the absence of external monitors (Kopp, 1982).

Although a child does self-regulate certain behaviors even in infancy when early self-regulation skills are being developed, much of a child's behavior is largely regulated externally by the caregiver. For example, the caregiver prevents the child from hurting another, cues the child to say thank you when given a treat, or directs the child to play fairly. This is accomplished through establishing rules of conduct, by teaching self-regulation behaviors, and by modeling. Pipp (1990) suggests that this external self-regulation period of time is called the sensorimotor internal working model stage. The child uses the caregiver's behaviors and expectations as his or her own, learning these behaviors through

observation and imitation. While Kopp (1982) argues that the influence of the caregiver is facilitating rather than causative in the development of the child's self-regulation, other researchers suggest that the caregiver has a direct impact on the child (Pipp-Seigel, et al., 1995).

As the child develops a growing sense of self, the child moves from the sensorimotor internal working model stage into the representational internal working model stage. The child then begins to appraise social situations and to adapt behavior accordingly. Whether to comply with the social expectations of the caregiver, or not, is now determined by the child, and no longer dependent upon external regulation alone. For example, the child may have been taught that hitting others was wrong. When faced with a confrontational situation, however, the child now has the ability to decide whether to hit or not. The decision of what action to take is influenced by the expectations and example set forth by the caregiver, as well as the personal experiences, temperament, and the child's own perceptions.

In a healthy relationship, synchrony, or "symbiotic harmony" develops as the caregiver and child begin to match interactional behavior (Emde, 1989; Isabella, Belsky, & Von Eye, 1989; Rothbaum, et al., 2000). Caregiver and child share the joy of mastery that results from the child striving to do what the caregiver does and approves of while learning to take control on his or her own. This type of interaction fosters imitation and identification, rules of turn-taking, fairness, appropriateness, and ownership. It also plays a significant role in intellectual

performance, language development and emotional responsiveness (Greenberg, Speltz, & Deklyen, 1993; Kuczynski & Kochanska, 1990; Landry, et al., 2000).

The change from external regulation to internal regulation allows the child to achieve a sense of independence and autonomy (Eisenberg, Fabes, Bernzweig, Karbon, Poulin, & Hanish, 1993; Feldman, Greenbaum, & Yirmiya, 1999) and is commonly referred to as the "terrible twos." The noncompliant behavior is still noncompliant, but also is a necessary and normal part of social development. Although the child begins to take over control, the caregiver continues to influence and shape the child's behavior throughout this process (Stevenson-Hinde, 1986; Thomas, Chess, & Korn, 1982). As language skills increase, the child begins to understand the informational content of the caregiver's communication about behavioral acts, but remains limited in ability to problem solve due to immature understanding and use of language. To assist the child, caregivers provide explicit directions and uses behaviors that are tied to the child's focus of interest independently from the caregiver.

Through repetition of interactions, self-regulation skills are learned and internalized. Whether the child self-regulates because of internal reasoning, or is simply acting out behaviors that have become internalized and automatic, is still argued in literature. Those holding an internal working model perspective typically believe that behaviors become internalized and automatic, or at least, semi-automatic, thus the child is acting out from a core personality trait. From a symbolic interactionist perceptive, the child accesses the memories of past interactions and behaviors and then makes a conscious decision about which

behavior to use. This difference in understanding has significant impact on understanding the functioning of the caregiver-child relationship.

**The Effect of Child Temperament on Caregiver Perceptions**

As stated earlier, temperament of the child greatly influences the quality of the caregiver-child relationship (Goldsmith & Alansky, 1987). Children with difficult temperaments (e.g., impulsive, unresponsive, or overactive) are known to elicit less positive disciplining practices from caregivers (Petit & Bates, 1984; Stern & Smith, 1999). They are more likely to resist caregivers' efforts to control their behavior, and are more apt to escalate behavior if the caregiver intervenes. Caring for a temperamentally difficult child has been found to be related to maternal stress, dissatisfaction in motherhood, and postnatal depression (Thomas & Chess, 1989; 1991; Thomas, et al., 1982).

Positive behaviors on the part of the caregiver have been shown to reduce the negative behavior in the child regardless of temperament (Belsky, et al., 1991; Crockenberg, 1981). Thomas and Chess (1989) use the concept "goodness of fit" to explain the differences in the effects of positive or negative behavior within the relationship. Goodness of fit refers to the child's characteristics, expectations, and demands matching those of the caregiver. In addition, "goodness of fit" refers to the influence of characteristics, demands, and expectations of the environment and socio-cultural context on the relationship.

**The Role of the Caregiver**

Besides providing for the child's physiological needs, the caregiver role includes several other components that are equally important to the caregiver-

child relationship. For the purpose of understanding how the caregiver's role effects perceptions, the following factors will be discussed: consistency, sensitivity, common focus of interest, power and control, and communication.

**Consistency**

A child's capacity to learn in any given moment is determined by internal rhythms. Our bodies and minds move through predictable rhythmic patterns on a daily basis, regulating when we sleep, wake, or feel hunger. The primary role of the caregiver is to provide physiological care and affect regulation (Emde, 1989) but the consistency of caregiving may be equally as important. Consistent interactional patterns are necessary because it is during this time that the child is extracting from the experience models or patterns of how he or she should act. It is easier to copy a model that is consistent than one that is not (Howes, 1998). Thus, a difficult child's chances of developing atypical behavior are reduced if he or she grows up in a family where there are clear rules and consistent enforcement of those rules (Maziade, Caperaa, Laplante, Boudreault, Thivierge, Cote, & Boutin, 1985). A child exposed to inconsistent discipline is at greater risk for developing behavior problems (Werner & Smith, 1992). Who the child interacts with is less important for the development of good social relationships than the fact that the child consistently interacted over a period of time with that same person (Bowlby, 1988; Lamb, 1978).

**Sensitivity**

Besides consistency, it is important for the caregiver and child to alter between fluctuating states of mutual engagement and disengagement. There

must be times the child and caregiver are together, and times when they are apart. The child's receptivity shifts throughout the day. In one moment, the child may be alert, attentive, and capable of tolerating the frustrations of a new challenge. Hours later, the child may be tired, hungry, fussy, or easily frustrated by any new challenge.

Awareness on the part of the caregiver about when to be available and responsive, and the ability to read the child's cues, is important (McCollum, Ree, & Chen, 2000). By being sensitive to these changing needs, the caregiver provides a safe and predictable environment that allows the child to develop necessary social skills and advance learning (Feldman, et al., 1999). It is the caregiver's responsibility to be empathetic, to facilitate the infant's affective sharing, and to reciprocate positively. Play and teaching are as important to the child as the need for protection and physiological needs being met (Brazelton & Als, 1979). When emotional availability or sensitivity are not optimal, the transference of self-control from the caregiver to the child may be problematic (Emde, 1989; Winnicott, 1965).

**Common Focus of Interest**

Through establishing a common focus of interest, the caregiver may maximize the learning opportunity of the child. By maintaining the child's interest in a learning situation, the caregiver facilitates a wide range of social processing skills. These might include fostering contingency learning, facilitating the child's motivation to learn, and helping the child develop a sense of self (Landry, et al, 2000). For example, the caregiver makes it easier for the child to shift gaze and

to verbalize about the shared interest by pointing out objects (e.g., person, thing, or event), maintaining the child's attention on the object, and talking about it. Children also show a higher rate of compliance to a caregiver's requests when the request reflects the caregiver's awareness of the child's involvement at the time. For example, the child is more apt to obey a caregiver if the caregiver says, "I can see you are still busy playing with blocks, but it is time for dinner. You can play with the blocks after you have finished eating." rather than "Put the blocks away. It is time to eat."

**Influence of Control and Power**

When faced with a confrontational situation with a child, a caregiver must activate power-relevant knowledge structures that serve to guide how the behavior is perceived and how it should be dealt with. If the caregiver perceives self as lacking power over the situation, he or she is more likely to use coercive control tactics. This is often because the caregiver tends to see him or herself as a victim of malicious and/or intentional acts on the part of the child (Bugental, et al., 1989). The caregiver might also perceive the child as the controller or cause of negative relationships within the family, and thus engage in behaviors that are focused on establishing or regaining control. These regaining control behaviors can be either cognitive or at an interactional level.

At a cognitive level, perceptions might be broken down into many units of understanding in order to regain cognitive control (Lewis, Bugental, & Fleck, 1991; Newtson, 1973). For example, the caregiver might use descriptive perceptions to label and give meaning to the behavior, then use evaluative

perceptions to determine that the behavior is consistent with that of the child's uncle whose behavior was never controlled. The caregiver might then use analytical perceptions of reactions towards the child that seemed to work in the past (i.e., time-out, yelling). Finally, the caregiver might perceive the efficacy of reactions that worked or did not work before deciding what action to take.

At an interactional level, the caregiver may react without cognitive processing. In this case, it is common for the caregiver to become over-reactive or hypervigalent (Bugental, et al., 1993; Fiske, Morling, & Stevens, 1996; Wright, 1996). For example, the caregiver might display anger at the loss of control by yelling, hitting or threatening without thinking through the process. Communication and appraisal patterns tend to become power-repair efforts, with the caregiver being more derogatory than positive when this happens (Bugental, Lyon, Lin, McGarth, & Bimbela, 1999; Fiske & Taylor, 1991).

Whereas all caregivers may, at times, engage in power-related interactions with children, caregivers with low-perceived power do so in a more indiscriminate fashion. They may respond to mildly challenging situations with high levels of distress whereas higher power caregivers might respond to the same cues with social interest (Bugental, Blue, Cortez, Fleck, Kopelkin, Lewis, & Lyon, 1993).

Caregivers who are unsure about their influence of power are exceptionally sensitive to power cues. As a result, the caregiver may focus heavily on social comparison, comparing power of self with power of child. Those who have a strong sense of parental influence, on the other hand, have no reason to socially compare themselves with the child.

Fletcher, Rosanowksi, & Fitness. (1994) found that for individuals with strong beliefs, perceptions, or passion about the nature of the interaction, the actions used tend to be automatic and unplanned. The mind automatically retrieves behavioral responses and acts upon them emotionally with the individual being only semi-aware of cognitive processing. This finding has been supported by numerous researchers (e.g., Andersen, Spielman, & Bargh, 1992; Bargh & Tots, 1988). In contrast, other researchers suggest that caregivers do not act unthinkingly based on emotion, but rather, make cognitive interpretations about how to respond. These responses are made reflectively and by choice, not programmed responses that the caregiver is unaware of or incapable of averting (Blumer, 1969; Bugental, et al., 1993; LaRossa & Reitzes, 1994). Knowledge structures about the relationship or circumstance may be automatically accessed, but not automatically put into action. They might simply serve as interpretive guides to behavioral options from which the caregiver then consciously chooses.

Relationship events that occur throughout the life cycle also influence caregiver and child perceptions. Stressful events, such as unhappy marital relationships, interpersonal conflict, and separation in a caregiver's relationship with a significant other, all influence the level of control a caregiver perceives he or she has (Bugental, 2000; Hetherington, Cox, & Cox, 1977). An example of how these stressors effect caregiver perceptions, and ultimately, the caregiver-child relationship, can be illustrated through the following example. If a caregiver was involved in a marriage relationship where there was conflict, the caregiver

might learn to avoid conflict with a significant other by maintaining a non-confrontational, positive disposition when confronted with conflict. The caregiver might smile more with submission and avoidance of conflict than with pleasure (Kelly, Morisset, Barnard, Hammond, & Booth, 1996). These behaviors might be used with, or in the presence, of the child. The child may then have difficulty interpreting what emotion, or the meaning of the emotion the caregiver is actually displaying. This confusion might then create a distortion in the child's perceptions about the meaning of certain caregiver behaviors.

**Communication**

Ambiguous communication signals are a key feature of ineffective socialization processes within a relationship (Grusec & Goodnow, 1994). If a caregiver gives ambiguous messages the child does not understand, but it is also common for a caregiver to show a high level of nonfluency or pauses during speaking when doing so (Mahl, 1987). Ambiguous or inconsistent messages are poorly understood by young children who lack the cognitive functioning to reason. The ambiguous messages might clue the child in that something is "amiss" but without the understanding of what it is that is amiss. Children may respond with confusion and distress and search for ways to come to an understanding. They might become over aroused in an effort to re-engage the caregiver or they may withdraw (Bugental, et al., 1999). By re-engaging the caregiver, even if in a negative way, the child regains control of the situation by being engaged in an interaction he or she can understand. By withdrawing, the child removes him or herself from the stress of confusion. Either response is a

protection effort on the part of the child. These two patterns of response--fight or flight--are characteristic of humans in response to stress, fear, confusion, and other perceived threats (Perry, 2001; Perry, Pollard, Blakley, Baker, & Vigilante, 1995).

A caregiver might also give confusing signals to the child in other ways. Negative messages might be communicated in benign ways. Making a negative statement, but adding a contradicting message with it (e.g., "just kidding") so the child is uncertain which aspect of the statement is true (Bugental, et al., 1989; Bugental, et al., 2000). Caregivers with a low-power perception commonly use this type of communication.

A caregiver might also verbally derogate the child for a particular behavior (e.g., whining or begging for a toy), but on another occasion, respond in the opposite manner (e.g., tolerate the whining and buy the toy) creating confusion in the child's interpretation of the interactional pattern. In addition, the communication patterns, although directed to the child, may actually be based on perceptions about other people, other events, or the setting. The caregiver may praise and buy a toy based on the perception that if the child tantrums others will think the caregiver is abusing the child, so that the child is bought a toy if others are present, but may be spanked for throwing the same kind of tantrum in the privacy of the home. The ambiguousness of these messages is a key feature of ineffective socialization processes (Grusec & Goodnow, 1994).

## Relationships within Relationships

The family plays a vital role in understanding how caregivers perceive the social and emotional development of their children (Radke-Yarrow, 1968). A family is a system that is a part of many other systems, including a larger extended family system, an ecosystem, a community system, and a cultural system. Families perform a variety of functions for the caregiver and child, including socialization, affection, economic sustenance, health care, domestic maintenance, recreation, and identification (Turnbull, Barber, Behr, & Kerns, 1988).

It is within the family context that children first learn about emotions and social responses (Bretherton, et al., 1986). In optimal situations, everyday routines, such as mealtimes, bedtimes, bathing practices, and play times, serve to teach the child regulatory rules that guide and direct self-regulation. These routines also assist children to learn expectations of the family and to practice cooperation, conflict resolution, and problem solving.

It has been hypothesized that a child constructs a sense of "self" in conjunction with the roles of other family members (Satir, 1988). Satir believes that from among the many roles defined by family members' interactions, the child will adopt a role held by no one else in the family in order to differentiate self from others, even if that role is negative. Thus, a child's self-concept may not be shaped by modeling significant others, but rather, to complement the personalities of others.

Just as synchrony is important in the caregiver-child relationship, it is also important in the family's relationships (Brackbill, White, Wilson, & Kitch, 1990). Infant dispositions have been correlated to the degree of synchrony within a family (Bretherton, et al., 1986). Families of children with atypical behavior often tend to lack synchrony within the family (Garbarino, Sebes, & Schellinbach, 1985). However, this is not to say that the lack of family synchrony is what caused the atypical behavior in the child.

Using the family systems framework, we know that perceptions, expectations, and behaviors of family members affect the perceptions, expectations, and behaviors of the caregiver and child. Interactional behaviors in one relationship effect interactional behaviors in another (Byng-Hall, & Stevenson-Hinde, 1991). Therefore, taking into consideration the differences within each of the dyadic relationships within the family is important to understanding how any one dyadic relationship functions (McCollum, et al., 2000).

**Parental Relationship**

Of particular significance is the caregiver's relationship with a significant other (Belsky, 1981; Cochran & Brassard, 1979). Belsky (1981) theorized that the relationship that begins the family, the marital relationship, has great influence on children. Although the marital relationship can be made up of varying partners that may or may not be legally wed (i.e., mother-father, mother-significant other, same-sex couple), for the purpose of simplicity, I will call this dyad the parenting relationship.

In the parenting relationship, it is not merely the physical presence of the partner that has the most influence on caregiver perceptions about the child, but rather, the instrumental assistance the partner brings to the relationship (Belsky, 1981; Keller, 2000). In other words, it is not enough that a partner exist, but that, the partner helps care for the child and support the caregiver emotionally and physically.

Caregivers who perceive themselves to have positive support relationships with a partner are more likely to relate positively to their child (Belsky, et al., 1991; Isley, et al., 1999). Children are more likely to obey caregivers that perceive high satisfaction within the parenting unit. When children do misbehave, caregivers with positive perceptions tend to report less concern about the behavior, while caregivers who are dissatisfied with the parental relationship are more likely to report disapproval of child behavior, and to view their child's behavior as more difficult in general (Emde, 1989). Engfer (1988) calls this the "spillover" effect. The harmony, or lack thereof, in the parental relationship is somewhat contagious in that it spills over into the caregiver-child relationship.

While some researchers have found the lack of adjustment within the parental relationship and support to be strongly correlated with increased atypical behavior in children (Goldberg & Easterbrooks, 1984; Jouriles, Murphy, Farris, Smith, Richters, & Waters, 1991), others have found no correlation. Emery (1988) found that parental conflict was highly correlated with externalized behavior in the child. Perceived parenting hassles, such as differences in beliefs about how to parent, or dissension about each others' role in parenting, has been

linked to atypical behavior in young children (Crnic & Greenberg, 1990: Katz & Gottman, 1997), Other researchers have found no correlation between satisfaction within the parental relationship and child behavior (Cowan & Cowan, 1992; Easterbrooks & Emde, 1988).

Even more interesting is the fact that children labeled as difficult by caregivers experiencing stress in the parental relationship, frequently are not different from other children (Christensen, Phillips, Glasgow, & Johnson, 1983; Emery & O'Leary, 1984; Webster-Stratton, 1989). This suggests that it is not necessarily the child's behavior alone that must be looked at when determining atypical behavior, but also the caregiver's perception of the child's behavior that is important. Additional studies may be needed to gain a better understanding of the relationship between caregiver perceptions about the parental relationship and caregiver perceptions of the child.

**Family Relationships**

Families must change and adapt to internal and external changes that occur throughout the life cycle. For example, accommodating the birth of a new child into the family system changes the status quo of the family. Roles, space arrangements, routine, and financial considerations must all be made. In a sense, each time a significant change occurs, the family must be "reinvented" (Combrinck-Grahm, 1990, p. 503).

The additional impact of raising a child with atypical behavior magnifies the intensity of change the family must make. In most cases, families do not anticipate having a child with atypical behavior. The event is involuntary,

unanticipated, and unexpected. The onset of behavioral difficulties in a family member can produce a state of crisis within the family. This disequalibrium disrupts communication patterns, family rituals and roles, as well as living patterns. The parental unit, and sibling and parental relationships, are all affected by the needs and behaviors of the child (Carter & McGoldrick, 1999). It is often difficult to sort out the effect the child has on the family and the family has on the child as the family re-establishes themselves. As Stoneman, Brody, & Burke (1989) said:

> Temperamentally difficult children are believed to place added stress on their parents, above and beyond the normative stress accompanying the presence of a child in the family. This added stress results in heightened parental depression and marital dissatisfaction. In turn, these negative mood states combine with decreased spousal support, which often accompanies marital dissatisfaction, to compromise competent parenting and to increase conflict between husbands and wives. The resulting use of ineffective parenting strategies leads to a lack of parent success in modifying children's irritating behavior, thus, further accentuating parental perceptions of the children as difficult to manage, intensifying feelings of depression and marital unhappiness, and precipitating marital conflict (p. 100).

When the family status quo is disrupted, attempts are made by family members to return the family to a level of homeostasis. Members of the family

may try to reinforce family rules and roles that were in place at a time of equilibrium. For example, if the child's behavior problem surfaced near the time a mother joined the work force, family members might try to persuade the mother that it was her change in role that caused the child's negative behavior. In an attempt to bring the family, as a whole, to homeostasis, family members might try to convince the mother that she should return to the home and stop working.

The relationship between the stress of life changes and risk of child atypical behavior is well established (Jensen, McNamara, & Gustafson, 1991). Stress is not, however, necessarily a negative thing. Families' coping and adapting to internal stresses, such as a young child transitioning from home life to school for the first time, or external stresses, such as the recent federal changes related to welfare reform, can lead to growth by motivating the family to change.

In the ideal situation, periods of disorder and disequalibrium are balanced and intermingled with periods of stability and equilibrium. If the periods of equilibrium and stability outweigh the disruptive periods, and if the family system has the necessary resources to withstand the periods of disruption, the family tends to function on an adequate level. It is when the amount of stress becomes overwhelming, often occurring when the demands outweigh the resources and support the family has, that the family system is at risk of breaking down. During family transitions or stages of disequalibrium, caregivers are more likely to change how they parent a child, possibly influencing long-term family outcomes (Levy-Shiff, Dimitrovsky, Shulman, & HarEven, 1998).

Where the caregiver is in the life cycle is also related to how the child's behavior is perceived. A caregiver who gave birth to the child at a later time in life when peers had finished raising their children will likely view the child's behavior differently than a younger caregiver raising a child during typical child-rearing years. The length of time a caregiver has been providing care to a child with atypical behavior also has influence on caregiver perceptions with the caregiver perceiving the child to be more difficult over time (Hooley & Richters, 1995).

**Sibling Relationships**

As stated above, the addition of any new family member creates new stress to which the family must adapt and adjust. The addition of siblings into the family structure creates change that has a unique effect on family perceptions. Of particular importance is how a child perceives the caregiver's behaviors to other siblings in relation to him or herself. Children are aware of, and monitor, differential treatment toward their siblings. Siblings' perceptions of differential treatment in terms of time and attention from the caregiver, greatly influences their behavior. A perception of caregiver partiality toward another sibling is a crucial mediating variable in child behavior that may increase the likelihood of sibling rivalry.

Sibling conflict and caregiver-child conflict tends to be higher in families where siblings perceive partiality (Adler & Furman, 1988). A child who perceives partiality toward a sibling, is at greater risk of developing depressive and antisocial symptoms. Whereas, the more positively treated sibling may actually

be protected to an extent from those disorders (Pike & Plomin, 1996; Reiss, et al., 1995).

The quality of relationships between siblings is also linked to the overall quality of the caregiver-child interaction. While harmonious sibling relationships seem to foster harmonious caregiver-child relationships, a harmonious relationship between caregiver and one sibling does not ensure peaceful relationships between other siblings (Parke & Asher, 1983).

When siblings are involved in sibling-conflict, caregivers tend to perceive the older child to be at fault, regardless of which child was responsible (Dunn & Munn, 1985). The younger child may then expect support from the caregiver in future sibling disagreements. The expectations of the child may then foster partiality in the caregiver, and over time, a pattern of interactional behavior that favors the younger child is set into place.

Family size also appears to be a predictive factor in caregiver-child interaction. As would be logically expected, less interaction occurs between a caregiver and any one child in a larger family. Children must share family resources and time, as well as caregiver attention. Perceptions of partiality may increase as a result.

**Multi-Family Level Relationships**

Family relationships exist among multiple levels of generations within the family (Bugental, 2000). These relationships may include grandparents, uncles, aunts, and cousins, and other influential people who may not even be blood-related to the family. Family relationships also exist in cases where one member

of the dyad is no longer physically present. For example, one parent may live elsewhere as a result of separation or divorce. A parent or family member may have died. Even during times of separation, expectations, rules, values, and roles may be carried out through memories of prior interactions with the person that is missing (Hinde, 1988).

The family serves to transmit family expectations and beliefs about behavior, socialization processes, history, goals, and other attributes from member to member and generation to generation. The transmission of attributes can be done through a direct tutorial process, for example, teaching children social manners, such as how to use a napkin or hold a fork during meal times. Family members also use less direct methods of guiding family beliefs, such as through communicating those beliefs in casual conversation (Dunn & Brown, 1994). The belief that "good people go to church" might be reinforced if a child mentions a negative act of a playmate and the family reacts by saying "that's because that family does not attend church." This reinforces the belief that because the child's family did not attend church, the child had bad behavior.

Not only is language used to transmit beliefs, but how the family plays and socializes with others also transmits beliefs to the child. The peer cultures the family interacts with all have an influence on the caregiver perceptions (Corsaro & Eder, 1990). The type of church, school, and neighborhood in which the family chooses to reside exposes family members to social structures that are more likely to share similar beliefs (Bugental, 2000; Parke & O'Neil, 1996). Although families tend to choose churches, schools, and neighborhoods that have similar

experiences, perceptions, and values, a family moving into a new community that has differing views will experience changes in their own views through exposure to the perceptions and beliefs of that community.

Family stories passed down from generation to generation, and recollections of past events, beliefs about past events, as well as hopes for future activities also influence family perceptions (Fivush, 1994; McCollum, et al., 2000: Rogoff, 1991). Family members might pass on stories about ancestors' parenting techniques, and how it was in the "olden days." These expectations influence how the caregiver perceives his or her own role in parenting. Likewise, the passing on of family hopes and dreams have influence on caregiver perceptions. A grandmother that instills hope in the caregiver that her grandson will be the first family member to attend college may influence the caregiver to reinforce the academic attainment in the child. It is believed that the transmission of generational beliefs and perceptions, as well as history and beliefs based on past events are more likely to come from mothers than fathers (Fincham, Beach, Arias, & Brody, 1998).

Bugental's (2000) four categories of perceptions can also be applied to the family. The caregiver has descriptive perceptions about how he or she perceives things to be within the family. For example, the father might be the "boss" and make final decisions regarding family matters. Perceived reasons for family-related events are analytical. For example, the caregiver might perceive the breakup of a marriage to be attributed to the child's difficult behavior. The way things should be within the family is also evaluated by the caregiver. The

caregiver might perceive his or her situation as less or more serious than that of another parent of a child with atypical behavior and base action upon that perception. In addition, the convergence or divergence between the way things are and the way things should be (efficacy perceptions), might cause the caregiver to see him or herself as the cause of the child's atypical behavior.

In addition to perceptions, there are socio-cultural factors that play a role in how the caregiver-child relationship functions. These factors are discussed in the next section of this paper.

