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The Identification of Behaviour Disorder Within the Community

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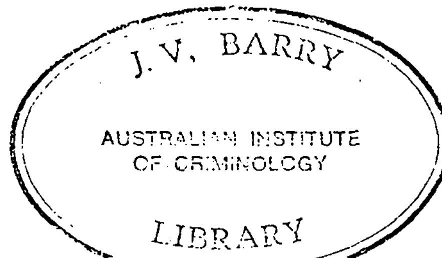
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THE IDENTIFICATION OF BEHAVIOUR DISORDER WITHIN THE COMMUNITY

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Introduction

In the last few years, increasing attention has been given to a group of people described as being 'behaviourally disordered'. The term Behaviour Disorder has generally been used to describe people who experience persistent difficulties in adapting to life within their community and whose behaviour is chronically disruptive or dangerous.

Studies have outlined growing concern, both in Australia and overseas, regarding the adequate identification and servicing of this group, which includes both children and adults (Behar,1985; Cullinan, Epstein and McLinden,1986; Epstein, Cullinan and Sabartino,1977; Epstein, Detwiler and Reitz,1985; Mitchell,1985; Mulligan, Lamb and Harris, 1981). In earlier decades, such people were either referred to psychiatric hospitals, where they might be detained involuntarily and without legal authority, or imprisoned. Following the introduction of policies of deinstitutionalisation, and with an increased emphasis on the rights of people with disabilities, difficulties have arisen in finding appropriate services for those with chronic mental disorders (Barber, 1985; Horsfall, 1987). For the behaviourally disordered, whose condition has not yet been adequately defined and whose behaviour results in major societal rejection, these problems are heightened (Mitchell,1985; Mulligan et al,1981).

Dame Roma Mitchell's Review of Services for Behaviourally Disordered Persons (1985) reflected concern in South Australia that State services were not adequately meeting the needs of Behaviourally

Disordered clients. Efforts to service this group have commonly resulted in multi-agency involvement, chronic rereferral, poor rehabilitation outcome and a sense of frustration amongst workers, families and clients. Servicing responsibility is often confused by the presence of other conditions, such as borderline intelligence, psychiatric disorder, substance abuse and brain damage (Mitchell, 1985; Mulligan et al, 1981).

As Behaviour Disorder in its more severe form generally results in persistent antisocial and criminal behaviour, the State's Department of Correctional Services (DCS) is likely to have extensive involvement with severely behaviourally disordered clients. DCS may then be required to contain and rehabilitate a person with psychological conditions that the correctional service was not designed or equipped to manage.

Whilst there is a pressing need for new resources to treat such offenders, efforts to provide these resources are hampered by a current lack of an adequate clinical definition and assessment procedure for behaviour disordered clients. The Dame Roma Mitchell Review has offered the following definition of Behaviour Disorder:

> Persistent or repeated behaviour of an antisocial or deviant nature which falls outside community norms and which is of such severity that at most times the person with the disorder is unable to look after himself or herself or his or her affairs

or is incapable of living in the community without resorting to unlawful or dangerous conduct. (Mitchell,1985, p 25.)

This definition gives a clear general description of a behaviourally disordered person's relationship with his or her community, but it is not behaviourally specific enough to constitute a clinical definition or to form the basis of an assessment procedure.

In terms of research contributions, definitions of Behaviour Disorder are currently variable, with no clear distinction being made between 'Behaviour Disorder' and related terms, such as 'Behaviour Disturbance','Emotional Disturbance', 'Antisocial Personality' and 'Conduct Disorder' etc. (Cullinan et al, 1986; Feldman, Kinnison and Harth, 1983; Mitchell,1985; Thomas and Chess, 1984; Wood and Lakin, 1982). In terms of professional perceptions and servicing expectations, however, such distinctions are important (Feldman et al,1983; Mitchell,1985; Wood and Lakin, 1982).

