

Psycho-Social Risk Factors of Conduct Disorder among Institutionalized Children

Abstract

The purpose of the present study was to find out the main psycho-social risk factors for Conduct Disorder among children and adolescents. For this reason, study was conducted in two phases. Data from children residing in Child Protection and Welfare Bureau, Rawalpindi, were collected after seeking permission. In Phase I, 25 children having some conduct issues, as reported by administration of the Bureau, were selected. Urdu translated version of Disruptive Behavior Disorder Rating Scale (Loona & Kamal, 2011) was administered as a screening tool for conduct related problems. On the basis of screening, 10 participants were selected who met the complete criteria of Conduct Disorder and volunteered to participate in research. In Phase II, bio-graphical interviews were conducted. Content analysis was done through line by line coding and various categories were produced from data that were further rated by another judge. Inter-rater reliability was 83%. Findings revealed the most significant contributing factors for Conduct Disorder including personal factors, peer related factors, and the familial factors. Personal factor as perceived by participants were personal motivation, cognitive deficits, witnessing media violence, urbanization, element of supernatural forces, and abuse. Familial factors included inter-parental violence, marital discord, siblings' influence, family size, and low socio-economic status, presence of step-mother, drug addiction in family, lack of parental supervision, stressful familial situation, and maternal psychopathology. While peer related factors included peer pressure, closeness with peers, and having no peer.

Key words: *Conduct Disorder, Delinquency, Parental Monitoring, Peers, Violence*

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INTRODUCTION

In the field of developmental psychopathology, childhood behavior problems including externalizing and internalizing problems are of significant concern. Externalizing problems consisting of disinhibited behaviors and other expressions of under socialization (Kovacs & Delvin, 1998) act as risk factors for the later juvenile delinquency, adult crime, and violence (Moffitt, 1993; Raine, 2002). Children with externalizing problems have low self-regulation skills that leads to under controlled behavior (Cole, Zahn-Waxler, Fox, Usher, & Welsh, 1996). Thus, it is extremely important to identify and to understand the early childhood behavioral problems to prevent their development in later life (Liu & Wuerker, 2005). The essential features of Conduct disorder (CD) is a repetitive pattern of behavior that is linked with the violation of societal norms and basic rights of others, manifested by presence of one criterion in the past 6 months or three or more criteria in the past 12 months (American Psychiatric Association [APA], 2000). The behavior can be categorized into four categories: Physical aggression to people and animals (bullying, fighting, using a weapon, stealing by confronting a victim, and forced sex); property destruction (fire settings, destroy the property of others); deceptiveness or theft (breaking and entering into others property, lying for personal gains, stealing without confronting a victims); and serious rule violations that is, spending night out of home before the age of 13, running away from home, being truant before the age of 13 (APA, 2013).

CD is one of the most common psychiatric disorders among children and adolescents between the age range of 4-16 years (Shamsie, 2001). Findings revealed that up to 40% of those who had been diagnosed with CD in childhood, serious psychological disturbances continued in adulthood (Shamsie, 2001). The disruptive, impulse-control, and CD all tend to be more common in boys than in girls (APA, 2013). Family structures including family size, home discord, and an antisocial parent acts as risk factors of CD (Capaldi & Patterson, 1991). Findings about the juvenile crimes in Pakistan revealed that those adolescents living in the rural set up were more likely to be involved in crimes as compared to those living in the urban areas. And adolescents who lived in joint family system were less involved in juvenile crimes as compared to those living in the nuclear family system (Shamim, Batool, Zafar, & Hashmi, 2009). Findings of a study revealed that low socioeconomic status along with a large family size acted as important factors for anti-social personality disorder (Farrington, 2000).

Patterson (1982) has related parenting styles with antisocial behavior, and believed that parents of children having conduct issues were less consistent with their use of rules; gave more vague commands; their reaction towards their child depended on their own feeling rather than what the child was actually doing; less likely to monitor

their child's whereabouts; and less concerned about their child's sociable behavior (Patterson, 1982). Undesirable parent-child connections are mainly associated with the child's conduct issues (Johnston & Mash, 2001). A study conducted in Pakistan explored the perceived parent-child relationship quality for determining aggression in adolescents. Findings showed that perceived quality of parent-child relationship was significantly related to aggression in adolescents (Fatima & Sheikh, 2009). Children's exposure to domestic violence makes them antisocial. Marital conflict influences emotional regulation of the child. This leads to imprecise appraisal of other social situations and ineffective problem solving (Cummings & Davies, 2002), which is reflected as their conduct related problems. In Pakistan, Feroz, Jami, & Masood (2015) conducted a study that showed that adolescents who perceived more domestic violence at home were more aggressive. Parental psychopathology can also effect development. Depressed mothers find it difficult to set the limits for their child and remain emotionally unavailable for their children, so these mothers are major risk factor of CD for their child. Children exposure to their mother's depression between the ages of 5 and 7 exhibit a successive increase in CD behavior by age 7 (Kim-Cohen, Moffitt, Taylor, Pawlby, & Caspi, 2005). Heavy use of alcohol by parents lowers their threshold for reacting adversely to their child's behavior and also may be associated with inept monitoring of the child's conduct and less parental involvement (Lahey, Waldman, & McBurnett, 1999).