## Socio-Cultural Factors

Socio-cultural factors include influences from the environment, social networks, the community, neighborhood, and culture. They also include the qualitative aspects of social meanings of these factors. These factors are explained and their relation to perceptions described.

### Socio-economic Status

One of the most common external factors that influences families is socio-economic status (SES) (McCollum, et al., 2000). SES refers to more than just income. It refers to the education level or occupation of the caregiver and is representative of many other intricate factors. SES largely affects the type of neighborhood in which a family resides, the family's experience with public transportation or violence, level of overcrowding, as well as the type of schools and social support services that are available.

Caregivers of middle SES are more likely to hold jobs or careers where individuals manipulate interpersonal relations, ideas, and symbols, whereas in

lower SES jobs, caregivers are more likely to manipulate things or objects. Careers associated with middle SES allow employed caregivers more self-direction than lower SES jobs. The caregiver's perception of "getting ahead." then, is more likely to be thought of as a result of the one's own actions rather than something that is outside the caregiver's control. Lower SES employed caregivers are more likely to be dependent upon the collective action of a group of employees, and be required to follow rules set down by someone in authority (Medinnus, 1967).

These differences in employment due to SES create different experiences, and thus different perceptions about life. Because of these experiences, individuals within differing SES develop different perceptions of social reality, aspirations, hopes, fears, and conceptions of what is desired (Kohn, 1977).

Demands of poverty influence perceptions and interaction patterns of the caregiver (Landry, Garner, Swank, & Baldwin, 1996). Risk factors from multiple domains are found more often in families from lower socio-economic backgrounds than any other economic backgrounds (Keller, 2000; Shaw, Owens, Vondra, Keenan, & Winslow, 1996). Crowded living conditions, lack of adequate transportation or child care, social isolation, and other factors associated with poverty all have significant influence on everyday interactions. A caregiver that is stressed over not being able to put food on the table is less likely to be attentive and emotionally responsive to a young child's need to play. It is not surprising then, that children from families with limited resources have been shown to have

greater externalizing behavioral problems (Cole & Dodge, 1996; Gabarino & Kostelny, 1996; Rutter, 1978; Shaw, et al., 1996).

SES can also influence caregiver values and goals in raising children. Caregivers chose certain characteristics in their child that they find desirable or offensive, and reinforce or encourage these behaviors in the child depending upon perceived need. In a tough neighborhood that has a high crime rate, the caregiver may encourage or reinforce self-protective skills in the child, such as fighting, or aggression for survival. In this case, a behavioral trait that might be viewed as negative by some, is viewed as positive in this culture.

**Community**

The behaviors the caregiver opts to reinforce in the child is also highly influenced by what is desirable by others within their SES (Stafford & Bayer, 1993). Community characteristics also play a role in caregiver perceptions and relationships. Besides the SES of the neighborhood, racial mix, population density, and population age distribution also play an important role (Bronfenbrenner, 1986; McDonald, et al., 1992).

Neighborhoods or communities in which there is low employment may be affected by social isolation. Low SES jobs tend to offer odd hours of employment, such as split shifts or night shifts. Transition rates are high in low SES neighborhoods, and crime tends to be higher all of which may keep families isolated from others for self-protection. Isolation, in turn, is related to a more negative physical environment, violence, less maternal warmth, depression, and

lack of parental control (Klebanov, Brooks-Gunn, & Duncan, 1994). Of particular importance is the exposure to violence.

By the time a child reaches the age of 18, the probability that he or she will have been touched directly by interpersonal or community violence is approximately one in four (Perry, 2001). Acts of violence have been identified as a possible cause of stress-related problems within families (Jencks & Meyer, 1990). In neighborhoods where there is violence, caregivers may, unknowingly, transmit hypervigilance of the dangers of a neighborhood to the child through the use of restrictive discipline. In an unsafe neighborhood where violence has occurred, the caregiver may set strict rules about whether or not, or when, a child can play with friends. This perception of danger may influence a child's belief that the world is dangerous or violent, and may promote aggression as an appropriate means of self-protection. Although a necessary skill in a violent setting, such behavior is not found to be as acceptable in other settings, such as a school.

A caregiver under constant threat, may also experience emotional distress, such as irritability, anxiety, and depression that will likely limit the caregiver's ability to effectively be involved, intervene, and monitor their child's behavior (Dodge, Pettit, & Bates, 1994; Pettit & Bates, 1984). McLoyd (1990) found that caregivers that perceived their neighborhood as dangerous were more intolerant of disobedience in their children because the environment threatened their child's safety. Consequently, the caregivers tended to use more restrictive discipline and more punitive methods of behavior management.

On the positive side, caregiver's attitudes and beliefs can also be mediators of the effects of poverty and neighborhood violence. A caregiver that transmits the perception that violence has consequences and does not provide tangible rewards may influence the child's belief that aggression is not beneficial as a means of self-protection (Patterson, Capaldi, & Bank, 1989). Neighborhoods can also provide the kind of social network support that promotes positive patterns of caregiver-child interactions within the relationship (Belsky & Isabella, 1988) and may serve to pass on positive cultural norms, values, and beliefs (Klebanov, et al., 1994).

**Social Support**

There is sufficient evidence to link social system support to positive patterns of caregiver-child interactions and relationships (Belsky & Isabella, 1988; Crockenberg, 1981; Stern & Smith, 1999). Social support may come from other family members, relatives, neighborhood, and/or community. Understanding how social support systems and other relationships affect the caregiver's perceptions is of considerable importance (Zeanah & Anders, 1987).

Having satisfactory social support from sources outside of the family has been shown to influence a caregiver's perceptions of his or her own capabilities and effectiveness as a parent (Crnic, et al., 1983). Social support, particularly support of friends and relatives, increases caregivers' perceptions of positive well-being, which in turn, has an effect on the caregiver's relationship with the child (Dunst, Trivette, & Deal, 1994; Early & Poermer, 1993).

Social support may protect a caregiver from the effects of stressful conditions in ways not related to the actual stressors, such as through perceived support from a local church or friendly neighbor. Just knowing the church or neighbor is there should the caregiver need support may buffer a stressful condition. This may result in modifications in the caregiver's cognitive processing of stressful events and may also foster self-generated resolution activity (Bugental, 2000; Melson, Ladd, & Hsu 1993).

Social support is typically broken down into categories of instrumental and emotional support. Instrumental support might be giving money, goods, advice, and physical help. Emotional support might be in the form of imparting empathy, understanding, or expressing concern during a time of need.

In a national study of 966 caregivers of children with serious emotional disorders, Friesen (1989) found that caregivers found spouses to be their greatest source of social support (60%), followed by grandparents (44%), and friends (43%). Most caregivers said that emotional support was the most help in a stressful situation (85%), followed by advice (64%), babysitting services (55%), financial aid (46%), and help in locating other services (31%). Sources of community support cited by caregivers included religious organizations (50%), other parents (50%), career (36%), recreation (32%), and hobbies (28%).

**Cultural Influences**

Most definitions of culture have focused on the intergenerational transmission of various combinations of symbolic (e.g., ideas, beliefs, and values) and behavioral (e.g., rituals and practices) factors (Schweder, et al., 1995). Symbolic

factors include caregiver expectations, goals, aspirations, values, gender roles, approaches to disciplining, religious or spiritual values, and ideas and beliefs about health, illness, and disabilities. Behavioral factors might include "scripts" about everyday routines, such as sleeping, feeding, and playing. They also include language and socialization practices. Shweder et al., (1995) suggest to understand culture one needs to combine symbolic and behavioral factors so that "the beliefs and doctrines that make it possible for a people to rationalize and make sense of the life they lead" and "patterns of behavior that are learned and passed on from generation to generation" (p. 867).

Caregiver perceptions serve as one of the most important ways children are introduced to symbolic and behavioral factors about culture (Gralinski & Kopp, 1993; Greenfield & Cocking, 1994; McCollum, et al., 2000; McGillicuddy-DeLisi, 1992; Weisz, Weiss, Alicke, & Klotz 1987; Weisz, McCarty, Eastman, Chaiyasit, & Suwanlert, 1997). While interacting with the child, hopes, expectations, experiences, and attitudes about people, the past, and the future are conveyed to the child. Caregiver perceptions about what to value, what behaviors to use in social situations, who the caregiver is as a person, how the caregiver views the world are all influenced by culture. For example, some cultures value modest living while others value wealth. Some cultures value mothers who stay home with their children while others value employment and career.

Through culture, caregivers learn from others what to expect in the course of development, what is considered "good" and "bad" (Emde, 1989). In some cultures, a child is raised by their mother until the age of six or seven, when the

child is then passed off to the father. In other cultures, the father takes an active role in raising the child at birth. In some cultures, a child is expected to work to help support the family at an early age, while in another culture the child is expected to obtain an education, with the family providing for the child's needs until they are ready to enter the working world.

Brooks (1973) suggests that culture is a distinctive way of life that links the thoughts and acts of the individual to the common patterns of the group. The community provides rules and models for beliefs and perceptions about behavior that cannot be disregarded by the individual without social penalty. Although all cultures must find a balance between individual autonomy and shared interests, there is considerable variation in each culture's practices (Shonkoff & Phillips, 2000). Those that place greater emphasis on autonomy will socialize their children in a way that promotes greater independence. Some cultures focus on the importance of an individual's responsibility to others before self. Neither orientation is more "normal" than the other. Each has benefits and costs, but a caregiver within a particular culture is expected to follow socio-cultural rules when parenting a child. Keller (2000) suggests four differences in roles of caregiving that can differ among cultures: primary care, body contact, stimulation context, and face-to-face exchanges.

Middle SES Americans, particularly those from a British cultural background, tend to be independence-oriented and to develop a concept of self based on one's potential future. When behavioral problems are encountered, they want to know how the child can be helped to function as an adult member of society.

Families of Japanese-American culture tend to see the behavior problem as shaming to the entire family and thus tend to underutilize help sources. Those of Italian-American culture, might attribute the behavioral problem to be caused by external forces outside the family. A family of Native American heritage might view the child's behavior as related to a spiritual force outside of the physical world. Therefore, a child's behavior in one culture may be interpreted and perceived differently than in another culture (Harwood, Miller, & Irizarry, 1995). Although particular cultures have similar cultural practices, each has qualitative differences within families of that culture. All families within a culture do not follow any one belief system.

Bugental, Krantz, Lyon, & Cortez, (1997) suggest that shared cultural perceptions provide "cultural scripts" the caregiver learns to follow that guide how they parent. Scripts that pertain to caregiving that are governed by culture include interpretations and beliefs about early development, desired developmental outcomes for children, and appropriate roles and behaviors of caregiving (Harkness, Super, & Keefer, 1995). To understand how a caregiver perceives his or her child and the relationship is dependent, then, upon understanding how the socio-cultural setting influences how the caregiver perceives child rearing practices.

## SUMMARY

In summary, child and caregiver characteristics, as does the caregiver's perceptions and the many relationships that influence the child-caregiver relationship. How the caregiver views the child's behavior, how the caregiver views him or herself, or other relationships greatly influences caregiver perceptions, as does how the caregiver perceives others in the community and society views him or herself. No one factor can be singled out independently, but rather, all factors must be considered when trying to understand caregivers' perceptions about their relationships with their children.

# CHAPTER III: METHODOLOGY

## INTRODUCTION

The objectives of this study were to explore, describe, and understand caregivers' perceptions about their relationship with their children who had been identified as having atypical behavior. I believed behavioral patterns, formed over time, existed and that these patterns were related to caregiver perceptions over time. To find those patterns and perceptions, I chose an inductive, qualitative approach using data collection methods that were described by Bogdon & Biklen (1982). I interviewed eight caregivers whose children were identified as having atypical behavior. To understand better the contextual factors that influenced the caregiver-child relationship, I obtained data from Parent Information Forms the caregivers filled out at the time of referral to a community program known as Success By 6 (SB6). I used data derived from the interviews and Parent Information Forms were used to explore common themes, or patterns that helped to explain the relationship between caregiver perceptions and how and why the caregiver-child relationships functioned as they did.

In the next section of this paper, I describe the methodological approach I used, give a rationale for my choice of approach, and describe the participants of the study. I also describe the data collecting procedures, data analysis, and limitations of the study.

## RATIONALE FOR METHODOLOGICAL FRAMEWORK

Some researchers have suggested the need to explore factors related to atypical behavior in young children in a non-traditional way that allows for a careful and in-depth examination of the phenomenon (Crittenden, 1988; Dumas, 1989; Thomas & Clark, 1998). This is because caregiver-child relationships have many differing and complex factors, making it difficult to examine fully in a traditional quantitative approach (Sigel, et al., 1992).

A common practice in research of caregiver-child relationships has been to measure specific interactional behavior, such as the caregiver's disciplinary practices or communication patterns, and to correlate these interactional behaviors directly with the child's behavior. This suggests a linear cause and effect relationship (Thomas & Clark, 1998). I believe there is a need to move beyond looking at supposed cause and effect relationships when studying caregiver-child relationships and caregiver perceptions about those relationships. Each relationship is different in that it is influenced by many contextual factors, such as social support, environmental conditions, or caregiver history. Thus, in order to understand how relationships function as a whole, it is important to understand the role those differences play in the functioning of the relationship.

Blumer (1969) and Charon (1998) suggest that we can only understand relationships by studying how those within the relationship interpret and give meaning to the relationship. In the case of the caregivers participating in this study, the meanings they assign to their relationships, guided by perceptions the

caregivers have about those relationships, help us understand how, and why, these relationship functions as they do.

Blumer (1969), as well as Bogdon and Biklen (1982) suggest using an exploratory approach when conducting this type of study, using methods such as interviewing participants, conducting systematic observations, or collecting artifacts. For the purpose of this study, I used two of these techniques. First, I accessed caregiver referral files through SB6, a program that acts as a focal point of contact for assessment and referral in cases where young children and their families are in need of mental health services. From the referral files, I gathered information about social, relational, experiential, and historical aspects of the caregiver-child relationship. Second, I conducted in-depth, face-to-face interviews with caregivers whose files I had accessed. This allowed me to gain a better understanding of their perceptions about their relationships with their children. The interviews were done in such a way that allowed caregivers to bring up experiences and perceptions *they* felt were important instead of responding to questions about what I thought was important as suggested by Spradley (1979). Combined, these techniques allowed me to examine how the caregiver-child relationships developed over time, the many contextual factors that influenced the relationships, and of how the relationships function today.

## SAMPLING

The SB6 program was in its first year of implementation after a one-year planning period at the time of this study. An initiative of the United Way of America, SB6 is primarily funded through the Bank of America. All United Way programs across America were provided with funding to develop a program that targeted children under the age of six with the focus of each initiative to be based on community need. Therefore, no SB6 is exactly like another. In Tennessee where this study took place, the focus of the SB6 initiative was based on a recent United Way needs assessment that indicated mental health as a top priority in the community. The steering committee that made this decision, and continued to take an advisory role with SB6, consisted of corporate business representatives, child care personnel, parents, special education providers, mental health providers, human services representatives, members of the medical community, and many others. SB6 does not provide services to children, but parents in need of support receive referral information about where to obtain needed services. SB6 does, however, provide information, training, and assessment to families, mental health professionals, and others working with young children.

When a family is referred to SB6, a coordinator (licensed social worker) contacts the family and determines the course of action to take. Sometimes, families are simply given information by telephone. In most cases, the coordinator makes a home visit to the family and conducts a detailed interview to determine the extent of the family's problem and to conduct a behavioral assessment of the child. The coordinator then provides the family with oral or

written material, refers them to an agency for assistance, or continues to support the family until the appropriate services are in place. Finally, the SB6 program conducts an exit interview by telephone or mail, and the case is closed.

For the purpose of this study, the SB6 coordinator agreed to contact caregivers that had accessed SB6 services within the last six months, inviting them to be a part of this study. In addition, she invited new referrals to participate in the study when she made the initial home visit. Only caregivers of children identified as having atypical behavior as measured by the Temperament and atypical behavior scale: Early childhood indicators of developmental dysfunction (TABS) (Neisworth, et. al, 1999) were invited to participate in this study. This type of sampling is called purposive sampling in that the selected sample population are information-rich cases (Fraenkel & Wallen, 1990). I do not have information on how many families were visited by the SB6 coordinator, or how many families she invited to participate in the study. I was only notified of families that agreed to be contacted by me for the purpose of this study.

During the initial interview, caregivers of children scoring 10 or higher on the TABS were given a brief description of this study and asked if they would be interested in participating. If a caregiver indicated an interest, the SB6 coordinator had the caregiver sign a release of information to allow her to pass his or her name and contact information on to me. I then contacted the caregiver, explained the purpose of the study in detail, and gave the caregiver the option of being a part of the study or to decline. If a caregiver was willing to be in the study, I read the consent form to the caregiver, and explained the contents of the

form in detail. I then had each caregiver sign the form, leaving a duplicate copy of the form with him or her.

I explained to the caregivers that although I was affiliated with SB6, my purpose was not to provide behavioral health services, and that he or she was under no obligation to participate in the study. I also explained to caregivers that if they decided not to participate in the study, their decision would in no way hinder services being received through SB6. I also gave each caregiver the option of discontinuing participation in the study at any time.

## RESEARCH CONTEXT

Eight interviews were conducted. Seven of the interviews took place at the caregiver's home. One caregiver requested that the interview not be conducted in the home because of strained relationships she had with another family member. I met this caregiver at a local elementary school after obtaining permission from the principal. Although my intent was to interview only one caregiver at a time from any one family, and had specified this during the initial contact, one father decided to come home from work early just to be a part of the interview process with his wife. I decided to conduct the interview with the couple rather than to tell him he could not be a part of the process.

I also specified to caregivers that it would be best to do the interview at a time when young children were not present. During two of the interviews, children were nearby but were asked to stay in an adjacent room. Whenever children came into the room where the interview was taking place, I tried to stop the

interview process to allow the caregiver time to tend to the child's needs or redirect the child back to the other room.

## PARTICIPANT CONFIDENTIALITY AND BENEFITS

To protect caregivers' identities, a pseudonym was assigned to each caregiver and this was used in all written material and oral communication with others. A master list of the names of the caregivers and identifying information was kept in a separate location from the actual transcripts and audiotapes. All data were kept in a locked file.

Caregivers were told there were no known benefits from participating in this study other than to have their story heard. It was my assumption after conducting the interviews that having someone listen to their stories was beneficial to most of the caregivers. Many enthusiastically shared their stories in detail, continuing with stories even after the interview process was completed. Some extended an invitation for me to stay and visit, or invited me to see the rest of their home, a gardening project, pictures of their children, or their child's bedroom. On at least two occasions, a caregiver followed me out to the car, wishing me well and talking to me until I drove away. The interview process seemed to be a positive experience for most.

I was aware of the risk of the caregivers becoming uncomfortable about what they were telling me or that a caregiver might tell me more than they had meant for me to know, but this did not seem to happen. As a precaution, I carried a

directory of referral sources from the SB6 office with me on interviews, but did not feel the need to use it.

The meaning of the caregivers' beliefs about their relationship with their child changed through the process of being interviewed and I tried to be sensitive to those changes as they occurred. For example, during the first interview, it became apparent to the couple I was interviewing that their child had improved dramatically since their initial home visit with the SB6 coordinator and that the child would probably no longer qualify as having atypical behavior. On many occasions, it was apparent that caregivers were reflecting on something I, or they said, changing their thought processes about the story being relating to me by the caregiver. I was aware that any leading question on my part steered the direction of the caregiver's thoughts. Therefore, I tried not to ask leading questions.

Caregivers were told at the beginning of the interview that if they revealed information about potential child abuse, I was obligated as a mandated reporter to share that information with designated authorities. Although there were several instances of caregivers talking about "whooping" their child, I did not feel this was reportable information, as "whooping" appears to be a regional term used frequently to describe disciplining a misbehaving child.

## DATA COLLECTING PROCEDURES

### Introduction

It is my belief that a caregiver-child relationship cannot be fully understood without knowing something about the many interactional experiences that took place that influenced how the relationship was shaped. Therefore, this study focused on caregivers' perceptions of relationships where the child had been identified as having atypical behavior.

Data about historic, relational, societal, and cultural influences surrounding caregivers' perceptions about their child's behavior were collected. Because caregivers had already been through a 2 - 2 1/2 hour interview process with the SB6 coordinator, it seemed less intrusive to use the information the coordinator had already collected rather than to repeat this interview process again. Data collection procedures, then, included 1) reviewing file information the SB6 coordinator had already collected, specifically, the Parent Information Form and TABS assessment results, and 2) conducting face-to-face interviews with the caregivers about their experiences and perceptions of the relationship. The following section presents a brief overview of these data sources, including theoretical support for their use. Procedural information, methodological issues, standards of verification, and limitations of this study are then discussed.

### Referral File Documents

The SB6 coordinator opens a working file on each referred family when she makes a home visit. The file includes contact information about the family, a Parent Information Form that addresses issues, a survey about training and

information needs the family has, TABS results, and notes about continued contact with the family throughout the information or referral process.

For the purpose of this study, I accessed data from the Parent Information Form and the TABS assessment. Once written permission was obtained from the caregiver, the SB6 coordinator made copies of these two forms for me at the SB6 office and used a black marker to mark out all identifying information. Pseudonyms were then assigned.

**The Parent Information Form**

The Parent Information Form is filled out by the coordinator with the primary caregiver of the child at the time of the initial home visit. The form contains information about the child's medical history, the caregiver's pregnancy, safety and health concerns, family reporting of substance abuse, trauma the family has experienced, and stressors the caregiver identifies as being significant. It also includes information about the family structure, schedule, activities, resources, and social support.

**The TABS Assessment**

The TABS assessment tool is a 55-item checklist completed by the primary caregiver of the child about his or her child's behavior. The TABS is divided into four sub-areas: detached behavior, hyper-sensitive/active behavior, under reactive behavior, and dysregulated behavior. The caregiver is asked questions in each of these four sub-areas and has the option of responding "No" - not like the child, "Yes" - very much like the child, or "Need Help" if the question addresses an area of need for the caregiver.

Sample items included: The child "wanders around without purpose," "is "too easily frustrated," or "has wild temper tantrums." If the caregiver responded "Yes" to 5-9 of the questions, the child was considered to be 'at risk' for atypical behavioral development. If the caregiver responded "Yes" to 10 or more items, the child is considered to be exhibiting atypical behavior.

**In-Depth, Semi-Structured Interviews**

In-depth, semi-structured interviews are considered to be a valid means of collecting data in a qualitative study and allow the researcher to gather a large amount of data rather quickly (Creswell, 1998; Marshall & Rossman, 1989). I prepared a set of guiding questions, or an interview protocol, to use during the interviews (see Appendix F). As the interview process continued, I added to the list questions that had arisen from previous interviews and the reflection process. I only used the list once, during the first interview, after which time I had memorized the questions. I did, however, jot down new questions as ideas came to mind, and took these with me in written form to use during interviews. Therefore, although each interview had similar questions, each was unique in that they included questions that surfaced because of the interview process and information from the files.

The interviews were approximately 1 ½ - 2 hours in length, with the exception for one interview that lasted only ½ hour. The interview that lasted ½ hour was with a caregiver who responded to my questions with short, clipped answers and volunteered almost no other information than what was asked directly of her. Therefore, my questions became more leading as I tried to stimulate

conversation and the conversation felt uncomfortable. I decided to end the interview at this point rather than press the caregiver for more information than she seemed comfortable in giving.

Each interview was audiotaped. Data analysis began immediately after each interview was conducted. Typically, I conducted the interview and then immediately wrote impressions about the interview process, the caregiver, and my reactions to the interview process in my research journal. I also wrote a description of the caregiver and the setting. I then transcribed the interviews verbatim, storing the audiotapes in a locked file and printing out the transcripts for easier reading.

## DATA ANALYSIS

Data analysis is a systematic method of examining information to determine the "whole," the "parts," and the relationship between and among the "whole" and "parts" (Creswell, 1998). It can be thought of as an ongoing, cyclical process that begins at the data collecting stage and continues throughout the study and into the writing stage (Lincoln & Guba, 1985). This process is spiral rather than linear.

To begin analyzing data, I reviewed the TABS assessment protocol and the Parent Information Form several times in hopes of gaining a global understanding about the caregiver, child, and contextual factors. I circled information that I thought was pertinent and made notes in the margins about possible questions to include in the interview process. From the TABS protocol, I gained an understanding of the type and intensity of the child's behavior that the

caregiver was experiencing. I reflected on this data before conducting the interviews and kept notes with me about information that was not clear on the Parent Information Form that I needed clarified or that needed elaboration. I also took notes in my research journal, noting any hunches, ideas, or insights about possible connections occurred.

I had proposed to print the transcript, review it, reflect, and begin eliminating portions of the interview that did not seem pertinent, and in fact, I followed this procedure for the first two transcripts. This is called data reduction. During the third interview, however, I discovered an idea or theme that I realized I had deleted from one of the first two interviews, so I changed my procedure. I reprinted the first two transcripts and from that point on, worked from unedited transcripts. I then went through each transcript with a black pen and crossed out parts of conversation that did not seem pertinent. In this way, I was able to recover information that I might otherwise have discarded that later seemed pertinent. Each time I added a new transcript to the 3-ring notebook, I went back and read each interview in its entirety. With each interview, I discovered new relationships between interviews and developed new questions about the meaning of caregiver's words that had not caught my attention originally. Writing findings in the form of notes or reflections as I did is considered the initial stage of sorting of the data according to Bogdan and Biklen (1982) and Creswell (1998). Glesne and Peshkin (1992) suggest this is a way of "keeping up with the data" (p. 132).

In the beginning of analysis process, I highlighted conversations that were obviously related to caregiver perceptions. For example, when a caregiver used words such as "I feel," or "I think" or "I hope" I highlighted these statements in pink, knowing they were stated perceptions. After several reviews of the transcripts, other possible themes became apparent. In one case, the caregiver stressed a point two or three times, suggesting that what she was saying had importance to her. In another case, I realized a caregiver had said something very different from what I had originally understood based upon the supporting information given in other parts of the interview.

