Parenting and Childhood Disorders

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ABSTRACT

Associations between childhood disorders and parenting were investigated on a sample comprising of 290 boys and girls in the ages (7–13 yrs), collected from Patiala city. Significant t tests indicated high anxiety and affective problems in girls while boys were found to be higher on conduct problems. Parental connection and regulation were found to be negatively associated with childhood disorders whereas physically coercive, non-reasoning and verbally hostile parenting were found to be positively associated with childhood disorders. Significant beta coefficients for connection, regulation, physical coercion, non-reasoning, verbal hostility and indulgence parenting predicted childhood disorders. The study affirms the importance of parenting in childhood disorders.

INTRODUCTION

The dramatic rise in child psychopathology has rung alarm bells for the mental health professionals worldwide. Evidence gathered by World Health Organisation predicts that by year 2020, childhood disorders will rise by over 50% internationally, to become one of the five most common causes of morbidity, mortality, and disability among children. Children less than 15 years constitute one third of the world’s population and 5%-15% are afflicted with mental health problems (Fombonne, 2005). 80% of children live in developing countries where child mental health services are meager, inaccessible or non-existent. More importantly, most childhood problems have lifelong deleterious consequences and costs both for children, families and societies.

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The statistic in our country is far more disturbing! We have the largest child population of 398.3 million (R.G.C.C., 2001) and perhaps the largest street children in the world (India child, 2000). In India 5% of children are affected by disability-sensory, physical and mental and 12.8% suffer from psychiatric disorders (ICMR, 2001), with conduct disorders, neurotic/anxiety problems, learning disorders and attention deficit hyperactivity disorder identified as the most common childhood disorders (Malhotra, 2005). In a recent study of prevalence of psychiatric disorders among school children (n=963) in Chandigarh, a rate of 6.33% has been reported among 4–11 years old. However the teacher’s estimation of prevalence rate of 10.17% was higher as compared to parents estimation of prevalence rate of 7.48%. The prevalence of psychopathology was significantly higher in boys (9.23%) than girls (4.43%) (Malhotra, Kohli & Arun, 2002). Reddy, Kaliaperumal and Channabasavanna (1997) conducted an outstanding empirical research on clinic referred 701 children at National Institute of Mental Health and Neuro Sciences, Bangalore. The childhood disorders were classified using clustering techniques. Six clusters were identified, namely, hysterical syndrome, anxiety, emotional disorders, conduct disorders, hyperactivity and scholastic backwardness. The discordant intrafamilial relationships, familial over involvement and parental control were found to be significantly associated with conduct disorders. For emotional disorders parents were found to be over indulgent and over expectant from their children. In another community study of socio-demographic correlates of psychiatric disorders on 620 children from urban slums of Maharashtra, Rahi, Kumaravat, Garg and Singh (2005) found higher prevalence of psychopathology in boys in the age 7–10 yrs, belonging to joint and large sized families. Most children were reared in strict family environment and children reportedly manifested ill effects of corporal punishment and hostility in their behaviours and psyche. It seems that despite the salience of family in child development, research on familial/parental correlates of behavioural problems in our country is apparently sparse. In addition the rapid rise in childhood behavioural and emotional problems, lack of elementary knowledge regarding child mental health, stigmatisation of psychological problems and paucity of child psychiatric services has compounded the agony of both parents and children manifold in the globalised social milieu. This study, therefore is an exploration of the relationship between parenting and child behavioural problems, for the role of parents along with mental health professionals is indisputably primary in amelioration of child psychopathology. It is imperative to understand that childhood behavioural and emotional problems is not “something that lies within the child” but in part, is a reaction to dysfunctional parenting, families and communities. Timely interventions and detections with children and
adolescents as well as with their parents and families can prevent the pain and suffering of developmental psychopathology and reduce or eliminate the manifestations of some disorders and foster integration into mainstream educational and health services, who otherwise require specialised intensive services. (WHO, 2005)

