An Exploration of the Development of Empathy in a Clinical Sample of Preschoolers in Relation to Child and Family Factors

Lindsey G Venesky

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AN EXPLORATION OF THE DEVELOPMENT OF EMPATHY IN A CLINICAL
SAMPLE OF PRESCHOOLERS IN RELATION TO CHILD AND FAMILY
FACTORS

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In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Lindsey G. Venesky

May 2013
AN EXPLORATION OF THE DEVELOPMENT OF EMPATHY IN A CLINICAL
SAMPLE OF PRESCHOOLERS IN RELATION TO CHILD AND FAMILY
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ABSTRACT

AN EXPLORATION OF THE DEVELOPMENT OF EMPATHY IN A CLINICAL SAMPLE OF PRESCHOOLERS IN RELATION TO CHILD AND FAMILY FACTORS

By
Lindsey G. Venesky
May 2013

Dissertation supervised by Kara E. McGoey, Ph.D.

In the current literature base of social-emotional development in early childhood there exists a paucity of research of empathy development due to the complicated nature of empathy in young children. The present study utilizes a preexisting dataset from a local therapeutic preschool program, and its methods include visual analysis, correlations, and independent samples t-tests. Results of the present study found that clinical behavior patterns negatively correlate with empathy development. Further, statistically significant group differences exist in affective empathy for children whose parents have a mental health diagnosis. However, results regarding adaptive skills were not found to be statistically significant. The present study contributes and expands the current literature base by exploring empathy development among a clinical sample of preschool-age children. The present study is also unique in its incorporation of specific family factors.
DEDICATION

This dissertation is lovingly dedicated to my husband, Michael Venesky, my sister, Stacey, and my parents, David and Diane DeBor. Their support, encouragement, and constant love have and will continue to sustain me throughout the successes and trials of life.
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Chapter I: Introduction

As children grow and develop, the numerous skills that they acquire, including those related to physical development, communication, and cognitive development, become essential to their daily functioning. This is especially true of social-emotional skills. Children begin to develop socially and emotionally as infants and continue to acquire appropriate skills, such as self-regulation and social skills, as they progress into early childhood (ages three to eight). Within the early childhood stage children learn to identify, label, and regulate emotions. Furthermore, children do not develop in social isolation but within social contexts, which provide modeling and structure for the acquisition of critical skills. These social-emotional skills directly relate to the child’s self-understanding as well as his or her ability to interact appropriately with others. Therefore, early childhood represents a critical period of human development and strongly influences a child’s later development and ability to function appropriately in various situations (Cole, Zahn-Walker, & Smith, 1994; Kopp, 1982; Merrell, 1996).

Unfortunately, children do not always acquire the social-emotional skills necessary for successful development. When young children lack these essential skills, there can be a variety of negative outcomes, such as the presence of a psychiatric disorder. As early childhood is a critical developmental period, the presence of significant social and emotional problems can be a concern for the development of psychiatric disorders later in life. Preschool-age children have developed to a point where significant behavior problems indicate a potential psychiatric diagnosis and the need for intervention (McDonnell & Glod, 2003; Merrell, 1996; Pavuluri & Luk, 1998; Seed, 1999; Webster-Stratton & Reid, 2003). On the other hand, it is still early enough in
the child’s development to intervene to prevent the problems from escalating.
Understanding typical development in early childhood is critical to understanding and providing support for the problems that can arise when children do not acquire the necessary skills.

A facet of social-emotional development that is not often considered in early childhood is that of empathy. Empathy refers to the recognition of another person’s emotional state, the understanding of that emotional state, as well as the response to that emotional state (Borke, 1971; Dadds, Hunter, Hawes, Frost, Vassallo, Bunn,…Masry, 2008; Howe, Cate, Brown, & Hadwin, 2008; Lovett & Sheffield, 2007). Empathy is also often referred to as a moral motive where most people feel empathetically distressed and motivated to help when witnessing another person’s misfortune (Hoffman, 1978; 2000; 2008; Eisenberg & Miller, 1987). Empathy involves numerous social and emotional skills and allows children to respond appropriately in varying social contexts. The largest growth in the development of empathy and related skills occurs between the ages of three and five. Despite the lack of research in this area, empathy proves to be an important aspect of social-emotional development, especially in terms of the critical skills acquired in early childhood.

**Significance of the Problem**

Within social-emotional development, empathy is a crucial skill whose acquisition helps children to interact appropriately with others through understanding and responding to others’ emotional states and perspectives. The few studies that have evaluated the development of empathy in preschool-age children have found significant relationships between empathy and specific child and family factors. These relationships
are important in understanding empathy within social-emotional development of young children as well as the support children require when they do not develop the appropriate skills. Unfortunately, the empirical support for these critical relationships is sparse (Blair, 2005; Dadds et al., 2008; Dadds et al., 2009; Iannotti, 1978). Further understanding of the interaction of empathy with other child and family factors could lead to practical problem solving in providing appropriate services for young children who experience social-emotional problems due to skill deficits. Unremediated problems that significantly impair these children’s daily functioning may lead to a diagnosis of a psychiatric disorder (McDonnell & Glod, 2003; Pavuluri & Luk, 1998).

As a lack of appropriate social-emotional skills may lead to a child developing significant behavioral problems, an early diagnosis of psychiatric disorders puts children at risk for more severe problems later in life. Research has found significant links between the early development of maladaptive behaviors and subsequent psychiatric disorders (Seed, 1999). For instance, an early onset of ODD and CD have been associated with more aggressive behavior, antisocial personality disorder, and an overall worse prognosis than children with a later onset of these diagnoses (McDonnell & Glod, 2003; McGee, Partridge, Williams, and Silva, 1991; McGee, Williams, & Feehan, 1992). Furthermore, research has revealed that children diagnosed with ADHD have an increased likelihood of developing a substance-use disorder in adolescence and adulthood, although this likelihood significantly decreases with the use of medication along with other forms of treatment (Biederman, Wilens, Mick, Spencer, & Faraone, 1999; Goldman, Genel, Besman, & Slanetz, 1998). Thus, it is critical to understand these early concerns in social-emotional development and use preventive measures to address
these problem behaviors before they escalate and further impair the child’s functioning. Although many social-emotional skills are connected with empathetic understanding of others, research has not evaluated the connection of these significant behavior problems to empathetic skills specifically.

Understanding early risk factors associated with later psychiatric disorders will help in the effort of identifying and providing interventions as soon as possible, such as in the preschool years (Seed, 1999). The preschool years provide an ideal opportunity to intervene with such social-emotional behavior problems. At this point, preschool-age children have developed to an extent where significant behavior problems indicate a potential psychiatric diagnosis and the need for intervention. On the other hand, it is still early enough in the children’s development to intervene to prevent the problems from escalating. Empathy plays a vital role in social-emotional development and has been found to interact with other child and family factors. Further evaluating the complex relationship of empathy and specific child and family factors will add to the current literature base and expand our understanding of the social and emotional experiences of preschool-age children, especially those who suffer significant behavior problems.

**Theoretical and Relevant Literature Base**

**Social-Emotional Development**

Although often described as a single phenomenon due to the complex interaction involved, social-emotional development is comprised of two developmental paths. In order to understand social-emotional development as it relates to young children, it is important to first understand the two distinct paths of emotional development and social development. Emotional development begins in infancy, during which time children
express emotions generally based on the immediate situation and/or environment. The child’s emotional experiences begin with simple polarity (positive or negative), evolve to include a variety of emotions, and then the child is able to regulate those emotions, which is typically achieved by middle childhood. Much of emotional development, including self-regulation, is influenced by social interactions between the child and his or her caregivers. The child’s acquisition of skills related to emotional development through social interaction inevitably leads to the child’s overall social development.

Social development can be explained by two relevant theories: Erikson’s Theory of Psychosocial Development and Social Learning Theory. Erikson’s theory for social development across the lifespan includes eight stages where the individual must find a balance in a specific developmental issue in order to move on to the next stage. The stages relevant to early childhood are that of Autonomy vs. Shame and Doubt and Initiative vs. Guilt, which typically occur during ages one to three and four to six, respectively. During the stage of Autonomy vs. Shame and Doubt toddlers quickly acquire skills in a variety of domains (e.g. communication, coordinated movement, social skills, etc.). It is important for the child to exhibit an appropriate level of self control while gaining self esteem in his or her ability to act independently. The parents’ role is very important in this stage as they provide boundaries that should help the child to achieve this balance. The stage of Initiative vs. Guilt involves the child internalizing behaviors and attitudes that were modeled by his or her parents. The child uses these internalized rules to guide his or her behavior toward a specific goal. As in the previous stage, the environment set up by the parents plays a vital role in the child achieving this balance. Similarly, Social Learning Theory describes how children learn by observing
and imitating the behaviors of others (Bandura, 1977). Bandura (1986) has since refined his theory, now referred to as Social Cognitive Theory, to encompass the cognition that accompanies this development. Internal factors, behavior, and environmental factors interact and influence the individual where the individual organizes and understands the present situation or experience (Bandura, 1986). Young children learn a variety of skills by observing others and are often able to use those skills in a variety of situations.

A social-cognitive development theory that is also relevant is that of Piaget. Specifically, in his Preoperational stage, from approximately two to seven years of age, young children are able to represent their experiences in language and beginning to form more sophisticated concepts. Egocentrism is a key component of this stage where young children perceive the world solely from their own point of view. It is not until later in this stage where children begin to understand the perspective of others can be different from their own. Thus, perspective-taking becomes a critical feature of development through this stage.

Within typical social-emotional development, children acquire critical skills related to identifying and regulating emotions as well as appropriately interacting with others. These skills directly relate to the development of empathy in young children. As they develop empathy, children learn to identify and understand the emotional states of others as well as respond appropriately to those emotional states. Empathy is a complex experience and is comprised of a developmental path all its own.

**The Development of Empathy**

The general definition of empathy previously described was further developed to encompass two subtypes: cognitive and affective empathy (Blair, 2005; Burke, 1971).
Cognitive empathy involves the recognition and understanding of another’s emotional state, while affective empathy involves the emotional response to the emotional state of another person. Both subtypes of empathy grow out of typical social-emotional development and are dependent on the acquisition of the relevant skills.

Denham (2006) refers to the acquisition of these skills as Social-Emotional Learning (SEL). Emotions are socialized whereby children’s understanding and response to the emotions of others are due to their interactions with others, especially their primary caregivers. Consistent with Social Learning Theory, children learn by observing others. Specifically, children are able to use the emotions modeled by others to recognize the emotions of others. Furthermore, children learn how to respond to the emotional states of others based on how adults respond to the children’s emotions. These skills are essential in the development of affective empathy.

With the acquisition of the necessary skills, a developmental progression of empathy was theorized where social perspective-taking was the foundation (Hoffman, 1975; 1976; 1978; 1981; 2008; Thompson & Hoffman, 1980). Hoffman (2008) proposes a six-stage course of empathy development beginning in the first year of life. Infants cry in response to the distress of another while toddlers will act in a way to diminish their own distress in experiencing the distress of another. Beginning at two years of age, young children make advances in distinguishing self and other and realizing that others experience inner states independent of their own. These basic components of empathy continue to develop until a mature empathetic understanding develops where children are able to empathize with individuals outside of specific situations as well as specific groups of people.
Perspective-taking is thought to involve understanding the thoughts, motives, and feelings of another person, without requiring an emotional response (Gove & Keating, 1979; Iannotti, 1985). Interestingly, when looking at the prosocial behavior of preschool-age children, Iannotti (1985) found that both cognitive and affective empathy are related to the ability of the children to understand the perspective of others.

The process of perceptive-taking is not as simple as it may appear for children this age. Young children are not able to understand the perspective of another until the decentering process occurs where the children is able to understand that another’s perspective may be different from their own (Piaget, & Inhelder, 1973). Preschool-age children are often able to recognize the emotions of others and utilize perspective-taking skills using situational cues as well as indirect requests by a teacher (Iannotti, 1985). Children are also able to infer the emotions of others and spontaneously exhibit prosocial behavior, such as sharing (Iannotti, 1985). As they develop perspective-taking skills, preschool-age children are able to identify the emotions of others and understand that they may feel differently (Gove & Keating, 1979). Thus, these perspective-taking skills contribute to the development of cognitive and affective empathy.

**Psychopathology in Early Childhood**

The development described thus far is considered typical for young children. Nevertheless, there are always instances where children do not develop along the typical path. In terms of social-emotional development, when children deviate from the norm, they often develop behavior problems. Children who have not acquired the necessary social and emotional skills generally have difficulty functioning within specific contexts (Blair, 2005; Dadds et al., 2009; Iannotti, 1978).
The social-emotional problems that typically arise in early childhood can be divided into two categories: externalizing and internalizing behaviors. Externalizing behaviors comprise antisocial behavior, aggressive behavior, hyperactivity-impulsivity, and inattentiveness (Merrell, 1996). Conversely, internalizing behaviors are characterized by symptoms of depression, anxiety, social withdrawal, and somatic complaints (Merrell, 1996). Deficits in social-emotional skills, such as emotional self-regulation, contribute to these behavioral problems. When these problems begin to interfere with the child’s daily functioning, this is referred to as psychopathology, and a diagnosis is typically made.

However, the behaviors used to diagnose disorders in older children and adolescents do not always present in the same manner in preschool-age children. Some behaviors, such as noncompliance, impulsivity, and hyperactivity, are developmentally appropriate in preschool-age children, and their presence should not automatically be assumed to indicate a disorder. On the other hand, it is not appropriate to dismiss these behaviors as simply “just a phase” if they are significantly impacting the child’s daily functioning. It is only when a child’s problem behaviors significantly impact his or her daily functioning, including behaviors and interactions with others, that a diagnosis is appropriate. The most common disorders present in preschool-age children are anxiety disorders, depressive disorders, Attention Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD; McDonnell & Glod, 2003). As with other social-emotional problems, behavior disorders can be described as either externalizing or internalizing.
**Externalizing Disorders in Early Childhood.** One of the most common externalizing disorders in childhood and adolescence is conduct disorder (CD), which involves behaviors that generally break societal norms and rules, such as aggression, destruction of property, and theft (American Psychiatric Association, 1994). However, these behaviors are not typically present until adolescence. Thus, there are two disorders that are considered precursors to CD: Oppositional Defiant Disorder (ODD) and Disruptive Behavior Disorder, Not Otherwise Specified (DBD NOS). Disruptive Behavior Disorder, NOS is more often diagnosed in preschoolers, as children at this age may exhibit externalizing behaviors, such as noncompliance and aggression, that significantly impact their functioning but not meet the full criteria for ODD or CD.

