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ANTISOCIAL BEHAVIOUR IN CHILDHOOD AND ADOLESCENCE

ESSAY

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INTRODUCTION

AND

AIM OF THE WORK

INTRODUCTION

One of the most common behavioural disorders of childhood and adolescence is the antisocial behaviour which is usually known as conduct disorders .

Behavioural disorders of children and adolescents should be studied seperately from those of adults. As childhood disorders differ from that of adults in being less stable and less well differentiated than adult disorders. Thus, it is useful to acquire specialized knowledge of the behaviour problems of children in order to treat them effectively. Also, to achieve a second goal, the prevention of adulthood disorders , it is essential that we gain an understanding of the conditions in childhood that persage or predispose an individual to further difficulties.

Disorders of conduct (antisociel behaviour) , of emotions and the special symptoms such as enuresis, soiling, sleeping and eating disorders are the commonest psychiatric disorders of childhood. Delinquency and antisocial behaviour began to be conceptualized as forms of emotional disorder and severe psychopathology . (Shafii and Shafii, 1982) .

Behaviourists suggest that aggression is a learned behaviour in response to frustration. No doubt , economic

dislocation, poverty, racial prejudism, movement from rural to urban ghettos, drug and alcohol abuse, child abuse and neglect, parental violence attribute to the increased incidence of destructive and antisocial behaviour in children and youth (Shafii and Shafii, 1982).

One of the frightening effects of watching violence on video is that of causing imitative behaviour. There is a clear association between the evil as seen in videos and read in books and subsequent actions of certain children as it lowers the resistance of some who under normal circumstances are able to contain their deep, violent feelings, they then live out what they have seen (Gray, 1987).

In recent years, there has been extensive debate concerning the effects of the portrayal of violence in the media, particularly on television and movies, on perpetuating violent and antisocial behaviour in children and youth. In many families, television has assumed the parental role of occupying children's time and keeping them quiet. Also, family violence is a major social problem, children who witness their father's assaultive behaviour toward their mother may be the unintentional victims of this violence. (Rosenbaum and O'Leary, 1981). The impact of family violence on children is suggested by many sources of clinical research, including intergenerational transmission of abuse and violence (Carlson, 1984).

Jaffe et al (1986) compared behaviour problems and social competence in 126 boys and girls (age 6-11) and did not have histories of psychiatric treatment or disorders, 58 children from violent families (36 boys and 22 girls) and 68 children from nonviolent families (33 boys and 35 girls), on the basis of maternal ratings. Children from violent families were current or recent (only for 6 weeks long) residents of transition homes for abused women, whereas mothers and children from nonviolent families had never sought refuge from a violent partner and reported no physical violence between adult partners since the child was 24 months old. Mothers from violent families were interviewed at the shelters and mothers from non-violent families were interviewed in the investigators' office. Girls from violent families were reported as showing more internalizing behaviour problems and a lower level of social competence than their nonviolent comparison group.

Boys from violent families were reported as demonestrating both internalizing and externalizing behaviour problems, in addition to having a lower level of social competence. For boys, the level of exposure to violence between parents was significantly associated with greater adjustment problems.

Children exhibiting conduct disorders typically report feeling unhappy or miserable, feedling unliked, and being treated less fairly than others, however, it is uncommon for them to indicate feelings of anxiety or fear. (Quay, 1979).

Conduct disorders is a complex clinical entity with respect to both symptoms and adult outcome. While some children with this diagnosis appear to be lacking overt anxiety, others express worries and exhibit borderline features or depressive symptoms (Meeks, 1980).

The adult outcome was also found to be heterogeneous, including sociopathy psychosis and neurosis.

The terms 'behavioural' and 'Conduct' disorders, are applied to children and youth, imply that these conducts and behaviours are more or less temporary, and sooner or later will diminish. The term 'personality' disorder refers , to maladaptive traits and enduring patterns that are more or less fixed. Conduct disorders in youth, if continued, will result in personality disorders in adulthood. However, there are some disorders of personality which do begin to manifest in childhood or adolescence (Shafii and Shafii, 1982).

Conduct disorder (antisocial behaviour) comprises an extremely heterogeneous group of behaviours,but it can be viewed as two dimensions: undersocialized and socialized. The undersocialized aggressive child is likely to be a boy with well-developed musculature who had experienced severe parental rejection often alternating with unrealistic over protection, unusual frustration and he has also escaped any consistent pattern of discipline. His general behaviour is unacceptable in almost any social setting. Persistant enuresis, even in advanced ages, is a common finding in this diagnostic group. In evaluation interviews, the undersocialized aggressive child is typically hostile, provocative, and uncooperative. He is so maladaptive in his responses that he is unable to disguise his pathology even temporarily. His hostility is not limited to adult authority figures but is expressed with equal venom toward his age-mates and younger children. Boasting and lying, with little interest in the response of the listenes, reveal his profoundly narcissitic orientation. Many undersocialized aggressive youngsters are only children who were unplanned and unwanted.

The undersocialized nonaggressive group contrasts with the aggressive group in that they respond to their

frustration and anger with devious techniques and flight, rather than direct aggression, they are less physically robust than the openly aggressive undersocialized, and they are significantly less likely to have siblings. The result of these characteristics is that the unaggressive undersocialized child is likely to feel weak, abandoned, mistreated , worthless, helpless, and hopeless. These youngsters may associate with delinquent gang, but they remain on the fringe of the group, because they lack the courage and loyality to gain genuine acceptance (Kaplan and Sadock, 1987).

The longitudinal history of the socialized group is a history of adaquate or excessive conformity that ended when the youngster became a member of the delinquent peer group, usually in preadolescence or early adolescence. There may have been evidence of other problems such as marginal or poor school performance, mild behavioural problems, and even neurotic symtpoms or shyness. The socialized delinquent is usually from a large family living under poor economic circumstances. The youngster himself is rarely guilty of criminal or antisocial acts alone. His misdeeds usually occur in the company of his peer group. The important constant in this diagnostic

category is the influence of the group on the youngster's behaviour,and his exterme dependency on maintaing membership in the gang. (Kaplan and Sadock, 1987).

Conduct disorder or antisocial behaviour is not early excessive noncompliance or the lack of social and work skills alone, but the combination of these factors that leads to long-term deviant outcomes. (Dishion et al, 1984).

Clearly, no other disorder of childhood and adolescence is so wide spread and disruptive of the lives of those who suffer it and of the lives of others. Thus it deserves continued investigations.

Aim of the work

This work has been conducted in a trial to:

1- To define the problem of antisocial behaviour (conduct disorder) in children and adolescents.

2- To detect or recognize the possible aetiology and factors behind the problem, classification, prognosis and the available lines of treatment.

3- To suggest recommendations in order to prevent or at least minimize its sequelae.

REVIEW OF LITERATURE

DEFINITION AND CLASSIFICATION

Conduct disorder is defined as a recurrent and persistent pattern of behaviour in which the rights of others and major social norms are repeatedly violated (Chamberlain and Steinhauer, 1983).

Patterns of behaviour labeled conduct disorders include verbally and physically aggressive behaviours and those that can be considered disturbing to others in the child's environment (Strauss and Lahey, 1984).

It is also defined by DSM III as follows: The essential feature of this group of disorder is repetitive and persistent patterns of antisocial behaviour that violates the rights of others, beyond the ordinary mischief and pranks of children and adolescents. The diagnosis is only given to individuals below the age of 18 years. (Kaplan and Sadock, 1987, Shafii and Shafii, 1982).

Classification of conduct disorder:

I- DSM III:

It is the most widely used classification system.

It provides :

Axis I: descriptions and diagnostic criteria for major disorders.

Axis II: descriptions and diagnostic criteria for minor disorders.

Axis III: concomitant physical disorders.

Axis IV: Associated stress

Axis V: Premorbid level of functioning

DSM III divides conduct disorder into 4 main groups defining each in tems of the common behaviour of its members along two major dimensions, aggression and level of social maturity:

1- Undersocialized or socialized groups depending on the ability to establish bonds of affection and feel empathy towards others.

2- Within the above two major groups, DSM III dividies the population further into aggressive and non-aggresive subgroups.

3- The final subcategory, atypical is essentially residential in nature.

Types of conduct disorders according to DSM III:

1- Conduct disorder, undersocialized aggressive:

a. A repetitive and persistent pattern of aggressive conduct manifested by either of the following:

- Physical violence against people or property e.g. vandalism ,rape, breaking and entering, firesetting,mugging, assault.

- Thefts outside the home involving confrontation with the victim e.g. armed robbery.

b. Failure to establish normal affective bonds as evidenced by no more than one of the following forms of social attachment:

- Has peer-group friendships that have lasted over 6 months.

- Extends himself or herself for others even when no immediate advantage is likely.

- Apparently feels guilt when such a reaction is appropriate not just when caught or in difficulty.

- Avoids blaming or informing on companions.
- Shares concern for the welfare of companions.

c. Duration of pattern of aggressive conduct of at least 6 months.

d. If 18 or older, does not meet the criteria for antisocial personality disorder.

2- Conduct disorder, Undersocialized, non aggressive :

a. A repetitive and persistent pattern of non-aggressive conduct manifested by either of the following:
   - Chronic violations of rules at home or at school.
   - repeated running away from home at night.
   - persistent serious lying in and out of the home.
   - stealing not involving confrontation with a victim.

b. Failure to establish normal affective bonds.

c. Duration of non-aggressive conduct of at least 6 months.

d. If 18 or older, does not meet the criteria for antisocial personality disorder.

3- Conduct disorder, socialized, aggressive:

a. A repetitive and persistent pattern of aggressive coudct manifested by either of the following:

- Physical violence against persons or property.
- Thefts outside the home involving confrontation with a victim.

b. Evidence of social attachment to others as indicated by at least two of the following:

- Has peer - group friendship that have lasted over 6 months.
- Extends himself for others
- Feels guilt when such a reaction is appropriate.
- Avoids blaming or informing on friends.
- Shares concern for the welfare of companions.

c. Duration of pattern of aggressive conduct at least 6 months.

d. If 18 or older, does not meet the criteria for antisocial personality.

4- Conduct disorder, Socialized, non-aggressive:

a. A repetitive and persistent pattern of non-aggressive conduct e.g. chronic violation of rules, running away from home, lying, stealing.

b. Evidence of social attachment

c. duration of at least 6 months

d. If 18 or more, does not meet the criteria for antisocial personality disorder.

5- Atypical conduct disorders:

The disturbance involves a conduct pattern violating either the rights of others or societal rules or normas and cannot be classified as one of the above conduct disorders. (American Psychiatric Association, 1980,Lewis et al, 1984).

As mentioned above, poor interpersonal relations are one of the principle characteristics of the under-socialized pattern. In contrast, strong peer loyalities are part and parcel of the socialized pattern.

Panella and Henggeler (1986) studied the social interaction patterns of black male adolescents classified as conduct disordered (undersocialized), anxious- with

drawn, and well-adjusted controls, the undersocialized group was less socially appropriate and showed a lower degree of positive affect and social competence when interacting with both strangers and friends of their own group.These researchers concluded that under socialized adolescents have difficulty exhanging the sensetive, responsive, and positive behaviours that are characteristic of friendship relations.

Knostantareas and Homatidis (1985) found that conduct - disordered children established dominance hirarchies among themselves, but that, compared to normal children, their hierarchies were less stable and their social relationships were unpredictable and poorly ordered.

These studies suggest that it is a lack of interpersonal sensetivity, responsiveness, competence and order that, when coupled with aggression, make the undersocialized individual aversive to other people, peers and adults.

The undersocialized aggressive pattern of conduct disorder is ubiquitous and well defined emperically.

The socialized syndrome, while less common and occuring much more often in later childhood and adolescence, is also firmly established as a major dimension of disorder.

Much of the research on conduct disorder has failed to consider the differences between the two disorders even though there is now considerable evidence for basic differences in their causes, correlates and cosequences.

II- Ninth edition of the International Classification of Diseases (ICD-9):

ICD-9 is the principle competitor of DSM III as a clinically derived toxonomy. It is used everywhere except North America and coexisting with DSM III in Canada (Stein and O'Donnell, 1985)

ICD-9 Classifies conduct disorder into:

1- Unsocialized disturbance of conduct:

Defiance, disobedience, quarrelsomeness, aggression, destructive behaviour, tantrums, solitary stealing, lying, teasing sibling.

2- Socialized disturbance of conduct:

Holds values of delinquent peers to whom they are loyal, stealing, truancy, staying out late at night.

3- Compulsive conduct disorder:

Disorders specifically compulsive in nature, Kleptomania.

4- Mixed disturbance of conduct and emotions:

Behaviours of either undersocialized or socialized conduct disorders but with considerable emotional disturbance, anxiety, misery,or obsessive neurotic delinquent. (Gould et al, 1984 Quoted from Quay,1986, Werry, 1985).

III- WHO multiaxial classification:

This system looks upon the process of diagnosis involving not only classification with regard to the nature of the disorder itself but with regard to the associated intellectual level, biological factors, and associated or etiological psychological influence.

According to WHO classification, conduct disorders includes some types of legally disturbed delinquency and

non-delinquent disorders e.g. fighting, bullying, destructive behaviour, cruelty to animals. The behaviour must be abnormal in its sociocultural context (Blashifield, 1984).

It is interesting to note that this system recognizes that legally delinquent behaviour may arise "naturally" out of a cultural milieu and thus may not necessarily be abnormal, in fact, there is no equivalent category to the two socialized conduct disorder of DSM III.

EPIDEMIOLOGY

As with any phenomenon whose definition is fuzzy and shades gradually into normal behaviour, reports of prevalence and natural history must be evaluated carefully for error and invalid comparison.

So, establishing the prevalence of conduct disorders presents a number of methodological problems.

Much confusion has resulted from the failure to take into account the fact that there are two seperate literatures dealing with conduct disorders, each surveying a rather different population.

The self-report literature suggests a high incidence of antisocial behaviour, most of it of mild or occasional nature. This literature contrasts markedly with studies of adjudicated delinquents, whose histories feature more serious antisoical behaviour repeated more frequently and over a long period of time.

Another important difficulty is that no study to date has obtained seperate prevalence estimates for undersocialized and socialized conduct disorders.

If only urban adolescents are studied and conduct disorder is defined so as to include the characteristics

of the socialized pattern, then the obtained prevalence estimate for " conduct disorder" no doubt includes both groups.

In 10 and 11 - year olds in Britain, population prevalence rates for conduct disorder for both sexes have been reported to be 4 percent in a rural area (Rutter et al., 1975) and 8 percent in an urban area (Graham 1979). In a stratified random sample, the difference in aggression between urban and rural children was studied by El Fangarry (1987). The sample was 440 child of both sexes and the number of boys was equal to that of girls. The children were 6 - 12 years old, mentally retarded and subnormals were discarded. The sample was presentative for all social classes. The investigator divided the sample into 2 groups. The first group consisted of 72 child (6 - 12 years) and half of them live in urban area and the other half in rural area. The second group was chosen to represent the late childhood period (10 - 12 years) as children during this period of development are exposed more to friction with others and so the behavioural characteristics of the child become more distinguishable. The investigator used this group as a control group. By observation and case study techniques, the investigator found that the rural child was more aggressive than the urban child although methods of expression of aggression was the same in both areas. Also, urban children were more physically and verbally aggressive and they showed their aggression in a more positive manner (they were more independent). The males were found to be more aggressive than females

and both sexes in urban areas were more aggressive than in rural areas.

In the study carried out by Rutter et al. (1975), the rate for all disorders was 6.8 percent, so it can be seen that conduct disorder was by the far the most prevalent.

Conduct disorder is the most prevalent form of specific childhood disorder, accounting for one third to one half or more of all cases. (Quay, 1986).

When hospital admission and clinic attenders have been studied, conduct disorder is also the most prevalent form of specific disorder (Stewart et al., 1981).

5 - 15 percent of all children show conduct problems serious enough to alarm some adults. Although not all these youngsters fit the diagnostic criteria of DSM III.

In America, the prevalence of antisocial behaviour seems to have important socio-economic linkage (Kaplan and Sadock, 1987).

In the Child Psychiatric Services, University of Louisville School of Medicine , out of 994 cases of children and adolescents, between the ages of 1 and 18 years, approximately 31 percent exhibited harmful or destructive behaviour toward others i.e. violent destructive behaviour fire setting, being

beyond the control of parents or other authority figures and serious antisocial behaviour including sexual assault on others (Shafii et al, 1979).

In all the above studies, it was found that conduct disorders were extremely common especially in boys with the rate for boys about twice that for girls.

Contradictory to the above conclusion, recent reports suggest an increase in female delinquency along with a shift in the nature of the offences comitted with more girls being convicted of violent offenses and more boys being considered in need of protection by courts. (Chamberlin and Steinhauer, 1983).

There have been a number of inquiries into the prevalence of specific characteristics of both undersocialized and socialized conduct disorder. Among three- year olds in a suburb of London •Richman et al, (1982) found that 12.4 % of boys were considered by their parents to have problems with siblings and 16.9 % to be overactive. However, lower frequencies were reported for rural three- years - olds in United States by Earls (1980) who found rates for boys of 3.7 % for overactivity, 7.5 % for problems with siblings or peers, and 7.5 % for difficultiness to manage.

These studies as well as others (Links, 1983) demonstrate that many of the specific behaviours related to the

undersocialized pattern are relatively common especially in boys. Thus the use of any single symptom to infer the presence of a disorder is unjustified.

Prepubertal children are most likely to exhibit aggressive behaviour, disobedience in the classroom and theft at home. On the other hand, adolescents with conduct problems are more inclined to be truant from school and to damage public property. Still other behaviours, such as criminal acts, are more likely to be engaged in late adoleseence (Strauss and Lahey, 1984).

Approximately 20% of all boys between the age of 10 and 17 years appear in juvenile courts, and 2 % of all children and adolescents are ruled legally delinquent. (Chamberlin and Steinhauer, 1983).

Characteristics of 100 visits by adolescents (Less than 18 years old) to a psychiatric emergency service were examined and compared with those of 100 visits by adults. Adolescents were less likely than adults to recieve diagnosis of psychoses and personality disorder but more likely to receive diagnoses of adjustment and conduct disorders (Hillard et al, 1987).

In spite of some contradictory findings and methodological difficulties, it is fair to conclude that persistent

and serious social misbehaviour is a phenomenon with a high prevalence rate and early onset, is highly associated with maleness and serious school difficulty, and persists into adulthoold.

AETIOLOGY

Conduct disorder is not simply the product of one cause. But it is a multifactorial disorder. The following factors may share in the production of the antisocial behaviour.

1- Biological aspects: (Genetic aspects)

All aspects of humen functioning are found to have, at least potentionally, biological determinants. (Stratton, 1983).

Until recently , researchers in this clinical field have simply classified objects as having a trait or not, an approach which has worked well but has definite limits.

Data on twins and adoptees will help to define the relative influence of environment and genes in forming the traits. There have been a number of studies involving parents and off spring but they are not yet conclusive especially with regard of the mechanisms involved.

Temperament:

Childhood temperament particularly the "difficult" may predict behavioural outcomes at statistically significant level. Since the majority of studies on infant

and early childhood temperament have isolated a pattern of behaviour often labeled 'fussy-difficult'(Rutter, 1982), it is tempting to think of this temperament variable as a precursor to childhood psychopathology, especially conduct disorder.

