XI.4 Non-delinquent conduct disorders

Israel Kolvin and Surya Bhate

Many children at one stage of development or another are perceived as naughty or mischievious but only a small proportion of these display behaviours which impair their relationships with others, inside or outside the family, or which are perceived by society as contravening social norms. This minority group is said to display 'conduct disorders'. A number of questions arise over the homogeneity of this group and about how to classify and diagnose these types of behaviour.

A conduct disorder gives rise to disapproval and distress, not in the child himself, but in those about him. It overlaps with what is viewed as official delinquent behaviour but also includes non-delinquent disorders of conduct, such as bullying, lying and disruptive classroom behaviour. Such behaviour is abnormal in its psychosocial context and is associated with other symptoms such as abnormal social relationships. Other behaviours typical of an individual with conduct disorder include truancy and stealing.

In this chapter school-age conduct disorders alone are considered.

DIAGNOSIS OF CONDUCT DISORDER AND PREVALENCE

A range of symptoms, such as lying, stealing, truancy, disobedience, destructiveness, aggression, poor relationships and wandering are suggested as being helpful in the diagnosis of conduct disorder, but as yet there is no consensus as to the severity, frequency and duration of such symptoms. There is lack of agreement about level of threshold, of severity and persistence (Offord et al 1986). However, such questions become relatively unimportant when considering whether the behaviour gives rise to impairment or handicap. Thus, antisocial traits do not necessarily imply an antisocial disorder, the latter being associated with impairment or handicap to the child or his social and family environment. If an attempt is made to define a threshold of symptoms, then minor changes can substantially modify prevalence rates (Boyle et al 1987).

Further, some conduct disorders are labelled as situational, in that they reveal themselves only in the home or the school, whereas others are pervasive, revealing themselves in both situations. Juvenile delinquency should be perceived as a special category of conduct disorder where persons have enacted potentially indictable behaviours, with some of the acts being known to legal agencies while others are known only through self-reports (Farrington 1973).

Prevalence is surprisingly constant across the UK and Canada and across time: about 6% for boys and under 2% for girls at 11 years of age or younger (Rutter et al 1970). More recent work in Canada reveals a rate of about 10% for boys and 4% for girls in early and middle adolescence (Offord & Waters 1983). In the north of England, there is an estimated rate of 25% of psychiatric disturbance for an industrialised urban area (Newcastle upon Tyne) for both early and mid-adolescence (MacMillan et al 1980, Place & Kolvin 1986). Of these, 11.3% are conduct disorders or mixed conduct disorders with the ratio of boys to girls being 2.6/1. The higher rates in boys may stem from their constitutional inclination to aggression, and great vulnerability to perinatal insult or psychosocial adversity (Rutter & Giller 1983).

DEVELOPMENTAL PERSPECTIVE

The behavioural features of conduct disorders and their associations vary across the age spectrum. In middle childhood, mixed neurotic conduct disorders are common and may be associated with aggression, especially in boys; aggressive conduct disorders are often remarkably stable over time (Robins 1966). It is known that troublesomeness as rated by teachers and peers in junior schools is predictive of subsequent (self-report) delinquency (West & Farrington 1977).

In adolescence conduct disorders, which may seem to emerge *de novo*, are often compounded of aggression, truancy, disobedience and disruptive behaviour, especially at school. Such behaviours are again predictive of subsequent delinquency (Mulligan et al 1963). Again, such behaviour is often situational in that it presents in school alone, but it may be pervasive. Weiss (1983) followed up hyperactive children in the USA (where the diagnosis for hyperactivity overlaps with that for conduct disorder with pervasive restlessness and poor concentration) in adolescence: hyperactivity declined with age but aggressive conduct appeared to remain stable.