Research has shown that Conduct Disorder has its roots in early childhood (Merrell, 1996). Behaviors that shape CD may be present as early as infancy and are often exhibited in a sequential pathway (Conduct Problems Prevention Group, 1992; Shaw, Keenan, & Vondra, 1994). In preschool, these children begin to have discipline problems due to a variety of externalizing behaviors, such as impulsivity, hyperactivity, and noncompliance, which can lead to a diagnosis of DBD NOS. These behaviors then typically develop into ODD by middle childhood and CD by adolescence. The progression of these disorders indicates the importance of recognizing and addressing externalizing behaviors early.

Another common externalizing disorder found in childhood and adolescence is Attention-Deficit/Hyperactivity Disorder (ADHD), which is characterized by a consistent pattern of inattentive, hyperactive, and impulsive behaviors that impair functioning across settings (American Psychiatric Association, 1994). ADHD is often a difficult to
diagnosis in young children as many of the behavior criteria are considered typical for the age group. It is when these behaviors significantly impact daily functioning that a diagnosis is warranted. ADHD is a complex phenomenon that involves a variety of behavior manifestations that children may struggle with including poor self-regulation (Nigg, 2005), difficulties in peer relationships (Larson et al., 2011), lack of behavioral inhibition, and low executive functioning (Barkley, 1997). In general, externalizing disorders present numerous behavioral problems in early childhood that are often difficult to diagnosis and understand within the developmental context of the age group.

**Internalizing Disorders in Early Childhood.** A common category of internalizing disorders that are present in early childhood is anxiety disorders. Anxiety disorders are characterized by excessive worry, irritability, restlessness, and difficulty with daily activities, such as eating and sleeping (Zero to Three: National Center for Clinical Infant Programs, 1994). In addition to anxiety disorders, young children are sensitive to drastic changes and other stressors in their environments. This often can lead to the development of Adjustment Disorder, which involves a disturbance of affect or behavior, such as irritability, anxiety, withdrawal, and occasionally oppositional and other externalizing behaviors, following a specific environment stressor (e.g., death of a family member, removal from primary caregiver(s), etc.; Zero to Three: National Center for Clinical Infant Programs, 1994). Symptoms of Adjustment Disorder can present as similar to other disorders but must involve a specific stressor that triggers the problems that the child is experiencing. Internalizing disorders are less stable over time and are often more difficult to diagnose in young children (Merrell, 1996). Preschool-age children may not be able to express internalizing problems that they may be experiencing,
and it is often difficult for parents to recognize the behaviors that may indicate an internalizing problem.

**Psychopathology and Empathy in Early Childhood**

Despite the importance of understanding social-emotional development in young children, the current literature base connecting psychopathology and empathy in early childhood is scarce. Iannotti (1978) found a connection between aggression and empathy in boys ages six to nine. The boys who were able to use skills related to empathy, such as perspective-taking, exhibited fewer aggressive behaviors and more prosocial behaviors (Iannotti, 1978). Although this study was conducted using a sample of boys in middle childhood, the results indicate the important relationship between social-emotional skills related to empathy and other behaviors, both positive and negative.

Dadds and colleagues (2008) conducted a study of empathy in a clinical sample of preschool-age children using the Griffith Empathy Measure (GEM) and the Strengths and Difficulties Questionnaire (SDQ). The results of the study indicate a relationship between the level of empathy reported by parents and the extent to which the children exhibited both internalizing and externalizing behaviors as reported by parents (Dadds et al., 2008). This study points to the importance of understanding empathy as it relates to problem behaviors, both internalizing and externalizing. Furthermore, early childhood has been found to be a critical time in identifying and addressing these issues to prevent the escalation and development of more severe behaviors later in childhood, adolescence, and adulthood.

**Variables related to psychopathology and empathy.** Empathy develops as a result of numerous variables in a child’s life. Research has found that there are several
factors that impact the development of empathy in young children. Specifically, several demographics were found to impact the development of and ability to exhibit empathetic behaviors in preschool-age children including age, gender, and socioeconomic status (Adams et al., 1993; Zinser, Perry, & Edgar, 1975). As expected, three-year-old children are less likely to exhibit empathetic behaviors than five-year-old children, as a result of the developmental progression of empathy (Adams et al., 1993). Adams et al. (1993) also found that gender interacted with the development of empathy in that preschool-age girls exhibited empathetic behaviors earlier than boys, but by the age of five, girls and boys exhibited empathetic behaviors at the same rate. Although research supports the influence of demographics on the development of empathy, further research would provide additional information on the complex interactions between these variables and empathy in young children.

Specific child and family factors have also been found to impact the development of empathy in young children. Barnett and colleagues (1980) found that parents’ attachment and discipline practices influenced their child’s development of empathy. However, these results were found to differ between mothers and fathers (Barnett et al., 1980). Researchers have found that parenting may be more important than temperament in children’s development of empathy (Cornell & Frick, 2007). The importance of parent and family interactions in the development of empathy is indicated in the research as well as theory, such as Social Learning theory. Nevertheless, it is important to remember that there are a variety of interactions involved in these variables as well.

As stated previously, there are numerous variables related to the internalizing and externalizing behaviors exhibited in young children. Some of these factors include
Problem behaviors, which often lead to the diagnosis of a psychiatric disorder, do not exist in isolation. Research has found that empathy is often related to these problem behaviors exhibited by preschool-age children (Dadds et al., 2008; Dadds et al., 2009). Empathy may be a significant influence in the development of problem behaviors as well as their interaction with others variables.

**Problem Statement**

With the paucity of research in this area, the purpose of the current research study is to evaluate the development of empathy in a clinical sample of preschool-age children. Specifically, this study aims to examine the relationship of empathy development with other child and family factors, including behavior patterns and family dynamics. Previous research has assessed individual relationships but has called for additional research in understanding the multiple relationships expected to exist between empathy and child and family factors (Blair, 2005; Dadds et al., 2008; Dadds et al., 2009).

**Research Questions and Hypotheses**

In this study, the following research questions and hypotheses will be posed.

**Research Question 1**

What is the relationship between a child’s development of empathy, as indicated by Griffith Empathy Measure scores, and his or her clinical and adaptive behavior patterns, as indicated by BASC-2 scores?

**Hypothesis 1.** A child’s development of empathy has a negative relationship with his or her clinical behavior patterns.
Hypothesis 2. A child’s development of empathy has a positive relationship with his or her adaptive behavior patterns.

Hypothesis 3. Children who display externalizing behaviors will exhibit lower developmental levels of affective empathy than children who display internalizing behaviors.

Research Question 2

What relationships do family factors have with a child’s development of empathy?

Hypothesis 4. Children whose parents have a mental health diagnosis will exhibit lower developmental levels of empathy than those children who do not.

Hypothesis 5. Children with a history of CYF involvement will exhibit lower developmental levels of empathy than those children who have never experienced CYF involvement.

Hypothesis 6. Children who were exposed to controlled substances in utero will exhibit lower developmental levels of empathy than those children who were not exposed to controlled substances.

Summary

Social-emotional development is essential to young children’s overall development as well as daily functioning. As a part of development, children acquire set of skills that aid them in a variety of emotional and social contexts. Within social-emotional development is the development of empathy, which involves understanding and responding to the emotional states of others. Early childhood proves to be the critical developmental period for the acquisition of social, emotional, and empathetic skills.
However, a lack of these skills leads to many preschool-age children experiencing significant behavior problems, and some to the extent of requiring a psychiatric diagnosis. There is a dearth of research in this area, specifically as to how these developmental skills interact with other child and family factors. The current study aims to add to and expand the current literature base by evaluating the relationship between the development of empathy in early childhood and other child and family factors, such as behavior patterns and family dynamics.
Chapter II: Literature Review

The first five years of life are a critical period of development in which children establish relationships, interact with their environment, and acquire skills that will be necessary for a successful life. Unfortunately, some young children develop maladaptive behaviors that significantly impact their daily functioning and prevent them from further developing the necessary skills to ensure success as they grow. Children may be aggressive or noncompliant, may be anxious or seem depressed, or may exhibit all of these behaviors. These problem behaviors create distress in their own lives, in their family, and in their classrooms, and will continue to escalate if they are not addressed (Merrell, 1996; Seed, 1999; Webster-Stratton & Reid, 2003). Prior to understanding and addressing the potential needs that these children may have, however, it is important to be aware of the typical course of social-emotional development and the critical skills that children learn early in life.

**Developmental Sequence of Social-Emotional Skills**

As children grow and develop, they acquire skills that are critical for their current and future development. These skills begin to emerge shortly after birth and continue to develop as children grow, interact with others, and increase their understanding of themselves and their environment. Each of the social-emotional skills that a child develops builds on previous skills and then leads into the development of future skills that impact functioning in various aspects of life.

**Emotional Development**

Emotional development begins in infancy, during which time children express emotions generally based on the immediate situation and/or environment. Emotional
experiences begin as simply positive or negative and then evolve to include a variety of emotions that the child learns to identify and label. Emotional self-regulation follows, and as a complex process, involves the child acquiring numerous skills to achieve regulation (Siegler, Deloache, & Eisenberg, 2006). Once children learn to recognize and identify a variety of emotions, they then learn to manage their response to the physical arousal that accompanies emotions.

Much of emotional development, including self-regulation, is influenced by social interactions between the child and his or her caregivers. Parents and families provide the context in which children observe and learn how to appropriately identify, express, and regulate emotions. As children learn to identify emotions through social interaction, their ability to regulate their own emotions depends on the regulation provided by the caregiver in the early years of life (Siegler, Deloache, & Eisenberg, 2006). For instance, when parents consistently meet the needs of their child as an infant, the child learns that his or her needs are able to be regulated and begins to regulate them independently as he or she develops into early childhood. Thus, emotional self-regulation is typically achieved by middle childhood. Children continue to grow in their understanding of more complex emotions as well as their social manifestations as they enter adolescence (Denham, 2006). Thus, the child’s acquisition of skills related to emotional development through social interaction inevitably leads to the child’s overall social development.

**Social Development**

Social development begins with the attachment between the infant and his or her caregiver. This first relationship is crucial to the child’s overall social development as well as to the nature of the child’s relationships in the future (Brazelton & Greenspan,
The child’s development continues from this point of attachment as he or she develops other relationships and gains a level of self-understanding (Thompson et al., 2006). Several theories further elaborate on the social aspects of development.

**Erikson’s Theory of Psychosocial Development.** Erik Erikson proposed eight stages of development throughout the lifespan in which the individual must resolve a specific developmental issue. Typically, the individual finds a balance within each developmental stage and acquires the appropriate skills to successfully move on to the next stage. Each of Erikson’s stages is briefly described below in terms of the developmental issue that must be resolved (Siegler, Deloache, & Eisenberg, 2006).

**Basic Trust versus Mistrust (birth to 1).** In the first year of life, infants must develop trust in their caregivers to find balance in this stage. Infants must trust that caregivers will consistently provide for them and fulfill their needs as they arise (e.g. feeding, social interaction, etc.). With these needs are met, infants learn that others can be reliable and trusted. Warm interactions with his or her caregivers allow infants to develop a comfort with other people and to be reassured by their presence and ability to provide appropriate care. However, if these critical needs are not met, infants develop a sense of mistrust and often have difficulty forming intimate relationships later in life.

**Autonomy versus Shame and Doubt (ages 1 to 3½).** In the toddler years, children begin to become more independent as they learn to walk and talk as well as develop basic self-help skills, such as feeding themselves. Over these years, children increasingly desire to make their own decisions and to try new things without the assistance of an adult. With this new mobility and sense for independence, children are
often at odds with their parents’ attempt to teach them what is appropriate behavior and what is not. When parents provide a structured, yet supportive environment, children will achieve self-control without losing any self-esteem. This lends to the development of autonomy and the balance for this stage of life. Nevertheless, some parents resort to severe punishment and ridicule in an attempt to control their child’s behavior. This leads the child to doubt his or her abilities and develop a sense of shame.

**Initiative versus Guilt (ages 4 to 6).** In the preschool years, children begin to internalize the rules and values of their parents and they set goals for their own behavior (e.g. learning the alphabet, building blocks, etc.) and work to achieve these goals. However, children also feel guilt when unable to live up to the standards put forth by their parents. The critical balance during this stage is between initiative and guilt where children develop their own goals and continue to try to meet them or develop the sense of worry and fear of never being able to achieve them. As in previous stages, the environment structured by the parents is essential for the child to find the proper balance between initiative and guilt.

**Industry versus Inferiority (ages 6 to 11).** As children continue to grow and begin formal schooling, they master the cognitive and social skills that are a part of the culture in which they live. This is a crucial time for ego development as children learn and accomplish skills related to school and social interactions. This is the first stage where environments outside of the family have a significant impact on the child’s development. Children must learn to navigate school, peer relationships, and the larger social world. When children find success in these experiences, they develop a sense of
competence and the ability to work diligently, referred to as industry. On the other hand, failure breeds feelings of inferiority or inadequacy.

**Identity versus Role Confusion (ages 12 to 18).** Once the ego develops, identity can be formed in adolescence. Adolescents experience drastic changes physically, emotionally, and socially as they near adulthood and increased responsibility. These changes can cause confusion as adolescents try to figure out who they are and where they fit in their world. They must move on from their lives as children and prepare for their future as adults. If adolescents do not form an identity, they will continue to be confused in their roles as they become adults.

**Intimacy and Solidarity vs. Isolation (ages 19 to 35).** As adolescents begin their journey as adults, they start to develop intimate relationships through friends, significant others, marriage, and the beginning of a family. Young adults search for mutually satisfying relationships with others as they seek companions and love. If young adults are successful in these searches, they can experience intimacy on a deeper level and further gain a sense of themselves in the larger social world. Without these successful relationships, young adults may feel isolated and distant from other people. In this case, young adults find it more difficult to create satisfying relationships and often develop a general sense of disconnect from the larger social world.

