INTRODUCTION
Conduct disorder is a clinical term referring to the clustering of persistent antisocial acts of children and adolescents. The condition is thought to be due to underlying psychopathology leading to significant impairment in one or more domains of functioning. Children are termed as conduct disordered when they exhibit an enduring pattern of antisocial acts, where there is significant impairment in everyday interactions at home and/or school, or when the child’s behaviour is deemed unmanageable by parents or teachers. The antisocial behaviour is of an intense nature and includes lying, cheating, stealing, aggression, temper tantrums, non-compliance, destructiveness and oppositional behaviour.

The definition of child conduct disorders is rather vague and imprecise and is relative to what is construed as "normal" and "abnormal" behaviour. The social and cultural context of conduct disorders is important in making sense of the way children and parents experience labelling and negative perceptions of their abilities.

These behaviours are not necessarily "abnormal" as most children at one time or another lie, defy their parents, or have a temper tantrum when they cannot have their own way. The distinguishing factor is severity and extent. For instance it is the level of the tantrum and disruption, the fact it
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occurs frequently and in more than one setting and is persistent over time. Hence the quality of the behaviour is different.

Identifying the signs

Conduct disorder is used to refer to a specific psychiatric disorder that presupposes the presence of a set of fairly well defined behavioural symptoms and that can usually be made only if certain criteria are met. (e.g. age and duration of symptoms)

Some children manifest conduct disorder in terms of overt aggressive and hostile acts towards others (e.g. setting fire, destroying property), while others show a pattern of covert, deceitful acts (eg. stealing, lying) without accompanying interpersonal aggression, and still others show a combination of these two patterns of antisocial behavior. These externalizing behaviour problems are characterized by high rates of hyperactivity, aggression, impulsivity, defiance, and noncompliance.

They are physically and verbally aggressive beyond what is seen among their peers. Usually, teenagers with serious conduct disorders engage in a number of unacceptable activities. Almost invariably, they seem to have little or no remorse, awareness or concern that what they are doing is wrong.

For example, children and adolescents with conduct disorders might bully, threaten and intimidate others. Typically, they initiate physical fights, sometimes using weapons such as bats, bricks, broken bottles, knives and guns. These are the children and later, the adolescents and adults who get
involved in muggings, purse snatching, armed robbery, sexual assault, animal torture and rape. Some children deliberately set fires, vandalize, and destroy others' property.

Teenagers with conduct disorders might break into other people's homes, buildings or cars. They might systematically lie to obtain goods and favors or to avoid obligations. They might con others, shoplift or get involved in forgery. They repeatedly violate rules, break curfew, run away from home or become truant. The severity of these negative or problem behaviours vary from youngster to youngster.

DIAGNOSTIC FEATURES

The DSM-IV (1994) categorizes conduct disorder behaviors into four main groupings: (a) aggressive conduct that causes or threatens physical harm to other people or animals, (b) non-aggressive conduct that causes property loss or damage, (c) deceitfulness or theft and (d) serious violations of rules. It defines conduct disorder as repetitive and persistent pattern of behaviours in which the basic rights of others or major age-appropriate norms or rules of society are violated. Subtyping is allowed based on the age of onset of symptoms. Severity can be specified as mild, moderate, or severe. The category is currently conceived of as a polythetic diagnosis in that no one specific criterion is necessary for and any combination of criteria will suffice to establish the diagnosis. There is no formal provision for evaluating the context in which these antisocial clusters occur. Both these features contribute to the fact that the category is inherently heterogenous. The current criteria
require that at least three of a list of the following fifteen antisocial behaviours be present over a period of 12 months and one of them has to be present in the past 6 months.

Aggression to people and animals

- often bullies, threatens, or intimidates others
- often initiates physical fights
- has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
- has been physically cruel to people
- has been physically cruel to animals
- has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- has forced someone into sexual activity

Destruction of property

- has deliberately engaged in fire setting with the intention of causing serious damage
- has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

- has broken into someone else's house, building or car
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- often lies to obtain goods or to avoid obligations (i.e., "cons" others)
- has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

- often stays out at night despite parental prohibitions, beginning before age 13 years
- has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
- is often truant from school, beginning before age 13 years
EPIDEMIOLOGY

According to research cited in Phelps & McClintock (1994a) 6% of children in the United States may have conduct disorder. The incidence of the disorder is thought to vary demographically, with some areas being worse than others. Since prevalence estimates are based primarily upon referral rates and since many children and adolescents are never referred for mental health, the number of teenagers affected by this disorder in India is unclear. Estimates vary by country, socio-economic status, and geographical locales. Large scale epidemiological studies conducted in several western countries indicate that conduct problems in general have a prevalence rate that ranges from 8% to 12% and that conduct disorder accounts for about 50% of that, with a prevalence rate of approximately 5%. Kazdins (1995) literature review estimates the prevalence of conduct disorder as from 2 to 6%. The DSM IV (1994) reports that the incidence of conduct disorder is as high as 6 to 16% in males under 18 and 2 to 9% in females. The onset of conduct disorder may occur as early as age 5 or 6 but more usually occurs in late childhood or early adolescence; boys outnumber girls in the prepubertal age range after which the two genders are more equal. The male-female ratio has been found to range between 5:1 and 3:1, depending on the age range studied, but at all ages boys predominate over girls. It is only in adolescence that the gap between the sexes begins to close because of the increase of the disorder in girls. Onset after the age of 16 years is rare according to the American Psychiatric Association (1994).
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Age

Symptoms of the disorder vary with age as the individual develops increased physical strength, cognitive abilities, and sexual maturity. Less severe behaviours (e.g., lying, shoplifting, physical fighting) tend to emerge first, whereas others (e.g., rape, theft while confronting a victim) tend to emerge last. However, there are wide differences among individuals with some engaging in the more damaging behaviours at an early age.

Gender

Gender differences are also found in specific types of conduct problems in males with a diagnosis of conduct disorder frequently exhibit fighting, stealing, vandalism, and school discipline problems. Females with a diagnosis of conduct disorder are more likely to exhibit lying, truancy, running away, substance use, and prostitution. Whereas confrontational aggression is more often displayed by males, females tend to use more non-confrontational behaviours. Gender differences and the development and persistence of child conduct disorders appear significant (Rutter, 1977). Patterson et al's (1975) work with aggressive children show that boys are much more likely than girls to develop aggressive behaviour problems and unchecked, they are likely to become more serious. Another study reveals that 73% of pre-school boys with behaviour problems has similar difficulties at age 8 compared to only 47% of girls (Richman et al., 1982).
The findings from most studies point towards a higher prevalence of conduct disorder among boys and girls. But alternate models proposed for girls’ antisocial behaviour suggest that girls are more likely to express their aggression in relational terms than in physical terms, or harming others through purposeful manipulation or damage to their peer relationships, such as by spreading rumors (Crick & Grotpeter, 1995).

**COURSE OF CONDUCT DISORDER**

The early onset conduct disorder begins formally with the emergence of aggressive and oppositional tendencies in the early preschool period, progresses to aggressive (fighting) and non aggressive (e.g. lying and stealing) symptoms of conduct disorder in middle childhood and then develops into the most serious symptoms by adolescence, including interpersonal violence and property violation.

Although few younger children meet the criteria for conduct disorder, most are in late childhood or early adolescence and few have an onset after age sixteen. The behaviours that ultimately result in a diagnosis of this disorder can be traced back to earliest childhood. In the youngest age group of three to six years old, parents report argumentations, stubbornness, and temper tantrums. As the child enters school, more oppositional behaviours are noted and fire setting and stealing may begin. Some girls have a late onset of conduct disorder that is usually associated with promiscuity and alcohol and substance use in the early teens.
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In middle childhood, the child may seem more alienated from social situations especially school with significantly more conflict with teachers which can be associated to poor parent teacher relationships. The child may experience low social competence and tend to be rejected by peers which results in fewer friends and identification with deviant peer groups. The child has social cognitive distortions, which manifest as difficulty in reading emotions and over perceive hostile intent in other. Social problem solving difficulties are evident from the more punitive as well as aggressive responses and fewer competent responses. The child has increased likelihood of variety of language and learning difficulties which affects his academic performance.