Fergusson & Lynskey (1995) found that the mother's age at the time of child birth, socio-economic status, number of children at the time of birth, and disciplinary parenting practices played an important role in the relationship between the mother's age and conduct problems in child. Joughin and Richardson (2002) suggested that children having teen age mothers showed more conduct symptoms at the age of 8, 10, and 12 years. Children with teen age single mothers inclined to live on lower incomes and they suffered from poor child-rearing practices. Those children who are raised in single parent family have high chances of delinquency (McCord, Widom, & Crowell, 2001). Single mothers are more likely to experience high levels of economic stress as compared to married (Ali & Avison, 1997), and this heightened stress can contribute to youth's increased problematic behaviors. Those children who grow up with single mothers had high chances of to grow up as aggressive (Hilton & Desrochers, 2000). Living in poor and criminal neighborhood increase the chance of delinquency for all those children who are brought up there (McCord et al., 2001). Lahey et al. (2000) reported that the drug availability and the high crime rates in the neighborhood act as risk factor for delinquency. Fite, Winn, Lochman, & Wells (2009) identified disadvantaged neighborhood act as unique risk factor for pro-active aggression which is another type of aggression, clearly predictive of later delinquency and substance use.

The National Research Council and the Institute of Medicine reported that the school policies concerning grade retention, suspension, and expulsion from school did not reduce the undesirable behavior rather they are associated with the increased delinquency in the children (as cited in McCord et al., 2001). Students with deviant social skills and poor academic performance are more likely to continue these behaviors (Barth, Dunlap, Dane, Lochman, & Wells, 2004). Furthermore, the research conducted in Pakistan about the delinquent behaviors suggested that problematic behaviors occur because of poor quality of education and absence of discipline. Half of the community school children were rated by their parents to be having behavior problems (Hussain, 2008). Children and adults with conduct issues have poor peer relationships with the other children having same behavioral problems. Children with CD have more aggressive, unhappy interactions, and rejection by other children without CD (Coie, 2004). Research indicated the strong association exists between the child's antisocial behaviors and their peers. When adolescents enter into a deviant peer group, their rate of school truancy and drop out leads to increase rates of delinquency (Lochman, 2003). Studies aforementioned have revealed many factors leading to CD among children. Literature review suggested in formulating research design for the current study, as none of the study in Pakistan has explored these psychosocial factors in institutionalized children through qualitative approach. Current study will help to delineate either the same factors would emerge or some new dimension will also become evident in indigenous context.

Gender was most consistently documented risk factor of CD (Robins, 1991). CD is more prevalent among boys with a ratio of 6 to 16 percent, while ratio among girls ranges from 2 to 9 percent (National Mental Health Association [NMHA], 2001). Boys with a diagnosis of CD frequently display aggression, stealing, damaging property, and school discipline problems. Girls with CD frequently show lying, truancy, substance use, and prostitution. Whereas, boys exhibit both physical and relational aggression (behavior that troubles social relationships of others), but girls tend to exhibit more relational aggression (APA, 2013). In the large 1999 and 2004 British surveys carried out in Great Britain among children and young people by the National Statistics, 5% of children and young people aged 5-15 met the criteria of CD (Green, Mc Ginnity, Meltzer, Ford, & Goodman, 2005). In terms of class, there is a marked social class gradient with CD more prevalent in lower class as compared to upper class (Green et al., 2005). Ethnicity also holds significance in this regard (see Goodman, Patel, & Leon, 2010). The prevalence of CD around the world is 5% (Scott, 2007). A study in US shows life time prevalence of CD as 9.5%, more prevalent in boys than females with a median age-of-onset of 11.6 years (Nock, Kazdin, Hiripi, & Kessler, 2006). In Pakistan, the crime rates are increasing day by day; there is marked increase in criminal activities from the year 2000 to 2010 (Waheed, 2010). Javed, Kundi, and Khan (1992) carried out a community study in

Lahore to find the emotional and behavioral problems in Pakistan; they found 9.3% prevalence of antisocial behaviors in children. Hussein (2008) carried out a study to determine a prevalence rate of conduct problems among children's attending different school settings in Karachi and findings revealed 48.7% conduct issues in boys and 35.2% in girls. The difference in prevalence rate may be because of use of different methodology, tools, and sample. Children with CD often suffer from other developmental problems, including being bullied (Johnson et al., 2002), having poor social competence, and low self-esteem (Renouf, Kovacs, & Mukerji, 1997), an increased likelihood of repeating a grade in school, being suspended or expelled from school, alcohol dependence, and drug abuse (Schubiner et al., 2000).

Research also revealed that children with CD are at extreme risk for school failure, peer rejection, violent behavior, suicide, serious criminality, and adult psychiatric illness (Kelly, Cornelius, & Lynch, 2002). CD exhibited during childhood and adolescence is a necessary precondition to be diagnosed with the Antisocial Personality Disorder in 18 years of age (Myers, Steward, & Brown, 1998). Therefore, early prevention through exploration of risk factors involved in developing conduct related problems is of utmost importance. Current study is aimed to explore those psycho-social factors in institutionalized children living in Child Welfare and Protection Bureau (CPWB), Rawalpindi. This is the only Center in Pakistan, which keeps and looks after the neglected, abused, or street children having the age range of 8-18 years. None of the previous studies in Pakistan has focused these children to find out psychosocial factors that lead some of the children out of many to develop conduct problems. Since in the CPWB only male children are accommodated, therefore, data is based on male children only. There is a lack of mental health studies for children in Pakistan, especially, on the risk factors of delinquent behavior (Hussein, 2008). Pakistan is undergoing through youth bulge. To harness youth's energies and to make them productive member of the society need much attention.