**Parenting and Depression:** Recent “discovery” on childhood depression is that children sometimes suffer from the same depressive symptoms as defined in the adult diagnostic systems (DSM-IV, APA, 1994). Investigators have assessed various parenting dimensions (including warmth/acceptance vs rejection, and autonomy vs control/overprotection) as well as more general aspects of parent-child relationships (such as attachment, trust, support and availability). This research has consistently revealed more negative perceptions of family interactions in depressed than in non-depressed children. Observational studies of dysfunctional styles of parent-child interactions are indeed associated with maladaptive social skills and problem-solving deficits, attachment difficulties, and other indicators of impairment that might eventuate in depression (NICHD Early Child Care Research Network, 1999). Interviews with parents of depressed children revealed that mother-child relationship were marked by poorer communication, decreased warmth, and increased hostility as compared to those of non-depressed group (Piug-Antich, Kaufman, Ryan & Willamson, 1993). Further observations of mother-child interactions reveal that mothers of depressed children set higher standards for their children’s success (Cole & Rehm, 1986); are more dominant in parent-child interaction (Garber & Flynn, 2001); and show less support, validation and positive behaviour towards their children (Sheeber & Sorenson, 1998). The studies reporting prevalence rates of DSM or ICD diagnoses of children in community surveys are relatively rare, because rates are not reported separately for children and adolescents. In general pre-adolescents school age children have a low lifetime rates of depressive disorders, generally less than 3%. Studies of children vary in their reports of whether boys’ and girls’ are equal or whether boys’ rates exceed girls’ rates of depressive symptoms prior to adolescence. However the basic findings of higher rates of depressive diagnosis and symptoms in girls during adolescence is well established (Cohen, Cohen, Kasen, Velez, Hartmark, Johnson, Rojas, Brook & Steining, 1993).

**Parenting and Anxiety Problems:** Anxiety disorders, namely generalised anxiety disorder or social phobias are widely recognised as among the most common psychiatric disorders affecting children, and yet these disorders are not well understood with regard to youth. Children with GAD are typically described as “little worriers by parents”. Children may experience worry
concerning performance in school, athletics, social relationships to the point of
being perfectionists. In children, though anxiety is an integral part of normal
developmental progression from dependency to autonomy, pathological anxiety
however may be distinguished from normal expected levels of anxiety, on the
basis of intractability of the anxiety, the pervasiveness of the fears and
avoidance, and the degree of interference in the child’s daily functioning
(Albano, Chorpita & Barlow, 2003).

Broader dimensions of parenting style, such as control and warmth, are
related to anxiety in the offspring (Parker, 1983) and Gerlsma, Emmelkamp
and Arrindell (1990) have extensively worked on effects of parenting on
depression and anxiety. Most findings implicate “affectionless control” as the
key variable in predicting predisposition to anxiety and depression (Gerlsma
et al., 1990). In an observational study of parents of children with anxiety
disorders (n=43) and parents of controls (n=32), Hudson and Rapee (2001)
found association between intrusive parenting and anxiety. Chorpita and Barlow
(1998) found a positive relationship between high degree of parental control
and increase in cognitive perception of uncontrollability, which in turn predicted
anxiety and elevations in the severity of anxiety.

**Parenting and Conduct and Oppositional Defiant Disorders:**
Oppositional defiant disorder is a pattern of negativistic, defiant and hostile
behaviours. Conduct disorder is repetitive and persistent violation of rules and
infringement of rights of others (APA, 1994). The attributes of parent-child
interactions that display moderate to strong relationship with children’s conduct
problems are low levels of parental involvement in children’s activities (Loeber
& Farrington, 1998), poor supervision and monitoring of offspring, harsh and
inconsistent discipline practices, physical punishment, parental neglect and
verbal hostility (Loeber et al., 1998). The most comprehensive model is
Coercion theory of Patterson (Patterson, 1982), which is supported by
microanalysis of parents and children in home observations of family interactions.
The pattern of harsh aversive hostile interchanges between parents and children
leads to development and intensification of antisocial behaviour. Patterson et al.
(1992) conclusively demonstrated “parents effects” from experimental
intervention studies designed to reduce parent child coercive interchanges,
that parenting skills training markedly reduced children’s risk for behaviour
problems. Similarly in a large sample of children with ADHD and comorbid
ODD and CD, Hinshaw (in press) discovered that reduction of negative and
ineffective discipline practices mediated the effects of combined medication
plus behavioural intervention on children’s disruptive behaviours and
social skills in school. With respect to oppositional defiant disorder, the rates

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between boys and girls appear similar in early childhood, but by the late preschool and early elementary years, male pre-dominance is distinct. On the other hand, as do boys, girls display increase in oppositionality and defiance in adolescence. With regard to conduct disorders, boys greatly outnumber girls in childhood and preadolescence, with ratios 4:1 (Lahey, Miller, Gordon & Riley, 1999).

Parenting styles have been defined as the constellations of behaviours that describe parent-child interaction over a wide range of situations and are presumed to create a pervasive interactional climate. The parenting dimensions incorporated in this study build upon the review of contemporary model of child rearing in India (Saraswathi, 1999) are akin to the stylistic dimensions of Baumrind’s typology. This study adopts the dimensional tradition as opposed to typological approach where specific dimensions of parent-child relationships are being assessed to test hypotheses of associations between parenting dimensions and childhood disorders. The parenting is conceptualised as seven parenting stylistic dimensions of connection, autonomy, regulation, non-reasoning, verbal hostility, physical coercion and indulgence (Robinson, Mandleco, Olsen & Hart, 2001).

