CHAPTER—I

INTRODUCTION

1.0 INTRODUCTION

Childhood should be a happy time, a time for playing, growing, learning and making friends and for most students it is. But some students’s lives are a constant turmoil. Some strike out at others, sometimes with disastrous consequences. Others are so shy and withdrawn that they seem to be in their own worlds. In either case, playing with others, making friends and learning all the things, a student must learn are extremely difficult for these students. They are students who is said to have some disordered behaviour. Students who exhibit disordered behaviour have been referred to by a variety of labels, including emotionally disturbed, maladjusted, emotionally handicapped, psychologically disordered, problem behaviour and so on. These labels may connote a wide range of problematic behaviour patterns ranging from relatively mild and transient disorders to juvenile delinquency to the profoundly and persistently deviant behaviour, typically referred to as psychotic. Even though variety of these labels reflect both extreme variation in the types of behaviour i.e. internalised and externalised included under the general rubric ‘disturbed’ or ‘disordered’, Kauffman and Kneedler (1981) prefers the term ‘behaviour disorders’, which carries the broadest and yet clearest denotation and connotation of the phenomena of behaviour that affect the regular and normal functioning of students and their social interpersonal environments. A clear cut definition cannot be given to this
comprehensive term, used for varied conditions as phobias, withdrawal, depression, anxiety, psychosomatic disorders, aggression, delinquency and a host of other deviations. Yet it is the basic term used by many international agencies of special education to describe the deviance of behaviour of students, although, various terminologies sprouted up in between.

The term ‘behaviour disorders’ is restricted to patterns of situationally inappropriate behaviour exhibited by an individual which deviate substantially from behaviour appropriate to one’s age with normal intellectual functioning with no severe sensory, motor, health or neurological deficits (Gill, 1998). But care should be taken to see whether this deviant behaviour significantly interferes with the learning process, interpersonal relationships or personal adjustment of the pupil. Discussion related to terminology and definition in the succeeding sections will make it further clear which type of students are to be included under this category and what type of interventions should be provided for them.

This chapter discusses the concept of behaviour disorders in general and conduct disorders in particular, theoretical and empirical basis for the study, objectives, nature and scope of the study.

1.1 CONCEPT AND NATURE OF BEHAVIOUR DISORDERS

Various terms are being used to describe the students who are educationally handicapped by exhibiting intense patterns of deviant behaviour frequently. Some of the terms are – emotional disturbance, emotional handicap, maladjusted, behaviour disorders, emotional or behaviour disorders, emotional and behaviour disorders, etc. the term “behaviour disorders” is used in the present study.
1.1.1 Behaviour Disorders – A Historical Perspective

Kauffman (1976, 1985) and Lam (1976) pointed out that Itard and Seguin, the beginners of special education for mentally retarded are also considered as the beginners of special education for the students with behaviour disorders. Since much importance was not given for the treatment of behaviour disorders as mental retardation, nineteenth century is considered as a period of ignorance and neglect regarding behaviour disorders (Despert, 1965; Kanner, 1962; Rubenstein, 1948). This is clearly evident when Cole (1989) reported that during this time students with behaviour disorders were sometimes confused with ‘mental defectives’ or ‘moral imbeciles’ or ‘minor delinquents’. In the beginning of twentieth century the umbrella term ‘maladjustment’ came into usage. But later in 1955, the Underwood Report of United Kingdom acknowledged confusion and found it necessary to stress that maladjustment should not be equated with deviant behaviour, delinquency, oddness or educational subnormality (Ministry of Education, 1955). So students who could have been described as ‘socially deprived’, ‘disruptive’, ‘disaffected’ or ‘mentally ill’ were categorised under ‘maladjusted’. Eventhough an uncertainty regarding terminology prevailed almost upto 1970s, in United Kingdom the Federal Government of United States brought forward the term ‘severe emotional disturbance’ from 1977 onwards. But after the first Individuals with Disabilities Education Act (IDEA) came up, in 1978, the term ‘Emotional’ or ‘Behaviour Disorders’ came to be favoured (Nelson and Pearson, 1991). Similar problem aroused in the case of definition, which was undertaken by Bower and his colleagues. Bower (1960) adopted an empirical approach of studying the characteristics of a previously labeled group to develop
criteria to guide labeling of a nonlabelled group. This was followed by Quay (1978) who led to the definition of four basic clusters of problem behaviour. Researchers like Cullinan, Epstein and Kauffman (1984) continued to add to the knowledge of the characteristics of students with behaviour disorders. Although several other models of definitions exist, empirical model of definition is adopted in the present study as it supports the Federal definition and encloses all the clusters of problem behaviour.

History shows that problems in terminology and definition lead to problems in prevalence also. Schultz, Hirshoren, Manton and Henderson (1971) found out that the rates reported by different states varied from 0.05% to 15%. Similarly Spivack, Swift and Prewitt (1971) found 16% to 40% of students rated as behaviour disordered by their teachers. Rubin and Balow (1978) reported a high prevalence rate (over 50%) of students with behaviour disorders by at least one teacher during their school career. A variation in this estimate may be because of lack of a standard definition for ‘behaviour disorders’. But after the current Federal definition of ‘behaviour disorders’ came up in 1977 Bower’s research found that 10% of the total population of students had behaviour disorders, whereas the remaining percentage of students reported by others were either having minor behavior problems or can be categorised under other labels. Smith, Wood and Grimes (1991) noticed that Bowers study was followed by a number of researches that advocated specific procedures in the identification of students with behavior disorders. Proper identification of students with behaviour disorders revealed that behaviour disorders led to other problems including academic backwardness (Algozzine, 1978). So, Carpenter and Apter (1991) proposed that proper intervention should be developed for students with behaviour disorders, so as
to bring them to the mainstream of education. Researches have revealed that several attempts were taken to identify various interventions which are useful in reducing the problems associated with behaviour disorders.

1.1.2 Behaviour Disorders – Terminology

Smith, Wood and Grimes (1992) pointed out that there is substantial professional and legal debate regarding the most appropriate term to use in describing those students who are educationally handicapped by unacceptable behavioural patterns. Several synonymous terms like serious emotional disturbance, emotional handicap, maladjustment, behaviour disorders, emotional or behaviour disorders were used interchangeably in different conditions by various authors and organisations who worked on special education. Cole (1989) suggested that the term maladjustment was replaced as it was found by Underwood Report of UK that it should not be equated with deviant behaviour whereas it represents a group of students who are nervous, having organic or psychotic disorders or educational and vocational difficulties. In this chaotic situation a special study was commissioned to determine the implication of replacing the terminology used in the Federal definition (PL 94-142), ‘serious emotional disturbance’ (Smith, Wood and Grimes, 1992). Research literature indicates that the label ‘emotionally disturbed’ has negative associations for teachers, parents and students (Antonak, 1980; Harasymiw Horne and Lewis, 1976; Tringo, 1970). This label consistently fall at the bottom of rank orderings of social acceptability as “mentally retarded”. Wood (1985) supported the above view by pointing out that, in a survey of teachers, only 13% preferred the term ‘emotionally disturbed’ whereas the remaining 87% of the respondents preferred to use ‘behaviour
disorders'. Tisdale and Fowler (1983) observed that teachers were more willing to apply the term ‘behaviour disorders’.

Kauffmann and Kneedler (1981) used this term in their articles as they found it as the comprehensive term that encompasses all the categories of problem behaviours that hinder learning. This was stressed by Gresham (1984) who advocated the adoption of the term ‘behaviour disorders’ by stating that this label recognises the fact that the major reason these students are referred and placed is primarily related to their disturbing overt behaviours rather than their disturbed covert emotions.

Above all Cole (1991) reported that The Council for Students with Behaviour Disorders (CCBD) in 1984 endorsed the term ‘behaviour disorder’ in the place of emotional disturbance stating the given reasons:

a. This term has far greater utility for education.

b. This term is not associated exclusively with any particular theory of causation.

c. The term will lead to a more comprehensive behavioural assessment that will be used in identifying such students.

d. This is less stigmatizing.

e. This term is a representative of a focus on educational responsibility.

f. It is more descriptive, accurate and more useful to educators in identifying and planning appropriate educational placements for students.

In general the term ‘behaviour disorders’ is more socially acceptable than seriously emotionally disturbed.

In some literatures the investigators have used the term “emotional or behaviour disorders” and “emotional and behaviour disorders”. But it is quite sure
that ‘behaviour disorders’ is an inclusive term for patterns of inappropriate behaviour whose underlying source is disturbed emotions and feelings. So in the present study the term behaviour disorders is used to represent the students who are handicapped by virtue of behavioural deviance. To be more specific, behaviour disorders refers to problematic behaviours ranging from internalised disorders like fear, anxiety, social withdrawal, uncommunicative and depression to externalised disorders like aggression, conduct disorder and delinquency.

1.1.3 Concept and Nature of Behaviour Disorders

To make the concept of behaviour disorders more clear, different definitions proposed by experts should be viewed. The epiphenomenal problem of deviance is complex and the definitions exist are many (Rhodes and Paul, 1978). There are nearly as many different definitions of behaviour disorders as there are different social agencies and experts dealing with troublesome students. Some of the definitions are discussed below.

Bower (1960, 1982) proposed that students with behaviour disorders are poor learners, although potentially able to learn; they have few, if any satisfactory interpersonal relationships; they behave oddly or inappropriately; they are depressed or unhappy and develop illnesses or phobias. A student with behaviour disorders exhibit these characteristics to a marked degree over a period of time.

The Federal definition of United States of America (1977) refers the students with behavioural disorders as ‘seriously emotionally disturbed’. According to definition serious emotional disturbance is a condition exhibiting one or more of the
following characteristics over a long period of time and to a marked degree which adversely affects educational performance:

(A) An inability to learn which cannot be explained by intellectual, sensory or health factors.

(B) An inability to build or maintain satisfactory interpersonal relationships with peers or teachers.

(C) Inappropriate types of behaviour or feelings under normal circumstances.

(D) A general pervasive mood of unhappiness or depression.

(E) A tendency to develop physical symptoms or fears associated with personal/school problems.

The term also includes who are Schizophrenic, but excludes socially maladjusted ones, unless they have serious behaviour disorders, since behaviour disorder is given an intrapsychic connotation.

Another definition was given by Iowa’s Public Schools (Knoff, 1995). Iowa’s definition – Behaviour disorders is the inclusive term for patterns of situationally inappropriate behaviour which deviate substantially from behaviour appropriate to one’s age and significantly interfere with the learning process, interpersonal relationships or personal adjustment of the student. Based on this students with behaviour disorders were categorised into four clusters.

1. Cluster I: Significantly deviant, disruptive, aggressive or impulsive

2. Cluster II: Significantly deviant thought processes manifested with unusual communication or behavioural patterns or both.
3. Cluster III: Significantly deviant behaviour patterns characterised by deficits in cognition, communication, sensory processing or social participation (antistic behaviour).

Significantly deviant means the behaviour is sufficiently distinct from his/her peer group to qualify the student as requiring some interventional programme on the basis of the disorder. Also the disorder is not maintained by primary intellectual, sensory, cultural or health factors.