I began to establish color codes for the various themes that were emerging as a way of organizing the data. Direct quotes about perceptions were in pink. Information about the child's behavior was highlighted in blue. Information the caregiver gave about social support or social stressors was highlighted in green. I also made notes in the margins of the transcripts about sub-themes that became apparent. For example, information about the child's behavior was highlighted in blue, but I began to realize patterns of "negative" child factors and "positive" child factors. I then added a secondary color code of yellow to positive attributes a caregiver stated about their child. I continued this process with other themes, double coding the data with the primary theme color and sub-theme colors. I then developed a diagram (See chart 1) that helped me visualize the structure of patterns and themes as they were being identified from the data as suggested by Creswell (1998) and Wolcott (1994). Although some researchers tend to develop elaborate lists of codes to guide their framework, I began with a

few categories, and expanded those categories as new ideas occur to me through continued review and reflection.

Data that were inter-related were then "cut and pasted" so it could be sorted. Wolcott (1994, p. 26) calls this the "quantitative side of qualitative research." Categories of data were then filed into folders labeled with theme headings, providing an organizational structure that allowed me the flexibility of rearranging data, expanding files, and adding to the data as the analysis process continued (Creswell, 1998). These reoccurring themes, supporting information, and extracts of caregiver's words were later organized and typed into narrative. Data reduction continued until the generation of new themes and pertinent information had been exhausted. These procedures helped me build a logical chain of evidence to support my findings (Creswell, 1998; Glesne & Peshkin, 1992; Wolcott, 1994).

Interpretation of the data involved making sense of the data, or the "lessons learned" (Lincoln & Guba, 1985). Throughout the study, I kept notes and reflections about my hunches, ideas, and insights in my research journal. From these interpretations, I developed overall descriptions of the caregivers and the interview process, focusing on perceptions, expectations and attributions the caregivers had of their child that related to contextual factors. Vignettes were developed to give the reader a clearer picture of the uniqueness of each case study and findings were organized into a written narrative that included visual diagrams to assist the reader in identifying themes.

## STANDARDS OF VERIFICATION

To ensure the trustworthiness of my findings, I used the following procedures

1. The research study began with a bracketing interview so that my biases and beliefs could be identified and documented.
2. A research journal was used to record my thought processes and experiences throughout the study.
3. A clarification check was used to verify that the information I had recorded was what the caregiver meant.
4. Findings were discussed with a debriefing group consisting of evaluation team members from SB6.
5. The caregivers' own words were used to support findings (Creswell, 1998; Lincoln & Guba, 1985).

### Bracketing Interview

All interactions with others are influenced by our own personal experiences that include stored memories, culture, preconceived expectations, and recognized or unrecognized biases and attitudes (Blumer, 1969; Rosnow & Rosenthal, 1997). Because I have worked extensively with young children identified with atypical behavior and their families, I had pre-conceived ideas about factors that might cause atypical behavior in a young child. It was important for me to be continually aware of these biases. For example, I knew that research studies often target the caregiver as the primary cause of atypical behavior in young children. I had to be aware of this bias and keep an open mind to other explanations for atypical behavior when interviewing the caregivers. I

also had to remind myself continually that I was not looking for causes of atypical behavior in young children, but rather, the caregiver's perceptions about his or her relationship with the child.

In addition, I had to remind myself that the label of "atypical behavior" was a construct of the authors who compiled the TABS assessment. Although based on research and extensive norming procedures, the term "atypical behavior" is a social construct that may or may not generalize to every situation.

Before conducting interviews or accessing files, the SB6 administration team conducted a bracketing interview, asking me about the study, my purpose for doing the study, anticipated outcomes, risks to caregivers, and my thoughts and biases about atypical behavior in young children. This turned out to be a lengthy process with this team extending the interview to a second, and then a third meeting. The SB6 administration team consisted of the director, coordinator, and two United Way representatives who oversee day-to-day operations. The bracketing interview became part of the team's agenda for three weekly meetings held on June 11, June 20, and June 26 of 2001. In addition, the administration team requested that I present the same information to the Advisory and Executive teams at their monthly meetings so that everyone involved in SB6 had a chance to provide input into the study or to question the procedures. These meetings took place on June 29 and July 11 of 2001. At the weekly Administration team meeting, members had questions, comments, and concerns to share, often asking me to reconsider a particular concept over time and to report to them at the next meeting.

Participating in the bracketing interview and recording my thought process in the research journal helped me be more aware of the affect these biases had on the interview process and interpretation of data, as suggested by Lincoln and Guba (1985). The process also changed my own beliefs about the relationship between caregiver-child relationships and child behavior. I realized how close-minded I had been and feel that I gained an appreciation for not jumping to conclusions or depending upon prior research as being "the truth."

**Clarification Checks**

Once all interviews were completed, I shortened them by editing out irrelevant statements or words. For example, I took out "ums" and "ahs," and condensed caregiver statements to make reading of the transcripts easier. My intention was to contact all eight caregivers and either bring transcripts to them or mail the edited transcripts for their review, however, Liz, Tara, and Beth could not be reached. Liz and Tara's phones had been disconnected and Beth had moved. A message was left on both Gary' and Darla's answering machine but neither responded. Edited transcripts were mailed to Bob and Lou, Kate, and Sally for their review. They were asked to read the transcript for accuracy and to not worry about grammar or spelling, but only to review for content to make sure that I adequately captured their thoughts and words. The caregivers were given contact information to reach me with any comments or corrections they would like to make. Kate left a message that her transcript looked fine. Bob and Lou were involved in a publicity project with SB6 and conveyed their thoughts to staff

that although they did not like some of their choices of words and grammar, the transcript was accurate. I did not hear from Sally.

**Debriefing Groups**

SB6 uses teams of volunteers from the community to help determine program direction, set policies and rules, and make decisions regarding the functioning of the program. The teams are composed of 5-10 people who have an interest in the program and are actively working with children identified with atypical behavior. These teams provide assistance in six areas: 1) communication and budgeting, 2) services and training, 3) child advocacy, 4) resources, and 5) program evaluation. In January of 2001, SB6 asked me to participate actively on these teams and I currently volunteer my time on two, the service team and the evaluation team.

SB6 requested that the evaluation team review and approve my research study on an ongoing basis in accordance to program guidelines. SB6, and members of this team, acted as a debriefing group throughout the study, meeting monthly for 1-2 hours. Transcripts were given to team members before meetings to be reviewed and team members were asked to identify themes they saw within and between interviews. They were also asked to highlight information that might be pertinent to understanding caregivers' perceptions about their children and social factors surrounding the relationship, and to identify caregiver quotes that best reflected the identified themes.

The members of the evaluation team included a retired pediatric nurse, a parent of a child with emotional and behavioral problems, a director of a large

child care center, the director of a regional Birth-to-3 intervention program, a kindergarten teacher, a representative from United Way, and the SB6 coordinator. Team members were asked to sign confidentiality forms (See Appendix D) and confidentiality procedures were discussed, not only with this team, but also with the Advisory Team and Executive Committee to ensure that all members of SB6 understood and approved procedures used in this study.

The evaluation team began reviewing the procedures and intent of this study on 26 April 01. At this time, the consent forms I had developed and the initial process that I proposed to take place were approved. Transcripts and process were also discussed and reviewed on June 5, July 12, August 21, September 20, October 25, and December 6 of 2001. A second debriefing group had been proposed, but I was unsuccessful in bringing this group together after several attempts due to scheduling difficulties.

## LIMITATIONS OF THE DATA COLLECTION AND ANALYSIS PROCESS

The limitations of this study are discussed in the next section of this paper. Limitations include selection bias, interviewer bias, and spurious conclusions.

### Selection Bias

There is a risk that the caregivers chosen to be a part of this study were not true representatives of the population I hoped to be studying. Comparing my data with research in the field, as well as consulting with the debriefing group was done to eliminate as much selection bias as possible.

## Interviewer Bias

I tried to keep my questions as simple and as non-leading as possible. To begin an interview, I asked an open-ended question, such as "tell me about your child" and "describe a typical day with your child," allowing the caregiver to steer the conversation while I supported their words with confirming nods or supporting words. I often repeated something they had told me to see if I heard what they said correctly, and at times encouraged caregivers to explain something they had related in more depth. Only towards the end of each interview when I sensed the caregiver needing direction did I interject any questions related to the Parent Information Form or to themes as I was beginning to identify.

I ended each interview by recapping main themes that seemed to emerge from the interview process that I thought were important to see if I was making correct assumptions and that the caregiver also thought the theme was important. For example, I would say something like, "So what I heard you say was that..." or "Am I correct in that ____ seems to be your greatest fear." I believe this increased the validity of my interpretations of what the caregivers' words.

## Spurious Conclusions

During the first three interviews, I began to identify themes that I used to direct future interview questions to other caregivers. During the transcription of the fourth interview, I realized that I was asking leading questions because of having identified these themes and drawing early conclusions. I immediately became more aware of this tendency to ask leading questions during the subsequent

interviews and, instead, kept my questions more open-ended. As stated earlier, I also struggled with not letting my experiences and knowledge of research about the origin of atypical behavior steer the direction of my questioning or findings.

## SUMMARY

The perceptions of a caregiver caring for a child with atypical behavior are implicit, and therefore, cannot be looked at directly. I have made the assumption that there is a cognitive process that operates in a conscious mode that helps guide the caregiver-child relationship and that the caregivers' expressions of incidences and experiences represent those cognitive processes.

Unfortunately, we are limited in being able to accurately assess thought processes and cognitions except through self-reporting measures, but one cannot assume accurate introspection and immunity from self-presentation artifacts and biases.

The data analysis process began at the start of this research study and continued throughout the writing stage of the project. Even when I thought all analysis was done, I continued to be surprised at how new insights surfaced each time I reviewed the transcripts or file contents. I then realized that data analysis is probably never fully completed, but something that is forever dynamic. Therefore, the findings reflect what was known that one particular point in time in the study.

In the next section of this paper, I provide vignettes of each of the caregivers I interviewed in hopes that the reader can visualize not only the caregiver, but

some of the factors that surround the caregiver-child relationship that are important to understanding the caregivers' perceptions.

# CHAPTER IV: ANALYSIS OF THE DATA

## VIGNETTES

Just as perceptions guide the caregiver's stories, so do my perceptions guide the writing of these vignettes. The vignettes were written immediately upon returning from each of the eight interviews with the caregivers. Sights, sounds, smells, and feelings were still fresh. I did not intend to use what I had written in this paper because I realized how subjective my words were. I wrote the vignettes in this fashion as a way of keeping first impressions fresh in my mind so that, if necessary, I could prevent those first impressions from fading over time as I continued on with this project.

When it came time to editing the vignettes into a more objective format, I was torn. After all, this research project is about the process of perceptions guiding thoughts and behavior. Even if I were to carefully edit the vignettes, taking out my "biased" thoughts, the reader is still left with a subjective, although less rich, description of the caregivers. My thoughts and perceptions would steer what information I presented to the reader, and what information I discarded. I made the decision to leave the vignettes in tact. They are exactly as I wrote them, moments upon leaving each caregiver's home. Therefore, I caution the reader to be aware of this when reading the vignettes and to recognize my subjective perceptions of caregiver descriptions.

On the other hand, leaving in my subject perceptions allows the reader to have a visual picture of the caregivers I interviewed and their children, allowing

the reader to see the interview process through my eyes. Hopefully, seeing the interviews through my eyes will give the reader insight into how I have interpreted the data and to come up with his or her own conclusions. In the next section of this paper, I will introduce you to the caregivers and their children.

Eight caregivers of children identified as having atypical behavior were interviewed. The information presented in the following chart was taken from the Parent Information Form and the TABS behavioral assessment. Although I met some of the caregivers' children, and have presented some descriptive information about them, the children were not the focus of this study. I have, however, included a brief introduction to the children, along with information about other factors that might have influenced the caregivers' perceptions such as socio-economic status, TAB scores, and area of most concern that the caregiver indicated on the TABS. This information is also presented in Figure 1: Caregiver Information on page 92.

**Beth**

*"Whatever I can do, I want to do it... you know? I want to get out there and start a new life for us."*

The interview with Beth was the only one that did not take place in a caregiver's home. When I called to make arrangements to meet with Beth, she expressed embarrassment at the idea of having me in her home. In her mid-twenties, Beth had recently moved back home to live with her mother after being in and out of women's shelters, spending time in a psychiatric treatment ward,

| CAREGIVER | CHILD | CHILD AGE | SOCIO-ECONOMIC STATUS | TABS SCORE | AREA OF MOST CONCERN |
|---|---|---|---|---|---|
| Beth | Logan | 2 1/2 | Low SES | 17 | Detachment |
| Bob & Lou | Ashley | 4 1/2 | High-Middle SES | 26 | Detachment<br>Unregulated |
| Darla | Ben | 5 1/2 | Low SES | 16 | Hypersensitive |
| Gary | Adam | 4 1/2 | Low-Middle SES | 16 | Detachment &<br>Hypersensitivity |
| Kate | Rene | 4 | Middle SES | 12 | Detachment |
| Liz | William | 4 | Low SES | 13 | Hypersensitive |
| Sally | Joe | 6 | Middle SES | 16 | Hypersensitive |
| Tara | Devin | 5 1/2 | Low SES | 21 | Hypersensitive |

**Figure 1: Caregiver Information**

and staying with friends. Her mother's apartment, she told me, would not be suitable for an interview because it was very small, unorganized, and cluttered. I assured Beth that I did not mind a small place or clutter, but she insisted we meet elsewhere because she was embarrassed to have anyone see the place. I was able to make arrangements at a local primary school that was a few blocks from where Beth lived and we set a date for the interview.

Beth lived in a rural community approximately one and one-half hours away from any major city. Beth lived in a mountainous region filled with rugged hills and gaping valleys. She arrived at exactly the predetermined hour with her two-year-old son in her arms. I had arranged for her son to play in the Birth to Three preschool room while we talked at a table in the corner. Her son, Logan, was not yet able to separate from his mother Beth told me, and so we would need to stay within visual contact of him or he would not let her talk to me.

Beth was very pretty and soft-spoken, with light brown hair and matching eyes. She was slender, dressed in jeans and a neatly tucked in shirt. She appeared shy and apprehensive, making fleeting eye contact and seeming to be nervous. When I brought the tape recorder out, she sucked in her breath and groaned. I was afraid for a moment that she would change her mind about having the interview audio taped, but then she laughed and said something about hating the way her voice sounded on a tape recorder. As Beth began to talk, she become very articulate, detailing her story with rich descriptions of past memories, but she never fully relaxed throughout the interview process.

A victim of sexual and physical abuse, Beth admitted to having many unresolved issues of her own. She had been diagnosed with bipolar disorder, was medicated and under the care of her doctor. She talked freely about these problems without over-emphasizing or indulging in them. Beth was a victim of rape, not once, but three times. In addition, she had suffered physical and emotional abuse from her mother. Her hope was to raise her son in a different environment and style than she had been raised. She had plans to save a little money in order to make the down payment on an apartment of her own as soon as the holidays were over. Her optimism for her, and Logan's, future came through several times during the interview.

At the same time, she appeared worried. She expressed concern that she would ever be able to leave the situation she now lived in. She said she really did not have support from anyone and did not have close friends, and that she and Logan rarely left the apartment. She admitted that depression often got the best of her and worried about Logan being cooped up in the apartment so much of the time.

Throughout the interview, she watched her son play; tense and grimacing as he tore through play items and materials. I assured her that he was okay and we could pick up the room after the interview, but she continued to be distracted by his behavior and frequently jumped up in what appeared to be attempts to rescue him when he did not seem to want, or need, her assistance.

Logan was a two-and-a-half year old boy with long, shoulder length curly brown hair and bright inquisitive brown eyes. As neatly dressed as his mother,

the resemblance between the two of them was remarkable. Beth had given him a rating of 17 on the TABS with Beth indicating that detachment and hypersensitivity were the areas of greatest problem to her.

Indeed, Logan was on "high-speed" at all times during the interview. He raced from toy to toy, never really settling to play and knocking over everything in his path. He would find an item to play with only to continue searching for its replacement before he actually got started, thus his eyes were always darting around the room for what would come next.

As Beth predicted, he did frequently came to her for reassurance, throwing himself on her legs or pressing himself into her body for a second or two, only to dart off in a new direction. The room was in shambles by the time the interview was done. It literally looked like a tornado had touched down amidst the toys and furniture. Beth reported that this was what Logan did in the home and it was impossible to keep the small apartment orderly, which was an issue with her mother. Beth said that most of the time she simply locked Logan up in her bedroom rather than have to face her mother's reprimand at the end of the day.

**Bob and Lou Smith**

*"I hope you have four-wheel-drive, Honey, because otherwise you ain't getting up here."*

These were the words of warning Lou gave me when I called for directions to her home. She was right. Bob and Lou's tastefully decorated and intentionally isolated home was nestled high in the Appalachian Mountains where modern technology loses importance. Indeed, becoming lost on a steep, winding gravel

road that caused the tires of my car to spin when I endeavored to climb it, I attempted calling Lou for directions, only to find that my cell phone had lost all service.

Managing to find my destination, I was surprised to be met at the door by Bob who I had been told would be at work and could not be a part of the interview. I quickly warmed to him as he explained that he had intentionally come home early to be a part of the interview process. Although the interview was set up with Lou, given the situation, I decided I was going to have to interview them both, rather than tell Bob he could not participate.

Bob, at an age when most of his peers were retired, complained good-naturedly about his choice to keep working to support Ashley. They were currently in what had turned out to be a lengthy courtroom process in hopes of gaining permanent custody of Ashley. A heavy-set man with graying hair, the thick-rimmed glasses he wore did not hide the insightfulness look in his eyes. Lou, a wiry and energetic woman in her early forties, had bright blue eyes that hinted of friendliness and candor. She worked as a full time mother to Ashley and the couple's five-year-old son, Brian, whom she laughingly told me was harder work than anything else she could do on the "outside." Bob was a factory worker, divorced, and the father of two adult children from a previous marriage. He mentioned with a catch in his voice, that he also had a son who had died at the age of eighteen.

The Smiths were the biological great aunt and uncle of Ashley, who was strikingly tiny, like a tiny porcelain doll that is perfectly proportioned. Although

Ashley was four years of age, she had the appearance of being no older than a toddler. She had curly, brown, shoulder-length hair and bright brown eyes. There was always a smile on her tiny face. She occasionally came into the room where we were interviewing and would climb up on my lap as if I was an established and familiar person in her life. The Smiths reported that his was a problem as Ashley would go with just about anyone who asked her.

The Smiths indicated on the TABS that Ashley's behavior was a 26, with their primary concerns in the area of detachment and hypersensitivity. They also scored Ashley high in being unregulated.

Bob and Lou had been in and out of Ashley's life since her birth, trying numerous times over the four years to win custody of her. They frequently had taken care of Ashley for weeks, and months, at a time when her biological mother was unable to care for her. At the time of the interview, Ashley had been in their sole custody for seventeen months while her biological mother fought to get her back. A court ruling was to take place later that same week.

The Smiths' pride and optimism for Ashley came out repeatedly during the interview process. Said Bob, "She knows her alphabet and she will say every word to you precisely, I mean she will pronounce every syllable!" while Lou added, "Yeah, I went "hey, that was...that was 6 words. Ashley just put together six words!" and we just praised her and praised her. It was just like watching a child take their first steps, you know, two steps, four steps."

Ashley was born to a mother who lived with a female mate. Under their care, Ashley suffered physical abuse and neglect. Bob and Lou told horrific tales of

Ashley being left alone for hours, and sometimes days, forced to fend for herself and to wrestle food away from the many animals that dwelled in her home. With nine large dogs and several cats, the Smiths claimed the house was infested with lice, rats, and a variety of bugs, and there was reportedly feces smeared across the floors. There were several areas of the floor where the floorboards were literally rotted through, exposing bare ground. In addition, they said, rats and roaches ran freely throughout the house. Bob and Lou recalled the numerous bites and sores they tended on Ashley's body, recounting the child's fear of getting out of bed in the morning without her shoes on, "Anytime she would be up, she'd grab those shoes first thing (Bob snaps his fingers twice)." Lou added, "But then we finally started to realize why? In addition, we said, "how come?" She said, "bite, bite." You see, she came from where everyone had to wear shoes or the bugs would get you."

During the interview, Bob and Lou comfortably bantered back and forth, filling in pieces of information the other left out and completing each other's sentences before either one could finish speaking. They frequently shared looks of intimacy that could only result from years spent living with someone. Bob spoke in a deliberately slow, thoughtful manner while Lou often spoke so fast and freely about multiple topics at the same time that it was sometimes difficult to follow her train of thought.

Both Bob and Lou stated that Bob was the chief disciplinarian in Ashley's life. If Ashley misbehaved during the day while under Lou's care, Ashley knew she had to face Bob's reprimand as well upon his return at the end of the day. Lou

spoke more about Ashley's physical care and the horrors of her past, as well as the fears she harbored about Ashley's future, while Bob shared more about Ashley's accomplishments and daily life patterns.

The interview went on for over two hours as each time I tried to end it, Bob or Lou thought of one more thing they wanted to tell me. Then they begged to escort me through their home and show me the children's rooms. Once there, out came toys and items from the children's closets, baby books, and other trinkets of memory. When I was finally able to work my way to the door, they walked me to my car and my last memory of them is seeing them waving to me through the rear view mirror on the car.

**Darla**

*"I think I done something wrong in the process of raising him.*
*I don't know what it is I've done wrong. I just know I did something wrong.*
*I just wish I had a perfect child, nothing wrong with him."*

After I stepped over broken bicycles and appliances, half-opened spilled over garbage bags, and a patchy rock-grass lawn, Darla met me at the door for the interview before I had a chance to knock. She lived in a low-income housing project near the center of the city she lived in. The apartment complex was poorly kept, with broken steps, peeling paint, and poor maintenance.

A tall, lanky woman who appeared to be in her early twenties, Darla wore her long blond hair in a straight blunt cut that fell to the middle of her back. She had a curious look in her eyes that contradicted the cautious lines on her face. Without a word, she ushered me into the small apartment, where the olive green paint on the living room walls cast an unusual hue to the room. The apartment was amply

furnished, very neat and clean, and I was immediately drawn to an entire wall, from nearly the floor to the ceiling, that was devoted to displaying pictures of children.

A young boy, about the age of four, peered out at me from behind a door. I assumed the doorway led to a back bedroom. He did not come out, but rather, retreated a bit when I made eye contact with him and smiled. He did not smile back. Darla did not offer me a seat, so I asked where I should sit down and she shrugged, and then motioned to a chair, still having not spoken a single word. She took a seat opposite me and leaned forward.

Thinking the boy peeked out at us from behind the doorway was her son, I asked her about him in hopes of building rapport. She grinned as if she found my question funny. An otherwise striking woman, I was surprised to see that she was missing several front teeth, and I wondered if this was the cause of her reluctance to talk or smile. My thoughts were confirmed when she immediately lifted a self-conscious hand to her mouth to shield her smile. Putting her hand over her mouth was an action she repeated several times throughout the interview. The young boy was not her son, she explained, but rather, a child she tended during the day while his mother worked. Her own son was at school, having just entered kindergarten.

Darla's son, Ben, had been referred to SB6 because of his difficult behavior at school. I asked Darla if he displayed the same behavior at home, as they claimed he did at school and she said that he did. She explained that his behavior had recently escalated at about the same time his father was once again in prison.

She was alone with sole responsibility for Ben and the apartment. She said she took in the young boy as a way of making a little money even though she really did not care to do so. She also added that she had no desire to work, or even go beyond the walls of her home, "I'm happy right here," she said, "don't want to go out and do anything. Taking care of this one is enough."

Darla was the mother of three children. Although she was not explicit in discussing the circumstances of why she only had Ben living with her at the time of the interview, she did mention that one child had been removed from her care by the county and that another child lived permanently with Darla's mother. I asked if any of the pictures on the wall were of her children and her face lit up with pride. She immediately stood and showed me pictures of all three children, each child seeming to have had a different father of differing race.

There were many pictures of Ben starting from when he was an infant to photos of him at present. He was a small boy with dark features and hair. His dark eyes, so dark that it was impossible to distinguish his pupils from the rest of his eyes, were bright. A smile warmed his face in every picture. The last picture of him was a school picture and the big smile he wore on his face showed that he was missing two front teeth.

Darla was unable to articulate the behaviors Ben was displaying at home and school that was causing her difficulty. When asked, she would say, "He's always in trouble." or "He don't want to listen." On the TABS, Ben scored 16, with hypersensitivity being the area of most concern.

The interview with Darla was the most difficult of the eight interviews I conducted. Each question I asked was responded to with a quick, fleeting reply, sometimes with hand over mouth, and sometimes with hesitancy and false starts into stories that she just as quickly stifled and never told. The interview lasted only half an hour and I left feeling like there was a lot more Darla could have said but for some reason, chose not to divulge.

## Gary

*"I suppose it sounds strange but I don't ever want to get married, ah, I know what it did to me and I don't want him to go through it."*

I was interested in interviewing Gary since he would be the first male single parent I had the chance to interview. Gary lived in a low-middle socio-economic in a busy section of the city. When I pulled up into his driveway, I noticed how neat the yard and house were in comparison to some of the neighbors. Gary had forgotten our appointment and it took a moment or two for him to come to the door. I could hear him scrambling as if he were very quickly putting things away and cleaning the place up. My thoughts were confirmed when he came to do the door, apologized several times, and continued to toss newspapers, toys, pillows and clothes into another room. He scooped up coffee cups and dishes, continuing to put things away for the first few minutes of my visit.

Gary appeared to be in his early thirties, with neatly trimmed brown hair and glasses. After apologizing yet another time, he finally reached over and turned off the television set that was blasting the news at a very high volume. The room immediately went dark as all of the shades and drapes were pulled. Gary quickly

jumped up and opened the front door, which allowed some light into the room, then switched on a ceramic lamp that sat on a coffee table between us. Finally settled, he seemed to relax, leaning forward and giving me his full attention. Throughout the interview process, he appeared very calm and methodically thoughtful as he took his time remembering certain instances in his life in response to my questions.

