Chapter I

Introduction

Childhood is the most tremendous and tender stage of life. The physical as well as psychological development of a child has great importance as it provides a sharp and sound base for behavior in later years of life. Therefore, the first and foremost task is to identify the factors which influence the processes of development and growth. Prospective follow up of children and adolescents have shown that child and adolescent mental disorders are caused by a multitude of factors, and may result in a wide array of adverse outcomes. Risk factors for the development of mental disorders in children have been attributed to child characteristics, and those of his/her parents and family as well as the environment in which he/she is brought up. Child characteristics may include sex, age, ethnicity, birth weight, physical health, temperament, intelligence, cognitive and psychological functions, pre and peri-natal exposure to illness, alcohol, drugs, malnutrition, infections and other environmental agents such as exposure to toxins, stress, infections, social environment and stressful life events. Family and parent characteristics include parental education, age, social class, employment, marital status and harmony, psychiatric and medical history, delinquency, substance use, parent-child relationships, parental handling and family function, family structure, neighborhood, and broader contextual influences like disadvantage and poverty, violence and overcrowding, dissatisfaction of needs, child
abuse and maltreatment, lack of affection and attention, insecurity, improper rearing and monitoring, parental alcoholism, and ineffective coping skills.

The term childhood disorders are referred to as psychiatric disorders, usually first diagnosed in infancy, childhood, or adolescence. While in some children, the disorder tends to get resolved by the time they enter into adulthood, in others it tends to persist and continue to be problematic even in adulthood. Most children resolve the crises of critical periods normally in the transition of development, but some of them may not be able to resolve it, and face problems and difficulties in coping with it, and are vulnerable to develop mental and/or behavioral problems. Disorders of childhood and adolescence have not received much attention as the adult disorders have received. Children and adolescents with psychological problems cannot seek help for themselves as the troubled adults do as children are less able to express themselves in words. The child’s existence and emotional development depends on the family or care givers. The disorders observed in children cover a broad spectrum varying in symptom content, severity, and duration. Some of the disorders are less severe such as anxiety disorders and hyperactivity; others seem to be more severe, such as pervasive developmental disorders, also called as childhood schizophrenia or psychosis, autism, etc. The developmental stages of every child are very important in the assessment for the diagnosis of mental disorders.
DSM IV-TR classification recognizes the following specific types of childhood and adolescent disorders: Mental retardation, Learning disorders, Motor skills disorder, Communication disorders, Pervasive Developmental disorders, Attention deficit and disruptive disorders (conduct disorder), Feeding and eating disorders of infancy or early childhood, Tic disorders, Elimination disorders and other disorders of infancy, childhood, or adolescence.

Childhood disorders affect about one in ten children and the most common may include depression, anxiety and conduct disorder, and are often a direct response to what is happening in their lives. Childhood mental disorders may hinder children to develop the resilience to cope with life problems and grow into well-rounded, healthy adults. Studies suggest that more children and young people have problems with their mental health today than 30 years ago. This may be because of changes in the way we live now, and how that affects the experience of growing up. As mentioned above, some children have extremely difficult and challenging behaviors that are outside the norm for their age. Conduct disorder constitute the largest single group of psychiatric disorders in children and adolescents and is the main reason for referrals to child and adolescent mental health services. They represent about 30 percentage of the consultations with children by general practitioners (Green et al., 2004). Therefore, it would be relevant to look at and analyze the significant psychological variables related to these behaviors. It is a matter of concern that an increasing number of cases
of anti-social behavior among children are being reported by juvenile courts. When looking at the issues of conduct-disordered children, the starting point for most psychologists is to accept that the problem exists in them and then to work out why children are becoming antisocial. The collapse of communities is often seen as a key influence in the rise of antisocial behavior in children, with young people growing up without positive role models and a framework within which to develop into sociable adults. The present research explores some factors related to the development of conduct disorder in children by examining important psychological variables like home environment, coping, personality, and adjustment.

**History and Definition**

Conduct disorder is the oldest of the diagnostic categories used in contemporary child psychology. Long before the origin of psychiatry and psychology as scientific disciplines, ‘out-of-control children’ was problematic to the community and people didn’t know how to treat these children. Aichhorn (1935) was the first person to apply psychoanalytic concepts and methods to out-of-control children. The medical diagnosis of conduct disorder was made in the year 1968. Conduct disorder, a psychiatric index of antisocial behavior shares similarities with delinquency, which is a criminological index. Many children diagnosed with conduct disorder are involved in social and legal systems (APA, 2000; Bennett, 1998); however, all conduct disordered children are not juvenile delinquents. While all delinquent behaviors are
defined as violations of the law, conduct disorder symptoms are not necessarily so defined. For instance, symptoms such as “has used a weapon” may be criminal offences, and thus overlap with delinquency, whereas “bullies, threats or intimidations” or “staying out at night despite parental prohibitions” may not necessarily be interpreted as violations of law. With regard to special education, many children with conduct disorder receive services under the emotional or behavioral umbrella, but not all (Gagne, 1977; Koonce, 2000; McGee, Williams, & Silva, 1984). So whereas conduct disorder is the term used in clinical settings, other disciplines may use a different nomenclature to identify similar groups of children and adolescents. For example, terms such as emotional and behavioral disordered are used in the schools, while juvenile delinquent or adjudicated youth may be used in the justice system. Hence, one adolescent may be served by multiple systems and have multiple labels. Because of the overlap of these terminologies, research on any one of these may provide insight into the others. Conduct disorder need to be professionally assessed by a child and adolescent psychiatrist, a pediatrician, a child clinical psychologist specialised in the area of behavior disorders or another professional who has the appropriate competencies. These professionals will make an assessment based on observations and interviews with the parents, teachers and children.

The essential feature of conduct disorder is centered on the violation of basic rights of others or major age-appropriate societal norms. The behavior can be grouped into
four main categories that together make up the diagnostic criteria: 1. aggressive behavior that may cause or threaten physical harm to other people or animals; 2. behavior causing loss or damage to property; 3. deceitfulness or theft; and 4. serious violations of rules. The behavior must have been evident for at least 12 months and cause significant impairment in daily living (APA, 1994). The individual behaviors that can be observed when conduct disorder is diagnosed may be common, problematic, and chronic. They tend to occur frequently and are distressingly consistent across time, settings, and families. These children function poorly in all areas of functioning. In fact, the behaviors clustered within the term "conduct disorder" account for a majority of the clinical referrals, classroom detections, being asked to stop participating in numerous activities, and can be extremely difficult (even impossible) for parents to manage.

