Disruption in the home

Children in control – children out of control

The subtitle of this chapter was chosen to illustrate the plight of many hapless parents who feel that their children appear to control large areas of family life while being, in many ways, out of control. The title may seem hyperbolic when applied to defiant pre-school children at one end of the age scale, but not quite so exaggerated when we think of the highly visible anti-social and aggressive behaviour of some teenagers. In many years of practice the authors have met parents who feel bruised (literally and figuratively) and abused (physically and emotionally) by young offspring, as well as older adolescents. Others, we suspect, remain silent – too embarrassed to admit the intimidation that is part of their daily experience.

A mother attending one of our parenting skills groups shared her concerns about Coralie, her 8-year-old daughter.

Coralie displayed frequent temper tantrums and disobedience from an early age. Even before she was a toddler she wasn’t easy, with her incessant restlessness and unending grizzling. She slept very little, which was exhausting. Although initially my partner Tom and I were told by the health visitor that she would grow out of these problems, we found that she became increasingly disobedient and aggressive. She was excluded from her nursery group before she started school. Tom and I tried every kind of discipline we could think of – threats, smacking, and taking away privileges. None of these worked. I’m convinced that her teachers blame us in private for her bad behaviour – saying that what she gets up to at school is unacceptable. They tell us that she has poor concentration and is hyperactive in the classroom. She bullies other children – particularly during breaks – and we get frequent phone calls to take her home from school because of what teachers call her ‘uncontrollable behaviour’. There are threats of exclusion. Other children don’t want to play with Coralie, and their parents are not at all friendly to me. Even my friends make it quite plain that although they welcome me to visit, it doesn’t apply to my daughter. She’s into everything and breaks things. It has all made me
very depressed, and it has caused rows with Tom who says it’s all my fault. He says I’ve spoiled her. If I’ve given in to her it is because she’s so strong-willed that I don’t seem to have any choice. Not that Tom helps much. I feel awful complaining like this because Coralie can show a very nice side to herself. The trouble is that it doesn’t happen very often.

Troublesome children do not always display anti-social behaviour as extreme as that of Coralie. Their defiance and aggression decline in frequency and intensity at a slower rate and at a later stage of childhood than their peers. However, there is a hard core of children notable for their ‘ingrained’ unwillingness or inability to adhere to the codes of conduct prescribed by family, school, and the community at large. No less than 15 per cent of children can be described as ‘oppositional and defiant’ during the course of the first five years of life, the larger proportion of them coming from inner-city rather than rural areas. While about one-fifth of children move out of the high-risk group during the primary school years, others join it. Over half of the children and adolescents referred to mental health services are assessed as having disruptive behaviour disorders. We are primarily concerned in this book with these ‘externalising’ behaviour disorders – the diverse collection of disruptive problems referred to as ‘oppositional defiant’ and ‘conduct’ disorders.

**Definitions**

In the fourth edition of the *Diagnostic Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994), a widely used psychiatric classificatory system, Oppositional Defiant Disorder (ODD), is defined as a repetitive pattern of defiance and disobedience, and a negative and hostile attitude to authority figures of at least six months’ duration. To meet the criteria, four of the following behaviours must be present:

- loss of temper;
- arguments with adults;
- defiance of, or non-compliance with, adult rules and requests;
- being a deliberate source of annoyance;
- blaming others for one’s own mistakes;
- being touchy and easily annoyed by others;
- frequent anger and resentment;
- spite or vindictiveness.

These behaviours must be frequent and lead to impairments of social and academic functioning.
The conduct disorders (CDs) overlap somewhat with the oppositional defiant disorders (ODDs). According to DSM-IV, CD criteria entail the violation of others’ basic rights, of age-appropriate norms and rules of society. At least three of the following 15 behaviours (categorised under four headings) must have been present over the preceding year to meet the criteria, with one present in the last six months:

1. **Aggressiveness to people and animals** (e.g. bullying, fighting, cruelty to people and animals, using a weapon, forced sexual activity, stealing with confrontation of the victim).

2. **Property destruction** (e.g. fire setting, other destruction of property).

3. **Deceptiveness or theft** (e.g. breaking and entering, lying for personal gain, stealing without confronting the victim).

4. **Serious rule violations** (staying out at night, truanting before the age of 13, or running away from home).

### Consequences of the conduct disorders

The consequences of children’s conduct problems are serious enough in the short term. Victims are distressed by the anti-social activities of these children. Perpetrators also suffer a sense of failure as their anti-social behaviour becomes increasingly self-destructive. Repeated episodes of disruption in the home, classroom and playground – verbal and physical aggression towards parents, teachers and other children – lead to rejection by adults and children. It is not surprising, given that children with CD are exceptionally difficult to manage, that their deviant activities lead to exclusion from schools and sometimes what amounts to physical maltreatment from their parents.

As time goes on, the lives of aggressive, anti-social children are likely be blighted by severe problems. These include:

- interpersonal problems (e.g. dysfunctional partnerships and parenthood);
- truancy;
- alcoholism;
- drug abuse;
- risky sexual activity;
- delinquency;
- adult crime.