- **Connection dimension** is high degree of warmth, nurturance, sensitivity and acceptance by parents...
- **Autonomy** is high degree of psychological freedom and democratic interactions between parents and children.
- **Regulation** is behavioural control that places consistent limits on child’s behaviour through reasoning about rules and establishing consequences for misbehaviour.
- **Physical coercion** is use of physical punishment/force (e.g., spanking slapping etc.) to control or discipline the child.
- **Verbal hostility** is use of abusive hostile manner to control, discipline or intimidate the child.
- **Non-reasoning** or punitiveness is meeting out punishment without justifications or plausible reasoning.
- **Indulgence** is pampering with frequent expressions of affection and yielding to the demands of the child, lax discipline, and acceptance of even under controlled behaviours.

*Childhood Disorders:* Childhood disorders are commonly conceptualised in terms of deviances involving breakdown in adaptive functioning, statistical deviation, unexpected distress and/or biological impairment. In this study

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childhood disorders are defined using the DSM-IV diagnostic criteria (APA, 1994). The oppositional defiant disorders and conduct disorders are externalising behaviours while anxiety and affective problems are internalising behaviours.

- Oppositional defiant disorder is pattern of negativistic, hostile and defiant behaviour lasting at least six months, during which four (or more) of the following are present:
  1. often loses temper
  2. often argues with adults
  3. often actively defies
  4. often deliberately annoys people
  5. often blames others for his misbehaviour
  6. is often touchy
  7. is often angry
  8. is often vindictive (APA, 1994)

- Conduct disorder is a repetitive and persistent patterns of behaviour in which the basic rights of other or appropriate societal norms or rules are violated as manifested by the presence of one criteria in the past six months:
  1. Aggression to people and animals
  2. Destruction of property
  3. Deceitfulness or theft
  4. Serious violation of rules (APA, 1994)

- Affective problem, depressed mood or loss of interest for a 2 weeks period, alongwith five (or more) of the following symptoms is the diagnostic definition of major depressive episode (DSM IV; APA, 1994).
  - Depressed or irritable mood or loss of interest most of the day
  - Markedly diminished interest in almost all activities
  - Decrease in appetite or significant loss of weight
  - Fatigue or loss of energy
  - Psychomotor agitation or restlessness
  - Feelings of worthlessness
  - Diminished ability to think
  - Recurrent thoughts of death
Anxiety problems namely: social phobia is marked and persistent fear of one or more social situations in which children are exposed to unfamiliar people, adults or peers. Generalised anxiety disorder is excessive and uncontrolled anxiety and worry (apprehensive expectation) about number of life events (past and future behaviours) and activities such as competence in sports, academics and peer relations occurring more days than not for at least 6 month. The uncontrolable worry and anxiety is associated with following symptoms (with at least three symptoms present out of six):

- Restlessness or feeling keyed up
- Irritability, nervousness
- Muscle tension
- Sleep disturbances, worries a lot
- Mind going blank and being easily fatigued
- Dependent
- Fearfulness, fears school (DSM-IV, APA 1994)

The objectives of the research was to investigate the relationship between parenting dimensions and childhood disorders in order to study the relationship of parenting dimensions with anxiety problems, affective problems, oppositional defiant disorders and conduct disorders. Further, gender differences in childhood disorders were also investigated.

It was hypothesised that:

- Verbal hostility, physical coercion and non-reasoning dimensions are positively related to childhood disorders
- Connection, regulation and autonomy are negatively related to childhood disorders
- Indulgence is negatively related to childhood disorders
- Affective and anxiety problems are more in girls while conduct and oppositional defiant disorders are more in boys

**METHOD**

**Sample**

The sample for this study included 290 middle class two parent families from Patiala city. The family income of the subjects was between Rs. 1,50,000–6,50,000 per annum. The parents were relatively well educated. The sample comprised of 290 children; 145 boys and 145 girls in the age range of 7–13.
years. Patiala is a city which consists of doctors, engineers, educationists, college and university teachers and business community. The city has a population of about 15,21,330 which is well educated and maintains a comfortable standard of living with literacy rate of 76% for males and 63% for females (Registrar general, 2001).