The financial costs of crime and correction for repeated juvenile offenses by children with conduct disorder are extensive. The social costs include citizens' fear of such behavior, loss of a sense of safety, and disruptions in classrooms that interfere with other children's opportunity to learn. The costs to the child and his or her family are enormous in terms of the emotional and other resources needed to address the consequences of the constellation of symptoms that define conduct disorder.
Epidemiology

Children below the age of 18 years constitute over 42% of India’s population and estimating the prevalence of mental disorders in children and adolescents is critical in providing the mental health services they need. DSM-IV reports prevalence in males of 6% to 10% and in females of 2% to 9% (APA, 1994). The ratio of males to females with CD is lower for the adolescent-onset type than for the childhood-onset type (APA, 2000).

Among the Indian studies, Deivasigamani (1990) has reported the prevalence of conduct disorder to be 11.13 percentage. Sarkar, Kapur and Kaliaperumal (1995) has reported prevalence rate of antisocial behavior to be 7.1 percentage; while recently Srinath, Girimaji and Gururaj (2005) have reported prevalence as low as 0.2 percentage. The prevalence of conduct disorder is 4.58 percentage more common in boys, majority has childhood onset, and one-third has co-morbidity with Attention Deficit Hyperactivity Disorder (Sarkhel, Sinha, DeSarkar, & Arora, 2006). Srinath et al. (2005) reported point prevalence rate for conduct and oppositional defiant disorder to be 1.3 percentage and Pillai et al. (2008) reported a rate of prevalence of 0.4 percentage for disruptive behavioral disorders.

Among the western studies Kashani, Daniel, and Sulzberger (1987) reported prevalence of 8.7 percentage, while Esser, Schmidt and Woerner (1990) reported prevalence of 0.9 percentage. The ratio of male to female CD is lower for the
adolescent onset type than for the childhood onset type. Attention-deficit hyperactivity disorder (ADHD) is the common co-morbidity in children with conduct disorder. The median 12 month prevalence rate of disruptive behavioral disorders (i.e., conduct disorder or oppositional defiant disorder) is 6 percentage.

British surveys in the years 1999 - 2004 show that 5 percentage of children and young people aged 5 to 15 years met the ICD-10 criteria for conduct disorders with a strict impairment requirement (Green et al., 2005). A modest rise in diagnosable conduct disorder over the second half of the twentieth century has also been observed when comparing assessments of three successive birth cohorts in Britain (Collishaw et al., 2004). In terms of class, there is a marked social class gradient with conduct disorders more prevalent in social classes D and E compared with social class A (Green et al., 2005).

Conduct disorder is more common in children of parents with antisocial personality disorder and alcohol dependence than it is in the general population. The prevalence of conduct disorder and antisocial behavior is significantly related to lower socio-economic factors.

**Symptoms**

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) indicates that for conduct disorder to be diagnosed, the patient has repeatedly violated rules, age-appropriate social norms, and the rights of others for a period of at least
twelve months. The following behaviors, with at least one having taken place in the
previous six months

A. Aggression to people or animals

B. Property destruction

C. Lying or theft

D. Serious rule violations.

A. Aggression to people or animals include:

1) Engaging in frequent bullying or threatening

2) Often starting fights

3) Using a weapon that could cause serious injury (gun, knife, club, broken glass, etc)

4) Showing physical cruelty to people

5) Showing physical cruelty to animals

6) Engaging in theft with confrontation (armed robbery, extortion, mugging, purse
    snatching, etc.).

7) Forcing sex upon someone

B. Property destruction include:

1) Deliberately setting fires to cause serious damage

2) Deliberately destroying the property of others by means other than fire setting

C. Lying or theft include:

1) Breaking into building, car, or house belonging to someone else
2) Frequently lying or breaking promises for gain or to avoid obligations (called "conning")

3) Stealing valuables without confrontation (burglary, forgery, shop lifting, etc.)

D. Serious rule violations include:

1) Beginning before age 13, frequently staying out at night against parents' wishes

2) Running away from parents overnight twice or more or once if for an extended period

3) Engaging in frequent truancy beginning before the age of 13

Depending on the intensity of symptoms, conduct disorder can be classified into mild, moderate and severe. Mild means there are few problems with conduct beyond those needed to make a diagnosis and all of the problems cause little harm to other people. Moderate means the number and effect of the problems is between the extremes of mild or severe. Severe means there are many more conduct symptoms than are needed to make the diagnosis (more than three in the previous twelve months or more than one in the previous six months), or, the behaviors cause other people considerable harm.
Types of conduct disorder

Based on the age of onset, conduct disorder may be divided into two types.

Childhood-onset type

This subtype is defined by the onset of at least one criterion characteristic of conduct disorder prior to age 10 years. Individuals with childhood-onset type are usually males, frequently display physical aggression toward others, have disturbed peer relationships, and may have had oppositional defiant disorder during early childhood and usually have symptoms that meet full criteria for conduct disorder prior to puberty. These individuals are more likely to have persistent conduct disorder and to develop adult antisocial personality disorder than are those with adolescent-onset type. The childhood-onset type is more highly associated with heightened aggression, male gender, oppositional defiant disorder, and a family history of antisocial behavior. The negative consequences of conduct disorder, particularly childhood onset, may include illicit drug use, dropping out of school, violent behavior, severe family conflict, and frequent delinquent acts. Such behaviors often result in the child's eventual placement out of the home, in special education and/or the juvenile justice system. These children usually meet the full criteria for conduct disorder before puberty, they are more likely to have persistent conduct disorder, and are more likely to develop adult antisocial personality disorder than those with the adolescent-onset type (American Psychiatric Association, 1994).
Adolescent-onset type

This subtype is defined by the absence of any conduct disorder criteria prior to age 10 years. Adolescent conduct disorder should be considered in the social context. Compared with those with the childhood-onset type, these individuals are less likely to display aggressive behaviors and tend to have more normative peer relationships (although they often display conduct problems in the company of others). These individuals are less likely to have persistent conduct disorder or to develop adult antisocial personality disorder. The ratio of males to females with conduct disorder is lower for the adolescent-onset type than for the childhood-onset type (American Psychiatric Association, 1994).