CLASSIFICATION

Conduct disorders

One of the main methods of classification of behaviour is to use multivariate approaches: factor analyses invariably have demonstrated emotional and conduct disturbance factors (Peterson 1961, Wolff 1971, Kolvin et al 1975, Quay 1979). These patterns have been demonstrated at all ages although attempts to draw finer distinctions of the conduct category have so far met with little success. For instance, the classic attempts to draw up a multivariate classification were by Hewitt & Jenkins (1949), who distinguished between unsocialised aggressive behaviour and socialised group delinquency. Children showing the former tend to have poor peer relationships, commit their offences on their own and are described as displaying aggressive behaviour patterns; the latter tend to commit their offences in the company of other children and are seen as being socialised within the local community. However, Hewitt and Jenkins based their research on a clinic population heavily weighted for delinquency; furthermore, these distinctions have not been widely replicated (Field 1967). Nevertheless, the strength of this work was that the behavioural patterns were found to be associated with family patterns similarly derived from multivariate analysis: unsocialised behaviour correlated with broken homes and family rejection, and socialised delinquency with parental neglect and social disadvantage rather than rejection.

Hyperactivity has also been described in some studies (Jenkins 1966, Schacher et al 1981) but this is not clearly distinguished from conduct disturbance. Some multivariate studies have reported separate aggressive and antisocial factors (Connors 1970, Wolff 1971) but this has not been widely replicated. For technical reasons, factor analysis may not be the best way of highlighting circumscribed groups of behaviour disorders (Rutter & Gould 1985).

Thus, in summary, multivariate approaches have identified the two broad diagnostic categories of emotional and conduct disturbance, the reliability and validity of which have been widely demonstrated. However, these approaches have been less successful in producing finer distinctions. Nevertheless, the World Health Organization and the American Psychiatric Association appear to have accepted enthusiastically the 'clinical validity' of such sub-categories of unsocialised aggressive and socialised delinquency. The precise relationship of attention-deficit disorders and hyperkinetic disorders to conduct disorders also still requires elucidation: there is indubitably some degree of overlap with conduct disorders but longitudinal research (Schacher et al 1981) suggest differences in outcome which would support such a distinction. In addition, there is as yet no good evidence that non-delinquent and delinquent conduct disorders can be differentiated adequately (Moore et al 1979) in terms of behavioural features, family and social background and outcome. Nor, indeed, is there as yet good evidence to support the division of conduct disorders into those with and those without aggression. Thus, in the UK, there remains the practice of categorising antisocial behaviour rather broadly into whether there is a conduct disorder alone or a mixed category of conduct and neurotic disorder. For practical purposes, in this chapter we consider only conduct disorders in school-age children, unassociated with delinquency.

Aggression

Some types of physical aggression are commoner in adolescence than in middle childhood. There have been various attempts to classify aggressive behaviour in adolescence. For instance, McCord et al (1961) classified aggressive boys into those with serious overt aggression and those who were normally assertive. Those showing overt aggression participated in a whole range of aggressive acts, including assaults; normally assertive boys had hostile responses that were sporadic exceptions to the general pattern of their lives.

Megargee (1970) has advanced the hypothesis that assaultive individuals can be divided into two quite distinct personality types: the undercontrolled and the overcontrolled. The under-controlled aggressive male has quite low inhibitions against aggressive behaviour, and responds with aggression whenever he is frustrated or provoked. The chronically over-controlled type has strong inhibitions against the expression of aggression, but the feeling of aggression gradually summates until it exceeds his inhibitions and he may then lash out and release his aggression in one serious act. Thus not all extremely assaultive persons are necessarily continuously aggressive. This may account for the paradoxical outbursts of violence sometimes seen in usually quiet and inoffensive individuals. Megargee & Hokanson (1970) also classified aggression according to severity: extreme, which is reserved for physical assault of homicidal intensity; moderate, used for lesser degrees of physical aggression, and mild, used for verbal aggression and physical aggression not likely to injure the victim seriously.