Tools
For measures of parenting behaviours, parents were asked to evaluate each item of the questionnaire, based on their behaviours of how they interact with their children on a 5 point scale. For measures of children’s behaviour, parents were asked to rate children’s behaviours on a 3 point scale. All items on the scales were translated into Hindi or Punjabi to assure that items were conceptually equivalent and connotative meanings were well understood.

*The Parenting Styles and Dimensions Questionnaire* (Robinson, Mandleco, Oslen, & Hart, 2001) consist of 32 items, 3 parenting styles and 7 stylistic parenting dimensions. The authoritative parenting style consisted of three stylistic dimensions: (1) connection–warmth/involvement, 5 items; (2) regulation-induction/reasoning, 5 items; (3) autonomy granting-democratic participation, 5 items. The Authoritarian pattern consisted of three stylistic dimensions: (1) verbal hostility, 4 items; (2) physical coercion, 4 items; (3) non-reasoning, 4 items. The permissive pattern consists of indulgence dimension, 5 items. Parents rated themselves on 5 point Likert type scale anchored by 1 (never) and 5 (always). The score of each parenting dimension was the mean of the sum of ratings of the items of parenting dimension that ranged from 1 to 5. The higher the score on a parenting dimension, the more the parents exhibited that parenting dimension in their interactions with children. The items of authoritative parenting style has alpha coefficient of .86, authoritarian style has .82 and permissive style has .64. The PSDQ (Robinson *et al.*, 1996, 2001) has been validated cross-culturally.

*Child Behaviour Checklist for Ages* (6–18 years), (Achenbach & Rescorla, 2001) consists of 118 items to be rated by parents on a 3 point scale (not true, sometime true, very true). The scoring was done with the manual for the ASEBA School-Age forms and Profiles For Child Behaviour Checklist for Ages 6–18 Years. The childhood disorders namely, Oppositional Defiant Disorders, Conduct Disorder, Anxiety problems and Affective problems were with the DSM-Oriented scales. The DSM-oriented scales comprise of problems that psychologists and psychiatrists from 16 cultures rated as consistent with the DSM-IV diagnostic criteria. The alpha coefficients for oppositional defiant problems is .86, conduct problems is .91, affective problems is .82 and anxiety problems is .72, respectively.
**Procedure**

The researcher collected the preliminary information about the children of the ages 7–13 years from the schools. The families were then followed up to obtain family details to select the target sample. The researcher met the subjects in their respective homes and informed them that the objective of the study was to examine children's behaviour in every day life situations. The questionnaire was then handed to the subjects with instructions of not to omit any question and, if they did not understand the question they should immediately seek clarifications. The researcher assured them that their responses would be treated confidentially and used only for research purposes. After the completion of the first questionnaire, the researcher carefully evaluated the answers to identify the childhood disorders. If any of the childhood disorders were identified, the parents were then handed out the second questionnaire. The subjects were then informed that the second questionnaire was a measure of parents behaviours towards their children. The parents were informed that their “collective behaviour as a parent” towards the children is the objective of the study of parent child relationship. The subjects were particularly instructed to sit together and understand the questions before giving their responses. The data analysis was based on responses of 290 families. After the data collection, the parents were debriefed.

**RESULTS AND DISCUSSION**

The scores for parenting dimensions, (connection, regulation, autonomy, verbal hostility, physical coercion, non-reasoning and indulgence) were derived by calculating the mean of the items of each dimension. The scores for childhood disorders were calculated from the scoring protocols of the Child Behaviour Checklist.

Correlations were then computed among parenting dimensions and each of the childhood disorders. Multiple regression analysis was then performed to find unique contributions of parenting dimensions to each childhood disorders. Finally, t test was run to find gender differences on childhood disorders.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Boys means</th>
<th>SD’s</th>
<th>Girls means</th>
<th>SD’s</th>
<th>N</th>
<th>Total Mean</th>
<th>SD’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety problems</td>
<td>7</td>
<td>2.39</td>
<td>10.66</td>
<td>1.69</td>
<td>70</td>
<td>8.97</td>
<td>2.72</td>
</tr>
<tr>
<td>Affective problems</td>
<td>9.5</td>
<td>2.57</td>
<td>14.5</td>
<td>3.91</td>
<td>60</td>
<td>11.5</td>
<td>3.52</td>
</tr>
<tr>
<td>Oppositional defiant</td>
<td>11</td>
<td>5.1</td>
<td>9.7</td>
<td>4.2</td>
<td>80</td>
<td>12.11</td>
<td>5.2</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>14.3</td>
<td>5.2</td>
<td>9.9</td>
<td>4.3</td>
<td>80</td>
<td>10.4</td>
<td>4.79</td>
</tr>
</tbody>
</table>
Pearson’s product moment correlations were computed between parenting dimensions and childhood disorders (Table 2). All correlations were significant. Positive correlations (r’s ranged from .64 to .90) were found between verbal hostility, physical coercion and non-reasoning parenting dimensions and childhood disorders. But negative correlations (r’s ranged from -.51 to -.98) were found for connection, regulation parenting dimensions and childhood disorders respectively. For indulgence and autonomy parenting dimensions associations with anxiety and affective problems were negative whereas for conduct and oppositional defiant disorders the associations were positive.