Quay et al. (1978) developed a model for behaviour disorders, which led to the definition of four basic clusters of problem behaviour. They are:

1. Conduct disorder (aggression, disobedience, irritability)
2. Personality disorders (withdrawal, anxiety, physical complaints)
3. Immaturity (passivity, poor coping)
4. Socialised delinquency (involvement in gang subcultures)

Classic study of Quay, Morse and Cutler (1966) established the following categories of behaviour disorders, which subsequently have been supported (Conners, 1970; Kauffman, Swan and Wood, 1979; Quay 1966). They are:

1. **Conduct disorder**: Characterised by aggressive, hostile and contentious behaviour (Quay et al., 1966).

2. **Personality problem** Characterised by anxious, withdrawn and introvertive behaviour (Quay et al., 1966).

3. **Inadequacy**: Immaturity: a less distinct factor involving preoccupation, lack of interest, sluggishness, laziness, daydreaming and passivity. This factor is linked to lack of interest in awareness of the environment (Quay et al., 1966).
Quay (1966) found that students with conduct disorders or aggressiveness comprise the largest percentage and hence of much interest to the investigator which was undertaken in the present study.

Researchers including Quay (1972, 1975) identified a fourth category which included a cluster of behaviors associated with juvenile delinquency. The behaviours included breaking of rules or laws against truancy, stealing and curfew violation. But in the later classification of Diagnostic Statistical Manual for Mental Health-IV, this category is included under conduct disorders.

Students with behaviour disorders exhibit a wide range of characteristics that differ in type as well as intensity (Bullock, Zagar, Donahue, Pelton, 1985). They are:

- Aggressive/acting out behaviours
- Social deficits
- Irresponsibility
- Inadequate peer relationships
- Hyperactivity/distractibility
- Lying, cheating and stealing
- Depression
- Anxiety
- Academic deficits

All students classified as having behaviour disorders do not exhibit all of these characteristics. The ones exhibited by a particular student will depend on the nature of behaviour disorder.
1.1.4 Classification of Behaviour Disorders

Students who experience behaviour disorders make up an extremely heterogeneous population. Professionals have subcategorised the group into smaller homogeneous subgroups so that they can be studied better. Several different classification systems are used to group individuals with behaviour disorders. One classification system is given by American Psychiatric Association (1994) in DSM-IV which is partially used in the present study.

Review of the studies of students with behaviour disorders have given consistent evidence for two broad clusters of childhood disorders. (Achenbach and Edelbrock, 1978)

1. Undercontrolled/Externalised disorders: Show behaviour excesses
2. Over controlled/Internalised disorders: Show behaviour deficits

1.1.4.1 Over controlled/Internalised disorders

Students with internalised disorder cause problems to themselves and frequently complain of bothersome fears and tenseness, of feelings of shyness, of being unhappy and unloved and of being inferior to other students. Symptoms shown are anxiety and depression. Main specific problems of overcontrol frequently found in a student are childhood fears, social withdrawal and depression (Quay, 1979). Childhood fears include school phobia which occurs at the beginning and sometimes the student refuse to go to school. But unlike students with internalised disorders, students with externalised disorders are judged negatively by others and requires attention.
1.1.4.2 Under controlled/Externalised disorders

The student with externalised disorders lacks sufficient control over behaviour that is expected in a given setting and is appropriate to his/her age. Thus they will become an annoyance to adults and peers.

Quay (1979) proposed two general categories under externalised disorders. They are:

i. Attention Deficit Hyperactivity Disorder (ADHD)

   (a) Concentrating on the difficulty of the task at hand.
   (b) Involve in non-goal directed activities.
   (c) Unable to control their activity at school at meal times.
   (d) Unable to stop and moving or talking, when required to be quiet.
   (e) Running like a motor.
   (f) Disorganised, erratic, tactless, obstinate and bossy.

ii. Conduct disorders

   The term ‘conduct disorders’ encompasses a wide variety of undercontrolled behaviours. Aggression, lying, destructiveness, vandalism, theft and truancy are actions usually covered under this head. The connecting thread in this array of behaviours is the violation of societal norms and the basic rights of others. (Jimerson, 2002)
1.2 CONCEPT AND NATURE OF CONDUCT DISORDERS

The definition of conduct disorders is rather vague and imprecise and is relative to what is construed as ‘normal’ and ‘abnormal’ behaviour. Social and cultural context of conduct disorders is important in making sense of the way students and parents experience labeling and negative perceptions of their abilities. (Gill, 1998) Herbert and Webster Stratton (1994) defined students with conduct disorders as students who exhibit an enduring pattern of antisocial behaviour, where there is significant impairment in every day interactions at home and/or school or when the student’s behaviour is deemed unmanageable by parents or teachers. Behaviour is of intense nature and include lying, cheating, stealing, aggression, temper tantrums, non-compliance, demanding, destructiveness and arguing behaviour. (Kazdin, 1995) The factor that determines whether a behaviour is abnormal is its severity and extent or the frequency with which it occurs and intensity of the behaviour. (Forehand et al., 1979)

As no clear cut definition of conduct disorders is possible, it is better to depend on the diagnostic definition for identification and placement. Within the ‘International Classification of Disease’ (ICD-10) (World Health Organisation, 1988) conduct disorders are defined as “repetitive and persistent patterns of antisocial, aggressive or defiant conduct. The DSM-IV-R (Code 312.8) (American Psychiatric Association, 1994) classification characterises the disorder as a “persistent pattern of behaviour in which the basic rights of others and major age appropriate social norms or rules are violated. The Diagnostic Criteria under DSM-IV-R (APA, 1994) is discussed in Section 1.7 in the same chapter. Essentially the DSM-IV-R criterion lays
emphasis on the pervasive nature of behaviour and its persistency, i.e. at least six months in duration. Additionally the disturbed behaviour should cause clinically significant impairment on social, academic or occupational functioning. (Herbert, 1991)

Legally conduct problems are defined as delinquent or criminal acts. Therefore preadolescents and adolescents who are identified as having conduct problems by legal authorities is considered as a juvenile delinquent which is a legal term used to denote a young person under 18 years of age committing illegal actions as assault, robbery or even truancy. (Cavan and Ferdinand, 1975)

In the present study, delinquent behaviour is also included under conduct disorders, as it is seen that conduct problems are leading to delinquent acts, as they form the gangs. Concept of conduct disorders is more clearly understood by adopting a multidimensional approach discussed in next section.

1.2.1 Conduct Disorder – A Multidimensional Approach

Understanding the nature of conduct disorder from a multidimensional approach will help to determine the normally of the antisocial behaviour. In addition, understanding the various dimensions involved with this disorder, aids in implementing appropriate interventions also. Several theories exist regarding the causes of conduct disorder. These theories involve genetic predispositions, physiological influences, social, familial and environmental influences and individual characteristics. Research suggests that these factors tend to exist in combination rather than isolation. This section provides information regarding various approaches that explains the nature of conduct disorder.
Dodge (2000) describes some risk factors for the onset of conduct disorder. These risk factors include biological factors, sociocultural contexts and life experiences. Biological risk factor like functional deficit in behavioural inhibition is linked to conduct problems. However Dodge (2000) noted that findings related to biological factors are not conclusive by any means. Therefore the sociocultural environment in which the student is born must be explored. Studies have shown that ecological conditions like low socio-economic status can dispose the student towards manifesting conduct problems. Similarly life experiences of the student such as parenting styles, peers and schooling can also affect a development toward conduct disorder. Dodge (2000) continues to emphasize that a single factor alone cannot account for the development of conduct disorder. It is believed that these factors cooperate with each other to provide the risk for the onset of conduct disorder.

Phelps and McClintock (1994) take the biosocial approach to conduct disorder. The biosocial approach states that neither social nor biological factors alone can explain the complexity of the behaviours and manifested by students with conduct disorder. But rather it is the interaction between the social and the biological factors that shed light on this disorder. They believe that this approach is helpful in identifying important interactive variables that place students at risk.

Developmental approach suggests that factors like sociological, environmental and physiological aspects influence the development of undesirable behaviours. These factors tend to be interrelated in nature and may manifest themselves at different points in the student’s development. This approach is further explored by adopting transaction 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).

Apart from these approaches Comings (1997) explores the notion that conduct disorder may be genetically related. Previous research assumed that conduct disorder are learned behaviours. But Comings (1997) provides empirical support, which suggests that there may be genetic influences that cause the behaviour. Evidence shows that conduct disorder 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.

In addition to these factors family dysfunction may also contribute to the formation of conduct disorders in students. They include parental adjustment, marital situation and socialization process. Moreover research has shown a direct relationship between parental antisocial behaviour and the manifestation of similar behaviour practices in students.

Thus since the nature of conduct disorders and factors contributing to it are complex and comprehensive a multidimensional approach was adopted to explain them.

1.2.2 Characteristics of Students with Conduct Disorder

Students with conduct disorders are students who exhibit enduring pattern of antisocial behaviour, 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. Behaviour exhibited by students with conduct disorders is of intense nature including lying, cheating, temper tantrums, demanding,
destructiveness, etc. (Webster-Stratton and Herbert, 1994; Webster-Stratton, 1991; Herbert, 1987, 1988). These behaviours are not necessarily ‘abnormal’ as most students 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, i.e. frequent occurrence and persistence of behaviour. (Webster-Stratton and Herbert, 1994; Forehand et al., 1979)

American Psychiatric Association (1994) has listed out the salient features of conduct disorder.

1. Central feature is the violation of the rights of others and the disregard for age appropriate social norms involving a very diverse range of behaviours.

2. Prominent characteristics are the non-compliance and aggression these students exhibit. Non-compliance can take a variety of forms such as not doing what is asked, arguing, resistance or opposite of what is asked.

3. Defiance towards authority figures such as parents and teachers in common.

4. Relatively unrestrained aggression and low tolerance.

5. Among young students, temper tantrums are common.

6. Early signs of conduct disorder, often seen initially within the family, include disobedience, lying, stealing and aggression towards others. When the condition worsens this type of behaviour it extends outside the family into the school and the local community.

7. Though they project an image of toughness, their self esteem is low.

8. Symptoms vary with age and with gender. There are two basic types of conduct disorder. Childhood onset in contrast to adolescent onset is associated with more
serious and persistent antisocial behaviour. Males tend to express themselves in more overt ways, such as fighting and confrontation, whereas females tend to express themselves in more covert ways, such as lying, truancy and running away from home. Suicide attempts are more common in girls with the disorder.

9. Keenness to start physical fights.

10. Using weapons in physical fights.

In addition to the above, Sommers-Flanagan and Sommers-Flanagan (1998) observed the following features.

1. Students with conduct disorder also exhibits impulsiveness, poor peer relations and poor school performance.

2. Usually they are not able to see the effects of their behaviour on others and they often have deficits in social skills.

3. They have little empathy and little concern for the feelings, wishes or well-being of others and have negative relationships with most people.

4. With parents and teachers difficulties tend to revolve around youngsters’ defiant behaviour.

5. With peers main problem is aggression and bullying.

6. Peer rejection often leads to lack of self esteem.

7. These students often lie about their problems, are sophisticated at manipulating others and avoid taking personal responsibility for their actions by blaming others (Kazdin, 1995).