Gary talked about what it was like to be a single father. Adam's mother left them both when Adam was one month old. Although he talked about this period of his life being painful and very difficult, he did so in such a way that he conveyed quiet resolve. He was more concerned with the present and future than he was of the past. Because he worked full time and was single, Gary relied heavily on childcare providers for Adam's care and this was a constant worry to him. Gary said he had never had a proper role model from which to learn parenting, and so he worried about both his own parenting skills as well as the skills of those who took care of Adam in meeting Adam's behavioral needs.

Gary was isolated from his own family, a mother and two siblings who continued to live together and who all dealt with significant mental health issues. Gary had learned over the years to become independent and not to rely on them for any kind of help. He seemed to have a quiet acceptance of their differences, however, and appeared empathetic to their situation. Some of the stories he related from his childhood were disturbing. For example, he recalled a time his mother barged into his classroom at school and announced to the class and his teacher that she was taking Gary out of school permanently so she could be

married. They would be moving away immediately. Gary was not able to recall if that was husband number two or three, for his mother had been married five or six times. He often confused these men when retelling his story, stumbling on whether a particular memory happened with husband numbered three or four. He never called them by name but simply referred to them as "her husband." No matter how many husbands his mother had in the past, Gary had memories of physical and sexual abuse and neglect from nearly every one.

Gary worked an early morning shift at a large company in a small, but quickly growing town near the edge of the Smoky Mountains. In order to get to his work by four-thirty a.m., Gary had to rise each morning at three a.m. to get himself ready for work and Adam ready for school. Adam was then dropped off at a childcare provider who lived just down the street until it was time for school. Gary was not happy with this arrangement.

Throughout the interview, Adam interrupted us, causing us to stop the interview until Gary could take care of his needs. Adam was quite large for his age, large boned and stocky. Although he was four years old at the time of the interview, he looked to be about the size of a six-year-old. He had white-blonde hair, much lighter than his father's, and vivid blue eyes. He bounded in and out of the room at top speed, sometimes plowing into his father with enough force to knock him backwards with the blow. Although Gary asked him to stop doing that several times, he continued to do so often. He also stood in between Gary and I as we talked, vying for my attention and putting himself in direct line of my vision with a mischievous smile on his face. When he left us to go to his bedroom, I

could hear buckets of blocks being emptied out, toys pulled from the shelves, and items hitting the walls. At one time Adam began tossing pieces of toys into the room where we sat and although Gary asked him to stop, it took a trip to the bedroom and a time-out from Gary to make him stop. Adam's score on the TABS was 16, with detachment and hypersensitivity.

This caused significant disruption in Gary's stories with him frequently re-entering the room and saying, "Now, what were we talking about?" I did not feel I got as much information from Gary as I would have liked, but I opted to end the interview when I sensed Gary's frustration over his son's behavior was outweighing his appreciation for me being there. Still, the conversation was insightful and I feel I obtained an accurate portrayal of Gary and his situation.

**Kate**

*"There is a piece of her that will always belong somewhere else."*

I met Kate, a single mother in her early forties, at her apartment. She had soft brown hair that she kept clipped short and oversized glasses that seemed to slip down her nose whenever she talked. The apartment was neatly arranged and decorated in old style furniture that smelled faintly of an antique store and lemon oil. Kate admitted she was fond of antiques and enjoyed a good antiquing excursion in pursuit of a new object or piece of household goods. Soft spoken and thoughtfully reflective, she took her time responding to my questions, often looking away for a moment or two while gathering her thoughts. She told a harrowing story of the history and background of her adopted daughter, Rene, who was five-and-a-half at the time of the interview and who had been adopted

by Kate at the age of three. Rene had been abandoned by her biological mother and placed in foster care. Her biological mother was mentally ill and had been in and out of hospitals, causing Rene to be neglected for long periods.

Kate described herself as a professional, educated, active woman who enjoyed outdoor activities such as canoeing and camping. She lived with another female who also had a young daughter, and although never stated outright, Kate hinted several times that the two adult women were involved in a relationship. Although Kate held a teaching degree, she was not actively teaching, and instead, was pursing her master's degree. Kate and her friend shared childcare duties, and seemed to have a shared working relationship in regards to household chores. Other than giving obvious hints about the relationship and a small amount of information about her friend, Kate spoke mostly of her daughter and very little about herself. Nevertheless, through her stories of Rene, I was able to pick out the perceptions of Kate.

For example, Kate had a love for knowledge and education and feared Rene would not measure up to her expectations, Said Kate, "I just want her to push a little bit more. I mean, I have always lived a very modest life, but also a very educated life with high values. I want that for her but she doesn't like that. She doesn't like when I read her books. She doesn't like to play the usual games." Her family lived in another state but she described them as being supportive and "there" when she needed them. Otherwise, Kate depended upon friends, her knowledge about child development, and the support of a small parenting group of adoptive parents that provided her with a social structure that seemed to be

working for Kate. She had had Rene assessed for behavior more on a whim than out of actual need. Behavioral screenings were being held at a local health fair and Kate had decided to get an opinion on Rene's behavior. She did not appear to have sought help out of need.

When asked to describe Rene, Kate thoughtfully sat back and characterized her perception of Rene in a series of descriptive adjectives... angry... insubordinate... manipulative... She also described Rene as being loving, insightful, and a resourceful survivor. She saw many of Rene's wrongful behaviors as simply tools of survival, developed during the many transitions Rene was forced to make in her early years of life. She also saw those same strengths as a source of concern in Rene's future.

Kate's primary concern in raising Rene was that the care and values she provided would not override the values and behaviors Rene learned as a young child. She even questioned whether those behaviors were innate and resistant to change. Kate described Rene as being "low class" and seeking out other "low class" playmates. She also said that Rene did not like schoolwork or reading, and as an elementary teacher, education was something that Kate highly valued.

In addition, the same behaviors that Kate saw as strengths in Rene, such as being very sociable and insightful, were causes for concern. Rene could easily manipulate adults using calculated charm. Kate perceived that she had the ability to "read" people and could adjust her own behavior accordingly to get what she wanted. In addition Rene often acted more the adult than the child and this worried Kate considerably.

I did not get to meet Rene but Kate did show me her picture. The picture showed a handsome young lady with a solemn look on her face. She wore her thin, straight hair back in a pony tail with a red bow. Blue glasses concealed the color of her eyes. She posed stiffly for the picture, giving the impression she did not like having her picture taken. On the TABS, Rene scored a 12. Most of Kate's concerns fell under the category of detachment.

The interview process with Kate was pleasant and relaxed, although I felt Kate was being politely reserved. In other words, although she answered my questions, I sometimes felt like she had more to say than she did, for some reason, choosing not to elaborate on a particular topic. The interview seemed to extinguish itself simultaneously when I felt I had asked all that I needed to ask at roughly the same time that Kate indicated she had told me all she could think of about her experiences.

**Liz**

*"Can't stand em, them 'ankees (Yankees). 'Ankees are rude. I don't care what part of the country they're from." "Did you know I was a Yankee?" I asked. Liz grinned, "That's okay. I'm a Red Neck (laugh)!"*

Liz was the most difficult interview to set up. When I called after her initial agreement to be a part of this study, her phone had been disconnected. A few days later, a social worker from SB6 gave me a new phone number; only to find this number had also been disconnected by the time I called it. I had given up on interviewing Liz when a third phone number was provided, again by SB6. I called and set up an interview appointment with Liz for the following day, and then asked her for directions. She told me she lived on the "main road" but she did not

really know the name of it. Having been in the town she lived in, I began describing roads from memory, giving a visual picture of where particular stores or landmarks were in hopes of building a visual map that both she and I could understand. I was then able to piece together what I hoped were trustworthy directions.

When I drove to Liz's house the following day, however, I could not locate her house, nor could I reach her by cell phone. I drove around the area I believed Liz's house was located and made notes of anything I thought might be an identifying marker to use when calling Liz again -- a large tree, a broken down barn, a road that had a fork in it with one lane tarred and the other in gravel. Using this makeshift map, I called Liz a second time and apologized for having not been able to find her. I described the area I had been in, pieced together some of what she said, and made a second attempt to see Liz the following day.

Liz lived in a remote area that was thickly wooded. The road that led to her house had no identifying sign, but I was able to spot her mailbox. I pulled into a small clearing that held two, very small cabins in extreme ill repair and a broken down singlewide trailer. There were chickens in the front yard, several cats, and a huge dog, all of which scattered when I opened my car door. I then noticed a small boy playing on his bike near a large mountain of smoldering garbage. I approached him to ask if this was where Liz lived.

The boy's brown eyes lit open wide and he jumped off his bike without answering, leaving the bike laying at my feet with its wheels still spinning. He took off at a dead run to the back of the cabins. I learned later that this was

William, Liz's son. He wore his brown hair in a "buzz" cut, leaving only a fraction of an inch of growth. He was small for his age and slender, so slender that the waist of his pants was scrunched together in folds and held in place with a belt. I believe if the belt came off, the pants would have fallen as well.

Left on my own, I opted to approach the middle cabin and an older woman came to the door. She was slight in stature, hardly reaching my chin, with her long hair pulled back into a long, graying braid that fell nearly to her waist. I assumed she was Liz and introduced myself. She stared at me a moment, then said, "Oh, you're that person who's coming. Liz is over here." She proceeded to yell "LIZ, LIZ!" at the top of her lungs and hurried over to the first cabin to pound on the door. I meekly followed her.

Several holes in the front door were patched with gray duct tape. Several cracks in the dirt stained windows were covered in the same way. Liz greeted us at the door with a smile and invited me in, while the woman, whom I later learned was Liz's mother, disappeared. The cabin was dark, with a pungent smell that reminded me of a combination of dust, mildew, and the dander and feces of animals. Indeed, a small black cat immediately came up to me and began rubbing against my legs.

Liz bid me to sit down while she finished what she was doing on her computer. I could see she was logged on to the Internet and I noted that the contrast of modern technology to the simple dwelling was remarkable. Liz wore her shoulder length blonde hair pulled back in a ponytail. She had on a baggy shirt and loose leggings over a portly shape.

The cabin appeared to include two rooms, the one we sat in and a room behind another duct-taped door that I assumed was a bedroom. The kitchen did not include typical cabinets or appliances but simply contained an open counter with dishes, both dirty and clean, pots and pans, clothes, and other items upon it. There was a ledge separating the kitchen area from where we sat in the living room, which contained the computer, a computer chair, a hard backed chair, and a dark, soiled coach. I opted for the hard backed chair and sat, the black cat immediately jumping into my lap for attention.

Liz worked at the computer another few minutes while I commented on her cat, the weather, and just about any other small talk I could think of. She finally logged off the Internet and made a comment about how much she enjoyed the computer. She asked if I had a computer and became very interested when I told her that I did. This computer, she told me, had been left by her old boyfriend. When he lived there, she was not allowed to touch it but now that he was gone, she could use it all she wanted.

I soon figured out that William, the little boy who had jumped off his bike and disappeared to the back yard, lived between the two cabins, the one we were in and the one I had first approached. Liz's mother lived in the middle cabin and Liz did not say whether anyone lived in the singlewide trailer. William, she said, was very shy and did not like strangers much.

Liz talked very openly about her life and her past experiences. She had been raped in high school and admitted to not knowing anything about sex or the prevention of a baby. Her father and mother were divorced but her father still

lived nearby and was a support to her. Her mother provided most of the care for William and had done so since his birth. Liz openly admitted that she did not want William and had nothing to do with him the first few months of life. She said that she had learned to love him, in part, through her mother's insistence. William was born premature and spent his first month of life in neo-intensive care. When Liz brought him home from the hospital she said her mother put him in a "shoebox" for a crib and dressed him up like a "baby doll." It was over two months before Liz got up the nerve to hold William. She said, "I thought about not keeping him, but my mom told me that he was a part of me and to just keep him so I did."

Liz did not work, did not own a car, and had never ventured further than the nearby town, which had a population of less than a thousand people, other than to attend a doctor's appointment in a nearby city about sixty miles away. She obviously lived in poverty and the Parental Information Sheet confirmed this. She brought in no income except what was provided by social security and welfare payments she collected on both herself and her son. She rated William's behavior as 13, with hypersensitivity being the area of most concern.

Besides the computer, Liz loved going to a local bar just down the road most nights of the week where she met up with friends, danced and sang karaoke. Her eyes lit up and she grinned when telling me about the neighborhood bar and the fun she and her friends had when they were there. Thursday nights were Lady's Nights and a glass of beer was only a dollar. Friday nights they had good bands sometimes and of course, there was always the karaoke. I asked Liz if she sang,

and she giggled and said that she did. When not at the bar or on the computer, Liz said she mostly slept, the medication she was taking for depression making her sleep at least twelve to fourteen hours a day. The interview was interesting and insightful, and I tried to ignore the persistent itch on my lower legs until I got back into my car where I noted I had been bitten several times by fleas.

**Sally**

*"It's the Mama. It's the Mama who is to blame, because she's the one who's always with him. I felt like, I've failed! I've failed! You know? As a parent, I've failed him."*

Sally lived in a rural setting, down a long winding gravel road. The yard had several broken down, rusty old vehicles, as well as old tires, appliances, and miscellaneous items. In contrast, the front of the house was surrounded by a large wooden porch, washed in white paint and delightfully decorated with pots of flowers, chimes, and other colorful decorations. Several bags and boxes of garden harvest sat next to a wicker lounge chair, where it appeared someone had been shelling peas, for pieces of green littered a small wicker table as if the person's work was still in progress.

Sally's home was richly and handsomely decorated, very orderly and clean. In the dining room, the table was set with impressive pieces of bone china, real silver utensils, and linen napkins next to wine glasses. It was as if the table was pre-set pending an important dinner with a guest but Sally admitted she simply liked the look of a set table and they typically used the kitchen table to eat on.

We passed through a living room area where an elderly man sat watching television, the volume turned up to a resounding level. Sally introduced me to him

as Papaw, but did not elaborate on whether it was her father or her husband's father. He barely lifted his head in a nod as we passed, his eyes never leaving the screen of the TV. Later in the interview, I learned he was Sally's father-in-law and the three of them shared living space and the parenting of Sally's son, Joe. Said Sally, "I'll tell him one thing, his daddy will tell him something else, and his papaw will tell something else... too many chiefs and not enough Indians."

Joe had been referred for behavioral services by his Head Start where they described his behavior as being impulsive and overly active. They suspected that he had attention deficit disorder, which Sally denied. A young woman in her late thirties, she had married an older man who was not interested in having children. She admitted having spent ten years begging and pleading with her husband for a child until he finally relented and Joe was born, "It took me ten years to convince him to let me have Joe. That's why I'm a lot more lenient with him."

Sally was a stay at home mom by choice and saw her primary role as being a good mother. She talked about Joe's birth and early months of life with a far away whimsical look on her face and described intimate scenes of cuddling, reading stories together, sharing nature, and going for walks with her son. She also felt guilty and blamed herself for Joe's problems at school saying if anything, she had spent too much time with him and had spoiled him, which caused his problems.

Sally loved to read and was proficient on the Internet so she frequently checked out books from the library or accessed information on the Internet about her son's behavior and parenting. She was also prudent about information she

read, pronouncing some of the information and techniques she read from experts as worthy and others as "hog wash."

Sally volunteered at her son's school and attended church. She had neighboring friends with whom she shared the gift of garden flowers. Her disposition was so cheery for much of the interview that I was surprised when tears surfaced on more than one occasion, typically triggered by memories of not so happy times.

About half way into the interview, Sally retrieved an eight-by-eleven picture of Joe from the other room which she proudly handed over to me. The picture was taken the day Joe graduated from Head Start and showed him in a shiny blue graduate gown and matching mortor board hat. He had neatly clipped brown hair and intelligent eyes that hinted of impishness. Seemingly comfortable in front of the camera, the face that grinned back at me from the cherished photo made me smile. Sally rated his behavior as a 16 on the TABS, with hypersensitivity being the area of most concern.

Sally's husband made a good income and the house they lived in belonged to the grandfather.

I believe the interview with Sally might have gone on all day if I had let it. As it was, I tried to end the interview several times when it appeared that I had obtained enough information but Sally wanted to talk on. I decided to oblige her, turning off the recorder, and continuing to chat with her for nearly another half-hour. When I left, she showered me with bags of fresh produce from her gardens and walked me to my car.

## Tara

*"I think I can handle it, but you know, when my oldest daughter had it. But then he came along and it is more stress on me and I am like, I don't know. I don't think so anymore. I don't think I can handle it anymore."*

Tara's house was located in a rural area at least twenty-five miles from the nearest town, but set within the boundaries of a sub-division made up of at least fifteen houses. The sub-division contained small, closely spaced houses, many of which seemed to be in need of a coat of paint. Old rusted cars littered many of the lawns. Tara's own front lawn had three old vehicles in it. When I arrived, several neighbors stopped what they were doing and stood in their yards to watch me enter Tara's house.

Tara answered the door with an apprehensive smile and invited me in. Heavy curtains drawn across the windows made the room dark and it took a moment for my eyes to adjust to the change of light. I assumed Tara kept the heavy, dark drapes drawn tight despite the sunny afternoon skies because of the close proximity of the other houses, and she confirmed my thoughts in the interview. The room was sparsely furnished with an old worn couch and matching chairs, a small wooden table between them. Tara beckoned me to sit, and I did. As my eyes adjusted, I noticed the only decorations were several pictures of her three children in various poses on the walls. An odd lizard in a light bulb heated aquarium sat beneath the pictures, along side a rapidly chirping parakeet in a cage.

I remarked on how beautiful her children were and Tara's dark brown eyes immediately warmed. She appeared to be Native American with dark hair and

skin. She began telling me about her son, whom I will call Devin, before I could explain the process and turn the tape recorder on. After a moment, I interrupted her and asked if I could tape record what she had said and began to explain the consent form and procedures. Before I could finish, she launched into a new tale about an event that had occurred the night before with her son as if unable to wait, the information just bubbling out.

Throughout the interview process, Tara gave me fleeting glances as if she were uncertain how I might react to her words. This was the hardest interview I conducted because her story was so filled with current despair and hopelessness. She openly wept several times throughout the process. When the interview was done, I walked away feeling as if I had violated her privacy.

Tara was a young mother in her mid to upper twenties. She lived in poverty and social isolation while battling the behaviors of two children diagnosed with Attention Deficit Disorder with Hyperactivity (ADHD). It was my perception that she suffered depression and she confided that her son, Devin, might possibly also suffer depression.

Devin had been a difficult child for most of his life. Born with his umbilical cord wrapped around his neck at least twice, he suffered some oxygen loss at birth. At around three months of age, he began experiencing high fevers that could not be explained, and Tara wondered if either of these events had something to do with his behavior today. In addition, her husband had a brother whom Tara thought had "it," the word she used to describe anything related to Devin and his

behavior. Her oldest daughter also had "it," was medicated, and seemed to be settling down into junior high and adjusting nicely.

A picture of Devin and his sisters was on the wall directly in front of me. The resemblance of Devin to his sisters was remarkable. All had the same dark brown hair lightly streaked with a lighter color of brown, and round, taupe colored eyes with thick eye-lashes. All three children were plump, like Tara, but not necessarily obese. They had the look of people belonging to an Alaska tribe of Indians with their round features, dark eyes and bronzed skin.

Devin's behavior was extreme, from pounding his head on the wooden floor until his nose bled, to diving off the top of a semi truck and putting a gash that required stitches into the back of his head, or attacking family members with a knife. Because these behaviors occurred repeatedly and unexpectedly, all tools and sharp objects were kept locked up or out of reach. However, Devin continued to be resourceful in his pursuit of dangerous objects and now used stones, bricks, or anything else that could be made into a makeshift weapon. Tara rated his behavior as a 21 on the TABS, with hypersensitivity being the area of greatest concern.

Tara felt as if the neighborhood resented and isolated her because of her son's behavior. She said, "They drive by and call things out the window at him and at me. How do they know? I mean, how could they know if I were on drugs or something?" Tara's husband worked full-time at night and attended school full-time during the day. It appeared from several things that Tara said that she felt alone and unsupported in her marriage. In addition, Tara's family lived in another

state. She did not know how to drive a car, and she had no friends. She did not understand many of the social service programs that were offered to her and could not get the state's Tenn-Care system (Tennessee's equivalent to Medicare) to cooperate with paying medical bills and prescriptions for herself and her children. She also suspected the school was not offering special education services to her children when they were supposed to be, but did not know how or to whom to go to for help.

After having helped families like Tara's for most of my career, it was very difficult for me to just sit back and listen to her story without offering my help or advice. As stated earlier, I felt terrible when I left and the memory of Tara and her situation stays with me today.

**One Final Note**

I had proposed to conduct between seven and ten interviews for the purpose of this study. Although I feel the eight interviews that were conducted gave me insight into caregiver perceptions about their relationships with their children, I would have liked to have included more. Unfortunately, SB6 was again undergoing personnel changes that put the program in a state of temporary limbo while replacements could be hired and oriented to the program. Rather than wait for the new staff to begin home visits, which would have taken at least two months, I decided to end the interview process.

## THE RESEARCH PROCESS AND FINDINGS

Just as the research question and sub-questions guided the direction of the data collection, they also directed the course of the research process and findings. The interviews and caregiver files generated a tremendous amount of information, and the research questions provided structure for narrowing topics and eliminating excess data.

I began data analysis by accessing the SB6 files on caregivers who had given written consent to be a part of this study. The TABS assessment, as well as the Parent Information Form, were reviewed for pertinent information related to the caregiver-child relationships. For example, the TABS assessment was reviewed for information about the type and intensity of the child's behavior as rated by the caregiver. The Parent Information Form provided information about milestones in the caregiver and child's lives, social support systems, and stressors the caregiver was currently facing. After reviewing the file, I wrote notes regarding any questions I had, or topics that might be introduced during the interview. For example, if a caregiver indicated the child had spent considerable time in the hospital, I wanted to make sure that this topic was brought up in the interview.

I then began the interview process, using the pre-written questions and the notes from information in the SB6 files. After each interview, I immediately wrote a vignette for each caregiver while this information was fresh in my mind. I also took notes in my journal about my impressions, thoughts, and ideas about possible themes or meaning in what caregivers had said. As I conducted each interview, I used my journal to compare and contrast themes that had emerged. I

began putting this information in chart form in hopes of drawing parallels or conflicting themes. I also listed questions that arose from the process and ideas that I had about particular things caregivers had said.

This process was conducted numerous times with numerous charts being drawn in an attempt to make sense of themes and contextual factors that were emerging in hopes of drawing logical conclusions about the caregiver perceptions. Even though I did not intend to do so, my first attempts at analyzing the data were based on trying to form linear connections between factors and perceptions. For example, if the interview was with a single parent, I was determined to link single parenting with a perception the caregiver had. I discovered that this was not possible. By attempting to put my preliminary findings into a visual format, I discovered that caregiver perceptions cannot be disconnected into separate entities and that caregiver perceptions are "circular" rather than "linear" in nature. Trying to put such complex ideas into a chart form was much like presenting three dimensional information in a two dimensional format.

For example, many of the caregivers reported feelings of inadequacy in dealing with their child's behavior, yet, those feelings of inadequacy were linked with other perceptions, such as how the caregiver thought others viewed his or her parenting skills, or, whether or not the caregiver felt the child's behavior was a result of an external element or their own parenting.

After struggling with this issue for some time, I returned to my research questions and the theoretical frameworks to guide the analysis process. I wanted

to show how perceptions were in a constant state of change over time and how even past perceptions changed as new experiences occurred. I finally was able to come up with a model that I call the Circularity of Caregiver Perceptions over Time, but even this model does not adequately portray the interconnectedness of caregiver perceptions with influences of the past, present and future. After failed attempts to fit my findings into several different models, however, this model worked the best so even though the model cannot show factors such as time or change, it does provide an adequate structure for organizing my findings. Figure 2: Circularity of Caregiver Perceptions over Time shows this structure.

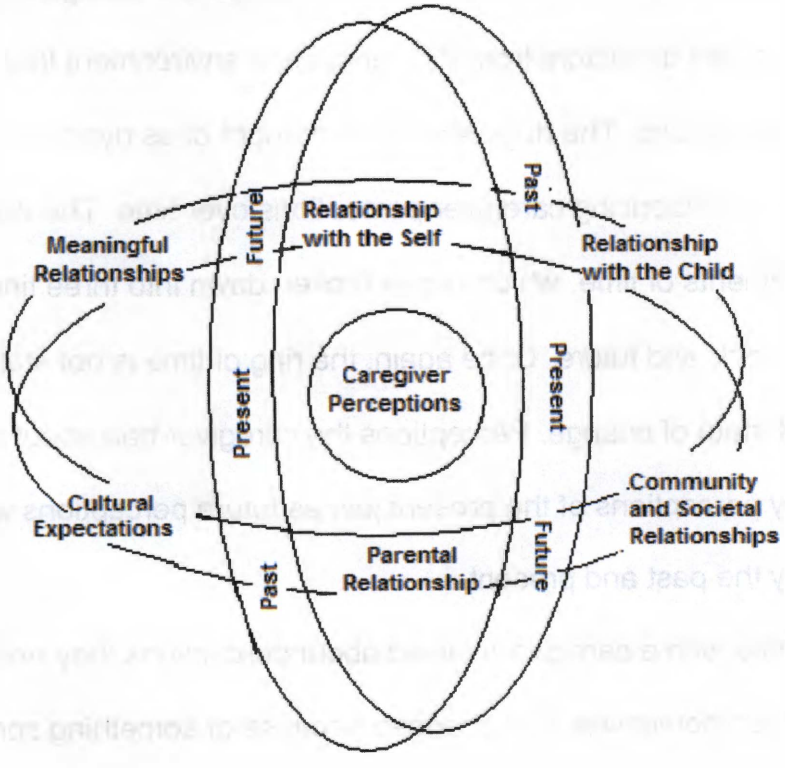


**Figure 2: The Circularity of Caregiver Perceptions over Time**

## THE CIRCULARITY OF CAREGIVER PERCEPTIONS OVER TIME

At the center of the model are caregiver perceptions. Caregiver perceptions were the focus of this study, therefore, I thought it appropriate to put them as the nucleus of my model. Perceptions the caregivers shared included perceptions of themselves and others in relation to their children's behavior. They also had perceptions of blame for who, or what, caused their children's behavior, including blame of the children, themselves, or others. They also shared perceptions of fear for the future. These perceptions were based on experiences and relationships the caregivers had with others over time.

