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Yesbergenova G.B. [1]

Senior lecturer of the department of general and applied psychology,
al-Farabi Kazakh National University, Kazakhstan, Almaty, e-mail: gulnur_2288@mail.ru

BEҺAVIOURAL DISORDER: INTERVENTION FRAMEWORK FOR SCҺOOLS AND COMMUNITIES

Behavioural disorders (BD) among school children and adolescents arguably represent a class of inveterate antisocial and disruptive behaviours that have been recognized to interfere with effective interaction with the environment. While behavioural disorder is often regarded as a relatively common phenomenon in all societies and well documented, yet various research efforts and treatment practices have all pointed to the fact that behavioural disorders have proved to be difficult to treat successfully. For this purpose therefore, certain possible correlates can be clustered into personal, family, school, and peer dimensions. It needs to be emphasized that any successful intervention programmes will most probably need to address these multiple factors and their interactions, requiring a multidimensional, multi-focus, preventive approach that encompasses the child's nature and family background. Both psychologists and school administrations may need to abandon traditional placement or exclusion activities in favor of a more comprehensive strategy that is based on inter agency collaboration and parent involvement and interventions. In this volume I will try to highlight some frameworks of understanding and proven intervention programmes for schools and the community. The article will close with an overview and rationale of contingent management programmes.

Key words: behaviours, disorder, peers, schools, parents.

Есбергенова Г.Б.

әлеуметтану және әлеуметтік жұмыс кафедрасының докторанты,
әл-Фараби атындағы Қазақ ұлттық университеті,
Қазақстан, Алматы қ., e-mail: gulnur_2288@mail.ru

Мінез-құлықтық бұзылулар: мектептер мен қоғамдастықтарға арналған араласу шеңбері

Оқушылар мен жасөспірімдер арасындағы мінез-құлықтық бұзылулар (МБ) қоршаған ортамен тиімді өзара іс-қимыл жасауға кедергі келтіретін жағымсыз әлеуметтік және жойғыш мінез-құлықтардың сыныбы болуы мүмкін. Мінез-құлықтық бұзылулар жиі барлық қоғамдарда салыстырмалы түрде таралған құбылыс ретінде қарастырылады және жақсы құжатталған болса да, әр түрлі зерттеу жұмыстары мен емдеу әдістері мінез-құлықтық бұзылулар табысты емдеу үшін қиын болғанын көрсетеді. Сондықтан осы мақсат үшін белгілі бір ықтимал корреляттар жеке, отбасылық, мектеп және құрдастары өлшемдеріне топтастырылуы мүмкін. Кез келген табысты араласу бағдарламалары, ең алдымен, осы көптеген факторларды және олардың өзара іс-қимылын ескеруі тиіс, бұл баланың табиғатын және оның отбасылық шығу тегін қамтитын көпмақсатты, алдын алу тәсілін талап етеді. Психологтарға да, мектеп әкімшіліктеріне де ведомствоаралық ынтымақтастыққа, ата-аналардың қатысуы мен араласуларға негізделген неғұрлым жан-жақты стратегияның пайдасына бөлу немесе алып тастау жөніндегі дәстүрлі іс-шаралардан бас тартуға тура келуі мүмкін. Бұл мақалада мен мектеп пен қоғамдастық үшін кейбір түсіну шеңберін және тексерілген араласу бағдарламаларын түсіндіруге тырысамын. Мақала контингенттерді басқару бағдарламаларын шолумен және негіздеумен аяқталады.

Түйін сөздер: тәртіп, тәртіпсіздік, құрдастар, мектептер, ата-аналар.

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Есбергенова Г.Б.