8. Deliberately lighting fires.

9. Vandalism
10. Tendency to hang out in gangs.

11. Lack of feelings of guilt or remorse.

12. Readily inform their companions and tend to blame others for their own misdeeds.

Some of the characteristics are observed in the beginning stage of conduct disorder whereas once they form a gang, they start exhibiting delinquent behaviours like vandalism, running away, setting fires, destruction, etc. In addition to these learning difficulties, cognitive difficulties are also crucial as identifying markers for the onset of conduct disorder. Because of all the above features, parents and teachers often exhibit a sense of helplessness due to noncompliance.

1.2.3 Factors Affecting Conduct Disorder

No single factor can account for conduct disorder. Rather many biopsychosocial factors contribute to the development of the disorder. Some of the factors associated with conduct disorder are discussed below.

(i) Temperament: Student temperamental attributes appear linked to the development of behavioural problems (Thomas and Chess, 1977; Thomas, Birch and Chess, 1968). A conflict or mismatch between a parent’s temperament with that of a student’s can lead to continued discord and tension. Among the three temperamental groups students with difficult temperamental pattern shows more tendency to develop conduct disorder. Yet Thomas and Chess (1977) argues that no one temperamental pattern guaranties that a behaviour disorder will not develop.

(ii) Cognitive and Social Skills Deficits: Milich and Dodge (1984) says, social cues during peer interactions are perceived incorrectly and hostile intent is attributed to innocuous situations. This is a major characteristic exhibited by students with conduct
disorders. Students displaying aggressive behaviour, seek fewer clues when making sense of a person’s behaviour (Dodge and Newman, 1981) and instead respond more to aggressive triggers (Goutz, 1981). It will lead to violent responses. Thus the students with conduct disorders who is lacking social cues may have difficulty in
a. Interacting with peers.
b. Social problem solving.
c. Defining problems in an appropriate manner.
d. Gathering enough information to generate solutions.
e. Empathising with other person’s views and feelings.
f. Processing social information.

(iii) Academic difficulties: Kazdin (1987) pointed out that low academic achievement in particular reading difficulties is characteristic of students with conduct disorders throughout their school career. The relationship between peer academic performance and conduct disorders is bi-directional. Hence it is not clear whether conduct problems precede or follow academic difficulties, though there is some evidence that suggest that cognitive problems may precede conduct problems.

(iv) Psychological factors: Students brought up in chaotic, negligent conditions generally become angry, disruptive, demanding and unable to maintain a progressive relationship with others. This may be due to lack of motivation or lack of role models. So they try to violate societal norms and are relatively remorseless. Emotional component also adds to the development of conduct disorder. When a student is unable to identify, manage or assimilate the feelings, the feelings will accumulate and sometimes it outbursts. This results in aggression and violent behaviour.
(v) **Child Abuse and Maltreatment**: Students who are exposed to violence for longer periods, especially those who endure physically abusive treatment often behave aggressively. The students exposed to such a situation may have difficulty in

(a) identifying their feelings

(b) verbalising their feelings

(c) perceiving a social situation

(d) controlling their violent behaviour

(e) negotiating with others

(f) establishing strong social relationship with others.

(vi) **Sociocultural factors**: Socioeconomically deprived students are at higher risk for the development of conduct disorder than children and adolescents who grow up in urban environments (Wichtrom, Skogen and Oia, 1996). Here unemployment among parents, lack of supportive social network and lack of positive participation in community activities seem to predict conduct disorder. In urban areas, conduct disorder develops due to the increased rates and prevalence of substance abuse. This does not indicate that substance use contribute to the onset of conduct disorder, but can aggravate the symptoms and prolong the disorder. This shows that no direct link is there between social class or region and conduct disorders, unless certain risk factors are included in the definition (Kazdin, 1987).

(vii) **School factors**: Behavioural problems in a child lead to poor relations with teachers and peers and hence receives less positive attention, encouragement and support and may lead to rejection or more disciplinary action (Campbell and Ewing, 1990; Rutter et al., 1976; Walker and Buckley, 1973). So peers become increasingly
mistrustful and respond in such a way as to greater the possibility of an aggressive response (Dodge and Somberg, 1987). Sometimes it put an end to child’s school career, thus leading to conduct problems outside the school. Interactionally the historical relationship between a family and school has also an impact on learning experience (Bronfenbrenner, 1979). Aversive experiences of parents with teachers reinforce parental helplessness, which forms a wedge between home and education. Hence a spiraling pattern of poor behavior, parent demoralization and withdrawal and teacher reactivity can ultimately lead to total lack of coordination in the joint socialisation of the child. So parent-teacher bond should be strong and long standing for the achievement of the child.

1.2.4 Types of Conduct Disorder

(i) Types of Conduct Disorder Mentioned under DSM-IV-TR (APA, 2000)

The types of conduct disorder mentioned in DSM-IV-TR (American Psychiatric Association, 2000) are (a) Childhood-onset conduct disorder and (b) Adolescent-onset conduct disorder.

(a) Childhood-Onset Type

If onset of at least one criterion characteristic of conduct disorder prior to age 10 years take place, conduct disorder is said to be childhood-onset type. Main features of this type are:

(i) Disruptive behaviours emerge early in childhood, usually as negative hostile and defiant behaviour.

(ii) As child grows, there is an escalation to behaviours more characteristic of conduct disorder especially lying, fighting and stealing.
(iii) By age 18, majority of youth with this type of disorder meet the criteria for antisocial personality disorders and often they are imprisoned.

(iv) This type mostly includes males.

(v) Incidence of childhood onset type conduct disorder is not strongly related to socio-economic class or ethnic group.

(vi) Combination of biological and psychosocial factors are largely responsible for this type of conduct disorders.

(vii) This type of conduct disorder is characterised by neurological or family deficits.

Although childhood onset type conduct disorders comprise only to 3% to 5% of growth with conduct disorders, they are believed to account for at least half of the offences committed by young offenders.

(b) Adolescent-Onset Conduct Disorder

This type embraces a group where any criteria characteristic of conduct disorder is absent prior to age 10 years. Major features of this type of conduct disorder are:

(i) Symptoms are developed when they reached the adolescent stage, but they don’t have any serious problems before adolescence.

(ii) Oppositional and illegal behaviour begins during adolescence and tend to take place in a group environment.

(iii) Adolescent onset conduct disorder is likely to involve urban, poor and minority youth.

(iv) Girls are also involved in this group.

(v) Problem behaviours demonstrate less aggression than childhood onset type.
(vi) Socio-cultural factors, school factors and environmental factors are largely responsible for the resulting behaviours during this stage.

Thus adolescent-onset conduct disorder involves more normalised behaviour that is reflected by biological and societal changes. Overall, the prognosis is good for growth with adolescent-onset conduct disorder.

(ii) Types of Conduct Disorder Mentioned under ICD-10

ICD-10 classification of Mental and Behavioural Disorders by World Health Organisation, Geneva (1992) proposed three types of conduct disorder. They are:

(a) Conduct disorder confined to the family context

(b) Unsocialised conduct disorder.

(c) Socialised conduct disorder.

Each one is discussed below in brief.

(a) Conduct disorder confined to the family context

This category comprises conduct disorder involving dissocial or aggressive behaviour and not merely oppositional defiant, disruptive behaviour. The major features of this category are:

(i) The abnormal behaviour is entirely confined to home or to interactions with members of the nuclear family or immediate household.

(ii) The disorder requires that the overall criteria mentioned in section 1.6 be met; even severely disturbed parent-child relationships are not of themselves sufficient for diagnosis.

(iii) There may be stealing from home specially focused on money or possessions.
(iv) Stealing is accompanied by deliberately destructive behaviour such as breaking of toys or ornaments, tearing of clothes, carvings on furniture or destruction of prized possessions of specific family members.

(v) Violence against family members and deliberate fine-setting confined to home are also grounds for the diagnosis.

b. Unsocialised Conduct Disorder

This type of conduct disorder is characterised by the combination by persistent, dissocial or aggressive behaviour, meeting the overall criteria mentioned in the Section 1.6 with a significant pervasive abnormality in the individual’s relationship with other students. The major characteristics of this type are:

(i) Lack of effective integration into a peer group

(ii) Disturbed peer relationships are evidenced chiefly by isolation from or rejection by or unpopularity with other students

(iii) Lack of close friends or lack of lasting empathic reciprocal relationships with others in the same age group is another major feature of this type.

(iv) Relationship with adults also tend to be marked by discord, hostility and resentment eventhough good relationships can occur.

(v) Mostly offending is solitary.

(vi) Typical behaviours exhibited by this type of students comprise of (a) bullying, (b) excessive fighting, (c) extortion or violent assault, (d) excessive levels of disobedience, (e) rudeness, (f) uncooperativeness, (g) resistance to authority, (h) severe temper tantrums, (i) uncontrolled rages, (j) destructiveness to property, (k) fire-setting, (l) cruelty to animals and other children.
(vii) Some associated emotional disturbance sufficient to meet the criteria of mixed
disorder is exhibited frequently by students of this category of conduct disorders.

This disorder is pervasive across situations, but most evident at school;
specificity to situations other than the home is compatible with the diagnosis.

(c) Socialised Conduct Disorder

This category applies to conduct disorders involving persistent, dissocial or
aggressive behaviour, meeting the overall criteria, mentioned in the Section 1.6
occurring in individuals who are generally well integrated into their peer group. The
key differentiating features of this type are:

(i) Presence of adequate lasting friendships with others of roughly the same age and
forming a peer group to which he/she is loyal.

(ii) Often, but not always, the peer group will consist of other youngsters involved in
delinquent or dissocial activities.

(iii) The socially unacceptable conduct of the student may well be approved by the peer group

(iv) Sometimes the student may form part of a non-delinquent peer group with his
dissocial behaviour taking place outside this context.

(v) Relationship with adults tend to be poor.

(vi) Emotional disturbances are usually minimal.

(vii) If dissocial behaviour involves bullying it may result in disturbed relationships.

(viii) Conduct disturbances may or may not include the family. This is most evident
outside the family context and specificity to school. This includes,

• conduct disorder (group type)
• group delinquency
• offences in the context of gang membership

• stealing in company with others

• truancy from school.

1.3 THEORETICAL PERSPECTIVES OF DEVELOPMENT OF CONDUCT DISORDERS

A brief account of the theoretical perspectives that explained the development of conduct disorder is given below.

1. Neurobiological Perspective

Gray (1987) proposed that people’s behavioural patterns are related to two subsystems of the brain having distinct neuroanatomical regions and neurotransmitter pathways. (McBurnett, 1992; Quay, 1993) The Behavioural Activation System (BAS) stimulates behaviour in response to signals of reward or non-punishment. In contrast the Behavioural Inhibition System (BIS) produces anxiety and inhibits ongoing behaviour in the presence of novel events, innate fear stimuli and signals of non-reward or punishment. Different behavioural patterns may result from the relative balance or imbalance of activity in these two neural systems. It is proposed that antisocial patterns of behaviour result from an overactive BAS and an underactive BIS, a pattern determined primarily by genetic predisposition. (Quay, 1993) Students with conduct disorders who show an early onset of aggressive symptoms display low psychophysiological and/or cortical arousal (Maggusson, 1988) and low autonomic reactivity (Pennington and Ozonoff, 1996). This may lead to antisocial behaviour, a failure to develop the anticipatory fear needed to avoid such behaviour, and a lack of conscience.
2. Social-Cognitive Perspective

Crick and Dodge (1994) presented social cognitive theory to account for the behaviour of aggressive students. In their model, a series of thought processes are presumed to occur during appropriate social interactions and to be absent or distorted during inappropriate social interactions. The thinking and behaviour of students with conduct disorders in social situations are characterised by deficits in encoding and interpreting information, deficits in social problem solving and poor verbal communication. Hence they depend on aggressive solutions. This theory also recognises the reciprocal interplay between students’ information processing skills in particular social situations and their database of social schemes, memories, knowledge and cultural values or rules. (Crick and Dodge, 1994) Parent-student interactions and the quality of early attachments are important contributors to this database. This model also recognises the influence of peer appraisals or reactions and of emotional processes as contributors to social adjustment.