METHODOLOGY

Objective of the study is to explore the psychosocial risk factors that underlie the development of conduct issues in institutionalized children. Present research is qualitative where biographical follow up interviews were conducted to cater the large contextual information. Research was carried out in two phases. In Phase I, screening for CD was conducted on children residing in CPWB. After screening, children who met the criteria of CD were selected for the biographical interviewing in Phase II. For the present study, the data were collected from the CPWB. It is the only Punjab Government center in Rawalpindi for those children's who were run away from their homes and were involved in some economic activities. These individuals are then brought to the Bureau by the police force because of their involvement in the

activities which are not appropriate for their age. So because of feasibility and accessibility, the data were collected from CPWB. The sample comprised of boys ($N = 25$) having the age range of 11-16 years ($M = 13.4$; $SD = 2.18$). For the present study, 25 children with antisocial tendencies were selected on the basis of reporting by administration authorities about their conduct related issues. Later out of 25, only 10 children were selected for the interviews.

Translated version (Urdu) (Loona & Kamal, 2011) was used for screening of CD to accurately identify children and adolescents having highest score on DBDRS. There were total 16 items which were related with CD that measure Aggression (8 items), Destruction of Property (2 items), Deceitfulness and Violation of Rules (3 items each). Alpha coefficient for (Urdu version) is .91 and both Spearman Brown, and Split-half correlation for Conduct items is .89 (Loona & Kamal, 2011). DBDRS have four response categories that are *never*, *very often*, *often*, and *always*. There was no cut-off score; if the individual scored on three categories, or the combination of categories, then the individual is having CD. Higher scores represent the high severity of conduct issues in the and low scores represent the less severity of conduct issues. It was rating scale for parents and teachers, so in the present study rating scale was taken by teacher/attendant of that child in CPWB about the child's current behavior.

Follow up in-depth interviews were conducted along with the specific guidelines based on the literature which helped the interviewer to remain focused about the objectives of the interview. Biographical interview guide mainly included questions related to symptoms and psycho-social factors that may lead to development of conduct problem in participants. Open ended questions were asked through which every setting of life (i.e. family, school, and neighborhood) was covered. The interviewer did not rigidly follow the guidelines rather order was changed case to case and additional questions were also asked depending upon the interviewee's response (see Patton & Quinn, 1990).

Proper procedure was followed to obtain the permission from the CPWB in order to collect data from children present in the Bureau. Research purpose, its significance, and use of the information so obtained through interviews were shared with authorities and participants. It was assured to authorities and participants that information would be used only for research purpose and would be kept confidential and anonymous. Written consent was taken from each child who participated in the research. No refusal came from any participant for the participation in the present study. After taking the permission, the DBDRS was used for screening purpose in Phase I on those individuals who were willing to participate. Out of 25 children, 10 highest scorers were selected for the follow-up biographical interviews in Phase II. They had high scores on the scale and met the full criteria of CD in Phase II. Consent

of the parents of five participants who were available on call was also taken. For rest of the children, parents had no contact with administration. In such cases, consent of attendants and authorities was sought. Parents of those 5 participants were also consulted for verification of the information obtained from the respective participants. Interviews were audio-recorded and then transcribed. During the interview, memo writing was also done to clearly understand the context of what the participants were reporting. Maximum 30-45 minutes were spent on each interview. After that, content analysis of textual information was done.

RESULTS & DISCUSSION

Content analysis was used to extract psychosocial factors leading to conduct problem based upon participants' responses in follow up interviews. First the content was analyzed through line by line coding and then codes were assigned to the core component of communication. After that these codes were then categorized into major categories. After establishing the categories, their inter-rater reliability was checked where two independent judges gave consensus about the categories emerged (Krippendorff, 2004). The frequencies and percentages were tabulated for respective categories. In Phase I, data of 25 boys currently having some delinquent tendencies, as reported by administrative authorities and respective attendants, were collected from the CBWB by using DBDRS. Ten participants with highly delinquent tendencies were selected who scored highest on the scale. Table 1 shows the frequencies and percentages along symptoms of CD among 25 participants.

Table 1: *Prevalence of Conduct Problem Behavior (N = 25)*

Themes	Categories	f (%)
Aggression to people and animals	Initiate scuffle	20(80)
	Initiate physical fighting	20(80)
	Hurt physical others	20(80)
	Bully others	17(68)
	Stealing by confronting a victim	18(72)
	Uses weapon	12(48)
	Hurt animals	9(36)
	Forced sex	9(36)
Destruction of property	Destroying other’s property	16(64)
	Involved in fire settings	6(24)
Deceitfulness	Telling a lie	22(88)
	Stealing without confronting a victim	13(52)
	Dacoit	8(32)
Serious violation of rules	Truancy form school	15(60)
	Truancy from home	9(36)
	Staying out at night	14(56)

Table 1 that highest scored category is telling a lie, and the lowest scored category is the involvement in fire settings. The most evident or reported behavior is initiate scuffle, physical fights, and physically hurt others and the least reported behaviors are involved in fire settings, being dacoit, forced sex, and hurting animals. If three or more categories or in the combination of the categories were endorsed, then the diagnosis of the CD is given. On the basis of prevalence of symptoms, 10 participants were selected for the further interviewing to explore psychosocial factors in developing CD.

