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A Note on a Study of Children with Antisocial Behaviour

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Introduction

"Antisocial behaviour" is a sociological terminology and not a clinical entity. It is a pattern of behaviour which violates the social norms. These norms differ from culture to culture and also from country to country. They may even differ in different social classes in one community. The tolerance in the family, at school and in the community plays an important part in determining the number of "antisocial children" as well as the severity of their behaviour seen by psychiatrists.

Antisocial behaviour if unchecked, in turn affects the immediate environment i.e. family, school or even the community. It may also develop into delinquency or adult crime. There are different approaches in dealing with this behavioral problem, of which psychiatric treatment is one.

There have been few studies on Chinese children with antisocial behaviour and even fewer done in a clinical setting. The purposes of the present study are (i) to outline the main antisocial symptoms presented by a group of children attending a psychiatric clinic and (ii) to compare the family background of this group with a control group in order that certain aetiological factors may be revealed.

Material and Method

From the start it was thought necessary that certain limiting criteria should be imposed: (i) the age of children should be below 14, (ii) their behaviour disturbances were not the result of organic brain damage or psychosis and (iii) the I.Q. of children should not be below 80. The patient group consisted of a consecutive series of children conforming to these criteria, presenting with antisocial symptoms and seen by the authors in a period of 3 years in an out-patient psychiatric clinic. The total number was 40 and their age range was from 5 to 13 years. The control group consisted of 54 children, also with age ranging from 5 to 13 years, randomly selected from 54 families attending an adjoining Maternal and Child Health Centre situated in the same building of the above-mentioned clinic.

Findings

1. Main disturbances presented by the patient group

Hostile disobedience	50%
Temper tantrum	40%
Distructiveness and aggressiveness	35%
Truancy	27%
Lying	13%
Stealing	10%
Running away from home	2%

2. Sex incidence

There were 29 boys (72.5%) in the patient group and 27 boys (50%) in the control group. The difference in sex distribution between the patient and the control group reaches the significant level of < 0.05.

3. Mean age at onset and at attendance of the patient group

The mean age of onset of behaviour disturbances of the patient group was 8.75

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years ± S.D. of 2.02 for girls and 8.39 years ± S.D. of 2.44 for boys and the mean age of their seeking psychiatric advice was 9.79 years ± S.D. of 2.195 for girls and 9.55 years ± S.D. of 1.86 for boys.

4. Intelligence

The intelligence of the patient group was first clinically assessed and then tested by means of the Progressive Matrices test administered by a colleague when they were mentally well to undergo this test. The control group was similarly assessed. It was found that of the patient group, none belonged to Grade I, 1 to Grade II, 26 to Grade III, 12 to Grade IV and 1 to Grade V, and of the control group, 1 belonged to Grade I, 8 to Grade II, 27 to Grade III, 15 to Grade IV and 3 to Grade V. Thus 13 (i.e. 32.5%) children in the patient group as compared with 18 (i.e. 33.3%) in the control group had intelligence definitely below the average (i.e. in Grades IV & V). This difference is not statistically significant ($p > 0.9$).

5. Probability of brain damage

Children with minimal brain damage can be of near average, average or even above average intelligence. Instead they often present with behaviour problems e.g. hyperkinesis, impulsivity and destructibility. In many cases, however, the behaviour disturbances may not be typical and thorough investigation and psychological testing give inconclusive result. In the present study, it would be interesting to enquire the parents about falls and physical ailments in the patient and the control group. It was found that 24 (i.e. 60%) of the patient group as compared with only 8 (i.e. 15%) of the control group had such a history. The difference is statistically significant ($p < 0.001$).

6. Parental attitudes

Assessment of parental attitudes must to a considerable extent involve biases on the part of the assessor. This could to some extent be minimized by discussion with the medical social workers who also saw the parents. In order to make comparison possible the parental attitudes were broadly categorized according to Kanner's classification (1955). Parental attitudes of mothers only were studied because it was not possible to get more than a minority of fathers, especially in the control group, for interview. The results are compared in Table 1.

Table 1

	Patient Group		**Control Gorup**	
Parental Attitude	*No. of mothers*	*%*	*No. of mothers*	*%*
Acceptance and affection	5	12.5	30	55.6
Overt rejection	22	55	14	25.9
Perfectionism	2	5	6	11.1
Over-protection	11	27.5	4	7.4
Totals	40	100	54	100

Comparison as regards overt rejection : $x^2 = 7.03$ $p < 0.01$
Comparison as regards perfectionism : $x^2 = 0.45$ $p > 0.5$
Comparison as regards over-protection : $x^2 = 6.72$ $p > 0.01$

7. Parental separation

By this we meant maternal or parental or dual parental separation from the child lasting more than three months and occurring in the first five years of a child's life. It was found that 8 (i.e. 20%) children in the patient group as compared with 4 (i.e. 7.4%) in the control group were reported to have parental separation as defined. This difference is not statistically significant. ($p > 0.1$)

8. Emotional relationship between parents

The emotional relationship was categorized into (i) good (ii) detached and (iii) at breaking point or already separated. This assessment was based mainly on the reply by the mothers to a number of questions in a questionnaire relating to, for example, the amount of time the parents spent together each week, the frequency of quarrels, the degree of sexual satisfaction as well as their own description. This was then supplemented by information given by the child. The results are shown in Table 2.