If this'difficultness' has a significant hereditary component, which most believe it does , then it could provide one source of a genetic contribution to conduct disorder (antisocial behaviour).

Constitutional-temperamental factors may make it more likely that a child will be difficult and thereby less likely to be socially rewarding to the parent and less able to amiably tolerate or respond to less-than perfect parenting skills (Thomas and Chees, 1984).

But there is still a doubt whether the association will be strong enough to be useful clinically.

Behaviour problems:

Whether genes actually have specific roles in the origin of children's behaviour problems is a moot question. If specific behaviour problems or clusters of be-

haviour problems related to conduct disorder can be shown to be genetically influenced then one might generalize these findings to carefully selected children manifesting high level of conduct-disordered behaviour.

Aggressiveness is known to be usually stable from early childhood into adult life, a fact which might imply genetic determinants but could equally results from a persistently poor environment. Antisocial tendencies are also stable, at least after the age of ten (Gersten et al, 1976). However, investigators who have looked for direct evidence of genetic influence on these traits in children have reported contradictory results.

Cadoret et al (1975) and Cadoret and Gath (1980) concluded that hyperactivity broadly defined, in adopted children was associated with antisocial behaviour and alcoholism in their biological parents.

Also, O'Connor et al (1980) compared parent ratings of problem behaviour on normal identical versus same sex fraternal twins who avaraged eight years of age (n = 216). On eight factor analytically derived scales, the intraclass correlations for the identical were higher. Even given a possible predilection of the parents of identicals

to view their children as more similar and the possibility that parents create a more homogeneous environment for identicals, the possibility of a genetic component in the conduct disorder type behaviour must be taken seriously.

More researches are needed to evaluate the relation between conduct disorder and genetics.

2- Biochemical factors

Rogeness et al (1982) have contrasted socialized (n=9), undersocialized (n=16) and normal control children (n = 20) on four biochemical factors measured in blood plasma:

Dopamine-beta-hydroxylase (DBH) which converts dopamine(DA) nor adrenaline (NA).

Monoamine oxidase (MAO) which inactivates DA and NA.

Catechol O-methyl transferase (COMT) which inactivates DA and NA.

Serotorin (5HT).

Results indicated that:

* Undersocialized group had significantly lower DBH activity, socialized group significantly higher activity than controls.

* COMT activity was higher in socialized compared with both undersocialized and control groups, the latter two did not differ.

* No difference in MAO or 5HT.

The relationship between plasma DBH activity and undersocialized conduct disorder is confirmed with larger sample sizes. One can also infer possible neurochemical involvement in severe conduct disorder from studies of highly selected groups and by determination of three metabolites 5-hydroxyindoleactic acid (5HIAA), 3-methoxy-4 hydroxyphenyl glycol (MHPG), and homovallinic acid (HVA). These metabolites were measured in the cerebrospinal fluid, unlike blood and urine studies, they were brain drived. The result showed that aggressive scores were significantly negatively correlated with 5-HIAA (principle metabolite of 5HT), significantly postively related with MHPG (the principle metabolite of NA), and uncorrelated with HVA (metabolite of DA) i.e. aggression is a function of serotonergic - catecholaminergic balance (Brown et al, 1982). But we must notice that there is multiple sources of any neurotransmitter and its metabolites.

Quay (1985) proposed that undersocialized conduct disorder reflects an overactive reward system and an under-functioning behavioural inhibition system resulting in impulsive, disinhibited and reward seeking behaviour.

According to Gray(1982), the principle neurotransmitter of the behevioural inhibition system is NA, while DA is apparently the principle transmitter for reward pathway. Thus, if very low levels of DBH can be interpreted to mean the availability of an excess of DA but a diminished amount of NA (due to lack of conversion of the former to the latter) then the reward system might be overenergized while the inhibition system is transmitter-deficient.

3- Faulty parental attitudes and child-rearing practices:

Are a major contributing element to the development of conduct disturbances. Behavioural deviations are responses to poor fit between a child's temperament and parental attitudes and practices (Kaplan and Sadock,1987).

In a similar way, there are many medical, psychological and environmental factors that can affect a parent's ability to tolerate frustration,, control irritability, and be energetic and resourceful enough to nurture and teach a child.

Parental psychopathology has been shown to strongly influence parent's perceptors of the child, interactions, and ability to make adaquate progress in therapy (O'Donnell, 1985).

4- Influence of the school: (for example rate of turn over among teachers).

Schools have a powerful social-learning impact on a child's behaviour. By providing contact with antisocial peer models, as well as inadequate and inconsistent forms of discipline, schools can have much the same influence that families can have (Rutter, 1985).

5- Conduct disorders are common and distressing complication of mental retardation.

As behavioural problems are much common in children who are unable to learn appropriate behaviour, they are less adapt at avoiding being caught, less well defended and because of urecognized social and legal discrimination . So the severity of intellectual handicap is an important factor in the development of the disorder.

Gath and Gumley (1986) carried out an experiment to detect the behavioural problems in retarded children. Data were collected, using interviews with parents and teachers

and rating scales, concerning the behaviour of two groups of mentally retarded children = 193 children with Down's Syndrome (DS) and 154 children with similar degree of verbal and motor handicap were identified in the same schools. 76 boys and 78 girls, 87 % of the children with DS and 89% of the controls lived at home with at least one parent while 7 children with DS and four controls were in long-stay hospitals. The proportions of children who had high scores on the Rutter or an additional behaviour checklist , were similar in the two groups. Deviant behaviour was markedly more common in both sets of retarded children than in their siblings next in age, 31% of the children with DS and 29% of controls were judged to be well adjusted, while 38% of the DS children and 49% of the controls had significant behaviour disorder. Conduct disorders were most common in the children with Down's Syndrome.

6- Peer rejection:

Aggressive behaviour is the most common problem associated with peer rejection, and childhood aggression is the strongest behavioural indicator of antisocial behaviour and delinquency (Roff and Wirt, 1985).

7- Family influence:

Conduct disorder is common in children in the same family as they share the most important environmental influence (Rowe and Plomin, 1981).

It was noticed that when the biological background is seriously deviant, children who are adopted have a better outcome (Rutter and Giller, 1983).

Also, it was found that in case of divorce, disorders in children depend on whether divorce improved or not the family relationship (Hetherington et al, 1982).

Jouriles et al (1987) noticed that children from violent families are more likely to suffer from conduct problems than children from non-violent marriages and thus confirming the family influence on the child's behaviour.

Emotionally discordant patterns of social interaction, weak family relationships, and inefficient supervision and discipline can also cause the deviant behaviour (Rutter, 1983b).

8- Recent undesirable life events:

A number of studies have examined the effects of stressors (e.g. parent divorce,birth of sibling, and hospitalization of the child) and have shown to be significantly

associated with conduct disorder (Dunn et al, 1981, Dunn and Kendrick, 1981).

However, a sample of children and adolescents (n= 157) attending a child psychiatry outpatient clinic with conduct or emotional disturbance were compared with community controls (n= 76) for the number and type of recent life events. A Life- Events Schedule for children and adolescents was developed and used as a semi-structured interview.

Four clinical groups were identifed according to their predominant presenting symptoms (conduct, mild mood, severe mood or somatic). An excess of events carrying a severe degree of negative impact was found for all four groups, compared with matched controls. Eleven classes of events were examined, there is a suggestion that two classes (marital/family, accident/illness) may be more important for conduct and mild mood disorders, and that a further class (permenant seperation)may be more important for somatic and severe mood disorders.

A firm statement on causality is not possible because the investigators could not be sure that all events antedate all symptoms, a prospective community-based study, concluded longitudinal, is required to examine the effects

of events on children who are initially free of psychiatric disorder and other factors not examined in this study may influence the findings (Goodyer et al, 1985).

The excess of mild events in conduct disorders suggests that the mechanisms by which recent stress affects these children may be different as these children have a lower threshold of response to external stressors (Goodyer et al. 1985).

This individual differences in response to adversity can be summerized as follows:

a. Age: as it indicates the child's social, emotional and intellectual maturity (Rutter, 1981b) e.g. hospital admission is likely to exert the greatest risk for behaviour symptoms between the ages of six moths-4 years.

b. Sex: boys are more vulnerable than girls to the extent that some authors refer to females as'the buffered sex! But Goodyer et al (1986) in his study on a sample of school-aged children attending a routine child psychiatry clinic, four clinical groups were classified based on presenting signs and symptoms, conduct (n=44), mild emotional (n= 55), severe emotional (n=32) and

somatic (n= 26). The groups were divided by age and sex and comparisons made between the groups and community subjects (n= 76) for the number of children experiencing one or more recent stressful life events. The results indicated that both sex and age exert no influence on the association between recent stressful life events and psychiatric disorder of school-aged children and adolescents.

Further studies are needed to confirm this finding.

c. Temperamental styles: are ossociated with differences in children's response to stress and genetic factors also may increase the vulnerability of the child to stress (Cloninger et al, 1981).

d. Coping processes: Could increase the risk of maladaptation or disorder while others could improve adaptation (Rutter, 1981b).

e. Pattering and multiplicity of stressors: the presence of chornic psychosocial adversity is worse in effect than acute stressors. Also, there are interactive effects between psychosocial adversities i.e. the presence of one potentiates the effect of a second or third (Rutter, 1983a).

f. Compensatory good experience: happy experience can buffer the impact of unhappy ones for example success in school perhaps componsates difficulties at home (Lazarus et al, 1980).

g. Catalytic factors: when combined with environmental stresses or hazards, either increase their effects or decrease their impact (Henderson, 1981).

9- Other contributing factors:

That could seriously affect a child's ability to acquire adequate prosocial behaviour or maintain sufficient self-control. They include depression, neurological impairment and psychomotor epilepsy (Lewis et al, 1982).

Social development in early childhood is important in determining the social behaviour of the individual later on. Personality theorists have stressed the importance of social development during childhood for later adjustment. Emperical studies have provided support for this theoritical position by demonestrating the long term consequences in terms of maladjustment of poor childhood social adjustment.

THE RELATION OF FAMILY INTERACTION AND ANTISOCIAL BEHAVIOUR

Fractures in the human bond, disorganization in the family, poor parenting, and disorders in mothering interfer with the development of caring attitudes and respect for other human-beings and societal rules. This lack of care and respect may manifest itself in the form of delinquent and antisocial behaviour. So home environment and family relationships are the most important factors in the percipitation of conduct disorders.

Some of these factors can be summerized as follows:

Parental characteristics and antisocial behaviour:

A survey of the research literature suggest that deviant parents have deviant children i.e. aggressive and antisocial boys tend to have fathers with same traits (Stewart et al 1980).

At a child psychiatric clinic 122 boys were scored on scales of aggressiveness, non compliance and antisocial behaviour. They all met the following criteria: one or other of their natural parents, or an immediate relative, was available for interview, they are between 5-14 years old, their I.Qs. were greater than 55 and they were free

of definite brain damage or dysfunction and free of psychosis. The data were collected from either the natural father or mother through a structured interview which included questions on 70 common emotional and behavioural symptons of childhood. Their biological fathers were scored on aggressiveness and antisocial behaviour. The fathers' scores were modestly but significantly correlated with those of their sons.

The correlations were also computed seperatly for the 64 boys whose biological fathers were no longer in the home and for the 58 whose father had stayed. Father-Son resemblances for the latter group were considerably higher than those observed in the whole sample, and for the father-absent group were insignificant. Thus, the father-son resemblances in aggressive and antisocial behaviour is higher in children stayed with their aggressive fathers. (Stewart and De Blois, 1983).

Parents of children with conduct disorders have been found to be maladjusted, inconsistent, arbitary and with explosive expressions of anger (Patterson, 1982). They are also inadequate and emotionally distant (Johson and Lobitz, 1974).

Social learning theorists have emphasized imitation of an antisocial model as one of the important factors in the development of antisocial behaviour in children. Parent's aggressiveness, parental alcoholism and criminality are associated with serious crimes comitted by their adult sons as their behaviour constitutes something to be identified with by their children (Offord, 1982).

It is suggested that there may be an interaction between genetic susceptibility and biological factors and adverse family factors in precipitating antisocial behaviour in children (Hutchings and Mednick, 1974).

Irritability in fathers seems to be less important than in mothers because fathers in these families often participate minimally in child rearing. (Patterson, 1982). Maternal irritability and depression have been found to play an important roles in the development of aggressive behaviour in children (Hetherington et al, 1982).

As depressed, irritable, negativistic, socially isolated mothers are not more likely to perceive their children's behaviour more negatively (Olweus, 1980) but also may respond more aversively to their behaviour.

Also, it has been suggested that the depression, low self-esteem and irritability of mothers of children with conduct disorders may be a secondry reaction to their failure in parental control and to the chronic high level of coercive behaviours they experience from their children. This was proved by decreased maternal depression and increased feelings of self-esteem and efficiency after successful treatment or reduction of antisocial behaviour in children. (Forehand et al, 1980).

Parent-child interaction and antisocial behaviour:

Studies using interviews and questionnaires have documented certain patterns of family relations in families having an antisocial or delinquent child.

In families of children who have undersocialized conduct disorder:

- Parents have been found to be rejecting, to use harsh, power-assertive punishment, to model aggressive or criminal behaviour and to be erratically permissive and inconsistent in enforcing rules (Parke and Slaby, 1983, Maccoby and Martin, 1983).
- They are responding to their children behaviour in a noncontingent manner. Perhaps it is because of a history

of these inappropriate reinforcement contingencies that aggressive children are less resposive to rewards and punishments, that are dispended by adults and parents, particularly by mothers (Patterson, 1982). It is not just whether parents are permissive or restricting in attempting to control their child but the type of reinforcements and punishments they use and the manner in which they are administered as well as the children's behaviour targeted by parents for their control attempts e.g. some parents may tolerate aggression but respond aversively to lying or theft, others may ignore stealing but suppress disobedience. (Patterson, 1982).

- They issue more commands (Terdal et al, 1976) and punish deviant behaviour more frequently. Punishment has an opposite effect with antisocial children of increasing the behaviour and accelerates coercive behaviour in aggressive children. This is because parents, especially mothers, of these children do not enforce their threats with firm, consistent consequences. Mothers in these families are especially vulnerable to falling into the "reinforcement trap" that is to say yielding to and thus reinforcing their children's coercive behaviour in order to gain immediate relief at the expense of even more

coercive behaviour in the future (coercive cycle) (Patterson, 1982). Several studies have showed that bosy are more likely to get involved in coercive cycles and are less likely to comply to parental commands. (Lytton and Zwirner, 1975).

In families of children who have socialized conduct disorders:

- Parents are focused on gratification of their own needs and are more distant and unfreindly although less coercive than parents of undersocialized aggressive children (Patterson, 1982). We might call the parents of such children parent - centered rather than child-centered. Their disengagement extends to a lack of monitoring of their children's activities outside the home.

- These parents show lack of concern with property violations and interpret such acts by their children so as to make them seem accepted and hence such behaviour goes unpunished when their children steal, these parents do not recognize that a serious problem exists. This may in part be because these parents view themselves as being rebellious and nonconforming and probably also mislabel their own antisocial behaviour (Pulkkinen, 1982). This

combination of an antisocial model and systematic mis classification of crimes against property may be related to the finding that many delinquents believe that their antisocial behaviour or acts are justifiable (Quay, 1986).

So it is not surprising to find that parent-centered families are more likely to produce conduct disordered children and delinquent adolescents with social and cognitive incompetencies.

Family conflict and the development of conduct disorders:

Block et al (1981) found that family conflict has been associated with conduct disorders. This relationship is found more in boys than girls (Whitehead, 1979). Boys are more vulnerable as they resond to marital conflict with antisocial behaviour which is easily observed and is noxious to other people, whereas girls react in a more internalizing way with anxiety and withdrawal and are less likely to be referred to clinicians (Block et al, 1981).

Another explanation is that parents are more likely to expose their sons than their daughters to conflict and to other stressors and that boys recieve less support and protection during stressful life events than girls , (Hetherington et al, 1982).

Boys may be relatively more vulnerable to problems of aggression in the first decade of life, whereas girls may develop personality problems in response to the sexual expectations and social pressures of adolescence. Finally, it has been suggested that males may be biologically predisposed to experience stresses. Recent evidence suggests that there is difference in response of the autonomic nervous system of males and females. (Quay 1986).

Rutter (1971), for example, studied a sample of London families in which one or both parents had been under psychiatric care. When marriages were rated as 'good', and there was little marital conflict, none of the boys showed antisocial behvaiour compared with 22 % when the marriages was 'fair' , and 39 % when the marriage was 'very poor'. He also found that the association between marital conflict and the son's antisocial behaviour was strongly affected by whether or not the son had a good relationship with one or both parents. As the good relationship with one parent has an ameliorating effect even in the presence of family discord (Rutter et al, 1983 a).

Quinton and Rutter (1984) have reported that conduct disorders are increased in frequency among children reared from infancy in institutions and this high frequency is found to be due to weak family relations.

The relationship between marital conflict and conduct disorders is stronger when the conflict is overt and the marriage is characterized by apathy. (Porter and O'Leary, 1980). This may be due to that:

- Parents who engage in overt conflict with each other usually exert more harsh and punitive disciplinary practices with their children as well established correlate of antisocial behaviour.

- An aggressive acting-out child produces tensions between parents, but one bit of data doesnot support this interpretation of cause and effect. It was found that marital satisfaction did not increase after problem behaviour in children had been successfully decreased by a therapeutic intervention (Quay, 1986).

- Another possibility , suggested by family therapists, is that children may develop behaviour problems to draw attention to themselves and distract the parents from their conflict. (Minuchin and Fishman 1981).

Emery, Weintraub, and Neale (1982) examined the relationship between marital conflict and problem behaviours at school for children who had a parent diagnosed as schizophrenic, unipolar depression, bipolar depression or with both parents normal. Children with a schizophrenic or affectively

disordered parent were rated by both teachers and peers as more aggressive and so more withdrawn than children of normal parents.

They found significant correlations between marital dissatisfaction and teacher ratings of disruptiveness and inattention and peer ratings of aggression only for the children of a unipolar or a bipolar depressed parent but not for children of a schizophrenic or normal parent.

The authors suggest that the effect of an affectively disturbed parent is largerly transmitted environmentally via a disturbed marriage, whereas the effect of schizophrenic parent may occur primarily through genetic transmission.

It is unfortunate that the authors did not analyze their data by sex or at least report the sex composition of the sample.

The sibling system and the development of antisocial behaviour:

Children with early histories of violence or coercive behaviour toward their siblings are more violent to people outside the family (Dengerink and Covery, 1981).

Comparative studies of children who are identified as being either social aggressors or delinquents involved in crimes against property find that their siblings will be labeled in the same way (Patterson, 1984).

Loeber et al (1983) found that 64 percent of mothers whose sons later become assaultive reported sibling fighting as a problem, whereas this was a problem in only 2 percent of sons who later became thieves.

Although physical aggression among siblings decreases with age but it remains a common way of resolving conflict, particularly for boys, throughout adolescence, (Straus et al, 1980).