Казахский национальный университет имени аль-Фараби, докторантка кафедры социологии и социальной работы, Казахстан, г. Алматы, e-mail: gulnur_2288@mail.ru

Поведенческие расстройства: рамки вмешательства для школ и сообществ

Поведенческие расстройства (ПР) среди школьников и подростков, вероятно, представляют собой класс закоренелых антисоциальных и разрушительных поведений, которые, как было признано, мешают эффективному взаимодействию с окружающей средой. Хотя поведенческие расстройства часто рассматриваются как относительно распространенное явление во всех обществах и хорошо документированы, все же различные исследовательские работы и методы лечения указывают на тот факт, что поведенческие расстройства оказались трудными для успешного лечения. Поэтому для этой цели определенные возможные корреляты могут быть сгруппированы в личные, семейные, школьные и сверстнические измерения. Необходимо подчеркнуть, что любые успешные программы вмешательства, скорее всего, должны будут учитывать эти многочисленные факторы и их взаимодействие, что требует многомерного, многоцелевого, превентивного подхода, который охватывает природу ребенка и его семейное происхождение. Как психологам, так и школьным администрациям, возможно, придется отказаться от традиционных мероприятий по разделению или исключению в пользу более всеобъемлющей стратегии, основанной на межведомственном сотрудничестве, участии родителей и вмешательствах. В этой статье автор пытается осветить некоторые рамки понимания и проверенные программы вмешательства для школ и сообщества. В завершении проводится обзор и обоснование программ управления контингентами.

Ключевые слова: поведение, беспорядок, сверстники, школы, родители.

Introduction

A lot of studies that were done on the problem of behavioural disorders (BD) in the past decades demonstrate that children with hostile attributional tendencies are more likely to experience behavioral difficulties in interacting with peers. Aggressive children tend to display a hostile attributional bias in that they are more likely than average children to attribute hostile intent to a hypothetical peer after an ambiguous provocation by the peer. Especially when the provocation is directed towards the aggressive child Furthermore, aggressive children are also known to have deficient in attributional skills. One study posits that when they are shown video recorded stimuli of benign provocations, the children also tend to demonstrate relative deficits in accurately interpreting others' intentions. They might as well misinterpret benign intentions as hostile, even when most of the presented cues favour a benign attribution (Dodge, 1993; Waas 1988).

Social information-processing theories of interpersonal behavior posit numerous possible mechanisms for behavioural responses (including attentional biases, response accessing, and response decision tendencies in addition to attributional and interpretational tendencies). Thus it is unlikely that attributional tendencies will be found to be the only mechanism by which the likelihood of aggressive responses is increased. These hostile attributional biases may appear to play more significant roles in mediating angry, reactive aggressive behaviours than in nonangry, proactive aggressive behaviours.

Disturbing antisocial behaviours in children and adolescents constitute a significant problem in children's mental health services and are perhaps one of the most serious public health challenges for many countries (Earls, 1989; Prinz, 1991). Several of these behaviour disorders appear to cluster together and have been designated variously as conduct problem, conduct disorder, or externalizing disorder (Kazdin,1987). Majority of the children and adolescents exhibiting this range of behaviours present with great frequency among cases defined as aggressive, disruptive, and difficult to teach by educators; as exhibiting specific learning disabilities and attention deficits/hyper activity by pediatricians; and as delinquent by criminologists.

Regardless of the label attached to the children exhibiting these behaviours, the nature, onset prevalence and prognosis of the syndrome appear to be remarkably stable and have critical significance to schools and society. Behavioural disorder (BD) constitutes a class of chronic, severe antisocial behaviours that typically begin in early childhood and extend into adulthood (Robins, Ratcliff, 1979) has outlined several facets of the syndrome differentiating it from other problems of childhood and from typical childhood behaviours. The first of these is antisocial behaviour. Children with BD typically and persistently manifest physical and verbal aggressions, stealing, lying and violation

of social norms and rights of others. A second component of BD is *chronicity.* Children with BD exhibit these serious disruptive and aggressive behaviours over months and years and they often are unresponsive to short-time home and classroom interventions. Such long time resistance to treatment is often a source of considerable stress to parents, teachers, and other children in the classroom. A third dimension of behavioural disorder is *impairment to functioning.* Children with BD exhibit antisocial behaviours in sufficient frequency and intensity to affect significantly their educational performance and interpersonal interactions. These dimensions suggest that children with BD often exhibit behaviours that clearly deviate from typical classroom and home behaviour. In addition, they often experience difficulties across academic periods and settings.