Table 2: *Frequencies and Percentages along Demographic Variables (N = 10)*

Demographic Variable	f(%)	Demographic Variable	f(%)
Age in years		Non-working	7(70)
12-13	7(70)	Education of father	
15-16	3(30)	Illiterate	8(80)
Onset of CD		Primary	1(10)
Childhood-onset	10(100)	Matric	1(10)
Adolescent-onset	0	Occupation of father	
Age of onset		Army	1(10)
5-6	2(20)	Mason	4(40)
7-8	6(60)	Painter	2(20)
9-10	2(20)	Flower seller	1(10)
Educational level		Shop-keeper	1(10)
Class 1	2(20)	Auto-driver	1(10)
Class 2	2(20)	Family size (No of siblings)	
Class 3	3(30)	1	1(10)
Class 4	2(20)	2	1(10)
Class 5	1(10)	3 (3)*	1(10)
Past employment status of children		4	1(10)
Non workers	3(30)	6	2(20)
Workers	7(70)	8 (1)*	2(20)
Barber	1(10)	9	1(10)
Shoe polisher	1(10)	12	1(10)
Beggar, flower seller	1(10)	Family structure	
Car washer	1(10)	Joint family system	3(30)
Server	1(10)	Nuclear family system	7(70)
House servant	2(20)	Divorced/Second marriage of parents	4(40)
Education of mother		Intact families	6(60)
Illiterate	9(90)	Family income (in rupees)	
Primary	1(10)	1000-10,000	9(90)
Occupation of mother		11,000-20,000	1(10)
Working	3(30)	Residential Area	
School maid	2(20)	City slum	1(10)
House maid	1(10)	Urban areas	2(20)
		Rural areas	7(70)

Note. * = step siblings.

Table 2 shows that age range of the sample is from 12-16 years. All participants have childhood-onset of conduct issues that is before ten years of age. Maximum participants have age onset of conduct issues between 7- 8. All have educational level less than primary. Most of the participants were earning money previously before coming to the Bureau. Majority of mothers and fathers were illiterate. All fathers and only three mothers have working status. Five participants have number of siblings above 4 and 5 participants have number of siblings below 4. Only three participants were from joint family system. Four participants have divorced or step parents and three participants have step siblings too. Two participants have only one step sibling, and one participant have three step siblings. Most of the participants have the family income range less than 10,000 PKR and only one participant having the family income range as more than 10,000 PKR. Seven participants reported about that their houses are located in rural areas, 3 in urban areas, and only one participant reported about the urban slum.

Out of ten participants, 8 participants were street children. Among these 8, only one participant left his house when he was 7 years old; 6 participants reported that when they were 9 years old they left their houses, and only one participant left his house when he was 10 years old. Out of 10 participants, 7 participants were brought to this center by the police officers, 1 participant lived in jail with his mother and now he has been sent to the Bureau by the police administration because of his aggressive acts in the jail; 1 participant was brought by the media (Geo news); and one participant was brought by his own father because of the behavioral issues. Before coming to bureau, seven participants got education from schools. One participant got nursery level education and then left the school because of no interest in studies; 3 participants got education up to class 1 and then left their school and home both; one participant got education up to class 2 and then left the school and home both; one participant got education up to class three and he was expelled from the school because of truancy; and only one participant got education up to class 5 and then left the school and his home too. Sample of the present study belongs to three different provinces of Pakistan that is Punjab, NWFP, and Sindh. During the interviewing, some participants were very vocal as compared to others, for example, Case 3, 4, 8, 9, and 10. It was not due to their verbal abilities, but as unique style of responding (i.e., rude and excited).

Table 3: *Prevalence of Conduct Related Behavior among Screened Participants (N = 10)*

Themes	Categories	f(%)
Aggression to people and animals	Initiate scuffle	10(100)
	Initiate physical fighting	10(100)
	Hurt physical others	10(100)
	Bully others	10(100)
	Stealing by confronting a victim	9(90)
	Uses weapon	8(80)
	Hurt animals	7(70)
	Forced sex	2(20)
	Destruction of property	Destroying other’s property
Involved in fire settings		4(40)
Deceitfulness	Telling a lie	10(100)
	Stealing without confronting a victim	8(80)
	Dacoit	2(20)
Serious violation of rules	Truancy form school	9(90)
	Truancy from home	8(80)
	Staying out at night	8(80)

Note. Multiple responses exist for each category.