Whilst there are evident areas of overlap between Behaviour Disorder and such factors as brain damage, criminality, borderline intelligence, psychiatric disorder, personality disorder and substance abuse, the nature and extent of this relationship has not yet been clarified (Fraser, Leudar, Gray and Campbell, 1986; Koller, Richardson and Katz, 1983; Mitchell, 1985; Richardson, Koller and Katz, 1985; Thomas and Chess, 1984).In reviewing the conceptualisation of childhood Behaviour Disorder, Kaufmann (1982) has proposed that it

should be viewed as a social learning dysfunction and this view is implicitly supported in many clinical studies with children and adolescents (Richmond and Blagg, 1985; Schloss, Schloss, Wood and Kiehl, 1986; Simpson, 1986).

Research amongst juveniles and the intellectually disabled has suggested that there may in fact be two distinct presentations of Behaviour Disorder - internalised (apathetic, withdrawn) and externalised (aggressive, defiant) (Atkins, 1985; Kohn, Koretsky and Haft, 1979; Rutter, 1967; Tustin, Kent, Bond and Haskill, 1987). At the same time, Behaviour Disorder within the community tends to be identified only in terms of its aggressive, disruptive presentation (Mitchell, 1985; Mulligan et al, 1981). There is some need to reconcile these differing views.

The present study addressed the problem of defining Behaviour Disorder from the point of view of servicing professionals. The purpose of the study was to test the hypothesis that Behaviour Disorder is recognised by professional workers as an identifiable disorder and that there is a constellation of behaviours, or categories of behaviour, that identifies Behaviour Disorder as distinct from other documented disorders.

Method

The Questionnaire

A questionnaire was made up of open questions, forced choice questions and 85 checklist items, constructed to obtain the following information:

1) respondents' definitions of behaviour disorder (open question followed by 85 checklist items)

2) respondents' definitions of severe behaviour disorder (open question followed by 85 checklist items)

3) respondents' level of confidence in defining behaviour disorder and severe behaviour disorder (forced choice questions)

4) respondents' evaluation of the Dame Roma Mitchell definition. (open question)

5) respondents' problems in servicing behaviourally disordered clients (open question)

The checklist items were derived from research studies into Behaviour Disorder and antisocial behaviour amongst adolescents (Kohn et al, 1979; Reitsma-Street, Offord and Finch, 1985), the intellectually disabled (Fraser et al, 1986; Koller et al, 1983; Richardson et al,

1985) and the general population (Mitchell, 1985; Mulligan et al, 1981; Thomas and Chess, 1984). Items were included to encompass the principle diagnostic features of Conduct Disorder, Borderline and Antisocial Personality Disorders and Psychopathy (DSM III-R, 1987; Hare, 1980; ICD-9, 1979; Raine, 1985). (Table 1)

The questionnaire was pilotted on 16 professional workers regarded as having relatively extensive experience with Behaviour Disordered clients, and was slightly modified to provide clearer information.

Respondents

The respondents were recruited to represent as evenly as possible the client populations most commonly associated with Behaviour Disorder - child/adolescent (15%), intellectually disabled (14%), criminally offending (18%), brain damaged (13%) and psychiatrically disordered (16%). An additional 'general' category covered those respondents who dealt with general community referrals (24%). The respondents were recruited through heads of institutions/agencies or through members of staff in supervisory positions. By occupation, they included 31% social workers, 14% probation officers, 15% psychologists, 12% psychiatrists, 10% nurses, 4% doctors, 4% residential workers and 3% teachers.