During those childhood years of 8 to 13, children begin to bond with certain friends. When children find themselves not in a social group, they feel rejected, hurt, and angry. Social outcasts tend to reach out to other social outcasts who typically display the characteristics of social disobedience, criminal activity, and violence. Children and adolescents who do not have bonds with socially acceptable kids feel they must act out for attention. Criminal activity, violence, and other socially unacceptable behaviours make children feel somewhat accepted with the attention that they receive.

Adolescent years are marked with commitment to deviant peer groups, delinquent acts including truancy and school drop out, substance abuse especially at 10-13 years and early sexual activities with continued alienation. Adolescents diagnosed with conduct disorder are always psychologically and/or psychiatrically evaluated, because family trauma and being socially outcast
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seem to be the top factors in determining the cause of conduct disorder. By the time adolescents reach the age of 13 without treatment, treatment becomes unusable. Once this age hits, children think nothing is wrong with them and that the outside world simply does not understand them. At this point, the stage change from conduct disorder to antisocial personality disorder begins.

Long-term research indicates that many adults with antisocial personality disorder have a history of conduct disorder as children and the likelihood of an adult diagnosis with antisocial personality disorder (APD) increases if attention-deficit hyperactivity disorder (ADHD) is present in association with conduct disorder. The types of behaviours exhibited by an adult with APD such as irresponsible behaviour at work, within family situations and friendships are similar to those that manifest in a child with conduct disorder. Thus the more juvenile equivalents of the adult behaviour such as recurrent truancy, shoplifting and running away from home are typical of conduct disorder. One of the major differences between the two age-specific disorders is that in antisocial personality disorder there is a noted absence of remorse which is usually present in children with conduct disorder.

CONDUCT DISORDER AND JUVENILE DELINQUENCY

The term Conduct Disorder and juvenile delinquency are often used interchangeably. But they are not the same though there is much similarity and considerable overlap. Conduct Disorder is a diagnostic term while Juvenile Delinquency is a legal term. Not all youth who are delinquent have
conduct disorder and not all youth who have conduct disorder are juvenile delinquent. Some youth who do not meet the criteria for conduct disorder may be incarcerated for such violations as marketing controlled substances or failing to meet the conditions of their parole. These individuals are classified as juvenile delinquents but would not necessarily receive a diagnosis of conduct disorder. Youth who have committed isolated but serious acts of misconduct could be deemed delinquent without receiving a diagnosis of Conduct Disorder. This may be because as Wassermann et al. (2002) has observed that incarcerated youth may not be able to indulge in misconduct because of the limited opportunity to do so as they are under observation.

ETIOLOGY

Conduct disorder can best be described as a final common pathway for several initially divergent developmental trajectories.

Many children who have been diagnosed with conduct disorder typically experience some type of trauma or imbalance before actually developing these characteristics. The behaviours exhibited by the child with conduct disorder makes one wonder what makes a child become so outwardly violent and corrupt.

Researchers have come to the conclusion that many factors contribute to the development of conduct disorder. Most commonly, stressful family situations seem to be a link to conduct disorder. The death of a family member, divorce and the remarriage of parents are stressful and confusing to
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children. During the time of divorce and remarriage, children typically think it is due to their fault that the situation occurred in the first place. Many begin to think of the things they could have done to make their parents remain together. However, children also think parents get divorced because they do not love them anymore. During the years of 8 to 13 years of age, many children also mimic the characteristics of their parents. If they see their father or mother yelling, they think that this is an acceptable behavior. When children do not understand the reasons for the situation, they desperately seek attention, even if it means acting out in an unacceptable manner. Children, thus, could begin shoplifting, bullying, being disobedient and even starting physical fights at school just for getting attention.

Other factors taken into consideration for the cause of conduct disorder are being biologically imbalanced and socially outcast within peer groups. Researchers have conducted many experiments trying to figure out if there is actually a biological or chemical imbalance within the brain that causes the characteristics of conduct disorder to develop. It has been shown that certain chemicals within the brain become imbalanced causing a decrease in decision-making and right/wrong perception. Certain types of medication have been prescribed to change the imbalance. A biological base, however, does not solely cause conduct disorder. In fact, peer groups are another link to the characteristics and diagnosis of conduct disorder.
Brain damage, child abuse, genetic vulnerability, school failure, and traumatic life experiences are some of the other factors that contribute to a child developing conduct disorder.

THEORIES OF ETIOLOGY OF CONDUCT DISORDER.

Several theories are proposed regarding the causes of conduct disorder. These theories include genetic predispositions, physiological influences, learning experiences, social, familial and environmental influences, and individual characteristics. Research suggests that these factors tend to exist in combination rather than isolation. In addition, the prevalence of these factors may increase or decrease the likelihood of this disorder.

Comings (1997) explores the notion that conduct disorder may be genetically related. He provides empirical support to show that this childhood behaviour as well as other disruptive disorders have a strong genetic component, are inherited by both parents, and share a number of genes in common that affect certain levels of dopamine in the brain.

Dodge (2000) describes some risk factors for the onset of conduct disorder. These include biological factors, socio-cultural contexts and life experiences. Other researchers hold that family dysfunction contributes to the formation of conduct disorders in children.
Frick (1993) explores three types of family dysfunction as well as implications for studying models that depict family causal relationships with conduct disorder. Parental adjustment, marital situation and socialization processes were found to be influential. Parental adjustment is examined over three domains: depression, substance abuse and antisocial behaviour. Although not directly related, Frick suggests that parental depression may contribute to adjustment problems in children which may lead to behaviour difficulties. Substance abuse in isolation does not place the child at risk for conduct problems. However, when determining the relationship of substance abuse, it is important to recognize the broader implications of subsequent parent behaviours and interactions with children. Unlike depression and substance abuse, research has shown a direct relationship between parental antisocial behaviour and the manifestation of similar behaviour practices in children.

The relationship of family dysfunction can be viewed from a three causal type relationships: mediational, bi-directional and third-variable where the family may directly influence the development of a conduct disorder. The child's antisocial behaviour may be attributed to the family's dysfunction or an unrelated variable may negatively affect the family and child. These models reflect the notion that parent/family effects on childhood conduct disorders are corelational and not directly casual.
Clarizo (1997) describes the individual and environmental factors that may influence the initial development, severity and chronicity of conduct disorders during childhood and adolescence.

Dodge (2000) notes that the socio-cultural environment in which the child is born must be explored. There are many ecological (e.g. low SES) conditions that can dispose the child toward manifesting conduct problems. These conditions display their effects at different points in the child's development. Life experiences such as parenting styles, peers, and schooling can also affect a development toward conduct disorder. Dodge continues to emphasize that a single factor alone cannot account for the development of conduct disorder. Rather, it is crucial to examine how these factors cooperate with each other to provide the risk for the onset of conduct disorder. As a result of this view, the interactive model is presented where the belief is that certain distal factors function only in the presence or the absence of another risk factor.

Phelps and McClintock (1994b) take the biosocial approach to conduct disorder. The biosocial approach states that neither social nor biological factors alone can explain the complexity of such behaviours as manifested by conduct disorder. Rather, it is the interaction between the social and the biological factors that can shed light on this disorder. As a result, these factors must be examined both independently as well as in interaction with one another. In their article, they address the issue of inappropriate research design that often results in faulty conclusions about the etiology of conduct
disorder. Phelps and McClintock believe that the biosocial approach is helpful in identifying important interactive variables that place children and adolescents at risk.

The developmental approach involves a variety of influences that affect the prevalence and onset of a particular behaviour. Specific to conduct disorders, a multi-dimensional approach must be taken in assessing the etiology of this behaviour. This approach includes such factors as sociological, environmental and physiological aspects, which tend to influence the development of behaviours among children and adolescents. These factors tend to be interrelated in nature and may manifest themselves at different points in the child's development. This view can further be explored by adopting the transactional developmental model. This model holds that we need to acknowledge the ways that distal risk factors correlate with each other and may even cause one another across time (Dodge, 2000). Understanding the nature of conduct disorders from a multi-dimensional approach will help to determine the normalcy of the antisocial behavior. Moreover understanding the various dimensions involved with this disorder aids in implementing appropriate interventions.