### Risks and protective processes: the early history

Estimates from prospective studies suggest that around 40 per cent of children with conduct disorders will exhibit anti-social personality disorder as adults.
Under-controlled (irritable, disruptive and impulsive) children at 3 years of age (according to a large-scale New Zealand longitudinal study, Woodward and Fergusson, 1999) were, in comparison with ‘confident’ children, at the age of 21:

- twice as likely to have a diagnosis of anti-social personality disorder;
- twice as likely to be repeat offenders;
- twice as likely (boys not girls) to be diagnosed as ‘alcohol dependent’;
- four times as likely to have been convicted of a violent offence;
- much more likely to report having attempted suicide.

The family plays a major role in indoctrinating and training the child for life. In the early years, from birth to 7 or 8, compliance with certain parental requests and instructions is vital if the child is going to learn social, intellectual and physical skills. Among the reasons for enforcing particular rules are needs for:

- safety – the child has to learn to avoid dangers;
- harmony within the family – an aggressive, defiant ‘brat’ sets the scene for an unhappy home and disharmony between the parents and siblings;
- the social life of the family – uncontrolled, destructive children are not welcome visitors and contribute to their own social isolation and that of their parents;
- the child to have a repertoire of social skills and a maturing concentration span which will allow successful participation in the school’s social and academic life;
- the child to have an awareness of her/his responsibilities as a member of a wider community.

Parents and teachers use various techniques to teach, influence and change the children in their care. They give direct instructions, set an example, model desired actions and provide explanations of rules (i.e. use inductive methods of discipline). Behaviour is positively and negatively ‘shaped’ in the desired direction by using material and psychological rewards, praise and encouragement, giving or withholding approval, and other psychological punishments such as reproof or disapproval. At its simplest level this learning process is as follows:

$$\text{Acceptable behaviour} + \text{Reinforcement} = \text{More acceptable behaviour}$$

$$\text{Acceptable behaviour} + \text{No reinforcement} = \text{Less acceptable behaviour}$$

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When the family fails in providing appropriate and consistent socialising experiences, children seem to be particularly vulnerable to the development of
anti-social conduct and delinquent disorders. Typically, children with persistent anti-social problems come from families where there is discord and quarrelling; where affection is lacking; where discipline is inconsistent, ineffective and either extremely severe or lax. It has been found that the parents of children assessed as anti-social differ from other parents. They tend to do the following:

- be more punitive, issuing more commands;
- provide more attention following deviant behaviour;
- be less likely to perceive deviant behaviour as deviant;
- be more involved in extended coercive hostile interchanges;
- give more vague commands;
- be less effective in stopping their children’s deviant behaviour.

Data from the Oregon Youth Study (Patterson, 1982) suggest that the most severe behaviour problems start early, arising from a complex interplay between individual difference characteristics (e.g. impulsiveness, poor behaviour control, aversive temperament) and environmental influences (e.g. ineffective monitoring and discipline, dysfunctional parenting). A feature of families who produce children with conduct disorders is the prevalence of coercive interactions. The cues or messages are frequently negative ones, the ‘sound and fury’ of criticism, nagging, crying, shouting and hitting out being the norm. Communication between members may be impoverished or practically non-existent. Parental ineffectiveness unwittingly reinforces their toddler’s discovery that whining, temper outbursts, hitting and other aggressive tactics succeed in gaining attention. The likely outcome of family systems which control behaviour by the use of verbal and/or physical pain is children who exhibit frequent (‘high rate’) aggressive actions. Coercive interactions, maintained by negative reinforcement, are most likely to operate in closed social systems where the child must learn to cope with aversive stimuli such as incessant criticism.

**Developmental pathways and transmission of conduct disorders**

There are two developmental pathways to the fully fledged CD condition: an early onset (before the age of 10) and a later onset during the adolescent years. The latter condition is difficult enough to deal with clinically, but is not usually as resistant to treatment as the early-starter version. Children whose conduct problems begin in their early years are three times more likely to develop violent anti-social careers than those youngsters whose misdemeanours have their onset at an older age. Children who display the more serious conduct disorders do not modify their behaviour as they get older. They retain conduct problems from the earlier years, simply adding more deviant behaviours to the previous repertoire.
Certain sub-groups of children with conduct disorders display more ingrained patterns of anti-social behaviour than others. Among the determinants (leaving aside the age of onset) are:

- the number of co-existing conduct problems (multiple types of conduct problems);
- the presence of Attention Deficit Hyperactivity Disorder (AD/HD);
- the possession of lower levels of intelligence;
- having a parent with an anti-social disorder.

There are three important aspects of co-morbidity to think about in planning treatment:

- the presence of AD/HD on top of CD leads to more severe and aggressive conduct problems, more persistent symptoms, and more peer rejection;
- the presence of anxiety in children with conduct problems seems to delineate a less severe disturbance, at least in pre-pubertal children. The moderating influence of anxiety may not hold, however, for adolescents with conduct disorders;
- the co-occurrence of depression does not seem to alter the course of conduct disorders.