TABLE I

85 Checklist Items

1. Social isolation
2. Abuse of others' trust
3. Low level of social interest
4. Poor use of leisure time
5. Oversensitivity
6. Attention-seeking
7. Poor contribution to group welfare
8. Being "easily led"
9. Inability/slowness to adapt
10. Rule-breaking alone
11. Rule-breaking in company
12. Superficial charm
13. Insincerity, "conning" others
14. Failure to learn from experience
15. "Using" others
16. Alienation from family
17. Sexual promiscuity
18. Lack of concern for others
19. Lack of empathy
20. Irresponsible behaviour
21. Irritability, "short fuse"
22. Social timidity
23. Chronic lying
24. Chronic stealing
25. Hyperactivity
26. Inappropriate sexual behaviour
27. Glibness
28. Frequent changes in close friends/sexual partner
29. Bad behaviour in group setting
30. Unresponsive to reward
31. Discordant family relationships
32. Low self esteem
33. Avoidance of new experiences
34. Avoidance of unfamiliar people
35. Frequent crying
36. Poor self-assertion skills
37. Poor communication skills
38. Shallow, short-lived feelings
39. Depressed moods
40. Suicidal ideas/behaviour
41. Poor grasp of reality
42. Anxiety
43. Overconfidence
44. Low frustration tolerance
45. Suspecting others' motives
46. Underachievement
47. Poor literacy/numeracy
48. Unrealistic ideas, ambitions
49. Frequent changes of job/interests
50. Grandiose view of own worth
51. Favouring immediate over long-term gain
52. Apathy
53. Poor task persistence
54. Truancy/absenteeism
55. Living for the present, no long-term plans
56. Unsuccessful crime
57. Variable level of performance
58. Fear of failure
59. Bored attitude
60. Poor self-help skills
61. Lack of initiative
62. Substance abuse
63. Self-injury
64. Disruptive behaviour
65. Abuse to those in authority
66. Tantrums, angry outbursts
67. Oppositional behaviour
68. Involvement in fights
69. Destruction of property
70. Sexual aggression
71. Assault
72. Not accepting responsibility for own behaviour
73. Poor emotional control
74. Wild, rowdy behaviour
75. Defiance
76. Intolerance of discipline
77. High-risk activity
78. Bullying
79. Impulsive behaviour
80. Inadequately motivated crime/antisocial acts
81. Unresponsive to punishment
82. Poor concentration span
83. Poor perception of cause/effect around own behaviour
84. Unpopular, not well tolerated
85. Mood swings

Results

The majority of respondents felt that they had a very clear or fairly clear perception of the nature of Behaviour Disorder (64% of respondents) and Severe Behaviour Disorder (55%). Seven checklist items were defined as characteristic of Behaviour Disorder by more than 50% of respondents. These items related to either aggressive, antisocial behaviours ('disruptive behaviour', 'tantrums, angry outbursts', 'low frustration tolerance', 'impulsive behaviour') or to deficits related to social adaptation ('not accepting responsibility for own behaviour', 'poor perception of cause/effect around own behaviour' 'failure to learn from experience'). The profile given of Behaviour Disorder showed some variation across groups, with a higher level of consensus within client groups than overall and even higher levels of consensus within professional groups (Tables 2 and 3).

Seven items were nominated as characteristic of Behaviour Disorder by less than 10% of respondents : 'frequent crying', 'superficial charm', 'avoidance of new experience', 'overconfidence', 'avoidance of unfamiliar people', 'glibness' and 'social timidity'. The nature of these items suggested that internalised disordered behaviours and some aspects of antisocial personality disorder are not generally seen as typical of Behaviour Disorder, even amongst the young or intellectually disabled (Table 4).

The 161 respondents who described Severe Behaviour Disorder in terms

TABLE 2.

Behaviour Disorder - Items Nominated By More Than 50% Of Respondents Overall And By Client Group

Client groups:

G = General (N=56)
B = Brain Damaged (N=30)
P = Psychiatric (N=38)
A = Adolescent/Child (N=43)
I= Intellectually Disabled (N=31)
C = Correctional Services (N=43)