Adolescents exhibiting conduct disorder behavior as a part of gang culture or to meet basic survival needs (e.g., stealing food) are often less psychologically disturbed than those with early childhood histories of behavior disorders. These individuals tend to have more normal peer relationships, and are less likely to have persistent conduct disorders or to develop adult antisocial personality disorder. Additionally, new-onset conduct disorder behavior, such as skipping school, shoplifting or running away in the context of a family stressor, often remits if appropriate support and interventions are provided.
Diagnosis and differential diagnosis

Conduct disorder does not develop overnight; instead, a variety of symptoms evolve over time until a consistent pattern violates the rights of others. Very young children are unlikely to meet the criteria for the disorder, since they are not developmentally able to exhibit the symptoms typical of older children with conduct disorder. A three year-old does not break into someone’s home, steal with confrontation, force someone into sexual activity, or deliberately use a weapon that can cause serious harm. However, school-age children may become bullies, initiate physical fights, destroy property, or set fires.

The average age of onset of conduct disorder is younger in boys than in girls. Boys most commonly meet the diagnostic criteria by 10 to 12 years of age, where as girls often reach 14 to 16 years of age before the criteria are met. Children who meet the criteria of conduct disorder express their overt aggressive behavior in various forms. The aggressive antisocial behavior may take the form of bullying, physical aggression, and cruel behavior toward peers. The children may be hostile, verbally abusive, impudent, defiant, and negativistic toward adults. Persistent lying, frequent truancy, and vandalism are common. In severe cases there is often destructiveness, stealing, and physical violence. The children usually make little attempt to conceal their antisocial behavior. Sexual behavior and the regular use of tobacco, liquor, or
non-prescribed psychoactive substances begin unusually early for such children and adolescents. Suicidal thoughts, gestures, and acts also are frequent.

Many of the children with aggressive behaviors fail to develop social attachments, as manifested by their difficulty in peer relationships. Such children are often socially withdrawn or isolated. Some of them make friendship to much older or younger persons or have superficial relationships with other antisocial youngsters. Most of them have low self-esteem, although they may project an image of toughness. Characteristically, they do not put themselves out of others, even if doing so would have an obvious immediate advantage. Their ego centrism is shown by their tendency to manipulate others for favors without any effort to reciprocate. They lack concern for the feelings, wishes, and welfare of others. They seldom have feelings of guilt or remorse for their callous behavior and try to blame others.

Conduct disorder children may have frequent encounters with unusual frustrations, particularly of their dependency needs, and with their consistent pattern of disciplines. Their deficient socialization is revealed in the excessive aggressiveness and in their lack of sexual inhibition. Their general behavior is unacceptable in almost any social settings. Further, severe punishment almost invariably increases their maladaptive expression of rage and frustration, rather than ameliorating the problem. They often bully those who are smaller and weaker than they. By boasting, lying, and expressing
little interests in the listener’s response, such children reveal their profoundly narcissistic orientation.

Evaluation of the family situation often reveals severe marital disharmony among the parents which initially may center on disagreements concerning management of the child. Many children with conduct disorder are children of unplanned or unwanted pregnancies. The parents, especially the father, often have antisocial personality disorder or alcohol dependence. The aggressive child and the child’s family show a stereotyped pattern of impulsive and unpredictable verbal and physical hostility. The child’s aggressive behavior rarely seems directed toward any definable goal and offers little pressure, success, or even sustained advantages with peers or authority figures (Slabber, 1999).

CD children who become part of a gang usually have age appropriate friendships. They are likely to show concern for the welfare of their friends or their own gang members and are unlikely to blame them or inform on them. In most cases, gang members have a history of adequate or even excessive conformity during early childhood that ended when the youngsters became a member of the delinquent peer group, usually in preadolescence or during adolescence. Also present in the history is some evidence of early problems, such as marginal or poor school performance, mild behavior problems, anxiety, and depressive symptoms (Cantwell & Baker, 1989).
Some degree of family, social, or psychological pathology is usually evident. Patterns of paternal discipline are rarely ideal and may vary from harshness and excessive strictness to inconsistency or relative absence of supervision and control. The mother has often protected the child from the consequences of early mild misbehavior but does not seem to actively encourage delinquency. Delinquency, also called juvenile delinquency, is most often associated with conduct disorder but may also be the result of other psychological or neurological disorders (Farrington, 1978).

No specific laboratory test or neurological pathology helps make the diagnosis of conduct disorder. Some evidence indicates that certain neurotransmitters, such as serotonin in the central nervous system, are low in some persons with a history of violent or aggressive behavior toward others or themselves (Kaplan & Sadok, 1972). Whether that association is related to the cause or is the effect of violence or is unrelated to the violence is not clear.

**Differential diagnosis**

Disturbance of conduct may be part of many childhood psychiatric conditions, ranging from mood disorders to psychotic disorders to learning disorders. Therefore, the clinician must obtain a history of the chronology of the symptoms to determine whether the conduct disturbance is a transient or reactive phenomenon. Isolated acts of antisocial behavior do not justify a diagnosis of conduct disorder; an enduring pattern must be present.
The relation of conduct disorder to oppositional defiant disorder is still under debate. Historically, oppositional defiant disorder has been conceptualized as a mild precursor of conduct disorder that 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 evidence indicates that the two disorders are independent. Many children with oppositional defiant disorder never go on to have conduct disorder, and, when conduct disorder first appears in adolescence, it may be unrelated to oppositional defiant disorder. 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.

Mood disorders are often present in children with some degree of irritability and aggressive behavior. Both major depressive disorder and bipolar disorders must be ruled out. However, the full syndrome of conduct disorder may occur and be diagnosed during the onset of a mood disorder. That is not the case of oppositional defiant disorder, which cannot be diagnosed if it occurs exclusively during a mood disorder. Attention–deficit/hyperactivity disorder and learning disorders are commonly associated with conduct disorder. Usually, the symptoms of those disorders predate the diagnosis of conduct disorder. All the above disorders should be noted when they co-occur. Children with attention-deficit/ hyperactivity disorder
often exhibit impulsive and aggressive behaviors that may not meet the full criteria for conduct disorder.

**Course and prognosis**

In general, children who have conduct disorder symptoms at a young age, who exhibit the greatest number of symptoms, and who express the symptoms most frequently, have the poorest prognosis. That is true partly because those with severe conduct disorder seem to be the most vulnerable to other disorders, later in life, such as mood disorders. Conduct disorder is also associated with substance abuse–related disorders later in life. It stands to reason that, the more concurrent mental disorders a person suffers from, the more troublesome his/her life will be. It was found that, although assaultive behavior in childhood and parental criminality predict a high risk for imprisonment later in life, the diagnosis of conduct disorder per se was not correlated with imprisonment (Kaplan & Sadok, 1972).