**Generativity vs. Stagnation (ages 36 to 65).** As young adults grow further into adulthood, work often becomes the focal point of life. It is during this stage that adults tend to be involved in creative and meaningful work, whether it is a career or work surrounding the family. This is the opportunity for adults to pass along values and traditions consistent with the family’s culture to their children. Adults want to take care
of others and be productive in a way that contributes to society, which Erikson refers to as generativity. However, the “mid-life crisis” often occurs during this stage where adults must face major life changes, such as work changes as well as children growing and leaving home. Adults must resolve this crisis along with finding balance in this stage to prevent feelings of stagnation and meaninglessness.

**Integrity vs. Despair (ages 65+).** Late adulthood is the time for reviewing one’s life and evaluating its meaning. In Erikson’s theory, integrity refers to feeling fulfilled and that one has made a contribution to life. In this stage, adults’ assessment of life is more general and encompasses a larger worldview where death is simply the completion. However, adults may see failures in their life and fear death as they search for meaning in their experiences. This struggle then leads to despair. Older adults must find the balance in reflecting on their experiences and finding meaning in their lives.

Although Erikson’s Theory of Psychosocial Development is often interpreted as a phenomenon that an individual must resolve independently of others, there is a social element with each stage. Each stage involves social interaction at some level in order to master the skills associated with it. For instance, in the third stage of Initiative versus Guilt, a preschool-age child must learn to internalize the rules set by his or her parents to learn to control his or her own behavior when attempting to reach goals. The child cannot find balance in this stage without the social interaction inherent in his or her parents setting boundaries for behavior. Thus, each stage within Erikson’s theory encompasses social interactions and learning through social contexts. Furthermore, individuals develop through five of the eight stages of Erikson’s theory between infancy and early adulthood, highlighting the importance of these developmental years.
Social Cognitive Theory. Albert Bandura expanded typical social development to include the way people learn through social interaction. Specifically, children learn through observing and imitating the behaviors of others (Bandura, 1977). Initially, children learn from their parents and then from their peers as they grow and place more importance on their peer relationships. Bandura’s initial theory, Social Learning Theory, has since been refined to encompass the cognition that accompanies this development, now referred to as Social Cognitive Theory. Inner states are comprised of cognitive activities and sociocultural contexts (Bandura, 1986). The relationship between cognition and context leads to action where people organize and understand their environment. Thus, internal factors, behavior, and environmental factors interact and influence the individual (Bandura, 1986). As these skills develop, young children work to understand and organize their environment within social contexts, therefore learning from these interactions and situations.

Over the decades, Bandura further developed his theory to include perceived self-efficacy, which refers to the extent to which an individual believes he or she can effectively control his or her own behaviors, thoughts, and emotions (Bandura, Capara, Barbaranelli, Gerbino, & Pastorelli, 2003). When parents set boundaries for their children, they provide a context for which the child can develop a feeling of self-efficacy. In terms of emotions and social development, parents allow the child to develop skills related to controlling his or her own behavior. Moreover, emotional self-regulation, in which children are beginning to regulate their own emotions and behavior and evaluate their ability to do so, is a skill that typically develops during middle childhood, generally between seven and eleven years old. Young children observe their parents and learn how
to control their behavior and regulate their emotions. Children initially imitate their parents’ behavior in response to different situations and learn to regulate their own behavior by determining what behavior is successful with that situation. Bandura’s theory of social learning helps to explain how children are able to develop critical skills related to social and emotional development.

**Piaget’s Theory of Social-Cognitive Development.** Jean Piaget proposed four stages of cognitive development that build upon each other and are essential to a child’s understanding of the world. Although cognitive in nature, these stages interact with social-emotional development in critical ways. Each of Erikson’s stages is briefly described below in terms of the developmental issue that must be resolved (Siegler, Deloache, & Eisenberg, 2006).

**Sensorimotor stage.** From birth to two years of age, infants’ cognition developments through their sensory and motor abilities as they perceive and explore the world around them. This information allows them to construct the very basic of concepts, such as time, space, and causality, although their experience is largely based on the immediate environment and their perceptions and actions. Object permanence is an important skill that infants develop in this stage (around 8 months old) where they realize that objects continue to exist even when they are out of view.

**Preoperational stage.** Young children, from approximately two to seven years of age, are able to represent their experiences in language and mental imagery, which allows them to store memories longer and to begin to form more sophisticated concepts. However, young children are still unable to reason through more complex scenarios. Egocentrism is a key component of this stage where young children perceive the world
solely from their own point of view. It is not until later in this stage where children begin to understand the perspective of others can be different from their own.

**Concrete operational stage.** From seven to 12 years of age, children can reason logically about concrete concepts and events. Children are able to solve logical problems that may require attention to multiple dimensions of understanding, but purely abstract concepts are still difficult for them to grasp. Children in this stage also struggle with thinking systematically in imagining alternative combinations of variables and situations.

**Formal operational stage.** Following 12 years of age, adolescents can think deeply about concrete events as well as abstract and hypothetical situations. This level of cognitive development allows adolescents to gain insight into the infinite possibilities within one’s experience. They are also able to reflect on deep questions about truth, justice, and morality. However, Piaget posited that not all people reach the formal operational stage.

**Early Childhood as a Critical Time for Social-Emotional Skill Development**

Due to the interactive nature of social and emotional development, it is appropriate to refer to this developmental sequence as social-emotional development. Across social-emotional development, the years of early childhood are extremely important. Early childhood is typically understood to include the ages three to eight. Children in this age group are also referred to as preschool-age children as most children attend preschool at this age prior to formal schooling. In addition, these ages correspond with the stage of emotional development when children learn to identify, label, and regulate emotions. These skills directly relate to the child’s self-understanding as well as his or her ability to interact appropriately with others. Hoffman (2008) describes the
development of empathetic behaviors in young children, specifically as children begin to understand the distinction between self and other including other others’ inner states (thoughts, feelings, desires) are independent of one’s own.

Furthermore, Erikson’s and Bandura’s theories of social development point to the importance of skills developed in early childhood. Erikson’s stage of Initiative vs. Guilt typically occurs during ages four to six. This stage involves the child utilizing standards internalized by what was modeled by his or her parents in regulating his or her own behavior in an attempt to reach goals. The modeling involved in learning behaviors relates to Social Learning theory and highlights the significance of early childhood in which children act on the behaviors that they have learned from others. Therefore, early childhood represents a critical period of human development and strongly influences a child’s later development and ability to function appropriately in various situations.

**Social-Emotional Problems that Arise in Early Childhood**

As early childhood is a vital developmental period for the acquisition of social-emotional skills, problems can arise when these skills are not appropriately acquired. With research support, federal legislation is passed to address these problems in young children. The Individuals with Disabilities Education Act (IDEA) was reauthorized and expanded to provide services to children in the birth to three age range, who were not included under the provisions of the initial legislation. The expansion of IDEA to provide services to young children reaffirmed and redefined the importance of providing services to the early childhood population (Merrell, 1996). When children do not develop typically, children and their families often require additional support to resolve these problems.
The social-emotional problems that typically arise in early childhood can be divided into two categories: externalizing and internalizing behaviors. Externalizing behaviors comprise antisocial behavior, aggressive behavior, hyperactivity-impulsivity, and inattentiveness (Merrell, 1996). Conversely, internalizing behaviors are characterized by symptoms of depression, anxiety, social withdrawal, and somatic complaints (Merrell, 1996). Deficits in social-emotional skills, such as emotional self-regulation, contribute to these behavioral problems. Although these two broad dimensions can be applied to behaviors of preschool-age children, the specific symptoms may appear differently in children of various ages as a function of age and developmental level (Merrell, 1996; Campbell, 1990). For instance, hyperactivity may look very different in a 4-year-old child in comparison to what is considered hyperactive for a 10-year-old child. Understanding what is developmentally typical for children this age is essential to determining what behaviors are truly problematic and should be addressed.

When a child does not develop typically and does not acquire the necessary skills associated with a particular developmental stage, problems may arise as a result of these skill deficits. When problems that result from such skill deficits begin to interfere with the child’s daily functioning, this is referred to as psychopathology, and a diagnosis is typically made. The manner by which a child arrives at a diagnosis is specific to that child’s developmental experience. This individualized experience is referred to as a developmental pathway that is unique to each child. Developmental pathways relate to the hierarchical-developmental nature of psychopathology, in which behavioral patterns emerge as a result of previous development (Merrell, 1996). Thus, a child’s development
directly impacts future behaviors whereby specific patterns in problem behaviors lead to psychopathology.

**Psychopathology in Early Childhood**

When children experience problems, whether externalizing or internalizing, to the extent that they struggle to function at an appropriate level for their age, a disorder may be present. Psychopathology is a general term that refers to the presence of any diagnosed psychiatric disorder. The most common disorders present in preschool-age children are anxiety disorders, depressive disorders, Attention Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD; McDonnell & Glod, 2003). It is only when a child’s problem behaviors significantly impact his or her daily functioning, including behaviors and interactions with others, that a diagnosis is appropriate.

However, many children who exhibit significant social-emotional and/or behavioral problems are not diagnosed for two reasons: (1) there are limited data on diagnosis and treatment, and (2) diagnostic criteria are often inappropriate for children in this age range (McDonnell & Glod, 2003; Pavuluri & Luk, 1998). Few studies have been conducted that specifically evaluate the diagnosis and treatment of disorders in early childhood. In terms of diagnosing disorders, there are two options for young children. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) provides diagnostic criteria for children, adolescents, and adults (American Psychiatric Association, 1994). The criteria of many disorders in the DSM-IV-TR refer to behaviors that are expected in children over a specific age (e.g., seven years old). An alternative set of diagnostic criteria was developed to serve as a more
appropriate basis to diagnose disorders in young children. The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-3) provides diagnostic criteria appropriate for young children, typically ages birth to three years of age (Zero to Three: National Center for Clinical Infant Programs, 1994). The issue arises for diagnosing disorders of preschool-age children whose age of four, five, or six years old does not fall within the diagnostic range of the DSM-IV or DC: 0-3. This lack of clarity adds additional complexity to understanding the significant problems that some preschool-age children experience.

Furthermore, as previously stated, the behaviors used to diagnose disorders in older children and adolescents do not always present the same in preschool-age children. Some behaviors, such as noncompliance, impulsivity, and hyperactivity, are developmentally appropriate in preschool-age children, and their presence should not automatically be assumed to indicate a disorder. On the other hand, it is not appropriate to dismiss these behaviors as simply “just a phase” if they are significantly impacting the child’s daily functioning. The frequency, duration, and intensity of problem behaviors help to distinguish typical age-appropriate behavior from pathology. A substantial number of preschool-age children who receive a diagnose will continue to exhibit those symptoms 42 – 48 months later, indicating that children who experience significant problems often do not grow out of them (Lavigne, Arend, Rosenbaum, Binns, Christoffel, & Gibbons, 1998). Understanding the specific developmental issue that is contributing to the problem that the child is experiencing allows for a better understanding of the overall problem as well as the impact the problem is having on the child’s daily functioning.
There are a variety of developmental issues that may contribute to both externalizing and internalizing behaviors exhibited by preschool-age children. As previously stated, many preschoolers who exhibit externalizing and/or internalizing behaviors struggle with emotional regulation and the ability to express negative emotions appropriately (Cole, Zahn-Waxler, & Smith, 1994). As a result of such developmental issues, specific behavioral problems lead to the development of disorders. Although there are numerous disorders associated with externalizing and internalizing behaviors, the disorders that are typically diagnosed in early childhood will be discussed in detail.

**Externalizing Behaviors and Disorders in Early Childhood**

Generally, there are two categories of problem behaviors: externalizing behaviors and internalizing behaviors. Internalizing behaviors will be discussed in the next section. Externalizing behaviors refer to behaviors that are exhibited in an outward manner, such as aggression, hyperactivity, defiance, and property destruction. These behaviors are often directed toward another person, situation, or object, and are also easily observable. Thus, there are psychiatric disorders that are aligned with these externalizing behaviors and are referred to externalizing disorders. These disorders can be diagnosed from early childhood into adulthood with different behaviors observed in each developmental stage.

One of the most common externalizing disorders in childhood and adolescence is conduct disorder (CD). Conduct Disorder involves behaviors that generally break societal norms and rules, such as aggression, destruction of property, and theft (American Psychiatric Association, 1994). However, these behaviors are not typically present until adolescence. Thus, there are two disorders that are considered precursors to CD: Oppositional Defiant Disorder (ODD) and Disruptive Behavior Disorder, Not Otherwise
Specified (DBD NOS). ODD is characterized by noncompliance, irritability, and vindictive behaviors (American Psychiatric Association, 1994).

The diagnosis of DBD NOS is appropriate for young children who exhibit some behaviors associated with ODD and CD but do not meet the full criteria for either disorder. Disruptive Behavior Disorder, NOS is more often diagnosed in preschoolers as children at this age may exhibit externalizing behaviors, such as noncompliance and aggression, that significantly impact their functioning, but not meet the full criteria for ODD or CD. Young children often exhibit behaviors that meet the criteria of aggression to people or animals, destruction of property, and/or serious violations of rules (American Psychiatric Association, 1994). Without addressing the externalizing behaviors associated with ODD and DBD, children’s problem behaviors will likely escalate and meet the criteria for CD (Shaw, Keenan, & Vondra, 1994).

In addition to the notion that ODD and DBD are precursors to CD, research has shown that Conduct Disorder has its roots in early childhood (Merrell, 1996). Behaviors that shape CD may be present as early as infancy and are often exhibited in a sequential pathway (Conduct Problems Prevention Group, 1992; Shaw, Keenan, & Vondra, 1994). As an infant and toddler, these children exhibit fussiness, non-compliance, and attention-seeking behaviors beyond what are typical for their age. In preschool, these children begin to have discipline problems due to a variety of externalizing behaviors, such as impulsivity, hyperactivity, and noncompliance. Preschoolers on the pathway to CD are also typically irritable and inattentive. It is typical for preschool-age children who exhibit these behaviors to be diagnosed with DBD. By the start of kindergarten and formal schooling, these children’s behaviors escalate to include aggression and oppositional-
defiant behaviors. These behaviors then typically develop into ODD by middle childhood and CD by adolescence. The progression of these disorders indicates the importance of recognizing and addressing externalizing behaviors early (Shaw, Keenan, & Vondra, 1994).