Table 3 shows that highly endorsed categories present in screened sample is initiating scuffle, physical fighting, hurting others physically, bullying, destroying other’s property, and telling a lie. After that, second highest scored category is stealing by confronting a victim, and truancy from school. Third highest scored category is use of weapon, stealing without confronting a victim, truancy from home, and staying out night. Fourth highest category is hurting animals. Involvement in fire settings is the second lowest scored category where 40% of participants reported about it; and the other least reported category is forced sex and being dacoit; only 20% participants reported about their involvement in these delinquent behaviors. Themes, codes, and categories of the risk factors were identified by the content analysis of the responses given by the participants during the interview. After the content analysis, various themes and categories of the risk factors were identified. Total 37 categories were established which were rated by a clinical psychologist other than researcher. Out of 37 categories, 31 categories achieved agreement among both raters. The total inter-rater reliability agreement established is 83%.

Table 4: *Categories and Themes of Risk Factors (N=10)*

Themes	Categories	f(%)
Abuse	Physical abuse	10(100)
	Sexual abuse	2(20)
Family influences	Inter-parental violence	7(70)
	Parental separation	4(40)
	Siblings influences (elder brother)	2(20)
	Family size	2(20)
	Low socio-economic status	2(20)
	Presence of step mother	2(20)
	Lack of parental Supervision	2(20)
	Drug addiction in family	1(10)
	Stressful familial situation	1(10)
	Maternal psychopathology	1(10)
	Self-motivation	Enjoy wandering
Enjoy to bully others		2(20)
Enjoy fighting		4(40)
No personal interest in home		4(40)
Enjoy stealing		1(10)
Enjoy to tease others		1(10)
Peer's influence	Peer pressure	6(60)
	Closeness to friends	4(40)
	Having no friends	1(10)
Cognitive deficits	Deficits in social skills	6(60)
	Low risk perception	4(40)
Media exposure	Media violence	3(30)
Urbanization	Desire to get urban	2(20)
Supernatural things	Black magic	1(10)
	Paranormal presence	1(10)

Table 4 shows the major themes of risk factors contribute in development of CD. Risk factors that contribute to the development of CD were abuse, family influences, self-motivation, peers influence, cognitive deficits, media exposure, urbanization, and supernatural things. Family influences majorly inter-parental violence and parental separation/single parenting, and peer influences including peer pressure to indulge in deviant activities followed by closeness with deviant peers emerge as major social factors as per participants' responses. Abuse, self-motivation, and cognitive deficits reflect personal or psychological factors. Media exposure to violence and urbanization are community related factors. Interestingly, two participants also reported a factor of any supernatural force that has brought such a negative impact on his life. As a secondary analysis which was not the main objective of the study consequences of having CD among participants were also explored. Table 5 shows the themes and categories of the consequences of CD. Five major themes were generated that is abusive, school influences, risky behaviors, drug related behavior, and family clashes.

Table 5: *Themes and Categories of the Consequences of CD (N=10)*

Themes	Categories	f (%)
Being abusive	Physical abuse	8(80)
	Sexual abuse	2(20)
School influences	Punishment from teachers	5(50)
	Expulsion from school	2(20)
Risky behaviors	Physical injuries	3(30)
	Self-mutilating behaviors	4(40)
	Prostitution	2(20)
Drug related behaviors	Drug use for pleasure	4(40)
	Drug supplier	2(20)
Family clashes	Parental conflicts	1(10)

Table 5 shows the major consequences of CD that produced the adverse effects in the life of participants including being abusive, indulging in abusing physically followed by sexually. In academic setting, experiencing punishment from teachers and 2 were even expelled from schools. Risk taking and risky behaviors increased that are reflected as experiencing more physical injuries, self-mutilating behaviors, and indulging in prostitution. A few started taking drugs to seek pleasure and 2 also indulged in supplying drugs to drug users. One also report that his deviant activities led to family clashes including conflicts between parents over his behavior.

The aim of the present research was to explore the psychosocial risk factors involved in developing CD among children. Children included in sample were institutionalized in CPWB. Administrative authorities and respective attendants of those children based upon their observations reported about the current conduct related issues of the children that had been present for the past 6 months (see APA, 2013). Out of 25, 10 children were screened through DBDRS for the further biographical interviews. After the interviews, information was thoroughly analyzed to extract codes through line by line coding. Line by line coding is used to identify the multiple categories in the content (Weber, 1990). After line by line coding categories were formulated by merging, overlapping codes. Lastly, these were extracted by using interpretative approach (Moretti et al., 2011). Through employing this method, themes and categories reflecting risk factors for CD were identified.

For the present research, the sample comprised of boys only. That may be taken as a sampling bias, but CPWB only accommodates boys. Target population for present study was institutionalized children who are living in controlled environment rather than roaming around streets without supervision and monitoring. This is the only institute that provide residence to homeless or street children therefore data were collected from children residing there. This was proved by the study conducted among Navajo Indians (531 male and 203 female respondents), results showed that

earlier age and male gender rather than female act as risk factor for CD (Kunitz et al., 1999). Since present research only targeted boys, therefore, we cannot claim that this does not exist in girls. The reason for more prevalence in boys can be high testosterone level and cultural factors where aggression in acceptable behavior in boys and parents often encourage that in boys as approved gender role. Boys are also more outgoing and parental monitoring and supervision gets less with age, which also promotes deviant activities in boys (Helgeson, 2012). The demographics, low family income separated or divorced parents and large family size contributes to the development of the CD. According to the findings, all children had childhood onset of CD. Research evidence shows that symptom profile and severity of symptoms of CD and functional impairment was significantly higher in childhood onset than adulthood onset (Jayaprakash, Rajamohanam, & Anil, 2014). Present research findings also revealed that all the participants have educational level less than primary level. Research findings revealed an increased likelihood of repeating a grade in school, school failure, being suspended or expelled from school among children with conduct issues (Schubiner et al., 2000).