Kolvin et al (1967) produced a classification based on a clinical study of aggressive youths. This classification is, in a sense, also hierarchical, as it comprises two broad groups — assertive and non-assertive. The assertive are hostile, tough youths (thugs) who wander round in groups, not quite aimlessly, and having a sense of expectation of trouble. They appear to obtain a kind of satisfaction and enjoyment from the hostility and aggressive episodes. The non-assertive group has a number of subgroups: paranoid aggressives who are continuously unapproachable hostile youths, catastrophic impulsive aggressors whose catastrophic outbursts must, almost inexorably, run their course; family-directed youths are those whose aggressive behaviour usually manifests itself only within the family; and, finally, a group of youths who show a cold and sadistic streak. There are overlaps with the Megargee classification in that the assertive and paranoid groups tend to resemble Megargee's under-controlled group while the catastrophic impulsive group resembles the over-controlled group.

A rare syndrome in childhood is episodic dyscontrol (Mark & Ervin 1970, Maletzky 1973) and this has been the subject of a review by Nunn (1986). The characteristic feature is episodic aggressive behaviour which apparently has minimal provocation. The aggression is usually directed at a close member of the family and in this and some other respects it tends to resemble the category of family-directed aggression described above (Kolvin et al 1967). In episodic dyscontrol the behaviour may give rise to serious injury; it is characterised by marked anticipatory fear and inaccessibility during an attack, and subsequent remorse. Common associations are a family history of epilepsy and temporal lobe abnormalities, which suggests that the condition has some basis in organic dysfunction of the neural substrate subserving aggression; however, clearly, there must be an interaction with family pathology.

Despite the above clinical endeavours to describe syndromes, Moyer (1968) pointed out that there had been no systematic or satisfactory attempt to elucidate the various kinds of aggression in order to work towards a viable classification, and this still remains true. The above clinical endeavours constitute important advances but these as yet have not been adequately followed up or satisfactorily replicated. Perhaps the search for clinical syndromes of aggression has been unsuccessful because the syndromes account for only a small percentage of the total cases of clinical aggression. It may be that we should be seeking ways of studying profiles on a wide number of dimensions of behaviour rather than attempting to place aggressive behaviour in adolescence into clearly defined clinical pigeon holes. Another possible reason for the lack of success is a determination, almost by a *tour de force*, to include all aggressive behaviour into discrete syndromes, rather than perceiving the lesser degree of severity of aggression as aggressive character traits (Shaffer 1978) which vary quantitatively, with only the greater degree of severity falling into more clearly defined categories.

PATTERNS OF CONDUCT DISORDER

Stealing

Stealing may occur in some as a solitary phenomenon and in others as a group phenomenon. Rich (1956) has tried to classify stealing: his first category is comfort stealing, which is seen as a response to emotional deprivation; the second is marauding offences, which occur in semi-planned or unplanned ways as a group phenomenon; the third category comprises a form of self-proving activities which are solitary and rather serious exploits, the purpose of which is to prove masculinity, or to confirm or improve status within a gang. The first of these categories is useful clinically but the clinical and predictive utility of the others has not as yet been adequately established.

Lying, disobedience and classroom disruption

Lying can be occasional or common; it may be used as a means of escaping punishment or to impress friends.

Some children show disobedience and other forms of

difficult behaviour in clasrooms to the extent that they disrupt classroom activity. Disobedience and classroom disruption are often combined with truancy and are often complained of by teachers dealing with children with school-based conduct disorders.

Truancy

Truancy must be distinguished from school phobia and the distinction is fully examined elsewhere (Hersov 1960, Hersov & Berg 1980). However, only a small proportion of persistent absentees are school phobics. It is not easy to estimate the true rate of truancy because there is no accepted method of calculating its prevalence (Place & Kolvin 1986) and because the rates vary widely from area to area. Nevertheless there are various estimates which suggest that 11% of 14-year-olds are frequent truants (Douglas et al 1968); 7% of the 10-year-old inner-London population are persistent non-attenders (Rutter et al 1970), and this rises to 20% in the 15-year-old group (Rutter 1980).