Patterson (1982) has developed a coercion hypothesis to account for the development and maintenance of behaviour leading to conduct disorders. According to Patterson, infants have a repertoire of coercive behaviours that are highly adaptive in shaping parental responses (e.g., crying when hungry or uncomfortable to get parent’s attention). As infants grow older, he majority
learn other ways to get their needs met. However, if parents fail to reinforce appropriate social behaviours and/or continue to respond to coercive demands, then a pattern of coercive behaviour and responses may be set into motion. For example, mother asks the child to put away his toys; the child whines and refuses; the mother then gives up and does it herself rather than listen to the whining, thus reinforcing the coercive behavior of the child. In a different scenario, if the mother escalates her demand by yelling and becoming aggressive rather than giving up, she may eventually get the child to comply; thus she is reinforced for her aggressive behaviour, and a pattern of negative coercion is created. Over time, these interactions can establish a pattern of escalating coercion between parent and child that eventually determines the way the child will interact with others.

Wahler (1980) believes that positive reinforcement can also play a role in the development of conduct disordered behaviour. According to this hypothesis, the child’s disruptive behaviour elicits either verbal or physical attention from the parent, thus inadvertently reinforcing the behaviour. In the previous example, the mother might approach the child and quietly try to talk to him to put up his toys by reasoning with him; the positive attention afforded by his refusal would then serve to reinforce the refusal.

These models focus on parent child interactions. Although much less has been written about conduct disordered behaviours in the school setting, these principles can operate in teacher–child interactions in the classroom (Atkeson and Forehand, 1984).
CAUSES OF CONDUCT DISORDER AND INTERPLAY OF RISK FACTORS.

On the basis of the majority of epidemiological studies from the industrialized West, it can be stated that between 5% and 10% of children in the age range 8±16 have significant persistent oppositional, disruptive or aggressive behaviour problems. The high prevalence and the severity of the problems arising from disruptive and aggressive behaviours in young children mean that they constitute a major health challenge. The conduct disorders are distinctive in conferring considerable risk to the individual and at the same time being embedded in his or her social context. The symptoms of the disorders also has an impact on family, peer, educational and wider social relationships. The origins, maintenance and cessation of the difficulties can not be understood independently of these contexts.

Merely enumerating risk factors is misleading without conveying some of the complexities in how they operate. These complexities have divert implications for interpreting the findings for understanding the disorder and for identifying at risk children for preventive interventions first risk factors to come in “package”. Thus at a given point of time several factors may be present such as low income, large family size, over crowding poor housing, poor parental supervision, parent criminality and marital discard (Kazdin 1995). Second overtime several risk factors become interrelated, became the presence of one risk factor can augment the accumulation of other risk factors for example early academic dysfunction can lead to truancy and dropping out
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of school which further increase risk for conduct disorder. Third, risk factors may interact with (be moderated or influenced by) each other and with other variables (Boyce and offord (1990 cited by Kazdin, 1997). As an example, large family size has repeatedly been shown to be a risk factor for conduct disorder. However, the importance of family size as a predictor is moderated by income if family income and living accommodation are adequate family size is less likely to be a risk factor.

The existence of biological influences does not preclude the role of the environment and other studies show that this disorder is most apt to revert among children whose parents are “maladjusted inconsistent, arbitrary and prone to explosive expression of anger Baum (1989, cited by Kazdin 1997). Their mothers are more likely to be depressed or anxious than women in general. Their fathers show a variety of problems as well including criminality, alcoholism, desertion and sexual promiscuity. The direction of causality is not clear in these correlations. Researchers are of the opinion that mutual influences among all these factors, with their effects, over time should be expected (Patterson, DeBeryshe Ramsay, 1989).

Although there is currently no agreement about a uniform model applying to all forms of conduct disorder, one possible model for the combination of causal factors is that of genetic liability triggered by an environmental adversity, mediated by other factors such as poor coping. Although there is some debate on the relative importance of the factors that
have been implicated, there is general support for the developmental nature of the disorder.

Though the exact cause of conduct disorder is not known, a variety of possible pathways, taken together, leads to development of conduct disorder. A genetic vulnerability, biological influences compounded by an abusive and neglectful upbringing with few models for coping with stresses other than through violence and substance abuse, combined with a psychological unwillingness to manage these stresses in other ways, converge in the person with conduct disorder.

Many children who have been diagnosed with conduct disorder typically experience some type of trauma or imbalance before actually developing these characteristics. The behaviour exhibited by the child with conduct disorder makes one wonder what makes a child become so outwardly violent and corrupt.

How these factors contribute to the development of conduct disorder is examined in detail in this section.
1. Genetic Vulnerability.

Many children and teens with conduct disorder have close family members with mental illnesses including mood disorders, anxiety disorders, substance use disorders and personality disorders. This suggests that vulnerability to conduct disorder may be inherited. Children with conduct disorder may inherit decreased baseline autonomic nervous system activity, requiring greater stimulation to achieve optimal arousal. This hereditary factor may account for the high level of sensation-seeking activity associated with conduct disorder. Estimates from twin and adoption studies show that conduct disorder has both genetic and environment components. The risk for conduct disorder is increased in children with a biological or adoptive parent with antisocial personality disorder or a sibling with conduct disorder. The disorder also appears to be more common in children of biological parents with Alcohol dependence, Mood disorder and Schizophrenia or biological parents who have a history of Attention-deficit/hyperactivity disorder or conduct disorder. Longitudinal studies indicate a link between conduct disorders and different generations and there is some evidence to suggest a genetic contribution. For example, twin studies have demonstrated a greater concordance of anti-social behaviour among monozygotic than among dizygotic twins (Kazdin, 1987). Adoption research has shown that a child separated from parents who exhibit deviant behaviour is at greater risk of developing similar behaviour patterns (Kazdin, 1987).
However as indicated by studies, genetic factors alone do not provide an adequate explanation for the onset of conduct disorders. Rather, these studies reinforce the view that it is an interplay between genetic and environmental factors which include negative home conditions (e.g. marital conflict, psychiatric dysfunction), poor family problem-solving and ineffectual coping strategies (Cadoret and Cain, 1981). It is likely that biochemical underpinnings and genetic vulnerabilities interact with environmental forces and individual characteristics to cause conduct disorder.

2. Neurological Dysregulation

Studies have found that neurological abnormalities are inconsistently correlated with conduct disorder (Kazdin, 1987). While there has been interest in the implication of the frontal lobe limbic system partnership in the deficits of aggressive children, these problems may be the consequence of the increased likelihood for children with conduct disorder to experience abuse and subsequent head injuries (Webster-Stratton & Dahl, 1995).

Some studies suggest that defects or injuries to certain areas of the brain can lead to behaviour disorders. In addition, conduct disorder has been linked to special chemicals in the brain called neurotransmitters. Neurotransmitters help nerve cells in the brain to communicate with each other. If these chemicals are out of balance or are not working properly, messages may not make it through the brain correctly, leading to symptoms. Further, many children and teens with conduct disorder also have other mental illnesses such as attention-deficit hyperactivity disorder (ADHD),
learning disorders, depression, substance abuse or an anxiety disorder, which may contribute to conduct disorder.

Children with conduct disorder are found, in some studies, to show the same autonomic under arousal that characterizes adults with antisocial personality disorder. This indicates that children with conduct disorder do not experience the same degree of anxiety and fear as do other children and this may be the raw material from which their disruptive activities result West (1982 cited by Kazdin, 1997).

Raine et al. (2000) found that prefrontal cortex volume was significantly smaller in violent, antisocial men than men in control group. The study indicates the prefrontal cortex—that region of the brain above the eyes and behind the forehead involved in judgment, planning, and decision making is not working right in criminals and potential criminals.

Bauer and Hesselbrock (2006) concluded that "the neurophysiologic substrate underlying conduct-problem behaviours is bilaterally represented within the prefrontal cortex."

3. Psychological and social factors.

Conduct disorder is more likely to be paired with diverse and complex disturbances in psychological domains. The origin of these disturbances is not clear, but their presence implies that many risks for conduct disorder are retained and internalized and is independent of specific environments.
Academic underachievement, learning disabilities, and problems with attention span and hyperactivity are all associated with conduct disorder. Hyperactivity, especially in the presence of poor parental functioning, is a risk; it seems to facilitate rapid development of conduct disorder. Neuropsychological deficits have been documented implicating frontal and temporal lobe dysfunctions. Laterality and language performance are disturbed. Higher personality functions are also affected. In complex social situations, children with conduct disorder have been shown to perceive fewer appropriate responses, lack the skills to negotiate conflict and lose their ability to restrain themselves when emotionally stressed.