3. Social Learning Theory

Social learning theory is a relatively new theoretical framework that is an outgrowth of learning theory perspective. (Garwood, 1983) It focuses on observational learning in social situations. Albert Bandura (1971a and b, 1973) and Walter Mischel (1971, 1973) stresses that observation learning plays major role in human adaptation. They proposed that learning of some behaviours is more dependent upon imitating another person than upon reinforcement or punishment. Research by Bandura (1965) reveals that punishing students for aggression results in more aggressive behaviour on their part as they are learning from parents how to aggress
physically and this imitative learning may direct student’s further behaviour. Bandura’s study also suggests that witnessing violence on television promotes aggressive behaviour among students. This is supported by other researchers who follow the social learning theory. (Ross, 1961, 1963; Hanratty, O’Neal and Sulzer, 1972; Liebert and Baron, 1972)

So viewing media violence may weaken the student’s inhibitions against behaving in the same way as it creates occasion for vicarious conditioning.

4. Developmental Perspective

Discussion from developmental view point include psychodynamic theory of Freud and Psychosocial Theory of Erickson.

According to the psychodynamic theory of Freud, social development is the acquisition of skills and abilities to control the unconscious motivational forces in a socially acceptable manner. So a student with conduct disorders lack these skills and abilities to control the unconscious motivational forces and hence result in antisocial activities. Freud also focused on students’s internalisation of parental or adult standards of behaviour through identification. In such case, paternal alcoholism or criminalism and anti social behaviour in either parent may lead to development of such behaviour in student through identification resulting in conduct disorders.

Erickson focused on the impact of societal influences on student’s social development. (Miller, 1983) According to Erickson, social development is the successful resolution of conflict from opposing forces as an individual progress from one stage to the next. If a conflict is not resolved at a particular stage, it will lead to conduct problems.
5. Moral Perspective

Piaget and Kohlberg stress on the fact that students’s moral judgements undergo developmental change in accordance with a well defined sequence of stages. As a result students come to resolve various moral dilemmas by progressively constructing and refining their own ethical position. According to Kohlberg and Piaget moral maturity depends on a person’s level of cognitive development. Mature moral reasoning relies on the cognitive judgemental processes of classification, grouping, each of which contributes to child’s ability to balance claims of justice. Morally advanced individuals, can look at a situation objectively and understand others want and needs. As a result of moral reasoning they develop empathy which includes both cognitive and affective components, each of which is a necessary prerequisite to the execution of social behaviours. Cognitive component includes comprehension of a social situation and affective component includes an emotional responsiveness that matches an individual’s personal feelings and emotions with another’s positive or negative emotion. This implies that moral reasoning is essential for removing the social cognitive deficits and social problem solving deficits of an individual. So students with conduct problems should be encouraged to exchange alternative points of view and to consider others’ perspectives or prerequisites for constructing moral values needed for decision making and prosocial behaviour. Before planning the intervention all the above theories have to be kept in mind.
1.4 TOOLS AND TECHNIQUES FOR IDENTIFICATION OF CONDUCT DISORDERS

Conduct disorders involve a heterogeneous group of behaviours that range in type and severity (Frick, 1998). So the identification criteria for identifying students with conduct disorders vary slightly among researchers, even though the basis is DSM-IV-TR criteria. Social interactions are opportunities for manifestation of behaviours and feelings. Students with conduct disorders are unable to process information during social interactions and hence they exhibit conduct problems (Milich and Dodge, 1984). As conduct problems are explicit, they can be easily identified. Students with conduct disorders are getting more chances to interact with their parents and teachers. Among them teachers are considered as the primary gatekeepers in the identification process and are more likely to identify students with conduct disorders (Boggiano and Barrett, 1992; Caseau et al., 1994; Gresham, Macmillan and Bocian, 1996; Kazdin, 1990; Walker and Severson, 1990) as they are working with the students for longer duration in different situations. Teachers can either observe or record the behaviours of students with conduct disorders informally or they can use some standardised tools for identification. Some of the tools and techniques for identifying students with conduct disorders are discussed below.

1. Informal Techniques

Many specific conduct problems can be identified by regular classroom teachers (Hammill and Bartel, 1982). Most of the classroom procedures involve informal techniques. Some of the techniques are:
(i) **Direct observation:** The most convenient method for identifying conduct problems is to observe it directly in the classroom. Direct, systematic observation of student behaviour can provide information and insights about the student’s social and emotional problems. The validity of teacher’s observation increases if behaviours are described and reported. The teacher should observe the conditions under which the behaviours occur and should record the frequency and duration of occurrence. In addition to the behaviours, the context in which the behaviour occur should also be observed.

Hall (1983) suggested three direct observation techniques.

(i) Automatic recording using machines.

(ii) Product-analysis technique by which the product of the behaviour is evaluated.

(iii) Observational recording of behaviour problems using anecdotal records.

Among the three techniques observational recording is mostly used in school settings.

(ii) **Informal self-respect techniques:** This technique provide a general idea of a student’s problems. Each student should be assured that the information provided is confidential and that only honest answers should be given. Wallace, Harsen and Elksnin (1992) noted that the teacher developed measures are generally as reliable and valid as those of widely used research instruments. Frequently used self-reporting techniques include checklist, interviews, sentence completion tests, autobiographies, etc. All these techniques provide opportunity for students to express opinions and feelings about themselves and others. Personal experiences, ambitions or interests can
be described using this method. Self reporting techniques become effective only when it is conducted privately and rapport reflecting an honest interest in the student is established. Recording should be done objectively and immediately.

(iii) **Sociometric technique**: Sociometric techniques are commonly used to assess social skills and related problems (Maag, 1989). Sociometric methodology is grouped into three categories: peer nominations, peer ratings and peer assessment.

(a) **Peer nominations**: This procedure involves asking students to nominate peers according to certain attributes or activities rather than specific behaviours. Thus nominations assess attitudes and preferences for engaging in selected activities with peers (e.g. preferred play partners, best friends, etc.). Peer nominations also can be keyed to negative criteria (e.g. least preferred play partner) (McConnell and Odom, 1986). Research suggests that positive and negative nominations measure two distinct dimensions of sociometric status (Gresham and Reschly, 1988; McConnell and Odom, 1986). Cole et al. provide a classification system for peer nominations that identifies five sociometric status groups: (i) popular, (ii) neglected, (iii) rejected, (iv) controversial, (v) average. This technique provides a detailed description of the social status of a student in a peer group and identify behaviour correlates for each sociometric group. Dodge (1983) pointed out that rejected students exhibit aggressive and disruptive behaviours whereas neglected students display withdrawn and fearful behaviours.
(b) **Peer ratings**: Here all students in a classroom rate one another on a Likert-type scale according to non-behavioural criteria. A student’s score on a peer rating is the average rating received from peers. Gresham and Elliott (1989) noted that these ratings tend to indicate a student’s overall acceptance level within the peer group.

(c) **Peer assessment**: In peer assessment, students are asked to nominate or rate peers on several behavioural characteristics. Students hear or read behavioural descriptions and then rate individuals according to the descriptions. One of the more popular peer assessment techniques is the Guess Who Technique (Kaufman, Agard and Semmel, 1985). Responses from the sociometric questionnaire indicating the number of items each student’s chosen may be recorded on a tally sheet to construct a sociogram, which provide a visual record of the social structure within the class.

(iv) **Standardised Tests of Assessment**

A few standardised tests to assess the conduct problems are available. Some of the devices are discussed below.

**a. Behaviour Assessment System for Children** This test is developed by Reynolds and Kamphaus (1992). It includes teacher, parent and self reports as well as a structured developmental history and observed classroom behaviour of the student. This is used for students whose age ranges from 2½ to 18 years.

**b. Behaviour Evaluation Scale-2** (McCarney and Leigh, 1990): This test is designed to yield behavioural information about students according to five subscales: learning problems, interpersonal difficulties, inappropriate behaviour, unhappiness/depression
and physical symptoms/fears. Items are stated in observable and measurable terms. Age range is from kindergarten to 12th grade.

c. Revised Behaviour Problem Checklist: Quay and Peterson (1987) developed this tool which include 89 items for use with students from kindergarten through 6th grade. This is used by teachers who indicate whether each of the items represents a problem for the student being evaluated. The scales included in this tool are conduct disorders, socialised aggression, attention problems-immaturity, psychotic behaviour and motor excess behaviour.

d. Student Behaviour Checklist: The Student Behaviour Checklist (Achenbach, 1991b) is designed for the age range 5 to 18 years. Various forms are included in the tool like teacher report form, direct observation form, youth self report in addition to the parent report, which is the major part. CBCL focus on behaviour problems of children. Various factors included in this tool can be classified as internalizing (withdrawn, somatic complaints and anxions/depressed) and externalizing (delinquent behaviour, aggressive behaviour). It also includes items that measure social competence in areas such as involvement with social organisations and relationships with friends.

e. Behaviour Rating Profile-2: This ecological approach to assessment was designed by Brown and Hammill (1990). In this instrument, the information is obtained from a number of sources in a number of settings. The four components included in this rating profile are student rating scales – Home, School and Peer, a Teacher Rating Scale, a Parent Rating Scale and a Sociogram. The test is individually administered (except sociogram) and is appropriate for children from 6½ to 18½ years old.
(f) Emotional or Behaviour Disorder Scale: McCarney (1994) designed this instrument to meet the criteria specified in the federal definition of behaviour disorders. Subscales included are academic progress, social relationships, personal adjustment and vocational. Individual administration is possible. The age range is from 4½ to 21 years.

(g) School Social Behaviour Scale: The School Social Behaviour Scales (Merrell, 1994) includes ratings of both social skills and problem behaviours. Subscales of the social competence area are interpersonal skills, self management skills and academic skills. The three subscales from the Antisocial Behaviour area are hostile irritable, antisocial-aggressive and disruptive-demanding. This has moderate correlation with Student Behaviour Checklist. It can be administered individually to students of kindergarten upto 12th grade.

(h) The Walker Problem Behaviour Identification Checklist: The Walker Problem Behaviour Identification Checklist (Walker, 1983) is a list of fifty behaviours that are typically observed in the classroom. These fifty items are broken down into five scales: Acting out, withdrawal, distractibility, disturbed peer relations and immaturity. It can be used for students studying in preschool upto grade 6.

(i) Walker-McConnell Scale of Social Competence: This was designed by Walker and McConnell (1995) to identify children with social skill deficits. There are three subscales in this instrument: Teacher-preferred social behaviour, peer-preferred social behaviour and school adjustment behaviour. This can be administered to teachers who had the opportunity to observe the student for at least two months. Although no age
range is noted in the manual, norms are provided for children from kindergarten through grade 6.