Findings revealed that those families having lower societal status (i.e. low income, poor housing, low social social class), or having large family size act as significant predictors of anti-social personality disorder at age 18 (Farrington, 2000). Those families where the number of siblings are large, but the resources of the families were very less; parents find it difficult to feed their all children, so they put their children to do some work at very early ages (for example father of Case 5 reported that he was flower seller so how could he feed his all the children) and these children were exposed to disadvantaged environment at the early ages. Seeing the various hardships outside, make them tougher to face the hardships, and meet their needs through delinquent means. Whereas, among low socio-economic status, the greatest prevailing insecurity was homelessness and hunger (for example, brother of Case 10 reported that we are poor people our eating [resources] is not good [sufficient]). Once the basic needs are not met, familial conflicts increase and the children may become truant from the home to get the financial and psychological relief for some time.

Divorced and separated parents increase the risk of conduct issues in the children, according to the findings, 4 participants had divorced parents, and research findings suggested that higher divorce rates are found between parents among those children who have conduct issues (Sholevar, 2001). There is a prevailing myth that step mother is “a wicked mother”. Participants generally believed that their step mother were very clever because she was the only one who was responsible for their parent’s separation. Someone replacing the role of biological mother leads to distress in the child and child may develop the hatred for the new mother. Marital discord causes CD in children, which is further one of the possible outcome of CD as well. Two-way

relationship exists marital conflict and CD (Fincham, Grych, & Osborne, 1994). This is also reflected in current study where participants perceived parental conflicts as reason for their conduct issues and in consequences conduct issues of the child also led to parental conflicts. According to findings, factor that has strongest impact on the participants for developing conduct issues was *family influences*. Out of total, 7(70%) participants had witnessed inter-parental violence and showed conduct symptoms; marital conflicts influence child's behavior because of its effect on emotional regulation.

Children exposed to domestic violence in their early stage may become antisocial. According to social learning theory, children imitate adult's behavior, if adults behave aggressively; children behave the same way through copying the actions of their adults (Bandura, 1969). Research showed that family discord and maladaptation strongly correlated which is associated with a roughly two-fold increase in risk for CD symptomatology (Meyer, Rutter, Silberg, Maes, & Simonoff, 2000). In the present research, 5(50%) cases reported where father initiated violence towards mother, and sometimes children tried to help mothers, but got punished by their fathers (for example, Case 3 reported "during the fight when we intervened to save our mother, father also beat us"), so the boys identify their father as more violent and they are likely to use same patterns of behavior in the future. Feroz et al. (2015) also found positive predictive role of childhood exposure to domestic violence for developing aggression among university students.

In a research on the 177 clinically referred children aged from 7 to 13 years, association was found between CD and several features of family functioning which was maternal parenting (lack of paternal supervision and persistence in discipline) and paternal adjustment (paternal anti-social personality disorder and paternal substance abuse) (Frick et al., 1992). Whereas, in the present research 2(20%) participants reported about lack of parental supervision; 1(10%) participant reported about his paternal drug usage; and only 1(10%) participant reported about the maternal psychopathology. All these parents' related factors lead to lack of monitoring and supervision at their part that lead to conduct problems in children (Patterson, 1982). CD result from a child's attempt to cope with a hostile environment or to gain social status among friends or *peer pressure* is referred to as one of the main reasons for getting into delinquency. According to the findings, 6(60%) participants reported about the affiliation with deviant peers. Research demonstrated that friend's delinquency predicted delinquency and substance use, and older male friends predicted antisocial behavior (McAdamsa et al., 2014). Present study also revealed that more the closeness with such friends; more is the chances of antisocial behaviors. Research in past also indicated that having the deviant peers with antisocial behaviors; and the more closeness with the deviant peers result into more

frequent deviant behaviors evidenced in boys rather than girls (Paul, Kathryn, & Hillary, 2004). In cultural context too, boys are approved to be more social and outgoing and once there is lack of supervision and monitoring by parents, conduct issues increase. Present research finding revealed that *peer rejection* is another risk factor of CD. Only 1 participant reported about that. Research findings showed that peer rejection and aggression in the early school years related with the early starting of conduct problems (Shari & John, 2002). Peers are very significant socializing factors. Healthy peer interaction with same age group leads to development of socially approved behaviors. Social rejection may lead to lowered self-esteem that later become evident in the form of overt aggression.

