Definition and Measurement of Children's Emotional and Behavioural Problems "A Review Article"

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Abstract

The current literature on children's behaviour problems provides several definitions, primarily the two broad-based categories: emotional (internalizing) and behavioural (externalizing). Although children's emotional and behavioural impairments may be evident at the personal, social, learning, and skills levels, the debate on the influence of culture is at stake. Besides giving general review about these issues the aim of the present paper is to expose the reader to have an idea about how behaviour problems are quantified. The article has also attempted to give an overview of the nature and structure of some of the valid and reliable instruments that are universally employed to measure childhood behavioural deviance.

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This article is intended to briefly review the definition of childhood behaviour problems and provide an idea about their cultural perception. This general review attempts to explore the main approaches employed in investigating childhood behaviour problems. In addition, the use of rating scales as popular measurement tools of behavioural adjustment will also be reviewed.

1-Definition of Emotional and Behavioural Problems:

Although it can be said that most children experience some sort of an emotional or a behavioural difficulty at some point in their development, which seems normal, profound difficulties are considered pathological. Several definitions of emotional and behavioural problems have been suggested. According to the British Department For Education (1993), emotional and behavioural difficulties range in type from socially intrusive (externalizing) to emotionally and socially withdrawn (internalizing) disorders. They may manifest themselves in many different forms and at different levels of severity. They may become apparent through withdrawn, depressive, aggressive or self-injurious tendencies. They may have single or a number of causes, and may be associated with school or family environments or physical or sensory impairments. Children's emotional and behavioural impairments may be evident at the personal, social, learning, and skills levels. Whether or not a child is judged to have emotional and behavioural difficulties will depend on the nature, frequency, persistence, severity or abnormality of the behavior compared to normal expectations for a child of the concerned (DFE., UK, 1993).

The current literature on children's problems centers primarily on two broad-based categories: emotional (internalizing) and behavioural (externalizing) problems (Achenbach & Edelbrok, 1983; Achenbach & McConaughy, 1987). Although behaviour problems have been grouped into internalizing or externalizing in most studies, still a number of children may display a mixture of difficulties. Internalising problems include loneliness, social withdrawal, anxiety, depression, or emotional problems. Externalising problems include aggression, hyperactivity, bullying, lying or stealing (Achenbach & Edelbrock, 1983).

Rutter, Tizard, & Whitmore, (1970) classified the problems into two groups in the Children's Behaviour Questionnaire (CBQ): neurotic (internalising) and social (externalising). The ‘neurotic' behaviours were ‘often worries about many things', 'often appears miserable, unhappy, tearful or distressed', 'tends to be fearful or afraid of new things or new situations', and 'has had tears on arrival at school or has refused to come into the building this year'. The 'antisocial behaviour were often destroys own or others' belonging,' 'frequently fights with other children,' is often disobedient,' 'often tells lies', 'has stolen things on one or more occasions', and 'bullies other children'. Richman, Stevenson, & Graham, (1982) defined behavioural problems as actions that would cause significant social or psychological disability to the others and that would cause concern to an experienced professional in the field. This means that the behaviour in concern falls outside the normal range.

It is so difficult to arrive at a reliable definition because an emotional or behavioural problem is not a thing that exists outside a social context, but a label assigned according to cultural rules (Burbach, 1981). An emotional

or behavioural problem is whatever an authority in a given culture feels is intolerable. Typically, it is behaviour that is perceived to threaten the stability, security, or values of that society (Rhodes & Paul, 1978). Divisions in world views or conceptual models are one more factor adding to the problems of definition. Moreover, problems are made by the differing intentions or aims of definition, by practical obstacles in measuring behaviours and emotions, by the range and variability of normal and abnormal behaviour, by the overlapping of emotional or behavioural problems with other disabilities, by the transitory nature of many problems during human development, and by the drawbacks inherent in describing and classifying deviance (Angold, 1989; Achenbach & Edelbrock, 1983;Burbach, 1981; Rhodes & Paul, 1978; Rutter, et al., 1970).