The rings of the model represent the relationships the caregivers were involved in, as well as factors from the caregiver's environment that might have influenced perceptions. The rings should be thought of as dynamic and ever changing, while influencing caregiver perceptions over time. The vertical rings consist of elements of time, which I have broken down into three time periods: the past, present, and future. Once again, the ring of time is not static, but rather, in a constant state of change. Perceptions the caregiver had about the past are influenced by perceptions of the present just as future perceptions will be influenced by the past and present.

For example, some caregivers talked about perceptions they once had about their children or themselves that changed because of something someone said or did, or as a result of analyzing their own situation. Likewise, perceptions the caregivers had about the future were often influenced by perceptions of the past. Some caregivers had perceived the future for themselves and their children with

fear due to past experiences they had with other family members with behavior problems.

The horizontal rings contain relationships that influenced caregiver perceptions over time. These relationships also greatly affected the caregivers' perceptions. I have grouped the relationships into six categories, including relationships with: 1) relationship with the child, 2) relationship with the self (caregiver), 3) the parental relationship, 4) meaningful relationships, 5) community and societal relationships, and 6) cultural expectations.

These relationships are inter-related, and in constant change. In other words, a caregiver's relationship with the self greatly influences the caregiver's relationship with a child. Likewise, a caregiver's relationship with the child greatly influences the caregiver's relationship with a significant other. There are numerous inter-relationship connections that can be made between the many types of relationships, making it nearly impossible to set boundaries around any one relationship suggesting where that relationship starts or ends. Again, this is one of the limitations of this model, and the reader must be aware that all aspects of the model are interrelated and in a constant state of change, influencing and altering the course of relationships, factors, and caregiver perceptions over time.

In addition, the reader should be aware that this model shows one moment in time and nothing more. The perceptions I have captured here no longer exist. They have already been altered by new experiences and the evolution of the relationship, itself. Even the fact that I interviewed the caregivers changed their

perceptions about what they told me then to how they perceive their children today.

I begin my description of findings by addressing the caregiver perceptions. There were many perceptions that emerged from the data, but some perceptions repeated themselves over and over again. It was these perceptions that I captured for analysis. In trying to make sense of these perceptions, I went back to my literature review and used the organizational structure presented by Bugental (2000) that organizes perceptions into four different categories: 1) descriptive, 2) analytical, 3) evaluative, and 4) efficacy.

Descriptive perceptions included labels the caregivers used about their children's behavior. Some caregivers perceived some of the children's behavior as normal while others labeled the behavior as not normal. Some caregivers externalized the children's behavior, referring to the behavior as "it." Some caregivers used descriptive labels they learned from others in society, such as ADHD or autism, while other caregivers searched for a label to use to describe their children's behavior that had shared meaning with others in society.

Caregivers also used analytical descriptions about their situation. These perceptions included whether or not the caregiver saw the child's behavior as deliberate or something beyond the child's ability to control. How the caregiver analyzed the child's behavior made a great difference in how the caregiver perceived the behavior.

Perceptions also included how the caregiver evaluated the child's behavior over time. For example, some caregivers had family members who had

"outgrown" the problem behavior over time. These caregivers had different perceptions about the behavior than those who determined the behavior was due to something that was innate with the child that could not be changed.

Perceptions of efficacy influenced how a caregiver felt about the child's behavior and about the self. If a caregiver felt he or she was the cause of the child's atypical behavior, the caregiver's perception of the child, and the self, was greatly different than a caregiver who felt the child's behavior was the result of someone or something that happened to the child.

As stated earlier, these perceptions are interwoven throughout the past, present, and future and are heavily influenced by relationships and factors in society and culture. One universal theme shared by all of the eight caregivers, however, was that of fear. Some caregivers expressed fear for the future, whether that fear was for their children, or for others who might be affected by their children's behavior. Some caregivers tied that fear to their own experiences of the past, or to perceptions of others in the present.

In trying to organize this information into a format that allows the reader to view the perceptions that emerged from the data about caregiver perceptions, I was again faced with the issue of trying to organize something that was dynamic and ever changing. Rather than listing caregiver perceptions, I decided to interweave those themes into the structure of time, using the past, present, and future as my structure.

## Perceptions of the Past

According to symbolic interactionism theory, we describe and interact with objects (people, situations, events) through the eyes of the past. The experiences of the past then, help us assign meaning to the present. The caregivers in this study often brought up stories of the past and related them to the present and the future. In particular, caregivers shared memories of being parented in their own family of origin. Caregivers also based some of their current expectations for their child on expectations that had been placed on themselves by others in the past. These perceptions were also heavily influenced by the expectations and practices of others in culture and society, in both the present and the past.

One of the most common themes to emerge was whether or not the caregiver had a past experience similar to what they were experiencing in the present.

### Relationship of the Self to the Child

Gary said that like his son, Ben, he had also been "hyperactive," "difficult," and "in trouble" and that he had "too much energy." Thus, Gary feared his son would experience some of the unpleasant experiences he had as a child.

> I just don't want him held back if it's just for his being hyper, ah, I mean if it is for learning that's fine, but not for being hyper. I was very hyper when I was his age. I was just like him and I was held back. Then, I was the oldest in the class and buying beer for everyone. It puts you in trouble.

Sally spoke of how her son was like herself saying, "He just can't keep his mouth shut, you know? I tease him that he's just like his mother. Sometimes I can't keep my mouth shut either."

Kate spoke of how she wished her adopted child had more of her own childhood interests and qualities.

> There are things that I thought she would be interested in doing, like I used to do, you know, like going for walks, and reading books. She's not into things like that. She has never liked to be read to. I give her all the opportunity to do these things and she just isn't interested.

In all three of these examples, caregivers are using perceptions of themselves to make sense of their child. Another theme that greatly influenced the caregivers' perceptions about their child were relationships the caregivers had with their family of origin.

**The Parental Relationship**

Most of the caregivers told stories about their families of origin and memories of being a child. They commonly spoke about their own parents and how past memories of being parented guided how they parented their child today.

Gary repeatedly emphasized how his past experiences had influenced the present and expectations for the future.

> I suppose it sounds strange but I don't ever want to get married. I know what it did to me and I don't want him to go through it. Step parents can be so mean. I mean, they don't have to love your kids and I don't want him to go through it.

Like Gary, the caregivers who chose to share memories and perceptions of their past and their families of origin, shared only negative memories. Liz said:

> I don't want to hit him. I was hit so I don't want to hit him. I got the belt buckle on me. I got soap in my mouth and everything, for saying bad words. But I don't hit him.

Beth also spoke of being hit as a child. She said, "I don't hit him or anything. I was hit and so I don't want to hit him."

Sally said:

> I was adopted . I love my parents, but they were older parents and my father died when I was eight. And that left my mother and she was real strict, um, not a very kind woman. At points, I try to overcompensate with him thinking I will never speak to my child that way, or I will never tell my child he can't do something. (Sally starts to cry.) I was yelled at most of my life and I found myself screaming at him and I had to find out that screaming is not going to get you anywhere.

**Meaningful Relationships**

Caregivers also talked about their relationships with others as a way of making sense of their child's behavior and their own relationships today. "Others" might include siblings, a significant other, or extended family members. Darla spoke of memories of her brother when she was a child.

> My brother, he used to be like my son. When my daughter is here, they're at it like cats and dogs. My brother and me used to fight like that, but the big difference between my brother and him is that my brother used to get in a lot of trouble at school, otherwise, they are exactly the same.

Tara compared her relationship with Devin to her relationship with Devin's sister.

> I knew there was something wrong, my other daughter, even she has her problems, you know, her attention

> deficit disorder, but she learned early how to talk, and how to walk and everything early. So did my other one. But him, he's just like, he didn't want to do it. I don't know if he couldn't or just wouldn't do it. He seems worser than compared to her.

Bob and Lou compared Ashley to their biological son by saying, "They are so different. It's like we have to have two sets of rules. One set of rules for him and one set of rules for her."

Tara also spoke of the influence of her extended family's perceptions.

> My mother-in-law, she knew that he had something wrong because she's got two sons that have it. Her youngest one and I think it was her oldest one had it and they had it really bad. The youngest one, he's still got it. He can't stand the kids, not for a length of time. He beats on himself, he's been in jail. He's threatened with knives and everything else. I mean, he's got a very bad temper. You're on pins and needles when he's around. And that's why he reminds me of him, because I remember when her son was younger. It was terrible.

**Community and Societal Relationships**

Relationships on this level included friends or acquaintances, those in the helping professions, church members, school personnel, and at times, complete strangers.

Bob and Lou spoke of the influence of their personal doctor's perception of how they were handling Ashley's atypical behavior, as well as that of a complete stranger Lou met in a hospital waiting room. The doctor told Lou "I'll see her a second time, but I know exactly what she needs," making reference to the fact that Lou was doing a better job of parenting than Ashley's biological mother had. He said he was "impressed" and commented that Ashley had "made great

progress." Lou also described a scene in a doctor's office waiting room where a complete stranger came up to her and said, "Boy, you done a good job with her." The woman knew Ashley when she still lived with her biological mother and explained that she could see a big improvement in Ashley's behavior.

At times, the caregivers even referenced the impact of a complete strangers' influence on them. Gary said:

> I talked to a lady the other day and she said that her son was twenty and that he was spoiled. She said that she raised her son like I was and now he's spoiled and lazy and I hope that I can not raise him like that. It's just so hard. I am just so overwhelmed. You have to be a parent, a nurse, a you just have to do so much. I just fear that I am completely messing it up. I know what it did to me. I know how he can turn out.

Bob and Lou talked about how they perceived their relationship with Ashley.

> Somebody at church just looked at me one day and said, "You know that God blessed you with this child. It was meant to be." Well, I'd never thought of it that way and I said, "God knew that she needed you and maybe you needed her and I thought that was okay."

**Cultural Expectations**

How caregivers acted within relationships at various levels, or how the caregivers perceived they or their children should act, also was influenced by cultural rules and practices. Some caregivers talked about unwritten rules they perceived to be in place while others accessed media sources for written or documented rules of practice.

Sally's perceptions of her relationship with her son were influenced by the media, particularly information from behavioral specialists and parents that she connected with through books and the Internet.

> Everything I was doing was right. I read a couple of books and she gave me some information that she had printed out of some books, and that really kind of helped me. I picked up a book, I can't remember the name of the book and I wish I could. To me it was standing over them, pounding into them that we are the boss and they have to do what we say. And I thought, that's not what you need to do. I wish you had a book where if you have this kind of situation, you could turn to this chapter and it would tell you exactly how to handle it.

The many books and articles Sally had read on the subject of parenting also seemed to cause confusion for her. She said, "You wish you had someone, you've got all of these people telling you please don't spank your children, you know? But a little whack on the behind is not going to hurt anyone, I think, anyway, is it?" Later, she said, "You'll have a book that tells you its okay to do one thing and another book that tells you it's not okay to do that. It is very confusing."

Gary also talked about accessing the perceptions of others through the media the desire to conform to cultural rules and expectations, but how those rules changed leaving him confused about what was right and what was wrong.

> I read books, and stuff, but everyone says you can't do that, ah, you can't learn to raise a kid by reading a book. Like whether or not it was all right to use spanking. They went and said it was bad and then it was good and, ah, I didn't know what to do. Sometimes I do go in there and spank him, ah, I don't know which is right.

Liz talked about how cultural practices had changed from when she was parented in the past and how she perceived she was expected to parent today.

> He gets on my nerves sometimes, when he does stuff. But the doctor won't give me no medicine for it, so.... so I just go in the other room , sit down, or something. Cause I don't want to hit him. I got the belt buckle on me. I got soap in my mouth and everything,

> for saying bad words. Parents today let their kids drink, smoke, and those things? If I did that, I would have gotten the belt.

## Perceptions of the Present

Just as perceptions of the past were influenced by the many relationships and experiences the caregivers had, so were perceptions of the present. As suggested by Sameroff and Emde (1989) the labels the caregivers in this study used to describe and their children gave insight into their perceptions. The most common themes to emerge were to whom or what the caregiver assigned blame for the child's misbehavior also gave insight into perceptions of the present. Another theme was how the caregiver labeled the child or child's behavior, whether the caregiver saw the behavior as deliberate or unintentional, or how the caregiver viewed their own role in relation to the child's behavior. These perceptions are discussed next.

### Perceptions about the Child

On the TABS assessment of atypical behavior, all of the children scored in the atypical level, with aggression, temper tantrums, frustration, anger, and unpredictable mood swings being highlighted as the most difficult behaviors all caregivers faced, yet, caregivers described their children using very different labels, including "moody," "sociable," "frightening," "witty," or "funny." While all caregivers used some negative labels to describe their child, some caregivers used negative labels exclusively when talking about their child.

Adam, Gary's son, had one of the highest scores on the TABS in relation to the other children in this study, with a score of 23 (a score of 10 or higher being

indicative of atypical behavior). All other children scored between 11 and 16 on the TABS. Said Gary, "If he don't get his way, he just pitches a fit, slams the door, you know, throws things, destroys his toys, ah, wrecks his train." But Gary also had many positive things to say about Adam, saying that Adam's behavior was "a lot better," and using positive or neutral words to describe Adam's hyperactivity such as saying he was "very active" or "busy."

Like Gary, Bob and Lou gave many examples of Ashley's "rages," "stealing," "lying," and "destroying things," and called their daughter "stubborn," "head strong," and a "fighter." They also used many positive descriptors, such as "real smart," "very intelligent," and "bonded to us."

Sally almost exclusively used positive descriptors to describe Joe.

> He's a very active boy, very energetic, you know? It is just that nothing slows him down. When he's disruptive, sometimes he just wants to help, or he wants to be the leader. He wants to be the one in charge. He's a good kid, a really good kid.

Kate described Rene's fits of "anger and rage," "swearing," "stealing," and "lying." She also described Rene as being very "keenly in tune" with other people's moods and feelings, calling her daughter "insightful," "sociable," "friendly," and "chatty."

Other caregivers, however, described their child solely in negative terms. Said Tara about her son, Devin:

> He starts throwing stuff at you. He goes into the kitchen sometimes and gets knives. He can't calm down. He goes into really bad rages. Grits his teeth. He's put holes in the walls and busted a window out and he tries to hurt himself. Sometimes he starts biting me and claws my face. He has no fear and he doesn't feel pain. Like, yesterday,

> he cut his hand. I mean, it wasn't real bad but it was bleeding and we all noticed it and he was like, he hadn't noticed it, like there was no pain.

Darla also used only negative descriptors of her son:

> He's got an attitude all the time. He likes to use a smart mouth. If he don't get his way, he'll pitch a big fit and start hollering and yellering, and doing all sorts of stuff. He doesn't want to do anything that he's told. He gets his anger up and I'm just waiting on the day, well, he set my mother-in-law's house on fire with a baby in it. My greatest fear is him going out and turning on me. That's what he tries to do now, but can't. But when he gets older, I don't know what I'm going to do.

Behavior As "It"

Some caregivers described their child's behavior by giving it the label of "it." Instead of saying "he is aggressive" or "she likes to hit," they grouped all of the behavior into a separate entity, "it." Tara did this several times in the interview.

> The school has already done the testing and said, yes, he does have 'it'. My older daughter don't have 'it'. I mean, when she was younger she had 'it' but I could handle 'it', but then he was born and then it was more stress on me and I was like... I don't think I can handle 'it' now.

Tara talked about her mother-in-law having two sons with "it." Liz also spoke several times during the interview about "it" when referencing her son's behavior.

Normal or Not Normal

Another label caregivers used to make sense of their child's behavior was to categorize the behavior in terms of normal or not normal. Liz said, "When he gets mad, or we say no, he gets one of them temper tantrums. He gets stiff. I don't know if that's normal or what." Bob and Lou said much the same thing. Bob said, "She has pretty good mood swings, but I don't know if that might be common for

women." Sally talked about having read book after book about "what was normal and what was not" in trying to figure out her son's behavior. Tara, Beth and Darla did not view their children's behavior as normal, and were searching for a label to assign the behavior in order to understand it or give it meaning. Tara said, "We need more tests done and we would have to pay another psychiatrist to have it done. It could be AD/HD, ah, J. thinks it's a depression."

Both the Smiths and Kate saw their children's behavior as atypical, but normal given the circumstances the children had been through. Both children had been adopted. Ashley had suffered tremendous abuse while Rene had suffered neglect. Bob and Lou perceived Ashley's difficult behavior as necessary in the world she had come from in order to "survive," describing the "protective wall" that Ashley had built around herself, and when describing some of her temper tantrums, Lou said, "she just needed to get it out" because of "all she'd been through."

Rene had been abandoned by her mother and put into several foster placements that failed. Although Kate saw Rene as deliberately misbehaving, she perceived the behavior as necessary in order for Rene to "survive" her past.

> One might think that's a little pathological to be that friendly, but it could be because she had to learn how to adapt. In fact, I'm sure of that. She has skills that have helped her adapt. I think that the insubordinate part of her is a strength of hers. It was pretty positive behavior to a very bad situation. She is overly friendly to people, but then, she had to be. It was pretty positive behavior to a very bad situation.

In addition to how a caregiver described a child's behavior, he or she described perceptions of the relationship she or he had with the child today.

Caregivers talked about whether they felt in control of their children's behavior or whether or not they felt they could change the children's misbehavior.

Deliberateness of Behavior

When describing their children's behavior, many of the caregivers made reference to whether or not they perceived their children to be in control of the behavior, deliberately or intentionally acting out, or whether the behavior was something the child could not control. Tara spoke of Devin's behavior as being intentional.

> My oldest girl learned early how to talk, and how to walk and everything early and so did my other one, but him, he's just like, he didn't want to do it. He doesn't care, you know, it is just... meanness. I think, it's just... he wants others to do what he wants them to do.

Darla saw Ben's behavior in much the same way, "He just doesn't want to do anything he's told to do." When telling about how her son was not yet toilet trained or dressing himself, Tara said, "He hasn't dressed himself yet, can't tie his shoes, or else he just won't. He doesn't care, you know?"

Sally, however, saw Joe's behavior as both something he could control and something he could not control at times. She talked about his "rages" or "fits of anger" when he seemed to lose control of himself, but she also said, "I do think he is trying but when he gets around other kids, it is wide open, a lot of it's the excitement, a new place. He's too active to settle."

**Perceptions of the Self**

In addition to giving labels to the child and the child's behavior, caregivers also put labels on themselves and their own behavior. Sometimes this label was

heavily influenced by how others perceived the caregiver, or how the caregiver perceived how they ought to behave. Labels the caregivers used about themselves included whether or not the caregiver felt in control of the situation or effective in dealing with the child's behavior and on whom the caregiver assigned blame for the child's behavior. The assigning of blame was heavily influenced by how the caregiver perceived others' viewed him or her, including members of society and culture and whether or not the caregiver felt blamed or whether the caregiver blamed someone else or something for the child's behavior.

An important theme to emerge was the perception of control. Bob and Lou shared several "strategies" they had developed that were effective in handling Ashley's behavior and keeping in control. They gave examples of "new rules" and other "disciplinary" tactics they developed in response to meeting Ashley's emotional needs within the relationship. It is difficult to capture exact words of the Smiths to describe their feeling of efficacy and control as their stories were long and detailed and interlaced with non-verbal clues such as intonation of voice and body language when telling these stories. For example, they related how they had corrected Ashley's eating problem (e.g., hoarding and stuffing food), how they used time-out and other disciplinary practices that effectively controlled Ashley's misbehavior, as well as how they had developed new ways of helping Ashley learn. They spoke of these memories with pride in their voices.

Gary expressed mixed emotions of whether or not he perceived himself to be in control. For example, Gary said,

> Sometimes what you do works and sometimes it doesn't.

> Usually I put him in my room on my bed and for some reason, sometimes he stays. Usually I can get him to turn off his TV and sometimes can get him to do what I want if I offer him a sucker. But other times I just let him be in control. I don't go to Wal-Mart on the weekend because I know how he will behave there.

When I finally asked Gary if he perceived himself to be in control of his son's behavior most of the time or not, he said, "No-Yes." Then he laughed. "Some days I am in control, other days I am not."

Darla spoke about perceiving herself to be ineffective when dealing with her son, Ben's behavior.

> I don't know what kind of discipline to do on him, I don't know. I've tried everything and I just don't...nothing helps. I done tried the corner, I done tried whooping him. I done tried sitting him in time-out. I've tried taking his toys away, his bikes away, and none of them work. I'm just waiting for the day when he goes out and does something that he's not supposed to and someone comes up to me and says your kid's in juvenile and what am I supposed to do?

She mentioned several times that other people did not have problems with her son. Darla said Ben's teacher at school said, "He's all right. He does everything right. No problems." Ben had been in Head Start the previous year with no problems being reported by the staff. When she took him to a physician or counselor, she felt that he deliberately changed his behavior to show the professionals his good side. "Everybody I take him to, he goes up to them and he doesn't do anything. But then he comes home and it just starts all over again."

Darla's perception of being out of control was connected to the fact that her spouse was in jail. "When my husband went to jail, Ben got really bad. That's why I called Success By 6, because he was putting holes in the doors, kicking

everything, and breaking everything." Later, when asked what she was going to try next regarding her son's behavior, she responded, "I don't know, with him (her husband) in jail."

Sally talked about what it felt like to perceive herself as not having control, and then the feelings she had when she began to perceive herself as being in control of Joe's behavior.

> He was the one in charge and that's where we came into a problem. I always felt like I'm such a poor mother, I can't even control my five-year-old. But now, things are getting better. I don't feel that way now. I feel in control. I mean, you pick your battles and take one day at a time, because, parenting is not an exact science.

In contrast, as an educator, Kate seemed to feel she had the necessary skill to make a difference in her daughter's life, but because she believed Rene's behavior was innate, she felt she would be ineffective in changing them. Kate said, "I feel as if her previous background comes through more strongly than my values. Like, it's built into her even though I've had her in the past as much time as they did and at an older age."

**Who Is To Blame?**

Some caregivers, like Sally and Darla, felt responsible for their child's behavior or guilty for not being in control of the relationship, or blamed by others. While others, like the Smith' and Kate, perceived that particular circumstances or experiences caused the child's behavior and made the relationship what it was today.

Self-Blame

Darla expressed concern about feeling blamed by others.

> Am I doing something wrong? I don't know what to do about it. He just don't do anything that I tell him to do. I've been trying to figure out what it is that I'm doing wrong for him to be like this towards me when he's not like that towards anyone else. I can't understand it.

Sally talked extensively about having once felt at fault for Joe's behavior and how she changed her perception from being blamed to understanding.

> I used to think I was such a poor mother. I couldn't even control my son.. I honestly felt out of control. At the beginning of this year, his school said that something had to be done. I mean, he couldn't sit down, he couldn't focus, he couldn't get anything done and I would cry because I thought it was my fault. I thought it was my fault! I was thinking, I'm the one that's with him all day. I was probably teaching him all this stuff. Maybe if I hadn't been... do you know what I am saying?

Gary also perceived himself to be a part of the cause of his child's behavior even though he attributed some of the cause to Ben's mother having abandoned them when Ben was just one-month-old and the lack of structure in Ben's first childcare. Like Kate, Gary felt somewhat to blame in that he did not feel he could adequately handle or change Ben's behavior. Gary said, "Basically, I just hold on. I just fear so much that I am completely messing it up. I may have spoiled him. I hope to not spoil him."

**Blamed By Others**

Like Tara and Gary, most of the caregivers talked about their perceptions of how they, and their children, were perceived by society or culture. Typically, these perceptions were supported by memories of experiences in social settings, such as Wal-Mart or the grocery store, where the caregivers felt judged by others, Tara also felt judged and blamed by others in her neighborhood.

> The people, they think you can't control your own kid, you know? I mean, you got all of them talking about you doing drugs and, you know, thinking that I messed him up. The people are like, you can't control your own kid, you know? You shouldn't bring kids like that in the store, you know? And I'm like, oh, please don't.

Tara also said:

> After what happened, you know, during school, we noticed that everyone, after everyone found out what's going on, my kids can't play with them either because... they're bad people. I mean, just cause we have a child that is that way. I've had them go by the house and say, "Look at the circus people."

Sally softly cried as she related memories of feeling blamed by society for Joe's behavior.

> I always felt like it was my fault. I was in tears thinking I'm such a poor mother that I can't even control my five-year-old. It's the mama. It's the mama because she's the one who's always with him. I felt like, I've failed, I've failed, and you know, as a parent, I've failed him.

Kate feared her daughter would not progress academically, which she perceived as an embarrassment to her in the eyes of her peer group who valued education. She said, "I get a little nervous. I mean, scholarship and education is

who I am." In the same way that societal expectations caused some of the caregivers to feel judged, positive perceptions of others were also integrated into how the caregivers made sense of their situation.

Sally talked about SB6 staff telling her she was "doing things right." About William's teacher, Sally said, "His teacher explained that he acted just like her son did and she went to college and all that." Sally talked extensively about the relief she felt that society, at least some members of society, were accepting of her and her son's behavior, which contributed greatly to her own feelings of efficacy and her outlook for the future.

**Blaming Someone or Something Else**

Some caregivers assigned blame to others for the difficulty with the children's behavior. For example, Sally and Gary felt others did not really understand their children. Sally attributed much of her son's behavior to "new rules" or a "new teacher" who just was not used to Joe's behavior. Gary that the day care setting Ben was in was too unstructured and that Ben's misbehavior was due to the lack of structure and the fact that the day care providers were not used to children and did not understand Ben. He said:

> They didn't have any kids but him and weren't used to having any kids. They didn't like him making messes, running, or that sort of thing. I don't think that was right. He needs structure.

Tara felt neighborhood children might be contributing to the problem. When I asked Tara about a statement on the parent information form that stated her son did not play well with other children, she said:

> Yeah, nobody will let him! The little boy next door just beats up on him all the time. I mean, if he goes and plays with him, the little boy wants to throw him to the ground, call him retarded, and idiot. He has had to hit him a few times, because of him being thrown on the ground and everything.