Any form of *abuse* is a stressful experience for a child. As the child grows and the abuse intensifies, the child is forced to deal with the tensions associated with the abuse fueled with anger and frustration (Jaffee, Moffitt, Caspi, & Taylor, 2003). Abuse or maltreatment came up as major contributing risk factor for the CD, experienced by all the participants in different forms. A study conducted on 70 substantiated cases of child abuse showed that 50% of the sample met the criteria of the CD in which 65% of the sample was physically abused and 62% of the sample faced sexual abuse (Lyttle & Brodie, 2010). According to present research findings, all the participants experienced physical abuse and only 2(20%) participants faced sexual abuse showing the severe symptoms of CD. According to present research, *self-motivation* and positive attitudes about the delinquent behavior was third major theme that contributed to the development of the CD. Participants reported that they get involved in risky behaviors because they get rewards in terms of goods, money, enjoyment, and fun. That's why they were more involved in risky behaviors. Self-motivation was proved as risk factor for CD by the study conducted on 24 juvenile offenders from 11 to 18 years old. Results showed that positive expectations or positive attitudes towards delinquency, liking what they do, and getting pleasure from these activities acted as risk factors for CD (Simoës, Margarida, Matos, & Foguet, 2008). It was also proved by psychoanalytic theories where the Id is considered as a dominant in behavior; delinquents just do what they want to do; they are more concerned with their biological needs and desires without thinking about consequences (Muuss, 1996). It can be assumed that in delinquents, Id based on pleasure principle is more dominant as compared to ego and superego, so they did whatever they wanted to do.

Cognitive deficits were another major theme, reported by more than half of the participants. Six participants reported about low social skills and 4 participants reported about low risk perception (for example, Case 3 reported, "when any one calls me with names, I beat them, otherwise not"). It shows that aggressive child has hostile attribution of others' behaviors and attend to the hostile cues only, having

hostile attributional biases, more inflexible in their choice of response, value the aggressive response, and then act out in a violent way. It was proved in past study focusing at associations between trajectories of conduct problems and social-cognitive competences through childhood into early adolescence. Results showed that in contrast to individuals with low conduct problem levels, all conduct problem groups presented with difficulties in both social-cognitive domains (Oliver, Barker, Mandy, Skuse, & Maughan, 2011). Exposure to violence through media is another risk factor that contributes to CD. It was confirmed in a research that media violence exposure is related to poorer executive functioning and this relationship may be stronger for adolescents who have a history of aggressive–disruptive behavior (Kronenberger, Mathews, Dunn, Wang, & Wood, 2004). Feroz et al. (2015) also found link between community and media exposure to violence in childhood as a predictive factor for aggression among university students. Current study revealed that 3(30%) participants reported about exposure to media violence, for example, Case 1 reported, “when I was in anger, I used to cut my hands, I saw in dramas where people hurt themselves”. So it means that exposure to violent media leads to violent acts in children and adolescents through observational learning. *Urbanization* is another main reason for getting into delinquency. Participants living in the rural areas were much inspired by the urban lifestyles that most of the children ran out from their homes to explore happening in the inner-city. World population growth is anticipated to be concentrated in megacities, with increases in social inequality and urbanization-associated stress.

A study conducted in Sao Paulo revealed the socio-demographic correlates, aspects of urban living such as internal migration, exposure to violence, and neighborhood-level social deprivation were associated with impulse-control disorders and high social deprivation with substance use disorders (Andrade, Wang, Anderoni, Silveria, & Alexandro-Silveria, 2012). Main research findings revealed that 2 (20%) participants reported about the desire to get urban, which became the cause of truancy, hence, migration from the rural areas to urban setting which are populace, lack cohesion, and much complex life patterns. Thirst for curiosity, exploration, stimulation, and risk taking in the absence of supervision and monitoring can be the reason for developing CD. According to the present research findings, another risk factor perceived by 20% of participants was *supernatural forces*. People surely believe that behind their illnesses or behavioral disorders there are certain supernatural elements which caused them to occur. This was proved by the study conducted to determine the public stigma against people with mental illness and the results showed that rural residents had significantly higher stigma scores for perceiving the supernatural causes behind the illnesses (std. $\beta = -0.09$, $p < .01$). So it was concluded that rural residents showed higher levels of stigma (Girma, Tesfaye, Froeschl, Moller-Leimkuhler, & Muller, 2013). In the sample of the present study, 7(70%) belonged to rural areas having

uneducated and socioeconomically less privileged background. Culturally, when anything goes drastically wrong beyond expectations, people often rationalize this because of some spell casted by others who are jealous of one's prosperous life. Sometimes things when really get out of control then there is inclination in masses, especially with less education, to justify it as some *asar* or *saya* [under the influence of some supernatural force as of jinn]. That may be the reason for participants giving same reason for their behavior either as denial or not understanding the real factor. As a secondary analysis, outcomes of CD were also explored to establish effect on social, school, and personal functioning of the participants. According to DSM-V (APA, 2013), the criterion of every psychological disorder is that it must affect the functioning of the individual's life. Those children and adolescents who faced abuse at the early stages of their lives, they learned this abusive pattern and used these patterns frequently in their later life. They imitated the aggressive behaviors and became abusive towards others (Bandura, 1969). According to present research findings, all the participants experienced physical abuse and only 2(20%) participants faced sexual abuse showing the severe symptoms of CD. Victims of childhood abuse were never comfortable with others closer to them; their early experiences taught them not to trust anyone, and they learned the same abusive behavior and acted out in more aggressive and violent ways (Berman, 2013).

