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## **From medical categorical approach to holistic contextual and systemic approach to diagnosis and treatment of social interaction problems and disorders of children and adolescents**

*Od medicinskega kategorialnega pristopa k holističnemu kontekstualnemu in sistemskemu pristopu v diagnosticiranju in obravnavi težav in motenj v socialni interakciji otrok in mladostnikov*

### **Summary**

This article presents a critical view of the widespread medical categorical approach to social interaction problems and disorders, which reinforces some false beliefs about this area and contributes significantly to the stigmatization and exclusion of these children and adolescents. We counter this with a holistic contextual and systemic approach, supported by numerous studies, which emphasizes the interplay of biopsychosocial factors. These factors can act as risk factors (as promoters and perpetrators) of problems and disorders or as support factors as we look for sources of strength and support in changing interaction problems. Research shows that there are multiple factors (risk and support factors) that influence different forms of antisocial behaviour, that they often act indirectly and are interconnected and intertwined in a complex network. The diagnostic approach and treatment should not be based on symptoms alone, but could be better described as research systemic. If we consider diagnosis as a research process, it is therefore in constant evolution and change, as some hypotheses are confirmed and others refuted over time. The expert is only one of the participants in this process, because the process means joint discovery

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and co-creation. And of course there is not just one expert, but most problems require multi-perspective approaches and the contribution of a group of experts. The multidisciplinary approach makes it possible to start from several theoretical paradigms, which promotes the conceptualization of problems from different angles. Similarly, the professional approach to change cannot and should not be focused solely on the child (and occasionally the parents) or on finding simple solutions (which the medical model offers). Help is always contextual and depends on many different factors and options that vary according to the needs of the individual child or young person.

**Key words:** problems and disorders in social interaction, categorical diagnostic approach, complexity, contextuality

### **Povzetek**

Predstavljamo kritični pogled na razširjen medicinski kategorialni pristop težavam in motnjam v socialni interakciji otrok in mladostnikov, ki utrjuje nekatera napačna prepričanja o tem področju tudi v laični javnosti in pomembno prispeva k stigmatizaciji in izločanju teh otrok in mladostnikov. Temu nasproti postavljamo holistični kontekstualni in sistemski pristop, ki na podlagi številnih raziskav poudarja preplet biopsihosocialnih dejavnikov. Ti lahko vplivajo rizično kot spodbujevalci in vzdrževalci težav in motenj ali podporno, ko iščemo vire moči in podpore pri spreminjanju interakcijskih težav. Iz raziskav je razvidno, da je dejavnikov tveganja in podpore, ki vplivajo na razne oblike nesocialnega vedenja več, da pogosto delujejo posredno ter medsebojno povezano in prepleteno v kompleksno mrežo. Diagnostični pristop in obravnava zato ne bi smela temeljiti zgolj na simptomatiki, temveč na raziskovalno sistemskem pristopu. Če razumemo diagnosticiranje kot proces raziskovanja, gre za neprestano nastajanje in spreminjanje, saj se nekatere hipoteze potrjujejo, druge pa ovržejo. Strokovnjak je le eden od udeležencev tega procesa, saj gre za skupno odkrivanje in soustvarjanje s klienti. In seveda večinoma sodeluje več različnih profilov strokovnjakov, saj večina težav potrebuje večperspektivno obravnavo. Multidisciplinarni pristop omogoča povezovanje različnih teoretskih paradigem, kar spodbuja konceptualizacijo problemov z več zornih kotov. Podobno tudi strokovni pristop k spreminjanju ne more in ne sme biti usmerjen zgolj v otroka in občasno v starše ali v iskanje preprostih rešitev, ki jih ponuja medicinski model. Pomoč mora biti kontekstualna ter odvisna od številnih različnih dejavnikov in možnosti, ki se razlikujejo glede na specifične potrebe vsakega otroka oz. mladostnika in njegovega okolja.

**Ključne besede:** težave in motnje v socialni interakciji, kategorialni diagnostični pristop, kompleksnost, kontekstualnost

## **1. Introduction**

The occurrence and treatment of mental disorders in childhood and adolescence, which are associated with disruptive behaviour in the environment, only really attract public attention in the case of various excesses (e.g. murders, rapes, cruel outbursts of aggression). The reaction of the lay public and to some extent also of the (quasi-)professional public (in various media) is generally oriented towards the need to punish such phenomena, remove them from the environment or at least treat them so that they do not threaten our “normality”. Excessive cases of behavioural disorders are encountered in narrower professional settings (in specialized outpatient treatments such as counselling centres, child psychiatric dispensaries, but also in educational institutions, crisis centres, etc.). At least in part (as my experiences from therapeutic sessions at the counselling centre show), similar behaviour can be found in kindergartens, primary and secondary schools and student residences. A fundamental tendency in dealing with various forms of disruptive behaviour is to simplify both the origins (causes) of such behaviour and the assumption that “doing something to the child/adolescent” will change their behaviour. Such a reduction of a complex and multi-layered issue has also taken place to some extent in the professional field (I will call it the medical model, as it is mainly established in psychiatry and partly in clinical psychology) with the so-called categorical diagnoses of the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) (APA, 2024; b.a. 2016) and the International Statistical Classification of Diseases and Related Health Problems (ICD-10-AM, 2019).