**TABLE 2**

Correlations of parenting dimensions and childhood disorders

<table>
<thead>
<tr>
<th>Childhood Disorders (n=290)</th>
<th>Anxiety problems (n=70)</th>
<th>Affective problems (n=60)</th>
<th>Conduct disorders (n=80)</th>
<th>Oppositional defiant disorder (n=80)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connection</td>
<td>-.98**</td>
<td>-.91**</td>
<td>-.80**</td>
<td>-.46**</td>
</tr>
<tr>
<td>Regulation</td>
<td>-.87**</td>
<td>-.92**</td>
<td>-.69**</td>
<td>-.51**</td>
</tr>
<tr>
<td>Autonomy</td>
<td>-.96**</td>
<td>-.55**</td>
<td>.66**</td>
<td>.68**</td>
</tr>
<tr>
<td>Verbal Hostility</td>
<td>.80**</td>
<td>.76**</td>
<td>.64**</td>
<td>.74**</td>
</tr>
<tr>
<td>Physical Coercion</td>
<td>.83**</td>
<td>.90**</td>
<td>.60**</td>
<td>.71**</td>
</tr>
<tr>
<td>Non-reasoning</td>
<td>.70**</td>
<td>.76**</td>
<td>.72**</td>
<td>.74**</td>
</tr>
<tr>
<td>Indulgence</td>
<td>-.69**</td>
<td>-.96**</td>
<td>.71**</td>
<td>.75**</td>
</tr>
</tbody>
</table>

** p<0.01 (two tailed).

Table 3 enumerates four sets of multiple regressions that were performed to ascertain the contribution of each parenting dimension to childhood disorders. The F statistic (the tests of simultaneous equality of regression coefficients) was found to be significant for conduct disorder, F(7,72)=58.66, p<.001, oppositional defiant disorder, F(7,72)=37.64, p<.001, anxiety problems F(7,62) = 264.9, p<.001 and affective problems F(7,52)=192.6, p<.001. For conduct disorders, the beta coefficients for non-reasoning, physical coercion, indulgence and connection were found significant. For oppositional defiant disorders, the beta coefficients for non-reasoning, indulgence, verbal hostility, physical coercion and autonomy were found to be significant. For anxiety problems, beta coefficients for connection were found to be significant. For affective problems, beta coefficients for indulgence, connection and regulation parenting dimension were found to be significant.
## TABLE 3
Multiple Regression analysis performed on Childhood disorders: Parenting Dimensions predictors.

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Adjusted R Square</th>
<th>F</th>
<th>Beta</th>
<th>t</th>
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<tbody>
<tr>
<td>Anxiety problems</td>
<td>.963</td>
<td>264.90***</td>
<td>Standardised Predictors</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>.018 Non-Reasoning .432</td>
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<td></td>
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<td></td>
<td>−.056 Indulgence −1.506</td>
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<td></td>
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<td></td>
<td>.020 Phy-Coercion .395</td>
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<td></td>
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<td></td>
<td>−.066 Autonomy −.460</td>
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<td></td>
<td>.034 Ver-Hostility .627</td>
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<td></td>
<td>−.028 Regulation −.543</td>
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<td></td>
<td></td>
<td></td>
<td>−.825 Connection −5.37 ***</td>
<td></td>
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<tr>
<td>Oppositional Defiant Disorder</td>
<td>.836</td>
<td>58.66**</td>
<td>Non-Reasoning 4.23 ***</td>
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<td>Indulgence 3.76 ***</td>
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<td>Phy-Coercion 3.84 ***</td>
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<td>Autonomy 2.95 **</td>
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<td>Ver-Hostility 2.63 **</td>
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<td></td>
<td>Regulation .116</td>
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<td></td>
<td></td>
<td></td>
<td>Connection −1.52</td>
<td></td>
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<tr>
<td>Affective problems</td>
<td>.957</td>
<td>192.629***</td>
<td>Non-Reasoning 1.46</td>
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<td></td>
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<td>Indulgence −10.19 ***</td>
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<td>Phy-Coercion −.128</td>
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<td>Autonomy .490</td>
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<td>Ver-Hostility 1.064</td>
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<td></td>
<td>Regulation −4.642 ***</td>
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<td></td>
<td>Connection −2.92 **</td>
<td></td>
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<tr>
<td>Conduct Disorder</td>
<td>.765</td>
<td>37.64***</td>
<td>Non-Reasoning 2.73 **</td>
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<td>Indulgence 2.08 *</td>
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<td>Phy-Coercion 2.72 **</td>
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<td>Autonomy 1.54</td>
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<td></td>
<td>Ver-Hostility −1.48</td>
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<td>Regulation −.193</td>
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<td></td>
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<td></td>
<td>Connection −3.08 **</td>
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</table>