Furthermore, there are a variety of influences on the developmental pathway to CD that contribute to a child’s development of these behavior patterns. Some of these influences include genetics, family stress, maternal depression, parental education level, poor attachment, and inadequate social skills (Patterson, 1982; Zahn-Waxler 1987). These influences often create an environment that is not conducive to the development of the appropriate social-emotional skills necessary for such children to improve the behavior problems that impair their functioning. Thus, effective treatment for conduct problems includes addressing social, emotional, and cognitive needs of young children while also providing training to teachers and parents to ensure the consistency in treatment and the consideration of all aspects of the presenting problem (Webster-Stratton & Reid, 2003). Moreover, children whose behavioral problems significantly impact their daily functioning require treatment that addresses their behaviors as well as the variety of factors that may influence their behaviors.

Another common externalizing disorder found in childhood and adolescence is Attention-Deficit/Hyperactivity Disorder (ADHD). In 2007, 8.2% of school-aged children were diagnosed with ADHD (Larson, Russ, Kahn, & Halfon, 2011). ADHD is characterized by a consistent pattern of inattentive, hyperactive, and impulsive behaviors that impair functioning across settings (American Psychiatric Association, 1994). Unfortunately, many of the classification criteria for an ADHD diagnosis, such as a
limited attention span and restlessness, are behaviors that are considered typical for young children. However, when these behaviors interfere with a young child’s daily functioning, the formerly typical behaviors now become problem behaviors. Although ADHD is often comorbid with DBD or other conduct disorders, ADHD has specific behavioral manifestations with which young children often struggle (Martel, Gremillion, Roberts, von Eye, & Nigg, 2010). For instance, Barkley (1997) posited that combined aspects of lack of behavioral inhibition, difficulty with sustained attention, and low executive functioning contribute to the behavioral deficits associated with ADHD. Many children with ADHD also struggle with self regulation (Nigg, 2005). However, it is often difficult to identify these deficits as concerns, especially in young children. Many of the deficits and behavior problems associated with ADHD are interconnected with other factors and are difficult to tease apart.

Specifically, some child and family factors often contribute to the particular problem behaviors associated with ADHD. For instance, it has been found that children from low socioeconomic families exhibit more hyperactive behaviors and have greater difficulties in peer relationships (Larson et al., 2011). Thus, ADHD is a complex phenomenon that has a vast research base that supports the patterns that are commonly seen in older children and adolescents (Barry & Kelly, 2006). There is less known about the presence of ADHD in young children, although it is a disorder that often fits the behavioral concerns of young children, similar to DBD.

**Internalizing Behaviors and Disorders in Early Childhood**

Conversely to externalizing disorders, internalizing behaviors refer to behaviors that are exhibited in an inward manner, such as sadness, withdrawal, and anxiety. These
behaviors are typically directed toward the self, and are sometimes difficult to observe, especially in young children who may not be able to verbally express their emotions. Similar to externalizing behaviors, there are psychiatric disorders that are aligned with these internalizing behaviors and are referred to internalizing disorders. These disorders can be diagnosed from early childhood into adulthood with different behaviors observed in each developmental stage.

A common category of internalizing disorders that are present in early childhood is anxiety disorders. Anxiety disorders are characterized by excessive worry, irritability, restlessness, and difficulty with daily activities, such as eating and sleeping (Zero to Three: National Center for Clinical Infant Programs, 1994). Anxiety disorders may be specific (Separation Anxiety, Social Phobia, Specific Phobia) or generalized (Generalized Anxiety Disorder). In addition to anxiety disorders, young children are sensitive to drastic changes and other stressors in their environments. This often can lead to the development of Adjustment Disorder, which involves a disturbance of affect or behavior, such as irritability, anxiety, withdrawal, and occasionally oppositional and other externalizing behaviors, following a specific environmental stressor (e.g., death of a family member, removal from primary caregiver(s), etc.; Zero to Three: National Center for Clinical Infant Programs, 1994). Adjustment Disorder can present as similar to other disorders but must involve a specific stressor that triggers the problems that the child is experiencing.

The developmental pathways for internalizing disorders are less clear than those of externalizing disorders. Internalizing disorders are less stable over time and are often more difficult to diagnose in young children (Merrell, 1996). Preschool-age children may
not be able to express internalizing problems that they may be experiencing, and it is often difficult for parents to recognize behaviors that may indicate an internalizing problem. A child may seem shy, quiet, or sad, but not necessarily indicating a problem. Similar to externalizing disorders, difficulties with social and emotional regulation may influence internalizing disorders as well. In these instances, children may lack the appropriate social and emotional skills to regulate their behavior and thus, resort to more internalizing behaviors, such as withdrawal, as a way to cope with the stress of such situations. Furthermore, some factors that have been found to influence the presence of internalizing behaviors in young children include extreme dependency of young children on their mothers, poor social skills, and maternal depression (Merrell, 1996). As with externalizing disorders, it is important to address all factors involved when treating internalizing disorders in young children.

**Prognosis of Early Onset of Social-Emotional Problems**

An early diagnosis of psychiatric disorders puts children at risk for more severe problems later in life. Research has found significant links between the early development of maladaptive behaviors and subsequent psychiatric disorders (Seed, 1999). For instance, an early onset of ODD and CD have been associated with more aggressive behavior, antisocial personality disorder, and an overall worse prognosis than children with a later onset of these diagnoses (McDonnell & Glod, 2003; McGee, Partridge, Williams, and Silva, 1991; McGee, Williams, & Feehan, 1992). Furthermore, research has revealed that children diagnosed with ADHD have an increased likelihood of developing a substance-use disorder in adolescence and adulthood, although this likelihood significantly decreases with the use of medication along with other forms of
treatment (Biederman, Wilens, Mick, Spencer, & Faraone, 1999; Goldman, Genel, Besman, & Slanetz, 1998). Thus, it is critical to understand these early concerns in social-emotional development and use preventive measures to address these problem behaviors before they escalate and further impair the child’s functioning.

**Measures of Externalizing and Internalizing Behaviors**

In examining the externalizing and internalizing behaviors in children, there are three commonly used measures: the Child Behavior checklist (CBCL; Achenbach, 1991), the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), the Behavior Assessment Scale for Children, Second Edition (BASC-2; Reynolds, & Kamphaus, 2004), and the Deveraux Early Childhood Assessment (DECA; Naglieri, LeBuffe, & Pfeiffer, 1995). Each of these measures is a rating scale that requires the respondent (e.g., parent, teacher, self) to rate the child’s behaviors to determine the specific behaviors that the child is currently exhibiting.

**The Child Behavior Checklist (CBCL).** The Child Behavior Checklist (CBCL) is a 140-item rating scale used for children ages 18 months to 18 years that include a parent, teacher and youth report (Achenbach, 1991). There are two versions of the CBCL: one for children ages 18 months to five years, and another for ages 6 – 18. The items comprised in this measure can be grouped into subscales: Aggressive Behavior, Anxious/Depressed, Attention Problems, Delinquent Rule-Breaking Behavior, Social Problems, Somatic Complaints, Thought Problems, Withdrawn, Externalizing, Internalizing, and Total Problems.

In terms of psychometric properties, the CBCL was found to have good reliability and validity (Achenbach, 1991). Measures of reliability, including test-retest (r = .89) and
inter-rater reliability (average r = .57; Achenbach, 1991) were found to be satisfactory. Criterion validity was also assessed and found to be acceptable (r = .85; Achenbach, 1991).

**The Strengths and Difficulties Questionnaire (SDQ).** The Strengths and Difficulties Questionnaire (SDQ) is a 25-item rating scale for children ages 3 to 16 that includes a report form for parents and teachers and a self-report form (ages 11 – 16; Goodman, 1997). The responses on the SDQ are reported as a total score as well as scores on five subscales: Hyperactivity, Conduct Problems, Emotional Symptoms, Peer Problems, and Prosocial Behavior.

In terms of psychometric properties, the SDQ was found to have acceptable reliability and validity (Goodman, 1997). The SDQ is reliable in terms of test-retest reliability (r = .70 - .85), internal consistency (r = .51 – .76), and inter-rate reliability (r = .39 – .62; Goodman, 1997). The SDQ was found to have moderate to high correlations with other behavior measures (r = .78 – .92; Goodman, 1997). Construct validity for the subscales are supported by the results of a factor analyses and found to be adequate (r = .71 – .76; Goodman, 1997).

**The Behavior Assessment Scale for Children, Second Edition (BASC-2).** The Behavior Assessment Scale for Children, Second Edition (BASC-2) is a 100-140-item rating scale used for children ages 2 to 21 that includes a parent, teacher, and self report (ages 8 to 18; Reynolds, & Kamphaus, 1992; 2004). There are three versions of the measure: preschool (ages 2 to 5); child (ages 6 to 11); and adolescent (ages 12 to 21). The responses provided to the BASC-2 are divided into clinical and adaptive scales to determine the specific behaviors that the child is exhibiting. The clinical scales include:
Hyperactivity, Aggression, Conduct Problems (ages 6 – 21 only), Anxiety, Depression, Somatization, Atypicality, Withdrawal, and Attention Problems. The adaptive scales include: Adaptability, Social Skills, Leadership (ages 6 – 21 only), Activities of Daily Living, and Functional Communication. On the teacher forms, the following scales are added to evaluate the child’s behavior in school: Learning Problems (ages 6 – 21 only) on the clinical scales and Study Skills (ages 6-21 only) on the adaptive scales. There are also internalizing, externalizing, and adaptive composites that group the scales appropriately.

In terms of psychometric properties, the BASC-2 has moderate to good reliability and validity (Reynolds & Kamphaus, 2004). Both the scales and composites have high internal consistency (r = .84 – .97) and test-retest reliability (r = .70 – .92; Reynolds & Kamphaus, 2004). Construct validity for the scales are supported by the results of a factor analyses and structural equation analysis (r = .69 – .98; Reynolds & Kamphaus, 2004). Thus, despite the extensive nature of the report forms, the BASC-2 provides a comprehensive perspective of the child’s behavior, including distinction between internalizing and externalizing behaviors. Beyond understanding children’s specific behavior patterns, there are additional skills and behaviors that are critical within social-emotional development.

**The Deveraux Early Childhood Assessment (DECA).** The Deveraux Early Childhood Assessment (DECA) is a measure that examines the protective factors of children ages two to five. The DECA is slightly different than the previously described measures in that it looks at specific protective factors or strengths of a child, such as initiative, self-control, and attachment, as opposed to problem behaviors or other
behavioral concerns. The DECA measure is then used as part of a program to help classrooms intervene appropriately for children who are found to have low protective factors and may warrant additional support.

In terms of psychometric properties, the DECA was found to have moderate to strong reliability and validity. The DECA is a reliable instrument in terms of internal consistency ($r = .80$ and above), test-retest reliability ($r = .55 – .94$), and interrater reliability ($r = .59 – .77$; Naglieri et al., 1995). Construct validity was also found to be moderate for the DECA ($r = – .65$; Naglieri et al., 1995). Overall, the DECA provides a unique, reliable, and valid assessment that evaluates the strengths and protective factors of young children.

**Empathy in Young Children**

A facet of social-emotional development that relates to many behavior patterns is empathy. Although definitions of empathy vary, the consensus among researchers is that empathy refers to the recognition of another person’s emotional state, the understanding of that emotional state, as well as the response to that emotional state (Borke, 1971; Dadds, Hunter, Hawes, Frost, Vassallo, Bunn,…Masry, 2008; Howe, Cate, Brown, & Hadwin, 2008; Lovett & Sheffield, 2007). This general definition of empathy was then developed to encompass two subtypes: cognitive and affective empathy (Blair, 2005; Burke, 1971). Cognitive empathy involves the recognition and understanding of another’s emotional state. This process includes decoding and labeling emotions through words and facial expressions, interpreting situational cues, and taking the perspective of the other person. Affective empathy involves the emotional response to the emotional state of another person. For instance, one may feel sadness upon hearing a friend has lost
a loved one. One makes a connection to the other person’s emotional state and responds to his or her specific situation. Due to the complexity of the empathetic experience, children must gradually develop empathy through the development of the skills associated with cognitive and affective empathy.

**Typical Development of Empathy**

Empathy develops as a result of previously acquired social and emotional skills. The definitions of cognitive and affective empathy illustrate the specific skills that are required for children to exhibit empathy toward others, such as recognizing and labeling emotions. The development of a distinction between self and other is also critical in the development of empathetic understanding. As stated previously, children develop social and emotional skills through their infant and toddler years primarily through interactions with others. Out of the development of social and emotional skills comes the capacity to develop empathy.

**Social-Emotional Learning.** Denham (2006) refers to the acquisition of these skills as Social-Emotional Learning (SEL). Emotions are socialized whereby children’s understanding and response to the emotions of others are linked to their interactions with others, especially their primary caregivers. Initially, the people with whom children interact exhibit a variety of emotions, which the children observe (Denham, 2006). This interaction leads to the development of other skills, such as the ability to recognize the emotional state of another person, and, thus, the development of cognitive empathy. Children are able to use the emotions modeled by others to recognize the emotions of others. Adults in children’s lives also react to children’s emotions, which can be both intense and frequent (Denham, 2006). Given that the adult’s response to the child’s
emotions is appropriate, the child will learn how to appropriately respond to the emotions of others. This skill is essential in the development of affective empathy.

A final dimension of SEL is explicitly teaching children about emotions (Denham, 2006). Although this is not generally necessary for children who follow a typical developmental trajectory of social and emotional skills, there are some children who may require explicit teaching in order to develop these skills, and, in turn, develop empathy. The issue of children who do not acquire skills along a typical developmental course will be discussed in another section of this chapter.

**Perspective-Taking.** As a result of social-emotional learning, children develop critical skills related to social interaction, understanding emotions, as well as empathy. The next step in this sequence is for the child to develop the ability to understand the perspective of another person, including the possibility that the other person’s perspective may be different from that of the child. Perspective-taking is thought to involve understanding the thoughts, motives, and feelings of another person, without requiring an emotional response (Gove & Keating, 1979; Iannotti, 1985). Interestingly, when looking at the prosocial behavior of preschool-age children, Iannotti (1985) found that both cognitive and affective empathy are related to the ability of the children to understand the perspective of others.

