Introduction

Conduct disorder is a repetitive and persistent pattern of behavior in children and adolescents in which the rights of others or basic social rules are violated. The child or adolescent usually exhibits these behavior patterns in a variety of settings at home, at school, and in social situations and they cause significant impairment in his or her social, academic, and family functioning ***(American Academy Pediatrics, 2003).***

According to ***Okasha et al. (1999),*** conduct disorders in Egypt represented 5% in 1967 and 8.2% in 1993, in studies held in outpatient psychiatric facilities in Ain Shams University Hospitals. As well, ***Barrickman (2003)*** found that, the male to female ratio has been to range between 5:1 and 3:1, depending on the age range studied, but at all ages boys predominate over girls. It is only in adolescence that the gap between the sexes begins to close because of the increase of the disorder in girls.

In Egypt, ***Abdel-Rasoul et al. (2007)*** reported that the prevalence rate of conduct disorder in a study sample, in Egypt, was 7.3%. The highest prevalence rate was observed among rural governmental school children (8.40%) and the lowest among urban governmental school children (6.03%). Prevalence rate of conduct disordered increased with grade of education: 6.84%, 7.02%, and 8.12% for children in the 3rd, 4th, and 5th grades of primary education, respectively.

Abd El-Rakeep et al. (2004) identified that children with conduct disorder are also likely to show academic deficiencies, as reflected in achievement level, grades, being left behind in school, early termination from school and deficiencies in specific skill areas such as reading. Youths with the disorder are likely to evidence poor interpersonal relations, as reflected in diminished social skills in relation to peers and adults higher levels of peer rejection. This disorder is marked by chronic conflict with parents, teachers, and peers and can result in damage to property and physical injury to the parent and others ***(American Academy of Child and Adolescent Psychiatry, 2001).***

Those with CD show high levels of anxiety and depression, are more likely to drop out of school, have impaired educational achievement, experience conflict with parents, substance abuse, get arrested in adulthood, have poor work history as adults, and have unstable relationships and future mental health problems ***(Frick, 2001; Frick & Dickens, 2006).***

Past research has suggested that CD is a critical mental health concern because it causes disruption in families, schools, and communities, as well as societal monetary costs, it is because of the serious nature of CD that there has been a great deal of research to gain more insight into the disorder ***(Hutchings, 2005),*** and also intervention have established both that parenting behaviors influence the development of childhood of conduct disorders targeting specific parenting skills are the most effective

way of preventing child behavior problems and may also reduce rates of subsequent arrest ***(Young & Jaffee, 2006).***

The role of the nurse is essential to engage in parental counseling, educational guidance and provide parent with a framework for understanding their child's condition ***(Mohr, 2003).***

Significance of the Study

The process of parent's learning to cope effectively with stress of having a conduct disorder child through training program can help the parent to get through and learn that while there is no cure for CD, until they can be dealt with a way that reduces stress and cope with the behavioral problems of the child.

The importance of the coping that parent's lack of knowledge about their child's deficits and their reliance on usual parenting techniques may result in inappropriate parent-child interactions. Consequently, parent training programs seek to improve parents. Abilities to cope with and manage the problems associated with childhood conduct disorder by providing information about conduct disorder, enhancing parenting skills, and supporting parents' sense of competence and also that, benefits of behavioral parent training programs are decreasing parental stress, improving parenting behavior and self-esteem, and reducing oppositional behavior by the children.

Aim of the Work

The aim of this study was to enhance the coping strategies (Intervention Protocol) of parent having children with conduct disorders.

This aim was achieved through:

- Assessing coping patterns of parents caring for children with conduct disorders.
- Implementing coping strategies' intervention protocol to enhance parents coping patterns.
- Evaluating the effect of this protocol on parents' coping patterns of care provided to their children.

Hypothesis:

Coping strategies intervention protocol for parents has a positive effect on their children with conduct disorders.

Review of Literature

Definition:

Sia and Breaky (2000) defined conduct disorders as an imprecise and controversial term used to describe a wide range of antisocial acts. These diverse behaviors are including aggressive acts, lying, stealing, fire setting, truancy and cruelty.