Tara also thought some of her son's misbehavior might be attributed to sugar. She said:

> I think a big problem with him, like on Halloween, the school gave him a bunch of candy and he got a bunch around here and it's like an addiction to him, you know? It's like, all that candy ain't gone and he has to have it all, eat it all, or forget you, you know? Cause he starts biting me. He bit my face. Clawed me. I mean, I knowed there was something wrong right there.

Bob and Lou, as well as Beth and Kate, felt their children acted as they did because of the children's past experiences with neglect or abuse. Lou said that Ashley's temper tantrums were a way for her to "vent" and "get it all out" from the many abusive and neglectful experiences Lou knew about to some she could only image.

Liz and Beth, throughout their interviews, responded to questions about their perceptions with explanations of their situation. So, rather than assign blame to themselves or others, or answer questions about why they felt their children behaved in the way they did, they responded by describing their experiences.

> Everybody was talking about my kid, but, I don't listen to them. I'm like, if you went through the stuff that I went through, you'd be in the same shoes too. I don't know nothing about no kid. I had that class about sex and stuff, but I didn't know anything about that. I got raped.

Beth talked over and over again about the abuse her son, Logan, had experienced.

> I don't know what they told you, but we both have been through a lot. My mother goes after him with a fly swatter. She hits him, hits his hands, hits his face, even when he isn't, well, really isn't even doing anything. He just comes by her and she hits him.

It should be known that I asked Beth if her mother was still hitting Logan and if any of the experiences she was related were in the present and she assured me that she was talking about the past, before she returned from a women's shelter to live with her mother again.

## Perceptions of the Future

When asked about the future, all caregivers shared one common perception, one of fear. For some caregivers, that meant fear for their child. They felt that their child was at risk for being shunned by society or thought of as being different. For other caregivers, the fear was for themselves or other people. Their children had already displayed behavior that put others at risk.

### Fear of the Child

More than one caregiver expressed direct fear of his or her child. Darla said:

> My greatest fear is him going out and turning on me. That's about what he tries to do now and when he gets older, I don't even know what I'm going to do. I'm just waiting for the day he goes out and does something that he's not supposed to and someone comes up to me and says your kid's in juvenile.

Later in the interview, she said "I'm afraid that one day he's going to take a match and flick it and drop it and it's going to scorch us." Ben had just recently

set another family member's house on fire with an infant child in the bedroom sleeping.

Tara also spoke of fear of her son when he got older and bigger. Speaking about how Devin needed to be medicated, but not being able to afford the necessary medication, she said, ""We don't know what's going to happen. What if he hurts somebody? She also mentioned worrying that Devin might "not be able to function in the world." She said:

> At times, I think about when he gets older, in case we don't get no help. Um, I've heard other people say their children stand over them at night with knives and stuff and I'm really scared about that. You get that feeling, oh gosh, when he gets older, if he goes into one of them rages, I won't be able to control him good, You never know what might happen and then he might not remember until he comes down.

**Fear for the Child**

Sally and Gary feared their children would be labeled as having atypical behavior, which in turn would set their children apart from others. Said Sally:

> I'm worried about the AD/HD (Attention Deficit Disorder/Hyperactivity). My thing is that, if he is labeled, his teachers will say "Oh, he's such and such." If they are treated differently they may act up a little more or misbehave a little more or try to get away with a little more. I don't want that. I want him to have the same opportunities as any other child. It doesn't matter what he has or how he has It. He needs to be treated just like any of the other kids.

As in all other topics, Gary spoke of both fearing the future and not wanting his son to be "treated different," he was also optimistic about the future. He said, "Things are getting better, um, I'm hoping that they are getting better. At least I'm a positive thinker (laughs)."

Kate expressed worry about Rene's future:

> I'm scared to think about her future, to think about her being fifteen. If we can get to eighteen without her being pregnant. It's just that with her being overly sociable, almost permiscuous with other people. I'm a little worried.

Bob and Lou also expressed fear of not be able to gain custody of Ashley or of her biological mother somehow getting Ashley back. The same stranger in the doctor's office waiting room that complimented Lou on how she had changed Ashley by saying "Boy, you done a good job with her?" also generated fear in Lou. Lou said:

> Fear set in. I thought, who the heck is this woman? I got scared. It was fear then because I didn't know which way, what this woman saw, and if she was going to tell, you know that I was there. everyone watches Ashley for me, but it's, you know, you can turn your back and somebody can swipe your kid.

Most of the caregivers' fear was tied to the influence of culture and society. As stated earlier, Kate worried that Rene would violate social standards by being too promiscuous or by getting pregnant. Tara, Darla, and Gary all expressed fear of going to public places because of what others might think or say about their child's behavior. Sally feared that others would judge her son and treat him differently than other children.

**Temporary versus Long-Lasting**

Whether or not a caregiver perceived a child's atypical behavior as something temporary or permanent also influenced how they perceived the future. Sally hoped Joe's behavior would be temporary, but worried that his activeness would not change.

> I think when I can get him into sports that will help him, becoming

> part of the team... maybe he's going to grow out of it a little bit, I mean that's a part of growing up. You realize you can't always be first, you have to take turns. But this activeness, I don't think he will grow out of.

Bob and Lou perceived Ashley's difficult behavior as something that was temporary. They gave many examples of how they were re-teaching her more appropriate behavior and helping her let go of behaviors that belonged to her past. Bob talked about "molding" Ashley, "rule setting," and changing Ashley's behavior through "discipline."

Kate, on the other hand, did not see Rene's behavior as temporary and perceived the longevity of the problem would continue to hinder her relationship with her child. Said Kate,

> I think she has never forgotten what her early experience was like. I mean, she was a baby, but how does she know how to swear? I feel as if her previous background comes through more strongly than my values. Like, it's built into her even though I've had her as much time as they did and at an older age.

Gary viewed Adam's behavior as something that would most likely go away because, as stated earlier, he had also been "hyperactive" and had "outgrown it." Tara pondered this thought as well.

> On my husband's side of the family, they think he'll outgrow it, but I'm like... maybe he won't, so what do we do then? I say this is a big problem now and I'm not going to wait around and have him do something really bad or have him not be able to function in the world, you know?

## A SYNOPSIS OF THE FINDINGS

At the start of this study, I asked '**What perceptions do caregivers have about their children who have been identified as having atypical behavior**.' I wanted to know:

- How do caregivers describe and make sense of their child's behavior?
- What factors do caregivers believe contribute to their child's behavior?
- What expectations do caregivers have for their child?

These questions were used to guide the interview process and collection of data, as well to make sense of the data and to compile findings. The information taken from the interviews and file documents provided insight into answers to these questions. In relation to the above questions, caregivers described many perceptions they had. Some perceptions were common to all. Other perceptions were strikingly different. Those perceptions that stood out the most were chosen to analyze further. These include perceptions of how to label the child's behavior, perceptions of blame, self-efficacy, support and fear.

As stated earlier, and supported through the actual words of the caregivers, caregivers either had a name for their children's behavior or searching for one. Labels of "it," autism, and ADHD were discussed. Caregivers also expressed a need to find the blame for their children's behavior. Some caregivers blamed the children, themselves, for deliberately misbehaving. Others blamed themselves for their children's problems. Still others blamed other sources outside the

caregiver-child relationship. Of those caregivers who blamed themselves, or felt blamed by others, for their children's behavior, there were issues of self-efficacy.

How caregivers perceived their support was also of significance. This support came from a parental relationship the caregiver was in, relatives, community members, and society. Although many caregivers had common sources of support, it was their perceptions of that support that varied.

Finally, all caregivers expressed fear when asked about their expectations of the future. Sometimes this fear was for their child and sometimes it was for themselves or others.

From these perceptions, I have extracted several themes, and sub-themes, which will be presented in the final chapter of this paper. I will also provide interpretation and discussion of these themes and sub-themes.

# CHAPTER V:
# INTERPRETATION OF THE FINDINGS

## INTRODUCTION

In Chapter IV, caregiver perceptions were discussed and supported with data from the interviews and file documents. The caregivers own words were used to give richness, depth and meaning to the research findings. Perceptions included labeling the child's behavior, blame, self-efficacy, support, and fear.

From these perceptions, I have extracted several themes and sub-themes. I have generalized these themes and sub-themes into the following five statements. Listed below each statement are the themes associated with each generalization.

1. Caregivers made sense of their children's behavior by assigning labels or names to the behavior.
    - Under the theme heading of 'Seeking Meaning,' I have included the sub-themes of ways in which the caregivers labeled their children's behavior.
2. Caregivers also made sense of their children's behavior by finding who, or what, was at fault for causing the children's behaviors and then assigning blame.
    - Under the theme of 'Who or What To Blame' I have included sub-themes about ways in which the caregivers assigned blame for their children's behavior.

3. Caregivers used perceptions of others from relationships they were in and support systems to help them make sense of their own behavior and their children's behavior.
    - Under the theme of 'The Importance of What Others Think' I have included sub-themes about the sources of influence the caregivers spoke of.
4. Caregivers relied on the support of others and had perceptions of the significance of that support.
    - Under the theme of 'Help in Time of Need' I have included sub-themes about the resources of support the caregivers relied on.
5. Caregivers had expectations about their future based on experiences they had with others over time.
    - Under the theme of 'What Is Going to Happen Next: Behavior over Time' I have included sub-themes about how caregivers perceived their future based on their experiences of the present and past.

These themes and sub-themes are discussed in the next section of this paper.

## SEEKING MEANING

All caregivers sought to assign meaning to their children's behavior. This theme is presented under generalization one. One way in caregivers did this was to assign a label or name for their children's behavior. Assigning labels allowed the caregivers to compare and contrast what they knew about their children's

behavior with what others knew about behavior. They did this by comparing their children's behavior to their own behavior as a child, or to the behavior of someone else they knew. In some instances, the caregivers looked to others in the community, society, or culture for a label they could assign to their child's behavior.

**What's in a Name**

According to symbolic interactionism, how we label, or name, objects in our environment helps us give meaning to the object, as well as to share that meaning with others. Caregivers used such labels as "mean," "witty," "hyperactive," to explain their child to me. These labels were based on experiences the caregivers had over time and were influenced by the multiple relationships in which the caregiver was involved, or the factors considered on both the horizontal and vertical rings in the model.

All caregivers either used or sought out labels to help make sense of, and explain, their children's behavior. Some caregivers adopted labels that were used by others, including other family members, members of society or culture. For example, many of the caregivers had been told that their children's behavior could be labeled as depression, ADHD, or autism. These are common labels that represent categories of certain behaviors that hold the same meaning for many people at many levels of society and across time. Caregiver's perception about their children's behavior, then, was influenced by the label attached to the children's behavior. For some caregivers, they did not yet have a label to put on their children's behavior and even these caregivers were searching for an

acceptable label to put on their children's behavior as a way of better understanding it.

Gary and Sally used the label of ADHD. Tara wondered if labels such as bipolar disorder or depression best described her child's behavior. Beth asked if Logan's behavior could be classified under the label of autism or ADHD. Sally did not want her son labeled ADHD because she feared he would be treated differently than others. Her perception was based on experiences she has had with someone labeled with ADHD who was treated differently by members of society. Her perception was also based on the many sources of information she accessed through the Internet and in her reading about societal practices in relation to individuals with ADHD. She felt that if this label was put on her son, he would experience difficulty in the future because of the assigned meaning of that label in society.

Although labels such as ADHD or autism do help members of a society or culture explain and make sense of a child's behavior, these same labels do influence the actual behavior itself. For example, autism was once a label used to describe a set of behaviors that were thought to be caused by a pathological mother-child relationship (Szymanski, 1998). Societal belief was that mothers of children with autism were cold and indifferent to their child causing the disorder.

If Logan had been labeled with autism in the 1950s, Beth would most likely have been perceived by others as a cold, uncaring mother. Being thought of as a cold and uncaring mother might have further influenced how Beth related to Logan in the relationship. She may have become cold and uncaring to fit the

label being given or she might have tried to counteract the effects of the label by becoming more involved with Logan. Either way, Logan's behavior would be affected by the label it was given.

Today autism represents a disorder thought to be the result of a neurobiological problem, at least in some cases. It is possible the label of autism will represent something quite different in the future as new understanding is gained. With each societal or cultural change in the meaning of the label, the course of the symptoms of the label, or the child and caregiver's behaviors, will be altered.

Gary was told that his son most likely had ADHD. For most people, the label of ADHD conjures up perceptions of a child who is hyperactive, impulsive, has a hard time sitting still, or is disorganized. Although there is some shared understanding of meaning in the label ADHD, meaning also depends on one's past experiences. For Gary, ADHD was something he was certain his son would grow out of because he had once been labeled hyperactive and he had grown out of it. Thus, Gary's past experience with ADHD not only affected his perception of his son's behavior in the present, but also his expectations for the future.

One of the first things Liz said to me at the start of the interview was that she hated "'ankees," and that "'ankees are rude." The label of "Yankee" had cultural meaning for Liz and labeling allowed her to share that meaning with other individuals in her culture. If someone says, "She's a Yankee," people from the

south understand that the label of "Yankee" means the person is from the north. For some, the label also means the person is rude.

I am originally from the north and am what people from this geographic area call a "Yankee." When coming to the south five years ago, this term surprised me as I had not heard it before except in relation to the Civil War. Yet, since that time, I have often been called a Yankee and understand that for most people of this geographic area, the term holds somewhat of a derogatory meaning. For others, the term is spoken more in play or jest. Either way, the use of the label of Yankee for Liz was based on something that happened in the past, the Civil War, and the meaning of the word has been passed down through what family systems theory calls a multigenerational process (Minuchin & Fishman, 1981).

**Behavior As "It"**

Of particular interest was how some of the caregivers used the label of "it" to represent a category of behaviors they saw in their children. This label, although representing something specific to the caregivers who used it, held relatively little meaning for me. "It" could have represented any number of things, depression, aggression, or ADHD. This is because I am not from this shared culture. Yet, the label has significant importance. The caregivers who assigned the label of "it" also talked about other family members or other people they knew with "it." They talked about "it" as a permanent thing one inherits, thus, they would not treat the child's behavior in the same way as a caregiver who saw the problem of "it" to be the result of a teacher or school administrator whom they would not have to be dealing with after that school year, as was Sally's case.

**Normal or Not Normal**

Another labeling theme that emerged was whether or not the caregiver perceived the child's behavior as normal or not normal. Obviously, this is a powerful label, for the label "normal" means the child's behavior falls within societal acceptance, while "not normal" indicates a problem. Some of the caregivers, such as Sally and Gary, tried to normalize their child's behavior through statements they made. Gary said, "I was like that when I was a kid." or, "I outgrew it." He was normalizing Ben's behavior for himself by comparing his child's behavior to his own, or minimizing the significance of the behavior as something that was temporary and could be outgrown.

Bob and Lou were seeing Ashley's behavior as more and more normal with each passing day. Beth searched for the meaning of Logan's behavior. She wanted to know whether it was normal or not and asked me for my opinion about this several times in the interview.

Sally's perception of Joe's behavior radically changed when she accessed books, the Internet, and the opinions of others about Joe's behavior. She no longer viewed his behavior as abnormal, but rather, a part of his personality. This change in perception was influenced by new experiences Sally had and information she gathered from the Internet and books she read.

Caregivers also assigned descriptive labels to themselves. Kate told me she was "educated" and "high class" in comparison with her adopted daughter being a "slow learner" and of a "lower class." Comparing these labels in self and child

was a tool Kate used to share meaning with me and to emphasize the difficulty in her relationship with Rene that she saw as a difference in class.

Bob and Lou saw themselves as having "done good" with Ashley while Darla said over and over again that she "must have done something wrong." These perceptions of self will be discussed in more detail later in this chapter.

## WHO OR WHAT IS TO BLAME?

The second generalization included themes and sub-themes about how caregivers made sense of their children's behavior by finding who, or what, was at fault for causing the children's behaviors and then assigning blame.

Some caregivers saw their children's behavior as something that was inherited, such as those caregivers who labeled the behavior as "it." Other caregivers worried about being at fault for causing the atypical behavior in their children. Still others blamed others who either did not understand their child or had caused their children to behave as he or she did through relational interaction.

### Blaming the Child

Caregivers that were given a label such as ADHD for their children's behavior, or those that assigned the label of "it," most often saw the child as not being responsible for the behavior, or at least not deliberately misbehaving. They explained that the atypical behavior was the result of the disorder the child had or the genes the child had inherited. As I stated earlier, labels are used as a way of sharing meaning. Caregivers that had labels for their child's behavior looked at

the disorder as causing the child's behavior and something that was out of the child's control. If the caregiver felt the child's behavior was deliberate, as in the case of Tara who said her son was "mean," blame was more readily placed on the child. She felt that he could control his behavior if he wanted to blamed him for not doing so.

**Self Blame**

This theme of who is to blame was carried over into the caregivers' perceptions about themselves. Some caregivers worried that they were the cause of the children's behavior, or worried that others saw them as the cause of the children's behavior, while others blamed other relationships or factors in society. Sometimes the caregivers' perceptions of blame were influenced someone in a close relationship with them, and sometimes the caregivers' perceptions were altered by complete strangers. For example, Tara talked about how her in-laws criticized her for how she parented her son. She spoke of this several times in the interview so her in-law's perceptions about her must have had heavy influence. Tara felt ineffective in dealing with her son's behavior. She said several times that she was "not being able to control him" and that she "did not know what to do." An influencing factor in Tara's case was that she was also socially and geographically isolated from others. She did not drive and lived in a neighborhood where she had no friends. Her husband worked full time and went to school nights. Her family lived on the east coast and her husband's family was critical of her. She did not mention accessing information from outside sources on parenting and did admit that she was suffering from depression. Therefore,

she was limited in sharing her experiences and the meaning of those experiences with others. Tara perceived that the individuals she did share relationships with had a negative view of her efforts in controlling her son.

Darla seemed to be caught up in this pattern of being blamed and self-blaming. She perceived the school personnel and her doctor as seeing her as ineffective because they did not have a problem with Ben's behavior. She also stated repeatedly that she had "done something wrong" and was the cause of his behavior. Because of this, she stated several times that she "didn't know what to do." After all, if she was the "cause" of the child's misbehavior, and she did not know what she was doing wrong or right, she had no idea where to go from there and was hoping someone could give her direction.

Gary expressed a mixture of feeling blamed and blaming others. Although he felt partially responsible for not being able to control Ben, he also alluded to the fact that Ben might have experienced abuse in his first child care setting and also made reference to the fact that Ben's mother had left them when Ben was just one-month-old. He blamed these other people in Ben's life for some of Ben's misbehavior.

Even though Kate felt she had an above average understanding of child development and behavioral outcomes, she did not feel she would be successful in correcting Rene's behavior. She also did not feel blamed or responsible for not being able to change Rene's behavior. She had pinpointed one particular factor that greatly influenced her perceptions of her daughter, and of her misbehavior

over time – genetics – and she did not feel she could change the outcome of something that was innate in Rene.

Some caregivers were able to resist letting the perceptions of blame from others alter their own perceptions of themselves. While Sally decided over time to discount her mother-in-law's criticisms about herself and to no longer let her mother-in-law's opinions effect her, Tara struggled with this issue. Tara cried openly when she spoke about the harsh words from her in-laws about her own parenting skills. She also mentioned over and over again her concerns about her neighbors' perceptions about her, demonstrating that what others thought about her greatly influenced her feelings of self-doubt and blame.

Gary mentioned he had been "adopted" by the family who first began taking care of Adam as an infant when Adam's mother abandoned him at the age of one month. Gary relied heavily on this adopted family's opinion of what he was doing right or wrong and said their perceptions were "helpful" even if they were negative about what he was doing with Adam. Unlike Sally, who discounted what her mother-in-law said, and unlike Tara who allowed other's perceptions guide how she felt about herself, Gary decided to use other's perceptions, even negative ones, as a way of better understanding both himself and his child's behavior. He did not block out the perceptions of others, nor internalize them, he simply used them to add to his own knowledge base of experiences.

**Who Is In Charge**

Self-efficacy was a perception all caregivers spoke about. Some caregivers felt they were adequately handling their child's behavior, while others did not.

Whether or not the caregiver felt in charge of the child's behavior, or effective in handling the behavior, largely depended upon the perceptions of others. Caregivers who felt blamed by others in relation to their children's behavior felt the least effective in handling the children's behavior.

Bob and Lou perceived themselves as being very effective in dealing with Ashley's behavior. Some of their perceptions of efficacy came from "strategies" they had put into place that worked, others from the influence of positive perceptions of others regarding how they cared for Ashley. Their family doctor, members from church, and the stranger in the doctor's office all shared their perceptions with Lou that they were doing a good job raising Ashley. Lou brought this up several times during the interview, giving multiple examples of how she and Bob had changed Ashley's behavior. She grinned each time she shared one of these experiences, demonstrating the pride she had in what they were doing.

Other caregivers did not feel good about themselves in relation to their child. Caregivers who felt themselves blamed for their child's behavior often shared feelings of being ineffective in taking care of their child and in meeting the child's needs. As stated earlier, Tara talked about feeling criticized by in-laws, her neighbors, and the school system. She also talked about feeling ineffective in dealing with her son's behavior. She said several times that she was "not being able to control him" and that she "did not know what to do."

Darla shared this same perception. She said over and over again throughout the interview that her son's behavior was the worst when he was with her and

most people did not have trouble with him at all. She also said many times that she "must have done something wrong" in raising her son.

In contrast, caregivers who felt they were supported by others and shared the perception that others saw them as not being the cause of their children's behavior, also shared feelings of self-efficacy. Kate saw herself as an effective caregiver and she felt the cause of Rene's behavior was genetics. Bob and Lou felt effective and they saw the cause of Ashley's behavior to be her poor upbringing.

Darla and Tara both felt blamed for their children's behavior. Darla mentioned several times that she "don't know what she did wrong" and Tara repeatedly said "I don't know what to do." Neither caregiver felt they could effectively control their child's behavior.

### Someone Else's Fault

Some caregivers put the blame for their children's behavior on someone, or something, else. Although Tara talked about Devin's behavior being like other family members and something that he did deliberately at times, she also talked about how Devin's behavior was made worse by people in the neighborhood. She spoke of how neighbors would not let him play with their children and how they called him names. She felt their behavior was causing some of Devin's problems.

Sally originally felt she was the blame for Matthew's behavior, but over time her perceptions changed and she began to believe that Matthew's behavior was not as bad as she originally thought it was. His problem was that others in the

community, namely his teachers, did not understand him or appreciate his vivid personality.

Beth saw her mother as the cause of Logan's behavior based on her perception that her mother had physically abused Logan in the past. She also say her mother as causing continued discomfort in both her, and Logan's lives in the present because of her mother's lack of understanding and patience. She saw many of the behaviors that Logan had as normal but perceived her mother's interpretation of those behaviors as wrong. For example, the morning of the interview, Logan had spilled a bowl of cereal. Beth had been glad her mother was not there to witness the accident because she felt her mother would have been too harsh on Logan.

## THE IMPORTANCE OF WHAT OTHERS THINK

The third generalization included caregivers perceptions about what others said about them and their relationships with their children. The perceptions of others greatly influenced the caregivers' perceptions in general. As stated above, it was important to many of the caregivers to know what label society would put on their children. The opinions and perceptions of others also heavily influenced who, or what, the caregivers blamed. These shared perceptions served as social and cultural rules that the caregivers felt were expected of them. These rules, then, influenced how they interacted with their children.

## Spare the Rod, Spoil the Child

Almost all of the caregivers talked about the issue of spanking. It was important to them to know whether the social norm allowed spanking or did not allow spanking. Several of the caregivers had strong opinions on either side of the issue, yet, they needed confirmation for their beliefs and looked to others for support.

Several caregivers sought my personal opinion on this subject knowing that I specialize in understanding and correcting children's behavior. Many spoke of being spanked as children, and even of finding spanking to be an acceptable practice. However, most caregivers spoke also of spanking no longer being accepted as appropriate by others in society. They sought the advice of those who were in a position to claim to know the truth, such as authors of parenting books or articles on the Internet, doctors, teachers, and even myself.

Some caregivers felt spanking was an effective tool in correcting problem behavior. Liz recalled being whooped on a routine basis, as well as having her mouth washed out with soap for having said something bad. She thought felt that one of the biggest problems in schools today was that teachers were no longer allowed to whoop the kids.

Liz also added that she did not whoop her own child because she had heard from others that this was no longer an acceptable practice and she did not want to get into trouble for doing something she should not do. Although Liz saw whooping as acceptable, she changed her behavior to conform to what she perceived society expected of her.

Sally said that she had read several books and accessed the Internet on the subject. She felt that spanking was an effective behavior management tool. Like Liz, she also felt that spanking was no longer accepted by others in society and so she wondered if she should continue using spanking as a disciplinary tactic. Both Liz and Sally, as well as Gary, asked me my professional opinion on the subject.

As a behavioral specialist, I realized the significance of my opinion on these caregivers and the power I had to alter their perceptions of the issue. Because they viewed me as an "expert" on the subject, had I said that spanking was the best way to deal with an offending child, my words may well have altered how the caregivers handled problem behavior in their child. Some caregivers might have returned to spanking their children, or would have then looked for further validation into what I said in order to alter how they were dealing with their children. On the other hand, had I said that spanking should never be used, these caregivers may have been even more influenced to never spank their children.

**Divine Intervention**

Bob and Lou assigned some meaning to their relationship with Ashley based on religious beliefs. They perceived the opportunity to raise Ashley as a test of faith. Lou spoke of changing her perception about her relationship with Ashley after someone at church told her "God blessed you with this child" and "God knew that she needed you and maybe you needed her." A caregiver who perceives God as challenging them with a child that has difficult behavior will

have different perceptions than a caregiver who perceives that God is punishing them. It is quite possible that the influence of feeling that Ashley was a gift from God influenced Bob and Lou's perceptions about their situation.

In an indirect way, spiritual guidance influenced how Liz cared for her son. She became pregnant with William through a violent act of rape. She did not want to have a baby and would have given William up for adoption had her mother not stated that "he was a part of me, so just keep him." Liz was reacting to her mother's spiritual guidance as to what was, and what was not right in deciding what to do with William.