The process of perceptive-taking is not as simple as it may appear for children this age. As described in Piaget’s preoperational stage, many children this age still experience egocentrism where it is difficult for them to understand the perspective of another person may be different from their own. However, as children develop through the preoperational stage, a decentration process occurs and perspective-taking skills
develop (Piaget, & Inhelder, 1973). The inference of the emotions of others is a difficult skill for preschoolers to learn, but even more so is understanding why someone feels the way that they do (Gove & Keating, 1979). Children are able to use concrete cues in their environment to prompt the use of perspective-taking and related empathy skills, but they also develop the ability to use these skills without such cues. Preschool-age children are often able to recognize the emotions of others and utilize perspective-taking skills using situational cues as well as indirect requests by a teacher (Iannotti, 1985). Children are also able to infer the emotions of others and spontaneously exhibit prosocial behavior, such as sharing (Iannotti, 1985). As they develop perspective-taking skills, preschool-age children are able to identify the emotions of others and understand that they may feel differently (Gove & Keating, 1979). Thus, these perspective-taking skills exist as a precursor and lead to the development of cognitive and affective empathy.

**The Development of Empathy.** A developmental progression of empathy was theorized where social perspective-taking was the foundation (Hoffman, 1975; 1976; 1978; 1981; 2008; Thompson & Hoffman, 1980). Once young children develop the ability to understand the perspective of others, they are more capable of correctly identifying and appropriately responding to the emotional states of others within varying social contexts (Adams, Summers, & Christopherson, 1993). Along with this theory came the investigation of the development of empathy in young children. Researchers found that there was a developmental progression in children’s ability to correctly identify others’ emotions within social contexts (Adams et al., 1993; Borke, 1971; Iannotti, 1978; Marcus, Telleen, & Roke, 1979). The results of these studies indicate that basics of mature of empathy begin to appear around three years of age, continue to
develop through early childhood and then plateaus by adolescence. However, there has been research to support that empathic precursors begin even earlier in life. Before 4 or 5 years of age, one can empathize but will little or no metacognitive awareness, where young children will display empathetic behaviors without being aware of or understanding them. Hoffman (1978; 2000; 2008) posits that empathy develops, along with the development of cognitive self-other concepts, in six stages. Each stage is described below as discussed by Hoffman (2008).

**Global empathetic distress: Newborn reactive cry.** Infants as early as six months of age cry in response to another’s cry by alert, possibly the first instance of empathy without awareness. Research has found that these infant cries are identical to spontaneous cries of actual distress indicating that the infants are not crying simply out of imitation or a painful reaction to an unpleasant sound (Sagi & Hoffman, 1976; Simner, 1971).

**Egocentric empathetic distress.** By 11-12 months, infants continue to respond to another person in distress by whimpering and watching the victim. However, any action the infant takes toward the victim is an attempt to reduce his or her own distress. This stage refers to egocentric empathetic distress because the focus is on reducing one’s one distress but the situation is contingent on another’s distress.

**Quasi-egocentric empathetic distress.** Around 14-months, children are less likely to cry or whimper empathetically, but begin to move toward a victim in an effort to comfort them through some form of physical touch, such as a pat. These interactions soon become more positive, such as through kissing, hugging, reassuring, and physically assisting. For instance, a 14-month old boy was observed to respond to a crying friend with a sad look, and then took his friend’s hand and brought him to his mother (Hoffman,
1978). These behaviors illustrate that the young children have realized that others exist independently of themselves, however the understanding that others have their own inner states will develop later. This is the beginning of a feeling of concern for the victim, as opposed to simply feeling personal distress due to another’s distress. Hoffman (2008) refers to this as sympathetic distress and believes that this may be the child’s first truly prosocial motive.

**Veridical empathy.** Once a child is two years old, he or she makes major advances in the self-other concept, including the understanding that others have inner states (thoughts, feelings, desires) independent of their own. Hoffman (2008) illustrates this advanced in understanding with David, a two-year-old child. David brought his own teddy bear to comfort a crying friend. When it didn’t work, David paused, ran to the next room, and returned with the friend’s teddy bear. This worked as the friend hugged his own teddy bear and stopped crying. David realized that his friend’s needs may at times be different from his own where he learned from his “quasi-egocentric” mistake of bring his own bear to comfort his friend. This story illustrates the beginning of perspective-taking in young children. Veridical empathy carries the same basic features of mature empathy but becomes more complex with age. For instance, a preschool-age child can empathize with his friend who misses one’s parents while older children can empathize with mixed feelings about a single situation. This advance in understanding also leads to the understanding that people can display emotions that they do not feel and feel emotions that they do not display.

**Empathetic distress beyond the situation.** As children grow and develop in their conception of self and others, they become aware that others can feel emotions (joy,
anger, sadness, fear, and low self esteem) not only in particular situations but in their lives. By middle childhood, children are typically able to understand and empathize with chronic issues in another person’s life, such as illness, poverty, or sadness/depression. Mature empathy becomes “a response to a network of cues from others’ behavior, emotional expression, immediate situation, and life condition” (p. 446).

**Empathy for distressed groups.** Children also begin to understand the troubles of not only individuals, but entire groups or classes of people (e.g. victims of chronic illness, the Holocaust, hurricanes and other natural disasters, etc.). The ability to empathize with a group’s distressing life condition is referred to as an empathy narrative, which typically begins with empathizing with an individual that is then generalized to the group. This mature level of empathy has impacted law, politics, and our society as a whole throughout history. Many social justice movements develop out of this level of empathetic understanding.

The greatest development of empathy and related skills occurred between the ages of three and five. Thus, as in the development of other social and emotional skills, the period of early childhood is critical to the development of empathy.

**Social Influences in the Development of Empathy.** As implied by the description of the studies on the development of empathy, children do not develop these skills in isolation. It is within social contexts where children learn how to correctly identify the emotional states of others and respond appropriately. From the initial social-emotional learning and the development of perspective-taking skills, children learn within social contexts and apply what they have learned to other situations. Specifically, children’s development of empathy corresponds with emotional connections with others.
and their ability to respond to them, usually in an attempt to comfort them (Chapman, Zahn-Waxler, Cooperman, & Iannotti, 1987). Chapman and colleagues (1987) found that the development of empathy positively correlated with the children’s prosocial behavior (e.g., helping others). When a social context was provided through a story, the children were more likely to exhibit skills related to empathy and express a desire to comfort the character in the story. Children recognized and responded to the distress of others based on the social context provided within the study, which indicates the critical nature of the social influences on the development of empathy.

The most important social context for young children is the family, specifically the child’s relationship with his or her parents. Barnett, King, Howard, and Dino (1980) found that young children develop empathy as an internalization of the empathy demonstrated by their parents. Children were more likely to exhibit skills related to empathy when they observed a parent exhibit the skill. This was especially true when the child observed the parent of the same gender (e.g., daughter observing her mother; son observing his father; Barnett et al., 1980). Similar to early social-emotional learning, children observe interactions between their parents and between their parents and others and learn how to recognize and respond to the emotional states of others. Researchers have found that parenting may be even more important than the child’s temperament in his or her development of empathy (Cornell & Frick, 2007). Although there are a variety of interactions between these variables (e.g., discipline style, attachment, etc.), the results suggest the empathy (and related social-emotional skills) exhibited by the parent strongly influence the development of empathy in the child. With the complex nature of the
development of empathy, accurately measuring empathy in young children is equally complicated.

Measures of Empathy in Young Children

Despite the critical nature of the development of empathy through the early childhood years, there is a lack of appropriate measures of empathy for children this age. Many empathy measures for use with older children and adolescents are questionnaires (Bryant, 1982; Garton & Gringart, 2005). However, the reliance on verbal responses for an accurate measure of empathy is inappropriate for younger children (Denham, 1986). Many of these questionnaires are based on self-report, which also poses a problem in early childhood during which time children have yet to develop appropriate insight to accurately respond to questions of this nature (Dadds et al., 2008). In order to resolve these issues, two measures have recently been developed and used to effectively measure empathy in early childhood: the SouthHampton Test of Empathy for Preschoolers (STEP; Howe, Cate, Brown, & Hadwin, 2008) and the Griffith Empathy Measure (GEM; Dadds et al., 2008).

SouthHampton Test of Empathy for Preschoolers (STEP). The SouthHampton Test of Empathy for Preschoolers (STEP) utilizes eight video vignettes of children in emotionally charged situations in which different protagonists interact with other people and exhibit a variety of emotions (angry, happy, sad, and fearful). The measure then evaluates the children’s ability to understand and share the emotional state of the protagonist in the story. Children use a computer program to click on an emotion face that corresponds with each of the four possible emotional states that they feel represents the protagonist’s emotion in the story. Then the children are asked to choose
an emotion face that corresponds to their own emotion after viewing the video vignette. Two scores are generated by the computer program: one for the child’s ability to understand, and one for the child’s ability to share in the protagonist’s emotional state.

Howe and colleagues (2008) found that STEP scores were positively correlated with parental report of their child’s emotional understanding and empathetic responding (r = .50) as well as teacher report of prosocial behavior (r = .61 - .64). STEP scores also indicated a developmental progression of emotional understanding and empathetic responding through the early childhood years. However, STEP showed only moderate concurrent validity with existing measures of empathy (r = .48 - .50; Howe et al., 2008). This, along with other limitations of the study, indicates the difficulty in the development of an appropriate measure of empathy in early childhood.

**Griffith Empathy Measure (GEM).** The GEM was adapted from Bryant’s Index of Empathy for Children and Adolescents (Bryant, 1982). The GEM utilizes the same 9-point Likert scale from strongly disagree (-4) to strongly agree (+4) with zero referring to neither agree nor disagree, but reworded the 23 items in a third person format to be completed by parents, teachers, and/or other caregivers. The GEM also incorporates two subscales: cognitive and affective empathy. Dadds and colleagues (2008) found that the GEM has acceptable internal consistency and test-retest reliability (r = .81; r = .69, respectively). GEM scores based on parent report were consistent with information gathered from direct observation of the children (Dadds et al., 2008). The researchers noted that there was a greater measurement error on the cognitive empathy subscale than the affective subscale, but that this was a similar pattern as other empathy
measures, including Bryant’s Index of Empathy for Children and Adolescents from which the GEM was developed (Dadds et al., 2008).

**Connecting Empathy and Psychopathology in Early Childhood**

Despite the importance of understanding social-emotional development in young children, the current literature base connecting psychopathology and empathy in early childhood is scarce. There are currently two lines of research that are most related to psychopathology and empathy development.

**Iannotti’s Research on Perspective-Taking in Young Children**

Iannotti (1978) hypothesized that perspective-taking is a critical skill for developmental empathy. As stated previously, perspective-taking involves “understanding another’s thoughts and motives as well as feelings” (Iannotti, 1985, p. 47). The skill of perspective-taking relates to cognitive empathy where one can use this skill to understand the emotional states of others. Furthermore, training children in role-taking skills should help the children express empathy toward other, increasing their altruistic behaviors and decreasing aggressive behaviors (Iannotti, 1978). To examine the relationship of perspective-taking skills and empathy, Iannotti (1978) conducted a study utilizing training in role-taking skills. The participants in this study included 60 boys (30 in kindergarten and 30 in third grade), all of whom were from predominately white, middle class schools. The sample was randomly assigned to the training group or the control group. The training group participated in 10 25-minute sessions that trained the children in role-taking skills, such as evaluating the perspective, thoughts, and reactions of a person based on a skit or story that the children acted out. Children were also asked to switch roles so that they were exposed to various perspectives other than their own.
The control group met for the same amount of time, and their sessions included the same stories but were only asked about them and were not required to act out or role play the perspectives in the stories.

To evaluate the participants’ role-taking skills, Iannotti (1978) used Selman’s dilemma’s to measure the children’s ability to provide reasons for behaviors, understand the difference between a person’s belief system and a social system, and realize the effect on behavior using a 6-point classification. To measure empathy, the children were asked to respond to 16 pictures by labeling emotions and determine if the character’s emotions matched the situation (e.g. sad boy at a birthday party). Aggression was measured by presenting situations to the children that would be considered irritating (e.g. being pushed out of line by a peer) and asking the children how they would respond. The final measure of altruism involved giving the children candy and then asking them to donate some or all of their candy to a poor child whose birthday was coming up. The children were left alone to donate in private and eat the remaining candy.

Iannotti (1978) found that the level of role-taking skills increased in both age groups in the training conditions. An increase in role-taking skills was also correlated with an increase in altruistic behavior (Iannotti, 1978). However, the role-taking experiences did not increase empathetic behavior in either group. Iannotti (1978) discusses a potential reason for this as that the measure of empathy was not appropriate. Given that the measure is not standardized nor was previously utilized, this may be an accurate criticism of this study. Furthermore, given the verbal ability of children, especially young children, it may be difficult to examine empathy based on verbal report. Finally, aggression was found to be independent of empathy and role-taking skills.
(Iannotti, 1978). Overall, this study provides useful information in the relationship between training children in role-taking skills and increasing altruistic behavior. Although the results did not support a connection to empathetic behaviors, the limitations of the measure used indicate that more research is necessary in order to understand the development of empathy in young children and how it may relate to other factors, such as aggression and prosocial behaviors.

In another study, Iannotti (1985) sought to examine the skill of perspective taking in a sample of preschool age children. Iannotti (1985) utilized three perspective-taking measures to assess this skill within social contexts with familiar peers and adults. Each measure involved a situation where the child had to make a decision (e.g. choosing an appropriate gift) by taking the perspective of another person. Procedures also included observations (e.g. prosocial behaviors and antecedents to behaviors) and teacher ratings of the children’s prosocial behaviors in the classroom. Iannotti (1985) also used the same empathy measure as described in his previous (1978) study. The participants included 52 children (21 girls and 21 boys), predominately from Caucasian, middle-class families, who attended two classrooms in a local preschool within a small Midwestern city.

In this study, Iannotti (1985) found that the types of role taking (situational vs. emotional) related to different types of prosocial and empathetic behavior. Children could understand the perspective of another based on situational cues when assisted by an adult while they exhibited more spontaneous prosocial and empathetic behavior when they were able to recognize the emotional states of another (Iannotti, 1985). This study illustrates an important relationship between affective labeling and empathy development. When a child is able to label the emotions of others, he or she can
understand the emotional states of others and why their perspectives may differ. These results point to the importance of understanding the development of empathy in young children and the need for further research in this area. Unfortunately, Iannotti (1985) was looking at specific prosocial behavior utilizing a measure of empathy that has not been found to be accurate in measuring empathy in young children.