Whereas many children occasionally exhibit some of the behaviours associated with disorder, the term abnormal conduct is applied when several antisocial behaviours covary and are persistent, uncontrollable, and/or significantly impair home and school functioning (Boyle, Offord, 1990). Considering the fact that behavioural disorder and its associated antisocial behaviours have significant costs across society, considerable research on the disorder has occurred. Although this research has failed in general to provide convincing evidence for effective treatments of the disorder, it has yielded powerful information to aid in understanding the syndrome. In summarizing the research activities (Dumas, 1989) noted certain well-substantiated conclusions about chronic antisocial behaviour. These conclusions may help to shed light on the nature, prevalence and outcome of the abnormalities.

Series of epidemiology studies, whether clinical or statistical have identified consistently, an antisocial behaviour Syndrome or disorder. According to Quay, this type of behavioural disorder is well-documented in the clinical and empirical literature (Quay, 1986). Thus numerous clinical and multivariate statistical studies have also provided consistent evidence for the syndrome. This behavioural disorder category appears robust given that it is stable across a variety of measures, informants and settings. Certain empirical evidence has also accumulated for the existence of other distinct subcategories within the behavioural disorder categories: undersocialized aggressive and socialized aggressive. Generally consistent with the empirical approach, Directorate of Social Monitoring (APA 1999) discusses three subtypes: solitary and aggressive, group and undifferentiated. The first subtype designated undersocialized-aggressive were documented in the works of Quay, and solitary aggressive characterised by aggressions, poor self-control, disruptive and difficulty in inter personal areas.

In many cases, undersocialized aggressive behavioural disorder has been associated with peer rejection, poor social skills and have often resulted in repeated failure of intervention programmes. The second major subtype, labelled socialized aggressive and group behavioural disorder is identified with delinquent behaviours carried out in group context. While socialized aggressive behaviour disorder lacks the isolated nature of undersocialized aggressive behavioural disorder it may as well include somewhat more positive prognosis. Other approaches of framing valid sub-categories of behavioural disorder have focused on distinguishing children on the basis of the child's salient symptoms (e.g. arguing, fighting and temper tantrums vs. fire setting, lying, stealing and truancy and the child's overt confrontational and covert or concealed antisocial behavior.

General characteristics of behavioural disorder as outlined in the Directorate of Social Monitoring (DSM) are presented in table 1

Table 1 – Disturbance of conduct lasting at least 6 months, during which at least three of the following have been present

1	has stolen without confrontation of a victim on more than one occasion
2	has run away from home overnight at least twice while living in parental or parent surrogate home (or once without returning)
3	has often initiated physical fights
4	has lied several times (other than to avoid physical or sexual abuse)
5	has deliberately engaged in fire setting
6	Is often truant from school (for older person, absent from work

7	ħas broken into someone else's home, building, or car
8	ħas deliberately destroyed other's property (other than by fire setting)
9	ħas been physically cruel to animals
10	ħas forced someone into sexual activity with him or her
11	ħas used a weapon in more than one fight
12	ħas stolen with confrontation of a victim
13	ħas been physically cruel to people

DSM – criteria for diagnose of behavioral disorder (Quay, 1986)

Behavioural disorder is common in the general population, and quite common in clinical referrals and classrooms for children with serious emotional disturbance.

Estimates of the prevalence of conduct disorder in the general population range from about 3 to 7 % (Castello, 1989). Behavioural disorders have been identified as the most prevalent form of childhood disorder, while children with BD represent the most common type of referral for children's mental health services. One study of the prevalence of antisocial and mal-adjusted behaviours in regular classrooms, reported the frequencies of such behaviours to be ranging from 4 to 6% in elementary schools. The same study claimed that prevalence rates dropped somewhat in the high school years, which may be interpreted that students exhibiting such behaviours may leave or be excluded from school in later school years (Cairns, Neckerman, 1989).

Behavioural disorders has the tendency to stabilize over time than other childhood disorders.