Despite the fact that many definitions of emotional or behavioural problems have been constructed during the past few decades none has resolved the problems of terminology, clarity, and usefulness (Angold, 1989). However, in 1991, the Mental Health Special Education (MHSE) Coalition in the USA suggested a more inclusive definition of emotional or behavioural disorders. It reads as follows:

1. The term emotional/behavioural disorder means disability characterized by emotional or behavioural responses in school programmes so different from appropriate age, cultural, or ethnic norms that they adversely affect educational performance, including academic, social, vocational or personal skills, and which (a) is more than a temporary, expected response to stressful events in the environment; (b) is consistently exhibited in two different settings, at least one of which is school-related; and (c) persists despite

individualized interventions within the education programme, unless, in the judgement of the team, the child's or youth's history indicates that suchinterventions would not be effective.

2. Emotional or behavioural disorders can co-exist with other disabilities.

3. This category may include children or youths with schizophrenic disorders, affective disorders, anxiety disorders, or other sustained disturbances of conduct or adjustment that adversely affect educational performance in accordance with section.

1- (source: MHSE Coalition, 1991).

In The International Classification of Diseases (ICD) 10th edition, the term 'disorder' is used throughout the classification, so as to avoid even greater problems related to the use of terms such as 'disease' and 'illness". Disorder' is not a precise term, but it is used to indicate the existence of clinically recognizable set of behaviours associated in most cases with distress and with interference with personal functions (International Classification of Diseases, 1992). In the present paper, the term "emotional and/or behavioural problems' is used interchangeably with "emotional or behavioural disorders'

2- Cultural Perception of Behaviour Problems:

Over the past few decades psychologists have developed increased interest in the study of culture and its influence on human development and psychopathology. Special attention has been drawn towards the significance and consequences of behaviour problems perceived within their cultural context. However, two contrasting conceptual positions are believed to influence the perceptions of behaviour problems and direct research in this

area: the Culture-specific position which professes that conceptualization, recognition, and treatment of psychopathology is primarily rooted in the belief systems of a given culture ; and Universalism which poses that there are certain features intrinsic to psychopathology which are invariant across cultures and which render it recognizable within any cultural context – that is , psychopathology is universal (Yau-Faiho, 1980).

Although it was felt that virtually all types of behaviour problems are found across cultures, their specific incidence and perceptions may vary considerably. Culture does not only define the situation that elicit certain behaviour problems, but also determines the degree to which they may be viewed as abnormal (see Yule, 1981; Al-Issa, 1982). In addition, the cultural theory of personality and psychopathology suggests that since the cultural world precedes the birth of the individual, culture will pattern the individual's development and his psychological makeup (LewisFernandez & Kleinman, 1994).

3-The Main Approaches to Investigating Childhood Psychopathology:

It is believed that progress in investigating childhood psychopathology depends on well developed, acceptable, and applicable approaches to measuring these disorders. Two main theoretical models have emerged.

3-1. The Conceptual-diagnostic Model:

This is a model whereby subcategories of emotional and behavioural problems are tied closely to the conceptual nature of psychiatric illness and diagnostic entities (Boyle & Jones, 1985). This model proceeds by the delineation of clinical disorders in a descriptive sense, and the diagnostic process thus consists of determining whether a child conforms to a particular description or not (Angold, 1989). Intensive clinical interviews are the main diagnostic tools for this model. This model has been criticized as being time-consuming, expensive, poorly delineated and unreliable (Achenbach & Edelbrock, 1978).

3-2. The Continuous-empirical Model:

This model applies factor analyses and related statistical techniques to lists of problem behaviours to derive syndromes that are scored on an intensity continuum (Boyle & Jones, 1985). This means that psychopathology is defined in terms of quantitative deviations from empirically determined population means. Scales established in this model can offer symptom counts, overall disturbance scores and sometimes cluster-analytical derived diagnostic groupings (Angold, 1989). Measures of this tradition are typically questionnaires for completion by parent teachers, or the children themselves (Achenbach & Edelbrod 1978). Extensive population norms may be available, and on strength of such measures is that an individual child performance can be referenced to such norms (Angold, 1989). This approach has been criticized on the ground that what it gains in reliability it sacrifices in meaningfulness (Boyle & Jones, 1985).