(j) **Pieres-Harris Children’s Self Concept Scale** (Piers and Harris, 1984): The scale covers many areas of self concept, including physical appearance, popularity, anxiety and happiness-satisfaction. Students have to respond ‘yes’ or ‘no’ to 80 declarative statements. Items are written on a third grade reading level and both positive and negative statements are included. Suggested age range is from 8 to 18 years.

(k) **Student Self Concept Scale** (Gresham, Elliott and Evans-Fernandez, 1992): This test includes 72 items that relate to the perceived confidence and importance of specific behaviours influencing the development of a student’s self concept. The student rates items on three dimensions (self confidence, importance and outcome confidence) to measure self concept in three areas: academic, social and self image. The scale can be administered either individually or in group to students from 3rd to 12th grade.

(v) **Tests Developed in India**

Compared to the number of tests available in Western countries, India has a very few tests. They are discussed here.

Ramaa, Ashok and Balachandra (1997) devised a schedule for assessment of behavioural problems in students. It includes a wide range of problems like mental retardation, attention deficit hyperactivity disorder, learning disabilities, conduct disorder, depression, hyperactivity, obsessive – compulsive disorder, phobic disorder, autism and psychosis. The test finds out the specific area of conduct problem of the students. Main purpose is to identify students with different type of disorders and to
include them or eliminate them according to the need of studies related to various behaviour problems and associated problems.

The Child Behaviour Checklist constructed by Achenbach (1991) was modified by Malavika Kapur in 1997 based on the Indian context. This modified version can be used for the age group of 2-16 years. CBCL items were grouped under ten subscales as Schizoid/anxious, depressed, uncommunicative, obsessive-compulsive, somatic complaints, social withdrawal, acts too young, aggressive, delinquent and other problems that do not fall in the other categories like sex problems, physical problems, eating disorders, etc. This can be administered to both teachers and parents.

1.5 ASSESSMENT OF CONDUCT DISORDERS – ITS MAJOR GOALS AND PROCEDURES

Conduct disorders involve a heterogeneous group of behaviours that range in types and severity and ultimately have strong implications for treatment. Furthermore there are a number of causes that lead to the development of conduct disorders. Therefore it is important to keep these factors in mind while selecting the assessment tools for the individual child. However, it is crucial to think of the individual child while assessing and recommending for providing intervention for a child (Frick, 1998).

Goals of assessment

Major goals of assessment of students with conduct disorder are to (a) gather relevant information about the student in social and instructional environments; (b) assimilate the data to create a comprehensive picture of concerns and (c) develop
short and long term goals and strategies for intervention. Therefore the assessment must identify both the strengths and needs of the student and the people and systems with whom he/she interacts (Rudolph and Epstein, 2000). This view is supported by Waddell and others (1999) who suggests that as conduct disorder is affecting multiple domains of functioning and showing a high rate of comorbidity with other disorders. Comprehensive assessment is required encompassing student, family, school, peers and community. Without a comprehensive assessment of conduct disorder, it is extremely difficult to offer effective intervention. So special care should be taken while assessing and identifying conduct disorder.

**Characteristics of Effective Assessment**

Some of the major characteristics of effective assessment are listed below.

1. **Comprehensiveness**: The assessment should provide information about:

   - **Specificity**: Objective and observable description of students’ problems.
   - **Strengths**: Strengths and available resources of the student like family, teacher and school setting (for developing intervention plans).
   - **History**: Duration of difficulties, their relationship to specific developmental or situational stressors and any previous attempts to resolve students’ problems.
   - **Intensity**: Severity of problems as they affect academic achievement, social skills and interpersonal relationships with different settings.
   - **Pervasiveness**: Extent to which difficulties occur in different settings.
   - **Persistence of the problem**: Extent to which difficulties have continued despite use of well planned empirically based and individualised intervention strategies.
• **Developmental and Cultural Functioning**: Students’ current developmental states and the extent to which the students’ behaviour is different from behaviour of normal students.

• **Cognitive and academic functioning**: Child’s cognitive abilities and academic performance.

• **Environmental factors**: People and systems that have an impact on the student and relationship between instructional social and community environment.

2. Use Multiple Sources of Information

Students’ behaviour often varies from setting to setting and information should be obtained from a variety of sources (McConaughy and Ritten, 2002). Sources include:

• Family members

• Teachers and other school personnel

• School records, medical records or other relevant records

• Peers

• Social service workers

Kauffman and Kneedler (1991) pointed out that prevalence estimates and screening procedures depend mainly on the adults’ judgements of children’s behaviour rather than children’s opinion of themselves or each other as adults are more concerned about evaluation and intervention. Hence these multiple sources are included in assessment.
3. Employ appropriate assessment methods

Potential effects of identifying a student as having conduct disorder necessitate the use of instruments that have high reliability and validity. Both direct and indirect assessment methods should be used as appropriate.

- Indirect methods may include behaviour checklists, structured interview, rating scales and other techniques like clinical interviews (Frick, 1998).

- Direct methods may include behaviour observation, standardised self reports from a child, curriculum based assessment and analysis of work samples. Functional behaviour assessment procedures are recommended to gather information about child’s behaviour in relationship to instructional and social environment (Knoster and McCurdy, 2002).

- Norms should be representative, current and appropriate for the individual being assessed in terms of age, culture/ethnicity and gender.

- Adequate assessment of conduct disorders should be multifaceted. It should involve evaluation of all domains of child’s functioning. This is because lags in any one of the domains may increase the risk of disordered behaviour (Ciminero and Drabman, 1977; Evans and Nelson, 1977), i.e. assessment must involve the child’s problem behaviours, social-interpersonal skills, cognitive skills, perceptual-motor performance, language and physical status (Kauffman and Kneedler, 1991).

4. Should provide a comprehensive formulation of the relevant issues

Results of assessment should provide working hypotheses about child’s behavioural and emotional functioning, developmental history, areas of significant
impairment in school (academic achievement, adaptive behaviour, social skills and interpersonal relationships) and impairment outside the school setting. Presence of social maladjustment along with conduct disorder should be noted for planning interventions (McConaughy and Ritter, 2002; Merrell and Walker, 2004).

Assessment of conduct disorder should be done by keeping in mind the developmental level of the individual. So assessments must be conducted in all areas of development including social, cognitive and emotional areas. This is because conduct disorder may not even be diagnosed until a certain age where such behaviours are seen to be age inappropriate. This is evident in the case of preschoolers who may not yet have the cognitive abilities to understand the ramifications of their behaviours, which in turn make it very difficult to provide a label as having conduct disorders.

In conclusion, while selecting the appropriate assessment technique, the individual child should be the focus rather than utilising one standard method for a large population. Therefore the best possible way is to include multiple informants in addition to child and use a qualitative as well as quantitative method of obtaining information about the child’s strengths and needs. But assessment will become complete only through the diagnosis, which provides a better view of child’s psychosocial strengths and needs.

1.6 DIFFERENTIAL DIAGNOSIS

Disturbances of conduct may be part of many childhood psychiatric conditions ranging from mood disorders to learning disorders. Therefore clinicians must obtain a history of the chronology of the symptoms to determine whether the conduct
disturbance is a transient or reactive phenomenon or an enduring pattern (Frich, 1998). Isolated acts of antisocial behaviour do not justify a diagnosis of conduct disorder; an enduring pattern must be present.

Historically, Oppositional Defiant Disorder (ODD) has been conceptualized as a mild precursor of conduct disorder, which is likely to be diagnosed in young children, at risk for conduct disorder. Children who progress from oppositional defiant disorder to conduct disorder do maintain their oppositional characteristics, but some evidenced indicates that the two disorders are independent. The main distinguishing clinical feature of the two disorders is that, in conduct disorder, the basic rights of others are violated whereas in oppositional defiant disorder, hostility and negativism fall short of seriously violating the rights of others.

Another type of disorders that can be comorbid with conduct disorder is depressive disorders. A recent report concludes that the high correlation between the two disorders arises from shared risk factors for both disorders, rather than one disorder causing the other. Thus a series of factors including family conflict, negative life events, early history of conduct disturbance, level of parental involvement, and affiliation with delinquent peers contribute to the development of mood disorders and conduct disorders. So a clear diagnosis is required to differentiate between both the disorders.

A third disorder that is commonly associated with conduct disorder is attention-deficit hyperactivity disorder. Usually, the symptoms of these disorders predate the diagnosis of conduct disorder. A child with attention-deficit hyperactivity
disorder often exhibit impulsivity and aggressive behaviours that may not meet the full criteria in conduct disorder.

In addition to all these types, substance abuse disorders are more common in students with conduct disorders. Researches have shown that there is an association between fighting behaviours as a child and substance use as an adolescent. Drug use may interfere with the development of positive mediators, such as social skills and problem solving that could enhance remission of conduct disorder. Thus once substance abuse develops, it may promote continuation of the conduct disorder. But a student with conduct disorders may or may not indulge in substance abuse. Obsessive compulsive disorder also frequently seems to coexist with conduct disorders (Biederman, Newcorn and Sprich, 1991). Thus the literature abounds with studies indicate that conduct disorders has co-morbid relationships with ODD, ADHD, depressive disorders, substance abuse disorders, obsessive-compulsive disorders and learning difficulties (American Psychiatric Association, 1994). This co-morbid relationships may lead to problems in identification of students with conduct disorders. To avoid such problems, the detailed description of DSM-10-TR criteria for conduct disorders is discussed in the succeeding section. Also a clear demarcation between conduct disorders and oppositional defiant disorder, the major precursor of conduct disorder is made by discussing the DSM-IV diagnostic features of ODD in section.

1.7 DIAGNOSTIC CRITERIA FOR CONDUCT DISORDER

Most parents report having conduct related problems with students at some time or another. However the conduct disorder label may only be warranted if those
behaviours are persistent and impinge on the basic rights of others, if major age-
appropriate societal norms are violated or if there is significant impairment in
everyday functioning at home or school. But still there exists a confusion in
identifying the markers of conduct disorder. To remove this confusion, American
Psychiatric Association (1994) putforth a set of negativistic behaviours as criteria in
the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV)
for labelling students with conduct disorder. DSM-IV categorises conduct disorder
behaviours into four main groupings.

a. Aggression to people and animals
b. Destruction of property
c. Deceitfulness or theft
d. Serious violation of rules

Conduct disorder is diagnosed if there is a repetitive and persistent pattern of
behaviour in which the basic rights of others or societal rules are violated. In addition
three or more characteristic behaviours must have been present during the past 12
months, with at least one behaviours present in the past six months. The disturbance
in behaviour must also have caused clinically significant impairment in social,
academic or occupational functioning. Conduct disorder may also be diagnosed if the
individual is aged 18 years or older, and the criteria are not met for antisocial
personality disorder (American Psychiatric Association, 1994). Conduct disorder is a
polythetic diagnostic category, as DSM-IV does not consider one specific criterion
alone for diagnosis and that any combination of three or more criteria are sufficient.

DSM-IV criteria for conduct disorder are:
**Aggression to people and animals**

1. Often bullies, threatens or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harms to others.
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim.
7. Has forced someone into sexual activity.

**Destruction of property**

8. Has deliberately engaged in fire setting with the intention of causing serious damage.
9. Has deliberately destroyed others property.

