

The Effects of Parental Beliefs and Expectation on the Perception of Compliance in Adolescents

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Abstract—Noncompliance accounts for the majority of referrals to psychologists in the US, and psychologists tend to put more emphasis on information provided by parents rather than their children. However, parents' perception of noncompliance in their children is influenced by their personal notions of how a child should ideally behave, as well as their expectations of their children's behaviour. Clinical complexity associated with diagnosis of disorders related noncompliance and the biased perception by parents, may lead to misdiagnosis of ODD and CD amongst adolescents.

Index Terms—Conduct disorder, compliance, clinical complexity, misdiagnosis, and oppositional defiant disorder.

I. INTRODUCTION

Noncompliance of children has been a major concern for teachers and parents as it is seen as an obstacle to their academic advancement and safety. Adults complain that noncompliance is an important and common problem with children [1]-[3]. This has led to noncompliance in children accounting for the majority of referrals to psychologists by adults in the US [4], [5]; with the prevalent rate of noncompliance, in clinical samples, ranging from 65% to 92% [6]. Moreover, severe noncompliance is one of the criteria for a child being diagnosed as having ODD (oppositional defiant disorder), CD (conduct disorder) [4] 'attention deficit hyperactivity disorder' (ADHD), mood disorders, psychotic disorders, autistic disorder [7], or being misdiagnosed as severely mentally handicapped [8]. This calls for a scrutiny of the perception of children's noncompliance by parents.

II. BODY

A. What is Compliance?

Compliance in children has largely been studied in the behaviourist tradition, which follows a positivist paradigm; therefore, an emphasis on objective observation is pivotal to its definition. Currently used definitions of compliance can be traced back to Forehand, who summarised pre-1977 studies and concluded that compliance can be defined in terms of latency and/or duration [9]. Latency refers to the time elapsed between asking the child to perform a task and the initiation of that task by that child; duration refers to the total time taken to complete the requested task. Since Forehand's review, researchers investigating compliance in

the behaviourist tradition, consistently continue to define it in these terms; for example, "...compliance [is] defined as the participant initiating the response specified by the instruction within 10 [seconds] of the instruction being delivered" [10]. Subsequently such definitions have also been adopted by the non-behaviourist tradition [11].

However, the above approach to defining compliance is flawed on multiple levels. Firstly, it leads to the exclusion of certain behaviours from the construct of compliance; for instance duration and latency are not appropriate measures for smoking when the sign in the school says 'do not smoke' or defying a parental demand to abstain from premarital sex. Secondly, definitions with predetermined standards are primarily concerned with the child obeying the instructions of an adult, which is a *practitioner-centeredness problem* [12]. A certain level of refusal behaviours in children are adaptive and functional [13] and in some cases total refusal behaviour is completely acceptable. Finally, on a cognitive level, it is problematic for an arbitrary person to categorise behaviour as compliant or noncompliant using arbitrary criteria. Refusal or uncooperative behaviours can take several forms, such as breaking a curfew or failing to do homework; each parent assigns a different *value* for each refusal or uncooperative behaviour, which may be socio-culturally shaped [14]. For example, parents from a certain culture may be more concerned about their daughter 'breaking the curfew' than 'failing to do homework'. Therefore, any arbitrary criteria by a third party places these definitions outside the parameters of parental cognition. A compliant and noncompliant behaviour is based on the perspective and beliefs of adults, which vary from person to person.

B. Family Related Cognitions

Family related cognitions have been explored and defined at various levels. Bugental and Johnston summarised them as: belonging to 1) The way things should be, *ideally*, in a family (evaluative-descriptive cognition); 2) The way things are *perceived* in a family (descriptive cognition); and 3) Convergence or divergence from the way things *are* and the way things *should* be in a family (efficacy cognitions) [15]. The parental beliefs on *ideal* levels of compliance, in adolescents, and their level of expectation for their adolescent is a form of evaluative-descriptive cognition. The parental perception of levels of compliance in their children is a type of descriptive cognition.

Parents' belief about what should be ideal levels of compliance for their adolescent children varies between parents [16], [17]. This directly impacts upon the behavioural expectations they have of their children and these expectations are generated as a result of these beliefs

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[18]. Sometimes children modify their compliance level according to parental expectations [19]. When expectation and level of compliance converge, parents are less likely to perceive their children's behaviour as problematic. On the hand, when the level of compliance does not meet their expectation, parents perceive those behaviours to be more problematic [7]. This convergence and divergence of ideal and perceived, is the third type of cognition (i.e. efficacy cognition) that was described earlier. Consistent with this view, research has shown that parental expectation affects how they perceive their children's behaviour as problematic [7], [16]. Kalb and Loeber also argue that perception of how problematic these behaviours are (descriptive cognitions), in turn influences their perception of the severity or frequency of noncompliance (descriptive cognitions) [2]. Therefore, they argue that these perceptions do not reflect the child's *actual* behaviour(s); rather it will be influenced by their perception of how problematic those behaviours are. This perception of *frequency or severity* of noncompliance plays a crucial role when assessing children's noncompliance.