The author of the present paper suggests the application of the latter model in the Sudan because rating scales and factor analyses, as the principal measurement tools of this model, facilitate the identification of structures of childhood behaviour problems in the Sudan (see, e.g. Shennan, 2003; Shennan & Sonuga-Barke, 2002). This model also offers the possibility of comparing patterns of childhood behaviour problems of Sudanese children with those obtained in other studies in different cultural settings.

4- Measuring Childhood Behaviour Problems:

It is vitally important for us to have an idea about how behaviour problems are quantified. It is also important to have an overview of the nature and structure of some of the valid and reliable instruments that are universally employed to measure childhood behaviour problems.

Traditionally, researchers have relied upon information obtained from significant adults about children's behaviour. There are two reasons for this. First, it is recognized that children do not present themselves for treatment but rather are the subject of parents' and teachers' complaints (Yule, 1981; Sonuga -Barke, Balding & Thompson, 1993). Second, for most types of behaviour problems, it has been shown that examination and interview with the child add little to the identification of the problems (Rutter &Graham, 1968). Investigators (e.g., Achenbach, 1980: Rutter et al., 1970; Quay, 1977) believe that adequate assessment of adult perceptions of childhood behaviour problems depends on a number of characteristics. These were recently summed up by Verhulst (1995):

1) Standardisation is needed for an instrument to facilitate comparison of findings from different studies, different locations, and different times of data collection.

II) A normative approach (i.e., the child's behaviour be compared with that of children in a reference group of the same age and sex)is essential for testing the generalisability of findings.

III) Multiple informants are needed to provide information about children under different conditions and in different situations.

Two methods have been widely adopted in order to assess parent's perceptions of their children's behaviour; the structured clinical interview (Angold, 1989) and the behaviour rating scales (Rutter, 1967). Both of these methods allow children to be assessed by a variety of individuals including teachers, parents, and psychological professionals. However, while interviews may provide a more objective and fine grained analysis of the child's problems most suitable for clinical diagnosis, behaviour rating scales are more likely to fulfill Verhulst's (1995) criteria. In addition, Aman, Werry, Fitzpatrick, Lowe & Waters (1983) have described four attributes of rating scales that make them attractive for the measurement of childhood behaviour problems:

a) They are simple, feasible, and usually readily accepted by raters. Rating scales involve the rater simply checking a box next to a series of statements about the existence of a behaviour problem in a way that indicates the severity of that problem.

b) If they are well constructed, they emphasise concrete and specific aspects of behaviour. Although this cannot remove elements of subjectivity

completely, the use of large numbers of items usually provide scale scores which enjoy sufficient reliability for clinical and research aims.

c) They are essentially problem oriented in the sense that they define problems of concern to those who take children to psychological and psychiatric services.

d) Such devices have been shown to have considerable validity as diagnostic and epidemiological tools.

In addition, questionnaire rating scales are reported to have a special importance when used for screening or survey objectives. For instance, Rutter, (1967) observed that questionnaires completed by teachers are very useful devices not only because school teachers have the opportunity to observe and compare large numbers of children but also because they are in a position to comment on the practical importance of the child's behaviour in relation to school performance. Parents' reports too are useful and can complement those of the teacher. Indeed a large number of studies have shown that individual problem behaviours are recognized by teachers and parents, with much consistency across different cultures and social groups (e.g., Taylor & Sandberg, 1984).

Furthermore although rating scales are often composed of many items and cover the full range of behavioural constructs of interest, the standardized nature of such scales allows factor and cluster analyses to explore item structure. This in turn allows items loading on particular factors to be summed to produce scores for subscales indicating specific problem areas (Tabachnick & Fidell, 1989). Factor scores are continually more reliable than individual items (Yule, Urbanowicz, Lansdown &Millar,

