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Children's temperament and parenting styles

Each child's social and emotional development is guided by their family and by the wider community and environment in which they are raised. The culture that the child is raised in will also impact on their upbringing and the way that their family and community interacts with them and develops expectations of them.

However, every child also comes equipped with their own individual temperament that strongly influences the way that they react to the world around them. For parents, this can mean the child-rearing style that they wanted to follow before their child was born is not a good fit with the temperament that their child displays. It can also mean that a child-rearing style that was developed through the experience of parenting their first child and worked well with that child, does not work as well with subsequent children.

Reactivity, sociability and self-regulation

A child's temperament can be assessed according to seven broad characteristics: sensitivity, activity level, intensity, regularity, adaptability, persistence and soothability (Ostergren, 2004). Other researchers divide temperament into three characteristics: reactivity, sociability and self-regulation (Bates & Rothbart, 2006). These characteristics do not explain why a child will behave in a particular way or what that child can do, but they do give an indication of how the child will interact with their world.

Sensitivity

The sensitivity of a child refers to how much stimulation—sound, touch, light and so on—it takes for the child to react to any given situation. Parents can get an indication of how sensitive their child is through everyday situations, like whether their child usually wakes immediately when the phone rings or sleeps through undisturbed.

Activity level

A child's activity level refers to how much a child moves about. Parents might observe their child's activity level at nappy changes – does their child lie still or wave their arms and legs around?

Intensity

Intensity refers to how strong or loud a child's reaction is to a change in situation. The Bates & Rothbart (2006) definition describes this as reactivity. Parents can get an indication of their child's level of intensity by observing their child's reaction in scenarios such as when they are hungry or their nappy is wet.

Regularity

Regularity refers to the manner in which a child responds to routine. Parents can get an indication of the regularity of their child by considering whether their child likes to wake or to eat at around the same time each day or seems to change from one day to the next.

Adaptability

The adaptability of a child refers to the way a child copes with change to routine or an intrusion into their space. Parents can observe their child's adaptability in terms of how their child copes with shifting from one activity to the next or a change in their current activity; for example, how their child reacts to getting in or out of the car; or what their child's reaction is when splashed with water unexpectedly in the bath.

Persistence

The persistence of a child refers to the child's level of persistence when developing new skills. Learning new skills is a constant for children in their first years of life, but parents could consider how easy it is to introduce a new food to their child's diet or how their child manages the challenges of learning to crawl or to handle a spoon when they are thinking about their own child's persistence levels.

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Soothability

Some children will be relatively easy to soothe when they are agitated or upset and others will be slower to settle. This is referred to as a child's soothability. (Ostergren, 2004; Colson & Dworkin, 1997)

The elements of each child's temperament are believed to be biological in nature and are thought to be visible from birth (Smart, 2007, Ostergren, 2004). Each child's temperament is unique to that child, and can vary enormously between one child and the next, even within the same family (Ostergren, 2004). However, temperament is not fixed. A child's temperament is likely to change to some degree over the course of that child's life, depending on the experiences they are exposed to (Smart, 2007).

A child's temperament plays a role in their overall wellbeing and can influence the experiences that they have in their life (Sanson, Hemphill & Smart, 2004; Scarr & McCartney, 1983). A child's temperament can also influence their development, relationships and their family.

Parenting style and temperament

When parents have considered their child's temperament, they may wish to think about their own temperament and how it could interact with their child's temperament as their child grows and develops. The way that they choose to parent their child—whether more authoritative or higher levels of warmth—will depend on a number of factors: how they were raised as a child; what pressures or stresses they feel in a given situation; their own temperament; and how they interact with their child's temperament.

Parents' expectations for their children will be strongly influenced by their child's temperament as well as their own temperament. For example, how does a parent who is naturally high on the intensity scale cope with a child who refuses to try a new food?

How well parents' temperaments fit with their child's temperament will have a large effect not only on day-to-day life, but on children's long-term social and emotional development (Ostergren, 2004). Supporting parents to think through the ways that their temperament and their child's temperament will interact in a range of ordinary situations — such as a toddler's tantrum at the shops — is essential. It can sometimes be easy for parents to only think of the impact of their child's temperament on daily life, but it's important to remember that it is a two-way street. Considering the role of both the child's temperament and the parents' temperament can help parents to be proactive and to adopt strategies ahead of time for situations that could be challenging for them and for their child.

Reflection

In your work with parents, how can you help them to think about their child's temperament?

How can you encourage parents to consider their own temperament and the role it plays in their parenting?

How can you support parents to take their child's temperament into account to assist them to be proactive rather than reactive in situations that are common in their daily lives?