A good prognosis is predicted by mild conduct disorder, the absence of coexisting psychopathology, and normal intellectual functioning. Although assessing treatment strategies is difficult because of the many symptoms involved in conduct disorder, it appears to be more difficult to design effective treatment programs for the covert symptoms of conduct disorder than for overt aggression.
Etiology of conduct disorder

No single factor can account for children’s antisocial behavior and conduct disorder. Researchers have not yet discovered what causes conduct disorder, but they continue to investigate the possible biological factors, psychological factors, sociological and familial factors, and child abuse and maltreatment;

Biological causal factors

The biological causal factors of conduct disorder include age of onset and association with antisocial personality disorders, neurobiological factors, and genetic factors.

Age of onset and association with antisocial personality disorder

Children who develop conduct disorder at an earlier age are much more likely to develop psychopathy or antisocial personality disorder as adults than are adolescents who develop conduct disorder in adolescence (Hinshaw, 1994; Moffitt, 1993). Although only about 25 to 40 percent of the cases of early-onset conduct disorder go on to develop adult antisocial personality disorder, over 80 percent of boys with early-onset conduct disorder continue to have multiple problems of social dysfunction (in friendship, intimate relationships, and vocational activities) even if they do not meet full criteria for anti-social personality disorder. By contrast, most children who develop conduct disorder in adolescence do not go on to become adult psychopaths or antisocial personalities but instead have problems limited to the adolescent years. The
adolescent–onset cases do not share the same set of risk factors that the child-onset cases have, including low verbal intelligence, neuropsychological deficits, and impulsive and attentional problems (Hinshaw, 1994; Moffitt & Lynman, 1994).

Neurobiological factors

Neurobiological factors in conduct disorder have been explored a little. However, research in attention–deficit/hyperactivity disorder (ADHD) suggested that conduct disorder and ADHD co-exist. In some conduct disordered children, a low level of plasma dopamine B-hydroxylase, an enzyme that converts dopamine to nor-epinephrine, has been found. That finding supports the theory of decreased nor-adrenergic functioning in conduct disorder. Some conduct disordered juvenile offenders have increased blood serotonin (5-hydroxytryptamine [5-HT]) levels. Evidences indicate that blood 5-HT levels correlate negatively with levels of the 5-HT metabolite 5-hydroxyindoleacetic and (5-HIAA) in the cerebrospinal fluid (CSF) and that low CSF-HIAA correlates with aggression and violence (Kaplan & Sadok, 1972).

Compared to normal controls, children with early and adolescent onset of conduct disorder displayed reduced responses in the brain regions associated with antisocial behavior (i.e., amygdala, ventromedial prefrontal cortex, insula, and orbitofrontal cortex). In addition, youths with conduct disorder also demonstrated less responsiveness in the orbitofrontal regions of the brain during a stimulus-reinforcement and reward task. It provides a neural explanation for why youths with
conduct disorder may be more likely to repeat poor decision making patterns. Youths with conduct disorder display a reduction in grey matter volume in the amygdala, which may account for the fear conditioning deficits. This reduction has been linked to difficulty processing social emotional stimuli, regardless of the age of onset. Individuals with conduct disorder are characterized as having reduced serotonin and cortisol levels (e.g., reduced hypothalamic-pituitary-adrenal (HPA) axis), as well as reduced autonomic nervous system (ANS) functioning. These reductions are associated with the inability to regulate mood and impulsive behaviors, weakened signals of anxiety and fear, and decreased self-esteem (Kaplan & Sadok, 1972).

ADHD, central nervous system (CNS) dysfunction or damage, and early extremes of temperament can predispose a child to conduct disorder. Propensity to violence correlates with CNS dysfunction and signs of severe psychopathology, such as delusional tendencies. Longitudinal temperament studies suggest that many behavioral deviations are initially a straightforward response to a poor fit between, on the one hand, a child’s temperament and emotional needs and, on the other hand, parental attitudes and child-rearing practices (Kaplan & Sadok, 1972).

Genetic factors

Behavioral genetic studies confirm moderate influence of genetic factors in the etiology of conduct disorder. The influence of genetic factors appear to be highest in early-onset, pervasive conduct disorder, and in children / adolescents with conduct
disorder and callous-unemotional traits. Many children and teens with conduct disorder have close family members with mental illnesses, including mood disorders, anxiety disorders, substance use disorders and personality disorders. This suggests that a vulnerability to conduct disorder may be inherited (Kaplan & Sadok, 1972).

Molecular genetic studies have shown associations between genetic variants of genes of the dopaminergic and serotonergic systems and conduct disorder. Some genetic factors moderate the impact of environmental adversity; for example, gene-environment interactions influence developmental risk for conduct problems, aggression and violence in children exposed to maltreatment (Caspi et al., 2002).

Twin studies have found greater concordance of antisocial behavior among monozygotic than dizygotic twins, and adoption studies have shown that criminality in the biological parent increases the likelihood of antisocial behavior in the child (Kaplan & Sadok, 1972).

There is accumulated evidence that genetic predispositions, leading to low verbal intelligence, mild neuropsychological problems, and difficult temperament are precursors to conduct disorders. Some of the conduct disorder children may have deficiencies in self control functions such as sustaining attention, planning, self-monitoring, and inhibiting unsuccessful or impulsive behaviors, which may help set the stage for a lifelong course of difficulties. Aspects of the personality, such as activity levels displayed by a child, emotional responsiveness, quality of mood, and
social adaptability are part of his or her temperament. The child’s difficult temperament may lead to insecure attachment because parents find it hard to engage in good parenting that would lead to secure attachment (Slutsky et al., 1997; Moffit & Lynam, 1994).

**Psychological factors**

Many psychological perspectives have emphasized the role of psychological factors in the development of conduct disorders. The main perspectives that attempt to explain the psychological influence on conduct disorders are the psychodynamic, behavioral, cognitive, and sociological and familial perspectives. These theories suggest that these factors tend to exist in combination rather than in isolation. The prevalence of these factors may increase or decrease the likelihood of conduct disorder.

*Psychodynamic perspective*

Psychoanalytic theories suggest aggressive, antisocial behavior as a defense against society, the result of maternal deprivation, or a failure to internalize controls. This perspective emphasizes that conduct disorder is not a reflection of the child’s actual personality structure but represents a symptom of intra-psychic tensions in the person. The nature of the conflicts and the motivational causes behind the anxiety leading to deviant behavior are quite varied. They may involve things such as an unconscious need for punishment, the desire to punish one’s parents, or efforts to
prove one’s masculinity (Shore, 1971). According to Shore, the core problem in conduct disorder is a defective ego. The functions of the defective ego meant that the tolerance for frustration, the ability to delay gratification, the adequate functioning of guilt, the development of sublimations, and the evolution of self-esteem. When these functions are not adequately enforced, antisocial-delinquent behaviors tend to result.