**From the Mouth of a Stranger**

Perceptions held by others in society, even the perceptions of others the caregiver does not personally know, greatly influenced these caregivers. Lou talked about a stranger in the doctor's office more than once in the interview. This stranger had told Liz that she was doing a good job with Ashley. The importance of this experience with a complete stranger seemed as influential to Lou as Tara telling about how the opinion of her mother-in-law influenced her own perceptions, even though Lou was influenced by a complete stranger and Tara was influenced by someone she knew well.

Darla spoke frequently about her perceptions of how Ben's teachers, doctor, and Head Start staff seemed to find her ineffective in handling Ben's behavior. Again, these are not intimate relationships, but rather, casual relationships that greatly impacted the caregiver.

Gary worried about what others thought about his ability to control his son in public places. He perceived himself, and his son, as not acting as others in society would expect them to act. This led Gary to change how he interacted with Ben. He no longer took Ben to public places such as Wal-Mart or the grocery store for fear that Ben's behavior would violate social norms or that others would perceive him to be an ineffective parent. So strong is the societal pull to conform to norms, that Gary felt stressed least members of society see him in a role with a son that was breaking those norms.

Several of the caregivers made comment about what it was like to take their child into a public setting. All expressed the feeling that others were critical of them for not being able to control their children's behavior. The risk of not being able to make their child conform to unwritten social rules caused great stress in their lives, demonstrating how the opinion of others can greatly alter the course of the caregiver-child relationship.

Although Sally made many comments such as "I don't care about what others think," she also talked about how she wished others, particularly Joe's teachers, could see Joe for who he was, someone who was not mean or intentionally misbehaving, but rather, someone who just needed a little more understanding. She saw his misbehavior in a positive light and she wanted others to share that perception.

## HELP IN TIME OF NEED

The fourth generalization included caregivers perceptions about their sources of support from others and the significance of that support. Caregivers had avenues of support, with support coming from other family members, friends, community members, or from a governmental or cultural level. Although some caregivers had more support than others, it was not necessarily the amount or type of support the caregiver had that mattered, but rather, how the caregiver perceived the support.

### Parental Support

A major influence on the caregiver-child relationship was the relationship between the caregiver and a significant other, or the parental relationship. This relationship does not necessarily have to be made up of biological parents. In Kate's situation, responsibility of raising Rene was shared with her female roommate. Bob and Lou had a traditional parental relationship with each other but were not the biological parents of Ashley, while Darla had a parental relationship with an absent husband and father who was incarcerated.

According to Engfer (1988), the parental relationship can have a spill over effect on other relationships influencing the caregiver-child relationship in a positive or negative way. Such a positive influence was seen throughout the interview with Bob and Lou, who joked with each other and shared special looks and touches. They teased each other and laughed over silly memories, and many times finished each other's sentences or made the same comment at exactly the same time. They also complimented each other on their parenting

techniques. Their positive attitude most likely influenced how they perceived Ashley present day and in the future.

In contrast, both Tara and Darla talked about not having the kind of spousal support they desired. Darla's husband was in jail. At one point in the interview, Darla was asked what she was going to do next in relation to the difficulty she was having with her son. She simply shrugged her shoulders and reminded me that her husband was in jail, as if the incarceration of her husband prevented her from taking action with her son. When asked point blank what she was going to do next, she simply stated, "I don't know with him in jail."

Tara's husband was a full-time student during the day and worked a full-time job at night. She spoke of feeling unsupported in her marital relationship and made reference to this several times throughout the interview. Kate spoke of her roommate sharing responsibility for Rene and talked about how important this support was for her. Liz talked about the man that had been in her life for the first four years of her son's life as being "like a father" to him. She stated that it was difficult no longer having him there, not for her sake, but for Matthew's sake. So concerned was she by his abrupt departure from their lives that she "hadn't told Matthew yet" because she "didn't know how." The man who had served as Matthew's surrogate father had been gone for six months at the time of the interview. Liz also relied heavily on her mother to share the parenting responsibilities, with Matthew living most of the time in an adjacent cabin with her mother.

Sally said that Joe had three parents, herself, her husband, and her husband's father. Sally said, "If he can't get it from one, he goes to the other, and if he can't get it from that person, he goes to yet another. Too many chiefs and not enough Indians."

In each of the caregivers' lives, there was someone who shared the parenting duties, except Beth who had no friends, did not associate with Logan's father, and did not trust her mother to help care for Logan. She spoke of the stress of not having someone to share parenting responsibilities. This stress most certainly affected her relationship with Logan, both on a physical and emotional level.

The parenting partner did not have to be the actual biological parent of the child. In some cases, as with Darla, Sally, and Tara the parenting partner was related to the child. In Kate, Bob and Lou's case, the child was adopted and none of them were biological parents, and Kate shared the responsibilities of raising her daughter with another woman. Gary shared the responsibilities with a surrogate family. Without the caregivers' rich descriptions of their situation, the support they received from a parenting partner might have been misconstrued. For example, the Parent Information Form asked simply if the caregiver was married and who lived in the household. Sally's father-in-law might not have been considered a parental support from that form. Gary's surrogate family certainly would have been missed if data was only taken from this form, showing how the role of parent can be shared in numerous ways.

## The Relatives

Some caregivers talked about how much the opinion of their relatives influenced how they felt about themselves and their situation with their children. Tara talked about how her mother-in-law was critical of how she cared for Devin. This greatly influenced her feelings of self-efficacy and blame. She did not have much contact with her own biological family and when asked why this was she said that they lived on the east coast. Apparently Tara felt the distance between them was a barrier preventing them from supporting her.

Sally talked about her mother-in-law being critical of how she handled Joe's behavior, but unlike Tara, Sally decided to not let her mother-in-law's perceptions interfere with her perceptions of herself, although she had allowed this to happen at one time. Once Sally changed her perception about herself in relation to her son she was able to joke about the influence her mother-in-law once had on her perceptions of herself. Changing her perception reduced the stress her mother-in-law once caused Sally even though the criticism her mother-in-law gave her was the same.

Gary shared many stories about the negative influence his family had on him and on his son. He did not like Ben to spend time with them, and in fact, had given up spending much time with his family himself because he found their influence too negative. He spoke of their influence on himself and how he had struggled to overcome their influence. He also stated that he could not be a part of their lives or he would get caught up in old, negative patterns that persisted that he no longer wanted to be a part of.

Bob and Lou talked positively about other family members and their support for Ashley for the most part. They talked of family get-togethers and opinions of brothers and sisters. They also spoke of fear because Ashley's biological mother was their niece and they worried she would gain information about where they went in public from other family members. They feared that she might stalk their family and try to take Ashley from them. This fear caused Lou to always have to be on the alert and "looking over her shoulder" when she was in public. She mentioned that the stranger who had given her compliments in the doctor's office at later caused her great concern because the stranger knew Ashley's biological mother and might tell her that she had seen them at the doctor's office.

Liz mentioned a father who lived nearby that was still a support to her although he was not really active in her life. She saw him "every now and then" and he "helped her out when she needed it." Beth said that she did not see her father or other family members, particularly her brothers, whom were responsible for her rape. The only contact she mentioned with other family members was her mother, whom she viewed as abusive.

**Differentiation**

Family systems theory supports the idea that families try to preserve equilibrium by acting in a manner that will cause events or behaviors of others to return to what is considered by the family to be normal or expected (Minuchin & Fishman, 1981). Typically, when an adult child leaves the family of origin, a certain amount of differentiation occurs. Gary talked about this and how he was still struggling with differentiating from his family of origin because of his mother's

continuous attempts to maintain homeostasis. His two siblings, although in their late thirties and forties, still lived with his mother playing much the same roles as they had as children. Gary spoke of how his mother continued to try to fit Gary back into the picture as well and how he had to mentally "cut her off" in order to preserve his own independence. He mentioned several times throughout the interview that he did not want to be like his family and did not want Adam to experience what he had gone through. Gary's memories and experiences of the past now influenced how he parented Adam.

Gary also spoke of his mother's marital relationships frequently throughout the interview, perceiving his past environment as unsafe, non-supportive, and emotionally enmeshed. The descriptive meaning he had assigned to his past experiences influenced his own personal values and beliefs, and expectations for the future. Marriage to Gary was something he did not want to subject Ben to based on the internalized perceptions he had of his own experiences as the child of a mother who was married multiple times to male abusers. Therefore, memories from Gary's past influenced present behavior, and his present behavior would influence the future for both himself and his son.

Some caregivers had made this transition, from family of origin to differentiation, while others had not. Beth had recently returned to a home that she both hated and feared. Liz had never left home, nor did she mention any inclination of doing so. Gary had struggled to make the transition while the Smiths never even mentioned their own families of origin.

## Community and Societal Support

Many of the caregivers relied on resources outside of their family and meaningful relationships with others. Some caregivers used these resources for emotional support, while others gained advice or knowledge. Some caregivers used community resources for assisting in the actual physical care of the children, while others relied on others for monetary reasons.

While some caregivers shared parenting responsibilities with a mate, others, like Gary, relied more heavily on others in the community. Gary relied on the family that provided child care for Ben not only for advice, but for emotional support in raising Ben. Gary also relied on neighbors to help care for Ben when he was away at work. Tara talked about trading child care services with the family of the boy whom she was caring for the day I interviewed her.

Of particular interest was how caregivers perceived financial support. Liz, Tara, Darla, and Beth lived in poverty. They relied on government support to provide physical care of their children, including food stamps, medications, medical care, and housing assistance. Gary and Sally, although not at the level of poverty of the others, received food stamps and other sources of income from the government.

According to McCollum, et al., (2000), poverty is a factor of society that greatly influences caregiver perceptions, yet the caregivers in this study differed greatly in their perceptions of their poverty.

Tara spoke endlessly about how poverty was influencing her difficulties with her son. She lived in what she perceived to be a critical and hostile

neighborhood, yet could not perceive herself leaving the neighborhood in the immediate future because the family was struggling financially. She also spoke of needing medication for both her son and an older daughter, but worried that she could not obtain the medication because Tenn-Care would not pay for it and she could not afford it.

Beth spoke of wanting a better future for Logan but could not perceive how that could happen. She was living with her mother because she could not afford to live on her own and because she had to care for Logan, she could not perceive how she could hold down a job. Beth and Tara perceived themselves as being restricted by poverty yet most of the caregivers were in similar situations and did not express perceptions of being restricted.

Yet, although Darla and Liz also lived in extreme poverty, both expressed contentment with their situation and poverty was not spoken of as a stressing factor. As stated earlier, Liz's doors and windows were held together with duct tape. I was not certain she even had running water or indoor plumbing, yet, she expressed such contentment with her situation. She never once mentioned feeling stressed by her situation. Darla also lived in a low-income project area. The state of the apartment complex she lived in was poor, yet she went so far as to say she wanted nothing more than what she had right now in life.

I was reminded of the old clique about whether or not the cup is half-full or half-empty. We all make the choice of how we view our lot in life. We can look at what we have in either a positive or negative light. That is our choice. Although

this concept is not a new one, this study gave me new meaning, and my perceptions have changed, thus influencing my present, my past, and my future.

As a member of a helping profession that has been taught to take a deficit approach to viewing the needs of others and applying a "fix-it" solution, I have learned that some things "don't need fixin'." Liz did not need anyone to fix her situation. She was content with where she was. Helping professions need to be aware of this difference in perceptions, especially since we are so drawn to accepting the societal norms of what is and is not a problem.

## WHAT IS GOING TO HAPPEN NEXT: BEHAVIOR OVER TIME

Finally, the last generalization concerns the expectations caregivers had about their future based on experiences they had with others over time. These expectations were based on experiences the caregivers had in the past and shared knowledge they had with others in the present. Experiences from the past and knowledge in the present helped caregivers perceive the behavior in the future.

A common sub-theme to emerge was whether or not their children's behavior was something the child would have for a lifetime or something the child would outgrow.

### Here to Stay

Because Kate's perceptions were that Rene had inherited "bad genes" from her biological parents, she deducted that Rene's behavior would not change, and predicted Rene's future based on this understanding. She spoke of Rene

maintaining a "low class" status despite a "high class" upbringing and feared Rene might "become pregnant before she was eighteen." Kate's perception of Rene's problem behavior as being unchangeable will guide the course of Rene's behavior. When Kate shared her perceptions of Rene to me, my perceptions of Rene were altered without even having met the child. I immediately thought of Rene in relation to other individuals that I consider "low class." Thus, if I were to even meet Rene, I my perception of her would be influenced negatively by what Kate told me, steering the course of my relationship with her in a different direction than if I had been told that Rene was of "high class" upbringing.

My perception of Rene could still be altered, however. If I met Rene assuming she was of "low class" status and then found her to be more like my experiences with "high class" individuals, my perception of her might change. Still, it is apparent how much influence labels have on our perceptions of others.

Tara deducted that Devin had inherited "it" from her husband's side of the family since other members of his family displayed similar behaviors to her son. She perceived that "it" would last into Devin's adulthood based on her understanding of her husband's family members having "it" well into their adulthood. Tara's perception that "it" will remain in her son's life will influence his actual behavior and her relationship with him. If she does not expect the behavior to go away, then she might not do anything to try to alter the course of the behavior. Her lack of intervention might then cause the behavior to be a life long part of Devin's life just as Tara predicted. If Tara thought that Devin's behavior

could be altered, she might be more inclined to seek intervention, thus altering the course of his behavior over time.

In all of these examples, experiences of the past that were shared with others influenced perceptions of the caregiver in the present and future. The understanding of these labels could change at any given time, however, if the caregiver was exposed to new experiences that contradicted with the meaning the caregiver had assigned to the label.

**Gone Tomorrow**

Bob and Lou talked positively about Ashley and their future. They also saw themselves as effective in meeting Ashley's needs and in being able to change her behavior. Although initially Ashley had one of the highest scores on the TABS of the participants in this study, by the time I interviewed them, their perception of Ashley's behavior had changed. This realization came to them during the process of the interview, which is a good example of how something as simple as sharing meaning with another can change the meaning of an experience. While being interviewed, Bob and Lou told their story of Ashley from beginning to end, and in the process reevaluated the intensity of her behavior by comparing her present behavior to behavior in the past. At one point in the interview they actually stopped and shared a laugh about this new perception of Ashley. Lou said if she had to fill out the TABS assessment again, Ashley would only "have a couple of checks" to indicate that she did not think Ashley's behavior would fall into the atypical category anymore. Their perceptions of Ashley's behavior, and how they labeled that behavior had changed.

Gary also saw Ben's behavior as something that could change, or at least be labeled differently when he got older. This understanding came from his own experiences of having been like Ben and growing out of the behavior.

As stated earlier, Tara and Kate thought that their children would continue to have problem behavior throughout time. Based on past experiences and the experiences and perceptions of others, they formed a very different perception about the future than was shared by Gary, Lou, and Bob.

The other caregivers were still uncertain about what to expect for the future. Sally was in a transition state, having first felt that her son would have problem behavior in the future but now readjusting her perception. This change in perception left her without a clear understanding of what to expect in the future. Like Sally, Darla was also in a state of transition and did not have a clear understanding of what to expect of the future. Her husband was incarcerated and her life was "on hold" until his release. Darla could not formulate, or at least did not express her own perceptions of the future because of this.

Liz and Beth talked about the possibility of their children's behavior being a problem in the future, but were not definite in their belief about the longevity of the problem. Liz stated that her son had "it" but did not express whether she thought "it" was something he would have for a lifetime or not. Beth also did not predict what Logan's future might look like. She was hoping for someone to give him a label so she could better make sense of what to expect of his behavior in the future.

The perception of fear was a theme that was shared by all caregivers. When asked what they felt the future would hold for them, all caregivers spoke of fear. Whether the fear was for their child or for themselves or someone else, all caregivers spoke of fear when asked about how they perceived their future.

**Fear for the Child**

Gary and Sally did not want their children labeled with ADHD for fear that others in society would treat their children differently based on that label. Tara feared her son would hurt someone, or herself, if something was not done to get his behavior under control. Kate feared that Rene would become pregnant or display loose morals.

Bob and Lou feared Ashley might be taken from them and put back with her biological mother. Beth feared she would never be able to break the bonds of poverty to get out on her own so she could raise Logan in her own way instead of being under her mother's influence.

**Fear of the Child**

Some of the caregivers feared what would happen to themselves or someone else if their children's behavior did not get better. Darla spoke of fear for her own life. She said that Devin had come into her bedroom at night with a knife. He had also made weapons to use against his siblings and neighbors. She feared that as he grew older, he would become more and more dangerous.

Like Darla, Tara also spoke of fear of her child. She was not able to control his behavior and she feared that if her husband remained in jail, she would not be able to gain control over him. He had already set a friend's house on fire in a

bedroom where an infant slept. She feared what else he might do to harm someone else.

Perhaps the perception of fear is influenced by a general societal perception. Fear of the unknown is something that is talked about in relation to a number of societal issues. I cannot explain why the perception of fear was shared by all caregivers in relation to other perceptions of self-efficacy, blame, or labels. This might be an area of future study that would be interesting to pursue.

These were the most prominent themes that emerged from the data. Although themes emerged from information taken from all caregivers, it is important for the reader to know that two of the interviews I conducted were quite different from the others. Therefore, I have included a special note about Liz and Beth.

## A NOTE ABOUT LIZ AND BETH

It is important to mention that the interviews with both Liz and Beth were different than those with other caregivers in that both focused discussion around their own experiences, expectations, and perceptions of themselves but not their children. Even when asked direct questions about past memories, or present conditions, they steered the conversation away from their relationship with their child to their own personal experiences. For example, when Liz was asked to describe her son's behavior, she responded with, "Sometimes he gets in them moods, but I get them myself. I got bad nerves or something, get depressed and stuff." She then went on to tell about her own experiences with depression, medication and medical attention.

Likewise, when Beth was asked to tell me about her son, she immediately began telling me about the abuse Logan had experienced from Beth's mother, then went into a story about a recent stay in a women's shelter and the experiences she had there. When asked if she was ever able to get out with friends, Beth responded "No. I can't. I don't want to leave him with her. I don't want him getting hit or anything." She then went into a lengthy story about that morning when Logan had dumped over a bowl of cereal by accident and how her mother would have "hit him." From there, she went back to previous experiences of her mother abusing Logan. Each time Beth was asked a question, the conversation centered on her experiences with her mother or Logan's experiences with her mother, but not Beth's experiences with Logan. Likewise, when Liz was asked questions, her responses centered around herself, but not in relation to her son.

## DISCUSSION

At the start of this research project if I were asked what the primary cause of problem behavior in children was, I would have confidently stated "the parents." I did not arbitrarily come up with this understanding, but based it on prior research. If you asked me today what the primary cause of problem behavior in children was, I would have to say something like, "Well... it's not as easy as all that." My understanding of caregivers of children with problem behavior has radically changed through conducting this study. For example, I pointed out earlier that Gary's other "parent" was actually an unrelated family that

helped him learn how to parent his son. Kate's parenting partner is a roommate. The label "parents" takes on a whole new meaning when looked at from the perspective of these caregivers.

One of the most radical changes that occurred in my thought process was to break free from a linear, or cause and effect model. At the beginning of this project, I criticized others for taking a linear, or cause and effect, approach and stated that I was not going to take this approach in this project. I found, however, that it is difficult to break out of this way of thinking because: 1) much prior research is conducted and presented in this fashion, 2) I live in a society where it is common practice by many to think in linear, or cause and effect ways, and 3) putting a multi-dimensional understanding of a concept or idea onto two-dimensional paper and model is a difficult task.

In writing the literature review in Chapter II, I presented factors associated with child behavior problems, the caregiver-child relationship, and caregiver perceptions. Unknowingly, I was trying to measure these factors, as one might weigh material on a scale. I looked at factors associated with problem behavior in children and caregiver perceptions, and then began piling these factors up on one side of the scale. If the scale tipped too heavily to one side, the caregiver obviously was loaded with enough factors (e.g., poverty, social isolation, a disability), to create difficulties, or at least perceived difficulties, in the caregiver-child relationship. Obviously, this is still a linear approach.

At the start of data collection I had to consciously make myself focus only on caregiver perceptions about those factors, but once again, found myself looking

for cause and effect relationships between perceptions and behaviors within the caregiver-child relationship. For example, instead of weighing factors related to problem behavior in children and caregiver-child relationships, I began weighing caregiver perceptions. If a caregiver had perceptions of being out of control, feeling unsupported, or fear of the future, I imagined a linear connection between those perceptions and the actual behaviors that were taking place in the caregiver-child relationship.

There is no linear or cause and effect relationship between factors or perceptions. Perceptions are dynamic and in a constant and circular state of change that spans across not just one caregiver's lifetime, but over generations of time as perceptions are passed down through a multi-generational process. This is the same process that helps cultures, societies, communities, families, parents, and caregiver-child relationships to maintain their identities and practices. At the same time, experiences change the meaning of cultural practices so that even though a practice or belief might be handed down generation-to-generation, the shared meaning of the practice or belief changes. Therefore, this study captures only one moment in time with caregivers having already moved beyond the perceptions that are reported here. Even the process of my conducting this study changed the perceptions and experiences of the caregivers.

In the same way, the transmission of understanding and meaning about ideas serves to maintain a certain status quo that may preserve and pass along understanding or meaning that is not valid. For example, "yankee," "ADHD," and

"autism" are labels that have shared meaning that may or may not be valid. Liz perceived Yankees to be rude. She obviously passed this information onto others because it was one of the first things she said to me. Had I been introduced to Liz as a Yankee, the label of Yankee might have steered the course of the interview differently because Liz thought she was talking to someone who she predetermined to be rude.

As it turned out, Liz was surprised when I told her I was a Yankee. Her eyes opened wide as the realization of what she knew from past perceptions and her present perception caused her to reevaluate her meaning of the term. She then laughed and retorted "That's okay. I'm a red neck." as a way of equalizing our relationship.

Sometimes, societal labels are wrong. I spoke earlier about the common 1950's perception of the cause of autism as a disorder caused by a cold and uncaring mother. For years, or decades, members of society believed that mothers caused their child's disability. Of course, today, we know this is not true, but the perception of parents causing their child's disability persists. I often conduct workshops for school systems and I frequently ask my audience of educators what is the number one cause of behavior problems in children today. They unanimously say, 'the parents.' As stated earlier, I am guilty of holding this same perception at the start of this research study. I do not have that perception today, however, and have altered how I conduct those same workshops for educators. I do ask this same question of the audience, but I then educate them on the importance of perceptions.

Individuals, particularly those in the field of education, must be aware of the influence of societal perceptions, recognizing that the shared understanding may, or may not, be correct. Not every child with autism is the same. Not every northerner (Yankee) is rude. Although the label of autism allows us a shared understanding about the disorder, and the term "Yankee" allows us to understand a person's geographic origination, the labels have varied meaning depending upon the culture and experiences of the people within society.

Because our perceptions and shared beliefs are represented through language, it is also important to consider the labels we use. For those of us in the helping professions, labels have become a necessary part of life. We must use them when identifying children in need of services. Insurance companies will not let you bill for your service if you do not first label the child or parent with a disorder. Yet, these labels can have a profound impact on not only the person being labeled, but also those who share the meaning of the label.

For example, if a caregiver is informed that the child he or she is caring for has a label of ADHD, autism, or even atypical behavior, the caregiver's perception of the child will not only be based on the child, but also on a collection of past experiences and perceptions about the label. This collection of perceptions and experiences, then, influence the actual experience in either a positive or negative way.

I have always argued on the side of knowing the label up front because knowing the label gave me a starting place when working with a new child. If I was told a child was autistic, I would use strategies and techniques that I knew

were effective in working with this disability. I believed this gave me a "head start" in understanding the child without "reinventing the wheel." However, I must also be careful that I do not let that label steer the course of what I do.

The implications of this are significant. By applying labels to children, we may be influencing them to behave as the label describes. Just as the caregivers in this study were keenly aware of perceptions of others and used these to form their own perceptions of themselves and their children, so might children labeled with behavior disorders do the same thing. Individuals who interact with a child while knowing the child's label and the shared meaning of that label, might interact with the child based on their perception of what the label means. The child's behavior and perception of self, then, are influenced by how other individuals interact with them. This makes me wonder how many children go through life "not changing" because they did not know they could, or how many times a child with atypical behavior is influenced to keep acting as he or she does simply because it is expected of him or her.

## IMPLICATIONS FOR RESEARCH AND PRACTICE

In the next segment of this paper, implications for future research and practice are discussed. In particular, I have focused my thoughts on the implications of using labels, for during the course of this study, it became apparent to me how powerful labels can be.

## Implications for Research

Although I have attempted to provide a structure for understanding the complexities in the perceptions of eight caregivers of children identified as having atypical behavior, this study does not begin to capture the dynamic relationship between perceptions over time, or even at a single time, for that matter. More studies like this, using a qualitative approach to understanding relationships, are needed. I believe such studies will compliment and add depth to the quantitative findings that are already in place.

In addition, my research focused only on the caregivers' perceptions. I did not take into consideration the perceptions of the child, or the perceptions of members of the other levels of the relationship model. Because relationships and perceptions involve a two-way transmission, a study that could capture the dynamics of a both sides of the relationship at the same time would be beneficial in understanding better the behaviors and actions within the relationship.

It would also be interesting to explore the relationship between caregiver perceptions and fear of the future. Why did all eight caregivers express fear about the future even if they had positive feelings about the present?

Moreover, what is the relationship between having perceptions of success in the caregiver-child relationship to the evolution of the relationship. Does success breed success? If so, this would then foster changes in practice that would support helping caregivers experience early success in the relationship in hopes that there would be a "snow ball" effect.

It would be interesting to conduct a study where individuals with similar situations are given entirely different labels. Some of the individuals could be labeled in a positive light, while others could use the traditional deficit driven model to determine the effect of such practices. A study that removed the label from the behavior, and then measured the impact of the change on caregiver perceptions would be beneficial. For example, caregivers that have been told their children have atypical behavior might be told instead that their child's behavior is simply different from the norm. A caregiver who blames him or herself for a child's atypical behavior might benefit from having his or her experience reframed into something positive. If the caregiver's guilt could be removed, perhaps the relationship would also change in a positive way and the change in caregiver perceptions about the relationship could be documented.

It would also be interesting to study the course of a societal perception over time. Like in the course of change in perception of the label autism, how has our understanding of other labels, such as ADHD or bipolar, changed over time.