Conduct disorder is defined by the diagnostic and statistical manual as a" repetitive and persistent pattern of behaviors in which the basic rights of others or major age-appropriate societal norms or rules are violated ***(American Psychiatric Association, 2000).***

According to ***Ashwill and Dorsk (2000)***, and ***Brigg (2001)*** conduct disorders was defined as aggressive and destructive behaviors usually seen during the developmental stage before, during or just after the onset of puberty. Interpersonal behaviors, aggressive and destructive behaviors and disorders are involving delinquency at this time that includes developing peer relationships, participating in activities outside the family, lessening family ties, and exhibiting independence

Conduct disorder is differentiated from other psychiatric disorders diagnosed in children by the following criteria: "persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated" ***(American Psychiatric Association, 2007).***

Epidemiology:

The prevalence of conduct disorder is estimated as approximately 9% for males and 2% for females younger than 18 years ***(National Institute for Health and Care Excellence, 2007).***

However, ***Scott (2007)*** found that, the prevalence of conduct disorders among 10-11 years old children was 4 % and that 1.5% of those 10-11 years old were of the non- socialized conduct disorder. On the other hand, ***Ray et al. (2007)*** found that older children admitted to a psychiatric unit set fires with others, away from home, while those under the age of ten set fires on their own at home.

Aggressive children especially of lower class parents, when became more aggressive in response to poor relationship outside the home, evoke punitive reaction from their parents ***(Patterson, 2004)***. However, the prevalence of conduct disorder or antisocial behavior seems to have important linkage to the condition of poverty, poor families may have insufficient time or energy to provide appropriate parenting during childhood ***(Hodgins & Muller-Isberner, 2000).***

Research also indicates that, approximately 20 - 25% of children with conduct disorder are underachieving in school relative to a level predicted by their age and intellectual abilities. ***Frick (2001)*** found that, conduct disorder and severe aggression were common among runaway and homeless youths

and were more prevalent than has been reported for the general population, also these findings suggested that, among runaway, severe aggression are more strongly related to other problems than is conduct disorder.

Regarding childhood age, ***Binder (1999)*** found that, symptoms of conduct disorder such as restlessness, destructiveness, fighting, disobedience, bullying and temper tantrum were common in boys than in girls. In this respect, ***Hodgins (2000)*** stated that after studying the record of delinquent fire setters, he found that, between, 79 youngsters there were only one girl. However, the male/female difference concerning the prevalence of conduct disorder as mentioned by ***Werry et al. (1994)*** was statistically significant; it was proved to be 8.1% vs. 2.7%. Males are more likely to be overtly aggressive this is because of the permissive attitude of the family and the society, for this overt aggressive behavior conducted by males. This attitude is socially imitated by other children and causes further reinforcement of this overt aggressive behavior.

The Egyptian Journal of Neurosurgery Psychiatry (2004), study was carried out to estimate the prevalence of conduct disorder (CD), in adolescent students in secondary schools, in Assiut City. It was carried out on 2123 students, 1627 (76.64%) students representing the technical schools, and 496 (23.36%) students representing the general schools, 1137 (53.6%) were males, and 986 (46.4%) were females. In general

schools, 50 (50.2%) students were positive for CD, 28 (22.1%) males and 22(18.1%) females. Male to female ratio was 1.2: 1. Regarding the clinical types, 79 (78.2%) students were of adolescent onset type, while 22 (21.8%) were students of childhood onset type. Regarding severity, 57 (56.4%) students of mild degree, 31 (30.7%) students of moderate degree, and 13 (12.9%) students of severe degree of CD. With increase age of onset, there is a decrease in the severity of CD. The age of onset of CD is higher in females than in males. So, CD is a major problem, as it affects a higher percent of students in the secondary schools.

Females' role tends to be more submissive, this is encouraged by the family, any aggressive behavior conducted by girls is culturally rejected. The hormonal pattern and body built of boys were found to be causing more activity and increase contact with other children in the community, which gives them the chance for imitating and reinforcing each others' behaviors. This provokes more aggression and increases the tendency for misconduct in boys ***(Shaheen, 1990).***

Thomas (2006) mentioned that, antisocial behaviors often appears to be strongly related to age. Many people tend to associate antisocial behavior with adolescent period; the peak incidence of crimes against property is at age 17 in America and 14 in England, with increasing age, there may be an increase in the occurrence of an unacceptable behavior.

In relation to child order, ***Koller (1995)*** mentioned that, there is a lower incidence of conduct disorder in the first order child with increased incidence in the second, third and fourth position. In addition, when the ordinal position was examined for families having four or more members, there was an increase in the second and middle ordinal position and decrease in the first and last ordinal position ***(Kratzer & Hodgins, 2000).***

Clinical manifestations:

The symptoms of conduct disorder include bullying others, initiating fights, using weapons, being physically cruel to others, and animals, stealing while confronting a victim, destroying property, breaking into others property, stealing items of nontrivial value, staying out late, running away, lying, deliberate fire setting and truancy ***(Kazdin, 2001).***

Diagnostic criteria of conduct disorder:

Conduct disorder is still a distressing problem in both industrialized and developing countries, it forms a large single group of psychiatric disorders in childhood and adolescence, in which the main feature persistent is socially disappeared behavior. This behavior may limit to the child's home and family, or it may extend to affect the wider community ***(Rossen & McKever, 2000).***