1984). In this respect, multivariate analysis of behaviour problems reveals consistencies in the identification of broad-band patterns (externalising vs. internalising) and more numerous narrow-band syndromes (e.g., hyperactivity, conduct problems, neurotic symptoms, depression etc.) in spite of differences in specific items present on different instruments (Achenbach & Edelbrock, 1983). These different levels of differentiation may meet different aims. For instance, the general distinction between broad-band problems may be useful for general management purposes. By contrast, narrow-band hyperactive, delinquent, aggressive, depressed, somatic and anxious syndromes, may provide a better basis for detecting specific causes and prescribing specific treatments (Achenbach & Edelbrock, 1983). Categories or syndromes based upon empirically derived classification particularly the broad-band internalizing-externalizing distinction have also been found to relate to differences on a variety of demographic, psychological, behavioural and social variables (Achenbach, 1978). Achenbach (1980), for example, reported that Hafner (1975) had found that externalisers had worse academic records, completed fewer grades, were less likely to finish higher schools, had fewer friends, and received poorer mental health ratings. Furthermore, parents of Externalisers have been found to differ from parents of Internalisers in being less strict with their child and less concerned about the child's problems, and in having more overt social problems, more marital separations and more overall pathology (Achenbach, 1980). In addition, factor structure can also be explored to examine the differences and relationships between ratings patterns of psychologically disturbed children by different raters (Touliatos & Lindholm, 1981), as well as adults living in different cultures (Reid, 1995). Rating scales have also been useful in exploring systematic biases in

raters' perceptions of behaviour problems and the level of priority given to behaviour problems by identifying subscales. For instance, Sonuga-Barke, Minocha, Taylor & Sandberg, (1992) compared teachers' ratings of Asian and English children with their actual levels of behavior and identified a tendency of teachers to overestimate activity in the Asian children.

For all these reasons behaviour problem rating scales have gained considerable popularity in the psychiatric literature, particularly in the area of childhood behaviour problems (Achenbach, 1980). In the following section examples of frequently used parents' and teachers' rating scales will be reviewed in terms of factor structure, psychometric characteristics and psychological correlates.

4-1. Using Rating Scales to Assess Parents' Views of behaviour Problems:

Parents play a central role in both the cause of their children's behavioural, emotional and personality problems (Holden & Edwards, 1989), and the referral of those problems to specialist services (Sroufe & Rutter, 1984). A basic research strategy has been to use parent's reports to identify childhood behaviour problems.

4-1-1. The Child Behaviour Checklist (Achenbach, 1978):

It has been suggested that the most widely used and popular problem report measure filled out by parents is the Child Behaviour Checklist (CBCL) developed by Achenbach (McMahon, 1984). This scale follows a normative-developmental approach by recording empirically derived behaviour problems and competencies for specific age groups (Daugherty &

Shapiro, 1994). Most of the behaviour problems were adapted from Achenbach's (1966) factor analytic study of case history data but were reworded to make them more appropriate for parents. The parent version of the CBCL is designed for children aged 2-3 and children aged 4-18. It includes questions about child and parent demographics, the child's competence in school and elsewhere, and a list of 118 specific problems on a 3-point scale. It also contains two open-ended items concerning other physical problems. Parents are asked to rate their children's behaviour in the following way: a 0 if the problem is not true of the child, a l if the item is somewhat or sometimes true, and a 2 if it is very true or often true. A total problem score is computed by summing all O's, l's and 2's (Achenbach & Edelbrock, 1978). The test-retest reliability of these problem over 1 week interval was high (.97;) Achenbach, 1978). Other forms of reliability (inter-parent agreement, .74) and discriminative validity (demonstrating significant differences between normal and clinical subjects) of the CBCL have been documented and support the usefulness of the instrument (Verhulst, 1995). Specific syndrome scales for this instrument were empirically derived through factor analyses of scores obtained from parents. For each sex/age group, a number of narrow-band syndromes were quite similar for different age- ranges with both sexes. Factor analysis yielded 8 syndromes designated as Withdrawn, Somatic Complaints, anxious/ depressed (Internalising categories), Delinquent Behaviour and Aggressive behaviour (externalizing categories), Social Problems thought Problems, and Attention Problems. In addition, second-order factor analyses of narrow-band scales supported the two broad-band groupings of externalizing and internalizing syndromes found with other scales (Verhulst,

1995). Versions of the CBCL have been translated into 25 languages and used in over 450 published studies (Achenbach, Conners, Quay, Verhulst, & Howell, 1989). A new edition of this scale appeared in 1991 which included minor changes in wording, provision for coordinating data from multiple informants and small changes in the scoring profile. (Daugherty & Shapiro, 1994).