9. Social Class

The families of the patient and the control groups were classified into 5 social classes and the classification was based mainly on the income, occupation and education of the principal earner of the family. Social Class I is the upper most level and V, the lowest. The results were shown in Table 3.

Table 2

Emotional Relationship	**Patient Group**		**Control Group**	
between Parents	*Number*	*%*	*Number*	*%*
Good	23	57.5	46	85
Detached	14	35	7	13
At breaking point or already separated	3	7.5	1	2
Totals:	40	100	54	100

$x^2 = 7.65$ $p < 0.01$

Table 3

	Patient Group		**Control Group**	
Social Class	*No. of families*	*%*	*No. of patients*	*%*
I &II	2	5	5	9.3
III	4	10	20	37
IV & V	34	85	29	53.7
Totals:	40	100	54	100

$x^2 = 8.81$ $p < 0.01$

Discussion

The significant findings found in this study were (i) antisocial children were composed of more boys than girls. (ii) They came from the lower social class families and (iii) had more falls and physical ailments in earlier life, which might suggest the possibility of minimal brain damage. (iv) There was poor emotional relationship between the parents and the maternal attitude was rejecting. Some might think there is nothing new in these findings but they must remember that impressions and facts are very different and studies of one kind or another were usually carried out to confirm or disprove impressions or postulates.

It is difficult for us to use statistical analysis of data alone to portray a vivid family structure and its dynamics. However this could be supplemented by an overall description of the more common family background and family interaction.

In reviewing the families of the patient group, the common family structures and dynamics could be grouped into 3 categories. The first group of children came from a large low social class family where the father, always busy, had long working hours and earned a low income or else he was irresponsible or even addicted to narcotics. The mother, also busy, had to do heavy household work as well as to work part time in factory to subsidize the family financially. The children were thus left to themselves with little attention given by their parents. They might quarrel at home, wander in the neighbourhood and seldom attend school for more than 1 or 2 years. In these families, few remarks of approval or rewards were even given to the children. In fact, the parents tend to think that children were a burden to them. They were given little or no pocket money. With the emergence of antisocial behaviour usually in the form of disobedience, truancy from school and stealing, the parents still exercised little discipline and control. Gradually they became destructive and cruel. By this time the parents became punitive and imposed restraint or corporal punishment which would make their behaviour worse. Finally, they became involved with the police who brought them to the clinic for psychiatric treatment. The difficulty in managing this sort of children was that the parents could not afford the time for guidance or to bring the children to attend the clinic regularly and continuously. To the child, the clinic was but another authoritarian figure against which rebellion was directed and as a result therapist-child rapport could not be established easily.

The second group of children came from higher social class families typically small in size. However the father spent little time at home because of social engagements and a few of them might have mistresses outside. The mother was usually preoccupied with her own problem and often had mild neurotic symptoms. The mother who was "soft" in nature was lenient towards her children and to some extent was over-protective. The children in these families were often bossy (domineering) and were rather demanding as regards to the things they wanted to buy and the way they performed a task. They would arrange time for work and play by themselves. Their motivation towards schooling was poor and not uncommonly, they had to shift from one school to another year after year. Because of her marital worries and the psychosomatic complaints, the mother easily felt bothered by their excessive demands. Then she tended to bribe their children materially or else delegated her responsibility to an amah or a close relative. The children's demand gradually became unreasonable and unbearable and when this excessive demand could not be met with, they would go into temper tantrum or even became destructive. This kind of disturbed behaviour was considered by the father as an indication of mother's incapability, and so he even paid less due respect to her. Therefore

the mother met stresses from both father and the child. Usually she attended the psychiatric clinic for advices first before the children were advised to attend. The difficulty in treating this sort of children is that the father is not accepting his self-involvement in the child's problem.

The third common group consisted of families apparently not abnormal and their families were of average size. Compared with his siblings, the child was not as intelligent and articulate. The parents initially showed no partiality towards any of their children. However, comments might be made on his comparatively less satisfactory performance in school or else he might receive comparatively less of praise in words because of his over inhibition and submission. The child himself was less able to express his problems and feeling and gradually felt that he was emotionally isolated and rejected. He began to act out his feelings by bullying his younger siblings, by playing truant or by stealing. His behaviour produced reciprocal reaction in the parents and siblings who felt that he caused the family to lose face and assumed a critical and depreciative attitude towards him. The child is often referred to the psychiatrist by the school or brought to the clinic by the parents themselves. This sort of children usually respond to treatment better.

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