**Deceitfulness or theft**

10. Has broken into someone else’s house, building or car.
11. Often lies to obtain goods or favours or to avoid obligations.
12. Stolen items of value without confronting a victim.

**Serious violation of rules**

13. Often stays out all night without parental permission (beginning before the age of 13).
14. Has run away from home overnight (at least twice).
15. Is often truant from school (beginning before the age of 13).

The criteria for conduct disorder in ICD-10 (World Health Organisation, 1992) are almost identical to DSM-IV-TR diagnostic criteria. Almost all students break the
rules from time to time. But involvement in one or even a few incidents is insufficient for a student to be considered to have a conduct disorder. Only when conduct problems occur at school, at home and in the community, it indicates that the behaviour is not a response to the immediate social context. Also conduct problems can be mild, moderate or severe depending upon the diverse range of conduct problems and its effect on others.

1.8 CONDUCT DISORDERS AND OPPOSITIONAL DEFIANT DISORDER

There is much overlap between Conduct Disorders and Oppositional Defiant Disorder. (Nottelman and Jensen, 1995) A hotly debated issue is whether Oppositional Defiant Disorder is a separate disorder from conduct disorder or a milder earlier version. (Patterson, De Garmo and Knutson, 2000) Symptoms of ODD typically emerge 2 to 3 years before those of conduct disorders. (Loeber, Green, Lahey, Christ and Frick, 1992) Since ODD symptoms come first, it is possible that they are precursors of conduct disorders for some students. However, most students who display ODD do not progress to more severe conduct disorders. At least half maintain their ODD diagnosis without progressing, and another 25% cease to display ODD problems entirely. (Hinshaw, Lahey and Hart, 1993) Thus for most students, ODD is an extreme developmental variation, but not one that necessarily signals an escalation to more serious conduct problems. (Speltz, McClellan, DeKlyen and Jones, 1999) In contrast, some cases of conduct disorders are almost always preceded by ODD and nearly all students with conduct disorders continue to display ODD symptoms. (Bladerman et al., 1996; Lahey, Loeber, Quay, Frick and Grimm, 1992) Even though much overlap is observed between conduct disorders and oppositional
Defiant disorder criteria under DSM-IV proves that they are two specific disruptive disorders. DSM-IV Diagnostic Criteria for Oppositional Defiant Disorder is discussed below, whereas DSM-IV Diagnostic Criteria for conduct disorders is discussed in Section 1.7 as it is more appropriate to deal under the section of assessment and identification of conduct disorders. DSM-IV diagnostic criteria for ODD:

A. Negativistic, hostile and defiant behaviour lasting at least six months, during which four of them among the following are present.

   (i) often loses temper
   (ii) often argues with adults
   (iii) often actively refuses to comply with adult requests or rules
   (iv) often deliberately annoys people
   (v) often blames others for his/her mistakes or misbehaviour
   (vi) is often touchy or easily annoyed
   (vii) is often angry and resentful
   (viii) is often spiteful or vindictive

B. Disturbance in behaviour causes significant impairment in social, academic, occupational functioning.

C. Behaviour does not occur exclusively during the time of psychotic or mood disorder.

D. ODD is not diagnosed when criteria for conduct disorders are met.

Consider a criterion met only if the behaviour occurs more frequently than is typically observed in individuals of comparable age and developmental level.
1.9 INCIDENCE

Atkinson and Hornby (2002) reported the following on the basis of their epidemiological studies. Conduct disorder is the most frequently occurring of mental disorders affecting students and adolescents. Its incidence ranges from 6 to 16 percent in boys and from 2 to 9 percent in girls (American Psychiatric Association, 1994). Early persistent and severe patterns of antisocial conduct only occur in 5 percent of students (Hinshaw and Anderson, 1996; Kazdin, 1995).

Conduct disorder is more prevalent during adolescence than childhood. The number of referrals for students with conduct disorders to all agencies is considered to be increasing. In childhood, conduct disorder is three or four times more common in boys, although this difference decreases by adolescence (Earls, 1994). In some boys onset occurs before the age of 10 whereas in some others onset occurs during adolescence. But in the case of girls, the onset occurs between 13 and 16. Persistence of behaviour is greater in boy than in girls although many girls still display severe conduct problems as young adults. Moreover conduct disorder is universal as it occurs in every culture and level of society; however, different cultures and societies may play different roles in the development and expression. Researches have shown that conduct disorder is found to be more prevalent in students and adolescents from socially deprived backgrounds.

Davison and Neale (1994) emphasised that since much of the behaviour considered as conduct problems has a high rate in the general population, a certain level of aggression or disobedience should probably be deemed normal. A survey of sixth grade students in a middle class suburb revealed that 26 percent had committed
minor shoplifting, 22 percent had defaced property and 45 percent had fought with another student (Richards, Berk and Forster, 1979).

Detailed surveys and researches prove that incidence and prevalence of conduct disorders is alarmingly wide and appears to be growing. Four to ten percent of students in the UK and USA meet the criteria for the disorder (Institute of Medicine, 1989; Rutter, Cox, Tupling, Berger and Yule, 1975). Estimates indicate that between one-third and one-half of students and adolescents referred for clinical help fall into the category. But research indicates that fewer than 10 percent of students with conduct disorder who need treatment or intervention actually receive them (Hobbs, 1982). If this is the case, later problems can develop leading to juvenile delinquency, adulterine, antisocial personality, etc. (Kazdin, 1985, 1987; Wadsworth, 1979; Farrington, 1978; Rutter, 1977; Oltmans, Broderick and O’Leary, 1977; Johnson and Lobitz, 1974; West and Farrington, 1973; Robbins, 1966). So at this peak hour, it is better to remember the saying “prevention is better than cure”.

1.10 THEORETICAL AND CONCEPTUAL MODELS FOR INTERVENTION

On the basis of the work of Rhodes and his colleagues (Rhodes and Head, 1974; Rhodes and Tracy, 1972a, 1972b), Kauffman identified six conceptual models for understanding and providing intervention for conduct disorders. A brief account of each one is given below.

(a) **Biogenic**: Biogenic model suggests that deviant behaviour is a physical disorder with genetic or medical causes. It implies that these causes must be cured to treat conduct disturbance. Treatment may be medical or nutritional.
(b) **Psychodynamic**: Based on the idea that a disordered personality develops out of the interaction of experience and internal mental process, ego, id and superego that are out of balance, a psychodynamic model relies on psychotherapy and creative projects for the child and parents rather than academic remediation.

(e) **Psychoeducational**: The psychoeducational model is concerned with unconscious motivations and underlying conflicts, yet also stresses the realistic demands of everyday functioning in school, home and community (Kauffman, 1993). Intervention focuses on therapeutic discussions such as life space interviews to allow children to understand their behaviour rationally and to plan to change it (Rieb, Beck and Coleman, 1982).

(d) **Humanistic**: The humanistic model suggests that the child with conduct disorder is not in touch with his or her own feelings and cannot find self-fulfillment in traditional educational settings. Treatment takes place in an open, personalised setting where the teacher serves as a nondirective, nonauthoritarian “resource and catalyst” for the student’s learning.

(e) **Ecological**: The ecological model stresses the interaction of the child with the people around him or her and with social institutions. Treatment involves teaching the child to function within the family, school neighbourhood and large community.

(f) **Behavioural**: Behavioural model assumes that the student’s inappropriate and undesirable behaviour has been learned from his or her history of interactions with the environment. So applied behaviour analysis techniques should be used to help the children learn new, appropriate responses and eliminate inappropriate ones.
The techniques suggested by one model alone cannot be used for planning intervention programme for students with conduct disorder. An eclectic approach should be employed while planning intervention by combining a number of theories, philosophies and methods (Beare, 1991). Models themselves are not entirely discrete; they overlap in certain areas. Most preferable models that can be used in educational settings are psychoeducational and behavioural models (Cullinan, Epstein and Lloyd, 1991).

One of the intervention typically associated with psychoeducational orientation to conduct disorders is, cognitive-emotional intervention (Carpenter and Apter, 1982). Cognitive-emotional intervention is a term used to embrace broad array of approaches that have emerged from developmental and social perspectives and also they are interventions for remediating emotional disturbance and behaviour disorders of school age children and youth (Carpenter and Apter, 1988).

Interventions based on behavioural model are referred to as behavioural interventions which utilise cognitive processes as a component of intervention procedure. Behavioural interventions are classified into cognitive-behavioural interventions and social-cognitive interventions. Cognitive behavioural interventions, though behavioural in nature, utilises the cognitive process by giving self control to the student’s own behaviour (Rueda, Rutherford and Howell, 1980). Social cognitive interventions are a group of techniques designed to teach the student better to comprehend and deal with social and interpersonal events (Greenspan, 1979).

In the present study a combination of both cognitive-emotional intervention and behavioural intervention is used. They are more effect driven than theory driven
as it is a pragmatic hybrid of developmental theory, social psychology and applied behavioural analysis. Also these are more applicable to students with conduct disorders to yield better results (Carpenter and Apten, 1988).

1.10.1 Approaches of Intervention

Wilson (1989) provides a useful framework in identifying four basic approaches of intervention which differ in the extent to which each focuses on overt behaviour or cognitive processes. A brief discussion regarding the four approaches is given below.

(a) Applied behaviour analysis: This approach focuses exclusively on overt behaviour with cognition seen as unnecessary to the understanding and modification of behaviour. The procedure applied here is operant conditioning where reinforcement is given importance for learning or modifying behaviour.

(b) Social learning theory approach: Another approach within the behavioural and cognitive perspectives is the social learning theory approach. The premise of this approach is that behaviour is a function of three interactive systems: behaviour itself, environmental influences and cognitive processes. Bandura (1977) proposed that people’s actions themselves produce the environmental conditions that in turn influence subsequent behaviour. How the environmental events are perceived and interpreted depends on the internal cognitive processes like beliefs, values, expectations, etc. Although learning principles including cognitive behaviour are central in how behaviour is shaped, the individual is a self directing agent of his or her own behaviour change.
(c) Cognitive behaviour modification: Third approach is cognitive behaviour modification which includes theories developed within the mainstream of behaviour therapy (e.g. Meichenbaum, 1977; Goldfried, 1988) as well as those formulated from a more distinctly cognitive perspective (e.g. Ellis, 1989; Beck and Weisbaar, 1989). The cognitive behaviour modification approach is similar to social learning approach but focuses to even greater extent on cognitive processes in explaining and modifying behaviour. Although they use a learning model and behavioural techniques, cognitive behaviour modifiers believe that the most effective treatments work directly and intensively on people’s self-defeating cognitions.

(d) Neobehaviouristic mediational stimulus response model: This approach make use of learning theories of Hull, Miller, Spence, etc. According to this approach, mediational models pay attention to what goes on inside the organism. Wolpe’s systematic desensitisation is a prime example of such a model. Systematic desensitisation seeks to extinguish anxiety by using imagery to visualize scenes that arouse anxiety. Internal processes are considered to follow the same laws of learning as do overt behaviours.

Among the four approaches, social learning theory approach and cognitive behaviour modification approach is given more importance in the present study eventhough applied behaviour analysis is used in between.