ITEM	% OF RESPONDENTS						
	All	G	A	B	I	P	C
Not accepting responsibility for own behaviour	67	77	56	57	52	74	77
Disruptive behaviour	65	66	58	57	65	65	
Poor perception of cause/effect around own behaviour	58	66	61	53	–	50	60
Tantrums, angry outbursts	57	59	53	70	–	66	67
Low frustration tolerance	55	57	–	–	–	66	67
Impulsive behaviour	53	61	–	50	–	61	58
Failure to learn from experience	52	68	–	–	–	68	58
Destruction of property	–	–	50	57	–	50	–
Irresponsible behaviour	–	50	–	–	–	58	65
Poor emotional control	–	55	–	–	–	–	–
Irritability, short fuse	–	–	–	53	–	–	–
Poor grasp of reality	–	54	–	60	–	–	60
Assault	–	–	–	57	–	–	–
Unresponsive to punishment	–	52	–	–	–	–	–
Attention seeking	–	–	–	50	–	–	–
Rule breaking alone	–	–	53	–	–	–	–
Abuse to those in authority	–	–	53	–	–	–	–
Substance abuse	–	54	–	–	–	–	–
Mood swings	–	–	–	50	–	–	–

TABLE 4.

Behaviours least associated with Behaviour Disorder

N=213, 21 did not complete checklist

ITEM	OVERALL %	C/ADOL %	I.D. %
Frequent crying	9	8	3
Superficial charm	9	6	10
Avoidance of new experience	8	6	6
Overconfidence	7	3	3
Avoidance of unfamiliar people	7	6	3
Glibness	5	6	10
Social timidity	4	3	3

C/ADOL = child adolescent population
I.D. = Intellectually Disabled population

TABLE 3

Behaviour Disorder - Items Nominated By More Than 50% Of Respondents Overall And By Professional Group

Professional groups:

SW = Social Worker (N=74)	PS = Psychologist (N=35)
PO = Probation Officer (N=33)	PY = Psychiatrist (N=27)
NU = Nurse (N=24)	DR = Doctor (N=10)

ITEM	% OF RESPONDENTS						
	All	SW	PS	PO	PY	NU	DR
Not accepting responsibility for own behaviour	67	69	-	79	63	83	50
Disruptive behaviour	65	61	57	76	63	67	80
Poor perception of cause/effect around own behaviour	58	70	-	64	-	58	60
Tantrums, angry outbursts	57	51	-	61	-	67	80
Low frustration tolerance	55	51	-	76	52	63	70
Impulsive behaviour	53	61	-	67	56	50	50
Failure to learn from experience	52	65	-	61	-	54	50
Destruction of property	-	-	51	52	-	67	50
Irresponsible behaviour	-	50	-	76	-	50	50
Poor emotional control	-	-	-	52	-	58	-
Self injury	-	-	-	-	-	50	-
Attention seeking	-	-	-		-	58	-
Poor grasp of reality	-	-	-	64	-	-	-
Lack of concern for others	-	-	-	55	-	54	-
Assault	-	-	-	-	-	63	-
Inadequately motivated crime	-	-	-	-	-	50	-
Abuse to those in authority	-	-	-	-	-	67	-
Chronic stealing						50	-
Inappropriate sexual behaviour	-	-	-	-	-	54	50
Intolerance of discipline	-	-	-	-	-	-	50
Involvement in fights	-	-	-	-	-	58	-
Living for the present	-	-	-	52	-	-	-
Unpopular	-	-	-	64	-	-	-
Social isolation	-	-	-	55	-	-	-
Poor concentration span	-	-	-	-	-	-	50
Family alienation	-	-	-	58	-	-	-

of the checklist largely nominated behaviours damaging to self or others. The most highly nominated items were : 'assault', 'poor perception of cause/effect around own behaviour', 'self injury', 'destruction of property', 'low frustration tolerance' and 'suicidal ideas/behaviour' (Table 5).

Respondents' answers to open questions on Behaviour Disorder extensively reflected many of the behaviours subsequently mentioned in the checklist, particularly those related to aggression, poor grasp of social expectations and poor social adaptation. Additionally, many respondents emphasised the relativity implied in the term 'Behaviour Disorder', pointing out that the discrepancy between societal expectation and individual behaviour may be dictated as much by the characteristics of a society as by those of the individual.