The rate of physical aggression among siblings is much higher than the rate of husband-wife violence or aggression directed toward children by parents (Straus et al, 1980). Moreover, siblings are more likely than parents to respond positivelly to socially aggressive behaviour (Patterson, 1982).

Siblings of aggressive children are more likely to initiate aggressive encounters and to sustain and escalate aggressive interchanges and progression from high rates of noncompliance to high rates of nonphysical coercive behaviours such as teasing and finally to physical aggression. (Patterson, 1984).

Highly aggressive children tend to be found in middle positions than only or youngest child positions. Interactions among sibling of families with a child who has a conduct

disorder are more coercive than those in families with a nondeviant child.

Of considerable interest is the finding that intervention programmes that have been orinted toward improving parenting practices or training families of delinquents or acting-out children in effective problem solving and coping techniques decrease antisocial behaviour and recidivism rates not only in the target child but also in his untreated siblings(Quay, 1986).

This lends some credence to the notion that children with conduct disorders are part of a larger dysfunctional family system.

Antisocial behaviour in children following divorce:

Many of the early studies have been criticized for methodological short-comings, particularly lack of control for sociseconomic status, age of the child at the time of seperation, the reason for seperation of the parents, and time since sepration and divorce.

In addition, characteristics of the child such as sex, age at testing, race, and birth order were seldom considered in early studies.

However, studies using more rigorous methodology and large scale surveys have confirmed the early studies' findings. These findings are:

- Boys in mother - headed divorced families in comparison to those in non-divorced families are more frequently delinquent, aggressive, antisocial, impulsive, non-compliant and rebellious against adult authority figures.

- They have less well internalized standards of moral judgement , are less controlled and less able to delay immediate gratification and are less able to deal flexibly with stressful problems (Zill, 1984).

Family interaction and divorce:

After divorce, custodial mothers, because of their additional stresses and responsibilities, may also become less psychologically and physically available to their children.

In addition, custodial mothers, particularly mothers of sons, frequently find themselves involved in coercive cycles with their sons. They usually suffer from low selfesteem, anxiety, depression and they usually find themselves in coercive cycles with their sons which inturn increase the feelings of helplessness and low selfesteem in mothers and further diminish their effectiveness in parenting (Hetherington et al, 1982).

Usually divorce is associated with extereme forms of antisocial behaviour in boys (Patterson, 1982) as it

represents an acute and severe type of stress. Patterson (1982) found in a sample of out-of-control families, those with absent fathers had observed rates of coercive behaviours twice as high as in two-parent households, more over, these families were more difficult, to treat than were intact families. Patterson attributes this to the mutual support and buffering provided by two parents.

In addition, mothers in one parent households are less likely to identify stealing in their young sons than are parents in two-parents families. (Loeber et al, 1981 Quoted from Quay, 1986).

The increased incidence of conduct disorders and delinquency in mother-headed households is not primarily to father's absence but also to stress and conflict within the home, inability of the mother to exercise adequate supervision, depressed income and living conditions, the mother's psychology and behavioural reaction to seperation as well as to the social and economic difficulties of her situation as a sole parent and the community attitudes towards the family and the child (Herzog and Sudia, 1973).

We must notice that it is not a simple matter of father availability and amount of contact, but that the quality of the contact and the presence of supporative figures.

The effect of sex of the child and cause of parental loss on adjustment of the child:

Self-control and acting-out behaviour in single-parent families are less marked for girls in comparison to boys (Wallerstein and Kelly, 1980).

Studies of both clinic and nonclinic samples have shown that conduct disorders are most likely to be found in children whose parents have been divorced than those in which the father has died. Children whose fathers have died are more likely to show depression, anxiety, or habit disturbance (Felner et al, 1980).

As an explanation for that, it has been suggested that:

- Children adopt the predominant behaviour exhibited by their parents during a crisis and that this becomes a guiding frame work for later behaviour and coping. So in case of divorce anger, depression, and hostility

are the displayed behaviours by the parents and adopted by the child. In the case of death, it is the parent's mourning,depression and withdrawal that is exhibited to the child (Quay, 1986).

- Divorcess are usually younger than widoms and have younger children. Younger children have been shown to create more stress in mothers than do older children also they experience greater economic stress and family problems as well as greater parental rejection (Felner et al, 1980).

- Widoms seem to have more extensive support systems, particularly from the spouse's family than are available to divorcees.

- Although boys are more severely affected by divorce, children in the custody of the same sex parent show fewer behaviour problems following divorce than do those with opposite-sex custodial parents (Warshak and Santrock, 1983).

Moreover, remarriage of a divorced mother is associated with increased levels of behaviour problems in girls but a decreased level of antisocial behaviour in boys (Santrock et al, 1982).

Children are less compliant to mothers than fathers, and as have been seen children are notably less compliant to divorced than nondivorced mothers. It is more essential for boys to have a male model whom they could imitate and who exhibits self-controlled, ethical behaviour. The image of greater power and authority vested in the father is more critical in controlling boys, who are culturally predisposed to be more aggressive (Hetherington et al., 1982).

It may be that the effects of being raised in a mother- headed, single-parent home do not appear in girls until adolescence, and then, rather than being manifested in aggressive acting-out behaviour, it is found in disruptions in heterosexual relationships.
Early interactions of daughters with a loving, attentive father may be an effective and nonstressful way of acquiring the attitudes, skills, and confidence that facilitate successful heterosexual behaviour relations. (Biller, 1976).

One study (Hetherington, 1972) has examined in detail some of the differences in heterosexual behaviour among adolescent, white, lower- and lower- middle- class girls from divorced, widowed or nuclear families. It was found that girls from the three types of families exhibited very

different patterns of behaviour in relating to male peers or adults. Many of the differences in the girls' responses to men were found to be attributable to the attitudes toward the father conveyed by the mother.

In girls from mother-headed homes, a disrutpion in relationships with males appeared either as excessive sexual anxity, shyness, and discomfort around males or as sexually precocious and inappropriately assertive behaviour with male peers and adults.
The former syndrome was more common when speration had occured because of father's death, the latter occured when seperation was a result of divorce. These behaviours did not occur in interacting with females.

These findings were supported by the longitudinal follow-up of the Wallerestein and Kelly (1980) study. They also report high rates of depression in adolescent girls from divorced families, however, since they have no nondivorced comparison group and since depression increases in adolescent girls, it is difficult to interpret this finding.

In summary, in considering the effects upon children of a marital disruption or of being raised in a single-parent home, the complex network of stresses and support systems

that accrue to these experiences must be considered. In mother-headed, single- parent families, the support systems available to the mother and the responses of the mother in coping with the demands of her situation may play a particularly critical role in the development of social and intellectual competence or of psychopathology in children.

ANTISOCIAL BEHAVIOUR AND FIRESETTERS

Fire setting is a dramatic and dangerous symptom, which in children caused at least 8 % of all recorded fires , over 4 % of fire causalities and deaths. (Fire statistics U.K. 1980).

In a preschooler, fire-setting may simply be an act of exploration by a poorly supervised child even though it can lead to tragic consequences.

Among school-age children, fire-setting may be one distinctive aggressive act among a myriad of unacceptable behaviours, such as stealing and using obscence laguage. Once these children discover the destructive force of fire without personally suffering from it, they may deliberately choose fire setting as a means of revenage on people who have deeply angered them.

Some children, are obsessively preoccupied with fire and draw pleasure from its awesome destructiveness. These children may use fire and their ability to set a fire to compensate for their feelings of impotent rage against their environment. Inadequate in every area of functioning, they feel isolated and unable to relate to others. They want to watch the fire, but they run away to safety, more out of fear of retaliation than a desire to save themselves.

In adolescence, fires may be set deliberately to cover a crime, to show the violent intention of a group against authority, or to provide a thrilling spectacle for diversion (Chess and Hassibi, 1986).

Firesetters are uncommon clinic referrals, the great majority being involved in fighting, disobediance and destructiveness and thus they fit better the diagnosis of conduct disturbance and appear to have the clinical and psychosocial correlates of the former.

Its clinical importance lies in the treatment and prognostic implications with the risks of their serious persistance.

Fire insurance records emphasized the predominance of adolescence boys with low intellegence, from criminal and psychotic families.

Recently, operational criteria have emphasized that firesetting occurs with unsocialized aggressive conduct disorders (Stewart and Cluver, 1982), attention deficit and specific developmental disorders, mental impairment and emotional disorders (Bumpass et al, 1983).

There is a significant association between fire setting and conduct disorder in children. As conduct

disorder was diagnosed in 64.5 % of the firesetters, and 76.9 % of the conduct disordered children were firesetters.

Heath et al (1985) were able to find a relationship between childhood firesetting and DSM III diagnosis in a representative sample of child psychiatric out patients (n = 204), 32 firesetters and 172 non firesetters, they found that childhood firesetting and the DSM III diagnosis of conduct disorder are strongly related.

Furthermore, the presence of firesetting and conduct disorder in the same individual showed a significant interaction effect that made these children more externalizing, less competent with regard to activities, and more pathological. One might think that the findings of a strong relationship between firesetting and conduct disoder could be circular as firesetting is mentioned in the DSM III as one possible example of conduct disordered behaviour.

However, it should be remembered that the diagnoses, were arrived at by using DSM III criteria, must not be based on a single criteria but the total clinical picture determines the diagnosis. It is important to note that not all firesetters are conduct disordered, 35 % of firesetters have other diagnoses.

Also, Kuhnley et al (1982) found in their analysis of the hospital charts of 56 children who had set fires and 58 patients in the same hospital who did not set fires, that conduct disorder and attention deficit disorder occured significantly more often in firesetters than in non-firesetters.

The principle conclusion in Jacobson (1985II)experiment was that the commonest diagnosis of firesetters was that of conduct disturbance, and their symptomatic and psychosocial profiles indicate marked antisocial and aggressive behaviour, rather than a broad range of syndromes.

The links between fire - setting and conduct disturbance are strengthened by:

1- Overlapping referral complaints.

2- The shared correlates of parental criminality, poor supervision, harsh or inconsistent discipline with considerable family discord and disruption.

The records of 79 children aged 8 - 16 years whose firesetting led to referral to a Children's Hearing (the Scottish equivalent of a juvenile court) were examined. The firesetters were children with multiple problems. 58 were already known to other agencies and there was

a particular association with a previous thefts (55) breaking and entery (38), truancy (24), and malicious damage other than firesetting (18). They had very disturbed backgrounds and absent or unemployed fathers. (Strachan, 1981).

3- It is a heterogeneous group with little consensus on its subclassification (Rutter and Giller, 1983).

4- Both mild mental impairment and specific reading retardation in firesetters are similar to those of conduct disorded.

While comparison of firesetters with conduct-disordered children revealed that:

1- Absence of situation-specific phobias in firesetters in contrast with conduct-disordered (Jacobson, 1985II).

2- Firesetters' relationships had revealed more social disinhibition and disturbance with other children.

3- Tics and most antisocial symptoms were more frequent in firesetters particularly lying, stealing and running away from home but fighting and violent assault were not.

4- Sexual misbehaviour featured more often in arsonists.

5- Sharp contrast between the peak ages of 8 in firesetters, and 13 in conduct disorders.

These results were reached by Jacobson (1985II). As the demographic, symptomatic, psychosocial and diagnostic profile of 104 child firesetters was investigated in a controlled note and item sheet study of all children referred to an Inner London Clinic between 1973 and 1981.

6- There is a male predominance in firesetters which is higher than the ratios for all others clinic referrals.

In a study of children who set fires, almost all of whom had aggressive conduct disorder, the boy to girl ratio was 14 to 1 rather than the 4 to 1 ratio seen in a series of children with conduct disorder who were attending the same clinic (Stewart and Cluver, 1982).

In Jacobson's study the ratio was 5 boys to 1 girl which is higher than the ratios of all conduct disorder.

Firesetting differs from other forms of delinquency in being almost exclusively male activity (Strachan, 1981). Less interest and greater fear of fires have been described in girls, as has less aggression both on a biological basis (Maccoby and Jacklin, 1980) and in response to family discord (Whitehead, 1979).

Pathological firesetting must be differentiated from playing with matches, by the frequency, severity, mode of discovery and the halo effects of symptoms e.g. violence. (Heath et al, 1983).

The specific factors associated with pathological firesetting are anger and frustration associating loss of good relationship with a parent, the arrival of a new step-parent, persistent parental violence and active encouragement (Fineman , 1980).

The best subdivisions of firesetters, are by age and reason for referral. Six-to 8- year-old domestic firesetters, referred primarily for other antisocial behaviour, were contrasted with adolescents referred for arson away from home with other boys. Referral primarily for firesetting, as opposed to other antisocial behaviour, was associated with more frequent, costlier and solitary arson and less deviance at follow-up (Stewart and Culver, 1982, Jacobson, 1985I).

The firesetters can also be classified into primary and secondry, the distinction between the primary and the secondry firesetters was associated with differences in firesetting behaviour, children in the primary group set more fires and more serious ones than children in the secondry group (Stewart and Culver, 1982).

In psychoanalytic literature much emphasis has been placed on an association between firesetting and enuresis as the symbolic manner in which the repressed sexual desire or drive is expressed.

Studies of children who set fires fail to substantiate such consistent association. Some authors have regarded the traid of enuresis, firesetting and cruelty to animals as having predictive value for occurance of violent behaviour in adulthood. Follow-up studies have not proved the validity of these claims.

Jacobson (1985[I])found that the postulated correlates of enuresis and sexual disturbance were not specific to firesetting being equally evident in conduct disordered controls. Firesetters' case history suggested that sexual excitement and conflicts subsided secondrily to treatment of the conduct disturbance, and the family disocrd or lack of supervison are far more likely than sexual disorder in children or family to determine later deviance (Mrazek and Mrazek, 1981).

Stewart and Cluver (1982) studied 46 children who had set one fire and had been admitted to a psychiatric ward. Their firesetting behaviour has been related to variables such as age, IQ, and psychiatric disorder in parents,

and to the distinction between children who present with firesetting as their chief problem and those in whom it is a secondry complaint.

Thirty subjects were followed up after one to five years. Seven, all boys and all less than 13 years old, were still setting fires, but these were less serious than the ones set before treatment. The persistent firesetters may have come from less stable homes and they tended to be more anti-social at follow up than children who no longer set fires.

So the short term prognosis of firesetting in young children, at least in those who are admitted to child psychiatry ward, is only fair and there are no reliable ways as yet to tell whether a child will stop setting fires or continue.

HYPERACTIVITY AND CONDUCT DISORDER

There is a problem presented by the intertwined nature of undersocialized conduct disorder and motor overactivity. Hyperactivity, as a behavioural characteristic is frequently found to be associated with the undersocialized conduct disorder dimension.

In addition, studies of children with diagnoses of conduct disorder often have large (upto 75%) subgroups who are motorically overactive as well as aggressive (Stewart et al, 1981) and studies of nonclinic population have frequently found correlations between conduct disordered behaviour and hyperactivity.

Most United States'clinicians believe that there is a common behavioural syndrome of children which is defined by developmental inappropriate overactivity, difficulty in concentrating and impulsivity but also includes, aggressiveness, anxiety, temper tantrums, learning problems, disobediance and antisocial behaviour. It is included in the DSMIII as attention deficit disorder with hyperactivity (ADD-H). (Cantwell, 1975, Barkley, 1981).

While admitting that the affected children are heterogenous and the origins of the disorder are unknown,Cantwell

(1975) argued that the available evidence points to a characteristic clinical picture, natural history, family background and patterns of findings on psychological tests.

In contrast, British clinicians regard hypekinesis as a rare disorder primarily seen in children with definite brain damage or dysfunction and it associates a variety of children's psychiatric disorder rather than forming a specific syndrome. Their definition involves extreme overactivity and inability to concentrate for more than a few seconds. It is included in the ninth edition of the World Health Organization's International Classification of Diseases (ICD-9) as hyperkinetic syndrome (Prinz et al, 1981).

The British investigators' work suggests that the definition which is commonly accepted in the United States includes too many behaviours and needs to be seperated from disorders of conduct.

So we can say that, one side believes that antisoical children are subgroup of those with hyperactivity i.e. hyperactivity is a seperate syndrome (Cantwell, 1975) and the other believes that overactivity and impulsivity are parts of the conduct disorder syndrome (Prinz et al, 1981).

Due to the different diagnostic practices between United States and United Kingdom 30 - 40% of children attending child guidence clinics in the U.S. are diagnosed as hyperkinetic compared with only 1.5 % in the U.K. (Sandberg et al, 1980).

The experiment carried out by Stewart et al (1981) supported the British clinicians' openion. Data were collected on 175 admissions to a child psychiatric clinic, primarily through structured interview with mothers. The children's ages ranged from 3 to 16, but only seven were younger than 5 and thirteen older than 14, so that 90 percent were aged 5-14. Forty-nine percent of the children were diagnosed as hyperactive and 46 percent as undersocialized aggressive, 34 percent had both disorders. Comparisons were made between the children who were hyperactive only, unsocialized only, hyperactive and unsocialized aggressive, and those with other diagnoses, on behavioural scales which were derived from the interview data but were relatively independent of the diagnostic criteria. On the scales of antisocial behaviour, egocentricity and reactivity, hyperactive and unsocialized aggressive children resembled those who were only unsocialized aggressive more than those who were only hyperactive. These results support earlier criticisms of a broadly defined syndrome of hyperactivity.

Also, Quay (1979) argued against the existance of hyperactivity as a primary diagnostic entity. He cited three sources of evidence for his claim:

a- In multivariate statistical studies, the variable of hyperactivity most often loads on a factor presenting conduct problems.

b- Hyperactivity scales correlate upto 0.90 with scales measuring conduct problems.

c- A number of 'methodologically adequate' studies have failed to uncover a factor dimension reflecting the classic hyperactive syndrome. Also factor-analytic studies of rating scales have tended not to support the notion of a primary hyperactive syndrome and have shown that hyperactivity is highly correlated with conduct disorder.

Trites and Laprade (1983), Glow (1980) findings contradict Quay's openion. Trites and Laprade subjects, were a stratified random sample of Ottawa area children. From this sample they selected 9583 English - speaking children between the ages of 4 and 22 years, case - wise deletion of missing data resulted in a subject pool of 9229

children. All subjects were rated on the Conners' Teacher Rating Scale. The data were then factor-analysed using a principle components solution. They found a group of children who appeared to be hyperactive but not conduct-disordered

These findings provide evidence for an indepent syndrome of hyperactivity in a sample of Canadian children. They suggested that the existance of subjects identifiable as hyperactive and conduct-disordered does not preclude the existance of seperate syndromes of either hyperactivity or a conduct problem.

Taylor et al (1986 II) stated that DSM III condition is common and the ICD-9 disorder is rare. Sixty boys, aged from 6 to 10 years, were studied after their referral to psychiatric clinics for antisocial or disruptive behaviour. Their scores on reliable measures of hyperactivity, defiant behaviour, emotional disorder and attention deficit were taken for the home, school and clinic settings, and subjected to two techniques of cluster analysis. Both gave a similar set of clusters, one of which had high scores on all measures of hyperactivity and attention deficit. The cluster analysis identified a group of pervaisvely hyperactive and inattentive children among those presenting with antisocial or disruptive conduct.