(a) Temperament

Considerable research has been carried out into the role of child temperament, the tendency to respond in predictable ways to events, as a predictor of conduct problems. Aspects of the personality such as activity levels displayed by a child, emotional responsiveness, quality of mood and social adaptability are part of his or her temperament. Longitudinal studies have found that although there is a relationship between early patterns of temperament and adjustment during adulthood, the longer the time span the weaker this relationship becomes.

A more important determinant of whether or not temperamental qualities persist has been shown to be the manner in which parents respond to their children. "Difficult" infants have been shown to be likely to display behaviour problems later in life if their parents are impatient, inconsistent
and demanding. On the other hand "difficult" infants, whose parents give them time to adjust to new experiences, learn to master new situations effectively. In a favourable family context a "difficult" infant is not at risk of displaying disruptive behaviour disorder at the age of 4 (Thomas and Chess, 1977; Thomas, Birch and Chess, 1968; Herbert, 1978).

Cognitions may also influence the development of conduct disorder. Children with conduct disorder have been found to misinterpret or distort social cues during interactions with peers. For example, a neutral situation may be construed as having hostile intent. Further, children who are aggressive have been shown to seek fewer cues or facts when interpreting the intent of others. Children with conduct disorder experience deficits in social problem solving skills. As a result they generate fewer alternate solutions to social problems, seek less information, see problems as having a hostile basis and anticipate fewer consequences than children who do not have a conduct disorder (Webster-Stratton and Dahl 1985)

(b) Cognitive and Social Skills Deficits

The conduct disordered child is more often than not attempting to resolve a problem through poor behaviour, though methods or techniques may be crude and the perception of the problem faulty. Social cues during peer interactions are perceived incorrectly (Milich and Dodge, 1984) and hostile intent is attributed to innocuous situations.
Children displaying aggressive behaviour problems seek fewer clues when making sense of a person's behaviour (Dodge and Newman, 1981) and instead focus in on, and respond more to aggressive triggers (Goutze, 1981 cited by Goutze 1987), leading to an inappropriate violent response. Deficits in social problem-solving skills lead to poor peer interactions (Asarnow and Callan, 1985). Problems may be defined in a hostile fashion, not enough information is gathered to generate effective solutions and the full consequences of aggression are not taken into consideration (Slaby and Guerra, 1988; Richard and Dodge, 1982). In addition there is a lack of empathy with the other person's views and feelings (Feshbach, 1989). It is unclear though whether this poor filtering or processing of social information is more attributable to negative interactions with parents, carers, peers or teachers rather than organic factors. If removed from their homes, youth with Conduct Disorder may have difficulty in staying in an adoptive or foster family or group home, and this may further complicate their development.

c. School-Related Factors

Academic Difficulties

The behaviour interferes with performance at school or work, so that individuals with conduct disorder rarely perform at the level predicted by their IQ or age. Their relationships with peers and adults are often poor. They have higher injury rates and are prone to school expulsion and problems with the law.
Low academic achievement is characteristic of conduct disordered children throughout their school career (Kazdin, 1987), in particular reading difficulties (Sturge, 1982). Rutter et al. (1976) found a 28 month delay in reading skills. The relationship between poor academic performance and conduct disorders is complicated as it appears that it is not only unidirectional but also bi-directional. Hence it is not clear whether disruptive behaviour problems precede or follow the academic difficulties, language delay or neuro-psychological deficits. Though there is some evidence which suggest that cognitive and linguistic problems may precede disruptive behaviour problems (Schonfeld et al., 1988).

In addition, delinquency rates and academic performance have been shown to be related to characteristics of the school setting itself. Such factors as physical attributes of the school, teacher availability, teacher use of praise, the amount of emphasis placed on individual responsibility, emphasis on academic work and the student-teacher ratio have been implicated (Webster-Stratton and Dahl, 1995).

**Child Interactions**

On starting school, the conduct disordered child can experience interactions which further shape and reinforce difficulties. Aggression and disruptive behaviour leads to rejection by peers (Ladd, 1990), sometimes lasting for a child’s school career. Peers become increasingly mistrustful and respond in such a way as to hasten the possibility of an aggressive response (Dodge and Samberg, 1987). Behavioural problems lead to poor relations...
with teachers as the child becomes labelled as a "troublemaker" and hence receives less positive attention, encouragement and support and more disciplinary action (Campbell and Ewing, 1980; Rutter et al., 1976; Walker and Buckley, 1973). Again an interactional vicious circle is created, the end result potentially being expulsion. Webster-Stratton’s (1994) work with conduct disordered children (3-7 seven year old) revealed that in excess of 50% had been asked to leave two or more schools.
School and Home Interaction

Interactionally the historical relationship between a family and school, has an impact on learning experiences (Bronfenbrenner, 1979). The child’s "bonding" to social institutions (both family and school) as well as the family’s bonding to the child and school can act as critical factors in the prevention of deviant behaviour. For instance, many parents of behaviourally difficult children have had aversive experiences with their child’s teachers. Such encounters reinforce an already existing parental helplessness, which mitigates against effective problem-solving, further driving a wedge between home and education. Hence a spiralling pattern of poor behaviour, parent demoralisation and withdrawal, and teacher reactivity can ultimately lead to total lack of co-ordination in the joint socialisation of the child.

In recent research, teachers reported that parents of children exhibiting significant behavioural problems showed less interest in getting to know them, had different goals for their children and placed less importance on education than parents with well adjusted children Coie et al. (in press cited by Gill, 1998). In essence where there is a positive long-standing bond, it is more likely that the child will flourish as parents feel more involved and are more supportive of their child achieving (Hawkins and Weiss, 1985). Reciprocally the school enables and encourages such a process by good communication, involving the parent and importantly by recognising the child’s accomplishments.

4. Parent and Family characteristics.
Poor family functioning, familial aggregation of drug and alcohol abuse, psychiatric problems, marital discord and especially poor parenting are all associated with conduct disorder. Abusive, neglectful parenting and child maltreatment are highly specific risk factors for the development of conduct disorder. The specific parenting patterns that contribute to the development of conduct disorder have been described as training in noncompliance by inconsistent responses to coercive behaviour of the child and by capitulating to demands in response to the child's coercion. There is fairly substantial evidence that viewing televised or other media violence and violence in the child's community contributes to the development of conduct disorder problems, especially in children who are at high risk for other reasons. Socio-economic disadvantage as manifested in poor housing, crowding and poverty exerts consistently negative influences.

Several characteristics of the parent and families of conduct disorder children are relevant to conceptualization of the dysfunctions. Among the salient characteristics are parent psychopathology and maladjustment, criminal behaviour and alcoholism. Parent disciplinary practices and attitudes also are associated with conduct disorder. Parents are likely to show harsh, erratic and inconsistent discipline practices. Dysfunctional relations are also evident as reflected in less acceptance of their children and in less warmth, affection, emotional support and attachment compared with parents of nonreferred youths. At the level of family relations, less supportive and more defensive communications among family members, less participation in
activities as a family and more clear dominance of one family member are also evident. In addition, unhappy marital relations, interpersonal conflict and aggression characterize the parental relations of antisocial children. These characteristics are correlated with and often antecedent to conduct problems, but do not of course necessary cause or inevitably lead to these problems. Webster-Stratton (1985) noted that half of all those children referred to the clinic with conduct problems were from families with a history of marital spouse abuse and violence.

**a) Parent Psychopathological Factors**

It is known that a child's risk of developing conduct disorder is increased in the event of parent psychopathology. Maternal depression, paternal alcoholism and/or criminalism and antisocial behaviour in either parent have been specifically linked to the disorder.

Mothers experiencing depression increases the risk of child conduct problems (Hall, 1991; Fendrich, 1990, cited by Gill 1998). In a recent community study by Williams *et al.* (1990 cited by Gill 1998), maternal depression when the child was aged 5 was found to be linked to parents’ and teachers’ reports of behavioural problems at the age of seven.