Present research finding revealed that 8(80%) participants reported about *being abusive* towards other. *Family conflicts* act as a risk factor as well as a consequence of CD. Marital discord causes CD in children, which is also an outcome for CD. It means two ways relationship exist marital conflict and CD (Fincham et al., 1994). Once child has deviant peers he spend much of time outside home and indulge in deviant activities, Culturally, it is taken to be mother's prerogative or responsibility to look after children at home, and father is devoid of such responsibility being bread winner. Quite often male child in a family is more outgoing that is why because of cultural restrictions, being female, mother cannot keep an eye on activities outside home of her male child. Living in neighborhood socioeconomically low and with less educated inhabitants, which is fertile turf for deviant activities, it becomes a huge task for mother to have control over activities of male child. Living in poor and criminal neighborhood increase the chance of conduct disorder in those children who are brought up there (Lahey et al., 2000; McCord et al., 2001). In such cases, father's role needs to be very important. Once father is absent physically or psychologically, deviant activities increase, so is parental conflict consequently.

Punishment and school expulsion was reported by the participants in the current study as outcome of their conduct related problems. Parche and Fortuna's (2011) findings revealed that 5(50%) participants reported about the frequent school punishment and 2(20%) reported about the expulsion from school. Children having the conduct issues

have no interest in studies, their major interest in outside activities was wandering, fighting, etc., as a result school dropout, expulsion from school, and punishment occurs. Substance use was another consequence that was associated with the CD. Four (40%) participants reported about their intake of drug. A study revealed that CD increases the risk of substance use and abuse in adolescents regardless of gender (Disney, Elkins, Matt-McGue, & Iacono, 1999). Participants reported about drug use because they wanted to take drugs for the sake of enjoyment.

Disadvantaged neighborhood is a risk factor for pro-active that later predicts delinquency and substance use (Fite et al. 2009). Another finding about the consequences of CD is the involvement in *risky or self-injurious behavior*. Because of risky behaviors there were high chances of their injuries. Three (30%) participants reported about their involvement in self-injurious behaviors. As CD leads to self-injurious behaviors was proved by research findings that 57% adolescents were identified as having self-harming symptoms at admission, in which children were reported to have high symptoms of CD as compared to adolescents (Preyde, Watkins, & Frensh, 2012). Three (30%) participants reported about experiencing increased physical injuries. A study in British Colombia showed that children with the behavioral disorders had more than 1.5 times sustaining odds of injuries than those without behavioral disorders (Brehaut, Miller, Raina, & McGrail, 2003). Because of low risk perception and sensation seeking participants may get involved in risky behaviors (Helgeson, 2012), hence, get more prone to physical injuries.

Although the present research provides an insight about the CD with special reference to its risk factors and consequences among institutionalized male children, nevertheless, various limitations are associated with current study that needs to be considered in future research.

- Sample was collected form the one specific welfare center in Rawalpindi that is not a representative of whole Pakistan which reduces the generalizability of the findings. In future, a large sample from different cities, different centers, or from the children who are out of school or home can be taken. Further purposive sampling was used. In future, random sample if possible can be considered.
- Current was retrospective study where information was taken through biographical interviews. Participants recollected their information about their past memories, but there may be chance that these participants may hide or controlled their information. Although, information was verified from some of the available family members, there were some parents who did not have the exact information about their child's outgoing activities. Some family members were also inhibited about giving their information. Therefore,

information can be collected from peers, either from school, or from neighborhood including significant others from the family members.

- Current was a cross-sectional study. CD being developmental in nature changes in due course of time. Therefore, in future longitudinal studies are recommended.
- For analysis, content analysis was used. In future, grounded theory is recommended to devise theory in indigenous context.

Implication of the present study based on three levels i.e. personal, familial, and peer level. These implications are especially suggested for the CPWB and the like where children are institutionalized. For those children who are risk takers, sensation seekers, and have low cognitive skills; certain activities for the sublimation of their negative energies can be planned to channelize these into positive outcomes basing upon their interests, for example, for children having interest in sports, sports activities can be promoted. Those children who are sensation seekers, thrill based or adventurous activities can be planned, for example, skating, bicycle racing, mountaineering, etc. Vocational training is highly recommended along academics to promote their survival and become productive member of the society. Self-advocacy training to speak for their rights is important to promote this very life skill to discourage sexual and other deviant activities. Assertive training is also helpful where peer influence is high to make them indulge in deviant activities.

It is suggested that communication skills of children can be improved, as sometimes because of hostile attribution or lack of social skills children develop such problems and are unable to seek help of others when they need it. Some of the children were not accepted by their families and disruptive familial patterns including parental conflicts were existing in their homes. Lack of supervision and monitoring is one of the underlying reasons for deviant activities in children. Therefore, if possible, workshop for respective parents can be arranged to improve upon their parenting skills and disciplinary techniques without getting punishing and hostile. For those families whose parents were divorced, foster parenting can be one of the options. Volunteers can be sought who could facilitate in these children's development. Those families who live in a very low socio economic status, financial help is recommended with the cooperation with *Bait-ul-Maal* and like to fulfill their basic needs so that family should accept their child and not leaving them in institutions.

CONCLUSION

In the present study, various psycho-social risk factors were found to be associated with the development of CD among institutionalized children that can be grouped as social, personal/psychological, community based, and supernatural forces.

Demographically most of them belonged to low socioeconomic and uneducated class with large family size. Consequently, participants were experiencing marked disruption in their social, school, and personal functioning that confirmed diagnosis of CD for the participants of the study.

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