It was found that children with conduct problems are markedly overactive or inattentive in some but not all situations but hyperkinetic children show severe overactivity and inattentiveness in nearly all situations (Pervasive hyperactivity).

Type of hyperkinetic syndrome were studied using data from general population epidemiological study of 10-to 11 - year - old on the Isle of Wight who were followed up at 14-15 years old. Characteristics of situationally hyperactive children were compared with those of pervasively hyperactive children, as defined in terms of the hyperactivity factor scores on the Rutter parent and teacher questionnaries. The association of situational hyperactivity with general emotional / behavioural disturbance was a nonspecific finding, situational unsociability was also related to disturbance. In contrast, pervasive hyperactivity, a clinically distinctive behaviour pattern, was strongly associated with general behavioural disturbance, persistence of overall disorder and marked cognitive impairment(Schacher et al, 1981). These findings indicate the importance of identifying the type of hyperactivity.

Stewart et al (1981) in their research found that hyperactive children had lower I.Qs, cognitive impairment,

neurological immaturity, younger age of onset and referral, smaller family size, poor peer relationship, a higher rate of accidental injuries and a good response to stimulant medication and a higher frequency of reading problems than those with conduct disorder.

A second paper from Iowa showed that pure hyperactive children were generally similar to those who also showed an aggressive conduct disorder except that those with pervasive hyperactivity had subnormal IQ scores and showed a history of developmental disturbance (August and Stewart 1982).

The same result was reached by Taylor et al (1986 I) in their study on a mixed group of 64 children referred to psychiatric clinics because of antisocial or disruptive behaviour. In addition, they found that the defiance (but not the hyperactivity) scales were associated with impairment of family relationshisp and adverse social factors i.e. hyperactivity was related strongly to neuropsychological test results and defiance to measures of interaction between family members. But, this is not yet justified.

The diagnosis of hyperkinetic syndrome was made in 20 % of mentally retarted children but in only 1% of children of normal intelligence (Rutter et al, 1975).

Both hyperactive and conduct disordered children have poor prognosis. The rate of delinquency of ADD boys has been reported to be 58 %. Suggesting a strong relationship between childhood ADD and delinquent (Satterfield et al, 1982).

Schachar et al (1981) found that poor outcome is associated with child's hyperactivity especially if was pervasive rather than with conduct disorder perse. Schleifer et al (1975) and Campbell et al (1977) had reached the same result.

August et al (1983) reached an opposite findings. They found that antisocial and delinquent behaviour reported in four-year follow-up studies of hyperactive boys may be linked to childhood aggression and undersocialized behaviour, rather than the syndrome of hyperactivity.

It was suggested that the parents of purely hyperactive children had less pscyhopathology than the parents of children with conduct disorder and psychopathology in parents of hyperactive is associated with the children's conduct disorder rather than their hyperactivity. (Stewart et al, 1981).

But, Cohen and Minds (1983) claimed that mothers of pervasively hyperactive children had been found to have a more controlling and negative style of interaction with their children.

Stewart et al (1980) failed to find any association between specific parental disorder and hyperactivity. Most of the aggressive boys in their study were also hyperactive. Their sample was 126 boys attending a child psychiatric clinic and the controls were other patients attending a psychiatric clinic, hyperactive boys were divided into sub-groups depending on whether they were also aggressive, non compliant and anti-social and the clinician who diagnosed the parents had no knowledge of the boy's problems.
They found that the general characteristic of families attending child pscyhiatric guidance clinic, was neurotic or depressed mothers as they tend to be inconsistent in disciplining their children, a factor that would magnify behaviour problems. Also disorders in the parents were related to the aggressive conduct disorder whether they were active or not.

The same reslt was reached by Sandberg et al (1980) in their experiment . Their sample was in the age group of peak-risk, that is primary school age. The sample consisted

of 226 boys, aged 5 - 9 years from 19 primary schools in Inner London. Hyperactivity and conduct disturbance were measured by parents and teacher questionnaires.

Lastly, we can say that hyperactivity and conduct disorder frequently present at the same time and in the same people. Stewart et al (1981) reported that two out of three hyperactive children had a conduct disorder as well.

Taylor et al (1986 II) suggested that the heterogeneous diagnosis of conduct disorder in ICD-9 and attention deficit disorder with hyperactivity in DSM III can be further refined as a 'hyperkinetic conduct disorder ' which could be:

1- Pervasive overactivity and restlessness, that is evident across two or more of the situations of home, classroom and clinic.

2- Impaired attention, detected either by psychometric tests or by directly observed impersistence and distractability in behaviour.

3- Absence of overt symptoms of severe anxiety or other emotional disorder.

4- Presence of severe degrees of persistent non compliance, aggression or destructiveness. They also show evidence of developmental delay, at risk of accident injury and with unsatisfactory poor peer relationships.

Children who meet the first three criteria but show no antisocial behaviour can be categorized in a seperate group of pure hyperactive disorder.

ASSESSMENT

The most common assessment methods of conduct disorders include: behavioural checklists completed by the teacher, parent or other informant procedures by which the youngster's behaviour is directly observed and recorded using a specific observational code. Self-report and psychophysiological measures have been used much less frequently than other techniques.

1. Behavioural Checklists:

Several behavioral checklists or rating scales are available for the assessment of conduct disorders. The youngster's parent and /or teacher is asked to complete the checklist concerning the child's behaviour.

a- Teacher ratings:

It has been suggested that because of the marked variability of child behaviour in clinical settings, teacher ratings might be of more utility in diagnosis and in the evaluation of treatment efficiency. (Loney, 1980). Teachers might also be more familiar with age appropriote norms and generally more experienced in objectively evaluating children's behaviour.

The most common assessment devices for evaluating conduct problems of elementary school children include:

* The Behavioural Problem Checklist (BPC) and the more recent Revised Behaviour Problem Checklist (PBPC).
* The Conners' Teacher Rating Scale (TRS).
* The Louisville School Behaviour Checklist (SBC)
* The Rutter Children's Behaviour Questionnaire for Completion by Teachers.

All have been shown to have adaquate test - retest reliability (0.80-0.90) and adequate internal consistency. (Boyle and Jones, 1985) and can be easily scored.

The RBPC has 22 items to assess conduct problems, the TRC has 15 items and the SBC has 23 items.

An adaptation of the Rutter Children's Behaviour questionnaire for completion by teachers (26 items) with the addition of further items was made by Behar and Stringfield (1974), and a factor analysis of that scale with data obtained on normal and disturbed preschool children provided evidence for three factors: factor I appeared to measure a "hostile-aggressive " dimension, while factor II tapped "anxious - fearful" behaviour. Factor III was labelled "hyperactive - distractible ".

Teachers' ratings of 1063 children (501 girls and 562 boys) were obtained using "Children's Behaviour questionnaire for completion by teachers ". Of these, 405 were Hindus, 218 Moslems and 228 General Population. The children were drawn from 37 schools in the Vacoas and Quatre Bornes area of Mauritius. The Children's age were between 7 and 8 years at the time testing. Data drived from the use of the scale in a developing country suggesting that its factor structure is stable over sex, and over racial groups. (Venables et al, 1983).

The conduct problem scales of all of these instruments have demonestrated sensitivity to treatment changes of a behavioural or pharmacological nature, where_as the Conners' TRS has been used most frequently in pharmacological investigations.

B- Parent Ratings:

In addition to BRC other parental rating scales include:

* Child Behaviour Checklist (CBC)
* Parent version of the Conners' Rating Scale.

The PBPC has 22 items assessing antisocial behaviour or conduct problems, while the CBC's conduct problem scale consists of 23 items for boys and 25 items for girls. Conners'

Parent Questionnaire has 7 items on the conduct factor. The CBC is the only instrument that contains scales with different items for boys and girls, recognizing that somewhat different behaviours may be related to conduct disorders for boys than for girls.

2- Mother - father agreement:

Mothers have been found to endorse more items on the conduct problem scale than fathers for both the 'disturbed' and normal samples. (Jacob et al, 1982).

Agreement between father and mother ratings on the conduct problems factor (agression) of the CBC ranged between 0.72 and 0.80 for varied ages of boys and between 0.33 and 0.68 for varied ages of girls. Interestingly, for an age range most often assessed in previous research, namely for girls between 6 and 11 years of age, parents had an agreement coefficient of only 0.33. (Achenbach and Edelbrock, 1983).

Furthur, it appears that parents agree less about girls' than about boys' behaviour problems. Whether this lesser agreement is due to more time spent by fathers with boys than with girls is not clear, but such time might influence the ratings. Although the overall 'mean' difference between mothers' and fathers' ratings was small, mothers' ratings of conduct problems were higher than fathers' ratings (Jacob et al, 1982).

3- Parent - teacher agreement:

Agreement between parent and teacher ratings is less than agreement between fathers and mothers. Many problems of children become manifest only when they attend school and have to face the more formal and structured aspects of a classroom. A comparison of the extent to which children display conduct problems in one place or another can be made by BPC and RBPC.

BPCs, from the parents and teachers of 132 children in an elementary in a suburban Long Island community, were examined. They found that girls were more likely to show conduct disorders at home than at school, while the boys did not display significantly levels of conduct problems in both settings. (O'Leary and Johnson, 1986).

Parents often feel their children's behaviour is within normal limits even though school personnel may see the child as quite deviant. Given different tolerance levels for certain types of behaviour, it is of course possible that teacher - parent differences that exist may reflect tolerance differences, not behavioural differences in children.

4- Behavioral observations:

There are several observational schemes that have been used to measure the behaviour of aggressive children in the classroom.

O'Leary et al (1979) developed a coding system for measuring classroom behaviour of aggressive boys that has sufficient reliability and validity to distinguish target conduct - problem children from randomly selected same-sex peers. The codes were designed to enable classroom observers to note the presence or absence of discrete behaviours. The observational coding system was an outgrowth of earlier observational schedules used at the Universities of Wahsinton and Illinois. When boys were selected from extreme aggression scores on the Louisville School Behaviour Checklist, the particular behavioural codes that differentiated aggressive boys from randomly selected boys were interference with others, noncompliance, aggression, off -task, vocalization and solicitation of teacher attention. A second coding system was developed for use in both formal and informal classrooms and has been used primarily in assessing children with conduct problems (Nurcombe and Gallagher, 1986).

Methodological issues with these codes such as presence of observer, frequency of observer checking, and observer drift (Changing observational criteria across time) have been summerized by Patterson (1982). Fortunately, reactivity to the presence of observers in the classroom does not appear to be a problem if there is an initial adaptation period for three to five days before actual data are obtained. Reliabil-

ities decrease if occasional reliability checks are not made and if the observer knows when he or she is to be checked. Finally, changes in observational criteria occur across time if restandardization of the observers does not occur periodically.

5- Self - reports:

Children with conduct disorders often have significant reading problems, and this reading deficiency may be one reason why self-reports of conduct problems are used much less frequently than teacher and parent reports. The paucity of self-report instruments may be due in part to the skepticism of behaviourally oriented psychologists about self-report measurments and their emphasis on direct observation (Finch and Rogers, 1984).

One of the few measures of self-reports of conduct problems for children is the Children's Inventory of Anger, which was designed to have a four-grade reading level. Drawings of faces with happy to mad faces were used as aids to provide visual images for the anchor points on the scale. The measurement device has good test- retest reliability when read to children individually, but the concurrent validity of the test appears questionable (Finch and Rogers,1984).

A child version of the CBc has been developed that is called the Youth Self-Report. It is designed for ages 11 to 18 years and requires a minimum of fifth- grade read ing skill. There are insufficient research reports about this instrument. But initial work with this instrument suggests that it is a promising measure.

Herjanic and Reich (1982) assessed the reliability of children's reporting by comparing mothers' reports with those of their children, who ranged in age from 6 to 16. The analysis of data revealed that there was little agreement between mothers and their children. In general, questions of children and their mothers that yielded reasonably high agreement were objective and concrete, factual and unambiguous and not easily misinterpreted . Research on self-reports of aggression by children has just begun to receive serious attention.

6- Psychophysiological Correlates:

Psychophysiological responsiveness with respect to both tonic (basal) and phasic (response to stimuli) levels have been extensively studied in children.

Heart rate:

Although studies of adults relating heart rate to antisocial behaviour have failed to find evidence for lower

resting levels, studies of antisocial, delinquent, high risk adolescents have obtained results in the direction of lower tonic levels.

Electroencephalogram (E.E.G.):

Most E.E.G. studies have used heterogeneous groups of subjects with behaviour problems. These studies have generally reported a higher than normal frequency of abnormalities, primarily excessive slow activity with poor background organization and the frequent occurance of paroxysmal or epileptic forms of activity. In a studied E.E.G. records of 78 girls admitted to adolescent unit of a psychiatric hospital. It was found that, the anxious group manifested more fast activity in the temporal region which might be expected in anxious and sensetive individuals and might also contribute to the inhibition of impulses orginating in lower parts of the central system. The under socialized group exhibited more generalized slow waves might be related to a lack of inhibition. The socialized group provided E.E.G. tracings more regular and more normal than either of the other two groups. But the study did not include a nonproblem control group and results could have been influenced by medication being taken by some, though not all, of the subjects. (O'Leary and Johnson , 1986) .

Basically, E.E.G. studies have been unrevealing with respect to the role of disturbed electerical activity in the brain in conduct disorder except to suggest a lack of involvement in the socialized subtype

Electrodermal Responding:

Delameter and Lahey (1983) studied children in the 10 to 12 years range whose primary diagnosis was learing disability. Within this group, those selected for high scores on a rating scale measure of undersocialized conduct disorder showed significantly lower levels of skin conductance during a continuous performance task.

Recently, Schmidt et al (1985) studied eleven conduct-disordered (CD) and 11 control (C) children. They were matched case by case on the basis of age, sex and race. Both the (CD) and the (C) groups were composed of seven boys and four girls, there were six black and five white subjects in each group. I.Q. for the (CD) group was 96 compared to 100.9 for the (C) group. These differences were not significant by t-test. All subjects and at least one parent was seen in a diagnostic interview. Children assigned to the conduct disorder group (CD) were required to meet the diagnostic criteria of undersocialized aggressive conduct dis-

order as listed in the DSM III. Additional requirements were: absence of pediatric or gross neurological disorder, depressive illness, psychosis or pervasive developmental disorder, no medication intake for at least 3 months and an I.Q. of at least 70 . In addition, subjects in both the normal and clinical groups had been raised by at least one natural parent. The experiment took place in two laboratory rooms seperated by a door and by a curtained window. The child was seated in a semireclining chair in one of the rooms, which was sound-proof. The experimenters operated the recording, stimulating and timing equipment in the adjoining room. The temperature in the laboratory was maintained at 72- 75^{o}F. An initial 5- min period was spent familiarizing the children with the laboratory. The electrodes were then attached to skin which had been rinsed with water and cleansed with acetone. A 10-min interval between electrode placement and the start of recording was allowed for paste equilibration. Before the start of recording, the children were asked to relax and to try to move as little as possible. Skin conductance level (SCL) was sampled every 30 sec during each 5-min rest peried. The (CD) and (C) groups were compared during periods of rest, moderate tone and loud bell stimulation. The (CD) group was best differentiated from

controls by lower activity first bell, while on tonic measures they showed normal values. The electrodermal profile of the (CD) children thus resembled that of adult sociopaths on phasic measures only. Lower electrodermal responsivity can be interpreted as reflecting a lower level of general arousability .

The behavioural inhibition system reacts to signals of pain , punishment and novelty to stop ongoing behaviour, the reaction to novelty among undersocialized children suggests the possibility of an underfunctional inhibitory system (Gray, 1982).

Additionally, passive avoidence (withholding responding to signals of punishment) is controlled by this behavioural inhibition system and passive avoidence behaviour is clearly impaired in psychopaths. (Hare, 1978).

The reward system responds to signals of both reward and relief from punishment. There is little evidence of a consistent deficit in reward, escape, or active avoidance learning in the undersocialized group. Overactive reward system very likely coupled with an underactive behaviour inhibition system may be implicated in the genesis of undersocialized conduct disorder.

TREATMENT

The incidence of spontaneous remission of conduct disorders in children is low. When left untreated, 15% of a group of 10-year - old with conduct problems still exhibited maladaptive behaviours at the age of 14.(Strauss and Lahey, 1984).

1- Behavioural therapy:

Behavioural therapists generally view conduct- type problem or antisocial behaviour as 'skills deficits'; the child has failed to learn to delay gratification or has not acquired the skills needed to obtain gratification appropriately. From this point of view, effective treatment will require the development of new, more socially appropriate, as well as the elimination of the norm-violating behaviour. Behavioural intervention with conduct disordered subject, have been conducted in institutions, in residential community settings (group homes), and in the home.

Treatment of children with antisocial behaviour or conduct disorders just as the treatment of children with other behaviour disorders is determined less by the symptoms themselves than by the child's personality characteristics, his life expectations and his family and school environment.

When the child's symtoms are due to recent stress, treatment is aimed to help the family in this period of crisis will also help the child,especially if the school staff can be mobilised to offer special understanding and support to him. In other cases, the pressures on the child are of longstanding and intimately related to serious personality disorder in one or both parents or to educational retardation. Some such parents respond well to prolonged psychiatric and/or social work treatment and meanwhile the child can benefit from psychotherapy. When parental personality disorders are so severe that no change is possible, the child needs a compensatory environment as a supplement to or substitute for his own home: a small day school for maladjusted children, or a residential school from which he returnshome only in holidays. Remedial teaching and the restoration of the child's self-esteem in the school setting, are important component of treatment.

Social skills training, parenting skills training, individual and /or group therapy, indentification and proper treatment of parental psychiatric illness, decreasing parental and marital stress, control of parental alcoholism, direct behavioural management of aggressive behaviour and proper management of learning disabilities are among the

many other tasks in trying to help a family and child with a conduct disorder (Wolff, 1978).

Loeber (1982) concluded that characteristics of the child played a more powerful part than environmental variables in determining the coarse of aggressive conduct disorder over the short term. This fininding might be taken to imply that treatment should be focused on the child rather than the family. Such a shift of emphasis has in fact taken place in recent years in the United States, training in impulse control and social skills are supplanting family therapy as the primary treatment of conduct disorders.

Social learning therapy programmes:

Data supporting the effecincy of social learning therapy have been gathered and are beginning to accumlate. Other methods of treatment have failed to be as consistently effective as social learning techniques. The social learning methods that have been employed involve teaching parents to use clear requests and instructions to their children, to increase rates of positive reinforcement for appropriate behaviours, and to decrease overall rates of punishment, and / or to implement between themselves and their children 'formal contracts ' that designate the responsibilities of each individual and the consequences of changed behaviour.

This treatment programme also involved home visits by therapists to assist in the implementation of the learned techniques, and the formulation of behavioural contracts that specified desired behaviours and their material consequences. This approach has been devised to alter the maladaptive family patterns believed to be primarily responsible for the maintenance of conduct problems.

Unfortunately, the response to this form of treatment varies among individuals. It was shown that the effeciency of social- learning therapy programmes is inversely related to the degree of deviance in the child's home life. Specifically, children from families that have been exposed to stressful events such as financial and marital difficulties, that exhibit maladaptive patterns of interaction , and that have infrequent contacts with extrafamilial persons are least likely to respond favorably to such treatment programme. (Strauss and Lahey, 1984).