4-1-2. The Conners' Parent Rating Scale, (Conners, 1990):

The Conners' Parent Rating Scale (CPRS) is also among the most widely used instruments for clinical and research applications with children because it is easy to apply and there is good evidence for its discriminative validity (Wicks, Nelson & Israel, 1991). In that, the CPRS discriminates between normal and hyperactive children and appears sensitive to drug treatment effects. It also has a stable factor structure (Conners, 1990). Having been used in hundreds of clinical and experimental research studies since its initial development, the validity of the CPRS has been well established applying a number of different methodological techniques (Conners, 1990). Conners initially developed a 93-item parent rating scale. These items were rated with four responses (not at all, just a little, pretty much, very much). Responses were coded as 1, 2, 3, 4. Analysis of the scale revealed eight factors. These were Conduct Problems; Learning problem; Psychosomatic; Hyperactive-Immature; Anxious-Shy; Restless-Disorganised; Obsessive-compulsive; and Antisocial behaviour (Conners, 1990). Norms were based on a sample of children aged 6 to 14 years. The questionnaire was also found to be useful in distinguishing the broad-band dimensions of behaviour problems (externalizing vs. internalizing)discussed earlier. A relatively stable factor structure was reported across a number of

studies (Conners, 1973; Werry, Sprague, & Cohen, 1975). Test-retest reliability over one year was found to range from .40 for the Psychosomatic factor to .70 for Hyperactive-Immature factor (Conners, 1990).

The original 93-item scale underwent a major modification by Conners in 1978 which led to a 48-item scale. The new revised scale was reported to have retained the main features of the original one (Conners 1990). This revised scale yielded a five factor structure. The factors were Impulsive-Hyperactivity, Learning Problems, Conduct Problems, Psychosomatic Problem and Anxiety (Goyette, Conners, and Ulrich, 1978). Although no specific test-retest scores have been reported on the CPRS -48, Conners has assumed that it would have similar reliability to those of the CPRS-93 and the Conners teacher scale (see Conners, 1990). However, in recent Sudanese and Bangali adaptations of the CPRS-48 test-retest reliability was judged to be satisfactory(Al- Awad & Sonuga-Barke, 2002; Pal, Chaudhury, Das & sengupta 1999).

Interestingly, Achenbach & Edelbrock (1983), reported a study that compared the CPRS and the CBCL in a group of referred boys. Achenbach's (1978) Externalising and Internalising scores correlated (.81 and .62) with scores on Conners' (1973) Conduct Problem and Anxiety factors, respectively. Achenbach's. narrow-band scales that corresponded to the scales CPRS & Conduct, anxiety, Hyperactivity, Psychosomatic and Antisocial factors correlated with the CPRS (i.e. scores ranging from.39 to .78, with a mean of .62; (Achenbach & Edelbrock, 1978). The results of this study indicate that the two questionnaires show a good degree of agreement over both broad-and narrow-band scales of behaviour problems.

4-2- Using Rating Scales to Measure Teachers' Views of Behaviour Problems:

After parents, teachers are considered the most important source of information about children's behaviour problems (Rutter et al., 1970). This is because although they are far less familiar with each particular child they have much more information about the age appropriate behaviour of children generally and so are in a position to make culturally appropriate judgments about dysfunctional behaviour. In addition to this, performance at school is particularly important in determining the child's future prospects and so even problems limited to school will still be of clear development significance (Lambert & Sandoval, 1980). Achenbach & Edelbrock, (1983) emphasized the importance of teachers , reports for the following reasons.

(a) Schools are a vital developmental field in which problems arise that may not be clear elsewhere.

(b) School-based social and academic skills are essential for successful adaptive development in the wider society.

(C) By virtue of training, experience and opportunity of observing children in groups, teachers are able to reports aspects of children's functioning not evident to parents.

(d) Teachers' reports are not likely to be affected by family dynamics, although they are affected by the interpersonal dynamics of the school environment.

(e) Teachers are often concerned with and involved in the referral and assessment of children for special services both within and outside the school.