1.10.2 Intervention Programmes for Students with Conduct Disorders

Many activity programmes are developed for training students with conduct disorders (Webster-Stratton and Dahl, 1995). Some programs developed focus on encouraging the child’s development in decision making and cognitive process.
Various other programs involved teaching the child interpersonal skills, problem solving skills, self talk and self control (Webster-Stratton and Dahl, 1995). These programs provided parents and teachers with the opportunity to focus on specific problems of a child and for these to be addressed. A few notable ones in some of the areas are discussed below.

(i) Social Skills Programme

(a) Walker Social Skills Curriculum

The ACCEPTS programme (Walker et al., 1983) is a social skills curriculum that teaches classroom and peer to peer social skills to students in kindergarten through sixth grade. Five areas like classroom skills, basic interactional skills getting along skills, making friends skills and coping skills were included in the programme.

(b) ACCESS programme (Walker, Todis, Holmes and Horton, 1988)

This program teaches peer to peer skills, skills for relating to adults and self management skills to the students at middle and secondary school levels. Thirty (30) social skills are presented in three areas as relating to peers, relating to adults and relating to yourself. This is designed for both general and special education teachers and can be taught either in small or large groups.

(c) Skill Streaming the Elementary School Child (McGinnis and Goldstein, 1997)

This programme involves teaching prosocial skills based on a structured learning method that involves modeling, role playing (reviewing, rehearsing and performing each of skill steps), performance feedback and transfer training. Here 60 specific prosocial skills such as asking for help, dealing with group pressure and accepting consequences are presented within the content areas of dealing with group
pressure and accepting consequences are presented within the content areas of dealing with feelings, classroom survival skills, alternatives to aggression, friendship making skills and dealing with stress.

(d) **Skill Streaming the Adolescent (Goldstein and McGinnis, 1997)**

This programme presents 50 prosocial skills such as starting a conversation, setting a goal and standing up for a friend within the content areas of beginning and advanced social skills, dealing with feelings, alternatives to aggression, dealing with stress and planning skills. A video programme is available illustrating the concepts and training procedures.

(e) **Getting along with others**

*Teaching Social Effectiveness to Children (Jackson, Jackson and Monroe, 1983).* This programme presents a direct intervention approach with systematic instructional methods. A tell-show-practice model of social skills training is used in which the students participate in role playing activities and learn adaptive coping responses. A notebook of skill lessons and activities present 17 core social skills. The programme guide provides teacher scripts and often 32 training activities and 5 main teaching strategies. It also includes a built in behaviour management system for reducing or eliminating problem behaviours.

(f) **Social Skills and Me (Crayne and Reynolds, 1983)**

This is a social behavioural curriculum intended for use with students with behaviour disorders in the first through sixth grades. Hundred (100) lessons in the curriculum focus on the skill areas of communication, responsibility, assertiveness and problem solving. Group and individual activities include relaxation exercises,
keeping a scrapbook individual student conferences, reinforcement time, and I like activities are also included in addition to specific lesson activities.

(g) Talking, Listening, Communicating (TLC)

The curriculum guide that outlines 156 activities to help students to build interpersonal relationships is developed by Bormaster and Treat (1982). Activities require thirty minutes or less which include paper and pencil as well as interactive activities. Topics included are preparing yourself, understanding yourself, communication, building groups, relating to others, developing creativity, making decisions, solving problems and ending a group in a positive manner.

(ii) Cognitive Development Programmes

(a) Transition (Dupont and Dupont, 1979)

This is intended for students from ages 12 to 15. It uses posters and pictures, eight cassette tapes with printed scripts, ditto sheets, discussion cards, a gavel and feeling word cards in a programme of activities that are primarily verbal in nature and are discussions oriented. Five units incorporated in the curriculum are communication and problem solving skills, encouraging openness and trust, verbal and nonverbal communication of feelings, needs, goals and expectations and increasing awareness of values.

(b) Coping with series (Wrenn and Schwarzrock, 1984)

This was developed for students from upper elementary through early senior high school grades. It contains four sets of five books each. The books are arranged around the themes coping with personal identification, coping with human relationships, coping with facts and fantasies and coping with teenage problems.
(c) Etscheidt’s Cognitive Behavioural Programme (1991)

Etscheidt’s programme components were adopted from the Hochman, Nelson and Sims (1981) Anger Coping Program, which provides students with a way to change aggressive responses into appropriate alternatives by modifying their thinking processes regarding the circumstances surrounding certain situations. The instruction also assists students in developing, evaluating and selecting appropriate alternative responses. Etscheidt’s goals included increasing self awareness; identifying a student’s reaction to peer influences, providing avenues to identify problem situations; and using problem-solving techniques to identify, evaluate and select alternative solutions for a specific social situation.

(d) Tools for Getting Along

This programme was intended to teach problem solving to students of fourth and fifth grades who exhibit conduct problems. This curriculum was designed using a problem-solving framework, focused on understanding and dealing with frustration and anger, since anger is a frequent correlate of disruptive and aggressive behaviour and can be preceded by frustration. Lesson included anger management and problem solving. Methods used are direct instruction, modeling, guided practice and independent practice for skill development.

(iii) Affective Development Programme

(a) Developing Understanding of Self and Others (DUSO)

The DUSO kits (Dinkmeyer and Dinkmeyer, 1982) are designed to encourage the social and emotional growth of students in kindergarten through fourth grade. Central character of the program is a Puppet, Duso and the Dolphin. A problem
situation and a story are presented, followed by role playing and puppet activities. The kit provides band puppets, posters, activity cards and audio cassettes of stories and songs. DUSO I (kindergarten through second grade) is used to develop appreciation of individual strengths and acceptance of limitations, beginning of social skills and awareness of feelings. DUSO II (third and fourth grades) help to develop a greater understanding of the purposive nature of behaviour more effective communication skills and a skill in recognising and making choices.

(b) Towards Affective Development (TAD) (Dupont, Gardner and Brody, 1974)

This affective curriculum is designed for normal children in grades three to six, but is appropriate for other special population also. Five major units included in this curriculum are Reaching in and Reaching out; your feelings and mine; Working together; Me: Today and tomorrow; and Feeling, Thinking and doing, Brainstorming, role playing and discussion group were included.

(c) Thinking, Feeling, Behaving

Thinking, feeling, behaving developed by A. Vernon is an emotional education curriculum based on the Principals of Rational Emotive Therapy. One volume is for students from first to sixth grade and another volume is for adolescents in seventh through twelfth grade. Each volume include 90 activities arranged according to grade level and organised into the categories of self acceptance, feelings, beliefs and behaviour, problem solving/decision making and interpersonal relationships. Activities include simulation games, stories, role plays, written activities, brainstorming and art activities. This curriculum helps to overcome irrational beliefs, negative feelings and attitudes.
(d) Human Development Programme (Palomares and Ball, 1974)

This programme popularly known as Magic Circle is used for teaching affective skills. Basic premise of the program is that teacher-led discussions that take place in a structured setting will help students to develop richer, more meaningful interrelationships with each other. Objectives of this programme include improving self control, listening skills and expression, learning the meaning of responsibility, fantasy and role expectations, and developing a positive self concept, trust and satisfactory interpersonal relationships.

1.10.3 Strategies for Training Skills in Students with Conduct Disorder

Based on the theoretical framework following strategies to acquire skills are suggested.

(i) **Mirroring**: This is an effective way used by the teacher for modelling the disruptive or undesirable behaviour to the student. The student sees it as clearly as possible in a controlled setting just as holding up a mirror. Mirroring is purely illustrative and never be used to embarrass or humiliate the student.

(ii) **Picture cues**: Use pictures of students exhibiting disruptive or antisocial behaviours in the class. Ask the students to recognise the person in the picture. They seem to instinctively know it is them. This strategy was also used to elicit the consequences of an undesirable behaviour. Similarly pictures displaying desirable behaviours are also shown for comparison. In between facial expression of the students were noted and recorded which displays either social approval or social disapproval, depending on the type of pictures exhibited. Double picture (desirable and undesirable behaviour) is there to
clarify initially the movement from old to new behaviour. This is replaced
with single picture cards identifying only on the desirable behaviour. It is the
second picture that becomes the student’s plan.

(iii) **Questions**: By using the visual cue, the teacher ask questions. For example, X
what are you doing in the picture. If the student says what he is doing
something, press the question a little further, by quoting the answer. If the
student refuses, allow some pause time and start answering the question for
him. After the answer, briefly describe the behaviour the student frequently
displays which is the one targeted in the picture. Then elicit the consequences
of the behaviour from others through questions by the teacher. This is so
effective as an aid to self awareness.

(iv) **Modelling**: (Learning by observing) This refer to a technique by which the
student observes a person demonstrating some behaviour from which he can
benefit. Here the model demonstrates the behaviour and the observer attends to
what model does. Both live models and symbolic model from books and
medias can be used.

(v) **Rehearsal**: Copying the target behaviour which is modeled until the behavior
is mastered. During rehearsal, it should be taken care that the student should
know the specific behaviour skill and its elements. Before the session starts,
make them understand why this behaviour is necessary. For them to know and
be able to do this behaviour. Give encouragement and evaluation in between.
Enable the student to self evaluate the behaviour, repractice them and try to
understand how a particular skill can be applied in the natural setting.
(vi) **Practice**: Practice does not really make anything perfect (Rogers, 2004), just better easier and normative. Pursue rehearsal through a discussion about practice. Reveal the purpose of practice and explain why it is important for the student and the class.

(vii) **Feedback**: Focus on the behaviour, not on the personality during feedback. Better give a descriptive feedback. Try to avoid overloading the student with too much information and always be an expectant. Feedback can also be given by mirroring.

(viii) **Self reflection**: After the feedback, allow the students to reflect the whole procedure they underwent during skill training. They should include which technique is easier, which part is harder and how far they could acquire the skill, etc.

1.11 CONTEXT NEED AND IMPORTANCE OF THE STUDY

Through social learning, a student acquires knowledge and understanding of socially acceptable behaviour which provides necessary security and stability. Students, through a dynamic two-way process of interaction with others learn to act and respond appropriately providing valuable lessons for life. Parents and children shape and influence each others behaviour on a daily basis. Behaviour then has a content and is situation specific. Unfortunately when such experiences become negative and rules and norms of behaviour become unclear and inconsistently reinforced, so the possibility for conduct disorder increases. Similarly several other inherent and environmental factors lead to conduct disorders.
The prevalence conduct disorders are alarmingly wide and appear to be growing (Rutter, Cox, Tupling, Berger and Yule, 1975). Estimates indicate that between one-third and one-half of students and adolescents referred for help fall in this category. According to research cited in Phelps and McClintock (1994) 6% of USA and UK meet the criteria for conduct disorder. India also shows alarming rates (Parvathavadhini, 1983; Kapur, 1985).

Another major factor that should be looked into is the consequences and later problems of conduct disorders. It is seen that students with conduct disorders are at increased risk of being rejected by their peers (Coie, 1990a). This rejection may lead to backwardness in academic achievement sometimes end in dropouts. Others may be abused by their parents (Reid, Taplin and Loeber, 1981) which can result in running away from home, becoming a juvenile delinquent and sometimes end in suicides. Later problems can include alcoholism, drug abuse, adult crime, antisocial personality, marital disruption, interpersonal problems and poor physical health (Kazdin, 1985, 1987; Wadsworth, 1979; Farrington, 1978; Rutter, 1977; Oltmans, Broderick and O’Leary, 1977; Johnson and Lobitz, 1974; West and Farrington, 1973; Robbins, 1966). This indicates the chronic nature of conduct disorders.