Although it is widely believed that behaviour modification is successful in an institutional setting , the lasting efficiency of such programmes for adolescents with acting-out and conduct problems has long been questionned.

At the Kansas Place Programme (Kirigin et al, 1979), a community - based, family - style, behaviour modification

programme-attempts were made to modify and improve social, academic, and self-care skills such that the the improvement made would be generalised to the natural environment. A comparison of 18 Achievement Place youth and 19 youths who were judged acceptable for Achievement Place but who were institutionalised instead, showed that re-institutionalization rate for the comporison group at two-year follow-up to be twice that for the Achievement Place group.

Another study was carried up by Moyes et al(1985),a follow up enquiry was done at one and two years on adolescent patients who had been through an institutional behaviour modification programme. The behavioural structure which they had utilized was composed respectively of a basic token economy, individual contingent behaviour modification programmes and comprehensive social and life skills training programmes. Tokens were earned regularly for a combination of task completion and appropriate behaviour, over a period of time varying from every 15 minutes to every two hours, depending on the individual's level of behaviour. Earring potential was split into three progressively higher levels of access to privilege. As the levels of privilege were moved through by any given individual, tokens had to be 'banked' to retain access to those privileges. Automatic loss of all privileges and return to the bottom of the ladder followed absconding.

theft, serious aggression leading to damage to persons or property, and fire-setting. Individual programmes were carried out as in convertional behaviour modification practice and may be used to modify dress, hygiene, posture, odd or bizarre behaviour, overactivity, underactivity, speech loss or excess volume, social or work behaviour. Reinforcement consisted of tokens phased into the general system, social praise, seperate privileges, cigarettes, and food. The third major functional component of the unit programme was social skills training and training for other life skils (Such as work, and household care, child care, and education). Again, level of effort, time keeping, etc were part of the token system, but actual level of ability, was not. Tokens were paied for specific allocated social behaviour practice outside sessions, and these were emphasized in an attempt to generalize any learning that had taken place. The progress of all patients was monitored at three-monthly interval by a full behavioural assessment procedure, which analysed the level of function on and outside the ward, progress, and target setting, with the use of a specific behaviour rating scale (deleveloped at the hospital), as well as behavioural baseline methods when appropriate. The treatment group (t) consisted of 78 young people (age range 14 to 25) of either sex (51 % male, 49 % female), who had behaviour or personality disorders of an antisocial or withdrawn type, and who were not

severely physical or organically impaired. The comparison group (C) consisted of 63 basically similar group people (mean age = 17 years) who had been accepted for admission but had not taken up the offer of a place (not admitted). Significantly more of the treatment group than the comparison group had improved in terms of behavioural outcome measures, and their level of independent living was greater.

However, due to the longstanding nature of the problems posed by behaviourally disorded individuals, it will be unreasonable to expect a cure - a complete remission of all problem behaviours. A far more feasible aim will be to minimise problem behaviours to within a more manageable and socially acceptable level. Achievement of this will provide the consequent aim of gradual integration into independent society. With these aims in mind, it seems fair to conclude that the results of this study have provided an encouraging demonstration of success in this field, especially in the lights of suggestions that social aggression and delinquent behaviour are problems which are stable over time.

There has been an increased emphasis over the past decade to train parents as therapists for their own children. In a number of research reports (Johnson and Katz, 1973), investigators have concluded that parent training is an effective treatment for such children. However, more recently

research which has investigated the long-term effects of these programme, has indicated that training parents is not always effective and does not guarantee lasting measurable effects for all parents (Johnson and Christensen 1975).

Some investigators have begun to examine why parent training programmes work for some families and not for others. Some authors found treatment failure connected to marital problems, others found that single- parent families were more likely to drop out of parent training than intact families. In addition, it was found that intact families were more successful in maintaining treatment effects than single - parent families.

Stratton (1985) carried out his experiment on subjects recruited from a behavioural clinic in a local pediatric hospital which had a specialized programme for the treatment and evaluation of children with conduct problems. Criteria for study entery were the following: the child was between 3 and 8 years old, he had no dibilitating physical impairment, intellectual deficit or history of psychosis and the primary referral problem was child oppositional behaviours e.g. refusal to follow requests, tantrums, aggression. Thirty families who recieved training for conduct-

disordered children were divided into two groups, father involved families (n = 19) and father - absent families (n = 12). In order to be classified as a father-involved family there had to be a father, boy friend, or stepfather who cared for the target child either with the mother or seperately in his home. In addition, he had to be willing to be involved in the assessment procedures and some of the therapy sessions. Father absent families had no father or boy friend living in the home or involved with the child interms of the assessment and treatment programme. Father-involved families included 14 boys and 4 girls and father-absent families consisted of 7 boys and 4 girls. Prior to the onset of parent training, data were collected for each family in regard to socioeconomic variables, and attitudinal and behavioural measures. After 3-4 ws of baseline data collection the 30 families recieved parent training which consisted of a series of nine 2-hr weekly training sessions. The first 4 ws of the treatment programme included a modification of the interactional model focusing on positive interactional and play skills. The last 5 weeks focused on teaching parents a specific set of operant techniques such as principles of praise, ignoring, giving commands and time out for child non-compliance and destructive behaviours. Immediately post-treatment both groups reported significant improvement

in their children's behaviour. Behavioural data showed significant increase in mother praises and reduction in mother negative behaviours, child non-compliance and deviancy . One year later the children continued to show reductions in non-compliance and deviance.

However, significantly more of the mother-child dyads who maintained behavioural improvements came from father-involved families. By training both parents, each can help remind the other of parent training techniques as well as reinforce and encourage each other in their efforts. It may also be helpful to plan several 'booster' sessions over the year following training, especially for father-absent, single-parent families who donot have a support system at home.

Several limitations of Stratton's study should be noticed. First , due to difficulty of scheduling times when the father was at home, only the mother and child behaviour interactions were systematically observed. A second important limitation was the failure to match the two groups in terms of family income. A third limitation was the lack of a comparison control group of father-involved or father-absent families who did not recieve treatment. It was diffcult to determine with certainty whether the changes compared

with the baseline were caused by the treatment or by the placebo effects, or if the more favorable long-term outcome for father-involved families was because fathers were trained or simply because they were present in the home.

As regards treatment of undersocialized aggressive conduct:

It is quite resistant to current forms of treatment. The age at which treatment is begun is an important determining factor in sucess because of the tendncy of this behavioural pattern to become increasingly internalizing and fixed and because of the greater practical ease with which overt aggressiveness can be managed in the younger child. Involvement of the family is essential. Conjoint marital therapy and family therapy with these families are extremely demanding. It is often necessary to seperate the child from his home to treat him effectively. Even in a placement outside the home, the youngster can be expected to continue his extra-ordinary aggressiveness. So those who are entrusted with the care of the child must be prepared to offer acceptance and affection for long periods of time with very little positive feedback.

Expectations for more socialized behaviour from the youngster are initially minimal, and are only gradually

increased. Medications, especially the phenothiazines, may be of temporary value in some undersocialized aggressive children and cannot substitute for the consistent and affective socializing experiences that the child needs for the development of internal controls and new adaptational skills.

Treatment of socialized nonaggressive youngster is difficult because of their lack of empathy, trust, and capacity to develop emotional attachment. Because the basic cause is rejection in the home, some of family therapy is indicated. However, this therapy is extremely difficult to arrange and continue, in view of the parent's usual lack of emotional involvement in the youngster. As they are chronic school failures, they often require skilled special educational help to experience any academic success. Active efforts to provide the youngster with pleasent and safe social experience are also an important part of treatment. Supportive group therapy, organized social clubs, and supervised recreational experience may help to reverse the pattern of hopelessness, defeat, and surrender that characterizes these youngsters. It is often necessary to provide treatment in a sheltered environment, such as an inpatient unit or residential treatment center.

Various forms of group therapy for the youngster with socialized conduct disorder are found to be relatively useful as reality therapy may be most effective in a group setting, either in self-help groups or in professionally directed groups. Basically, these groups use a core of reformed delinquents who understand the rationalizations, denials, and self-justifications of the gang member, and vigorously confront the youngster with the realities of his predicament and the inevitability of eventual negative consequences to him if he persists in delinquency. The crucial task is to convert the group orientation toward more convential values. This conversion may require seperation from the previous peer group, and transplantation to an entirely new environment, as in training schools and therapeutic camping programmes. Many youngsters with socialized conduct disorder do not recieve psychiatric treatment at all, but are, instead, remanded to training schools or reformatories. Therapeutic optimism is very much warranted in this group of youngsters.

2- Medications:

In a recent review of psychological therapies in child psychiatry, it was found that psychodynamically oriented residential institution and long-term unfocused in-

dividual counselling are ineffective. The combination of serious effects of conduct disorders together with generally poor results from psychosocial treatments and/or environmental manipulations has spurred wide spread clinical use of pharmacological agents in these children despite the absence of data supporting their efficiency. The clinical attitudes, understandably, toward both psychosocial and pharmacological treatments has been one of attempting any acceptable approach rather than let these children drift out of society.

A- Neuroleptics:

Antipsychotics (major tranquilizers) act through blocking Dopamine receptors in the limbic system and strial sytstm. In addition, they reduce the sensory input to the reticular formation (Okasha, 1983).

Thioridazine (Melleril), haloperidol (Butyrophenones) and perphenazine (Trilafon) are reported to be effective in reducing aggressive behavior in psychotically disturbed children.

Campbell et al (1982) compared chlorpromazine, haloperidol and lithium carbonate in conduct disordered children with aggression, hyperactivity, and explosive affect.

They reported beneficial effects from all three medications but excessive sedation with chlorpromazine. Lithium and haloperidol were as effective as chlorpromazine in reducing aggression but with fewer side effects. Haloperidol has been reported to impair cognitive functioning at higher doses (0.05 mg/kg/day) compared to lower doses (0.025 mg/kg/day). However, haloperidol also has been reported to have only minor effects on cognition at a dose that has beneficial effects on aggressive behaviour. Haloperidol has a mild negative effects on congition, apparently not severe enough to impair classroom performance. Lithium has no adverse effects on cognition.

Campbell et al (1984) recently reported a large, placebocontrolled, double blind study of the effect of haloperidol and lithium carbonate in the treatment of 61 carefully diagnosed undersocialized aggressive type conduct disorder children. These hospitalized children had been refractory to all previous treatment attempts. Both medications were clinically meaningfull and statistically significant in reducing aggressive behaviour. Lithium was prefered over haloperidol because it has less effect on cognition and is safer in light of the incidence of extrapyramidal reactions, and dyskinesis associated with haloperidol use.

Neuroleptics are commonly used in the treatment of aggressive children but, haloperidol had no advantage over lithium and had more side effects.

Neuroleptics have serious short and long term effects and should not be used unless necessary, when other medications have failed, and , if needed, should be periodically withdrawn to assess continued need. Monitoring for dyskinesis, both directly induced and withdrawal induced, should be frequent and careful.

B- Lithium:

There is increasing evidence that lithium carborate might be useful in the treatment of children with severe aggressive behaviours. In general, there are two types of clinical situations where lithium might be considered. The first is in a child with conduct disturbance who may have an underlying bipolar disorder. The second is in the treatment of undersocialized conduct disordered per se.

Lithium is used relatively little in child psychiatry. The most recent review raise cautious optimism that lithium may prove useful in the treatment of serious childhood disorders with aggressivity as a major feature, particularly in the presence of affective disturbance.

Delong (1978) reported 12 patients, all with family histories of affective illness, who had severe behaviour disorders characterized by extreme hostility and aggressivity with explosive anger, poor attention span, and distractability, extreme, recurrent, short mood swings (in nine); and lying, stealing, and fire-setting (in ten). All the children improved on lithium in a blind, placebo-cross over study with results measured by parent reports.

Of importance in the discussion of conduct disorders is the antiaggression effects of lithium. A large well- designed, double-blind, controlled study was undertaken on severely aggressive prisoners, many of whom were adolescents. This study demonstrated a highly significant antiaggression effects of lithium in men not thought to have affective disorders although that diagnosis may be difficult to make (Cutler and Heiser, 1978).

Lithium is equally efficacious as halopridol in improving aggressive outbursts and appears to be generally safer, with fewer short and long term problems.

Of coarse, lithium is not free of serious side effects or clinical management problems. The toxicity side effects include:

1- Central nervous system effects:

Characteristic lithium-induced E.E.G. changes in children with conduct disorder (58 % of whom had abnormalities at baseline). Neurologic toxic effects are extremely rare at therapeutic blood levels. Lithium posioning causes severe neurotoxicity.

2- Neuromuscular effects:

Very fine tremors of the fingers.

3- Renal effects:

The most frequent is lithium induced diabetes insipidus. Complaints of transient polyurea and polydipsia are frequent , and a smaller number of patients will go on to have frank diabetes insipidus. In case of frank diabetes insipidus the concentrating defect can be overcome by the use of hydrochlorothiazide diuretics in such a way that lithium can be continued. The diuretic dose is adjusted to normalize urine output, and the lithium dose is readjusted by following blood levels as if it were being started for the first time. Electrolyte levels, particularly potassium must also be closely followed. Lithium-induced diabetes insipidus is completely reversible following lithium withdrawal. (O'Donnell, 1985).

Renal biopsies of chronic lithium patients have revealed convuluted tubule and collecting duct lesions and chronic interstitial atrophy in a small percentage (12-15%) of patients. There was little correlation between kidney abnormalities and duration of lithium treatment. Lithium has not been related to any case of actual renal failure. Baseline and follow up kidney function tests had been reported for four children(age varied betwen 13 and 15 years) who were chronically maintained on lithium for three to five years. The dose of lithium varied from 750 to 1000 mg/day, with a mean of 850 mg/day. Serum lithium levels were estimated at least once every 2 months with flame photometry and were maintained between 0.5 and 1.0 meq. /liter. The children were provided with a standard hospital diet of 2000 calories and 8 g of salt. None of the patients showed any glycosuria or proteinuria. Microscopic examination of urine did not reveal any significant abnormality in any of the cases. The levels of blood urea and serum electrolytes were within the normal range. The investigators concluded that all the children tolerated the drug well and side effects such as, nausea, vomiting, and tremors were only transient i.e. side effects had not been a problem; and there was no impairment of renal function (Khandelwal et al, 1984).

4- There are other less common effects of therapeutic levels e.g. cardiac effects with T-wave flattening or inversion, but with little evidence of clinical significance except in patients with pre-existing cardiac pathology; gastrointestinal effects are frequent but usually mild. Endocrine effects include weight gain and increased carbohydrate craving. Characteristic maculopapular rash. Lithium is known to be related to thyroid function(O'Donnell, 1985).

Lithium requires detailed medical baseline studies including electrocardiogram, electroencephalogram, liver function tests, electrolytes, renal function tests (including creatinine, creatinine clearence, 24 hour collection and ideally antidiuretic hormone levels and concentrating testes),thyroid function tests, general physical examination, neurological examination and a detailed medical history. When properly managed, lithium is a generally safe medication.

C. Anticonvulsants:

Are used in conduct disorders with seizures. The appropriate anticonvulsant is used with the most reasonable psychotherapeutic and psychosocial steps indicated for patient and family education and support.

However, there is as yet no clear basis for treating even severely aggressive conduct disorder with anticonvulsants in the absence of clinical seizure disorder, with or without abnormal E.E.G. As Lewis et al (1982) pointed out that, there might be a significant number of undiagnosed temporal lobe epileptics among populations of severe delinquents.

Hermann et al (1980) and Pritchard et al (1980) reported that psychological dysfunction is more likely to develop with early onset of temporal lobe epilepsy. So, it is important to specifically question for the presence of psychomotor phenomenan, such as sudden unexplained sensations of fear, anger, hunger, euphoria or other symptoms indicating the presence of temperal lobe epileptic focus.

The presence of these symptoms, particularly when the electroencephalogram is positive, raises the odds that the patient suffers from psychomotor seizures and warrants a trail of anticonvulsant.

For treatment resistent, severely aggressive conduct disorder, particularly with even a nonspecifically abnormal E.E.G., a carefully monitored treatment trial can be

conducted in only a few weeks, with very little risk to the patient. If the trial appears to be effective, the clinician, patient and family can then weight the advantages and disadvantages of continuing medication treatment.(O'Donnell 1985).

D- Stimulants:

Rogeness et al(1982) reported that a combination of methylphenidate and a phenothiazine (Thorazine) seemed to be the most effective form of pharmacology for their under-socialized patients. This would make sense because methyl phenidate releases stored DA and NA while phenothiazines are DA blockers. Thus, the effect of the combination of drugs might well be to agonize the behavioural inhibition system while antagonizing the reward system (DA), thus establishing a normal level of dynamic inhibition.

Attention deficit disorder (ADD) and hyperactivity are often associated with conduct disorders that can range from oppositional to severe aggressivity and antisocial behaviour. It may be that some type of physiological overactivity makes it difficult to respond to the ordinary rewards in life as well as the ones built into treatment.

It was reported that dextroamphitamine improved antisocial behaviour in hyperactive boys. At least, it can be said that there is no evidence that stimulants are useful in the treatment of conduct-disordered children uncomplicated by ADD.

E- Antidepressants:

It was noted that many children with 'masked depression ' presented with aggressive behaviour and delinquency and the antisocial behaviour followed the onset of depression.

Carlson and Cantwell (1980) evaluated 102 outpatient children, of 28 children diagrosed as having an affective disorder, eight also met criteria for ADD or conduct disorder. They concluded that more traditional methods of assessment overlooked the diagnosis of depression in 60 % of children who satisfied criteria for affective disorder and that the majority of missed depression had been initially diagnosed as undersocialized aggressive reactions or adjustment reactions. The depressed delinquents' antisocial behaviour did not differ in severity or type from the behaviour of the nondepressed delinquents. Relapses of antisocial behaviour occured only when depressive symptoms recurred and usually abated after the depression was again treated.

There are no studies of tricyclic antidepressents in the treatment of children who have only a conduct disorder diagnosis. These medications are very toxic and no child should have access to them.

F- Propranolol:

A B-adrenergic blocker, has been reported to effectively control sudden rage outbursts and violent behaviour in adult patients with acute brain damage from multiple causes (Yudofsky et al, 1981) and in one 12-year- old boy with postencephalitic psychosis (Schreier, 1979).

Lastly, we can conclude that no clear guidelines can be given for the pharmacological treatment of conduct disorders.

The literature as a whole is confusing because of the variety of diagnostic schemes, vagueness of terminology, heterogeneity of study groups, varying doses of medication, and study design flaws that make intepretation difficult. Each child diagnosed as having a conduct disorder should be very thoroughly evaluated for other, more treatable, conditions as psychosis, affective disorders, epileptic disorders or ADD. There is evidence that their proper treatment may lead to amelioration of the conduct symptoms

regardless of the apparent sufficiency of the sociological or psychological explanations for the conduct disorder behaviour. Also, there is new evidence that lithium carbonate may be an effective and relatively safe treatment for undersocialized aggressive conduct disorder perse.

It should be explained as clearly as possible to everyone involved in a given case (parents, patients, judges, attorneys, probation officers and school authorities) that any component of the recommended treatment whether psychosocial or pharmacological, will be undertaken only as a part of general, comprehensive treatment plan and should not be considered adequate treatment alone.