4-2-1. The Teachers' Behaviour Questionnaire (Rutter, Tizard & Whitmore, 1970):

The Rutter child Scale B was developed by Rutter, Tizard & Whitmore in 1967 to be completed by teachers to complement the scores derived from the Parent Scale (PBQ). It was primarily designed to identify clinically significant behavioural disturbances among large groups of children with sufficient accuracy to examine possible relationships with physical, social and cognitive factors. It consists of 26 items that span the same range of problems as the parent scale. The Questionnaire was reported to have satisfactorily achieved this aim for investigations carried out in the Isle of Wight study (Rutter et al., 1970)and in a number of subsequent studies (Rutter et al., 1975). The questionnaire has been used in over 80 studies in many different countries (Elander & Rutter, 1996). Both validity and reliability of the scale are well established (Rutter et al., 1970; Rutter, et al., 1975). The product moment of the test-retest reliability was .89 and the inter-rater reliability was .72 for the total scores (Rutter et al., 1970). However, the most noticeable strengths of the scale are brevity and simplicity that make it highly cost effective in very large samples and where children need to be selected for more intensive assessment (Elander & Rutter, 1996). In terms of validity, the discriminative power of the scale was tested by comparing the scores of children in the general population with the scores of children attending psychiatric clinics for behavioural or emotional problems (Rutter et al., 1970). For a more accurate assessment of validity, the scale's power to discriminate between neurotic and antisocial children was tested. For about 90% of antisocial children and 80% of neurotic children the questionnaire diagnoses and the clinical diagnoses were in agreement (Rutter et al., 1970). Although the scale satisfactorily

discriminates between conduct and emotional disorders, it also shares with other questionnaires of its kind the common characteristic of not being able to differentiate between specific types of emotional disorders (e.g., depression versus generalized anxiety).

Factor analytic studies of the Rutter's scales have shown the characteristic distinction between externalizing problems and internalizing problems (Rutter, et al., 1970) with some support for the distinction between conduct problems and hyperactivity. The original Isle of Wight data of the scale had been re-analysed in 1981 and showed that a hyperactivity factor emerged independent from aggressiveness in several principal component analyses (Elander & Rutter, 1996). However, Venables, Fletcher, Dalais, Mitchell, Schulsinger, & Mednick (1983) examined the factor structure of the Rutter's teacher scale in a primary school population in Mauritius and reported two factors, hyperactiveaggressive; and worry-fearful. The investigators considered these findings to be consistent with those studies that were able to identify one single factor denoting hyperactivity and aggression when the data involved a predominantly normal group (Venables. et al., 1983).

4-2-2. Teacher's Report Form (TRF; Achenbach & Edel 1981):

Similar to the (CBCL) in its format and profile, this scale has also been developed by Achenbach to be completed by teachers. It is designed to get teachers' reports of their pupil's problems and adaptive functioning in a standardised fashion which allows for a comparison of sex and age differences. The teacher is asked to rate a child on 113 behaviour items using a 3-point scale for each item. Social or adaptive competence is

assessed through a series of items that evaluate the degree and quality of the child's involvement in activities (E.g., sports & hobbies), social interaction (e.g., through) organizations and peers), and school history (Daugherty & Shapiro, 1994). The TRF has been shown to differentiate, with a good degree of precision, between psychiatric-referred and non- referred children and it has demonstrated a good concurrent. validity when compared with the Conners Revised Teacher rating Scale (Edelbrock, Greenbaum & Conover, 1985). Test-retest reliability over intervals ranging from one week to four months was between .64 and .89 and inter-rater reliability for teachers was found to be reasonably high (Achenbach & Edelbrock, 1983). Factor analysis of the TRF for 450 boys referred to mental health services showed eight reliable factors, labeled Anxious, Social Withdrawal, Unpopular, Self-destructive, Obsessive-Compulsive, Inattentive, Nervous-Overactive, and Aggressive. Second-order factor analysis yielded the usual two broad-band syndromes: internalising and externalising (Achenbach & Edelbrock, 1983). By employing the TRF with clinically referred and nonreferred 4-16year-old children, Achenbach & Edelbrock, were able to identify externalising and internalising behaviour problems across gender, SES, and race. Problems were reported more frequently for lower SES children and for boys with undercontrolled, externalising behaviours, whereas the problems reported most frequently for girls tended to be overcontrolled, internalising behaviours. Describing it as a sound psychometric instrument for the assessment and classification of behaviour and emotional problems among children, Harris, Trye, and Wilkinson, (1993) employed the TRF in samples drawn from primary and junior schools in South Wales and reported substantial support for its validity.