The reason for this is undoubtedly the desire to provide guidance and to navigate the various symptoms (in which the benefit can undoubtedly be recognized). I see the problem in the fact that such categorizations are based on the symptomatic level (expressed by the individual), which at the same time requires an approach focused on that individual. Such an approach is thus exclusively aimed at first identifying certain deficiencies, obstacles, deficits, problems or disorders of the individual and then also (at least mainly) treating this individual, who must be “optimized” according to notions of “normality”. In our opinion, the medical model is the one that reinforces misconceptions about the totality of behavioural problems and disorders, even among the lay public, and contributes significantly to the stigmatization and exclusion of these children and adolescents. For this reason, many parents may even refuse help when confronted with their child’s problematic behaviour (Hladnik & Kobolt, 2011; Razpotnik, 2011).

In this article, I would like to present a different perspective on these types of problems, a perspective that is oriented towards a contextual and systemic approach, an approach that aims to emphasize the intertwining of biological, psychological and social factors in a holistic sense (Carr, 2015) and that ties in with a constructionist view of behavioural disorders (Potter, 2014). Unfortunately, in this regard, there are no simple explanations for a particular behaviour (which can only be seen as a symptom of something that is behind that behaviour) and unfortunately, there are no simple solutions in this regard either, as these are always contextual, always dependent on many different factors and possibilities. However, such an approach has a really (at least seemingly) simple solution to both the question of origins and the question of solutions: joint research and joint discovery, not only at the symptomatic level and not only with a view to the disorder (deficits) itself, but also to supporting factors and the strengths of the search.

## 2. Terminology and its connection with conceptual approaches

In the field of treating problems and disorders of social interaction (hereafter referred to as PDSI), there may be confusion about which term is most appropriate. The understanding of these problems has changed over time, paralleling shifts in the paradigms of parenting, education, normalcy, normalization, social care, and deviance (Razpotnik, 2011). Of course, terminology is not really a matter of grammar, but is always related to fundamental conceptual starting points. And in this field, a whole range of terms are used, some of which are similar, some of which overlap - and of course, adding to the confusion, the same terms are often used for different phenomena (not only in lay language, but also in specialist terminology). The following terms are used in this area, for example: aggression, violence, disruptive behaviour, behavioural and personality disorders, criminality, delinquency, psychopathy, sociopathy, neuropathy, behavioural problems and disorders, conduct problems, antisociality, oppositionality, dissociality, asociality, social integration problems (disorders), emotional, behavioural and social problems/disorders.

I myself avoid terms such as delinquency and criminality (which are legal terms and usually mean unlawful behaviour). I do not equate PDSI with the term "conduct disorder" (in the ICD-10 and DSM-4 classifications). Conduct disorder refers to long-lasting, recurring, different symptoms that appear in different areas of life. If one views behaviours as a symptom of different processes (they can be a symptom of inappropriate living conditions, trauma, abuse, inadequate

regulation of emotions and needs, etc.), then it is somewhat inappropriate to speak of a "symptomatic disorder," whatever the term "conduct disorder" may mean. I do not even use the terms psychopathy and sociopathy (terms that have been used in the past in relation to medical approaches) as they reflect a belief in the "impairment" of the individual. Although I must point out that nowadays even some (quasi-)experts in the field (Golob, 2018) vehemently declare psychopathy also occurs in children or at least try to camouflage it with the term "callous children".

What all these terms have in common is that they start from the observed, i.e. symptomatic level, i.e. from what is reflected externally in a behaviour. In some cases, authors who emphasize the difference between externalized and internalized problems/disorders attempt to overcome this (Kobolt, 2011; Myszker, 2008; Myszker & Stein, 2018; Novak and Mihic, 2018). In doing so, they point out that internalized problems are problems or disorders that are directed against the person and not against the environment, only that the individual keeps them inside or even hides them and that they are internalized and remain invisible and hidden (Mikuš Kos, 2017). Precisely because they are often overlooked, they remain unnoticed and unrecognized (because they do not disturb the social environment), or they give the feeling that they do not need any special treatment at all. However, I must emphasize that even if they are not expressed in the behaviour itself, they can represent a much larger and more complex disorder (e.g. eating disorders, depression, suicidal thoughts, self-image disorders, etc.) than some externalised behaviours that are perceived as very problematic by the social environment (e.g. physical aggression).