Generally and in its most serious form, behavoural disorders often has an early onset and may progress to lifelong course, which in later years may develop into serious delinquency in adolescence and antisocial personality disorder and criminal behaviour in adult stage. Longitudinal studies also have provided consistent findings regarding the stability of aggressive behaviour, sometimes being compared to that found for intelligence, whereas other disorders of childhood (e.g. internalizing disorders) may respond to treatment or ameliorate spontaneously over time. Indeed some aspects of behavioural disorder may persist in a relatively constant form throughout the developmental part indeed. "A commmon belief that antisocial children will "grow out" of problem behaviours seems unfounded"(Robins, 1966). Individuals exhibiting serious antisocial behaviours in adolescence and adulthood typically engaged in similar behaviours when they were very young. This also suggests that serious delinquent behaviour often may represent a syndrome comprising multiple antisocial behaviours that resists treatment and runs in families. In terms of syndrome's durability, resistence to short-treatment, and disabling effects, it is safe to compare and categorise the disorder into mental retardation, autism and blindness.

Among childhood disorders, the prognosis for change for children with behavioural disorder is relatively poor.

In many cases, because the syndrome may become an enduring condition requiring continuous monitoring and maintenance to gain and sustain treatment progress, it has become necessary that the prognosis for children with the disorder remains guarded. While series of diverse interventions targeted towards the syndromes have been reported, reviews of outcome results of these interventions have suggested that most treatments have been minimally effective particularly when antisocial behaviours which have an early onset, are diverse, and are pervasive, long term-problems in almost all of adult functioning are prominent (Frick, Lahey, 1991). These areas include education, occupation, interpersonal relations, health, relations with authorities and mental health. Many, if not all of the children with BD will more likely abuse substances and to suffer from alcoholism.Thus the extended consequences of the syndrome seems to be severe and pervasive.

A psychosocial framework for understanding behavioural disorder

Behaviour disorder is a complex problem with multi facets, covariates and determinants. Ħowever a number of characteristics seem to cluster within and around the syndrome in a systematic

way encompasing personal, familial, school and peers factors. (Jessor, 1991) has proposed that these dimensions provide a useful framework for understanding and preventing childhood psychopathological including behavioural disorders. Personal, family, school and peer variables associated with behaviour disorder, along with interactions among them, may provide a powerful explanatory and planning mechanism for providing comprehensive services to children with BD.

Given the resistance of the disorder to most treatment strategies, a comprehensive, intergrated intervention approach that addresses these dimensions and their interactions may be necessary to have a a preventive or remedial effect on the disorder. Personal characteristics. Children and youth with BD often exhibit relatively stable personal characteristics that covary with and may mediate antisocial behaviours (Cheney, Sampson, 1990). These characteristics may be particularly important because their onset frequently appears quite early in the child's development history. These often precede the occurrence of serious antisocial behaviours and may serve as markers for subsequent severe externaslizing behaviours.

Personal characteristics associated with subsequent conduct disorder may appear in preschool years, sometimes as early as age 2. These may include resistance to discipline and irritability, developmental cognitive and language difficulties, and early aggressive behaviours. Cognitive factors also play very important and well-documented roles in antisocial behaviours and conduct disorders (Dodge, 1993). Antisocial children often exhibit a cognitive response bias in which they interpret ambiguous interpersonal stimuli as being hostile. This cognitive bias may result in and justify aggressive responses to the misperceived hostile stimulus. Children with conduct disorders also may be deficient in problem-solving skills particularly in generating multiple and/or prosocial problem solutions. These children tend to be limited and inflexible in solution generation, resulting in a narrow repertoire for responding to conflict situations.

Parent and family factors.

Among the most well-demonstrated percusors and covariates of behaviour disorders are parent and family characteristics and behaviours. Children with BD often come from families experiencing considerable stress in which members are alcoholic or engage in criminal activities or from families in which other members exhibit psychopathology. These factors are perhaps the most significant family factors in relation to behaviour disorders are parent-child interactions and parent management practices (Loeber, 1990). General patterns of discipline practices of parents of children with BD often show externalising and tend to consist of a combination of inconsistent and highly punitive behaviours that may increase both deviant behaviours and alienation in their children.