According to Bird (2001), as far as a normal child is concerned, the psychic pain resulting from such guilt motivates the individual to punish himself and to avoid similar behavior in the future which could result in equal discomfort. However, children with conduct disorder do not experience guilt over their misconduct because of underdeveloped super-egos. The lack of punishment from such a superego makes them feel no need to change their behavior, which explains why their aggression and violation of social rules tend to be recurrent.

Schoenfeld (1971) held that conduct disordered children develop superegos that are weak or defective. The main causes for this include parental deprivation, lack of affection, as well as lax and erratic discipline. Since the superego is actually an internalized image of parents, the absence of such ones almost inevitably results in incomplete internalization or a defective superego. Even when parents are present, if they fail to show warmth toward their children, it is hardly likely that such children will identify with them and internalize their values. Also, if parents administer
discipline in a lax and inconsistent manner, then the child’s superego will be too weak and erratic to effectively control primal impulses that push for expression.

**Behavioral perspective**

The behavioral perspective suggests that children use the techniques of modeling and operant conditioning to develop and maintain conduct disorder. Children brought up in chaotic, negligent conditions generally become angry, disruptive, demanding, and unable to progressively develop tolerance for frustration necessary for mature relationships. As their role models are poor and often frequently changing, the basis for developing both an ego-ideal and a conscience is lacking. The children are left with little motivation to follow societal norms and are relatively remorseless.

According to this perspective, aggression among conduct disordered children stems from learned behavior. Children who observe others behaving in aggressive ways while watching aggression and violence on television, movies, and video games are more likely to demonstrate the aggressive behaviors they have witnessed. Children who witness aggressive behaviors at home, such as physical fighting, pushing, and shoving (push someone) are at increased risk for learning the same observed behavior. Children with conduct disorder often live in families in which there is a high level of conflict that takes a physical form.

Children would imitate antisocial peers. Association with deviant peers may influence the development of conduct disorder in two ways: 1. a selection process
whereby youth with aggressive characteristics choose deviant friends, and 2. a facilitation process whereby deviant peer networks bolster patterns of antisocial behavior (Hinshaw & Lee, 2003).

**Cognitive Perspective**

Some experts believe that conduct disorders can reflect problems with moral awareness (notably, lack of guilt and remorse) and deficits in cognitive processing. In terms of cognitive functions, intelligence and cognitive deficits are common amongst youths with conduct disorder, particularly those with early-onset and those who have intelligence quotients (IQ) one standard deviation below the mean, and severe deficits in verbal reasoning and executive functions. Executive function difficulties may manifest in terms of one’s ability to shift between tasks, plan as well as organize, and also inhibit a proponent response. These findings hold true even after taking into account other variables such as race, socioeconomic status, and education. It is important to note that IQ and executive function deficits are only one piece of the puzzle, and the magnitude of their influence is increased during transactional processes with environmental factors (Pennington & Benneto, 1993).

**Sociological and familial perspectives**

Sociological theories suggest that conduct disorder result from a child’s attempt to cope with a hostile environment or to gain social status among friends (APA, 1994). They argue that inconsistent home life contribute to the development of the disorder.
These theories suggest that socioeconomically deprived children, unable to achieve status and obtain material goods through legitimate routes, are forced to resort to socially unacceptable means to reach those goals. Such behavior is normal and acceptable under circumstances of socioeconomic deprivation, as the children are adhering to the values of their own subculture.

Kazdin(1995) mentioned the importance of family and social context factors as causal variables in conduct disorder. For example, having a confused “idea” or relationship with the primary caretaker can result in disorganized early attachment and can signal later aggression in the child (Lyons-Rith, 1996). Children who are aggressive and socially unskilled are often rejected by their peers and such rejection can lead to “a spiraling sequence” of social interactions with peers that exacerbates the tendency toward antisocial behavior (Dodge, 1980). Dodge (1993) integrated the constructs of social information processing patterns and knowledge structures into novel theoretical framework for understanding the etiology of conduct disorder. It is hypothesized that early experiences of physical abuse, exposure to aggressive models, and insecure attachment relationships lead a child to develop structures of the world as a hostile place that requires coercive behavior to achieve desired outcomes. Later, when this child is presented with provocative stimuli, these knowledge structures lead him/or her to interpret these stimuli as a threat to the self. The child evaluates the probable outcomes of aggressing in this instance as favorable and engages in
aggressive behavior. Repeated experiences of this sort strengthen the child’s knowledge structures, make this processing pattern more automatized and lead to conduct disorders.

The combination of rejection by parents, teachers, and peers leads these children to become isolated and alienated. They often turn to develop deviant peer group for companionship at which point, a good deal of imitations of the antisocial behavior of their deviant peer models may occur.

Generally, family settings of conduct disordered children are typically characterized by ineffective parenting, rejection, harsh and inconsistent discipline, and often parental neglect. Frequently, the parents have unstable marital relationships, are emotionally disturbed or sociopathic, and do not provide the child with consistent guidance, acceptance, or affection. Patterson (1996) concluded that parents who are themselves apprised as having antisocial characteristics are very likely to be ineffective in their parental skills. Family discord, such as the conflict and disharmony accompanying divorce, can be instrumental in the development of conduct disorders. Such parental discord and hostility are conceptualized as contributing to poor and ineffective parenting skills-especially ineffective discipline and supervision. These children are trained by the family directly in antisocial behavior by coercive interchanges and indirectly by lack of monitoring and consistent discipline. This in
turn, leads to association with deviant peers and the opportunity for further learning antisocial behavior.

In addition, low socioeconomic status, poor neighborhoods, parental stress and depression appear to increase the likelihood of developing conduct disorder.

*Child abuse and maltreatment*

Children who are exposed to violence for long periods, especially those who endure physically abusive treatment, often behave in aggressive ways. Such children may have difficulty in verbalizing their feelings, and that difficulty increases their tendency to express themselves physically. In addition, severely abused children and adolescents tend to be hyper vigilant; in some cases, they misperceive benign situations and respond with violence. Not all physical behavior is synonymous with conduct disorder, but children with a pattern of hyper vigilance and violent responses are likely to violate the rights of others.