N=290, * p<0.05 (two tailed), ** p<0.01, *** p<0.001.
To find significant gender differences on childhood disorders, t tests were computed. Significant gender differences were found for anxiety t (70)=4.9; p<0.001, affective problems, t(60)=5.7; p<0.001, and conduct disorders t(80)= 4.12, p< 0.001.

As the current study was an exploration of parenting stylistic dimensions and its associations with childhood disorders assuming parent-child effects model, the results were considered separately for parenting dimensions and disruptive disorders and emotional disorders respectively. Major models of child psychopathology including attachment (Bowlby, 1988), psychodynamic (Freud, 1957), emotion theories (Thompson & Calkins, 1996), information processing (Crick & Dogde, 1994) and cognitive behavioural models (Alloy, Abraham, Tashman, 2001), have been cited to understand the processes mediating parenting and child psychopathology.

Parenting Dimensions and Disruptive Disorders: In consonance with the epidemiological studies (Lahey et al., 1999) our findings indicate boys more conduct disordered than girls. Over indulgence of boys is the hallmark of Indian child rearing (Konantambigi, 1996). Despite excessive affection, disciplining strategies are often strict and punitive. Punitive parenting practices impede inductive reasoning, self regulation, emotion regulation, which in turn precipitates proclivities for conduct disordered behaviour. The culture and gender specific explanation is supported by the significant regression findings of physical coercion and non-reasoning parenting dimensions for conduct disordered children. Though the findings are invariant for gender, the presumption of differential parental expressions for boys and girls is cited in child-rearing literature (Kakar, 1999).

Contrary to our hypothesis, regression findings indicate that indulgent parenting significantly contributes to oppositional defiant and conduct disorders. As noted by Baumrind (1991) lack of balance between warmth and control in indulgent parenting promotes high level of individual development and agency at the expense of development of communion. Steinberg (1994) further explained that indulgence fails to provide guidelines to children for effective regulation of their behaviour and therefore parents run the risk of raising children with problems in their regulating behaviours. Accordingly children were found to exhibit impairments in maturity, impulse control, social responsibility achievement and predisposition towards delinquency, defiant behaviours and conduct problems (Steinberg, Lamborn, Dornsbuch, Darling & Mounts, 1994).
In consonance with western findings, the correlations revealed that high levels of punitiveness/non-reasoning, verbal hostility and physical coercion are associated to high levels of oppositional defiant and conduct disorders, respectively. Most comprehensive explanation in this field is the coercion theory of Patterson (1992), which is supported by microanalyses of in-home observations of family interaction. By adhering to child’s escalating demands and backing down from requests, parents negatively reinforce the child’s increasingly defiant behaviour patterns. With the escalation of child’s misbehaviour—harsh, punitive and hostile disciplinary practices are met by child’s temporary capitulation. Such mutual training in aversive responding fuels both defiant, aggressive child behaviours and greater levels of punitive/harsh parenting. The social-cognitive information processing model explains the influence of punitive parenting through their instigation of early-stage cognitive deficits and distortions. A series of investigations of clinic as well as community samples of aggressive and conduct disordered children have revealed, underutilisation of pertinent social cues and attributional distortions (Dodge, Price Bacorowski, 1990).

Similar to authoritative stylistic (Baumrind, 1991), regulation and connection parenting dimensions are found to be negatively associated to conduct and oppositional defiant disorders, with regression findings pointing to lack of connection and warmth in parent-child relations as significant predictor of conduct disorders. Lack of sensitivity, responsivity, and warmth towards children creates insecure parent child bond and fosters a negative general view of world as unsafe and insecure place. Cumulatively “these negative affective-cognitions” are proposed to manifest as behavioural problems (Bowlby, 1988). In their seminal formulation Greenberg, Speltz & DeKlyen (1993) reported “behaviour problems in children are often strategies for receiving attention or gaining proximity to caregivers who may not be contingently responsive”. Our results are in congruence with the studies mentioned earlier. In addition, social information processing models propound that negative parent child emotionality/insecure parent-child bond fosters negative attributional styles about parent-child relationship which is subsequently extended to peer relationships. Proclivities towards hostile evaluations and responses in turn have been proposed to increase children’s susceptibility to poor peer relationships, social skills deficits, aggression, social isolation and depression (Petit, Dodge & Bates, 1993).