Temperament can have long-term effects on development

The Australian Temperament Project is a longitudinal study that looked at the temperament of children from 2,443 rural, regional and metropolitan Victorian families. The Project considered how the interaction of the child's temperament and the parents' parenting style affected long-term developmental outcomes (AIFS, 2012). Results revealed that, for children of particular temperaments, the parenting style that they experienced had a more significant effect on long-term outcomes than for children of other temperaments (Letcher et al, 2004).

For temperamentally vulnerable adolescents — identified as children who rated high on reactivity — better quality parenting that offered higher levels of warmth, lower scolding and yelling, lower levels of physical punishment and higher levels of monitoring and supervision resulted in lower levels of problems (Letcher et al, 2004). Children who were temperamentally 'easier' did not have the same relationship between parenting style and later problems (Smart, 2007).

Temperament can only ever provide parents with a framework to start to grasp the complexity of their child. Taking time to think about the particular nature of their child's temperament can offer an opportunity for parents to reflect on their own innate temperament and the effect it can have on their child, the way they interact with their child, and the way they will develop expectations for their child's behaviour.

Sleep and temperament

One area where supporting parents to learn about their own and their child's temperament can be very useful is when addressing concerns about sleep and supporting families to adopt positive sleep routines.

Many child and family health nurses will have encountered parents that are feeling frustrated and exhausted when it comes to their child's sleep. Many will also have worked with families who are spending hundreds of dollars to employ night nannies to come in to the home or are on a waiting list for a spot in a sleep school. Whether parents are feeling the pressure of returning to work or trying to minimise the change that a new baby will always bring to a family's life, sleep can become a flashpoint.

There is a broad range of advice, much of it contradictory, that is available for parents who are struggling with their child's sleep and the disruption to their own sleep that it can cause. Books, websites, other family members and even well-meaning strangers may all offer their thoughts to parents about the solution to their child's sleeping.

A crucial aspect of the child and family health nurses' role is providing evidence-based information to parents and caregivers. By drawing on a solid evidence base, nurses can help to support families to make it through the challenge of adjusting to the changes to sleep habits that a new baby introduces.

Working with parents to help them to consider not only their child's temperament but their own, can be a challenge. Recognising that their child's behavioural style is intrinsic to the child and not a creation of the parent—particularly during periods of behaviour that can be frustrating—may help.

Controlled comforting: new research

Almost 60 studies have shown that techniques like controlled comforting can help most families reduce their baby's sleep problems. Results from the largest and longest of these studies, conducted in Australia, found that parents who are offered information about these techniques when their baby is older than six months, report improved sleep for their baby and themselves, and that their own wellbeing continued to improve up to when children turned two years of age (Hiscock et al, 2008). The study also accords with the findings of an Australian follow-up study published in 2012 which showed that, at the age of six, there were no long-lasting harms or benefits to children or parents who had used controlled comforting when the child was a baby (Price et al, 2012).

Price's study confirmed the findings of an earlier follow-up study, carried out when the children were four, which also showed that there were no long-term harms or benefits for child, child-parent or maternal outcomes from the use of controlled comforting in infants aged over 8 months.

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Forthcoming changes to the *Diagnostic and Statistical Manual of Mental Disorders*

In May this year, the fifth major revision of the *Diagnostic and Statistical Manual of Mental Disorders*, (DSM-V), will be published. The American Psychiatric Association publishes the DSM, setting a common standard and language worldwide for the full range of mental disorders, including autism and attention-deficit hyperactivity disorder (ADHD).

Classifications in the DSM are determined on the basis of symptoms and the level of impairment that children experience as a result of symptoms. For example, if the child's symptoms are an impediment to them making friends, that could be considered an impairment.

The DSM is a major international diagnostic tool; DSM classifications go on to have an influence in policy decisions, service delivery and research. There are a number of conditions that will have altered classification in the upcoming edition of the DSM, but autism and ADHD are the two that are most relevant for the families that child and family health nurses will see.

International Classification of Disorders

The other guide that is used for diagnosis of mental disorders like autism and ADHD is the International Classification of Disorders (ICD), produced by the World Health Organization. One of the concerns raised by the Olga Tennison Autism Research Centre (OTARC) (Vivanti, 2012) is that there may be two different sets of diagnostic criteria available once the new edition of the DSM is released. The DSM is the major diagnostic guide in Australia; ICD is used in Australian hospitals for disease classification of both inpatients and outpatients.

Autism spectrum disorders

A major change to the forthcoming edition of DSM, particularly from the perspective of child and family health nurses, is a change to the way that autism is classified. Autism has been in the DSM since edition three in 1980. In the new edition, the definition that currently exists as four different subtypes of autism will be merged into one category that will be referred to as autism spectrum disorder.