Depression also impacts on parenting behaviour directed at the child. For instance studies have shown that mothers increase the frequency of commands and in response the child non-complies at a higher rate (McMahon and Forehand, 1988; Webster-Stratton and Hammond, 1988). Depressed
mothers are highly critical of their children, find it difficult to set limits and emotionally are often unavailable. Importantly negative attention is focused in on poor behaviour resulting in it being reinforced (Webster-Stratton and Herbert, 1994).

There are two views as to why maternal depression leads to child conduct disorders. The first considers that mothers who are depressed misperceive their child's behaviour as maladjusted or inappropriate. The second considers the influence depression can have on the way a parent reacts toward misbehaviour. Depressed mothers have been shown to direct a higher number of commands and criticisms towards their children, who in turn respond with increased noncompliance and deviant child behaviour. Webster-Stratton and Dahl (1995) suggested that depressed and irritable mothers indirectly cause behaviour problems in their children through inconsistent limit setting, emotional unavailability, and reinforcement of inappropriate behaviours through negative attention.

Research into paternal factors and their contribution to the development of child conduct disorders is limited, hence great caution should be taken not to blame mothers solely for child behaviour problems.

Deviant behaviour in either parent appears connected to child conduct problems. Criminal behaviour and alcoholism in the father in particular places the child at greater risk (Frick et al., 1991). Children with parents who have antisocial personality disorder are likely to develop deviant behaviour. Also grandparents who exhibit anti-social behaviour are more likely to have
conduct disordered grandchildren. Again the nature versus nurture debate is relevant here in that it is unclear how much poor behaviour is shaped and modelled from parents and how much linked to a set of genetic predispositions (Webster-Stratton and Herbert, 1994).

b) Familial Contributions- Interparental Relations, Divorce, Marital Distress, and Violence

Conduct disorder is associated with several causative and maintaining factors, with family functioning being an important one. This is especially true in the Indian context, where a lot of the problem behaviours manifested by adolescents with conduct disorders are in the family context. Marital relationship of the parents is a key aspect of family functioning, affecting a number of other dimensions of family functioning, including adolescent adjustment.

Family characteristics appear to have an impact on the development and maintenance of conduct disorders. Conflict between parents prior to and surrounding a divorce is associated with (child behaviour problems) but not a strong predictor of child behaviour problems (Kazdin, 1987). Boys show a significant deterioration in behaviour following divorce. Though there is a considerable variation in how lone parents and their children do after separation or when the marriage legally ends. One hypothesis for the poor outcome for some children is that the stress of divorce triggers off a process for the lone parent characterised initially by an increase in depression and irritability, leading on to a loss of friends and social support, which heightens
the risk of greater annoyance, ineffectual discipline and poor problem-solving, which in turn adds to depression and stress levels, completing the vicious circle (Forgatch, 1989).

The inter-parental conflicts surrounding divorce have been associated with the development of conduct disorder. However, it has been noted that although some single parents and their children become chronically depressed and report increased stress levels after separation, others do relatively well. Forgatch (1989) suggested that for some single parents, the events surrounding separation and divorce set off a period of increased depression and irritability which leads to loss of support and friendship, setting in place the risk of more irritability, ineffective discipline and poor problem solving outcomes. The ineffective problem solving can result in more depression, while the increase in irritable behaviour may simultaneously lead the child to become antisocial.

More detailed studies into the effects of parental separation and divorce on child behaviour have revealed that the intensity of conflict and discord between the parents, rather than divorce itself, is a significant factor. Children of divorced parents whose homes are free from conflict have been found to be less likely to have problems than children whose parents remained together but engaged in a great deal of conflict, or those who continued to have conflict after divorce. Webster noted that half of all those children referred to their clinic with conduct problems were from families with a history of marital spouse abuse and violence.
Marriages characterised by conflict and aggression, observed by children, appear to be linked to the development of conduct disorders. This behaviour being shaped up and modelled by parents as an "appropriate" way of dealing with problems and then copied by the child. Also if aggression is not present in marital conflict, there is less likelihood of conduct problems developing (Jouriles, Murphy and O’Leary, 1989). In addition such conflict has been shown to be associated with negative perceptions of a child’s adjustment, inconsistent handling, an increase in punitiveness, decreased reasoning and fewer rewards being used (Stonemen, Brody and Burke, 1988).

Frick et al. (1989), looking at the association between marital distress and child conduct disorders, found that the quality of psychological adjustment and marital satisfaction, (has a significant impact) significantly impacted on the quality of parent-child interaction. But no association was found with environmental factors such as poverty and low economic status. Similarly Simons et al. (1994) concluded that the level of support between parents had a significant impact on parenting abilities and thereby on the development of conduct disorders.

c) Family interaction, parent–child relation, family adversity and insularity

Life stressors such as poverty, unemployment, overcrowding and ill health are known to have an adverse effect on parenting and to be therefore related to the development of conduct disorder. The presence of major life
stressors in the lives of families with conduct disordered children has been found to be two to four times greater than in other families.

Research has suggested that parents of children with conduct disorder frequently lack several important parenting skills. Parents have been reported to be more violent and critical in their use of discipline, more inconsistent, erratic, permissive, less likely to monitor their children, as well as more likely to punish pro-social behaviours and to reinforce negative behaviours. A coercive process is set in motion during which a child escapes or avoids being criticised by his or her parents through producing an increased number of negative behaviours. These behaviours lead to increasingly aversive parental reactions which serve to reinforce the negative behaviours.

d) Parenting Skill Deficits

Parenting style and the effectiveness of learned child management skills play a vital role in what a child learns. Parents who have not acquired effective parenting skills have a greater tendency to lack confidence and self-efficacy, to be more critical and punitive, to lose their temper and resort more readily to physical punishment, to be more permissive, erratic and inconsistent, to have difficulties tracking and monitoring children’s behaviour, and to be more likely to reinforce poor behaviour whilst ignoring or punishing pro-social behaviour (Sansbury and Wahler, 1992; Webster-Stratton, 1992, 1985; Patterson and Stouthamer-Loeber, 1984; Patterson, 1982).
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One of the most common conduct problems is non-compliance. Research indicates that parents of such children give commands that are vague, negative and frequent. They are delivered in a threatening, angry, humiliating and nagging manner. They are unrealistic and the child is interrupted before there is time to comply (Gambrill, 1983; Patterson, 1982; Forehand et al., 1979)
Coercion Hypothesis

Parent-child interaction does not occur in a vacuum. It occurs within different social and environmental contexts which it influences and is influenced by. Hence such interrelationships are systemic and include the child, parents, siblings, extended family, school, community, society etc. Such social systems are living forces which continually shape and influence behaviour. Patterson’s (1982) coercion hypothesis or process illustrates how family members get trapped into continually playing certain roles within conflictual situations, to such an extent it becomes a vicious circle. Each member has a part to play in an unfolding family drama which is run time and time again (often reciprocally reinforced).

Thus, when looking at conduct problems, one has to look well beyond the child to realise the full impact, and within the family the negative consequences are often huge. For instance, high rates of aversive child behaviour can often be linked to reduced family interaction, an increase in isolation, fewer shared recreational activities, loss of self esteem and increased negative attributions towards other family members (Gambrill, 1983).

Learned Helplessness

Seligman’s (1975) theory of learned helplessness is valid when looking at parenting behaviour, attributions, beliefs and the interrelationship between them. For instance a parent with a long-standing child conduct disorder can
experience constant "defeat" in effectively managing behavioural problems. The parent cognitively makes sense of this by believing that whatever they do the child will remain the same, hence rationalising inaction or doing nothing. As the parent feels increasingly powerless so more control is given to the child, whose behaviour deteriorates, which then feeds or provides evidence for the negative attributions. The child or "little devil" becomes distant, less attractive and pleasurable to be with, leading to a higher risk of physical punishment and abuse. The parent then feels "trapped", "useless" and believes that the child is behaving maliciously in order to "get back at them" and so the cycle continues (Webster-Stratton and Herbert, 1994; Webster-Stratton and Hammond, 1988). Also such poor self esteem is linked to low parental satisfaction, further impacting on the child (Johnston and Mash, 1989).