The open responses shared an ethical concern that people should not be labelled 'Behaviour Disordered' simply because they did not endorse the prevailing value system. At the same time, Behaviour Disorder was described by most respondents in terms of social evaluation, such as unacceptable behaviour (14%), behaviour that is inappropriate (11%), harms self or others (11%) or is consistently outside social norms (9%). 10% of respondents expressed the belief that Behaviour Disorder could <u>only</u> be defined in terms of social rules and expectations. The predominant factors of Severe Behaviour Disorder were dangerousness to self and others (28%), major societal rejection (10%) and a need for continued management by others (8%).

TABLE 5

Severe Behaviour Disorder Top Ten Items

161 respondents defined certain behaviours as indicative of Severe Behaviour disorder

Client groups:
G=General (N=42) A=Child/Adolescent (N=25) B=Brain-damaged (N=22) I=Intellectually Disabled (N=19) P=Psychiatric (=21) C=Correctional (N=32)

ITEM	% OF RESPONDENTS						
	ALL	G	A	B	I	P	C
Assault	01	01	02	01	03	01	-
Poor Perception of cause/effect for own behaviour	02	04	02	01	08	-	-
Self injury	02	01	04	03	03	08	06
Destruction of property	04	08	05	06	08	-	05
Low frustration tolerance	05	-	-	09	08	-	02
Suicidal ideas/behaviour	06	01	01	-	08	-	-
Disruptive behaviour	07	-	-	09	-	02	02
Tantrums, angry outbursts	07	-	-	03	08	06	02
Inadequately motivated crime/ antisocial behaviour	09	08	-	-	06	08	05
Impulsive behaviour	10	-	07	03	-	03	-
Unresponsive to punishment	10	06	-	-	01	-	-
Sexual aggression	10	04	10	06	03	-	-
Not accepting responsibility for own behaviour	10	08	07	-	08	-	08
Poor grasp of reality	-	06	-	-	-	08	01
Failure to learn from experience	-	-	-	-	02	03	-
Involvement in fights	-	-	05	06	-	-	-
Irresponsible	-	-	-	-	-	03	05
Unpopular,not well tolerated	-	-	-	-	-	08	08
Abuse to those in authority	-	-	-	-	-	08	-
Unresponsive to reward	-	-	-	-	06	-	-
Poor emotional control	-	08	-	-	-	-	-
Chronic stealing	-	-	10	-	-	08	08
Chronic lying	-	-	-	-	-	08	-
Lack of concern for others	-	-	10	-	08	08	-
Substance abuse	-	-	-	-	-	06	-
Alienation from family	-	-	-	-	-	-	08
Lack of empathy	-	-	-	-	-	08	-
Defiance	-	-	07	-	-	-	-

With respect to the Dame Roma Mitchell definition, 30% accepted it as an appropriate definition of Behaviour Disorder. Many more felt that it was a reasonable basis for definition, but suggested modifications, such as acknowledging that many behaviour disordered people are still capable of living in a community (11%) and do not necessarily have criminal involvement (6%). 18% felt that it was appropriate, but in fact described Severe Behaviour Disorder. 5% pointed out that it was not an appropriate definition for children or the intellectually disabled, who need this level of support for other reasons.

Specific difficulties in treatment were mentioned by almost 40% of the sample. 8% of respondents stated that Behaviour Disorder was unresponsive to common therapies and a further 15% viewed it as beyond current professional research, training, understanding or expertise. Another 16% made more specific comments on the difficulty of treating Behaviour Disorder, such as unresponsiveness to drugs or insight therapies, the difficulty of implementing behaviour modification programs in a community setting, the client's disruption of existing programs, difficulties in motivating and inducing change, overdependency and therapist exhaustion.

Discussion

Behaviour Disorder in the Community

The results indicated that Behaviour Disorder is generally regarded as a recognisable disorder. The finding that it is characterised by both aggressive, disruptive behaviour and by deficits related to the process of social adaptation is consistent with the conclusions of previous studies (Mitchell,1985; Mulligan et al, 1981). The perceived involvement of social learning ability in the aetiology of Behaviour Disorder is also in keeping with clinical and research findings (Richmond and Blagg, 1985; Schloss et al, 1986; Simpson,1986).