PDSI refers to the interactivity of the entire set of needs, behaviours, emotions, beliefs and attitudes of an individual and their social environment. Thus, it is not simply a symptom that someone would recognize in an individual (a certain range of behaviours that are socially less or not at all acceptable, such as aggressive behaviour, oppositionality, disregard for norms, etc.), but rather an inextricably intertwined and interactive relationship between the individual and their environment. In this sense, it is practically unjustified to separate the individual from the social environment (Bečaj, 1997), since from birth (or even earlier) the individual lives and experiences the reality they create together with the environment in which they find themselves. The social system is not a milieu in which the individual is located as an isolated entity and between which precise boundaries could be drawn. Therefore, conduct disorder can be viewed as a social construct, as the definition of problematic behaviour depends on social and cultural expectations, beliefs, and contextual factors (Canino et al., 2010; Byrne, 2010).

PDSI also partially overlaps with the concept of disruptive behaviour. Disruptive behaviour is also associated with social interaction, and its basic characteristic is that in most cases it is not disturbing for the person who exhibits such behaviour, but for the social environment itself, i.e. for the person who is confronted with such behaviour (Vec, 2011). For this reason, the actors of disruptive behaviour usually do not feel the so-called disease pressure to change their behaviour. For these children and adolescents, only the consequences they receive from their social environment due to their behaviour are disruptive (rejection, aggression, hostility, etc. from peers, punishments, retaliation as well as aggression, revenge, etc. from adults). The concept of disruptive behaviour, as already seen here, focuses on the responsibility for “causing” discomfort for an individual who functions in a certain way, which at the same time (too) often goes hand in hand with the need to (merely) change the individual with disruptive behaviour.

Precisely because PDSIs are always socially situated, in this paper I would like to examine them not so much from the (increasingly used in our country) medical perspective (which for me is represented by the ICD-10 and DSM-4 classifications), but primarily from the contextual (or more narrowly: contextual constructionist) aspect (e.g. Loseke et al., 1999 in Potter, 2014), which I see as linked to the systems approach (e.g. Fingleton, 2005) and the holistic approach (e.g. Timmerman & Emmelkamp, 2005).

Modern approaches try to focus on non/functionality in the satisfaction of the child's basic needs in interaction with the environment (which I present later in the continuum of problems, picture 1), and not so much only on the symptoms (as is common in the so-called categorical approach). It would therefore be important to talk about problems and disorders in the satisfaction of needs in important areas of life (which can be reflected in the emotional, behavioural and social areas), and not, for example, about behavioural and emotional problems/disorders (the most commonly used technical term in Slovenia today).

### 3. **A medical perspective on conduct disorders**

The medical perspective of behavioural disorders is strongly based on two manuals – DSM and ICD (Tyrer, 2014).

#### 3.1. **Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5)**

DSM is a manual for classifying mental disorders published by the American Psychiatric Association (APA). The first manual (DSM-1) was published in 1952

and the current one (DSM-5) in 2013. It is mainly used in the United States of America for clinical and research purposes, for the regulation of psychotropic drugs, health insurance policy making and more broadly in legislation and policy (APA, 2024; b.a., 2016; Porter, 2024). It defines the cluster of disruptive behaviour as follows:

- Attention-deficit hyperactivity disorder (ADHD)
- Oppositional defiant disorder (ODD)
- Conduct disorder
- Intermittent explosive disorder (IED)
- Disruptive mood dysregulation disorder (DMDD)

A prerequisite for belonging to one of the categories is that problems in early childhood development in the form of at least three of the 15 symptoms occur over a longer period of time - more than six months – and in several areas (at school, at home, in social situations) in which the rights of other people are violated. Conduct disorders encompass a broad range of behaviours covering four domains: aggressive behaviour towards people and animals, destruction of property, deception and theft, and rule violations (APA, 2024; b.a., 2016; Porter, 2024):

The DSM-5 also defines antisocial personality disorder, which should not be diagnosed before the age of 18. Unlike the DSM-4, this version added another subtype of conduct disorder, namely the subtype of callous-unemotional traits in children (which involves lack of empathy, disregard for the feelings of others, lack of consideration for others, causing significant harm to others, and greater concern for the effects of one's actions on oneself than on others). I should mention here that some use this subcategory to recycle the characteristics of psychopathy for the period of childhood and adolescence and portray these disorders as a threat to the school system and life in general. However, the estimated prevalence of callous-unemotional traits in childhood and adolescence is only 10-30% within the entire category of conduct disorders (Janjušević, 2016) - the incidence of which is already estimated at 2-10% in the DSM-5 (Mohan et al., 2023; Porter, 2024) in the total population. Similar estimates also come from other representative surveys, for example Canino et al. (2010) write of 3.2 % of conduct disorders, Merikangas et al. (2010) of 2.2 % and 6.5 % of oppositional defiant disorder in adolescents. Meta-analysis of Polanczyk et al. (2015), in which they included 41 different studies from 27 countries, speaks of 5.7%.