As evidenced in the above the learned helplessness hypothesis is that those who experience events which they feel they have no control over, develop motivational, cognitive and emotional deficits (Abramson, Seligman and Teasdale, 1978; Maier and Seligman, 1976; Seligman, 1975). Abramson, Seligman and Teasdale (1978) made a distinction between universal and personal helplessness. In universal helplessness the person believes that no-one can solve the presenting problem, whilst in personal helplessness the person believes the problem is solvable but not by them (low self-efficacy expectations). Research suggests that personal helplessness is often characteristic of parents with children who suffer from a conduct disorder. For example, such parents will often compare their children to others who they
believe are better behaved as their parents are more capable of dealing with behaviour problems. Such attributions are further reinforced by other family members, friends and professionals etc. who also attribute the behaviour problems to poor parenting skills (Webster-Stratton and Herbert, 1994).

5. Environmental stress and other social factors

Low socio-economic status and not being accepted by their peers appear to be risk factors for the development of conduct disorder. Social theorists have suggested that poverty, abuse, neglect and poor parenting all contribute to the development of conduct disorders. Conduct disordered youths are likely to live in conditions of overcrowding, poor housing and high crime neighbourhoods and to attend schools that are in disadvantaged neighbourhoods. Many of the untoward conditions in which families live place stress on the parent or diminish the threshold for coping with everyday stressors. The net effect can be evident in adverse parent-child interaction in which parents inadvertently engage in patterns that sustain or accelerate antisocial and aggressive interactions (Patterson et al., 1992). Also contextual factors (e.g. poor living conditions) are associated with other influences (eg: deviant and aggressive poor group, poor supervision of the child) that can further affect the child.

Overall research indicates that major life stressors such as poverty, unemployment, cramped living conditions and illness have a negative impact on parenting and are related to many childhood problems including conduct disorders (Kazdin, 1986; Rutter and Giller, 1983). Families experiencing
behavioural problems report an incident rate two to four times higher than non-clinic families (Webster-Stratton, 1990). More daily life "hassles" and life crises lead to aversive and coercive parent-child interactions, potentially resulting in inappropriate and ineffectual practices such as a sudden loss of temper leading to physical punishment (Whipple & Webster-Stratton 1991; Webster-Stratton 1990; Corse, 1990; Forgatch, Patterson and Skinner, 1988). In addition, isolated, multi-stressed mothers have a tendency not to involve family and friends in problem-solving discussions and when this is attempted it is not reinforced (Wahler and Hann, 1984)

There does not appear to be a direct link just between social class and child conduct disorders, unless certain risk factors are included in the definition. Hence, when these factors are excluded by controls, the relationship is not significant (Kazdin, 1987).

6. Correlates and associated features

Individuals with conduct disorder may have little empathy and little concern for the feelings, wishes and well being of others. Especially in ambiguous situations, aggressive individuals with this disorder frequently misperceive the intentions of others as more hostile and threatening than is the case and respond with aggression that they then feel is reasonable and justified. They may be callous and lack appropriate feelings of guilt and remorse. It can be difficult to evaluate whether displayed remorse is genuine because these individuals learn that expressing guilt may reduce or prevent
punishment. Individuals with this disorder may readily inform on their companions and try to blame others for their own misdeeds.

Some of the most violent youngsters are likely to be those who have been the most severely abused themselves. Their way of dealing with the abuse is to dissociate their feelings from action. They thus appear to be cold, detached and lacking in empathy. Yet, because it is the most deeply disturbed teenagers who tenaciously maintain their bravado, boast of their offenses, and threaten others with further violence. They are often passed over to the justice system without effective psychiatric evaluation and intervention. Self-esteem is usually low, although the person may project an image of “toughness”, Poor frustration tolerance, irritability, temper outbursts and recklessness frequent associate features. Accident rates appear to be higher in individuals with conduct disorder than in those without it.

Conduct disorder is often associated with an early onset of sexual behaviour drinking, smoking, use of illegal substances and reckless and risk-taking acts. Recently, there seems to be a significant increase in such nonaggressive aspects of conduct disorders as running away, truancy and substance abuse. It is common for troubled teenagers to use drugs and alcohol. The teenager may use drugs and alcohol in an attempt to self-medicate for symptoms of anxiety, depression, thought disorders and hyperactivity. They may wish to blot out memories of abuse or treat insomnia. Some think they need drugs or alcohol just to be able to face another day in a
violent, abusive household. Illegal drug use may increase the risk that conduct disorder will persist

Conduct disorder behaviours may lead to school suspension or expulsion problem in work adjustment, legal difficulties, sexually transmitted diseases, unplanned pregnancy and physical injury from accidents on fights. These problems may preclude attendance in ordinary schools or living in a parental or foster home. Suicidal ideation, suicide attempts and completed suicide occur at a higher rate than expected. Conduct disorder may be associated with lower than average intelligence academic achievement, particularly in reading and other verbal skills is often below the level expected on the basis of age and intelligence and may justify the additional diagnosis of a learning or communication disorder.

Individuals diagnosed with conduct disorder exhibit neuropsychological deficits. These deficits affect verbal comprehension skills and IQ levels (Moffitt, 1993). These verbal skill deficits include impaired social judgment, weak language processing, and poor auditory memory (Moffitt, 1994). Conduct disorder often develops into antisocial personality disorder, so it is not surprising that antisocial persons share the same verbal skill deficits. The deficit in verbal understanding may well be cause for what seems to be impulsivity because the children are more likely to act on their own will when they do not understand what is going on. Delinquent children are shown to consistently score lower on IQ tests than children who are not delinquent.
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In many instances, unrecognized and untreated learning disabilities and cognitive deficits create deep frustration for a child. Thus the entire school experience gets filtered through defeat and humiliation. A child may then stop attending school or skip challenging classes. Once he leaves the structure of school which might have been a major opportunity he had for experiencing positive success, he may engage in delinquent behavior. For some children, delinquent behaviour, however unlawful or unacceptable, provides them with both the status among their peers and the opportunity for some reinforcement that they are unable to find at school.

More and more, child psychiatrists and other mental health professionals are recognizing the role played by prior physical, sexual and emotional abuse in the genesis of certain kinds of aggressive and inappropriate sexual behaviours. Substance abuse or mental illness in parents such as psychosis, severe depression or manic depressive disorders (affective disorders) can have a grave impact on the children in the family. Birth order and size of the family have both been implicated in the development of conduct disorder. Middle children and male children from large families have been found to be at an increased risk of delinquency and antisocial behaviours.

7. Conduct Disorder and Anti Social Personality Disorder

Long-term research indicates that many adults with antisocial personality disorder have a history of conduct disorder as children and the likelihood of an adult diagnosis with APD increases if ADHD is present in
association with conduct disorder. The types of behaviours exhibited by an adult with APD such as irresponsible behaviour at work, within family situations and friendships are similar to those that manifest in a child with conduct disorder. Thus the more juvenile equivalents of the adult behaviour, such as recurrent truancy, shoplifting and running away from home are typical of conduct disorder. One of the major differences between the two age-specific disorders is that in antisocial personality disorder there is a noted absence of remorse which is usually still present in children with conduct disorder.
MANAGEMENT OF CHILDREN WITH CONDUCT DISORDER

There is only modest evidence that treatment of conduct disorder is effective. Several recent reviews of the literature and a meta-analysis of over 500 studies show that a wide variety of treatments have been tried and on the average only show modest effect sizes. There is consensus among experts that early intervention is better; prevention is more effective than treatment, (although the evidence for effective prevention programs is also incomplete); and extensive approaches in naturalistic settings are preferable to those who work intensively in special settings, which bear little or no resemblance to the patient's daily environment. Dramatic interventions such as shock, incarceration or boot camps are not supported by the evidence and may even have negative outcomes. Realistic programs should be multimodal, addressing deficiencies in the multiple domains of functioning. Finally, treatment packages should reflect the developmental needs of the child because there is no one intervention that is effective across all ages.