**Dadds and Colleagues’ Research on Empathy in Early Childhood**

Dadds and colleagues (2008) conducted a study to further the research on empathy development in early childhood. As stated previously, young children often do not have the verbal abilities to appropriately report their thoughts and behaviors related to empathy development. Also, there are no standardized measures of empathy in early childhood. To address these gaps in the research, Dadds and colleagues (2008) developed the Griffith Empathy Measure (GEM) and conducted a large-scale study to standardize the measure. As described above, the GEM was adapted from Bryant’s Index of Empathy for Children and Adolescents (Bryant, 1982), which utilizes a 9-point Likert scale and reworded items that are appropriate for preschool age children. To standardize the GEM, Dadds and colleagues (2008) used 2,612 children ages three to sixteen from schools in Sydney, Australia. The sample was largely Caucasian, from families with both parents living in the home, and with a relatively diverse socioeconomic status. All of the children assessed were referred to a clinic for mental health issues and/or behavioral concerns. Dadds and colleagues (2008) administered the GEM to the children as part of their evaluation at the clinic and conducted statistical analyses to assess reliability and validity as well as the factors included in the measure. The Strengths and Difficulties Questionnaire (SDQ) was also administered to all children in the sample.
In addition to the psychometric properties of the GEM discussed previously, Dadds and colleagues (2008) found that the GEM factored into two subscales that fit the constructs of cognitive and affective empathy. Furthermore, a strong negative correlation was found between the developmental level of empathy and behavioral and emotional problems. A strong positive correlation was found between the developmental level of empathy and prosocial behavior. Furthermore, the results across ages showed a developmental progression of empathy, which is consistent with previous research. The researchers discussed some limitations in the study, including measurement error and a desire for replication and an expanded use of the GEM. Further research in this area would allow for greater understanding in the development of empathy in young children, specifically those who experience emotional and behavioral problems.

**Variables Related to Empathy in Young Children**

Empathy develops as a result of numerous variables in a child’s life. Research has found that there are several factors that impact the development of empathy in young children. Specifically, several demographics were found to impact the development of and ability to exhibit empathetic behaviors in preschool-age children including age, gender, and socioeconomic status (Adams et al., 1993; Zinser, Perry, & Edgar, 1975). Adams and colleagues (1993) used the Borke Empathy Scale (Borke, 1971) that uses pictures and statements that require children to demonstrate an awareness of another person’s feelings and then identify emotions that are considered an appropriate response to a given situation (e.g. sad when a peer refuses to play with the child). The participants included 217 children (113 males and 101 females), ages three to five, from four university preschools in the Southwest United States. As expected, three-year-old
children are less likely to exhibit empathetic behaviors than five-year-old children, as a result of the developmental progression of empathy (Adams et al., 1993). Adams and colleagues (1993) also found that gender interacted with the development of empathy in that preschool-age girls exhibited empathetic behaviors earlier than boys, but by the age of five, girls and boys exhibited empathetic behaviors at the same rate.

Zinser and colleagues (1975) examined specifically the prosocial behaviors exhibited by young children as they related to socioeconomic status. The researchers developed a situation where young children were asked to donate candy to other children where the children on both sides were of varying socioeconomic status. The participants included 56 children (28 four-year-olds and 28 five- and six-year-olds) who attended three kindergarten classrooms in East Tennessee. All participants came from middle class homes. Zinser and colleagues (1975) found that all of the children, regardless of age or their own socioeconomic status, were more generous in sharing their candy with children whom they assessed to be “poor.” This study does not specifically address empathy in young children but is an early study on the prosocial behaviors spontaneously exhibited by young children and its connection to socioeconomic status. Both of the previously described studies point to specific child and family factors that contribute to prosocial and empathetic behaviors. Although research supports the influence of demographics on the development of empathy, further research would provide additional information on the complex interactions between these variables and empathy in young children.

Specific child and family factors have also been found to impact the development of empathy in young children. Barnett and colleagues (1980) used the Feshbach and Roe
(1968) measure of empathy that involves four pairs of narrated slide sequences depicting young children exhibiting emotions in response to various situations. Parents were also interviewed about discipline style using hypothetical situations adapted from Hoffman and Saltzstein (1967). The results indicated that parents’ attachment and discipline practices influenced their child’s development of empathy (Barnett et al., 1980). However, these results were found to differ between mothers and fathers (Barnett et al., 1980). When mothers were found to be more empathetic than fathers, the children viewed empathy as a gender-specific trait, which was reflected in their own empathy development (Barnett et al., 1980). Researchers have found that parenting may be more important than temperament in children’s development of empathy (Cornell & Frick, 2007). The importance of parent and family interactions in the development of empathy is indicated in the research as well as theory, such as Social Learning theory. Nevertheless, it is important to remember that there are a variety of interactions involved in these variables as well.

As stated previously, there are numerous variables related to the internalizing and externalizing behaviors exhibited in young children. Some of these factors include genetics, family stress, maternal depression, parental education level, poor attachment, and inadequate social skills (Merell, 1996; Patterson, 1982; Zahn-Waxler 1987). Problem behaviors, which often lead to the diagnosis of a psychiatric disorder, do not exist in isolation. Research has found that empathy is often related to these problem behaviors exhibited by preschool-age children (Dadds et al., 2008; Dadds et al., 2009). Empathy may be a significant influence in the development of problem behaviors as well as their interaction with others variables.
Summary

The preliminary research on the relationship between the exhibition of externalizing and internalizing behaviors and the development of empathy is promising in illustrating the important interaction between these two phenomena in young children. Research has found that preschool-age children who have acquired the necessary social-emotional skills are more likely to exhibit empathetic and prosocial behaviors. Conversely, the children who have not developed these critical skills are more likely to exhibit externalizing and internalizing behaviors that significantly impact their daily functioning. Despite the paucity of research, empathy appears to be a crucial element in the behaviors, whether positive or negative, exhibited by young children.

However, there are numerous variables that also interact with problem behaviors and empathy that require further research. The display of significant externalizing and internalizing behaviors in young children likely indicates the presence of a psychiatric disorder. The research on problem behaviors and empathy has not included the influence of psychiatric disorders in preschool-age children. By examining the more significant behaviors of children diagnosed with various disorders, the relationship between problem behaviors and empathy may become clearer.

As a critical period of development, the preschool years provide the opportunity to address the concerns of children’s problem behaviors by examining all aspects of the child’s life that may impact their current functioning. Addressing the needs of the child requires considering factors related to the child’s development, behaviors, family, and community. With this information, it may be possible to better understand the critical role that empathy plays in the interaction of these variables and to prevent the child’s
problem behaviors from escalating into more severe behaviors and psychiatric disorders in the future. Specifically, this study aims to evaluate the relationship between behavior patterns and the development of empathy in preschool-age children. Furthermore, particular child and family factors will also be investigated as they relate to the development of empathy in early childhood.
Chapter III: Method

As a result of aforementioned literature base, the paucity of research evaluating specific child and family factors relevant to empathy development in a clinical sample of preschoolers warranted further examination. The present chapter describes the methodology of the study. Specifically, the chapter outlines the purpose, sample, instruments, research design, procedures, and data analysis utilized in the study. The chapter concludes with the specific research questions that the researcher developed to evaluate and contribute to the existing literature base.

Purpose

This study aimed to better understand the development of empathy in preschool-age children as it relates to specific child and family factors. Specifically, the purpose of the study was to evaluate the development of empathy in young children who exhibit significant externalizing and internalizing behavior problems. Other family factors, such as parental mental illness, prenatal substance exposure, and involvement with Children, Youth, and Family services (CYF), were also hypothesized to influence the development of empathy. To that end, the researcher utilized a select subset of data for analysis from a pre-existing data set compiled within a local therapeutic preschool program.

Sample and Participant Selection

Data Source and Collection

This study utilized data from a local therapeutic preschool program, comprised of children who live in the Pittsburgh area and were referred for treatment due to social, emotional, and/or behavioral difficulties. Assessment data were collected every six months, whereby each child within the program was evaluated by a licensed psychologist.
to assess progress and current functioning. The evaluations included a face-to-face
caregiver interview, developmental assessment, examination of the child’s functioning, as
well as his or her relationship with the caregiver. The evaluation of the child’s progress
and current functioning also included data from behavioral measures completed by the
caregiver and teachers and were discussed during the evaluation. The data from these
regular psychiatric evaluations were entered into a database and included assessment
results as well as information about the child and family.

Participants

The participants included in the data set were 25 preschool-age children who
participated in a therapeutic program. The sample included 16 males (64%) and 9
females (36%) between the ages of 3 and 6 with an average age of 4 years, 2 months.
The sample was composed of 64% of the children who identified as African-American
(16 children), 24% identified as Caucasian (6 students), and 12% of the children
identified as biracial (3 children). This convenience sample was chosen due to the
relevant data provided through frequent psychiatric evaluations conducted on each child
as part of their participation in the therapeutic program. A number of agencies and other
entities refer children to the therapeutic program. These entities include Children, Youth,
and Families (CYF) services, school districts, service coordination agencies, and other
early childhood centers. The agencies referred the participants to the program due to
significant behavioral difficulties as well as family factors (e.g. foster care, substance
exposure in utero, etc.) that put the participants at-risk for the development of issues
related to development and behavior. Following an initial evaluation, a psychologist or
psychiatrist determined the child’s eligibility for the therapeutic program. Each child
who participated in the therapeutic program has a psychiatric diagnosis. The diagnoses of the children included in the dataset consisted of Attention-Deficit/Hyperactivity Disorder (13 children), Disruptive Behavior Disorder, Not Otherwise Specified (10 children), Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (8 children), Depressive Disorder (3 children), Anxiety Disorder (2 children), Reactive Attachment Disorder (2 children), and Mood Disorder, Not Otherwise Specified (1 child). Nine children had comorbid diagnoses. Parents completed informed consent for assessment and treatment prior to the intake evaluation and the child’s enrollment in the program. Identifying information was removed from all data prior to entry into the database.

**Instruments**

As part of regular psychiatric evaluations, two instruments measure various aspects of the participants’ behaviors: the Behavior Assessment Scale for Children, Second Edition (BASC-2), and the Griffith Empathy Measure (GEM). Both measures are rating scales that aim to utilize multi-informants (e.g., parents and teachers) to gather the most comprehensive information regarding the child’s behavior at home and in the classroom.

**The Behavior Assessment Scale for Children, Second Edition (BASC-2)**

The Behavior Assessment Scale for Children, Second Edition (BASC-2) measures behavior patterns in children and adolescents. The BASC-2 is a 100-140-item rating scale used for children ages 2 to 21 that includes a parent, teacher, and self report (ages 8 to 18; Reynolds, & Kamphaus, 1992; 2004). There are three versions of the measure: preschool (ages 2 to 5), child (ages 6 to 11), and adolescent (ages 12 to 21). The
responses provided to the BASC-2 are divided into clinical and adaptive scales to determine the specific behaviors that the child is exhibiting. The clinical scales include: Hyperactivity, Aggression, Conduct Problems (ages 6 – 21 only), Anxiety, Depression, Somatization, Atypicality, Withdrawal, and Attention Problems. The adaptive scales include: Adaptability, Social Skills, Leadership (ages 6 – 21 only), Activities of Daily Living, and Functional Communication. On the teacher forms, the following scales are added to evaluate the child’s behavior in school: Learning Problems (ages 6 – 21 only) on the clinical scales and Study Skills (ages 6-21 only) on the adaptive scales. There are also internalizing, externalizing, and adaptive composites that group the scales appropriately.

In terms of psychometric properties, the BASC-2 has moderate to good reliability and validity (Reynolds & Kamphaus, 2004). Both the scales and composites have high internal consistency (r = .84 – .97) and test-retest reliability (r = .70 – .92; Reynolds & Kamphaus, 2004). Construct validity for the scales are supported by the results of a factor analyses and structural equation analysis (r = .69 – .98; Reynolds & Kamphaus, 2004). Thus, despite the extensive nature of the report forms, the BASC-2 provides a comprehensive perspective of the child’s behavior, including distinction between internalizing and externalizing behaviors. Beyond understanding children’s specific behavior patterns, there are additional skills and behaviors that are critical within social-emotional development. Such skills that relevant to this study are related to the development of empathy.

Griffith Empathy Measure (GEM)
The Griffith Empathy Measure is a rating scale that measures the development of empathy in children, specifically preschool-age children. The GEM was adapted from Bryant’s Index of Empathy for Children and Adolescents (Bryant, 1982). The GEM utilizes the same 9-point Likert scale from strongly disagree (-4) to strongly agree (+4), but reworded the 23 items in a third person format to be completed by parents, teachers, and/or other caregivers. The GEM also incorporates two subscales: cognitive and affective empathy. Dadds and colleagues (2008) found that the GEM has acceptable internal consistency and test-retest reliability (r = .81; r = .69, respectively). GEM scores based on parent report were consistent with information gathered from direct observation of the children (Dadds et al., 2008). The researchers noted that there was a greater measurement error on the cognitive empathy subscale than the affective subscale, but that this was a similar pattern as other empathy measures, including Bryant’s Index of Empathy for Children and Adolescents from which the GEM was developed (Dadds et al., 2008).

**Research Design**

The study utilized a small sample longitudinal research design by conducting several statistical analyses to answer the proposed research questions. Each specific analysis is discussed in greater detail in the Data Analysis section below. The dataset included information collected over three time points. However, the researcher only utilized the first time point in analyses due to substantial missing data across the other time points. Further, missing data prevented the use of teacher report data leaving parent report data the sole source of information regarding the participants’ empathy development and behavior patterns.
The independent variables were the family factors identified in the participant sample: the presence or absence of parental mental illness, prenatal substance exposure, and CYF involvement. The dependent variables were empathy development (affective empathy, cognitive empathy, and total empathy as identified by GEM scores) and child behaviors (clinical and adaptive behaviors as identified by BASC-2 scores). The researcher included analyses that evaluated relationships among all variables as well.

**Procedures**

As described above, the sample used in this study originated in a preexisting database from a local therapeutic preschool program. As a result of biannual psychiatric evaluations, data collected from parental report and assessment measures (BASC-2 and GEM) were entered into the database. Parents completed informed consent for assessment and treatment prior to the intake evaluation and the child’s enrollment in the program, acknowledging the use of the child and family’s information for research purposes. All identifying personal information was removed from the database before it was provided to the researcher. The specific portion of the database utilized in this study included the participants with data entered for each of the family factors as well as at least one complete entry of the BASC-2 and GEM instruments. As a result, the analyses examined only the parent report data for the first time point within the database.