Parents interactions in these families often are predominantly nagative particulaly in response to negative child behaviours. Positive behaviours either are not reinforced or are responded to with aversive reactions. Negative child behaviours often gain parent attention that are both aversive and inconsistent, resulting in increased, but unpredictable, attention for antisocial conduct versus prosocial behaviour (McGee, Short, 1991). The combination of this pattern of parent discipline tactics appears to be highly predictive of antisocial behaviour in their children. In so far as parent management practices constitute a relatively malleable factor in conduct disorders in their children, they on the other hand represent a positive and promising intervention area for schools and professional child psychologists.

School factors. Commonly school variables long have been associated with juvenile delinquency and conduct problems these recently have received attention in theoretical models of the development of models of antisocial behaviours, delinquency and conduct disorder. Usually, the children exhibiting antisocial behaviours have also been identified as poor readers. Antisocial and delinquent behaviour have been related to poor academic performance as well as to low school participation and disruptive behaviour in the classroom (Shapiro, Hynd, 1993). Increased rates of truancy also have been attributed to conduct disorders among school children.

Although variables as poor academic achievement constantly have been shown to relate to delinquent and antisocial behaviour, causal relationships between the two remain unclear. Both academic underachievement and conduct problems may tend to be related to similar antecedent variables including low economic status, family problems, and intellectual neurological, and language deficits (Walker, Stieber, Ramsey, 1991). Regardless of the nature of causal relationships associated with achievement and behavior disorder, their connection is well demonstrated and may have important implications for schools.

Peer Factors. This factor is based predominantly on peer group as an agent of socialization and a predictor variable in personality formation. A child's socialization process as it happens among peers with

whom a child spends lots of time together. Thus, other factors in addition to personal and family are the peer variables which have also been associated with conduct disorders. In many cases children exhibiting antisocial behaviours have often been found to be rejected by their peers often in response to their negative behaviours, even when these peer groups may consist of several highly aggressive children, all of whom exhibit similar characteristics (Tremblay, Masse, Perron, 1992). Frequently formed during early adolescence, these deviant groups become involved in serious deinquent and antisocial behaviours.

Family/parent intervention activities

It is generally known that parents and guardians traditionally have been relatively passive consumers of educational services and often have had only sporadic contact with school personnel. Their limited contacts most often have been for periodic reporting purposes or couls be the result of some problems associated with academics or behaviour in the classroom. Even though school administration are mostly aware of the significance of family and community influences on student behaviours, relatively little emphasis has been placed on interventions for improving and/or using these influences to remediate educational and behaviour problems, principally for fear of being regarded incompetent, after all parents tend to trust the school teachers as the people who have been specially trained to be able to coerce children into proper behaviour through varieties of disiplinary measures (Wolf, Braukmann, Ramp, 1987). At the same time, parents on the other side are expecting the school to be able to inculcate good manners into the children they have trusted in the custody of the school. Never-the-less, school personnel on their part have noted the critical role of parental alienation in the development of BD and the importance of parental commitment to schools and education in successful intervention for BD.

In the light of the critical roles that parents can play in the development as well as in the treatment of conduct disorders, schools and school psychologists must work on parent interventions on two fronts. Both must compel a nontraditional orientation to the role of parents in education. First, they must develop mechanism for involving and empowering parents in educational activities with and for their children. Developing such frameworks will require considerable flixibility and resolution in the schools, but may be necessary in that parental commitment may be the sin qua non of successful trestment of BD (hawkins & Weis, 1985). Second, schools and school psychologists should emphasize interventions that inprove parenting skills and management practices. Training in these areas may be a critical component of effective interventions with this complicated population.