### 3.2. **International Statistical Classification of Diseases and Related Health Problems (ICD)**

ICD is published by the World Health Organization and contains a special chapter on mental disorders, is more widely used. Currently, the Australian Modification, Version 11 (ICD-10-AM, 2019; Tyrer, 2014) is used, in which emotional and behavioural disorders characteristic of childhood and adolescence are classified according to the following categories (F90-F98):

- F90. Hyperkinetic syndrome (general restlessness and disturbances of attention and concentration);
- F91. Conduct disorders (persistent and often repeated dissocial, aggressive or defiant conduct that clearly exceeds the objectively acceptable limit; it is a dominant behavioural style that impairs the child's development and integration into the environment and not just occasional inappropriate reactions and behaviours to certain external stresses); these include a) conduct disorder confined to the family context, b) unsocialized conduct disorder (dissocial or aggressive behaviour associated with abnormalities in relationships with other children), c) socialized conduct disorders (they are basically capable of developing interpersonal relationships but generally behave in a dissocial and aggressive manner), d) oppositional defiant disorder (usually occurs in younger children but is mainly characterized by marked defiant, disobedient, disruptive behaviour that does not involve criminal acts or more extreme forms of aggressive or dissocial behaviour), e) other conduct disorder, f) unspecified conduct disorder.
- F92. mixed disorder of conduct and emotions characterized by a combination of persistent aggressive, antisocial, or defiant behaviour with obvious and prominent symptoms of depression, anxiety, or other emotional problems.
- F93. Emotional disorders with onset specific to childhood (e.g., separation anxiety in childhood, phobic anxiety in childhood, social anxiety in childhood).
- F94. Disorders of social functioning with onset specific to childhood and adolescence (elective mutism, reactive relational disorder in childhood, etc.).
- F95. Tic disorders.
- F98. Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence (e.g. water and/or stool loss, feeding disorder, stuttering, etc.).

In the medical model, the search for direct links between symptoms and behavioural disorders is recognized, e.g., Pardini and Frick (2013) directly state that there are unique causal factors underlying behavioural problems in children. However, as Carr (2015) notes, there is evidence that the DSM and ICD categorization

systems have problems with reliability, coverage, and comorbidity, which calls into question their validity. This is due in large part to the fact that emotional problems and disorders in children occur either as dimensional psychological traits or as a result of complex interactional problems. In addition, Essau and Conradt (2006) warn that classifications are mainly used to facilitate communication between the professionals involved, while for the child they only mean additional stigmatization. Therefore, it is not necessary that the classification brings a guarantee of all the necessary help and support to alleviate permanent problems and for better functioning of the child and family in social interaction, which is the main argument for the classification of behavioural disorders under psychiatric diagnoses (Hawes, 2020).

The basic criticisms of the medical model can be categorized into the following areas:

- derivation from symptoms;
- the search for direct links between symptoms and behavioural disorders, for causal factors;
- the problem of comorbidity;
- the problem of partiality (not systemic, interactionist, holistic...);
- several factors are at work (not causes), they are complexly interrelated, some factors acting indirectly (SES, parents' education...);
- does not take into account environmental factors (marginalized groups, criminal environment, school culture...);
- the question of the appropriateness of including behavioural disorders in psychiatric diagnoses.

The problem of partiality, the complexity of some relationships between factors or prevention and the importance of interactionist environmental factors in the context of PDSI are highlighted below.

## 4. **A systemic, holistic view of the factors influencing PDSI - complexity**

### 4.1. **The continuum of PDSI in the interdependence of need satisfaction**

The diversity and the intensity of problems in social interaction can be illustrated by the continuum, which was designed with the aim of presenting modern approaches to understanding disruptive behaviour that focus on the functionality on the one hand and the inability to satisfy the child's bio-psycho-social needs on the other (Vec, 2011).

Figure 1  
Continuum of emotional, behavioural and social problems (Vec, 2011, p. 128)

Temporary, minor, „ordinary“ problems that do not require special help (the child overcomes them himself in interaction with the social environment).	Problems that hinder the satisfaction of the child's needs (problems that the child cannot solve constructively by functioning). The child needs help in the context of different approaches (teachers, counsellors in elementary school can provide it).	Problems that more strongly hinder the satisfaction of the child's needs.  The child needs special help.	Disorders (the child has a disturbed attitude towards reality, the social environment and himself), satisfies needs in a way that significantly endangers himself and/or the environment. The child requires treatment in a specialized institution (educational institution, residential group, ...).
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It should be emphasized that the boundaries between the groups described are not clear and unambiguous. Moving along the continuum to the next groups, both the children/adolescents and their social environment (parents, siblings, peers in the class, teachers, etc.) need more and more help to cope with the problems, which also becomes more specialized, and in relation to the total population they always cover a smaller proportion of children who need help (Vec, 2011).