As research on the factors that contribute to conduct disorders has progressed, attempts are made to develop new and effective interventions. However recent studies concluded that short term ‘cure’ is not possible for conduct disorders, but some interventions are quite valuable. Intervnetions developed so far are mainly practiced in clinical settings with the help of therapists or other professionals in the field. It consists of both prevention and remediation, although these are not separate entities.
In mainstream prevention and treatment of conduct disorder focuses on developing skills of the child and all the environmental factors, which is quite impossible within a short time. In addition to this a student is spending more time in school. So teacher is the best person to identify the problems, as well as providing intervention. So the present study is intended to develop an intervention programme for students with conduct disorders that is applicable in school settings and can be used by the classroom teachers.

1.12 STATEMENT OF THE PROBLEM

The Problem

The problem is to diagnose the specific areas of conduct disorder and specific skills lacking in a student with conduct disorders and to develop a cognitive emotional intervention programme to assist the students to improve their self concept, cognitive problem solving skills, social cognitive skills, assertive skills, social problem solving skills, scientific attitude and self control.

1.13 NATURE AND SCOPE OF THE STUDY

The present study is an attempt to identify students with conduct disorders from V to XII, to analyse the specific types of difficulties and deficits among them and to provide them with an intervention programme. This is an exploratory and experimental study. In the context of the present status of research and the resulting need for intervention in the area of conduct disorder, an attempt was made in this study to answer the following questions.

(i) What percentage of students studying in grades V to XII exhibit conduct disorders?
(ii) What is the prevalence of students with conduct disorders in Kerala state in terms of demographic characteristics like type of school, grade and gender?

(iii) What is the percentage of students exhibiting different types of conduct disorders among students studying in different types of schools?

(iv) Is there any difference in the percentage of students exhibiting conduct disorders among male and female students?

(v) Is there any difference in the percentage of students exhibiting conduct disorders among different grades?

(vi) Is there any quantitative difference between normal students and students with conduct disorders in grades VII, VIII and IX?

(vii) Is there any qualitative difference between normal students and students with conduct disorders in grades VII, VIII and IX in various emotional and behavioural problem and skills?

(viii) Whether the remedial programme developed on the basis of cognitive emotional interventional procedure is effective in overcoming the conduct problems of students and improving their skills?

Thus the study attempted to find answers to the above questions. A systematic procedure for identifying and assessing students with conduct disorders would be an invaluable tool to the teachers, students to identify with their specific problem areas. Among the two types of conduct disorders adolescent – onset conduct disorders were mainly concentrated as it is difficult to manage the cumulative effects of conduct disorders which persist over several years from childhood.

Finding out the prevalence of students with conduct disorders makes the teachers and school authorities aware of the severity of the problem and necessity of
implementing immediate intervention. Comparison of the performance between students with conduct disorders and normal students in various aspects and skills, namely self concept, social skills problem, scientific attitude, social cognitive skills, assertive skills, problem solving skills and emotional intelligence will help in providing more opportunities for the student with conduct disorder for self expression and social interactions. This also help teacher to identify the underlying factors even behind the learning problems also. Analysis of the problems in behaviour and emotions and skill deficits in behaviour by students with conduct disorders help in understanding the specific problems faced by them which in turn will help in planning appropriate intervention programme.

The causative factors for conduct disorder are varied and a consensus on this is yet to be established. Intervention cannot attempt correcting the causative factors of conduct problems, as it has taken into consideration only student factors even though other factors like parental, school and societal factors highly influence conduct disorder. So at the most the intervention programme provides opportunities developing some new skills in the student to facilitate the student’s growth, development and adaptive functioning. The present study is restricting to the skill development in the area of social competence, few behavioural modification techniques, development of positive attitude and values, and helping the students to utilise their cognitive processes effectively during social situations, rather than trying to correct the underlying factors. What best can be done is helping the student with conduct disorder to learn and master skills that enables him/her to negotiate with the developmental challenges including effective interactions with others, successful
completion of developmental tasks and contacts with the environment and use of approaches that increase adaptive functioning which best suits the student. Exhibiting desirable behaviours is significant in social interactions (Kazdin, 1990). Social interactions are complex phenomena which involve higher order cognitive processes. So according to Webster-Stratton and Dahl (1995) students with conduct disorder should be also taught, problem solving skills, self statements that facilitate self control and prosocial behaviours rather than antisocial behaviours; which is evident in the present intervention programme. Even though conduct problems and skill deficits vary from individual to individual, most have something in common. So teaching and practicing of skills were conducted commonly for all students with conduct disorder so that those who lack the skill, develops it, whereas others can strengthen the skills during training process. Each skill is merged with other skills so as to get continuity.

The intervention programme developed would be suitable to the teacher to teach in small groups, as it is feasible for a classroom teacher. This is considered as an important milestone towards achieving universalisation of elementary education. The unmanageable students with conduct disorders, sometimes become dropouts can be managed easily by teachers using the skills instruction and teaching of self instruction. This will lead to improvement in social skills, problem solving skills, self control, etc. which equips the individual to lead a harmonious balanced life. Development of cognitive skills can lead to improvement of the level of academic performance also. Thus altogether a visible change is evident in students, which can indirectly influence the surrounding environment.
1.14 OBJECTIVES OF THE STUDY

The specific objectives of the study were as follows.

1. To find out the percentage of students exhibiting conduct disorder from students studying in grades V to XII in Kerala state.

2. To estimate the prevalence of students with conduct disorder in Kerala state in terms of demographic characteristics like type of schools, grades and gender.

3. To determine the frequency of students exhibiting different types of conduct disorders belonging to different groups based on type of schools, gender and grades.

4. To find out whether there is any significant difference between normal students and students with conduct disorder of grades VII, VIII and IX in
   a. Level of self concept
   b. Level of Scientific attitude
   c. Level of emotional intelligence
   d. Extent of social cognition
   e. Extent of assertion
   f. Number of social skills problems present

5. To find out whether there is any qualitative difference between normal students and students with conduct disorder of grades VII, VIII and IX in
   a. Level of self concept
   b. Level of Scientific attitude
   c. Level of emotional intelligence
   d. Extent of social cognition
   e. Extent of assertion
   f. Number of social skills problems present
6. To plan a remedial intervention programme for students with conduct disorders to improve
   a. Level of self concept
   b. Level of Scientific attitude
   c. Extent of Social cognition
   d. Extent of assertion
   e. Problem solving skill and to
   f. Reduce the number of social skills problems present

7. To study the effectiveness of the above mentioned programme for students with conduct disorders in improving the
   a. Level of self concept
   b. Level of Scientific attitude
   c. Extent of Social cognition
   d. Extent of assertion
   e. Problem solving skill and to
   f. Reduce the number of social skills problems present

1.15 HYPOTHESES OF THE STUDY

   The present study verifies the following hypotheses.

1. There is a significant quantitative difference between normal students and students with conduct disorders in grades VII, VIII and IX in
   a. Level of self concept
   b. Level of Scientific attitude
   c. Level of emotional intelligence
   d. Extent of social cognition
   e. Extent of assertion
   f. Number of social skills problem present
2. There is a qualitative difference between normal students and students with conduct disorders in grades VII, VIII and IX in
   a. Level of self concept
   b. Level of Scientific attitude
   c. Level of emotional intelligence
   d. Extent of social cognition
   e. Extent of assertion
   f. Number of social skills problem present
   g. Problem solving skills

3. The remedial programme developed in the study will be effective in improving the
   a. Level of self concept
   b. Level of Scientific attitude
   c. Extent of social cognition
   d. Extent of assertion
   e. Problem solving skills and to
   f. reduce the number of social skills problems present

1.16 OPERATIONAL DEFINITION OF KEY TERMS

Operational definition of key terms used at various stages of the study is given below.

Conduct disorders – This refers to the repetitive and persistent patterns of antisocial aggressive or defiant conduct (Diagnostic definition of conduct disorder given by ICD – 10 (WHO, 1988).

In this study the term conduct disorders refers to enduring pattern of antisocial behavior, where there is significant impairment in everyday interactions at home or
school or when the student’s behaviour is deemed unmanageable by parents or teachers. Antisocial behaviour is of an intense nature and includes lying, cheating, stealing, aggression, temper tantrums, non compliance, destructiveness and oppositional behaviour.

Identification – In this study identification is based on the basis of both exclusionary and inclusionary criteria mentioned in table 3.5.

Intervention – A broad array approaches based on some theoretic perspectives. In the present study intervention refers to cognitive emotional interventions and behavioural interventions. Behavioural interventions include cognitive behavioural interventions and social cognitive interventions. Cognitive emotional intervention includes cognitive and affective intervention.

Cognitive-Emotinal Intervention – It is an intervention typically associated with a psycho-educational orientation to behavioural disorders of school age children and youth.

Cognitive-Behavioural Intervention: These are interventions though behavioural in nature utilises the cognitive process by giving self-control to the student’s own behaviour.

Self-monitoring: This is one of the stages of cognitive behavioural intervention where the person is made to attend to his/her own specific behaviour in a conscious and systematic fashion.

Self-evaluation: This is another stage of cognitive behavioural intervention, where a person compares his or her observations during the self-monitoring stage against some pre-established standard.
**Self-reinforcement**: This is the third stage of cognitive-behavioural intervention which involves self-presentation of rewards following the occurrence of behaviour to increase the probability of that behaviour in future.

**Social-cognitive intervention**: This term refer to the group of techniques designed to teach the student better to comprehend and deal with social and interpersonal events.

**Self-instruction**: Self-instruction is the process included in social cognitive intervention by which a person provides verbal prompts to oneself in order to direct or maintain a particular behaviour.

**Social problem solving**: Social problem solving is a part of social cognitive intervention to teach a person, the cognitive process for decision making in solving ordinary social problems.

**Self Concept** – Self concept is the understanding about oneself in the present studies refers to the score a student receives in the self concept scale.

**Assertive skills** – Assertive skill help us individual to express his/her wants, needs, opinions, feelings or rights. In the study the assertive skills refer to score a student receives in the assertive skill assessment questionnaire.

**Social skills** – The ability to respond to a given environment in a manner that produces, maintains and enhances positive interpersonal (between people) effects. In this study, social skills problem checklist was used. Those who receives less score in the social skills problem checklist is said to possess social skills.

**Emotional intelligence** – Emotional intelligence is the ability of an individual to identify, understand, assimilate and manage his/her own emotions during social
situations. Those who said to have scored more in the Emotional intelligence test is said to have high emotional intelligence.

**Social cognition** – This refers to the way in which people reason about themselves and others in social situations using their cognitive processes.

**Problem Solving Skill** – The ability to define and solve problems. It was assessed by conducting and informal assessment for students.

### 1.17 DELIMITATIONS OF THE STUDY

1. The study was restricted to identify students from grades V to XII. It would have been desirable to include students from lower grades also, as changes could be made from the beginning itself. But due to the difficulty in carrying out experiment of tools and lower grades were avoided from the study.

2. The study was restricted to students with adolescent onset conduct disorder.

3. The students selected for Intervention were only taken from grades VII, VIII and IX because of availability of the students for intervention regularly.