The most commonly used method of classifying conduct problem in children is described in the task force on DSM-IV ***(American Psychiatric Association, 2000).***

According to DSM-IV Diagnostic Criteria for Conduct Disorder:

A. A conduct disorder is a repetitive and persistent pattern of behavior in which the basic right of others or major age appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months ***(American Psychiatric Association, 2000).***

- Aggression to people and animals:
  1. Often bullies, threatens, or intimidates others.
  2. Often initiates physical fights.
  3. Used a weapon that can cause serious physical harm to others.
  4. Has been physically cruel to animals.
  5. Has stolen while confronting a victim.
  6. Has forced someone into sexual activity.

- Destruction of property:

1. Has deliberately engaged in fire setting with the intention of serious damage.
2. Has deliberately destroyed others' property (other than by fire setting).

- Deceitfulness or theft:

1. Has broken into someone else's house, building, or car.
2. Often lies to obtain goods or favors or to avoid obligations (i.e., cons' others).

3. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).

Serious violation of rules:

1. Often stays out at night despite parental prohibitions, beginning before 13 years.
2. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).
3. Often truant from school, beginning before age 13 years.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.

Classification of conduct disorder:

Subtypes of conduct disorder:

Specified types based on age of onset:

There are two subtypes of conduct disorder outlined in DSM-IV, and their diagnosis differs primarily according to the nature of the presenting problems and the course of their development.

The first, childhood onset type is defined by the onset of one criterion characteristic of conduct disorder before age 10.

Children with childhood-onset conduct disorder are usually male, and frequently display physical aggression; they usually have disturbed peer relationships, and may have had oppositional defiant disorder during early childhood. These children usually meet the full criteria for conduct disorder before puberty; they are more likely to develop adult antisocial personality disorder than those with the adolescent-onset type ***(American Psychiatric Association, 2000).***

The second, the adolescent- onset type'' is defined by the absence of conduct disorder prior to age 10. Compared to individuals with the childhood-onset type, they are less likely to display aggressive behaviors. These individuals tend to have more normal peer relationships, and are less likely to have persistent conduct disorders or to develop adult antisocial personality disorder. The ratio of males to females is also lower than the childhood-onset type ***(American Psychiatric Association, 2000).***

- **Unsocialized conduct disorder:**

This type is characterized by the combination of persistent dissocial or aggressive behavior and not merely comparing oppositional, defiant disruptive behavior with pervasive abnormality in individual relation with others ***(Kaplan & Sadock, 2000).***

- Socialized conduct disorder:

It involves persistent dissocial or aggressive behavior, it occurs in individuals who are generally well integrated into

their peer group ***(American Academy of Child and Adolescent Psychiatry, 2001).***

- Oppositional defiant disorder:

It is seen in children below the age of 10 years, it is defined by the presence of markedly defiant, disobedient, provocative behavior ***(Loeber et al., 2002).***

Mixed disorders of conduct and emotion

It is characterized by the combination of persistently aggressive, dissocial with overt and marked symptoms of depression and anxiety ***(American Academy of Child and Adolescent Psychiatry, 2001).***

- Pepressive conduct disorder:

This category requires the combination of conduct disorder of childhood with persistent and marked depressed mood ***(Devito & Hopkins, 2001).***

Severity of conduct disorder:

Cooklay (2001) classified the level of severity of conduct disorder as following:

Mild form:

Few of any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others (e.g., lying, truancy, staying out after dark without permission)***(American Psychiatric Association, 2000).***

Moderate form:

Number of conduct problems and effect on others intermediate between "mild" and "severe" (e.g., stealing without confronting a victim, vandalism**.**

Severe form:

Many conduct problems in excess of those returned to make the diagnosis or conduct problems cause considerable harm to others ***(American Psychiatric Association, 2000).***

Etiology of Conduct Disorder:

The exact cause of conduct disorder is not known, but it is believed that a combination of neurological, genetic, environmental, and social factors play a role.

1–Neurological factors

Some studies suggest that defects or injuries to certain areas of the brain can lead to behavior disorders. In addition, conduct disorder has been linked to special chemicals in the brain called neurotransmitters that help nerve cells in the brain communicate with each other. If these chemicals are out of balance or not working properly, messages may not make it through the brain correctly, leading to symptoms. Further, many children and teens with conduct disorder also have other mental illnesses, such as attention-deficit/hyperactivity disorder (ADHD), learning disorders, depression, substance abuse, or anxiety disorder, which may contribute to the conduct disorder ***(American Academy of Child Adolescent Psychiatry, 2001).***