**Data Analysis**

**Correlations**

Correlations were calculated to determine the strength and direction of relationships among family factors, empathy development, and child behavior patterns. The analysis included specific family factors: the presence or absence of parental mental
illness, prenatal substance exposure, and CYF involvement. Empathy development was identified by cognitive empathy, affective empathy, and total empathy scores on the GEM. Child behaviors were identified by the use of both clinical and adaptive scores on the BASC-2. A p value of less than .05 was required for significance across the correlations.

**Research Question 1.** What is the relationship between a child’s development of empathy, as indicated by Griffith Empathy Measure scores, and his or her clinical and adaptive behavior patterns, as indicated by BASC-2 scores?

**Hypothesis 1.** A child’s development of empathy has a negative relationship with his or her clinical behavior patterns.

**Hypothesis 2.** A child’s development of empathy has a positive relationship with his or her adaptive behavior patterns.

**Hypothesis 3.** Children who display externalizing behaviors will exhibit lower developmental levels of affective empathy than children who display internalizing behaviors.

**Analysis.** A correlation among specific clinical and adaptive behavior domains as measured by the BASC-2 and empathy development as measured by GEM scores allowed for an evaluation of the relationships among these variables in both strength and direction.

**Independent Samples T-Test**

An independent samples t-test was conducted to determine group differences in a child’s empathy development across family factors. Each child’s empathy development was identified by cognitive empathy, affective empathy, and total empathy scores on the
GEM. The analysis included specific family factors: the presence or absence of parental mental illness, prenatal substance exposure, and CYF involvement. Child behaviors, as identified by the use of both clinical and adaptive scores on the BASC-2, were also included in the analysis. A p value of less than .05 was required for significance for results of the t-tests.

**Research Question 2.** What relationships do family factors have with a child’s development of empathy?

**Hypothesis 4.** Children whose parents have a mental health diagnosis will exhibit lower developmental levels of empathy than those children who do not.

**Hypothesis 5.** Children with a history of CYF involvement will exhibit lower developmental levels of empathy than those children who have never experienced CYF involvement.

**Hypothesis 6.** Children who were exposed to controlled substances in utero will exhibit lower developmental levels of empathy than those children who were not exposed to controlled substances.

**Analysis.** An independent samples t-test allowed for an evaluation of group differences in empathy development and child behaviors across the family factors of parental mental illness, prenatal substance exposure, and CYF involvement. Significant t-test results indicated group differences in scores with regard to other variables. For this study, group differences were determined in the children’s empathy development and behavior patterns in reference to the presence or absence of these specific family factors.

**Visual Analysis**
The researcher utilized visual analysis as an additional method of evaluating the proposed research questions through the use of Tableau Desktop software (Tableau Software, Inc., 2013). Tableau Desktop is an interactive software program that analyzes data through visual representations. Visual analysis allowed for inferences to be made regarding the relationships among variables. Scatterplots were created to visually represent the data in order to examine relationships among variables described in the research questions. Specifically, scatterplots incorporated scores on several subscales of the GEM and BASC-2, which were plotted on opposing axes to illustrate their relationship. Further, the data points were coded by different shapes to represent the family factors of prenatal substance exposure, parental mental illness, and CYF involvement within the relationships represented by the plot. The inclusion of the family factors in the plots allowed for additional analyses illustrating the relationships among numerous variables.
CHAPTER IV: RESULTS

The present chapter provides the results of all analyses conducted to evaluate the proposed research questions. Following a brief description of the preliminary analyses, the chapter outlines the results to each specific research question, including results from both statistical and visual analyses. Tables and figures are included as needed to further illustrate the results.

Preliminary Analyses

The present study conducted analyses using correlations and independent samples $t$-tests. These analyses have two assumptions in common: independent cases and normal distribution. As each case within the sample represents a single child, the data for each case is independent of the others. Due to the small sample size, normal distribution was a concern. As indicated by the Kolmogorov-Smirnov test, some of the scores of specific scales on the BASC-2 and GEM were not normally distributed, such as Somatization, Atypicality, and Total Empathy. However, most of the composite scores (e.g. Externalizing Problems, Internalizing Problems, Adaptive Skills on the BASC-2) were intact in terms of normal distribution. Thus, the composite scores of the BASC-2 were analyzed to maintain this assumption. Conversely, $t$-tests do not require population variances to be equal as some other analyses, such as Analysis of Variance (ANOVA), require indicating the appropriateness of the use of $t$-test procedures in the present study.
Research Questions and Hypotheses

Research Question 1

What is the relationship between a child’s development of empathy, as indicated by Griffith Empathy Measure scores, and his or her clinical and adaptive behavior patterns, as indicated by BASC-2 scores?

Hypothesis 1. A child’s development of empathy has a negative relationship with his or her clinical behavior patterns.

Hypothesis 2. A child’s development of empathy has a positive relationship with his or her adaptive behavior patterns.

Hypothesis 3. Children who display externalizing behaviors will exhibit lower developmental levels of affective empathy than children who display internalizing behaviors.

Analysis. Correlations were calculated to determine the strength and direction of relationships among family factors (parental mental health, prenatal substance exposure, CYF involvement), empathy development (cognitive empathy, affective empathy, and total empathy scores on the GEM), and child behaviors (aggression, externalizing problems, internalizing problems, Behavior Symptoms Index, and adaptive skills scores on the BASC-2).

Results. Visual analysis of these variables indicated a negative relationship between clinical behavior patterns (Externalizing and Internalizing Behaviors on the BASC-2) and empathy (Affective and Cognitive Empathy on the GEM). The trend lines indicated a stronger relationship among affective empathy scores with externalizing and internalizing behaviors with the strongest relationship between affective empathy and
internalizing behaviors (see Figure 1).

Figure 1

*Scatterplot of Clinical Behavior Patterns and Empathy*

Affective empathy has a statistically significant and negative correlation with aggression, externalizing behaviors, internalizing behaviors, and the Behavior Symptom Index on the BASC-2, but a positive and statistically significant correlation with parental mental health (see Table 1).
Table 1

Statistically Significant Correlations with Affective Empathy

<table>
<thead>
<tr>
<th>Variable</th>
<th>Correlation Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression</td>
<td>-.571**</td>
</tr>
<tr>
<td>Externalizing Behaviors</td>
<td>-.542**</td>
</tr>
<tr>
<td>Internalizing Behaviors</td>
<td>-.671**</td>
</tr>
<tr>
<td>BSI</td>
<td>-.468*</td>
</tr>
<tr>
<td>Parental Mental Health</td>
<td>.468*</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01

Those children in the sample who demonstrated high levels of externalizing behaviors overall (hyperactivity and aggression) and aggression specifically were reported to display low levels of affective empathy (r = -.542, r = -.571, p < .01, respectively). Similarly, the children who demonstrated high levels of internalizing behaviors overall (anxiety, depression, and somatization) were reported to display low levels of affective empathy (r = -.671, p < .01). The BSI composite on the BASC-2 includes the hyperactivity, aggression, and depression subscales. The children whose scores on the BSI were elevated also displayed low levels of affective empathy (r = -.468, p < .05), which is expected given the statistically significant correlation with both externalizing and internalizing behaviors. There were no statistically significant correlations among affective empathy and the children’s adaptive behavior scores (adaptability, social skills, activities of daily living, functional communication, and adaptive skills on the BASC-2). Conversely, those children who have parents with mental health diagnoses were reported to display high levels of affective empathy (r = .468, p <
Further, cognitive empathy has a statistically significant and negative correlation with aggression, externalizing problems, internalizing problems, and the Behavior Symptom Index (see Table 2).

Table 2

<table>
<thead>
<tr>
<th>Statistically Significant Correlations with Cognitive Empathy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable</strong></td>
</tr>
<tr>
<td>Aggression</td>
</tr>
<tr>
<td>Externalizing Behaviors</td>
</tr>
<tr>
<td>Internalizing Behaviors</td>
</tr>
<tr>
<td>BSI</td>
</tr>
</tbody>
</table>

* *p < .05

Those children in the sample who demonstrated high levels of externalizing behaviors overall (hyperactivity and aggression) and aggression specifically were reported to display low levels of cognitive empathy (r = -0.477, r = -0.468, *p < .05*, respectively). Similarly, the children who demonstrated high levels of internalizing behaviors overall (anxiety, depression, and somatization) were reported to display low levels of cognitive empathy (r = -0.479, *p < .05*). The BSI composite on the BASC-2 includes the hyperactivity, aggression, and depression subscales. The children whose scores on the BSI were evaluated also displayed low levels of cognitive empathy (r = -0.493, *p < .05*), which is expected given the statistically significant correlation with both externalizing and internalizing behaviors.
Further visual analysis of adaptive behavior patterns and empathy indicated a slight negative relationship with affective empathy and adaptive behaviors (adaptability, social skills, activities of daily living, functional communication, and adaptive skills on the BASC-2) while there was a positive relationship between cognitive empathy and adaptive behaviors (see Figure 2).

Figure 2

*Scatterplot of Adaptive Behavior Patterns and Empathy*
However, there were no statistically significant correlations found among affective or cognitive empathy and the children’s adaptive behavior scores.

**Research Question 2**

What relationships do family factors have with a child’s development of empathy?

**Hypothesis 4.** Children whose parents have a mental health diagnosis will exhibit lower developmental levels of empathy than those children who do not.

**Hypothesis 5.** Children with a history of CYF involvement will exhibit lower developmental levels of empathy than those children who have never experienced CYF involvement.

**Hypothesis 6.** Children who were exposed to controlled substances in utero will exhibit lower developmental levels of empathy than those children who were not exposed to controlled substances.

**Analysis.** An independent samples T-test was conducted to determine group differences in empathy (GEM scores) and child behaviors (BASC-2 scores) as rated by parents across family factors (parental mental health, prenatal substance exposure, CYF involvement).

**Results.** Visual analysis illustrated the distribution of children whose parents had mental health diagnoses and those who did not in relation to clinical behavior patterns (Externalizing and Internalizing Behaviors) and empathy (Affective and Cognitive Empathy on the GEM). The distribution indicated a general trend of lower empathy scores for children whose parents had a mental health diagnosis. Further, the affective empathy scores had a tighter distribution surrounding the trend lines (see Figure 3).
Figure 3

Scatterplot of Clinical Behavior Patterns and Empathy in Relation to Parental Mental Illness

$T$-test results indicated that there were statistically significant group differences in affective empathy for children whose parents received a mental health diagnosis and those children whose parents did not (see Table 3).
Table 3

*Statistically Significant Group Difference in Relation to Parental Mental Illness*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$t$-value</th>
<th>df</th>
<th>Mean Difference</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affective Empathy</td>
<td>-2.484</td>
<td>22</td>
<td>-14.0*</td>
<td>-1.02</td>
</tr>
</tbody>
</table>

*p < .05

The children who had a parent with a mental health diagnosis differed significantly from those who did not in relation to their development of affective empathy ($t(22) = -2.484, p < .05$). The effect size (-1.02) indicated the large effect of parental mental illness on affective empathy.

Further, visual analysis illustrated the distribution of children who had a history of CYF involvement and those who did not in relation to clinical behavior patterns (Externalizing and Internalizing Behaviors) and empathy (Affective and Cognitive Empathy on the GEM). The distribution indicated a relatively even distribution among scores (see Figure 4).
Figure 4

Scatterplot of Clinical Behavior Patterns and Empathy in Relation to CYF Involvement

T-test results indicated that there were statistically significant differences in the Behavior Symptoms Index (BSI) for children who had a history of CYF involvement and those who do not (see Table 4).
Table 4

*Statistically Significant Group Difference in Relation to CYF Involvement*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$t$-value</th>
<th>df</th>
<th>Mean Difference</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSI</td>
<td>-2.259</td>
<td>22</td>
<td>-12.6*</td>
<td>-0.82</td>
</tr>
</tbody>
</table>

*$p < .05$*

As described previously, the BSI composite on the BASC-2 includes the hyperactivity, aggression, and depression subscales. The children who had a history of CYF involvement differed significantly from the children who did not in relation to their BSI scores on the BASC-2 ($t(22) = -2.259, p < .05$). The effect size (-0.82) indicated the large effect of CYF involvement on BSI scores. There were no other statistically significant group differences in empathy development or behavior patterns in relation to family factors.

Finally, visual analysis illustrated the distribution of children who had a history of prenatal substance exposure and those who did not in relation to clinical behavior patterns (Externalizing and Internalizing Behaviors) and empathy (Affective and Cognitive Empathy on the GEM). The distribution indicated a relatively even distribution among scores (see Figure 5). There were no statistically significant group differences in empathy development of behavior patterns in relation to prenatal substance exposure.
Figure 5

Scatterplot of Clinical Behavior Patterns and Empathy in Relation to Prenatal Substance Exposure
CHAPTER V: DISCUSSION

Results of the present study illustrated the relationships among child and family factors within a clinical early childhood population. An initial evaluation of children’s behavior patterns and empathy development indicated a number of significant relationships. The children who exhibited higher levels of clinical behavior patterns, such as aggression, hyperactivity, and depression, demonstrated a lower level of both cognitive and affective empathy. These results were consistent with the first hypothesis of the present study, which posited a negative relationship between empathy development and clinical behavior patterns. This relationship was expected given that children who exhibited higher levels of clinical behavior patterns would often display lower levels of empathetic skills, such as perspective-taking. These skills were often lacking in children who exhibit aggressive, disruptive, or even anxious behaviors.

However, the hypothesized distinction in empathy development in relation to internalizing and externalizing behaviors was not supported as described in the third hypothesis. Children who exhibited internalizing behaviors and those who exhibited externalizing behaviors displayed similar patterns in their development of cognitive and affective empathy. Internalizing and externalizing behaviors were both found to have a significant and negative relationship with cognitive and affective empathy. The difference in how each of these behavioral domains relate to empathy was minimal. These findings may relate to the nature of the children’s presenting problems where the majority of the children included in the study were diagnosed with externalizing disorders (e.g. Disruptive Behavior Disorder, NOS; ADHD) with only a few children having solely internalizing disorders (e.g. Anxiety Disorder, NOS) with the remaining children with
comorbid diagnoses. Future studies may want to include a larger, more distinct sample to answer this question.