PROGNOSIS

The seriousness of the public health problem is further underscored by the poor outcome of children with conduct disorders. Approximately one-third go on to have antisocial behaviour as adults. In addition to those who have persistent sociopathic behaviour, another third to half have other personality disorder diagnoses, psychiatric diagnoses, or poor social outcome. Traditional psychological treatments have not been proved effective in improving the outcome in conduct disordered delinquent children (O'Donnell, 1985).

Adult antisocial behaviour or criminality rarely arise denovo, and the ranks of adult offenders are filled by those who were conduct disordered.

A quarter to a half of children who have conduct disorder persist in being antisocial 42 % of patients who had been treated for conduct disorder, or mixed emotional and conduct disorder, still had a conduct at follow-up, 53% were well, and 7 % had other disorders. (Kelso and Stewart,1986).

The long term prognosis of socialized conduct disorder is relatively favourable in comparison with undersocialized conduct disorder (Kaplan and Sadock, 1987).

The better prognosis of the socialized group may be due to either the ability to change or the ability to make an adequate social adjustment in adulthood as they have unimpaired cognitive skills, good social skills, learning ability, and affiliative needs. Undersocialized group does not adjust well in institutional settings and their behaviour is resistance to change. (Henn et al, 1980).

Predictors of the persistent of antisocial behaviour:

1- Robins and Ratchiffe(1979) found in a study of young black men that each of six kinds of 'antisocial behaviour, before the age of 15 (drug use, sexual intercoarse, getting arrested, going with a bad crowd, drinking and truancy) heightened the risk of antisocial behaviour in adult life, while the variety of early deviant behaviours raised the risk of ten types of antisocial behaviour in childhood. Factors which predicted that any youth in this sample would be highly antisocial as an adult were, in order of importance, the variety of antisocial behaviour in childhood, drug use before 15, being placed out of the home, and growing up in extreme poverty.

Loeber (1982) concluded that the main predictors of outcome for antisocial or delinquent children are the frequency, severity and variety of the antisocial behaviour in

childhood, the occurance of such behaviour both at home and at school, and the age of onset. The more antisocial the child and the earlier the onset, the greater the persistence of the problem.

Farrington (1978) has reported research on a sample of boys in inner-city London who were first contacted at age 8 and who were followed until they were about 22. A multitude were collected, including measures of aggressiveness at ages 8, 10, 12 and 14 based on information obtained from their teachers. At ages 16 and 18 was determined on the basis of the boys' responses to questionnaire. A group of 27 violent delinquents was identified using conviction records up to age 21. Ninety-eight others who had been convicted of other types of crime were calssified as non-violent delinquents. Nearly half the violent delinquents had been rated aggressive at age 12-14.

It is also of interest that a measure of 'daring' at 8-10 were related to violent delinquency, 13-12 percent of the 'daring' boys become violent delinquents while only 3.9 percent of those rated as not daring did so.

2- A sample was taken from subjects who were referred to the child psychiatry clinic at the University of Iowa. The

criteria for admission to the group of 183 boys and girls were being aged 5-16, having an IQ above 55 and freedom from continuing neurological disorder, autism or psychosis. Ten (8%) of these potential subjects could not be found, and the parents of 28 (22%) refused to take part. The actual follow-up sample comprised 91 boys. Onlyfifty-three boys with aggressive conduct disorder were followed up 2 years after their original examination. Twenty-four (45%) no longer had the disorder and were classified as improved. A discriminant function analysis identified characteristics of the boys and their families which accurately predicted the outcome of 85 % of the boys. Among the predictors of persisting conduct disorder were:

A variety of antisocial or aggressive symptoms, quarrelsomeness, fire - setting, the frequency of accidental injury before the age of six and the number of times the mother had been married. The first three had a negative influence on the boys' state while the last had a positive effect. (Kelso and Stewart, 1986).

a- The mothers of boys who no longer had aggressive conduct disorder had been married more often than mothers of boys whose disorders persisted. Keeping in mind the strong history of antisocial behaviour and alcoholism among fathers of these boys.(Stewart et al, 1981).

Boys who were improved at follow-up more often had stepfathers which tend not to be antisocial or alcoholic.

b- Firesetting emerged as a relatively powerful predictor of outcome as this behaviour marks a more serious form of aggressive conduct disorder, and hence a worse prognosis. Also the family histories of these boys, taken from their medical records , usually showed a high rates of antisocial behaviour in the parents(Stewart and Culver, 1982).

c- Accident proneness predicts the persistence of behaviour problems. As this item and firesetting reffect a degree of bravado and impulsiveness (Bijur et al, 1983).

A high rate of accidental injury is related to aggressiveness in boys, psychiatric disorder in the parents especially depression in mothers, and to other factors which affect mother's ability to care for their children such as personal immaturity and poor housing. (Taylor et al, 1983).

3- Criminality or antisocial behaviour of the family members as well as the parenting technique applied when the child was young also predicted delinquent behaviour (O'Donnell, 1985).

It was found that histories of natural fathers of being arrested, treated for alcoholism and violence, and other similar events are strong predictors for the persistence of conduct disorder i.e. deviance in the boy's relatives heightened the risk of persistence of conduct disorder (Kelso and Stewart, 1986).

4- In a study spanning 22 years carried by Huesmann et al (1984), data were collected on the aggressiveness for 600 subjects, their parents, and their children. Subjects who were the more aggressive 8-year-olds at the end of the study were discovered to be the more aggressive 30-year-olds, at the end of the study.
The stability of aggressive behaviour was shown to be very similar to the stability of intellectual competence, especially for males.
Early aggressiveness was predictive of later serious antisocial behaviour including criminal behaviour, spouse abuse traffic violations, and selfreported physical aggression. Furthermore,, the stability of aggression across generations within a family when measured at comparable ages was even higher than the within individual stability across ages.

It is concluded that, whatever its causes, aggression can be viewed as a persistent trait that may be influenced

by situational variables but possesses substantial cross-situational consistancy.

The stability of aggression over 22 years was found to be about.50 for boys and .35 for girls .

Also it was showed that aggressiveness in childhood predicts heavy drinking among adolescent boys and alcoholism in middle age men. In addition, it presents a risk of delinquency (Pulkkinen, 1983) and criminality or antisocial personality. The well-proven stability of aggressiveness further implies that it can show itself in different forms.

Jenkin et al (1984) reported that 45 % of children having temper tantrums at 2 years (20% of the study sample) were found to be still having it at age 3, while of the 17 % of the sample having tantrums at age 3 still have frequent tantrums at age 4.5.

Early aggressiveness displayed in school has a reasonable chance of turning into severe antisocial aggressiveness in a young adult. It was showed that primary school measures of aggression were significantly related to later delinquency and criminal behaviour for males but not for females (Roff and Wirt, 1984).

Fisher et al (1984) have reported on the stability of parent ratings of externalizing behaviour assessed at ages 2 to 6 and at ages 9 to 15. The stability values obtained in this study were lower than many of those reported for aggressives. This may be due, at least inpart, to the fact that the externalizing dimension at follow-up encompasses more than just aggressive behaviour (or even conduct disorder) and includes scales related to attention problems as well.

Overall, it is clear that aggressive behaviour persists from the preschool to the school years and later and that early aggressive behaviour presages later conduct disorder, probably of the undersocialized type.

5- Mitchell and Rosa (1981) studied large random samples (3258 boys and 3046 girls) between 5 and 15 years old who had been rated by their teachers as to behaviour and health. They selected the 10 percent of boys who were most deviant and compared them to a nondeviant group matched boy-for-boy for ages and school. Data on criminality were collected from official records and offenses were classified as theft, damage to property and inter-persoral violence. Of the 321 matched pairs, 19.6% of the deviant group had been convicted of one offense as compared to 9 % of the controls. Theft was twice as frequent (15.6%) as was damage

to property (5.0%). Interpersonal violence was low in both groups and most significantly different.

This study suggested that while general behavioural deviance is related to delinquency, those behaviours most predictive (truancy from home, stealing, and lying) are those related to scoalized aggressive conduct disorder. A recent study, has compared the adult outcomes of the two different forms of conduct disorder. The investigators used the case files in a state institution for delinquent boys to classify subjects as undersocialized conduct disorder - aggressive (n = 51), socialized conduct disorder (n = 107), and undersocialized conduct disorder- unaggressive (n = 49). The defining criteria for the last group were a mixture of both internalizing (e.g. fearfulness and timidity) and externalizing (e.g. chronic disobedience,stealing at home) behaviours. The adult criminal records of the subjects were obtained from official sources including arrests, convictions, prison terms, and types of crimes.

Analyses of the training school's records found that the socialized group had done better while increased than the undersocialized groups combined, they had spent less time in the institution, had been discharged at younger age, and had fewer returns to the school.

The data on adult criminal activity revealed that the likelihood of conviction on an adult charge was significantly greater for the two undersocialized than for the socialized group. The behaviour of a socialized aggressive conduct persages later to official delinquency as it involves misappropriation of other people's property, school truancy and curfew violation. While unsocialized aggressive behaviour persists into late childhood and adolescence, it does not seem to foretell legally defined delinquency. (Henn et al, 1980).

6- August et al (1983) followed a group of boys who had aggressive conduct disorder and were hyperactive comparing them to boys were purely hyperactive.

Both groups had been recruited from a psychiatric clinic. They found that hyperactivity was a predictor for the persistance of conduct disorder. As eleven of 30 boys (37 %) who had diagnosed as having aggressive conduct disorder still had conduct problems after four years, eight had the aggressive type and three a non aggressive type. None of the purely hyperactive had developed conduct disorder.

Also children identified by teachers and parents as having both the problems of hyperactivity and conduct disorders were more prone to later behaviour disturbance than

were those with only one of the problems (Taylor et al, 1986 II).

7- Large family size and low social class boys have the highest rate of delinquency.

Roff and Wirt (1984) studied samples of over 1000 boys and girls in third-through sixth-grade students who were first classified as low, middle, and high peer status on the basis of socioeconomic ratings. Teacher interviews were then conducted about the most and least popular boy and girl in each classroom and a middle status peer of the opposite sex for the most popular child.

Delinquency and adult criminality (boys only) defined by official records were the outcomes of interest. For the low-status children, the teacher interviews were analyzed to identify problems apparently associated with peer rejection. Additionally, data on socioeconomic state and a rating of family disturbance were obtained. For all boys with teacher interviews, the delinquency rate was 26.3 percent, with low-status boys in the lowest social class having the highest rate (46.3 %), the reliability for peer status and social class as predictors was significant but quite low. For girls the overall rate was 8.2 percent with a similar pattern.

Of particular interest was the finding that within the low-status group, boy's aggressive behaviour was significantly correlated with delinquency as was the predelinquent scale. For girls, aggression was significantly related to aggression and more so to delinquency.

JUVENILE DELINQUENCY

Delinquency is a legal entity, the delinquent is a person under the age of majority who has been found guilty in court of a breach of the law.
Experts in the social phenomenon of delinquency are sociologists and criminologists, not mental health workers. Yet individual delinquents may suffer from a clinical disorder.
Child psychiatrists and other mental health workers have a useful role to play in identifying and contributing to the management of those delinquents whose antisocial behaviour is related to clinical syndrome. Child problem behaviour is predictive not only of juvenvile delinquency but of adult crimes as well.

Definition of delinquency:

The term juvenile delinquency refers to young persons, generally under 16-18 years of age, who engage in behaviour that is punishable by law. (Mussen et al, 1979).

Juvenile delinquency is a legal concept rather than psychopathological disorder. It is a heterogeneous category, covering acts as diverse as thefts, vandalism, violence against persons, durg abuse, and various kinds of heterosexual and homosexual idecency (Farrington, 1986).

Classification of delinquency:

The basic purpose of classification is an applied one, that of enhancing prediction of outcome and choice of management and remedial strategies.

One such classification system is called 1- level (Interpersonal Maturity Level). According to the theory underlying this system the ways in which individuals perceive the world and themselves change as personality develops and as interactions between them and their environment result in successively new integrations of experience into social perceptual frames of reference.

Seven levels of interpersonal development are distinguished along a continum from birth to full maturity:

I_1 : Seperation of self from environment.

I_2 : Persons and events are viewed as sources of either frustration or short term pleasure. Frustration tolerance is low. Capacity of understanding other's behaviour is poor.

I_3 : These individuals interact with others mainly in terms of oversimplified, extrenally determined value systems and assume that others do the same. They try to manipulate the environment to provide 'giving' rather than 'denying' responses. They perceive the world and their

part in it largerly in terms of power. Although they have learned to assume stereotyped roles, they cannot understand the needs, feelings, or motives of others, and they are unmotivated to plan for the future.

I_4 : Those whose understanding and behaviour are integrated at this level have internalized a set of standards they use to judge their own and other's behaviour. They have some ability to understand the reasons for behaviour and relate to others on an emotional and long-term basis. They are strongly influenced by those they admire and because of the rigidity of their standards, they are prone to feeling self-critical and guilty. Their identifications are with over simplified models based on black-and-white definitions of good and bad with little tolerance of gray.

I_5 : These individuals understand that people are complex and not simply either good or bad. Empathy with different kinds of people become possible. Standards for the self and others are less rigid and there is not one right, easy answer for each problem. Less than 1 percent of delinquent population falls into this category and it was found that only 2 percent of a nondelinquent population had achieved integration at the I_5 level.

I_6 : They see self and others in more complex ways in viewing behaviour in terms of both general principles and the specific histories of the people involving and distinguishing between a stable self and the role engaged in.

I_7 : A hypothetical ideal level. (Pauker and Hood, 1979).

It was found that most delinquents tend to fall into levels 2,3 and 4, within which nine empirically derived subtypes of delinquency have been established, based on the individuals's typical ways of conducting relations with others.

I_2 : Asocial, Aggressive (Aa): responds with active demands and open hostility when frustrated.

Asocial, Passive (A_p): responds with whining, complaining, and with-drawal when frustrated.

I_3 : Passive Conformist (CFm): responds with immediate compliance to whoever seems to have the power at the moment.
Cultural Conformist (CFc): responds with conformity to specific reference groups (delinquent peers).
Manipulatory (Mp): Operates by attempting to undermine the power of authority figures and / or usurp the power role for themselves.

I_4 : Neurotic, Acting-out (Na): responds to underlying guilt with attempts to outrun or avoid conscious anxiety and condemnation of self.

Neurotic, Anxious (Nx): responds with symptoms of emotional disturbance to conflict produced by feelings of inadequacy and guilt.

Situational Emotional Reaction (Se): responds to immediate family or personal crisis by acting-out.

Cultural Identifier (Ci): responds to identification with a deviant value system byliving out his or her delinquent beliefs.

DSM-III and I-level differ in several important aspects. DSM-III is derived from a clinical population (children coming to psychiatric attention) and attempts to avoid theoretical bias and maintain descriptive purity. I levels, on the other hand, draw their form from careful examination of a large number of delinquent youth but are shaped by a theoretical preference that takes history and development factors into account. Specific subtypes are based on statistical manipulation of observed and inferred characteristics and have been subjected to much scrutiny for validity and reliability. (Chamberlain and Steinhauer, 1983).

Sociocultural correlates to juvenile delinquency:

Children from low income families tend to have many siblings, which may make peer influence more important relative to parental influence, tend to receive poor nutrition and medical care from conception inwards, and tend to be exposed to lax and erratic child management practices and to parental conflict, violence and drug abuse.

1- Social class:

Social class or socioeconomic status , has been an important variable because of the belief of sociologists that humen behaviour could be explained by reference to societal variables.

The social class of the family has been measured primarily according to rankings by sociologists of the occupational perstige of the family bread winner. Persons with professional or managerial jobs were raked in the highest class, while those with unskilled manual jobs were ranked in the lowest.

Over the years, many other measures of social class have become popular, including family income, educational levels of parents, type of housing, overcrowding in the house, possessions, dependence on welfare benefits, and general life style.

More seriously, the social class of a child is sometimes defined not according to the circumstances of his or her parents but according to the characteristics of the area of residence or school (Roff and Wirt, 1984, Mueller and Parcel, 1981).

The relation with juvenile delinquency is a matter of some dispute. The majority of American researchers who have carried out major community surveys have found very little relationship between social class (usually measured by parental occupation) and juvenile delinquency (whether measured by official records or by self-reports). It was common to argue that low social class was related to official delinquency but not to self-reported delinquency, and hence that the official processing of offenders was biased against lower-class youth i.e. based on ecological (area) correlations (Farrington, 1986).

The major argument against this conclusion drives from the important longitudinal survey of a national sample of over 1700 adolescents directed by Elliot. Elliot and Huizinga(1983) found that there was a considerable relation between social class and self-reported delinquency prevalence rate (meaning the number of persons comitting acts), there was a considerabale relation between low social

class and incidence rate (meaning the number of acts committed) i.e. low social class youth differed not in their likelihood of committing any offense but in the numbers of offenses they committed. British surveys usually found a relation between social class and delinquency.Ouston (1984) in his tudy on London boys and girls,found a relationship between social class and official delinquency. It was found that official delinquency varied inversily with occupational perstige and with parental occupation.
In addition, official delinquency was found to be related to low family income, unsatisfactory housing, neglected accommodation, support by social agencies, physical neglect by parents, and erratie parental work record but not occupational perstige.

There is some evidence of lower - class bias in police processing of offenders. Farrington and Bennett (1981) showed that children of manual workers who were arrested were more likely to be prosecuted in court than other arrested children. Several American researchers have found no evidence of class biases in official processing. Class bias do not invariably tend to magnify the number of lower-class children in official records as children of higher - class parents are more likely to attend child guidance clinics because their mothers warried more about their problems.

Wing (1980) showed that autistic children in the community tended to be representative of all social classes, but that those with higher-class parents were more likely to be seen in clinics.

It was found that five factors were independently predictive of official delinguency, low family income , large family size, poor parental child-rearing behaviour ,convicted parents, and low intelligence.

Low family income did not predict delinquency indepdently of low intelligence, whereas low intelligence did predict independently of low family income. Therefore,, it is possible that poverty was related to delinquency partly because of the tendency of poorer parents to have less intelligent children, i.e. intelligence thought to be an important mediator between social- class and behaviour - problem children because lower-class mothers used simpler langauge and were less verbal in interacting with their preschool children. Lastly, it appears that the characteristic of the parents, of the family and of the home living conditions matter much more than parental occupation (Wolkind and Rutter 1985).

2- Social change, Deprivation and delinquency:

Recent increase in delinquency appear to be related at least in part to changes in the structure of society,

increased mobility with a consequent disruption of well-established cultural patterns and family ties, the increased population growth and the lack of clear sense of national purpose and concern with social problems.

In the centers of large cities which are characterized by economic privation, rapid population turnover, and general disorganization, delinquency is often an approved tradition, and there are many opportunities for learning antisocial behaviour from delinquent peers.

Moreover, delinquency occurs about twice as frequently among the children of immigrants as among those of native born parents.

3- Personality and delinquency:

Delinquents have been found to be socially asserative, defiant, ambivalent to authority, lacking in achievement motivation, resentful, hostile, suspicious, and destructive, impulsive, and lacking in self-control (Davids, and Falkof 1975).