Children and adolescents in the first group are able to overcome temporary, developmental and situational problems in interaction with the social environment (if this is only functional). Various forms of disruptive behaviour are developmental (and are also normatively regulated by the environment through socialization and upbringing). For example, younger children show more behaviours that are disruptive in social situations. Studies (Trembley et al., 2004) have shown that only 28% of three-year-olds show no physical aggression, with at least 27% of three-year-old boys and 19% of three-year-old girls hitting or pushing their peers at least occasionally. No less than 58% of three-year-olds, regardless of gender, showed moderate irritability and 14% showed severe irritability; 57% of these were boys. With increasing age, disruptive and aggressive behaviour decreases, which is inversely proportional to the experience of stress and emotional problems (Kelly et al., 2010; Zimmer-Gembeck & Skinner, 2010). In elementary school, the incidence of developmental physical aggression decreases and is about 9-12% in boys and about half as much in girls (who experience

more emotional stress), while it is still 3-8% in high school students (Currie et al., 2008; Dekleva, 1997; Pušnik, 1999; Olweus, 1978; Trembley et al., 2004). Studies (Pavlović et al., 2008) also show how many children have experienced physical violence depending on their age (at the age of 9, 17% of children report it, at the age of 13 8.4% and at the age of 17 4.2%).

Developmentally disruptive behaviour begins to disappear with an appropriate, completely normal response (if it does not escalate or if it is not overlooked) from the social environment (parents, teachers, peers...) (Justicia et al., 2006). In this area, those who are confronted with such behaviour need more help than the child themselves (e.g., raising awareness about insisting on demands, helping to understand the child's developmental characteristics, etc.). Similarly, with more targeted help from professionals trained in this area (teachers, counselling services, etc.), the children/adolescents in the other group can constructively overcome the problems that have arisen and satisfy their needs. Some of the children in this group and all of the children in the third and fourth groups already have more pronounced problems that can no longer be dealt with functionally. For these children, the experts therefore point out the need to refer them to counselling programmes for children with special needs, as the nature of their problems requires more specialized approaches to help both the child and their social environment. In the last, fourth group, the children's problems are so pronounced that they are disorders that usually require treatment in specialized institutions (e.g. residential groups, crisis centres, educational institutions, etc.).

#### 4.2. From medical models to thinking about (multiple) risk factors and their interrelationships (comorbidity)

Authors and researchers who go beyond the medical view of PDSI repeatedly speak of statistical correlations (influence) of certain factors within the entire spectrum of PDSI (Coie et al., 2000; Greenberg et al., 1993; Lahey et al., 1999; Sagar et al., 2019). In contrast to medical models that have attempted to pinpoint the causes of antisocial behaviour (e.g., Lahey et al., 1999), modern approaches emphasize that there are more factors (and not causes) that influence different forms of antisocial behaviour, that they often act indirectly, and that they appear interconnected and intertwined (Burke et al., 2002; France et al., 2010; Loeber et al., 2009; Stringaris & Goodman 2009). The same influence of factors rather than causality also affects prevention interventions related to PDSI, as many authors emphasize (e.g. Car, 2015; France et al., 2010; Potter, 2014; Prothrow-Stith, 1987; Reiss, 2013). If I try to summarize the diverse research in this area, it could be said that there are some basic factors that can act either as a threat

or as a preventive measure on the mental health of the child as a whole, as well as specifically on the occurrence of PDSI. These are: the family, the individual, the management with which it meets in different situations (kindergarten, school, clubs...), groups in which they are involved, and environmental factors (a similar categorization is described by several authors, e.g. Bradley & Hayes, 2007; Carr, 2015; Coie et al., 2000; Sagar et al., 2019).

In addition to the individual, **the family** is recognized in many studies as one of the most influential factors, especially in early childhood (with increasing age it loses influence, so that other factors often play a more important role in adolescence, e.g. the influence of peers). The pathology of the parents themselves or their pathological behaviour (e.g., abuse, maltreatment, alcohol and drug abuse) plays a particularly threatening role, as does the parenting style of the parents (Winsler et al., 2005) and their ability to form a secure attachment (Greenberg et al., 1993; Theule et al., 2016), parents' mental health (Karimzadeh et al., 2017) and their partner relationships, conflict management, relationships between parents (Puff & Renk, 2014), separated families (Theunissen et al., 2017), education, employment, etc., with parental stress playing a somewhat smaller role (Mak et al. 2020; Solem et al., 2011). A number of studies that establish a connection between the socioeconomic status of the family and PDSI also remain unnoticed (Burke et al., 2002; Carr, 2014; Puff & Renk, 2014; Reiss, 2013). Patel et al. (2018), for example, found that low parental income increased the likelihood of behavioural disorders by 1.5 times.

In identifying factors related to **the individual**, quite a few authors separate biological and genetic factors (in the sense of predispositions) from factors that are otherwise closely related to the individual, but are also the result of certain interactions of the latter with the (especially closest) social environment.