Conduct disorder is seen as one of the most common forms of psychopathology and also one of the most costly in terms of personal loss to patients, families and society. As the disorder is complex and pervasive, it also is one of the most difficult conditions to treat. The lack of resources in the families and communities in which CD develops adds to the complexity of the treatment and also by the tendency of the juvenile justice and school systems delaying in bringing children with CD to the attention of therapists or concerned professionals.
Treatments for conduct disorder have focused on psychosocial interventions and parent training and in some cases the use of medication. They typically focus on helping young people understand the effect their behaviour has on others and developing skills for behavioural change. Treatment is rarely brief since establishing new attitudes and behaviour patterns takes time. However, early intervention that targets risks in multiple areas offers a child a better opportunity for reducing and eliminating symptoms. Several effective psychosocial treatments have been identified for CD. Among the available psychosocial interventions, Parent Management Training (PMT) (Patterson, 1982) has been demonstrated to be especially promising. PMT has focused on altering coercive parent-child interactions that foster aggressive child behaviour in the home and that distinguish families with antisocial children.

A promising treatment is cognitive behavioral Problem-Solving Skills Training (PSST) (Kendall and Braswell, 1985), which focuses on the cognitive processes and deficits that are considered to mediate maladaptive interpersonal behaviors.

Another effective psychosocial treatment is Videotape Modeling Parent Training (Webster-Stratton, 1984), which includes a videotape series of parent-training lessons and is based on the principles of parent training originally described by Hanf (1969). Henggeler et al. (1986) developed Multi Systemic Therapy (MST) which utilizes therapeutic interventions that are based on a family-ecological systems approach to delinquency and adolescent
psychopathology. This treatment simultaneously considers the multiple systems of which an adolescent is a part (i.e., family, peers, and extra familial systems). The findings indicated that the use of a family-ecological treatment decreased conduct problems, anxious-withdrawn behaviours, immaturity and association with delinquent peers significantly. Family-ecological treatment differs from traditional family therapy approaches through the emphasis placed on the utilization of theory and research findings within the field of developmental psychology and child-clinical psychology. The primary goal of family-ecological treatment is the reduction of an adolescent’s behavioral problems, but additional benefits occur. For example, mother-adolescent and marital relations in families are evidenced to be warmer and the adolescent typically becomes more involved in family interactions.

No medications have been demonstrated to be consistently effective in treating conduct disorder, although four drugs have been Lithium and methylphenidate have been found (one double-blind placebo trial each) to reduce aggressiveness effectively in children with conduct disorder (Campbell et al., 1995; Klein et al., 1997b), but in two subsequent studies with the same design, the positive findings for lithium could not be replicated (Rifkin et al., 1989; Klein, 1991). In one of the latter studies, methylphenidate was superior to lithium and placebo. A third drug, carbamazepine, was found in a pilot study to be effective, but multiple side effects were also reported (Kafantaris et al., 1992). The fourth drug, clonidine, was explored in an open trial, in which 15 of 17 patients showed a significant decrease in aggressive
behavior, but there were also significant side effects that would require monitoring of cardiovascular and blood pressure parameters (Kemph et al., 1993). The Blueprints for Violence Prevention Initiative is a comprehensive effort to provide communities with a set of programs whose effectiveness has been scientifically demonstrated. With the Office of Juvenile Justice and Delinquency Prevention support, the Initiative also provides the information necessary for communities to begin replicating programs locally. The Initiative identified 11 prevention and intervention programs that meet a strict scientific standard of programmes effectiveness and have been proven to be effective in reducing adolescent violent crime, aggression, delinquency, substance abuse, predelinquent childhood aggression and conduct disorders. By outlining high standards of programmes effectiveness, reviewing outcome evaluation results for numerous programmes and identifying successful programmes, the Blueprints Initiative has helped answer some of the questions about what does and does not work in violence prevention (OJJDP Blueprints for Violence Prevention, 2001). In a recent review of prevention efforts in this arena, Wasserman and Miller (1998) conclude that identifying developmental precursors is key to in the prevention of violent behaviours. Successful interventions and prevention programs are those that are able to attend to correlated risks in the family, community, peer and individual domains. Such multi-modal programs have been found successful at various developmental levels.
Based on studies in western countries and in India, certain risk and protective factors have been identified. These would enable the clinicians to focus on therapeutic efforts to alleviate the problem caused by risk factors and draw strength from the protective factors and plan an individually tailored package to suit a particular child. A broad framework for such a multimodal therapy should equally emphasize psychodynamic and behavioural approaches.

In India treatment packages need to be different for those who are in remand homes, those in psychiatric clinics, those identified in school or through community surveys and those who are at-risk population such as children in slums, working children and street children. Stumphauser's (1976 cited by Kapur, 1995) observation about western correctional institutions that the remand homes and orphanages rather than being a place where youth are rehabilitated provide an environment where youth learn new anti-social behaviour is even more applicable to Indian correctional facilities and other institutions where destitute children are taken care of. Researches carried out on these have pointed to the pessimistic future for the children staying there.

Longitudinal studies on the conduct disordered in the schools and community have not been reported in the Indian setting. Child behaviour therapists have tired to modify these troublesome and antisocial behaviour in many setting including the youth’s own home, community based group homes and more restrictive residential settings. Interventions generally employed are cognitive behavioral treatments using conceptual model of aggression,
contingency management includes token economy, timeout and seclusion, instruction and commands. Child skills training including general social and conversational skills, problem solving skills, self control and combined social cognitive skills is also used. Parent, marital and family skills training has also found to have a positive outcome. A psycho educational evaluation may uncover intellectual and learning problems that could cause academic and behavioural problems that, in turn, put the adolescent at risk for truancy and disruptive behaviour.

The goal of treatment for conduct disorder is to help the child learn to regulate his or her own behaviour. This is accomplished through behaviour therapy and psychotherapy, which help the child develop better self-esteem and learn how to control and express anger appropriately. For treatment to be successful, it must include the child, the family, and the school. If the child’s home environment has contributed to the development of a conduct disorder, he or she may need to be removed from that environment and placed somewhere more supportive. Children with additional conditions such as attention deficit hyperactivity disorder, depression or those displaying extreme aggression may also be treated with medication. Often, treating ADHD and depression will help improve a conduct disorder.

The earlier a conduct disorder is treated, the better a child’s chance of functioning in society as he or she gets older. Children who live in a home where they feel loved and valued, and where boundaries for behavior are clearly established, are less likely to develop conduct disorders. Pay attention
to whether your child is having difficulty in school, academically or socially, or is showing signs of depression. Treating these types of problems before they affect the child’s self-esteem can go a long way in preventing future problems.

**Intervention**

**a) Parent Management Training**

Many times, treatment for conduct disorders is family-focused. Parent management training has been used with considerable success with aggressive youngsters, especially when parents themselves are not significantly unstable or disorganized. The degree of alienation that the teenager has experienced in the family is an important variable in family-based treatment. When they can participate fully, this method helps parents recognize and encourage appropriate behaviours in their teenager and discipline the teen more effectively. In order to interact with their teenager in new ways parents learn to use positive reinforcement. They learn to link misbehaviour to appropriate consequences and develop better ways of negotiating with their teenager. Once the parent-child relationship improves, many youngsters are better able to navigate their social and academic worlds without getting as upset and disruptive. Often, however, teenagers are resistant to this kind of treatment and feel that adults are ganging up on them.

Many variations of parent training exist, but most are focused on breaking the cycle of coercive interactions between parent and child. In
accordance parents are encouraged to support prosocial behaviours rather than coercive ones by learning and implementing such skills as using positive reinforcement, negotiating compromises and using only mild form of punishment. In this treatment parents are the clients and no direct intervention with the child is attempted.

b) Family Therapy

Functional family therapy, a promising treatment approach, involves the entire family in therapy which is based on a family systems approach that presupposes that the problem behaviour of the child is serving a function in the family, a maladaptive one. The goal is to get family members to understand these dynamics in their day–to-day interactions and to alter them to more adaptive ways of communicating with one another. More specific goals are i) to increase positive reinforcement and reciprocity among family members and ii) to help them negotiate constructively and learn to identify alternative solutions to conflicts that arise. These goals are actively identified and worked on by family members during sessions with the help of the therapist.