Regulation consists of parental behaviours characterised by communication of set of rules, enforcement of rules with explanations and monitoring and supervision of whereabouts of children. Low degree of behavioural
regulation, inconsistent monitoring with little or no inductive reasoning have been found to engender emotional dysregulation, non-compliance, cognitive deficits, and non-conformity of family and societal rules. Consequently children had low self esteem and self worth as well as impairments in individual development and self regulation (Steinberg, 1990). Prospective research has linked lack of sensitivity and poor regulation to maladaptive outcomes as antisocial behaviours (Petit, Bates & Dodge, 1997).

Autonomy granting is positively linked to disruptive problems. These results are however in contrast to research in North America, where autonomy granting is associated with psychosocial adjustments in children (Baumrind, 1991; Maccoby, 1992). Although speculative, the cultural variable may have altered the pathways between parenting variable and child adjustments. It is conceivable that parent-child democratic interactions and psychological freedom given to the children to regulate their activities is misunderstood, misattributed or misused by the children. Although these findings suggest that children’s autonomy should be circumscribed, firm conclusions should be reserved for researches investigating culture and parenting as function of disruptive behaviours.

Parenting and emotional disorders: Despite inconclusive gender differences on anxiety and affective problems in childhood (Rutter, 2000) our finding indicates girls as more anxious and depressed than boys. This may be due to gender differential child rearing. In the Indian culture parents are overprotective of girls. They socialise girls to be psychologically and socially dependent on interpersonal relationships. It is argued that these socialisation experiences place them at a risk for emotional problems by setting the stage for overinternalisation of their own and others’ problems. Keenan & Shaw (1996) propose that girls’ earlier development of basic psychobiological, cognitive, and emotion regulating capacities promote socialisation patterns that push girls into internalising manifestations.

Interestingly, with exception of indulgent parenting dimension, our research findings are similar to the western classic research on parenting styles of Diana Baumrind (1991). The links of less indulgence to more internalising problems may be, in part attributed to emotional dysregulation in children derived through parental modeling and conditioning of inappropriate emotions. Parental intolerance, constrained warmth and infrequent expressions, affection cause emotional arousal and negative affect and if this affective state persists it may manifest into pervasive anxiety. Barlow (2000) observed that transitory/sudden changes in emotional arousal manifest as state anxiety and if it persists
for longer durations it manifests as trait anxiety. Besides children’s self-worth and self-evaluation are contingent on parents’ evaluations. Withdrawal of affection and low tolerance is perceived as distressful, which precipitates loss of self-worth, self-doubt, negative affect and interpersonal stress. Negative interpersonal beliefs and schemes have been found to confer risk for affective problems in face of interpersonal stress. These notions are congruent with life stress models of depression exploring specific domains of stress and mediating processes that confer risk for depressions (Hammen, 1992).

Parental verbal hostility, physical coercion and punitiveness are positively associated while parental connection, autonomy and regulation are negatively associated with anxiety and affective problem. The prominent studies of parent-child relationships (Maccoby & Martin, 1983; Baumrind, 1991; Stormshack, 2000) validate these findings. Strict unquestioned obedience, non-reasoning, verbal abusiveness/harshness are authoritarian, power assertive control techniques that deter children from achieving self-efficacy, self-confidence and a sense of personal integrity. Such exposure to higher levels of restrictive control, combined with lack of warmth and affection, discouragement of autonomy and detachment increases the risks for more internalising symptoms, such as, self-devaluation, social submissiveness, low self-esteem, anxiety, low moods and diminished independence. Supporting the above argument are our regression findings of low parental connection, regulation and indulgence that significantly predict affective problems in children. The psychoanalytic theories (Freud, 1957), object relations theories (Fairbairn, 1952), attachment model (Bowlby, 1988) conceptualise disruptions in parent-child relations as the primary vulnerability factor for depression—either through emotional deprivation, rejection, insecure bonding or inadequate parenting. Complementing these conceptual advances, a considerable body of empirical evidence (for reviews Gotlib & Hammen, 1992; Lovejoy, Graczky, O’Hare & Neuman, 2000) have documented associations between depression and maladaptive parenting. Parenting variables, including hostile parent-child interactions (Lovejoy et al., 2000); insecure parent-child attachment, diminished autonomy and relatedness (Pavlidis & McCauley, 2001); high maternal hostility and decreased warmth (Puig-Antich et al., 1993) have been linked with childhood depression.