Genetic-biological factors are mainly congenital, but some also arise as a result of influences before the child is born (e.g. drug, tobacco and alcohol abuse by the mother) or at birth as a result of complications (problems with breathing, blood circulation, injuries from difficult births...). Factors that significantly influence PDSI include gender, temperament, impulsivity, attention problems, hyperactivity, hypersexuality, mood and emotional instability and intelligence.

For example, the incidence of behavioural disorders (Essau & Conrath, 2006) is three to four times higher in boys than in girls during childhood, they also appear earlier in boys, the problems last longer and often manifest themselves in outwardly directed aggression, while this is often self-directed only in girls, and with age, especially covert forms of aggressive behaviour increase (repression, acting out, etc.).

Intellectual deficits are also one of the factors strongly associated with PDSI (Ruddick et al., 2015), as is autism (Christensen et al., 2009). Attention deficit hyperactivity disorder significantly increases the likelihood of behavioural disorders. According to various researchers, one-third to one-half of children with ADHD develop various PDSI - from poorer academic performance, behavioural disorders, mental health problems, sexual problems, poorer social integration, lower popularity... (Carr, 2015; Erskine et al., 2016; Gagne et al., 2020; Timmerman & Emmelkamp, 2005). And while ADHD declines with age (only about half of those who had ADHD as a child have such problems in adulthood (Eskander, 2020)), PDSI often persists. As Bregant (1987) noted, the social environment often reacts impatiently to attention and concentration problems, and the child reacts to this impatience with antisocial behaviour. A similar mechanism for the development and maintenance of PDSI can also be assumed for autism, mood and emotional instability, lower intelligence, etc.

Factors that are categorized as individual factors but originated in the early interaction with the environment are different, e.g. (germs) of personality structures, internalized constructs, beliefs of socio-cognitive abilities, poorer academic performance than expected according to one's own abilities, lack of work habits, unwillingness to exert oneself in an activity, lack of active interests (Justicia et al., 2006; Webster-Stratton & Taylor, 2001).

To ensure a safe, enjoyable and effective learning environment, the skills of adults in **managing** an individual child or group are also crucial (this refers to the management of classes by the teacher as well as other key adults, e.g. coaches in sports activities, leading various interesting activities, etc.). In the preschool period, the kindness of an adult is usually enough to become a "star" for children, but as the child grows older, other qualities are needed more and more. Teaching style (DiGennaro et al., 2007; George et al., 2007) and skilful or unskilful guidance are important factors in limiting and in some cases even encouraging or maintaining disruptive behaviour.

Stevenson et al. (2020) point out that despite the importance of developing classroom management skills, many teacher education programmes do not require specific courses or experiences to develop these skills. Rather than acquired knowledge, classroom management skills are therefore influenced by the experiences of the teachers themselves (Stough et al., 2015). This has implications for the negative effects of teacher turnover (Ingersoll et al., 2018), the disproportionality of disciplinary measures and the overuse of punishments and other ineffective behaviour control practices.

Leading a group such as a class requires not only knowledge of teaching content, but also knowledge of the developmental psychological characteristics

of children and adolescents, the maturity level, abilities, interests, etc. of the individual child or adolescent. These skills influence the way the class is run, which indirectly affects PDSI (Roseth et al., 2008; Stough et al., 2015). For example, if the activity in the group exceeds maturity and ability, if the initiative that comes from the child is not carried out, if an activity takes longer than they are able to concentrate, sit still, listen attentively, etc., the likelihood of disruptive behaviour occurring increases.

Simonsen et al. (2008) outlined five evidence-based principles of classroom management: (a) provide structure; (b) monitor, identify, and reinforce small steps toward expectations; (c) actively engage students; (d) develop a continuum of strategies to reinforce appropriate behaviour; and (e) develop a continuum of strategies for responding to inappropriate behaviour.

**Environmental** factors include both the immediate environment with which the child or adolescent interacts on a daily basis (e.g. the school with its institutional characteristics) and the wider environment (neighbourhood, society). Several studies have confirmed that, for example, a criminal or marginalized neighbourhood or the availability of drugs in the environment in which the family lives play a role (Farrington, 2005, 2007; Sagar et al., 2019). The increasing prevalence of mental health problems in general is also associated with social changes, such as the consequences of the economic crisis (Butterworth et al., 2009), which can affect children's and adolescents' mental health through parents and the family environment (Anagnostopoulos & Soumaki, 2012).