C. Effects on Assessment of Noncompliance

According to DSM-4-TR, noncompliance is one of the diagnostic criteria for CD and ODD, which is measured in terms of *frequency* and *severity* [20]. For instance, one of the diagnostic criteria for ODD is that the child "often [frequency] actively defies or refuses to comply with adults' requests or rules" (p.102). Also, the DSM-4-TR uses similar subjective wording in diagnostic criteria for CD, such as, the child 'has deliberately [severity] destroyed others' property', [is] '*often* [frequency] breaking the curfew', or [is] '*often*

[frequency] truant from school' (p. 99). Therefore, psychologists often use subjective assessment methods to evaluate children's noncompliance [21].

This subjective measurement could amount to what is known as 'clinical complexity' [22] when assessing CD and ODD, due to variation in evaluative-descriptive cognition:

- 1) Parental belief of ideal levels of compliance and their expectations (evaluative-descriptive cognitions) vary from parent to parent [2], [17], [23]. Therefore, parental perception of severity or frequency of noncompliance (descriptive cognition) would also vary, without *truly* reflecting a child's *actual* noncompliance. For example, conduct problems in children are more common among those whose parents have biased beliefs and expectations about children's behaviour [7].
- 2) Any bias in parental descriptive cognitions has serious implications in assessment of noncompliance, because the psychologists may misunderstand the extent of noncompliance. This is due to psychologists inclining to agree more with parents than children about children's problematic behaviour [24].
- 3) Further, parents are seen as advocates for access to referred services for their children in England, where diagnosis for CD and ODD are made [25].

This clinical complexity, particularly in relation to potential bias in descriptive cognitions, may lead to children being misdiagnosed with CD or ODD, as shown in Fig. 1 below:

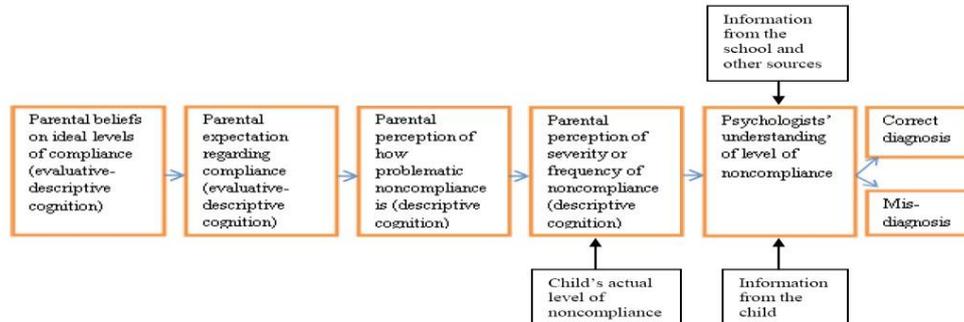


Fig. 1. The effect of beliefs and expectation on psychologists' understanding of noncompliance

D. Adolescence

The milestone of adolescent development is accentuated not only by physical and cognitive maturity but also by the development of 'self' [26]. For instance, Smetana et al. indicate that adolescence begins in biology and ends in culture [27]. These developments prepare adolescents for 'autonomy', which is essential for adaptive psychological functioning [28]. This is a challenge for parents, who have to revise the rules and levels of noncompliance to accommodate the development of such autonomy [29]. They may also be annoyed that cognitive maturity, during this period, allows adolescents to skilfully win arguments over parents [30]. These new developments could be interpreted as defying parents' expectations of their children, in complying with requests and rules, when they are hesitant to accommodate their child's autonomy during adolescence [31]-[33]. For example, Collins found a higher discrepancy between parents' perception of *ideal* and *perceived*

behaviour among children who are going through the transition to adolescence, in comparison to younger or older children [34]. This discrepancy may be due to the fact that parents continue to expect adolescents to comply as younger children, even though adolescents are going through a stage of acquiring autonomy [29].

E. Parental Knowledge

One of the aspects of 'parental knowledge' refers to parenting skills and the extent to which parents understand developmental norms, milestones and the process of child development [35]. This is one of the variables that may affect their belief about an *ideal* level of compliance. Ehrensaft et al. suggest that "...if parental complaints reflect not only the child's behavior, but also the parent's appraisal of the behavior in relation to the child's developmental level, we may expect these to *decrease* from pre-adolescence to adolescence and emerging adulthood" [36]. However, scholars agree that parental complaints tend

to increase when their children move into adolescence [37]-[40]. There is substantial research dedicated to particular aspects of parental knowledge, such as parenting skills [41]. However, there is a severe paucity of research in other aspects of parental knowledge, such as parents' knowledge of adolescence development.

III. CONCLUSION

The diagnosis of CD is higher at the onset of adolescence in the US [42] as well as in the UK [43] and coincides with an increase in parental complaints about adolescents. The DSM-4-TR goes on to identify 'adolescence onset type' as a separate category of CD [20]. It is feasible that the rise in diagnoses of conduct related disorders is due to clinical complexity, which is associated with biased parental beliefs and parental expectation of compliance being *inconsistent* with adolescent development. Due to such clinical complexity, psychologists should proceed with caution when diagnosing CD and ODD among adolescents. Information could be collected from various sources rather than primarily relying on parents. This may help to minimise clinical complexity. There appears to be a paucity of research in this area. Therefore, further research is needed to directly measure the effect that parental beliefs and expectation have on their perception of compliance in their adolescent children.

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