From the developmental perspective, cognitive models based investigations of the antecedents of depression-related cognitions implicated the role of maternal negative attributional style, social learning, socialisation styles/caregiving by parents, and family disruptions. Empirical investigations of the
proposed variables have been found to predict depressogenic views of self and world over time (Alloy et al., 2001). Garber and Flynn (2001) found that depressed children’s negative view of the self and world arises through modeling of cognitive style of parents, internalisation of the negative feedback and maladaptive parenting styles.

Although a less pervasive pattern of relationship was found between parenting dimensions and anxiety in children, our results were generally similar to the research findings of Parker (1983) and Rapee (1997). Correlational findings suggest significant associations between lower levels connection, inadequate regulation, diminished autonomy and anxiety in children. Parker (1983) argued that unresponsive parenting may lead to disruption and distress in the child over the course of development as it conveys to the child that his actions may not control or influence important stimuli (i.e. reinforcers) in the environment, as parents are not contingently responsive to the child’s needs. The diminished autonomy, in our research operationalised as restriction and constraint on the child’s ability to manipulate or engage in the environment independently connotes behavioural control by delimitation of autonomy which subtly differs from overprotection dimension of Parker’s research findings. Nevertheless, the specific effect of behavioural/psychological control and low responsivity of parents, what in turn constrains and narrows the behavioural options of the child has visible implications for the child’s development in a sense that events are not under child’s control. It is this lack of control that fosters increased risk for anxiety and mood disorders. Perhaps this research is the most thorough explication of parenting dimensions as the mediational links in the model of control cognitions and anxiety (Chorpita & Barlow, 1998). Overlapping the parental variables of control and responsivity is the construct of “affectionless control” which is implicated as the a key determinant of anxiety or phobias (Parker, 1983; Gerlsma, Emmelkamp & Arrindell, 1990). Our regression findings support the construct, in part, for only lack of connection/support significantly predicted anxiety, in our study.

While reviewing the evidence of acquisition of specific vulnerabilities from the learning experiences that predispose child to anxiety, Barret, Dadds, Rapee and Ryan (1994) exploring the parenting effects found that parents of anxious children spend great deal of time focusing/discussing potentially threatening nature of ambiguous situations with their children by misinterpreting ambiguous cues as threatening, and hence reinforce escape and avoidance tendencies in ambiguous situations. Research has identified modeling and conditioning processes in the parent-child interaction that significantly serves
to increase anxious cognitions in children (Barett, Rapee & Dadds, 1993; Chorpita & Barlow, 1998).

The present findings of high parental verbal hostility, punitiveness and physical coercion suggest positive association with anxiety, but regression coefficients did not significantly predict anxiety in children. Some evidence suggest that parents who use punitive and power assertive control strategies tend to rear children who are fearful, shy, timid, anxious and dependent (Rapee, 1997). Similarly in an observational study of parents of children with anxiety disorders (n=43) and parents of controls (n=32), Hudson and Rapee (2001) found association between intrusive parenting and anxiety.

The correlational designs as ones reported here do not specify causal relationships or explicate on the direction of the parent-child transactional processes. This article reflects the assumption of unidirectional parent to child effects model whereas the child to parents effect models are also quite possible. There is empirical evidence suggesting that parenting styles can be influenced by antisocial behaviour dispositions and may evoke negative parenting (Pettit et al., 1993). More so, the bias in self reports is a possible confound. Therefore before any conclusions can be drawn it is suggested that the conclusions are further validated with observational and experimental methodologies. Notwithstanding the limitations of the study, our results have generally supported the findings in western literature but with few exceptions. Given the complex dynamics of antecedents of childhood disorders, research does not support granting central etiological status to any single risk or causal factor. Rutter (2000) observed, there are many possible contributors to children’s risk for disorders, and parenting behaviours are embedded in complex environmental conditions, so that it is rather complicated to determine the extent to which parenting behaviours singularly affect psychopathological outcomes. For example, it is possible that maladaptive parenting does not cause psychopathology per se but interact with latent genetic risk factors and cause phenotypic manifestation of psychopathology.

Despite above stated methodological limitations, the investigation has underlined the criticality of parenting in child psychopathology. The gist of the study is that the absence of positive parenting is as significant as is the presence of negative parenting in the development of childhood disorders. If negative parenting precipitates disordered behaviours, positive parenting has the overwhelming potential to contain it.
REFERENCES