By the term 'the institutional background of disruptive behaviour', I mean the entire set of factors that form the culture of the institution at all levels (as defined by Schein, 2004). Lee (2007) summarizes that the following factors can contribute significantly to the expression of disruptive behaviour:

- the physical environment itself; the school should provide a safe, comfortable and friendly environment for work and relaxation (disruptive behaviour can be triggered by narrow corridors, garishly painted rooms, poor lighting, etc.);
- the learning environment (e.g., the school should be a safe, comfortable and friendly environment for work and relaxation);
- the learning context; classrooms should be a stimulating environment;
- the provision of activities outside the classroom; where there are opportunities for learning and social activities outside the classroom that both students and staff can enjoy and benefit from, less disruptive behaviour will occur.

Accepted beliefs and values that can be equated with a healthy organizational culture according to Olsen & Cooper (2001) or indicators of school ethos according to Lee (2007) can be summarized into the following guidelines:

- good leadership based on mutual trust, solution orientation (not so much on constant problems solving), satisfaction (both with children, parents and staff) and good relationships (mutual consideration and respect), students are valued as persons;
- effective introduction of change based on joint planning;
- a clearly formulated and realistic mission, a positive and supportive attitude towards children, a developmental approach where staff understand the characteristics of children's social, emotional and cognitive development;
- the school's fundamental approach to creating an orderly environment where staff can carry out their duties and students feel able to work without distraction or intimidation. It is about how clearly boundaries are set for student behaviour, whether there is consistency of action within those boundaries, whether the rules are justified and repeated, and whether the school as such takes into account the importance of time (in setting and changing boundaries);  
collaboration with parents.

Research shows that there is a significant correlation between aggression and the overall school climate, especially with the quality of the relationship between teachers and children, as well as the connection between children, friendly relationships and the absence of unhealthy competition (Krall, 2003; Popp, 2003). The rigid attitude of teachers and the use of institutional power have been identified as risk factors for the development of aggressive behaviour at school (Popp, 2003).

During the transition from childhood to adolescence, **the group** (circle of friends, classmates, peers in other activities) becomes more important to the individual (Farmer, 2003; Kelly et al., 2012; Steinberg & Monahan, 2007). The group can influence PDSI in a variety of ways; sometimes it acts as an independent factor in the emergence of disruptive behaviour, but more often, in conjunction with the very individual characteristics of group members and/or inappropriate management, the group is a contributing factor in the emergence and maintenance of PDSI. Let us take a look at some of the basic elements (which I have derived from various authors - Abrams & Rutland, 2011; Alderman & Green, 2011; Davis et al., 2021; Gençer, 2019; Gruden, 2021; Johnson & Johnson, 2014; Johnson et al., 2008; Wilson et al., 2001) that can be a source of disruptive behaviour among group members:

- group norms; they are a source of disruptive behaviour when individuals, due to the desire to be included in the group, behave as they believe the group expects them to behave and/or accept some of its norms that are not consistent with those accepted in the broader social context;

- “culture” of dealing with conflicts and problem situations; it is closely related to the norms of the group, with the exception that it concerns specific norms of behaviour in conflict and problem situations;
- coercion and violence in the group; sometimes the adolescent accepts certain behaviours in group situations but does not internalize them, does not personally approve of them;
- unclear or unstable structure (communication, group roles, social forces, etc.);
- phases of group development;
- unclear or contradictory goals.

#### 4.3. **The complexity of the association and interaction of risk and protective factors**

PDSI in children are usually the result of complex interacting factors (Carr, 2015; Sagar et al., 2019), ranging from biological factors (e.g. neurological abnormalities detected by magnetic resonance imaging, elevated serotonin levels, ADHD) to factors related to parents (substance abuse, depression, somatization, psychopathology, parents' strict parenting style, marital conflicts), peer factors (integration problems), social environment factors (criminal neighbourhood, availability of drugs) and contextual factors (low income, unemployment, unsuitable housing conditions). Similarly, Lahey and colleagues (1999) identify several risk factors for antisocial behaviour: the individual (e.g., temperament, intelligence), parents (their antisociality, parenting styles, interactivity of child characteristics and parenting styles), peers, and socioeconomic status. They also emphasize that genetic influences have only indirect effects on antisocial behaviour, as they influence the predisposition and social environment of the adolescent.

Many modern researches in this area find that the influence of factors is often indirect. Morrison et al. (2003), for example, found in their longitudinal study that the mother's interaction (which is meant to be empathetic and promote prosocial behaviour) with the child, who is barely involved in kindergarten, is positively related to both social behaviour and academic success in high school. Stright et al. (2001) found that parents who explain educational tasks to their child at a developmentally appropriate level while providing emotional support are more likely to have children who are willing to participate in class, who ask the teacher for help when they need it, and who work responsibly. Amato and Rivera (1999) found that children commit fewer disciplinary offences and have fewer social and emotional problems when parents spend more time with them, show their own emotions, and build closer relationships with them at different ages. Social support and the diversity of the social network are indirectly

related to social skills, behavioural problems and the child's well-being through parenting. Social support and social network diversity are also indirectly related to fewer behaviour problems at school through the warmth expressed in the relationship and responsiveness to the child, as well as warmth and sensitivity or sensitivity to the child's needs and the problems they face (Marshall et al., 2001). In addition, the authors also found an indirect link between the diversity of the social network in which the child is integrated and a greater number of cognitive stimuli from the parents and the child's better developed social competences. Farrington (2005, 2007) also talks about the indirect influence of factors, such as the parents' low income, their unemployment and lower education can have an influence on the guidance, stimulation and creation of opportunities that are reflected in the child's behaviour. On the other hand, the criminal behaviour of the parents, peers and the environment in which the family lives can serve as an antisocial behaviour model for the child's circumstances. He also points out that poor parenting, divorce in the family, and low anxiety can influence a child or adolescent's antisocial behaviour through feelings of isolation and poorer socialization.