Truancy is commonly associated with other features of conduct disorder, namely aggression and delinquency (Farrington 1980). There is evidence to support the hypothesis that scholastic deterioration occurs in children who persistently absent themselves from school. Furthermore, poor school attenders have higher rates of neuroticism as measured by the Junior Eysenck Personality Inventory (Kavanagh & Carroll 1977).

Research into home environments reveals that truants often come from disadvantaged homes (Galloway 1976, Fogelman et al 1980) and that mostly they are absent from school with their parents' knowledge (Galloway 1976). Truants are likely to be offspring of parents who were themselves truants (Robins & Ratcliff 1979). They come from less cohesive home environments and have less satisfactory relationships with their parents (Galloway 1983).

Truancy is an intractable problem. Although a wide range of treatments have been reported as successful, few have been studied systematically. The most impressive are the behavioural treatments (Yule et al 1980). Berg & Fielding 1978 and Berg et al (1978) have reported that adjournment of court proceedings, which compelled relatively full participation of the family and the community services, was a more successful manoeuvre than imposition of a legal supervision order. Other approaches have been tried but as yet in most of these the method tends to be flawed in one or another way.

Aggression

This is an important component of conduct disorder. The clinical attempts to classify the more severe degrees of aggression are described above.

Fire setting

This is a relatively rare but serious phenomenon which is reported as occurring in 2–3% of clinical referrals (Jacobson 1984). The fire settings peak at about 8 and again at 13 years of age. The younger fire setters tend to do so in their own homes whereas the older ones do so outside their home (Stewart & Culver 1982). Fire setting is often accompanied by signs of other serious antisocial behaviour in terms of being more destructive, more antisocial and aggressive and with problems of interpersonal relationships (Jacobson 1984). These children tend to come from seriously disturbed and violent home backgrounds (Stewart & Culver 1982).

Teenage pregnancy

Teenage sexuality arouses a strong societal response. It is often stated and thought that young people today are sexually promiscuous and therefore adolescent sexuality is a problem which needs attention and help. There is very limited evidence to suggest that young people today are promiscuous, although it is clear that teenagers are more accepting of premarital sexual behaviour and engage in sexual activity at an earlier age than in the post-war era. There have been enormous changes in societal values regarding sex: we have moved from a notion equating premarital sex as sin to a more tolerant attitude in the 1960's and '70s. Attitudes have changed concurrently with the improved status of women, socially and economically. The women's movement brought dramatic changes in sex-related issues: these have been particularly evident in surveys concerning homosexuality (Yankelovich 1974) and subsequent changes in the legislature of most countries decriminalising homosexual activity in consenting adults, and the destigmatising of sexual activity in teenage girls.

Teenagers may have to face a number of issues with regard to sexuality (Levine & Valle 1982): these include pregnancy, abortion, sexual abuse including incest, rape and confusion of sexual identity. Unwanted pregnancy brings major social, economic and medical complications. A high proportion of adolescents who seek abortion are known to become pregnant again within a year. Counselling, including readily available and confidential contraceptive advice is crucial. In spite of 'sex equality', boys continue to expect girls to take contraceptive precautions. Sexual abuse including incest in now increasingly identified and recognised. Although the majority of teenage prostitutes report themselves to have been victims of sexual abuse, incest or rape, it should be noted that disclosure of sexual abuse requires sensitive and wise handling: insensitive handling can prove as damaging as the experience itself.

In the past, teenage sexuality was often viewed as representing antisocial behaviour; in Western society it is no longer viewed in this way. However, a small proportion of teenage girls participate in prostitution and this must be

viewed as antisocial behaviour. In addition, those who are highly sexually promiscuous may place themselves at serious risk.