Retrospective studies indicate that most anti-social adults have childhood histories of anti-social behaviour. And anti-social parents tend to have anti-social offspring. Having a convicted parent at the age of 10 is the best single predictor of anti-social personality at the age of 32. The mechanisms of imitation and modelling of, and identification with, delinquent parents undoubtedly play a role in this trans-generational pattern.

**Costs to society**

There are enormous costs involved in the apprehension and incarceration of offenders, and arising from the vandalism of public property. Of particular concern to the community is the feeling that much anti-social behaviour in young people has a mindless quality about it that defies comprehension. Reports in the media of parents being unable to manage their children, of anti-social behaviour towards fellow pupils (bullying, intimidation and blackmail), attacks on teachers, the flouting of the law on the streets (vandalism, muggings and hooliganism) all tend to confirm the public perception of life under siege. The most alarming aspect is that the incidence of crime, violence and wanton destruction increases as one descends the age scale. A small hard core of persistent offenders is responsible for a disproportionate amount of crime; the 1996 statistics indicated that 10- to 17-year-olds made up around 25 per cent of offenders convicted or cautioned for an indictable offence.
Restoring the balance

Prevention

A qualitative analysis of what parents said about their children’s troublesome behaviour revealed a preoccupation with aggression, their dominant misbehaviour. They complained that:

■ their children’s aggression could take various forms and be directed towards different members of the family;
■ they felt victimised; the children often acted aggressively towards them, to an extent amounting at times to a need to be ‘on guard’ in case the child should unexpectedly hit them;
■ the children were unpredictable – at times highly tyrannical, destructive and defiant, and at other times loving – a rapid turnabout that caused particular distress;
■ there were many incidents when their children had been destructive, causing damage to the house or household objects.

Can parents pre-empt the development of such anti-social attitudes and behaviour? Research indicates that ‘authoritative’ parents tend to raise children who have high self-esteem and who cope confidently with life. These parents tend to direct their children’s activities in a rational manner determined by the issues involved in particular disciplinary situations. They encourage verbal give-and-take and share with the child the reasoning behind their policy. They value both the child’s self-expression and his or her respect for authority, work and the like.

In the case of the mother (for example), she appreciates both independent self-will and disciplined conformity. Therefore, she exerts firm control at those points where she and her child diverge in viewpoint. But she does not hem the child in with restrictions. She recognises her own special rights as an adult, but also the child’s individual interests and special ways. She uses reason as well as power to achieve her objectives. Her decisions are not based solely on the consensus of the group or the individual child’s desires, nor does she regard herself as infallible or divinely inspired. This approach to parenting has been categorised as ‘democratic’. Many persons other than parents have an influence on children’s personality and behaviour but parents can encourage a strong ‘immune system’ in their offspring – protection against some of the stresses and snares of growing up. Such a system would depend, in part, upon:

■ strong ties of affection and respect between themselves and their children;
■ firm social and moral demands being made on their offspring;
■ the consistent use of sanctions;
- techniques of punishment that are psychological rather than physical, such as threats to withdraw approval;
- an intensive use of reasoning and explanations;
- responsibility given to children and adolescents.

These generalisations are guidelines that can be interpreted to meet the particular values and circumstances of clients. They are given in Appendix I, pp. 159–161.

**Treatment**

The central theoretical assumption of behavioural work is that much abnormal behaviour and thought (cognition) in children is on a continuum with normal (non-problematic) behaviour and thought. The laws of learning that apply to the acquisition and changing of normal functioning (e.g. socially approved) behaviour and attitudes are assumed to be relevant to the understanding and modification of dysfunctional actions and cognitions. Of course, there is much more to learning, and learning to behave in a deviant manner, than is conveyed by influences from the environment. The difficult task of restoring a reasonable balance of authority and control within the family is most effectively carried out, according to the evidence, by skills training for parents as individuals or within groups (variously called ‘Behavioural Parent Training’, ‘Parent Management Training’ and ‘Behaviour Management Training’) (see p. 43). Manuals describing behaviour management training can meet, in part, the need for widely available, standardised and economical interventions, referred to earlier. This approach directly addresses major conditions (e.g. failures of parenting and socialisation) that are known to contribute causally to childhood behaviour problems.

The therapeutic methods derive (at the strategic level) from Social Learning Theory and (at the tactical level) from Cognitive-Behavioural Therapy. Behavioural Parent Training (BPT) refers to programmes that train parents to manage their child’s behavioural problems in the home and at school. In BPT parent–child interactions are modified by social learning principles and techniques in ways that are designed to promote pro-social child behaviour and to reduce anti-social or oppositional defiant behaviour. Procedures and typical ‘scenarios’ are practised in the individual or group sessions and then applied at home. Both types are discussed in later chapters. Extensive studies indicate the remarkable success of this approach in dealing with disruptive behaviour disorders.

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**Select bibliography**