5-Levels of Agreement Between Parents and Teachers:

Despite the fact that parents and teachers are both in a good position to judge levels of behaviour problems amongst children the levels of correspondence between them are usually only modest (Touliatos & Lindholm, 1981). Findings from various studies have indicated that the correlation between parent and teacher ratings of children's behaviour problems assessed by rating scales rarely reaches 0.4 (Goette, et al., 1978; Verhulst et al., 1988). Peterson, Becker, Shoemaker, Luria, and Hellmer, (1961) found the average correlation between parent and teacher was 0.34. In another study on normative data using the CPRS and CTRS Goyette, et al., (1978), reported that although parent and teacher factor correlations were found to be relatively acceptable (0.41), they were still lower than mother-father correlations (0.51). Using the Behaviour Problem Checklist (BPC), Quay, (1977) reported a comparison of ratings from mothers, fathers, and teachers. The inter-parent correlation were 0.78 for Conduct Problem (CP) and 0.67 for Personality Problems (PP) factors, while the parent-teacher correlation were much lower: 0.33 for CP and 0.41 for PP. This might suggest that the differences between school and home based measures was the result of the situation rather than the rater. In most studies which have examined the status of Hyperactivity in relation to antisocial/aggressive behaviours, there is relatively little agreement between the teacher and par ratings (Conner, 1990).

Furthermore it appears that parents report more problems than teachers. For instance, Vermeersch & Fombonne, (1995), using the CBCL and the TRF, investigated attention and aggressiveness problems among French school-aged children Their results indicated that French parents

reported more aggressive behaviours and attention problems in their children than did teachers. This was confirmed in a study by Touliatos & Lindoholm, (1981) who found that not only did parents report a greater number of behaviour problems in their children than did teachers but also that the correlation between them were generally low or low to moderate.

Elander & Rutter, (1996) reported that reliability and validity were generally better for teachers' ratings than those of parents, and several comparisons between groups of children using both scales (Rutter's) have found significant differences only for the teachers' scale.

This pattern of poor agreement might be in part due to differences in behaviour at home and in the classroom. For instance, the difference between home and school contexts will affect the range of behvaiours that can be meaningfully reported (Achenbach & Edelbrock, 1983). Parents in general are in a better position to observe a greater range of their children's behaviour in many situations and over much longer periods. Teachers have the advantage of being in a position to perceive, compare, and rate the individual child's behaviour among other schoolchildren. This means that teachers can observe the child's social skills, peer relations, and responses to tasks demanding attention, persistence, and organisation (Elander & Rutter, 1996). In other words, teachers are in a better position to observe failures to attend to structured tasks. Conversely, the presence of somatic complaints and delinquent behaviour syndromes in parents' ratings might only indicate parents' greater opportunities to observe these behaviours (Edelbrock & Achenbach, 1983). In addition, children's problems may be a direct response to the social situation at home or school (Emery, 1982; Loeber & Dishion, 1984). A child may be unhappy at home and well adjusted at school and

vice versa (Mitchell & Shepherd, 1966). On the other hand, factors relating to parents' and teachers' rating style might be responsible. That is to say disagreement maybe due to the informants' differing standards for judging the child's behaviour, as well as the different impact that these might have on the child's functioning (Emery,1982).

The choice of informant should be determined by the needs of the particular enquiry undertaken. In this respect, Achenbach and Edelbrock, 1978) emphasized that because observers and situations inevitably influence children's behavior, it is probably more useful to determine which observers' rating are most predictive of other important characteristics than to look for high levels of agreement among different observers. Verhulst, (1995) argues that despite their disagreements, each informant's perspective may validly contribute to the general assessment of a child's needs. For instance, instead of interpreting low agreement between teachers and parents as low reliability, it should recognized that both may contribute valid but different data Discrepancies between teachers and parents may be as informative as agreement between them (Verhulst,1995).