Many of these traits appear defensive in nature, reflecting impaired selfconcept, and feelings of delinquency, emotional rejection, and frustration of needs for self- expression (Gold and Mann 1972).

Social behaviour and personality characteristics of delinquents are likely to be manifested early in their development. Adolescent delinquents are viewed by their teachers as poorly adapted, less considerate, and fair in dealing with others, less friendly, less responsible, more impulsive and more antagonistic to authority. In their school work, they are much more easily distracted and daydreamed. These social and acadamic problems appear to reflect underlying emotional problems and disturbed home environment. (Mussen et al, 1979).

4- Parent - Child relationships of delinquents:

Studies of parents of delinquents show a high fre - quency of deviant or criminal behaviour and less mature moral judgements in families of delinquents.
The difference between parents of delinquents and nondelinquents are not confined to ethical judgements but extends to antisocial behaviour. Parent-child relationships of delinquents are characterized by mutual hostility, lack of family cohensiveness, and parental rejection, indifference dissension or apathy.

Olweus (1980), using a statistical method that clarifies the causal relationships among multiple covarying factors,

showed that four variables were most important in determining adolescent delinquent behaviour:

1. Mother's permissiveness for aggression.
2- Mother's negativism toward the child.
3- Temperament: the child's constitutional, inherent predisposition to being irritable is correlated with delinquency.
4. Violent parental outbursts, physical punishment and threats i.e. the use of power-asserative methods.

An extensive study of 862 Swedish adopted men and 913 adopted women was reported in an article by Sigvardsson et al (1982). They were able to show that biological parents with either alcohol abuse or with criminality alone tend to produce children with the same problem. Also , parents and offspring with criminal behaviour alone strongly tended to commit only petty, nonviolent crimes whereas most of the violent and repetitive criminals were alcohol abusers. In addition, the number of crimes committed correlated positively with the severity of the alcoholism.

For petty criminals, social status and environment did not contribute to the development of criminal behaviour unless there was a genetic predisposition. There were also gender differences, while the genetic antecedents were similar,the

predisposition had to be more severe for a female to become criminal.

The investigators in this study strongly emphasize that although congenital predisposition was the largest identified contributor to variability, most (16%) of the variability was not explained. In other words, although it seems to be clear that criminality is genetically influenced, the factors influencing the development of criminal behaviour are heterogeneous and their interactions are very complicated.

5- Ethinc group:

It is clear that blacks in the United States are far more likely to become official delinquents than whites but consistently high ratios (3:1) reflect discrimination in official processing rather than differences in delinquent behaviour as black-white ratios for official delinquency are much greater than corresponding ratios for self-reported delinquency.

The discrepancy between official and slef-reported measures also explained as that black - white ratio was greater for the most serious offenses, and that this ratio was diluted

in most self-report questionnaires by the over representation of trivial offenses. It was also found that black males were especially likely to under report this offending, and therefore concluded that the questionnaries were differentially valid by race (Farrington, 1986).

In London, Landau (1981) discovered that black youths were more likely to be taken to court than whites. Black-white differences may not hold independently of other predisposing factors e.g. blacks belong to different subcultures with different sets of values from the dominant white culture.

Rutter et al (1975) outlined some of the deprivations suffered by the black families, especially in regard to lower-status jobs and poorer-quality housing. Ouston (1984) was able to show that her black-white differences in official delinquency did not hold independently of differences in social class or teacher's ratings of attainment. Batta et al (1975) explained the low delinquency rate of Asians in their studies by reference to the close Knit, highly controlling Asian subculture.

It is not clear, however, that ethnic differences in delinquency do hold independently of differences in other individual, family and social factors.

6- The Peer group

It was found that most adolescents commit their delinquent acts in small groups (of two or three people) rather than alone.

Hindelang (1976) found that offenders in groups were more likely to be picked up by the police than those acting alone, even after controlling for the frequency and seriousness of offending.

Using the self-report method, Hindelang (1971) in the United States found that only 2 out of 18 acts (drinking alcohol and using marijuana) were more often committed with others than alone.

Interestingly, group offenders did not usually commit acts more often than individual offenders.

Hindeylang (1976) concluded that fighting and carrying a weapon (more characteristics of undersocialized conduct disorder) were often committed alone, while taking cars, destroying property, getting drunk, using pot or pills, and burglary (more characterstic of scialized conduct disorder) were often committed with others.

In a British self-report survey based on a small sample of 54 boys aged 11 to 14, Shapland (1978) reported that 60 percent of acts were committed with peers, 10 percent with adults, and 30 percent alone.While group offending is very common,delinquent gangs,with

a recognizable identity, a leadership structure and some kind of uniform are not. But later studies disagree about the extent to which gang memership is an important factor in the totality of delinquency. It was reported that about 1/3 of all juveniles arrested for violence were gang members, and that gang members accounted for about 1/4 of all juvenile homicides. O'Hagan (1976), in a small survey of 60 institutionalized Scottish delinquents, found that 80 percent claimed to be members of juvenile gangs that engaged in theft, vandalism or violence. Morash (1983) studied over 500 youths in Boston and found that there was a negligible assiciation between being a member of a stereotypical gang and committing delinquent acts.

There is a possibility that the commission of delinquent acts encourages an association with other delinquents, perhaps because "birds of a feather flock together " or because of the stigmatizing and isolating effects of court appearences and institutionalization

Studies in the United States (Roff and Wirt, 1984) showed that delinquents are usually unpopular with their peers.

The importance of peer influence has been identified in other kinds of problem behaviour e.g. marijuana use, and

sexual experience were significantly related to the extent to which their friends approved of and provided models for these acts.

If delinquent peers facilitate delinquency, it should be possible to reduce delinquency by redcing delinquency of peers. So the peer group can have an important role in producing, maintaining , and reducing delinquency.

7- The neighbourhood:

It was concluded that variations in delinquency reflected variations in the social values and norms to which children were exposed, which tend to be consistent overtime in any given area.

Burisk and Webb (1982) tested this hypothesis using recent data in Chicago and more sophisticated quantitative methods. They concluded that the distribution of delinquency was not stable but reflected demographic changes. Variations in delinquency rates in different areas were significantly correlated with variations in the percentage of non-white, the percentage of foreign born whites, and the percentage of over crowded households.

Similar ecological studies have been carried out by Power, et al (1972). They found that official delinquency

rates varied with rates of overcrowding and fertility and with the social class and type of housing of an area, local authority renting, percentage of land used industrially or commercially, population density and with the proportion of the population under age 21.

Comparisons of larger areas have usually revealed high delinquency rates in inner-city areas and low rates in rural areas. In general, delinquency rates have varied more reliability with the social class of areas than with the social class of individuals. It was reported in a national American survey, that drug use was highest in the largest metropolitan areas and lowest in the non metropolitan areas.

A number of methodological problems with the researches should be noted. First of all, it might be argued that disordered behaviour is more likely to be recorded in cities, perhaps because there is more police activity or better psychiatric services. The fact that the urban-rural differences hold up in self - reported delinquency studies suggests that this cannot be complete explanation.

A second problem is the difficulty of defininining a community. In most projects, areas are defined according to census or

electoral districts, which may not reflect real community bounderies. Hence, real differences between neighbourhoods may be blurred.

A third problem is that delinquency rates are almost always calculated according to the areas of residence of offenders, which may be different from the areas in which offenses are committed.

Finally, the fact that delinquency is greater in certain areas does not necessarily mean that the areas have some causal influence. It could be that deprived people tend to congregate in deprived inner-city areas, perhaps because it is only in these areas that they can afford to pay the rents. It may be that the problem people cause the problem areas rather than the reverse (Farrington, 1986).

In favor of the proposition that inner-city living causes delinquency, Osborn (1980) found that moving out of London was associated with a significant decrease in offending. Also, Rutter (1981a) showd that the differences between Inner London and the Isle of Wight held even when the analyses were restricted to children reared in the same area by parents reared in the same area.

This result demonstrates that the movement of problem families into problem areas cannot be the whole explanation of area

differences in disorder. Differences in family and school factors may be part of the explanation.

It may be that some aspects of the neighbourhood is conductive to delinquency perhaps because the inner city leads to a breakdown of community ties or neighbourhood pattern of mutual support,or perhaps because the high population density produces tension, frustration, or anonymity.

Sociocultural theories of delinquency:

Most sociocultural theories of delinquency were designed to explain the presumed high delinquency rates of lower-class young males living in inner-city areas.

One of the postwar socioculatural theories to attract wide attention was the differential association theory of Sutherland, which was essentially a social learning theory proposing that delinquent attitudes, motives, rationalizations and techniques of committing crimes are learned during interaction with others in intimate personal groups. Hence, children from criminal families and from criminal areas and those with delinquent peers will be most likely to commit delinquent acts.

The social learning theories were opposed by strain theories in the late 1950s and 1960S . These suggested that lower-class youths commit delinquent acts because of the discrepancy between their aspirations and thier ability to achieve goals of status or marital success.

The social learning and strain theories were largerly supplanted by control and labeling theories in the 1970S. Labeling theory is concerned with social reaction to delinquency rather than with the socicultural factors. Control theory is based on the assumption that people do not commit delinquent acts if they have a strong bond to society.

The trend in the 1980S is toward more complex integrative theories. Elliot et al (1985) attempted to combine strain, control, and social learning theories. One of their key ideas is that delinquency results from differeential bonding to conventional and delinquent groups.
There are three alternative paths to delinquency:

1- Strain theory path occurs when conventional bonding (produced by effective early childhood socialization) is attenuated by poor school performance and limited opportunities for achieving goals. Delinquency acts as alternative method of achieving material success.

2- The control theory path occurs when childhood socialization is ineffective, producing weak internal and external controls over delinquency.

3- Social learning path occurs when delinquency is reinforced by an individual's interpersonal network. The reinforcer for delinquent behaviour is the peer group.

It follows that delinquency is most serious when strain, weak conventional bonding, and strong bonding to a delinquent peer group occur together. This theory guided the design of Elliot's national longitudinal survey.

Another integrative theory of delinquency was proposed by Farrington (1986). He suggested that delinquent acts are the end product of four-stage process:

* In the 1st stage: Motivation arises and the main desires which produce delinquent acts are for material goods, status among intimates, and excitement. These desires are greater among children from poorer families.

* In the 2nd stage: a legal or illegal method of satisfying the desire is chosen . Children from poorer families are less able to satisfy their desires by legal methods, and so they tend to choose illegal methods. The relative inability of poorer children to achieve goals by

legitimate methods is partly because they tend to fail in school and hence tend to have erratic, low-status employment histories.

* In the 3rd stage: a motivation to commit a delinquent act is magnified or opposed by internalized beliefs and attitudes about lawbreaking that have been built up in a learning process as a result of a history of rewards and punishments.

* The 4th stage: is a decision process in a particular situation and is affected by immediate situational factors. Whether the tendency to commit a delinquent act becomes the actuality depends on the costs, benefits, and probabities of the outcomes.

The last theories largerly fit the known facts about delinquency and attempt to explain the role not only of sociocultural factors but of other factors as well.

Treatment of delinquency:

Juvenile delinquency is almost always measured using either official records collected by the police and other criminal justice agencies or self-reports by children (Farrington, 1984). Peer reports of offending have been used, but only rarely, and the same is true of systemic observation (Buckle and Farrington, 1984).

A recent development is the use of victim reports of the characteristics of offenders. The major problem with the dominant method of official records of delinquency is that they reflect not only childhood behaviour but also reactions of official agencies. In other words , factors related to official delinquency may be associated not with offending but with the likelihood of selection for processing by police and the courts.

In both male and female incarcerated delinquents the psychiatric assessment may reveal numerous minor or major neurological signs and indications of severe psychopathology such as visual and auditory hallucinations, parnoid ideations, and illogical thinking process (Chess and Hassibi, 1986).

Psychotherapy may be useful when the child has internalized or poor selfimage and his delinquent behaviour can be best provided in a structured setting in which the delinquent is protected from further risk of involvement in antisocial activities while every attempt is made to help him with his defeciencies.

When the adolescent's delinquency is traceable to intrapsychic and neurotic conflicts, individual psychotherapy and parental supervision will help him to control his acting his out behaviour.

Treatment of delinquent adolescents who are psychiatrically ill represents a particularly difficult problem. These youngsters are likely to show the same rate and degree of psychological and neurological impairments as their non-delinauent peers. However, external factors as well as higher aggressivity of the delinquent group make their treatment in psychiatric settings difficult, and in most correctional facilities, mental health needs of the inmates are neglected (Shanok et al, 1983).

Social programmes aimed at removing poverty, creating jobs, cleaning slums, etc., are commendable goals and may in the long run be effective in combating juvenile deliinquency. However, the psychiatrist's expertise can be best used in studying the individual's difficulties in his relationship with his society and providing suggestions and programmes to help him.

CONCLUSION

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Socialization is the process by which children acquire behaviours, beliefs, standards, and motives that are valued by their family and cultural groups.

Parents are the principle and most influential - but not the only - agents of socialization, especially during the early years when they typically have more intensive and frequent interactions with the child than any one else does.

Aggressive behaviour is common in preschool children, declines during the early school years, rises at adolescence and declines more between the ages of 15 and 21 years.

In all cultures, children must be socialized to exercise some control over their aggressive motives and responses. The forms and amounts of aggression a child exhibits depend primarily on social experiences, including reinforcement received for such behaviour, observation and imitation of aggressive models, and the degree of anxiety or guilt associated with the aggressive expression.

Frustration often produces increased aggression, but children differ widely in their reactions to frustration.

Aggressiveness is fairly stable characteristic, boys who are highly aggressive during the preschool period are also likely to be highly aggressive in later childhood, adolescence, and adulthood.

Highly aggressive children grow up in aggressive milieux. Members of their families stimulate and perpetuate each other's aggressive behaviour, and mothers and fathers are inconsistent in their handling of aggressive responses, sometimes reinforcing them and sometimes punishing severely.

The mothers of boys who score high in tests of self-esteem are accepting, supportive, concerned, and affectionate. These mothers establish rules consistently and use rewards rather than punishment in efforts to change their children's behaviour.

In contrast, parents of boys with antisocial behaviour are inconsistent in discipling, give their children little guidance, and generally use harsh punishment.

Observation of parental models and identification with parents are of utmost importance in acquiring prosocial behaviours such as honesty, generosity, kindness, altrusim, consideration of the rights and welfare of others.

Frequent use of power-assertion (control by physical power or material resources) by the mother is associated with low levels of prosocial behaviour, while induction (reasoning, pointing out painful consequences of the child's behaviour of others) is positively correlated with this kind of behaviour.

When children are exposed to prolonged or multiple seperations or to repeated threats of abandonment on the part of angry parents, children develop hatred in case the parent will actually leave.

As a result, abnormal expressions of hostility occur irrational acts of aggression against parents and also delinquency.

Relationships with brothers and sisters may also be significant regulators of children's social behaviour.

So unsocialized, aggressive behaviour in children can be considered environmentally caused but with predisposing constitutional factors. Unsocialized aggression occurs in muscular boys as a reaction to experience of frustration within the home. Less muscular boys from similar backgrounds may wander instead.

Children living in fatherless homes , and are reared primarily by their mothers are usually suffering from conduct disorder. Adverse effects of divorce on the young boy's social behaviour may be considerably reduced if the fathers are well adjusted and maintain contact with their sons.

A number of people outside the family - most prominently peers, teachers, and characters portrayed on television - participate in significant ways in the process of socializing the child.

Children's contact with their peers and peer influences expand greatly during school years, and children actively search for their places in the social world during this period.

The school may provide an efficient programme for augmenting the aggressive and the antisocial behaviour of some children because peers frequently reward children's antisocial behaviour and serve as models of this behaviour that are closely observed and readily imitated. Observations of peers' behaviour may also have socially desirable outcomes.

Teachers can serve as therapists by modifying their pupil's responses through behaviour modification techniques,

such as manipulating rewards and punishments to reduce the aggressive and the antisocial behaviour and to increase cooperation.

The size of the school attended may also affect the student's social behaviour. Students in small schools participate in more activities than those in large schools, and they are likely to report that their involvement helped them to develop social skills, increased their self-confidence, and gave them a feelings of accomplishment.

Because children spend more time watching television, thus television can affect their behaviour in important ways. These effects can be positive, enhancing prosocial activity, or negative, promoting antisocial behaviour.

Children and adolescents tend to react to violent programmes with higher levels of aggressive behaviour, both physical and verbal, and with increased aggressive attitudes. Exposure to programmes that feature cooperation, sympathy, sharing, and understanding other's feelings produce some lasting positive changes in children's behaviour i.e. the impacts of television may be profound and lasting.

There is a strong association between educational retardation and aggressive behaviour especially in boys.

In case of brain - damaged children without gross intellectual or physical handicap, when there are family and social stresses and educational handicaps of a kind known to predispose to conduct disorders, they are particularly prone to develop aggressive and later also delinquent behaviour.

When intellectual retardation and conspicuous physical handicap accampany neurological disease, the risk of all types of psychiatric disorders is greatly increased.

Most descriptions of the behaviour of autistic and other psychotic children include aggression and temper tantrums, especially when the child's obsessional behaviour patterns are frustrated.

Lower social class children are often of low I.Q. and more prone to serious reading retardation, so conduct disorder is more common among low social class children. Also, teachers, negative evaluation of the ability and behaviour of lower class children- especially boys- is likely to reinforce their learing difficulties and their aggressive and other antisocial behaviour.

Lower class parents probably are different to their children: more punitive and more restrictive with rules

than middle class parents. They also differ in their fostering of cognitive, especially language, development in their children, particularly when the sibship is large. Because duller, less verbal and more aggressive in response to more aggressive role models, lower class children evoke more negative and hostile responses at school and these tend to reinforce their antisocial behaviour.

Fire - setting is less common but a serious symptom. Many children go through a phase of playing with matches and lighting fires but this responds to parental training and precept. Children who instead progress to starting fires at home, or at school or elsewhere, are often expressing severe, deepseated feelings of aggression arising from a disturbed relationship with their parents and they usually have bad prognosis.

For the child who presents a history of repeated accidents or of accident- prone behaviour, a careful evaluation of family and especially parental interactions should be made. The child's impulsivity and self-harm may be related to problems of marital discord. The preoccupations of parents with their own needs and interests can markedly reduce their investment in activities as parents. Unresolved parental anger, resentment, or ambivalence toward the child can also result in neglect of normal considerations of safety.

Stealing can sometimes be an expression of anger or of revenge for real or imagined frustration by parents. It is also evident that the child's internalization of control has not reached a level where temptation can be resisted. Stealing is sometimes learned from parents. Another formulation that leads children to steal is their sense of the lack or loss of something, perhaps on an emotional level, such as a feeling of not being cared for. In many instances of children's stealing there is a strong element of the child's wanting to be caught, almost as if the theft was arranged so that a confrantation with the parents could serve the child's need for an 'emotional reward'. Children may find, in effect, that this is one way in which they can compel parents to show an intense feeling toward them , and this gives them a power over their parents that they cannot resist using. Almost all children steal something at some time during their childhood. It is important to respond to the event appropriately. It is also important that the act not be over emphasized, lest the behaviour or the response to it becomes so exciting that it is reproduced in future periods of discord.