It can be concluded that the above research findings show that the diversity of the social network and the good social support that the family receives through the quality of the relationship between the child and the parents have an impact on how the child functions in other areas of life.

Some authors point to a direct link between influencing (risk) factors and preventive (protective) factors (Bradley & Hayes, 2007; Carr, 2015; France et al., 2010; Potter, 2014; Prothrow-Stith, 1987; Reiss, 2013; Scott et al., 2016; Webster-Stratton & Taylor, 2001). With such an approach, it is appropriate to go beyond causal and simplistic explanations derived only from the recognized frequency and intensity of PDSI symptoms. Modern models address this area multidimensionally, e.g., severity and preventive measures of behaviour problems as a function of age (Car, 2006; Webster-Stratton & Taylor, 2001). These models emphasize the greater influence of certain factors in early childhood: parenting styles (ineffective, with less control, with less cognitive stimulation), individual factors (attention deficits, learning difficulties, poor conflict management, poorer social skills), contextual family factors (poverty, parents' criminal behaviour, abuse of various substances, stress, family conflict), and later the greater influence of factors related to school and peers (ineffective teacher response, aggressive classroom behaviour, peer rejection, dealing with difficult peers) (Webster-Stratton & Taylor, 2001).

It can rightly be assumed that the degree of influence of the factors changes with development (Lahey et al., 1999; Timmerman & Emmelkamp, 2005). Thus,

in early childhood, biological and genetic predispositions as well as traumatic experiences, inadequate upbringing, the development of an insecure attachment, pathological characteristics of the parents have a greater influence, later the influence of already established personality traits, unrealistic thinking and even later problems in social functioning gain strength, still later social influences, situational and environmental variables, abuse of various substances.

5.

## Conclusion

The basic approach could be described as research-systemic. The very discovery of the factors that influence PDSI (the so-called diagnostic process) is in fact a process that cannot be limited to a few meetings between the expert and the child. It is a “diagnosis” in constant evolution and change, as some hypotheses are confirmed while others are refuted over time. In this research process, the expert not only pays attention to the risk factors that have influenced the PDSI or contribute to its maintenance, but also examines the strength factors (i.e., those that need to be built, maintained, and strengthened) (Alderman & Green, 2011; Johnson et al., 2008; Wilson et al., 2001). The expert is only one of the participants in this process, because the process involves joint discovery and co-creation. And, of course, there is not just one expert; most PDSIs require more discussion perspectives and input from a diverse group of experts (Christensen et al., 2005). The multidisciplinary approach makes it possible to start from different theoretical paradigms, which promotes the conceptualization of problems from different points of view.

The therapeutic approach to PDSI is also important, as it cannot (and should not) focus solely on the child (and occasionally on parenting). Thus, there are no simple solutions (as offered by the medical model), nor are there solutions that apply to an entire group of disorders (e.g., children with ADHD and conduct disorder, or children with conduct disorder whose parents are too permissive). Professional help is always context-dependent, it always depends on many different factors and possibilities. In concrete terms, this means mitigating or eliminating threatening factors, but also restoring, maintaining and enabling those that have a protective effect (France et al., 2010). And these two factors are slightly different for each child (achievable, possible, realistic...), they are different for each family, each class, each important adult who accompanies the child, they are also different in each environment. It is therefore necessary to involve not only all the people involved with the child, but also various experts from different disciplines in the search for solutions. However, their effectiveness is often limited by the ability to build a (therapeutic) relationship with both the child and all others involved in PDSI.

A support programme for the prevention of PDSI will be effective if we take into account all (achievable) factors, both individual, family, group, leadership and contextual factors that influence development, so that we not only reduce the likelihood of risky behaviours occurring, but at the same time promote positive development that is well adapted to the social environment in which the child or adolescent is involved. These programmes should be based on both adolescent characteristics and relevant contextual characteristics (Justicia et al., 2006). For a child to eventually become a healthy, productive adult, they must satisfy a number of needs, which include feeling valued as a person, receiving an education appropriate to their abilities, having an established network of satisfying relationships, gaining a sense of usefulness and desirability, having a built-in support system, and facing the future and opportunities with an optimistic attitude.

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