Similarly, the second hypothesis assumed that higher levels of adaptive behavior patterns would coincide with higher levels of empathy development, but this hypothesis was not supported by the results of the present study. Although visual analysis indicated that children who demonstrated higher levels of adaptive skills also displayed higher levels of cognitive empathy, the relationship was not found to be significant. The children’s development of affective empathy related minimally to their adaptive skills. The lack of significant results in reference to adaptive skills may relate to the clinical nature of the participants. The low levels of adaptive skills often observed in children who exhibit clinical behavior patterns may have influenced the evaluation of their development of empathy. The slight relationship between adaptive skills and cognitive empathy indicated by visual analysis could imply that understanding the emotional states of others may be more closely related to other adaptive skills, such as social skills and adaptability, than the emotional responses to others’ states.

Further, the incorporation of family factors provided a unique context in the examination of children’s behavior patterns and empathy development. The first hypothesis evaluated the influence of parental mental health on children’s behavior and development. Children who have a parent with a mental health diagnosis displayed lower levels of affective empathy than those children who did not have a parent with a mental health diagnosis. However, no significant difference was found in behavior patterns between these two groups of children. Given that all of the children in the sample were already diagnosed with a psychiatric disorder, this finding is not surprising. The next
hypothesis considered the family’s history of CYF involvement. Although no significant differences were found in empathy development, those children who had a history of CYF involvement differed in their levels of hyperactivity, aggression, and depression (as indicated by BSI scores on the BASC-2). The separation from a primary caregiver can have a significant impact on a young child’s behavior and is inherent in the presence of CYF involvement with the family. Considering this impact, it is expected that these children would exhibit higher levels of clinical behaviors. It may be that the children’s reactions to such events, as observed in aggressive or depressive behaviors, are more directly influenced than their development of empathy. The final hypothesis examined the influence of prenatal substance exposure. However, the results did not support the hypothesis and indicated no significant difference in children’s behavior patterns or empathy development in relation to prenatal substance exposure. As previous literature supports the hypothesis of prenatal exposure negatively impacting children’s behavior, there may be another cause for the lack of support found in the present study. For instance, as all of the children in the sample had a psychiatric diagnosis, the clinical level of their behaviors may have reduced the influence of prenatal substance exposure. Further, the occurrence of prenatal substance exposure differs from the other family factors as it is more removed from the child’s daily life than either parental mental health and CYF involvement. More research with a clinical sample evaluating the influence of prenatal substance exposure may more clearly determine its impact on young children’s behavior and development.
Conclusions

The results of the present study provide a unique context for understanding children’s empathy development in relation to their behavior patterns and specific family factors. The study contributes to knowledge across several domains, including developmental theory, research of empathy development and its connection to psychopathology in young children, the incorporation of social influences and family factors in understanding child development, as well as implications for practice.

Developmental Theory

In examining an early childhood population, the results of the present study coincide with two specific developmental stages: Erikson’s Initiative vs. Guilt stage and Piaget’s Preoperational stage. Erikson’s Initiative vs. Guilt stage describes children’s internalization of the rules and values of their parents while setting goals for and eventually regulating their own behavior. The connection between children’s behavior patterns and development of empathy established by the present study indicated the complexity of development at this young age and the interdependence of development across domains, especially within social-emotional development. This complexity was illustrated by the connection of empathy development with the behaviors, both externalizing and internalizing, exhibited by young children found in the results of the present study. In order for children to begin to set their own goals and regulate their behavior, they must first develop the necessary social-emotional skills that serve as prerequisites to behavioral regulation. Many children who exhibit internalizing and externalizing behaviors have yet to develop skills that would contribute to age appropriate behavioral regulation. Thus, in order to address self-regulation in young
children as established by Erikson’s theory, the preceding skills, including empathetic skills, must also be considered.

Similar to Erikson’s Initiative vs. Guilt stage, Hoffman’s Veridical Empathy stage (Hoffman, 2008) occurs during the early childhood years and consists of major advances in the self-other concept. Hoffman’s theory of empathy development builds on previously developed developmental theories and refers to changes in a child’s development of perspective-taking skills as the Veridical Empathy stage. As seen in the results of the present study, the presence of clinical behaviors, such as aggression, hyperactivity, or anxiety, further complicate this development and may hinder a child’s ability to successfully progress through Erikson’s and Hoffman’s stages. Additionally, parents provide the structure and stability for children in this stage of development. Various family factors, such as parental mental illness and involvement in the CYF system, impede parents’ ability to provide the appropriate environment to foster successful development.

Further, Piaget’s Preoperational stage highlights the beginning of perspective-taking skills where young children progress from an egocentric perspective to considering the perspectives of others. In this stage, children are also beginning to form more sophisticated concepts in acquiring knowledge and understanding of their environments. The development of empathy evaluated in the present study is consistent with Piaget’s Preoperational stage in that it points to the emergence of related skills within social-emotional development. Similar to Erikson’s Initiative vs. Trust stage, a child’s progress through Piaget’s stage can be complicated by the presence of clinical behaviors and maladaptive family factors. As demonstrated by the results of the present
study, empathy development is interrelated with clinical behaviors and family factors where young children may struggle in making age appropriate progress through this stage of development. With these complications, a child may not develop the necessary perspective-taking skills required for appropriate empathy development specifically and social-emotional development in general, which then impacts his or her ability to understand and respond appropriately to the emotional states of others.

By contributing to these developmental theories, the results of the present study indicate that child development is multifaceted and dependent on numerous aspects both within the child’s own development and abilities as well as the parents’ abilities to support the child’s development.

**Social Context of Empathy Development**

As implied by the development of empathy described above, children do not develop these skills in isolation. Young children learn skills related to social-emotional development, and specifically empathy, within social contexts. Thus, research supports a strong relationship between the development of empathy and prosocial skills (Chapman et al., 1987; Dadds et al., 2008; Hoffman, 2008; Iannotti, 1978; Iannotti, 1985).

Interestingly, the results of the present study are inconsistent with prior research in evaluating the relationship between adaptive skills and the development of empathy. The specific factors within the adaptive skills composite on the BASC-2 include adaptability, social skills, activities of daily living and functional communication. Many of the previous studies examining prosocial behaviors and empathetic skills, such as perspective-taking, look specifically at social skills in young children, including sharing, turn taking, and offering to help. The adaptability and social skills subscales on the
BASC-2 consist of similar items that have been evaluated in prior research (e.g. sharing possessions, waiting turns, and offering to help peers). However, neither of these scales, nor the adaptive skills composite, significantly correlated with empathy scores on the GEM, despite a slight positive relationship indicated by the visual analysis of cognitive empathy and adaptive skills. Although the exact cause for this inconsistency with prior research is unknown, it may be speculated that the participants of the present study having a psychiatric diagnosis impacted the relationship between their development of empathy and their adaptive skills. None of the previous studies included a clinical sample of children. Thus, the present study is unique in that aspect. The results of the present study may indicate a distinct relationship between prosocial behaviors and empathy development in young children with clinical diagnoses.

Moreover, the measurement of empathy may differ from that of other prosocial or adaptive skills as empathy development incorporates a distinct set of skills not often included in other assessments of similar social-emotional functioning. For instance, the items on the GEM identify specific empathetic skills, such as recognizing others’ moods through verbalizations or facial expressions, reacting to others’ emotional states through words or actions, as well as understanding why someone may feel a particular emotion within a given situation. On the other hand, items on the BASC-2 related to prosocial or adaptive skills include behaviors that illustrate social-emotional development more generally, such as sharing toys and waiting turns during an activity, as well as more specific adaptive skills, including dressing oneself and transitioning between activities. When considering this distinction in identifying prosocial behaviors, the lack of significant findings for empathy development and adaptive skills may be less surprising.
Nevertheless, the overlap among these behavioral domains in terms of measurement and theory indicate that their relationship would be stronger than what was established by the present study. Further research would provide more information regarding these unexpected results.

**Evaluating Empathy Development in Young Children**

In comparison to other studies specifically evaluating empathy development in young children, the present study both coincides with previous studies and extends this line of research. Specifically, the present study coincides with Iannotti’s research in examining the relationship between empathy development and prosocial behaviors. Through the use of hypothetical scenarios, observations, and teacher report, results indicate a significant relationship between prosocial behaviors and empathetic skills, specifically perspective-taking skills (Iannotti, 1978, 1985). Dadds and colleagues (2008) also found a strong positive correlation between the developmental level of empathy and prosocial behavior. However, the results of the present study do not support the prior studies in finding that to be a significant relationship. As described above, the cause for this inconsistency may relate to the unique sample utilized in the present study compared to others. Further, the use of a standardized measure of empathy development of young children is consistent with the research of Dadds and colleagues (2008). Dadds and colleagues (2008) also furthered this line of research by utilizing a clinical sample of children in evaluating empathy. With the use of a clinical sample, the present study coincides with the research by Dadds and colleagues (2008) and extends the research by incorporating family factors.
The present study extended this line of research in a number of ways. As all previous studies on the development of empathy in young children utilized children who were predominately Caucasian, the diverse sample used in the present study contributes to the knowledge of empathy development across racial and ethnic backgrounds. Further, the present study incorporated family factors (parental mental illness, prenatal substance exposure, and CYF involvement) that had not been considered in previous research. Evaluating these family factors provides a unique context for understanding empathy development in young children who also have clinical diagnoses and behavioral concerns.

Implications for Practice

Beyond its theoretical and research implications, the present study also contributes to practice in working with young children and their families. Notably, cognitive and affective empathy were found to have significant relationships with children’s clinical (internalizing and externalizing) behaviors indicating the importance of empathy development in relation to addressing behavioral concerns. When providing intervention support to young children who exhibit behavioral challenges, both internalizing and externalizing, it is critical to assess and incorporate those children’s empathy development. As behavioral excesses, especially aggression, relate to empathy development, disregarding the importance of developing empathetic skills in interventions will prove to be insufficient in providing a comprehensive intervention that will both reduce challenging behaviors while increasing prosocial behaviors, such as perspective-taking skills.
Despite the importance of parental influence on a child’s development of empathy, there is a paucity of research studies exploring empathy development in young children that incorporate factors outside the child’s own abilities and behaviors. Significant group differences in affective empathy when examining parental mental health point to the potential impact of parental mental health issues on the development of empathy in young children. In providing services to young children and their families, the understanding of this connection between affective empathy and parental mental health allows clinicians to target important areas of intervention both the parents and the child. This relationship further argues for the importance of involving the parent in the child’s treatment, especially within a clinical sample of young children.

Similarly, group differences in the Behavior Symptom Index on the BASC-2 suggest a relationship between CYF involvement and specific child behaviors, such as aggression, hyperactivity, and depression. Many children who have a history of CYF involvement and possibly were removed from a primary caregiver exhibited more challenging behaviors, including those of aggression, hyperactivity, and depression. The knowledge of the connection between a child’s behaviors and his or her experiences provide a context for intervention and support. Thus, interventions and treatment for children without such a history may differ than for those children who do have a history of CYF involvement, although the presenting behavioral concerns may be the same.

When addressing children’s clinical symptoms, it is imperative to consider the other variables that may influence those behaviors. Despite the relationship between empathy and clinical symptoms, few early childhood interventions target empathy development. Even with the use of a empathy development intervention, it is essential to
consider all of the potential influences on that development and determine other possible areas in need of intervention. Further, parental involvement is essential to children’s success in treatment, so family factors, such as parental mental illness, must also be taken into account when planning treatment. Without the involvement of parents, the child’s treatment is likely to be less effective and is far less comprehensive than incorporate the parents and their own needs while supporting the child.

**Limitations**

Despite the promising findings of the present study, it is not without limitations. Due to the use of a preexisting dataset, the internal validity is limited. Although the dataset included all relevant variables in answering the proposed research questions, there was no opportunity for the researcher to add to the dataset by collecting additional information regarding the children or families. The substantial amount of missing data limited the analyses that could be conducted, specifically limiting the analyses to the first time point and only parent report data. The incorporation of teacher report data would have added to results and usefulness of the data across settings. Further, the sample size was smaller than expected, thus limiting the statistical power of the analyses as well as the possibility to conduct more complex analyses in evaluating relationships among variables.

Moreover, the sample size utilized in the present study limits the ability of the results to generalize beyond the study. The results indicate the relationships found among a group of preschoolers enrolled in a single therapeutic preschool located in Southwestern Pennsylvania. However, the participants’ racial and ethnic backgrounds provided more diversity than previous studies evaluating empathy development in young
children. Thus, despite the small sample size, the study makes a unique contribution to the literature base with more diversity in the participants.

A final limitation of the present study is the use of parent report to provide information regarding children’s behavior patterns and development of empathy. The absence of observations of behavior in the present study allow for the possibility that the parents’ report of behaviors is not accurate. Although Iannotti (1978, 1985) utilized an observation and situational procedure in measuring empathy, these measurements were not standardized. A standardized observational method for evaluating empathy is not currently available, providing a challenge to research in this area, especially with young children.

**Recommendations for Future Research**

Considering the significance of the present findings in line with previous research, further studies would contribute to the knowledge and research base in understanding empathy development in young children. Although a standardized measure using parent report has added to the instruments able to evaluate empathy development, there remain limitations in solely using parent report, as discussed above. Thus, the development of a standardized observational method of empathetic skills and other behaviors relevant to the development of empathy would provide a more comprehensive and accurate measure of empathy in young children. Similarly, the present findings point to the importance of interventions that directly target empathy development and its related skills. The literature base would benefit from the evaluation of current social-emotional interventions that incorporate empathetic skills, such as perspective-taking skills, as well
as the development of interventions that are specific to the development of empathy in young children.

Additionally, due to inconsistencies brought forth by the present study in examining the relationship between development of empathy and adaptive skills or prosocial behavior in a clinical sample, further research devoted to this specific question would provided further insight to this relationship and what factors, if any, may alter the relationship.

Extending the present study to include other groups of children will also add to the literature base. Further research considering the development of empathy in children of diverse backgrounds is warranted given that this study is the first where the participants were not predominately Caucasian. These additional studies may highlight significant ethnic and cultural differences in empathy development and other relevant factors. Finally, further research evaluating behavior and empathy in young children with clinical diagnoses will provide additional information regarding the connection of these variables as well as better inform intervention and treatment practices.
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