In order to understand the underlying pathology of conduct disorder better, there is a need to examine the influence of the variables like home environment, coping, personality and adjustment. Home is a place to which one brings the everyday run of social experience, to sift, to evaluate, to appraise, to understand or to be twisted, to foster, to be magnified or ignored, as the case may be (Bossard, 1948). It is hard to think of a factor that carries more weight in children’s adjustment than their family life. Family is of central importance to human beings for their growth, development,
and their very existence. Family influences are fundamental. They precede and determine other factors that support the development of an individual. The environment in which a child grows up has a great influence on his emotional and personality development and home constitutes a major part of the environment.

It has been noted that children raised in impoverished family environment due to separation, divorce, remarriage, violence, abuse or neglect tend to have an elevated risk of emotional and behavioral problems including early conduct problems and young offending. When we examine the association between family processes and childhood behaviors, it is possible that increased behavioural problems could be a response to the processes of change or it may be that these increases are due to the parental conflict and disharmony that frequently precedes family changes. There is mounting evidence that exposure to parental discord is the critical factor leading to behavior problems in children (Emery & O’Leary, 1982; Long & Forehand, 1987; Porter & O’Leary, 1980; Rutter & Giller, 1983). This evidence includes the finding that children from divorced homes display more behavior problems than children from homes in which a parent has died.

Family life shapes and encourages children’s social nature. Regardless of their family configuration or economic circumstances, children benefit from a stable and supportive family climate. Their abilities, values, beliefs, self-esteem and character
develop mainly within the family context. It is within the family unit that most children and adolescents establish their individuality.

One of the most consistently researched aspects involved within the models proposed for the etiology of conduct disorder has been the role that certain parental styles have in the development of conduct disorder. Parental styles and home environment have been consistently found to be a precursor of conduct disorder in many studies. Parenting style refers to the combination of rearing strategies and personalities of an individual parent. McIntyre and Dusek (1995) found that children and adolescents with authoritative parents reported greater support coping and problem-focused coping relative to adolescents from authoritarian parents. Thus, children from cohesive homes may use active or approach-oriented coping behaviors more frequently when dealing with stressful circumstances than children from less cohesive homes, which may use avoidant strategies to a greater extent.

Families characterized by high levels of conflict, aggression, and hostility are often lacking in acceptance, warmth, and support. Research studies that assessed these characteristics of family life reported reliable associations between them and a broad array of mental health risks, including internalizing symptoms such as depression, suicidal behavior, and anxiety disorders (Chorpita & Barlow, 1998; Kaslow et al., 1994), and externalizing symptoms such as aggressive, hostile,
oppositional, and delinquent behavior (Barber, 1996; Rothbaum & Weisz, 1994; Steinberg, Lamborn, Darling, Mounts, & Dornbusch, 1994).

One of the most important characteristics of parents of seriously delinquent violent juveniles is physical abusiveness toward their children and toward each other; there are several ways in which one might understand how abuse begets violence. First, parental violence becomes a model of behavior. Second, it often results in CNS damage that contributes to a child’s difficulty controlling impulses and functioning well at school or on the community; and finally it engenders rage that is frequently displaced from the abusing parent onto other, such as teachers and peers.

The family environment and the quality of the parent-child relationships are also likely to influence the types of coping strategies parents suggest to their children. These associations are more likely to be observed with coping strategies that involve parental participation, such as support seeking. We would expect that parents who have warm, accepting relations with their children to suggest support seeking more often than parents who are distant from and rejecting of their children. Similarly, parents in homes characterized by cohesion, openness of expression, and lack of conflict should suggest support seeking more often than parents residing in more conflicted households. A second way in which parents may influence their children’s coping choices is by modeling how they handle their own stressful situations that arise.
Not all children are affected equally by the stressors in the society and the family. Understanding their differential effects is an important research issue. The strategies that children use to cope are one source of children’s differential vulnerability to the effects of stress. In general, coping researchers agree that the study of coping is fundamental to an understanding of how stress affects children, for better or worse. From the perspective of basic research, coping represents an important aspect of the general processes of self-regulation of emotion, cognition, behavior, physiology and the environment (e.g., Eisenberg, Fabes, & Guthrie, 1997; Skinner, 1995). From a more applied perspective, coping research is significant in two ways. First, psychosocial stress is a significant and pervasive risk factor for psychopathology in childhood and adolescence (Grant, Compas, Thurm, McMahon, & Ey, 2000). In the broadest sense, ways of coping are the basic categories used to classify how children cope. They capture the ways in which children actually respond to stress, such as through seeking help, rumination, problem solving, denial, or cognitive restructuring.

Several categorization systems have been proposed in studying the effects of coping; however, a four-dimensional model comprising of active coping, avoidance coping, distraction coping, and support seeking coping proves to be most adequate (Ayers, Sandler, West, & Roosa, 1996). Some of these dimensions are related to lower levels of problems. For example, active coping, which includes problem solving
and positive cognitions about stressful situations, is related to fewer emotional and behavioral problems (Sandler et al., 1997). It is suggested that this positive relationship between active coping and better child adjustment may be a result of the child improving the situation or interpreting the situation as less threatening. Ayers (1991) found that the children, who use, avoidant coping strategies, rather than active coping strategies, were more likely to report depression, decreased self-esteem and conduct disorder. Therefore, if a child is capable of improving or re-interpreting a situation through active coping, this may provide a buffering influence on the negative behavioral effects.

Sandler et al., (2000) suggested that if children’s coping efforts are successful, their sense of efficacy will increase, and they will be more likely to use that coping strategy in the future. However, if children’s coping efforts are met with negative outcomes, they may be less likely to use that strategy in the future and may feel a sense of helplessness and hopelessness, which would be expected to be associated with internalizing and externalizing problems.

It has been found that environmental variables like home environment and the coping styles adopted by children may influence the development of conduct disorder. Temperament and personality may also be factors that predispose the children to conduct disorder, as conduct disorder is the product of an interaction between individual and the environment.
The impact of personality and temperament were rather neglected in research in favor of sociological explanations for conduct disorder and delinquency for many years. Personal variables such as temperament and personality are also prominent factors in the development, maintenance, and severity of conduct disorder. Personality disorders for children and adolescents can be described as conduct disorder. But most of the conduct disorders do not lead to a personality disorder in adulthood.

In children, the existence of a set of traits that collectively constitute a difficult temperament (e.g., negative mood, lack of perseverance, inability to adapt to situations, readiness to be distracted, intense emotional reactions, hyperactivity and social withdrawal) is found to be strongly predictive of impaired psychosocial adaptation in adolescence and adulthood. Chess and Thomas (1984) found that a difficult temperament is especially predictive of conduct disorder if the child comes from a dysfunctional family. Several longitudinal studies have specifically identified “difficult temperament”, which includes irregularity, predominantly negative withdrawal to new stimuli, slow adaptability, and intense emotional reactivity to the environment, as an important predictor for later externalizing behavior problems (Bates, Bayles, Bennett, Ridge, & Brown, 1991; Olson, Bates, Sandy, & Lanthier, 2000).