INTELLIGENCE, ACHIEVEMENTS AND CONDUCT DISORDER

There is evidence of a relationship between conduct disorder and intellectual and educational handicap (Rutter et al 1970) and the relationship is particularly strong in the case of severe reading retardation. The strength of the association is demonstrated by the fact that one-third of children with conduct disorders have reading retardation and one-third of those with reading retardation have conduct disorders. What is the basis of this relationship?

First, it could be postulated that the reading retardation is secondary to conduct disorder, but there is little evidence to support this. Second, the conduct disorder may follow learning disorder. The latter may give rise to a sense of poor self-esteem and lack of confidence about school work (Rutter et al 1970, Rutter & Giller 1983). The hypothesis that frustrations secondary to reading retardation can give rise to conduct disorder derives from the work of Richman et al (1982), who demonstrated that at 8 years old there was no association between reading retardation and conduct disorder, and Rutter et al (1975), who demonstrated a strong association at the age of 10–11 years. This hypothesis is further supported by reports that improving academic achievements are associated with reduction in antisocial behaviour (Ayllon & Roberts 1974). A third hypothesis is that both disorders may arise from a common factor. Offord (1982) argues strongly that the common factor consists of co-existing adverse family factors; other possibilities include common temperamental anomalies and developmental delays. It is unlikely that these various factors will act independently but rather that each potentiates the effect of others (Rutter & Giller 1983).

ORIGINS OF CONDUCT DISORDER

Temperamental factors

In their longitudinal study of temperament, Thomas et al (1968) have reported that they were able to predict aggressive behaviour in childhood from temperamental patterns which were detectable at an early stage of development. However, although certain temperamental clusters appeared to be stable during the first 5 years of life, this stability was not necessarily fixed, but evolved 'through continuous parent-child and child-environment interactions' (Carey & McDevitt 1978). Temperamentally difficult babies are likely to elicit negative responses from their carers and these two-way interactions may contribute to subsequent antisocial disorder (Rutter 1978). Nevertheless, from all accounts, even infants with difficult temperaments appear eventually to shift towards lesser degrees of behavioural difficulty (Thomas & Chess 1977).

There is also evidence that aggressive behaviour tends to be persistent across later childhood and adolescence (Farrington 1978), which Shaffer (1978) suggests constitutes empirical support for the concept of an 'aggressive character trait'. He goes on to point out that many people consider persistent aggression to be constitutionally determined.

One of the questions that arises is whether, in adolescence, despite modifications and adaptations of both behaviour and temperament, aggressive behaviour remains associated with particular patterns of temperament. In fact, this has not proved to be the case (Kolvin et al 1982) as, although aggressive behaviour was associated with adverse temperamental patterns, the adverse temperament scores were spread across all dimensions. However, one possible specific pattern consisted of peaks of the temperamental dimensions of high activity and negative mood in the case of aggression severe enough to be referred to a clinical department; these two dimensions were those that had proved to be predictive of stability of diagnostic groupings in previous research (Carey & McDevitt 1978). Another question is whether types of aggression are similarly associated with a particular pattern of temperament; Kolvin et al (1982) found that this was not the case. Thus the differences of temperament appear to be one of degree and are related to severity of aggression rather than type.

Social factors

Social factors are known to be associated with conduct disorders. Although conduct disorders occur more frequently in the lower social strata (West & Farrington 1977), more recently research links environmental deprivation more closely than social class differences with later antisocial behaviour (Kolvin et al 1989). It suggests that, fundamental to these conduct disorders, are poor qualities of care and management of the children. This is consistent with the findings of Lefkowitz et al (1977) that socio-economic deprivation was related to conduct disorders in males in later rather than mid-adolescence.

However, intrafamily factors are likely to make a major contribution. For instance, loss of father by divorce rather than death is powerfully associated with conduct disorder in boys; maternal irritability also appears to be related to conduct disorder (Patterson 1982) Children are particularly vulnerable if they live in homes where the divorce has been preceded by seriously discordant family relationships (Rutter & Giller 1983).