Truancy is another presentation of conduct disorder. It has been found to be associated with sex, age, home environment, the shcool the child is supposed to attend, poor

educational achievement and psychiatric disturbance. Teenagers are particularly affected and there is a predominance of boys. Truancy affects less affluent homes and families where there are numerous adverse social factors, including large family size. There is a definite association between delinquency and truancy even in girls. Truants are lazy, aggressive, rebellious, uncaring, defiance,destructiveness, uncooperativeness and other evidence of poor relationships.

Lying is another conduct problem. It is important first to determine whether a lying child is developmentally capable of understanding what he or she has said or whether the parents may be misinterpreting statements that sound untruthful to them but not be so intended by the child, as lying is a form of fantasy for the child that is, most lying is an effort to cover up something that the child does not want to accept in his or her behaviour. Finally, lying - like stealing - can be the result of parental modeling and it becomes abnormal only when severe and persistent.

Aggressive behaviour is a common cause of referral to child psychiatric and child guidance clinics. It often occurs in company with other conduct disorder symptoms. It is also sometimes a part of a pattern of hyperactive behaviour with poor impulse control, or an association with organic brain damage.

If disapproved sexual behaviour and masturbation are present in excess, or if they are manifested in a socially unacceptable way, then they are considered as symptoms of conduct disorder. Sexual intercourse at an early age is another manifestation of failure to accept the pattern of behaviour laid down by the adult world.

All children with conduct disorder of whatever kind usually share certain characteristics. They are predominantly boys, they tend to come from lower socioeconomic backgrounds, they frequently have educational difficulties and their future outlook is less good than that of children without antisocial behaviour.

The conduct - disordered child is usually a 1 - to 8-year - old child who is referred by the school or other agencies with the presenting complaints of aggressive behaviour toward peers, defiance of teachers and other authorities, little regard for the rights of others, lack of concern for rules and regulations even when they are for his own safety. He lies even when lying does not seem to serve any purpose. He has stolen money from other children and merchandise from stores, at times objects for which he does not have any use. He may have engaged in sexual activities and may have spent most of his time on the street on the periphery of groups of older delinquent children. Although he has average

intellingence, he is unintreseted in school work and may be behind in reading. He is ill informed despite being 'street-wise'. His family lives in a slum area of the city, his home is over croweded and dirty. His father may be drinking excessively and having continuous conflict with the mother; or he may be a child of a mother just parted from a violent husband the child's mother is neglectful or unavailable. She may have been delinquent herself and may have spent time away from her own home during her own childhood or adolescence. Discipline is more dependent on the parents' mood than on the child's activities. He may be punished for any infraction of the parental commands, although no effort is made to censure his misbehaviour outside. He may be shielded or lied for when neighbours and police are concerned, only to be brutally punished for having caused trouble for the parents. He is punished if he takes money from his parents' pockets, but no body seems to notice that he has brought a new toy home.

Delinquent adolescence is an older child, 13 - 15 years of age. He has been repeatedly involved in delinquent acts and has been arrested several times. He may have appeared in court on one or more occasions, charged with robbery, assault, or possession of stolen goods. He may have used narcotics and alcohol. He may have engaged in a variety of

sexual misbehaviour, such as rape and sodomy. He spends all his time outside home even at night. His attendance in school is irregular and only for the purpose of meeting with his companions. His social relations are limited to association with others like himself. In a psychiatric interview, he may present a facade of cooperation in order to 'con' the psychiatrist into helping him avoid the consequences of his behaviour. He may express regret about what he has done or make promises for the future, however, his plans, when fully described, do not seem to be quite realistic. He has very little tolerance of frustration and becomes irritable when he fails to achieve his purpose.

Delinquent girl is more likely to have been engaged in sexual misbehaviour. Pregnancy, prostitution, use of drugs and alcohol, and shoplifting may be the presenting complaints. She may have run away from home in numerous occasions. Her relationship with her parents is usually unsatisfactory. She may complain of depressed mood and nervousness or various somatic symptoms.

The idea that delinquent behaviour or act usually committed in small groups, is a familiar one. But delinquents are no more likely to belong to gangs or groups than non-delinquents. Therefore, delinquent acts are to be explained purely in terms of the characteristics of

individuals. But it seems that broadly there are four possibilities, that group contexts perse encourage offending, that individuals are swayed by the inclinations of their associates. (i.e delinquency is conformity to the expectations of the group), that a shared fate generates shared inclinations among associates, that the group context encourages the expression of individual behavioural inclinations, and that a group setting increases the probability that individuals will behave in ways which are antisocial, immoral or illegal.

Conduct disorders are complex conditions for which as yet there are no adequate explanations or predictably reliable treatments. Mild conduct problems usually subside with little or no treatment. There is no evidence for the successful treatment of antisocial children with psychotherapy or social case - work techniques, although this does not mean that such methods are not effective for some patients. Behavioural modification programmes are still the most important, effective, and available method of treatment.

Before starting the treatment, data gathering should include information regarding constitutional and organic factors, cognitive and perceptual development, family history and functioning, social, academic achievement, and situtional factors. These data are collected from the parents, grandparents, and teachers.

Copperation among parents, teachers, probation officers, police, social worker, and therapists, is essential especially when working with the undersocialized group.

Parents are also trained to be behaviour therapists for their own children. The parents are trained to follow a programmed text and to use social reinforcements, 'time out' and token systems. Methods of training parents have involved modelling sessions in the clinic, group training, home visits, and the training of new parents by parent experts. This method fails if the parents are suffering from any psychopathology and thus the children of these parents must be seperated from them. Their treatment is carried out in a day- care center or in a boarding school.

Treatment carried out by the teachers in the classroom may be fruitful in the management of conduct-disordered children whose parents can not follow through a consistent plan.

Most of the undersocialized aggressive youngsters are chronic school failures and, therefore detest and avoid traditional classroom learning. They often acquire skilled special educational help to experience any academic success. This portion of the treatment is essential to raise self-esteem and may encourage appropriate socialization in the school.

Treatment of the socialized group depends on any approach that alters the attitudes of the entire group, or that seperates the youngster from the deliquent peer group and offers him contact with strong adult male leaders and less delinquently oriented peers, is quite likely to improve the group's delinquent behaviour.

In case of stealing, it is important that the parents help the child to undo the theft by returning the stolen articles, or by rendering their equivalent either in money that the child earns or in services. When it is apparent that children are not able to control temptation, money and valuable objects should not be left in their paths to increase the chance of stealing.

In the management of truancy especially when it is not very severe or persistent, school itself has an important role to play. This can be carried up by rewarding children for good attendance and thus creating an atmosphere which discourages absence, making the curriculum more relevant and attractive.

Many children and adolescents diagnosed as having conduct disorders also suffer from undiagnosed neurological or psychiatric disorders. Medications sepcific for these conditions such as neuroleptics, lithium carbonate, anti-

convulsants, stimulants and tricyclic antidepressents should be used when there is sufficient evidence for the presence of a responsive condition regardless of the apparent sufficiency of the sociological or psychological explanations for the conduct disorder behaviour. Also, there is new evidence that lithium carbonate may be effective and relatively safe treatment for undersocialized, aggressive conduct disorders per se.

There is evidence that non delinquent conduct disorder during the early and middle school years often lead to delinquency at adolescence, especially when there is also school failure. In boys, delinquency is strongly associated with adult sociopathy, both when it manifests as antisocial conduct and as aggression in childhood. Such individuals often have difficulty in making stable marriages, and thus put the next generation at risk also.

Antisocial children who could return to their own families after psychiatric hospitalization did better than those for whom other managements had to be made.

RECOMMENDATIONS

RECOMMENDATIONS

The parent is the child's first and most important teacher. The parents teach the infant how to trust, rely on, and depend on people and circumstances - the basis for the child's future view of interpersonal relationships.

Parents who display aggressive and temperamental outbursts in response to minor frustrations model a style of behaviour which may find ready imitators. With appropriate training and support, parents will learn to be therapists in behaviour modification with children.

1- Regular sessions with a professional worker who discuss current problems with parents and child. The physician should not directly point out possible errors of management, as the use of non - directive techniques offer the best chance of offending changes in parental attitudes towards children.

2- The parents need education about the child rearing pracities and the normal social and behavioural development of the children. These sessions must also be given to the teachers.

3- The purpose of discipline is to provide children with incentives, reasons, values and the instrumental means to

achieve self-discipline. Discipline is too often seen only in terms of punishment, whereas at its healthiest it is a complex set of attitudes, behaviours, formal and informal instruction, rewards and punishments that serve not to inhibit, restrict, subjugate, or repress children. It is important that parents be secure and explicit in their attitudes and values regarding child rearing, especially as they discipline. Difficulties in control or adaptive socialization in children often stem from contradictions and conflicts between parents over the systems of expectations, rewards, and punishments that will be appropriate to the disciplining of children.

4- Punishment is an aspect of discipline, it includes a variety of techniques for fostering approved and discouraging disapproved behaviour. For the punishment to be effective.

The shorter the delay between an act of transaggression and the punishment for it, the more effective the punishment will be in preventing repetition of the prohibited behaviour.

Punishment of high intensity is likely to interfere with learning. Two principal recommondations emerge - first the intensity of punishment should be high enough so that only a mild to moderate anxiety is generated second, for the preschool child the rules and the discriminations surrounding expected behaviours should be simple.

Punishment is most effective when it takes place in the context of a warm, affectionate and generally accepting relationship between parent and child. Parents should understand that being affectionate and kind toward their children and praising them is not in conflict with the need from time to time to punish them.

Reasoning and physical punishment are more effective together than physical punishment alone in bringing about the incorporation of upproved behaviours in children, moreover, combinations of reasoning with non physical forms of punishment, such as deprivation of privileges, or withdrawal of nurturance, are more effective than any one alone. Reasoning alone is more effective than any punishment alone. As internalization of standards (the acquisition of self-discipline) requires a cognitively oriented training procedure.

5- Parental consistency is an important factor in promoting approved behaviour in children. Erratic disciplinary procedures, including punitiveness and laxity, are highly correlated with increased delinquency. Consistency is relative, no individual can be totally consistent in child rearing. It is important, however, that parents establish a generally consistent style in terms of what, when, how and to what degree punishment is appropriate to each transaggression. Inconsistent discipline builds resistance to changes in respense to later, more consistent behaviour.

The physician must instruct and encourages parents in maintaining reasonable and appropriate disciplinary procedures, even if favourable results are not immediately forthcoming.

As children get older, physical punishment becomes much less effective and its negative effects increase.

Reinforcement of the approved behaviour such as cooperation, helpfulness, and sympathetic, prosocial behaviour. Encouragement by helpful and kind words has been shown to reduce aggressive behaviour.

In displays of affection, of anger and its control, of respect, honesty, and openness of communication, parents model behaviour that children identify with an imitate.

Parents should try to achieve honesty with their children, accepting their children, respecting their rights, giving them consistent management, love,warmth, praise, reward and security. They should encourage their children towards early self-control. They should avoid frustration in children and over gratification of the child's desires.

6- Schools are the most important areas of case detection. There is a tendency for teachers to be permissive about aggressive children in the hope that they will become

socialized, thus delaying urgently needed therapy. Early disovery of the case provides a chance that regular positive reinforcement of acceptable classroom behaviour by the teacher, coupled with consistent nonresponse to aggressive and disruptive conduct, leads to a dramatic fading out of this conduct and also, as a happy by - product, a more cheerful, encouraging teacher and a more congenial classroom atmosphere.

7- Schools must keep a watchful eye on absence with frequent roll calls, and random spot-checks, and contracting parents immediately whenever any doubt arises about why a particular child is away and rewarding children for good attendance.

8- All parents should know what their children are watching on television, should decide whether certain programmes are appropriate, and should feel in no way reluctant to meet their own standards in imposing restrictions on the time and content of television viewing.

Since television is effective in instigating aggressive behaviour and attitudes, it could be equally useful in promoting desirable social behaviour. Exposure to prosocial television programmes produce some lasting positive changes in children's behaviour, including greater persistence at tasks and ability to tolerate delays as well as more obediance to school rules.

SUMMARY

SUMMARY

Antisocial behaviour is a recurrent and persistent pattern of behaviour in which the rights of others and major social norms are repeatedly violated.

The classification of conduct disorders presented by DSM III is based on the interpersonal relations and level of aggression. It divides conduct disorders as follows:

Undersocialized aggressive, undersocialized non aggressive groups which are characterized by physical and verbal aggression, non-compliance, intrusiveness, lack of self-control, and impaired interpersonal relations.

Socialized aggressive, socialized non aggressive groups which are characterized by delinquent activities e.g. group stealing, truancy carried out in a peer group context.

Atypical conduct disorder.

The aetiology of this antisocial behaviour is still not clear and it may be due to one or more of the following factors: biological determinants, biochemical factors, faulty parental attitudes, schools as a powerful social - learning agencies, as a complication of mental retardation, a behaviour associating peer rejection as a trial to gain their approval, ineffecient supervision and discipline, as a result of recent undesirable life events or stresses, and any other cause interfering

with the acquisition of adequate prosocial behaviour e.g. depression, psychomotor epilepsy.

Conduct disorder is one of the most prevalent childhood disorders, and it is more prevalent among males than females in ratio of 2 : 1. This can be explained on the basis that females usually react to stress in a more internalizing way, and parents usually seek medical advise for boys more than girls. As they are trying to avoid stigmatizing the girl by being a visitor of a psychiatric guidance clinic. Also , conduct disorder was found to be more common among children of divorced mothers as these children are exposed to both financial and emotional stresses. They also lack an authority figure especially boys who also lack a model to imitate.

But the effect of this lack can be deteriorated by the presence of father substitute e.g. a grand-father or stepfather.

Minor and some major conduct disorders clear up without treatment. Children with severe conduct disorders tend to become adults with personality diorders.

Treatment of conduct disorders is mainly carried out by behavioural modification programmes. Conduct disorders

should ideally be treated by alternation of the social and family circumstances. On the other hand the repairing of family relationships in severe cases may be difficult and sometimes an impossible task. So the treatment can be carried out in day care center, boarding school or foster home. Drug treatment is used when there is an associated condition such as epilepsy, depression, severe anxiety or hyperkinetic behaviour.

Juvenile delinquency is a more severe form of conduct disorder. Delinquency is usually taken to mean the commission of acts which are against the law and which could thus lead to police action e.g. vandalism, fire - setting and fire- raising. It usually occurs in correlation with the low socioenonomic class, social change and deprivation, high frequency of deviancy in the families of delinquents, and peer group as delinquency occurs usually in groups.

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١ـ حسن عبد الفتاح الفنجرى ـ "العدوان لدى الاطفال ـ " دراسة مقارنة لظاهرة بين اطفال الريف والحضر ـ رسالة ماجستير غير منشوره ـ قسم الدراسات النفسية والاجتماعية ـ معهد الدراسات العليا للطفولة ـ جامعة عين شمس ١٩٨٧.

ARABIC SUMMARY

الموجـــز العربـــــى

السلوك العدائـى للمجتمع فى مرحلتى الطفولـه والمراهقـــــة

السلوك العدائى للمجتمع هو نموذج متكرر مستمر من سلوك يتميز بانتهاك حقوق الاخريين والمعايير الاجتماعية الاساسية • ومن امثلـة هذه الاضطرابات التغيب عن المدرسة دون استئذان ـ السرقة وهى تعبير عن نقص أو فقد شئ قد يكـــون عاطفى مثل الشعور بعدم اهتمام الاهل بالطفل • الكذب ايضا من امثلة السلوك العدائى للمجتمع كما ان التصرف العدائى كثيرا ما يحدث مع اعراض اخرى للاضطرابات السلوكية •

كما ان السلوك الجنسى مثل الفضول الجنسى الزائد او الاتصال الجنسى فـــى سن مبكرة يعتبر من مظاهر الاضطرابات السلوكية •

ويمثل انحراف الاحداث درجة شديدة من السلوك العدائى للمجتمع الذى يـــؤدى الى المثول امام المحاكم • كما ان الرغبة فى التخريب تمثل المشاعر العدوانية تجاه عالـــم الكبار وبالرغم من ان اشعال الحرائق من اقل الاعراض شيوعا الا انه اكثرها خطورة وهـــى تعبر عن العدوان الناتج من العلاقة المضطربة مع الوالديـن •

ومن الاسباب التى يحتمل انها تؤدى الى هذا النوع من الاضطرابات السلوكى هى : ـ استعداد وراثى لدى الطفل ، خطأ فى أسلوب تربية الطفل او قد يكون السبب فى المدرسة حيث انها تعتبر مؤسسة لتعليم السلوك الاجتماعى السليم • وقد يكون هذا السلوك مصاحب للتخلف العقلى او قد يكون نتيجة لرغبه الحدث فى قبوله كعضو بجماعة من الاصدقـــــاء او كنتيجة لضغوط لم يستطع الطفل مواجهتها •

وهذا النوع من الاضطراب السلوكى كثير الحدوث وينتشر بصفة خاصة بين الذكور اكـــر من الاناث وعلى وجة الخصوص اطفال الامهات المطلقات وذلك نتيجة لتعرضهم لضغوط ماديـة وعاطفيـــة وهو يعتبر من اكـــر انواع الاضطرابات السلوكية انتشـــارا •

وقد وجد ان خصائص شخصية الطفل ومحيط الاسرة والمدرسة وخبرته في الحياة هي اهم العوامل التي تحدد اسلوب علاج هؤلاء الاطفال وعندما تكون الاعراض بسبب ضغوط متكرره فان هدف العلاج يكمن في مساعدة الاسرة في مثل هذه الازمات اما في الحالات الاخرى التي تكون فيها الضغوط على الطفل مستمرة ومتصلة باضطرابات خطيرة في شخصية احد او كلا من الوالدين فان الطفل يحتاج الى بيئة بديلة مثل المدارس الداخلية المتخصصة .

وعندما يكون هذا النوع من الاضطراب السلوكي من النوع المتوسط فانه عادة ما يزول دون الحاجة الى علاج ولكن بقليل من الارشاد .

وعادة ما يتم علاج هؤلاء الاطفال بطرق العلاج السلوكي المختلفة . اما عن العلاج بالادوية فاستخدامه محدود ومقصور على علاج الامراض الاخرى التي قد تصاحب هذا النوع من السلوك العدائي للمجتمع .

واذا لم يتم علاج الاطفال المصابين بدرجة شديدة بهذا النوع من الاضطراب السلوكي فان هذا عادة ما يؤدي الى اشخاص ناضجين يعانون من اضطرابات شديدة في الشخصية .٤

جامعة عين شمس
معهد الدراسات العليا للطفوله
(القسم الطبى)

السلوك العدائى للمجتمع
فى
مرحلتى الطفوله والمراهقة

رسالة مقدمه من

الطبيبه // سامية سمير ثابت
بكالوريوس طب وجراحه

توطئه للحصول على درجة الماجستير
فى الدراسات الطبية العليا
للطفولـــه

اشراف

الاستاذة الدكتورة / زينب بشرى
استاذ الطب النفسى بكلية الطب - جامعة عين شمس

الدكتور / مصطفى النشار
مدرس أنف واذن وحنجره

معهد الدراسات العليا للطفولـه
جامعة عين شمس
١٩٨٧