A difficult temperament seems to be a common precursor for mental problems in general. Having a difficult temperament at age’s 3-4 years predicted poor psychiatric
adjustment at ages 17-24 years. Furthermore, the uninhibited children at age 21 months significantly tended to be identified as aggressive at age 13 years, according to self and parent reports (Schwartz, Snidman, & Kagan, 1996). Among the temperament-related behavioral characteristics that can be ascertained at an early age, aggression against others, weak emotional self-control, and disobedience are most predictive of adolescent conduct disorder, independently of both the family environment and the nature of the child's peer group.

Conduct disorder may be the consequence of incompatibility between the child's temperament (e.g., one who is impulsive without great inhibitory capacities) and the demands of those close to him/her in the family (e.g., child-raising style). Some family interactions are more relevant to overt child problem behavior whereas other family interactions are associated with covert acts. Patterson’s coercion theory (Patterson, 1982; Patterson, Reid, & Dishion (1992) describes the pernicious impact of chronic coercive interchanges between parents and children and between children and siblings. Patterson’s contribution (Patterson 1982; Patterson et al., 1992) is particularly important because he demonstrated that adults’ responses to aggressive child behaviors follow an escape-avoidance paradigm. To avoid escalation of children’s aggression, adults often fall into the reinforcement trap of giving in to children’s aggression to reduce their discomfort. Children consequently learn that aggression pays off.
The probable temperamental and personality characteristics of conduct disorders are impaired behavioral control, lack of guilt feelings, physical aggression, less empathy, inability to recognize emotions such as anger and sadness in others, lower level of affective morality, egocentrism (the tendency to relate everything to oneself), narcissistic personality, and novelty seeking (exploratory excitability, impulsiveness, extravagance) coupled with relatively low levels of pain avoidance dimensions (i.e., low levels of fatigability, timidity, fear of the unknown, and anticipatory anxiety), dependence on compensation (lack of empathy, little sensitivity to social reinforcement), and determination (low level of individual maturity and sense of responsibility).

Temperament, personality and home environment may interact with the coping styles adopted by children with conduct disorder. The influence of all these factors on levels of adjustments of conduct disorder is also relevant in the present study.

The psychological term adjustment implies mastery over one’s environment and being at peace with oneself (Sarason, 1993). When a relationship between an individual and his environment is according to established norms then that relationship is considered as normal adjustment. For instance, when child adjustment is concerned, one who obey his parents, who is not unduly stubborn, who studies regularly and has neat habit is considered well adjusted. Abnormal adjustment means problem behavior or maladjustment. Maladjustment takes place when the relationship
between an individual and his environment is not according to established standards
or norms. A delinquent child is called maladjusted when he/she is violating certain
moral codes.

According to Waterman’s (1992) optimal psychological functioning model, well
adjusted children and adolescents are those who do not jeopardize their health and
safety, feel comfortable with family members and peers, have reasonably positive self
esteem, perform adequately in school, have realistic goals, participative in close
friendships and cope adequately with the changes/hassles that are inevitable part of
their everyday lives. Although vast majority of children and adolescents are well
adjusted, psychological disorders are common among them. It may range from mild
(temper tantrums) to extremely serious ones (e.g., conduct disorder). Children’s
emotional adjustment and school adjustment are vulnerable to a host of life stressors,
especially chronic family conflict. It is hard to concentrate in school when one’s home
life is unstable or conflictual. Witnessing heated parental arguments, experiencing
separation from a parent and living with a distressed single parent may negatively
affect the adjustment level of children.

As children grow older, they are expected to be both adjusted to the demands of
social life and behave in accordance with the social expectations of their age levels.
The level of social adjustment shown by children depends on the quality of the family
environment, motivation, and guidance. The degree of social adjustment attained by a
A person can be judged on the basis of when a person’s behavior or overt performances comes up to the expectation of the members of the group to which one belongs, adjustment with diverse groups, positive thinking about groups and people and personal happiness. Along with adjustment, the ability to acknowledge one’s difference and to strive in a creative manner are also indicators of positive mental health.

Thus, instead of a single variable, multiple interacting variables like characteristics of the child (age, sex, temperament, and, pre-divorce adjustment), parents (psychological adjustment, impulse control), family process variables (conflict, communication, co-operation, parent-child relationships, and child-rearing practices), legal and status variables (custody, residential arrangements), economic status and change, and social support conditions influence the development and maintenance of conduct disorder. In view of the significance and gravity of the problem, the present study is an attempt to understand conduct disorder, the psychological factors related to it and to compare the conduct disorder children with normal children along these variables. So the present study is titled as “Comparative Study of Conduct disorder and Normal children along Home Environment, Coping, and Adjustment”.

Need and significance of the present study

The scope of the problem in regard to conduct disorder is large. Conduct disorder has a significant detrimental impact on the quality of life of the child, the family, and the society at large. Children with conduct disorder are at high risk of experiencing future disadvantage through social exclusion, poor school achievement, long-term unemployment, juvenile delinquency and crime, and poor interpersonal relationships leading to family break-up in adulthood, and divorce and abuse of their own children. Approximately two-thirds of all the children referred to psychological and social service agencies are eventually labeled oppositional, aggressive, or ‘conduct disordered’. The need to develop and evaluate effective interventions that alter aggressive behavior in children is particularly important because studies have consistently shown that conduct disordered children are at high risk for developing psychiatric disability as adults, particularly for juvenile delinquency and crime. There is a need for provision of easily accessible remedial and preventive programs. This study may provide a sound understanding of the important variables related to conduct disorder like home environment, coping, personality, and adjustment. It will be a comprehensive evaluation of the influence of these variables on the development of conduct disorder in children. Since the study is a comparison between normal children and conduct disordered children, it may also provide an understanding of the
differences between them in home environment, coping, personality, and adjustment. This understanding may be helpful in counseling and other intervention programs.

The importance of home as a major factor in an individual’s development has long been recognized by social scientists. Within a family systems framework, family members are seen as mutually interdependent. These influences are considered reciprocal in nature, with children influencing parental behavior and parents influencing child behavior. In the Indian setting, families are highly cohesive and bound by close kinship ties. We live a shared life and subordinate individual autonomy to family cohesiveness. The study may supplement the research on how family environment affects child behavior and the development of childhood disorders.