6- Limitations of Rating Scales

While there is no doubt that rating scales offer a standardized, convenient and quick way to assess levels of behavioural adjustment in children they have a number of limitations which must be taken into account.

First, ratings by someone who already knows the child (such as a parent or teacher) may be subject to influences irrelevant to influences that are irrelevant to the child's behaviour (Asher & Wakefield,1990). For instance, Eysenck & Eysenck, (1985) indicated that one important element influencing behaviour ratings is the personality of the rater. For example, neurotic parents may be easily threatened by some behaviours, while some others may be reluctant to admit inappropriate responses in their children's behaviour. In this respect, Asher & Wakefield, (1990) concluded that parents with a high N score on the Eysenck Personality questionnaire tended to report more child behaviour problem. Rutter and Quinton (1984), too, argue that parent psychiatric status would certainly affect the ratings of their children. Maternal mental state or psychiatric symptomatology were closely related to overt inaccuracy in ratings by personality disordered parents (Rutter and Quinton, 1984).

Second, factors in the child, other than their behaviour might influence the ratings. In this way Taylor, Heptanstall, Sonuga-Barke, Sandberg & Bowyer, (1997) reported that parent's might be differentially sensitive to girls' overactivity and tend to adopt a lower problem threshold. The same problem can occur when adults are rating children from different ethnic minorities. As reported earlier Sonuga-Barke et al. (1992) showed that teachers seems, in a similar way to be differentially sensitive to the deviant behaviour of Asian children living in London.

Third, on the other extreme, unfamiliarity with children who have recently joined a class may reduce teachers' accuracy in rating (Rutter et al., 1975). Moreover, the level of disturbance in the class or school of the child being rated might negatively influence a teacher's rating (Elander & Rutter1996).

Fourth, most of the measures reviewed above are primarily designed to examine and assess child behaviour problems in the American culture. Despite this their formats permit cross-national comparisons provided that sufficient attention is given to the need to detect patterns of particular importance in those other countries (see e.g., Verhulst, 1995). For this reason numerous studies have been undertaken to determine whether the factor structure of such Rating Scales would remain essentially unchanged if applied to school-aged children belonging to different cultures.

7-Conclusion

The present paper has attempted to review the various definitions of emotional and behavioural problems and to highlight the difficulties that have been implicated in arriving at a sharp and precise definition. The two broad-band; internalizing (emotional) and externalizing (behavioural) grouping has gained some kind of popularity. However, the Mental Health Special Education (MHSE) Coalition in the USA (1991) and the British Department For Education (1993), suggested a more inclusive definition of emotional or behavioural disorders which has been accepted as well by the WHO in The International Classification of Diseases (ICD) 10th edition. In addition, psychologists have developed special interest in the significance and consequences of behaviour problems perceived within their cultural context. For instance, two contrasting conceptual positions are reported to have influenced the perceptions of behaviour problems and direct research in this area. These are the Culture-specific and Universalism. Bearing this notion in mind, investigation in childhood psychopathology have opted to depend on well developed, acceptable, and applicable approaches to measuring these disorders. Two main theoretical models (the Conceptual-

diagnostic and the Continuous-empirical) have emerged to satisfy this aim. In this endeavor, an important task for experts in childhood psychopathology has been the identification of child behaviour problems and the accurate communication of these to other concerned professionals. One valuable tool in reporting this information is the use of behaviour rating scales. In this respect, parents' and teachers' ratings of children's behaviour are frequently used by mental health professionals in the assessment of childhood deviance and disorder. These scales are simple, feasible, easily understood and responded to by raters. However, before rating scales are ready for use, validity and reliability must be demonstrated, normative approaches must be adopted, and multiple informants providing information about children must be contacted. In response to the claim that psychological disorders may vary in prevalence, course and expression across different cultures researchers have tried to design culturally sensitive studies and attempted to compare findings from culture to culture. Although most of the popular rating scales employed in measuring child behaviour problems are developed in the West, most reported attempts to standardize and use these scales in other societies appear to have been successful. Despite the fact that rating scales are useful and effective in measuring children's behaviour problems, they have also several limitations that should be taken into consideration.

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