When teenagers are willing to work with their parents in therapy, this approach can help family members learn less defensive ways of communicating with each other. It can foster mutual support, positive reinforcement, direct communication, and more effective problem-solving and conflict resolution within the family.
c) Social Skills Training

Social skills training focuses on teenagers in an effort to enhance their problem-solving abilities. Through such programs, a youngster can learn to identify problems, recognize causes, appreciate consequences, learn to verbalize feelings and consider alternate ways of handling difficult situations. Because most teenagers with conduct disorder feel alone and alienated from the adults in their lives, efforts are made to diminish mistrust of others, especially adults. This type of training helps the youngster seek and become receptive to support and encouragement.

d) School-Based Treatment Programs

These are in wide use throughout the country, in the west, whether in special residential treatment environments, designated community-based schools or specific programmes in mainstream schools. These programs can reintegrate the student into regular classes as the youngster’s behavior allows. Successful school-based programmes often assess the teenager’s strengths, interests and potential and provide special programmes to help the youth achieve skill in a particular area.

e) Cognitive-Behavioural Therapy

Behavioural therapy may help adolescents control their aggression and modulate their social behaviour. Teenagers are rewarded and encouraged for proper behaviour. Cognitive therapy can teach defiant teens self-control, self-guidance and more thoughtful and efficient problem-solving strategies,
especially as they pertain to relationships with their peers, parents and other adults in authority.

d) Medication

Since conduct problems tend to arise from a tangle of biological, emotional and social stresses, there is no single class of medication that has been found especially useful. Even when another psychiatric problem has been defined (such as ADHD, depression, manic-depressive illness or schizophrenia), medication is seldom sufficient to alter significantly the conduct disorder symptoms. If the teenager has underlying ADHD, the use of stimulants may help reduce negative behaviours and impulsiveness. Lithium, a mood stabilizer, has also been shown in some studies to reduce aggression. In some cases, anticonvulsant medications such as carbamazepine (Tegretol) have significantly curbed aggressive outbursts. Used judiciously to address specific clinical findings in each individual case, appropriate medication can enhance the success of other treatment modalities.

Given the rather dramatic and disturbing quality of the conduct disorder symptoms, it is important to keep in mind that not all behaviourally disturbed teenagers go on to become antisocial or criminal adults. On the other hand, more often than not, ongoing, adequate medical, emotional, educational and social supports are required for many years if teenagers with severely disturbed behaviour are to go on to lead meaningful lives and become productive members of society.
Operational definition of key terms.

Conduct Disorder

DSM IV defines Conduct Disorder as repetitive and persistent pattern of behaviours in which the basic rights of others or major age-appropriate norms or rules of society are violated.

Adolescence

The term adolescence comes from the Latin verb ‘adolescere’ meaning to grow in maturity. In this sense adolescence is a process rather than a period, a process of achieving the attitudes and beliefs needed for effective participation in society (Rogers 1972). Early adolescence extends roughly from 13 to 16-17 yrs and late adolescence covers the period from then until 18 (Hurlock, 1983). In girls it appears earlier than boys.

Conduct disordered children.

In the present study children who met the criteria for conduct disorder as per the Developmental Psychopathology Check-List for children were referred as conduct disordered children.

Normal Children.

Children who did not meet the criteria for conduct disorder and did not have any psychotic or neurotic features and developmental delays as per Developmental Psychopathology Check-List for children were referred as normal children in the present study.
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Psychosocial factors

According to Chaplin (1973 cited by Nicholas 2000), Psychosocial factors are defined as factors pertaining to a social relation which involves psychological factors.

In the present study the psychosocial variables intended for assessment are alienation experienced by conduct disordered adolescents, relationship with parents as perceived by the child, parental attitude, personality disorder traits in parents of conduct disorder children, family environment and factors such as gender, ordinal position, parental education and economic status.

Alienation

Alienation is a deep-seated sense of dissatisfaction with one’s personal existence, an estrangement from one’s social group (e.g., family, workplace, community, or bureaucratic institution such as government agency, school or religious groups). According to Schacht (1971 cited by Nicholas 2000) a person alienated is to claim that his relation to something else has certain features which results in avoidable discontent or a loss of satisfaction.
Parent-child relationship

Relationship between adolescents and their parents involve the expectation the children have about their parents and the expectations that parents have about their children.

Attitude

Attitude is an enduring, learned predisposition to behave in a consistent way toward a given class of persons, objects, situations etc. It is positive or negative. It possesses both cognitive and emotional components.

Family environment and interaction

Family environment denotes the socio environmental characteristics of the family and family interaction is seen as an opportunity to maintain, establish and promote parent-child relationships. In addition, family interaction is an opportunity for parents to evaluate their own parenting capacities and gain knowledge of new practices and views about parenting.

Relevance of the present study.

Conduct disorder is one of the most difficult conditions to treat, because the disorder is complex and pervasive. It is also one of the most common forms of psychopathology in the west and the most costly in terms of personal loss to patients, families and society.

The incidents of school violence in India and the increased rate of criminality in adults in India points out to the urgency in studying Conduct
Introduction

Disorder and to come out with an intervention strategy to arrest the progress of the symptoms in to the next level. Besides, several studies have shown the link between anti social personality in adults and the presence of conduct disorder traits in these adults during their childhood or adolescent years. Conduct disorder if unchecked can cause serious harm to the healthy development of the next generation, mental health of spouses and families there by affecting the society.

The scope of the problem, together with the knowledge that it is highly stable and chronic in nature and that available treatments are often limited, provide strong argument for the development of preventive approaches. The challenge is great, but effective preventive interventions must be found if one is to reduce the scope and severity of conduct disorder to a level that will be significant and noticeable for society as a whole. Conduct disorder increases the risk of several public health problems, including violence, weapon use, teenage pregnancy, substance abuse and dropping out of school. The stability of antisocial behaviour overtime leads to the conclusion that early intervention in budding conduct disorders may be essential. Young children displaying oppositional defiant and other antisocial characteristics should be identified and worked with as early as possible, even in the preschool years. The child who has been thrown out of school more than one time because of his aggression and who appears to be shaping his parents behaviour rather than vice versa is a good candidate for early intervention. The argument has
been made that if antisocial behaviour has not come under control by the time a person is eight years old it should be viewed as a chronic condition.

The life long pattern of conduct disorder and the transmission of the problem within families from one generation to the next underscore the importance of a developmental and life span perspective. It will be important to identify the course and various paths and to examine developmentally opportune points of intervention. Over the course of development, influences vary in their contribution to conduct disorder. For example during adolescence, the influence of peers on the appearance of conduct problem behaviour is marked. Identifying how such influences operate and precursors to such influences has obviously important implications for intervening. A broad range of social interventions is required to have an impact on such conduct problems. According to Kazdin (1987) conduct disorder cannot be cured but its symptoms can be managed and controlled with careful intervention

Conduct disorder has proven to be a very complex type of disorder in children and adolescents in terms of diagnosis, treatment and assessment. One primary reason for this is that there is a great deal of comorbidity with other dysfunctions such as ADHD. In addition, many factors need to be considered when diagnosing and treating a youth with conduct disorder. Some of these primary factors to consider include personal characteristics, cognitive development, the family system, peers, school environment, ecological elements (such as SES) and so forth. As a result of these factors, it
is then crucial to focus on the child’s developmental level and the developmental progression of conduct disorder. The child or adolescent’s dysfunction and problem behaviours cannot be taken in isolation of these factors. Rather, several of these elements need to be considered in combination with one another in order to attain a comprehensive view of the child’s/adolescent’s strengths and degree of impairment. The degree of impairment is an important piece to attend to as it provides information about the areas of difficulty and how such difficulties have come about which in turn can provide vital information for the appropriate treatment techniques to use with the youth.

In conclusion, information about the epidemiology and etiology of conduct disorder provides much needed knowledge regarding the appropriate assessments to be used with the individuals and in turn allowing for effective treatment plans and outcomes. It is important to note again that no single factor contributes to conduct disorder and that there is no one type of assessment or treatment that is best to use with all children. Rather, a combination of factors must be analyzed in combination and in isolation of one another in order to achieve knowledge about this very commonly diagnosed dysfunction and to treat it.

The study of psychosocial correlates and management has serious implications for developing a treatment module for adolescents thereby preventing its progress to serious conditions like antisocial disorders in adulthood. The present study has its significance at this point of time in India,
as there is a dearth of studies related to this topic in India. And the psychosocial variables studied can help to understand more about conduct disorder and can lead to constructive packages of intervention needed to reduce the severity of conduct disorder and its progression to the next level.

In view of the above mentioned, the present investigation attempts to examine the role of some psychological and social factors in conduct disorder among adolescents and to assess the efficacy of psychological intervention.