The wider social environs of the neighbourhood and the school also make a contribution (Rutter et al 1975, 1979, Gath et al 1977). Such effects appear to have an influence over and above qualities of the school intake and are

exemplified by school characteristics, including school ethos, emphasis on appropriate behaviour and academic achievements.

AETIOLOGY AND MECHANISMS

Aetiological factors are often viewed as being similar in relation to antisocial disorders and to delinquency, on the basis that delinquency is merely a more severe variation of conduct disorder (Moore et al 1979). However, it would be unwise to adopt this position as, in many senses, delinquency is qualitatively different from non-delinquent conduct disorders. Nevertheless, the distinction between delinquency and non-delinquent conduct disorders has not been fully established.

The sex differences in this context are well described in the literature. Possible factors are the greater vulnerability of boys to perinatal insults and to family disturbance and also the constitutional predisposition of boys to aggressive behaviour (Maccoby & Jacklin 1980). However, the evidence relating brain damage to psychiatric disturbance is not specific to conduct disorder. Psychiatric disorder is increased many times in the presence of brain damage (Rutter 1977). Such influences are apparently independent of social adversity (Offord et al 1986). Thus, brain damage could have a direct effect or else it could be mediated through cognitive impairment, scholastic difficulties or even through affecting temperament. As mentioned previously, temperament as represented by hyperactivity is closely related to conduct disorders: children with pervasive hyperactivity are four times more at risk of conduct disorder 4 years later than those with situational hyperactivity (Schacher et al 1981).

OUTCOME

The best evidence for a relationship between conduct disorder in childhood and adult psychopathy derives from the longitudinal study of Robins (1966). However, this population contained a high proportion of delinquent children and so the conclusions do not further our understanding of the outcome of the sub-groups of non-delinquent conduct disorder. Nevertheless, in a later review Robins concludes that most of the moderately antisocial children and over one-half of the seriously antisocial children are not antisocial as adults (Robins 1978). Better evidence derives from Farrington (1978), who reports that although there was stability of non-delinquent conduct disorders in an inner-city London cohort, nevertheless such disorders were not strongly predictive of subsequent delinquency. However, aggressive conduct disorders in school-age boys are remarkably stable (Olwens 1979). Poor scholastic achievements make an important contribution to negative outcome. Nevertheless, the outcome is not necessarily antisocial and does not preclude the later emergence of neurotic or affective symptomatology.

TREATMENT AND MANAGEMENT

Mild disorders may respond to little other than parental counselling; indeed, historically, individual counselling or psychotherapy was the most favoured form of treatment. However, in the severer forms of conduct disorder the psychotherapeutic approaches had led to only moderate success and considerable disenchantment and this is particularly true in relation to the more deprived and disturbed children. Nevertheless, over the last decade three broad thrusts of treatment have emerged: group, behavioural and family therapy. The Newcastle school project (Kolvin et al 1981) has demonstrated that group therapy of the Rogerian variety and behavioural approaches undertaken by teachers have led to significant improvement in adjustment of children with conduct disorders, but especially so in the case of children with emotional disorders; most striking (and quite unexpected) was the evidence that treatment effectiveness seemed to increase with time — that is, the 3-year follow-up from the baseline showed, overall, more and greater positive results than did the intermediate 18-month follow-up. These treatments were more beneficial in the case of children with neurotic disorders than those with conduct disorders.

Behavioural approaches must be viewed as having particularly powerful effects. These potent approaches are based on training teachers (Kolvin et al 1981) or parents in behavioural techniques (Patterson 1974) and helping parents to work collaboratively with the school (Patterson et al 1973). Other workers have pointed out that children coming from stable families are more likely to respond favourably to this type of approach (McAuley 1982). Becker et al (1967) demonstrated the efficacy of social reinforcements in relation to approved behaviour in a classroom. So far the evidence in favour of the efficacy of family therapy in conduct disorders is scant. Nevertheless, it would seem sensible to undertake counselling with the parents as an activity which is complementary to behaviour modification and group therapy.