In externalizing disorders, there is evidence for shared environmental inputs for the development of disorders. So family interventions focused on changing social environments or parenting styles may be preventive, or at least reduce the occurrence of conduct disorder. The study may provide insights for the development of awareness programs for parents in identifying the tendencies for deviant development, in taking preventive measures, and in dealing with problem children.

The study may give an idea about how children use various coping strategies when they encounter stressful situations. It may also provide relevant information on effective coping strategies that may promote mental health, right from childhood.
Another important point is that understanding the factors that influence the acquisition of various coping styles may give us insights into why children respond to stressful situations as they do. Understanding the socialization influences, like family on the coping process may suggest potential targets of interventions aimed at increasing the efficacy of coping approaches that children use. The ways in which children and adolescents cope with stress are potentially important mediators and moderators of the impact of stress on current and future adjustment and psychopathology. A wide range of psychological interventions for the treatment and prevention of psychopathology are designed to enhance the coping skills of children and adolescents. Information about the basic nature and efficacy of coping in childhood and adolescence may help improvise these interventions.

The coping strategies used by children with conduct disorder have been less researched. So it is necessary to expand knowledge in this area for better outcomes.

The study may help to remove the stigma related to conduct disordered children, at least to some extent. Compared with normal children, children with conduct disorder encounter many troubles at school as well as in other social settings. They are sometimes the victims of harsh punishments and mental torture. This, in turn, may adversely affect the overall development of the child and may lead to self devaluation, low self esteem, depression, apathy, taking revenge to the authorities, juvenile crime, etc.
The study also explores the personality patterns of conduct disordered children. Studies on the relationship between personality and adjustment among conduct disordered children are relatively rare. This study may give some knowledge to practitioners about the personality characteristics of conduct disordered children. The study of the personality patterns may help to distinguish children who become antisocial adolescents from those who do not, on the basis of their personality in late childhood years.

The school counselors and teachers may not have the adequate knowledge and skills to tackle the problem and usually land up in blaming the victim. This study is expected to provide a sound understanding of the main causes of, and nature of children with conduct problems; thereby educators and parents can be helped to bring them up in socially appropriate manner. In addition, it may also help in refining the attitudes of teachers, parents and others toward conduct disordered children. In this sense, this study is expected to offer an opportunity to improve the long-term quality of life of children and families affected by this problem.
Objectives

The main objectives of the present study are:

1. To understand the background characteristics of conduct disordered children.

2. To examine whether there are significant differences between the conduct disordered and the normal children in home environment, coping, personality, and adjustment.

3. To examine whether there are significant differences between the two groups of conduct disordered children, based on the type of disorder (childhood onset and adolescent onset) in home environment, coping, personality, and adjustment.

4. To examine whether there are significant differences between male and female conduct disordered children in home environment, coping, personality, and adjustment.

5. To examine whether there are significant differences between dropout and school going conduct disordered children in home environment, coping, personality, and adjustment.

6. To examine the nature and the magnitude of interrelationships among home environment, coping, personality, and adjustment of children.
Hypotheses

Pursuant to the above objectives, the following hypotheses were formulated for the study.

1. There will be significant differences between the conduct disordered and the normal children in home environment.
2. There will be significant differences between the conduct disordered and the normal children in their coping styles.
3. There will be significant differences between the conduct disordered and the normal children in personality.
4. There will be significant differences between the conduct disordered and the normal children in their level of adjustment.
5. There will be significant differences between the childhood onset and the adolescent onset type of conduct disordered children in home environment.
6. There will be significant differences between the childhood onset and the adolescent onset type of conduct disordered children in their coping styles.
7. There will be significant differences between the childhood onset and the adolescent onset type of conduct disordered children in personality.
8. There will be significant differences between the childhood onset type and the adolescent onset type of conduct disordered children in their level of adjustment.
9. There will be significant differences between the male and the female conduct disordered children in home environment, coping, personality, and adjustment.

10. There will be significant differences between the dropout and the school going conduct disordered children in home environment, coping, personality, and adjustment.

11. There will be significant relationship between home environment and the coping style of children.

12. There will be significant relationship between home environment and personality of children.

13. There will be significant relationship between home environment and adjustment of children.

14. There will be significant relationship between coping and personality of children.

15. There will be significant relationship between coping and adjustment of children.

16. There will be significant relationship between personality and adjustment of children.
**Definition of key terms**

**Conduct Disorder**

Conduct disorder is a “mental disorder of childhood and adolescence characterized by repetitive and persistent violations of the rights of others and of social norms and rules, including bullying, aggressive and threatening behavior towards people or animals, deliberate destruction of property, deceitfulness or theft, with the behavior causing significant impairment in social, academic, or occupational functioning” (Oxford Dictionary of Psychology, 2006). In this study, conduct disordered children comprised of inmates of juvenile justice homes, who were already diagnosed as conduct disordered children by qualified personnel using appropriate screening tools.

**Normal Children**

Even though the use of normal children against children having some disorders is not considered appropriate, in the present study the term is used to highlight the fact that they were not having any identified psychological problems including conduct disorder. The use of non-conduct disorder children may leave the question whether they have other problems than CD.

**Home environment**

Conditions, circumstances, etc., of the place one lives, especially with one’s family and which affect their life (Oxford Dictionary of Psychology, 2001).
In this study ‘Home Environment’ means the psychological climate and physical condition or circumstances of families, which is assessed using the ‘Home Environment Scale developed by Sarla Jawa (1997).

**Coping**

“Constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the recourses of the person” (Lazarus & Folkman, 1984).

In the present study, CSCY (Coping Scale for Children and Youth by Brodzinsky et al., 1992) was used to assess coping skills in children and adolescents, to identify strengths and weaknesses in the area of coping skills, or as an indicator of change in coping skills during or following an intervention. It measures both active and avoidant modes of coping.

**Personality**

Personality is the dynamic organization within the individual of those psychophysical systems that determine his unique adjustment to his environment (Allport, 1937).

In this study personality is considered as the combination of Inertia, Activation and Stability (IAS). The IAS rating scale (Mathew, 1995) developed on the basis of classical trait conceptions of Thamas, Rajas and Sathwa was used to measure
personlality. In this scale, thamas is the mode of inertia, rajas is the mode of activation and sattva, is the mode of stability.

**Adjustment**

According to Davidoff (1987), ‘Adjustment is a process of attempting to meet the demands of self and environment’.

In the present study, adjustment is measured by looking at the frequency of problems experienced by the children in five wide areas viz., health, social, school, self, and home. This was assessed using the tool developed by Rammers and Bauernfeind (1951).