Of the many intervention programmes in existence, one intervention approach that has been integral in the treatment of BD is the use of the so called ‘contingency management programmes’. This contigency management applies the approach of operant conditioning to change children’s behaviour. That is, a child or adolescent’s behaviour is shaped through a systematic structuring of the consequences for his or her behavoiur (Ross, 1981). The contigency management progammes have certain basic components which involve the establishment of some clear goals that include (1) positive behaviours (e.g., proper expression of anger, prosocial interactions with peers, respectful comments to adults) that are designed to be increased by providing consistent positive consequences when they are exhibited, and (2) negative behaviours (e.g., aggression, noncompliance to adults, rule-breaking behaviour) that are designed to be decreased through consistent negative consequences when they are exhibited. The rationale for contingency management programmes in the treatement of conduct disorders is based on the assumptions that conduct disorders develop, at least in part, as a result of a failure of the child or adolescent to learn to modulate his or her behaviour.

In many theories, this failure to develop behavioural control is a direct result of poor rearing environment in which primary socializing agents, such as a child’s parents, fail to provide consistent and appropriate consequences for the child’s behaviour. The consequnces may be inconsistent, nonexistent, or even inappropriate in the sense that problematic behavoiur may actually be reinforced by the parent (Patterson, 1986). Primarily, the programmes for contingency management are designed to provide a corrective learning environment for the children or adolescents by establishing very clear behaviour expectations and consistent consequences for their behaviours.

It must be mentioned that while the primary rationale for contingency management programmes focuses on compensating for inadequate socializing environments, some rationale can as well be made for these programmes based on some of the individual predispositions to conduct disorders. For example, a subgroup of children with conduct disorders have a specific response style that leads to their behaviour

to be more driven by rewards than punishments labeled the “reward-dominant” response style (O’Brien, Frick, 1996). Besides a raft of studies on the subject has revealed that many children with conduct disorders have intellectual deficits, particularly verbal deficits, that can interfere with their ability to associate their behaviours with their consequences, particularly if their consequences are delayed or inconsistent. In both of these cases, the rationale for contingency management programmes is that such children, because of their individual predispositions, are more susceptible to the less-than-optimal contingencies that operate naturally in their environment. Therefore, there is a need for more structured environments in which the contigencies for their behaviour are very tightly controlled in order to prevent further behavioural disorders.

The development of sophisticated and multisystem treatment of behavioural disorders has been a great advancement for the treatment of simpler forms of offending, but simpler forms of treatment such as parent training have not been thoroughly examined and tested. While it is clear that family therapy in general has been effective with adolescent offenders and certainly may be more beneficial than individual therapy alone, it is understanding the case to recommend that more investigation and knowledge-building needs to be done (Pettit, Bates, Ddge, 1983). It is widely agreed that the area deserves more attention, given the increased rates of juvenile offending over the years, and the often high corresponding costs that are incurred at the societal level as a result of public and private properties destruction, incarceration law enforcement, mental health services and remedial education.

In addition to these, there are more inherent personal costs involved with the emotional and physical harm to victims of antisocial behavior and the distress that juvenile-offending youths and their families experience. In view of the potential for negative consequences, the need to understand and apply more effective forms of treatment for adolescent antisocial behavior is clearly warranted and cannot be overemphasized. (Chamberlain, Rosicky,1995; Һenggeler et al.,1993).

Conclusion

In this article attempts have been made to reiterate the fact that behavioural disorder is a difficult and multidimensional class of behaviours that have been known to be resistant to diverse treatment strategies. The article also shows that characteristics and stability of the disorder have been well-documented, as have personal, family, school, peer, and other correlates. The article also discusses the rationale for contingency management programmes. The article maintains that successful interventions for the disorder must take into account the complexities of the syndrome, thus requiring collaboration and coordination across a number of settings and among the numerous community agencies serving these children. The volume also contends that more research and practices need be put in place by schools to address the common feature in the experience of children including those with behaviour disorder, as schools and school psychologists may be the appropriate leaders in service provision to this population. Such leadership may require additional training and expertise, along with organizational flexibility. It also advocates for the complimentary collaborations between family and educational establishments in recognition of the significant role played by the parents in causing and treating behavioural disorder and thus represent a positive and promising intervention area for schools and professional child psychologists.

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