## Implications for Practice

I have argued the negative impact labels can have, yet, changing practice is not easy. As mentioned before, we use labels as a way of sharing important information and meaning and it is doubtful our society is ready to do away with labels. Perhaps it would be beneficial to begin educating those who work with children and families about the effect, both positive and negative, labels can have on the person being given the label. Those in the helping professions could be challenged to become aware of the labels they use and the meanings they

assign to those labels. Professionals could be taught that labels are not the person being given the label. This practice as already started with professionals being encouraged from a federal level to change the way they word labels. For example, rather than saying "I am working with an autistic child," the professional should say, "I am working with a child with autism."

Although I made this change in labeling years ago, I did so mostly to be "politically correct" and to adhere to policy. I went along with this change without knowing the importance of making this change. Although I understood first order change in changing my language, not until I did this study did I experience second order change and understand the importance of making this change.

I believe it would be beneficial when making changes such as this to give more explanation of why the change is being made. I did not know that something as simple as rewording labels could cause such a change in shared meaning between individuals. I now pass this on to others when I conduct workshops and presentations and am amazed at the number of people who will come up to me afterwards to say their perception of their child's disorder and their optimism for the child's future has been altered.

In addition, educators and those in the medical fields or with the most influence on children and their families need to be educated on how their own positive expectations and perceptions can alter the course of the child's behavior within the caregiver-child relationship. I still recall to this day the first time I sat in a school meeting to determine eligibility for services for a child with learning disabilities and speech and language problems. I remember the psychologist

who had done the assessment saying to the family that their son, who was six at the time, would never amount to anything. He would never be able to earn his high school diploma or to live independently. I received a similar report on my desk just this week from a referring psychiatrist on a child I will begin treating.

In both of these cases, the caregivers were devastated and the impact of these reports is staggering. In the first case, the caregiver believed the assessment results, became depressed and lost hope for the future. This obviously changed the way the caregiver interacted with the child. If I thought a child could not learn and had no potential, I would be less likely to work hard at getting the child to learn.

I think back on this family remembering that the father and mother soon divorced and the father started drinking again. The child was removed from their custody shortly after a domestic squabble between them that became physical and I lost track of the child. I can only imagine he has by now fulfilled the predictions of that psychologist.

I predict the outcome of the second family, however, will be different. First of all, I have already explained to them that assessments capture only one moment in time and they certainly cannot predict the future. I laid out strategies for addressing their child's issues. The family told me they once again were filled with hope instead of despair and that they would do everything they could to help their child out. The implications of my perception influencing their perceptions is phenomenal. We have already learned that positive perceptions will steer the relationship in a positive way and that negative perceptions will steer the

relationship in negative ways. This family's course of direction, based on their change in perception, has been altered.

Those in the helping fields must be made aware of the powerful impact their own perceptions can have on the course of other's lives. There are some powerful studies done on this, including the study about blue eyes and brown eyes, where an educator began showing favoritism to those with blue eyes and ignoring the rest of the class. Her preference greatly affected how those children learned and felt about themselves. This study, and more like it, could be made an mandated part of training so those in the helping profession could be made more aware of the power of perceptions.

We can also nurture this idea in our every day lives. Several of the caregivers I interviewed talked about how they felt criticized in public when their child misbehaved. I, too, have witnessed others stare or scorn a parent that is unable to control a misbehaving child. Yet, what caregiver has not been faced with this problem at some level or another?

If someone were to smile at a caregiver struggling with a misbehaving child instead of showing criticism, perhaps that caregiver would be influenced in a positive way to deal with the child's behavior. I frequently hear caregivers say that they knew how to handle a misbehaving child but did not do so because of fear of what everyone else would think.

In this same way, cultural beliefs and expectations are shared with others and passed down through generations. If someone reading this paper decides to take the same action, then my efforts have been doubled. If ten people decide to do

this, and then they influence then other individuals, imagine the impact on society.

There have been suggestions that school systems become the catalyst for change, providing social services to families along with education but here lies another problem. As a society, we continue to blame each other for problems, rather than take personal responsibility.

Making schools a community home for parents, children, educators, and other community members alike would be greatly beneficial in creating a community that shared common meaning of experiences, rather causing individuals to point the finger of blame on each other. This is not a new concept, but one that has surfaced in recent years as a suggested model for improving parent involvement within the schools and to help relieve financial strain. I believe there will be no reunification of caregivers and schools until there is a change in how both educators and caregivers perceive each other and the misbehavior in the child. There was a time not so long ago when this was customary practice and not thought of as some radical change. It is curious why and how this practice got lost somewhere in the multigenerational transmission process.

A few years ago, there was a move on a national level to return to the concept of the "small town school." School districts were urged to limited the number of children in classes and decision making authority was returned to school administration levels instead of at a higher level. The intent was for schools to be able to utilize their strengths and proportion money and resources to the areas of

their own need that might or might not be shared by another school. This is good in theory, but I do not believe the social implications are fully understood.

Children with disorders, particularly behavior disorders, are still singled out and a stigma is assigned to the family. Rather than working together to resolve the problem, in most cases, the school and/or family erects barriers that prevent them from working effectively to battle the problem. Ideally, community resources should work together, viewing the problem not as a caregiver's difficulty with a child that has become a nuisance to the school, but a societal issue that is caused by many factors, including those in society. Thus, the problem should become a community problem and be dealt with on a community level instead of an individual child and caregiver level. The inter-connectedness of relationships over time and across levels, as demonstrated in this study, shows the importance of making changes at any one level.

## REFLECTIONS

This research project has served to change the way I view families of children with behavioral issues and the focus of my practice. As a pediatric behavioral specialist, I no longer will treat a child or family for a behavioral or mental health problem without thinking about the problem over time and the interconnectedness of past, present, and future relationships and experiences to which the family has been exposed. I also am more aware of the impact of labels, both in accepting the meaning assigned to them by society, and in assigning them to others. I try to impress upon clients that their children are not

"ADHD" or "autistic" but rather, their children have ADHD or autism symptomatic behaviors that may or may not persist into the future.

In addition, I have learned to take more time in understanding the relationships and experiences clients and their children have had instead of focusing just on the child's behavior in the present. I try to help families understand how all of these factors are interconnected and a part of why the child behaves as he or she does today.

I also am very aware how my perceptions can influence the course of every client I meet and how important it is to be aware of my own perceptions in relation to others I work with.

I wish I could say that I no longer follow a linear model in trying to understand the world. That is easier said than done. Viewing the world in a more circular manner takes time and practice but at least this study opened my eyes to the possibility.

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# APPENDICES

# APPENDIX A

# Application for Review of Research Involving Human Subjects

## I. IDENTIFICATION OF PROJECT:

**A. Principal Investigator :** Catherine R. Swanson Cain
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**Faculty Advisor:** Dr. Susan Benner
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sbenner@utk.edu

**Department/Unit:** Department of Education
Inclusive Early Childhood Education

**B. Project Classification:** Dissertation

**C. Title of Project:** Caregivers' Perceptions of Children Identified as Having Atypical Behavior

**D. Starting Date:** April 2001

**E. Estimated Completion Time:** August 2001

## II. PROJECT OBJECTIVE:

To explore caregivers' perceptions of their relationship with a child in their care that has been identified as having atypical behavior.

## III. DESCRIPTION AND SOURCE OF RESEARCH PARTICIPANTS:

Purposeful sampling will be used in this research study with caregivers selected from referrals provided by Blount County's Success By 6 Program hosted through the National United Way Foundation located at 351 High Street, Maryville, TN.

Once children are referred to the Success By 6 program, a coordinator goes into their home and administers the Temperament and Atypical Behavior Scale (TABS). The TABS assessment tool is a 55-item checklist given to the primary caregiver of the child exhibiting difficult behavior. A cumulative score of 10 or more on the TABS is considered to be relatively unusual and represents atypical behavior.

Seven to ten adult caregivers that have a child that scores at 10 or higher will be asked to participate in this study.

## IV. METHODS AND PROCEDURES:

Two forms of data collection will be used in this research project: Referral File Documents from Success By 6 files, and in-depth, face-to-face interviews.

**Referral File Documents**

The referral files at the Success By 6 Program contain the TABS assessment results, a Parent Information Form, referral information, and an Exit Interview Form once the referral has been completed. For this study, I will use data from the TABS assessment protocol and the Parent Information Form.

The TABS assessment results will provide information about the type of behavior the child is exhibiting and the caregiver's perception of the intensity of the behavior. The Parent Information Form provides information about the child's medical history, pregnancy information, safety concerns the family has, family history of substance abuse, mental health concerns identified by the primary caregiver, trauma, and stressors the family has experience. It also includes information about the family structure, schedule, activities, and resources available to the family, which are important contributions to understanding the caregiver-child relationship in its social context.

The referral file information will be read to gain information about possible issues or topics that might help guide the interview process. This information will also provide helpful insight into the social and contextual factors relevant to understanding the caregiver's perceptions about their relationship with their child. Accessing this information before the interview help guide the interview process and allow me to keep the interview at a conversation level, focusing on the effect these experiences had on the caregiver, rather than on collecting information about the actual events.

Justine Leehans, the Success By 6 Coordinator, makes initial contact with the family to complete the TABS Assessment and the Parent Information Form. During this initial home visit, Justine will ask families if they are interested in being a part of this study. She will briefly explain the study and if a family is interested, will ask permission for me to contact them. I will then contact the family and set up a time to go to their home to explain the study in detail and to obtain their signature on a consent form giving me permission to access the TABS and the Parent Information Form, as

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It is my intention to conduct 1-2 interviews per week and to begin transcribing the data as soon as interviews are conducted. Transcription of this type of interview takes approximately 4-5 hours each. Data analysis will begin immediately upon transcription of interviews. A research journal will be kept to record my thoughts, ideas, and information I gather from the interviews that I feel might be important to the data analysis process. Using this time management plan, gathering data could take anywhere from 6-10 weeks, depending on the number of referrals that come in to the Success By 6 Program.

**Procedure**

At the initial intake, the coordinator will ask caregivers if they are interested in being in this study. If caregivers are interested, she will ask permission for me to contact them. I will then telephone them to arrange a time to come to their home to explain the study and obtain permission to access their file at the Success By 6 office and to interview them (See Appendix C). Caregivers will be told they are under no obligation to take part in this study and that the study is not related to Success By 6 work in any way. They will be provided with a copy of the signed consent form.

**Data Analysis**

The Parent Information Forms, TABS assessments, and interview transcripts will be reviewed several times over, drawing from the data information that seems pertinent to understanding the caregiver-child relationship.

Data reduction will be used to categorize reoccurring patterns or themes from data while discarding data that does not seem pertinent. As themes emerge, they will not only help to guide and shape the interviews, but will provide structure for organizing data. Themes will be broken down into sub-themes that will be sorted and coded, which is the "quantitative side of qualitative research" (Wolcott, 1994, p. 26). To do this I will begin to highlight information that is inter-related and develop rules for coding, arranging my data so that comparisons of ideas that are similar and different can be noted. From this categorized data, patterned regularities to which I will assign meaning will emerge. This process of data reduction will continue until the search for patterns is exhausted.

Throughout the study, I will have kept notes and reflections about my hunches, ideas, and insights. From these interpretations, I will develop overall descriptions of the caregivers and what I believe their perceptions are, focusing on their expectations and attributions of their child and the research questions that guide the study. Vignettes will be developed about the caregivers to give the reader a clearer picture of their uniqueness.

Findings will be put into narrative form using actual statements of the caregivers whenever possible to support my findings

**Standards of Verification**

To ensure the trustworthiness of my findings, I will use the following procedures 1) begin with a bracketing interview and keep a research journal throughout the study, 2) use member checks, 3) discuss findings and their possible meanings with debriefing groups, and 4) use the caregivers' own words to support my findings

Bracketing Interview and Research Journal

All interactions with others are influenced by our own personal experiences that include stored memories, culture, preconceived expectations, and recognized or unrecognized biases and attitudes. Because I have worked with young children identified with atypical behavior and their families, I have pre-conceived ideas about factors that may cause atypical behavior in relation to the caregiver. I will begin this project by having a Ph.D. candidate interview me about my thoughts, assumptions, and biases about atypical behavior in young children and the caregiver-child relationships. I will continue to bracket these thoughts, assumptions, hunches, and ideas in a research journal throughout the duration of the study.

Conducting a bracketing interview and keeping a research journal will help me be more aware of how these influences affect on my interpretations throughout the research project in hopes of keeping them from leading the direction of the study.

Member Checks

Once the review of files and transcriptions of interviews have taken place, I will contact 2-3 of the caregivers a second time and ask if they would be willing to review their transcripts for accuracy. I will then bring the transcripts to their home. I will tell caregivers not to worry about, or correct their grammar, but to focus instead on the meaning of their words. I will instruct the caregivers that they may edit, delete, or add to anything they have said. I will then set a time to pick up the corrected transcripts the following week. Having 2-3 caregivers as representatives of the group check their transcripts accuracy will improve the trustworthiness of my findings.

Debriefing Groups

Success By 6 uses teams of volunteers from the community to help determine program direction, set policies and rules, and make decisions regarding the functioning of the program. These teams are composed of

5-10 people who have an interest in the program and are actively working with children identified with atypical behavior. These teams provide assistance in six areas: 1) communication, 2) training, 3) child advocacy, 4) service delivery, 5) resources, and 6) program evaluation.

Success By 6 has requested that the evaluation team approve and review my research study on an ongoing basis in accordance to program guidelines. Success By 6, and members of this team, have agreed to act as a debriefing group for the purpose of this study. A debriefing group helps verify that the meaning I have derived from the data collection and analysis is what others might also derive.

The members of this team include a pediatric nurse who is retired, a parent of a child with emotional and behavioral problems, a director of a large child care center, a United Way representative, the director of a regional Birth-to-3 intervention program, and a kindergarten teacher. The evaluation team meets once a month for approximately 1 1/2 hours. The Success By 6 director and coordinator also work closely with this team. They meet once a week for approximately 1 1/2 hours. These team members will act as debriefing groups for this project and will sign confidentiality forms (See Appendix D).

I also belong to a research group consisting of Ph.D. candidates in the process of writing their dissertations. This group consists of students from the social work department, child and family studies, and education. This group meets once or twice a month for approximately 2 hours. Group members will be asked to sign a confidentiality form before reviewing transcripts (See Appendix E).

Pieces of the transcripts will be presented to the debriefing groups for review and members' interpretations will be solicited. I will compare members' interpretations with my own interpretations to ensure that my findings are consistent with members of these groups.

Participants' Own Words

I will use caregivers own words to support my findings and the themes I have extracted from the data. Caregivers' actual words will add richness and depth to the narrative as well as support the trustworthiness of my findings.

## V. SPECIFIC RISKS AND PROTECTION MEASURES:

**Confidentiality**

Caregivers will be assigned pseudonyms on all written materials. A master list of participants, identifying information about the participants, and their code number will be kept in the coordinator's locked file with family files.

Only the blackened out copies of the forms with their pseudonyms will be used when working on data analysis. Transcriptions will be kept on computer disk and stored in a locked file cabinet at Claxton Addition, Room 423. The actual transcriptions of interviews and research journal will not be shared with anyone in their entirety except my Ph.D. committee. Tape recordings of interviews and the signed consent forms will be kept in a locked file cabinet for three years following the completion of the research project after which time the audio tapes will be erased and the interviews destroyed.

All precautions will be made to protect the participant's anonymity by always using their assigned pseudonym when discussing this research project or in writing results.

**Acknowledged Risk**

The interview may trigger hidden emotions or feelings the caregiver did not realize they had. The actual experience of being interviewed will change the meaning of their relationship with their child as these memories emerge. There is also a risk of the caregiver becoming uncomfortable about what they have told me or in telling me more than they had meant for me to know. I will be sensitive to this issue and stop the interview if I feel there is a risk to the caregiver. I will also carry with me a listing of support services provided by Success By 6 that includes contact information to refer the caregivers to should this happen.

It is also possible that a caregiver has done harm to a child in the form of neglect or abuse. Caregivers will be told at the beginning of the interview that if they reveal information about potential child abuse, as a mandated reporter, I will have to share that information with DHS Child Protection.

## VI. BENEFITS:

There are no direct benefits for the caregiver from participating in this research study, although the caregivers may derive satisfaction from helping to contribute to the understanding of atypical behavior and from having their story shared and heard.

## VII. METHODS FOR OBTAINING "INFORMED CONSENT" FROM PARTICIPANTS:

Upon approval of this proposal, the Success By 6 coordinator has agreed to ask caregivers that have a child who scores 10 or higher on the TABS if they are interested in being involved in this study. The coordinator will explain to caregivers that the study is not related to the Success By 6 Program in any way and that they are under no obligation to participate. If

they are interested in being a part of this study, she will ask permission for me to contact them. I will then make a home visit to the caregivers' homes to explain the study and to have them sign the consent form. I will tell caregivers they are under no obligation to participate in the study and that the study is not related to Success By 6 or any other behavioral or mental health service. I will also tell them they can drop out of the research study at any time. Once caregivers sign the consent form, I will leave them a copy of the form.

## VIII. QUALIFICATIONS OF THE INVESTIGATOR TO CONDUCT RESEARCH:

I have a BS in Early Childhood Special Education, a Minnesota state license in Early Childhood Education and Early Childhood Special Education, as well as a license in Post-Secondary Education: Parent Education and Child Development. My M.Ed. is in Special Education and Administration and I am currently working on my Ph.D. in Education with a concentration in Early Childhood Education.

I have been working with young children and their families for over twenty years as a special education teacher in a public school setting. In the last five years I worked in a residential setting for children with extreme atypical behavior and social-emotional problems.

## IX. FACILITIES AND EQUIPMENT TO BE USED IN THE RESEARCH:

The recording of interviews will be done on a tape recorder and kept in a locked file cabinet in the Early Childhood office (423 Claxton Addition). Copies of the interviews will also be made.

## X. RESPONSIBILITY OF THE PRINCIPAL INVESTIGATOR:

By compliance with the policies established by the Institutional Review Board of The University of Tennessee, Knoxville, the principal investigator subscribes to the principles stated in "The Belmont Report" and standards of professional ethics in all research, development, and related activities involving human subjects under the auspices of The University of Tennessee, Knoxville. The principal investigator further agrees that:

a. Approval will be obtained from the Institutional Review Board prior to instituting any change in this research project.

b. Development of any unexpected risks will be immediately reported to the Compliance's Section.

c. An annual review and progress report (Form R) will be completed and submitted when requested by the Institutional Review Board.

d. Signed informed consent documents will be kept for the duration of the project and for at least three years thereafter at a location approved by the Institutional Review Board.

**XI. SIGNATURES:**

**Principal Investigator:**
**Signature**_____**Date**_____
**Catherine Swanson Cain**

**Chair of the Departmental Review Committee:**

**Signature**_____**Date**_____
**Dr. Susan Benner**

**Faculty Advisor:**

**Signature**_____**Date**_____
**Dr. Amos Hatch**

**Faculty Advisor:**

**Signature**_____**Date**_____
**Dr. Sharon Judge**

**Faculty Advisor:**

**Signature**_____**Date**_____
**Dr. Priscilla Blanton**

**XIL: DEPARMENT REVIEW AND APPROVAL:**

**The application described above has been reviewed by the IRB departmental review committee and has been approved. The DRC further recommends that this application be reviewed as:**

**[ ] Expedited Review – Category(ies):**

_____

**OR**

**[ ] Full IRB Review**

**Chair, DRC:**

**Signature**_____**Date**_____

**Department Head:**

**Signature**_____**Date**_____

**Protocol sent to Compliance Section for final approval on**_____

**Approved: Compliance Section**
**Office of Research**
**404 Andy Holt Tower**

**Signature**_____**Date**_____

# APPENDIX B

# Success By 6 Consent Form

I, Kristen Pearson, director of the Success By 6 Program of Blount County give Catherine Swanson Cain permission to access referral files of caregivers who have given written consent allowing her to access their file for the purpose of conducting a qualitative research study being conducted through the University of Tennessee, Knoxville, about atypical behavior and caregiver-child relationships.

It is my understanding that Cathie will photocopy the TABS assessment protocol and the Parent Information Form at the Success By 6 office for the purpose of obtaining information that will help her formalize interview questions and add depth of understanding to her research. I also understand that Cathie will blacken out any identifying information about the caregivers and their children and will replace this information with pseudonyms.

Referral file documents will be destroyed upon the completion of this research project.

_____ _____

Signed Name Date

# APPENDIX C

# Caregiver Consent Form

Dear Parent/Caregiver,

You are invited to take part in a research study. I am interested in talking with because you have contacted Success By 6 about your child's behavior. Since you know your child best, you can greatly help others better understand how you perceive your relationship with your child by sharing your story.

If you would like to be in this study, you will be interviewed for approximately 1 1/2 to 2 hours. This interview will be an informal conversation, but will be audio taped to help me remember what you said. You will not be asked to give any identifying information on tape recording, and if this happens, this information will not be included in the transcription of the interview. Once the transcription is complete, the audiotape will be erased.

In addition to the interview, I am asking permission to access your child's referral file at the Success By 6 Office in order to gather information about your child's scores on the TABS Assessment Tool. Specifically, I will be accessing the information you have provided about your child and family's history and experiences on the Parent Information Form. These two forms will be photocopied at the Success By 6 Program, but any identifying information about you, such as your name, address, or telephone number, will be blackened out before any document leaves the Success By 6 office so that it can not be linked to you in any way. The copy of the TABS and the Parent Information Form, as well as transcripts of the interview will be destroyed at the completion of the study.

This research project is not associated with the United Way Success By 6 Program in any way. They have not shared any information about you with me. If you agree to be a part of this study, you are not required to give any information you are not voluntarily willing to give. You may stop talking at any time and end the interview, or decide to not be in this study. None of the information you share with me will be shared with anyone in such a way that it identifies you unless you happen to share information regarding your child's safety. As a mandated reporter, I am required to relate to designated authorities at the Department of Human Services any information given to me about issues of abuse or neglect.

The interview will be typed into written form and pieces of it will be presented to colleagues and an evaluation team at Success By 6 to determine if I have correctly interpreted what you have said. No identifying information about you or your child will be included with these parts of the transcript. Instead, I will assign a fictious name for you and your child to be used in the written narrative.

By telling your story, you will not only be helping others learn more about caring for a child identified as having atypical behavior, but it is hoped that you will also gain something from the experience by telling your story to another. I cannot promise or guarantee that you will derive any other benefits from this research project. The information I gather from the interview and the referral file, will be used in scientific publication but the information used about you or your child will not include identifying information.

If you are interested in being in this study, please fill out the information at the bottom of this page. If you have questions or concerns and would like to talk with me before signing this form, I can be reached at the address and phone number below.

Thank you very much for taking the time to read this letter.

Sincerely,

Catherine Swanson Cain
423 Claxton Addition
University of Tennessee
Knoxville, TN 37996
(865) 974-6228

**********

**____ Yes, I am willing to take part in this research project and you can contact me to set up a time to interview me. I understand that I am giving permission to be interviewed, and that the interview will be audiotaped. I also understand that you will be accessing my child's referral file at the Success By 6 Program office to obtain a photocopy of the TABS assessment results and the Parent Information Form.**

_____ _____
**Name** **Date**

_____ _____
**Signature** **Telephone**

_____
**Address**

_____

# APPENDIX D

**Success By 6 Evaluation Team**
**Confidentiality Agreement**

**As a member of the Success By 6 Evaluation Team, I understand that I will be reading transcripts of confidential interviews. Therefore, I have an ethical responsibility to keep this information in strictest confidentiality. I will not discuss the information with anyone outside of this team.**

_____ _____

**Name** **Date**

# APPENDIX E

## DEBRIEFING GROUP CONFIDENTIALITY AGREEMENT

**As a member of an academia research group, I understand that I will be reading transcripts of confidential interviews. Therefore, I have an ethical responsibility to keep this information in strictest confidentiality. I will not discuss the information with anyone outside of this group.**

| | |
|---|---|
| **Name** | **Date** |

# APPENDIX F

## Caregiver Interview Guide

1. The caregiver's thoughts and feelings regarding their child when:
   - The child was born
   - at key points in the child's life as identified by the Parent Information Form
   - when they first realized they had an emotional investment in the child
   - a time when the caregiver most felt like a parent
   - how the caregiver would describe their child to others

2. Why the caregiver thinks the child acts as he or she does.

3. The caregiver's present thoughts, feelings, fears, worries, hopes, joys, sorrows in regards to their child today. In the future.

4. The activities and events that the child and caregiver engage in:
   - on a day to day basis
   - rites/rituals/celebrations/holidays

5. The caregiver's thoughts and feelings when:
   - with the child for a short period/long period of time
   - away from the child for a short period/long period of time

6. To what extent is the caregiver's routine, activities, life organized around the child's needs and activities.
   - how are conflicts in time, energy handled
   - work arrangements/child care arrangements

7. The extent that others are involved in the caregiver-child relationship
   - spouse/significant other
   - extended family
   - neighbors
   - friends
   - community

8. The extent that work (school/home life) is rewarding.
   - gratification/burdens
   - a typical day
   - incidences of distress/stress
   - outcome/rewards/recognition

9. How do caregivers perceive their relationship with their child should be (The "ideal")?

# VITA

## Catherine Swanson Cain, LMFT

Catherine Swanson Cain has been working with families of young children for nearly thirty years. Through those years, she developed an interest in working specifically with families of young children with behavioral or mental health problems.

Catherine has worked as a school behavioral consultant for Head Start and elementary schools in northern Minnesota. She also received training specific to the behavioral needs of children with autism and holds both a B.S. and a M.Ed. in Education from the University of Minnesota.

After helping to develop a behavior intervention program for children ages 0-7 with several behavior disorders, and supervising that program for just over five year, Catherine left Minnesota to pursue her Ph.D. in Tennessee. She continues to provide workshops and presentations to families, educators, and professionals on a variety of behavioral health issues. She also teaches several Internet classes on behavioral health issues and disorders in young children.

While working towards her Ph.D., Catherine also obtained her Tennessee license in Marital and Family Therapy. Today, she has a clinical practice assisting families of children with behavioral health issues.