This will mean that some of the symptoms that are likely to be brought to child and family health nurses as parent concerns, or that could prompt a referral if noticed as part of your practice, may be considered differently as part of an autism assessment.

There will no longer be the diagnostic concepts of:

- autistic disorder
- Asperger's disorder
- pervasive developmental disorder – not otherwise specified (PDD-NOS)
- childhood disintegrative disorder
- the 'triad' of symptoms (social impairments, communication impairments and restricted or repetitive behaviours).

Under the revised definition of autism spectrum disorder in the new edition of the DSM, the presence of 'social/communication deficits' and 'fixated interests and repetitive behaviours' will be key to a diagnosis.

New category: social communication disorder

If children do not show clear repetitive behaviours, but do show the social and communication behaviours currently often thought of as part of the autism spectrum, then they may be diagnosed under the new category of 'social communication disorder': an impairment to the social uses of verbal and non-verbal communication.

There is not yet any funding allocated to support children who are diagnosed with social communication disorder; however, it is likely that a funding review will be conducted after the new DSM is released.

Attention deficit hyperactivity disorder (ADHD)

There will also be a number of changes to the assessment criteria for ADHD, a condition that affects around 5 per cent of children and adolescents. The expected changes in the new edition of DSM are more likely to impact on diagnosis and treatment for adolescents and adults. However, for families seen by child and family health nurses, there are likely to be an additional three hyperactive-impulsive items in the list of criteria for the condition, bringing the total to 12 items in this domain. At present, children under 17 need to demonstrate six of these for an ADHD diagnosis; that number seems unlikely to change.

ASD and ADHD co-morbidity

Under the DSM-IV, people cannot be concurrently diagnosed with both ADHD and any of the autism spectrum conditions. Many children with ADHD experience social and communication difficulties that are

consistent with an autism spectrum disorder and similarly, many children with an autism spectrum disorder experience inattention and hyperactivity symptoms that are consistent with ADHD. Under the DSM-V, this change will allow practitioners to diagnose both an autism spectrum disorder and ADHD concurrently. This change will help to properly classify the range of impairments experienced by children suffering from both of these conditions.

Revising the DSM

The decision to change the way that autism is defined in the DSM was driven by a range of research, including research from the Olga Tennison Autism Research Centre (OTARC) at La Trobe University in Melbourne. The research showed that the different diagnoses that were available under the umbrella term of autism spectrum disorder were being attributed on the basis of severity of symptoms rather than on diagnostic definition (Vivanti, 2012).

OTARC has released a position paper on the DSM changes and hosted a webinar for interested practitioners in mid-February 2013. A recording of the webinar is available on their website at www.latrobe.edu.au/otarc/info/dsm-changes

What these changes could mean for families

It is not yet known what impact the changes to the classification of autism spectrum disorder may mean for Australian families. There have been reports in the US predicting what percentage of people may be affected (ABC News, 2012), including that some people may lose their diagnosis, but there is no way of knowing precisely what is going to happen. What does appear likely is that fewer children will be diagnosed with autism spectrum disorder in the future as a result of these changes to diagnosis requirements. Some of these children may instead receive a diagnosis of social communication disorder; however, some children may receive no diagnosis at all.

OTARC has also raised some concerns about the changes, which child and family health nurses may find reflected in the concerns of parents and families who hear about the forthcoming DSM changes. The major concern is likely to hinge on what these changes may mean for the funding that families qualify for under the federal government's Helping Children with Autism package and also for disability funding in schools.

As this edition of *Community Paediatric Review* is being published ahead of the publication of the new edition of the DSM, there is no information on what changes, if any, the federal government will make to their package of support for families with children diagnosed with autism or to the eligibility requirements for the package. Check the website for the Helping Children with Autism package, www.fahcsia.gov.au/our-responsibilities/disability-and-carers/program-services/for-people-with-disability/helping-children-with-autism, for updates.

The upcoming changes to the diagnostic criteria for autism spectrum disorders have been the spur for mainstream media coverage over the past year. It seems likely that when the DSM-V is published in May, more media coverage will follow. Ensuring that families and their health practitioners—including child and family health nurses—are kept accurately informed about the changes and their impact will be an important and ongoing challenge.

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About the Centre for Community Child Health
The Royal Children's Hospital Centre for Community Child Health (CCCH) has been at the forefront of Australian research into early childhood development and behaviour since 1994. The CCCH conducts research into the many conditions and common problems faced by children that are either preventable or can be improved if recognised and managed early.

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Community Paediatric Review supports child and family health nurses in caring for children and their families through the provision of evidence-based information on current health issues.

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