Consensus of definition was higher within client groups (Table 2). Some of the variability of perception between client groups may have been a product of the fact that respondents were asked to nominate only those disordered behaviours that were characteristic of Behaviour Disordered clients, but not of their client group generally.

There was even greater consensus within professional groups (Table 3), indicating that the setting and the professional role from which the worker usually viewed the client gave rise to differing perceptions. The perception of nurses, for example, seems to have reflected the problems experienced when dealing with the hospitalised, brain-damaged population with which most nursing respondents worked, whilst the view of probation officers focussed on the social and interpersonal difficulties that precluded adequate rehabilitation. There was an unusually low level of consensus amongst psychologists, who are

possibly only sent for when clients begin disrupting environments and breaking the furniture. With the exception of psychologists, however, all groups saw Behaviour Disorder as a combination of chronically disruptive and socially maladaptive responses.

Whilst it is clear that the presentation of Behaviour Disorder may vary considerably, this need not mean that Behaviour Disorder is not an homologous disorder. Its presentation depends both on the opportunity for a disordered behaviour to occur and on the degree to which a behaviour is outside social norms and expectations for that setting.

With respect to the contextual aspect of Behaviour Disorder, some respondents expressed an ethical concern that the presence or absence of Behaviour Disorder may be a reflection of societal value judgements rather than a disorder in the individual. For a person to be considered Behaviour Disordered as defined by the respondents in this study, he or she would have to show deficits in social adaptation that would render him or her unable (as opposed to unwilling) to learn new behaviours across settings. The more socially demanding the setting, the more evident the Behaviour Disorder would be. This perception is consistent with previous findings that Behaviour Disorders that are not resolved in childhood or adolescence tend to become more marked in adulthood, when the social demands are greater (Thomas and Chess, 1984).

Behaviour Disorder and Psychiatry

The results of this study also indicated that Behaviour Disorder and Psychopathic or Antisocial Personality Disorder were not seen as the same thing. Three of the seven least nominated items related to the 'egocentric/duplicity' factor measured by Raine (1985), using Hare's (1980) psychopathy checklist. It appears that behaviourally disordered clients, whilst being socially damaging and disruptive, were not seen as misusing others in a calculated way; their social interactions were generally regarded as defective rather than antisocially directed.

Despite several points of similarity with Conduct Disorder, Oppositional Defiance Disorder and Attention Deficit Hyperactivity Disorder (DSM III-R, 1987) none of these profiles corresponds exactly with respondents' perceptions of Behaviour Disorder. The social learning problems observed by the respondents are not a feature of the Disruptive Behaviour Disorders of DSM III-R. According to the general perceptions expressed in this study, Behaviour Disorder cannot be identified within the present psychiatric classification system.

Behaviour Disorder as a Learning Disability

The hypothesis that Behaviour Disorder originates from a disorder of social learning is consistent with the profile and servicing difficulties described by the respondents and also with the observed multiple aetiology of Behaviour Disorder (Mulligan et al, 1981).

Learning ability in educational terms has historically proved to be vulnerable to various influences, including personality characteristics, brain damage or disease, biochemical imbalance, psychiatric or emotional disorder, developmental disability and environmental input. It is therefore reasonable to expect that social learning ability can be similarly affected by one or more of these factors, and that when a person already has an intrinsic handicap, he or she is more vulnerable to poor environmental factors, with an increased risk of becoming behaviourally disordered (Sigman, Ungerer and Russell, 1983; Richardson et al, 1985). Whilst there may be little that can be done to alter genetic and physical determinants, progress into the treatment of educational learning difficulties indicates that learning disorders are likely to be variably treatable, with a better prognosis if identified early.

Treatment programs targetting the social interactions of behaviourally disordered people have generally focussed on whole interactions or areas of behaviour (e.g. appropriate approach behaviour, eye contact, active listening) without addressing the issue of exactly where in the process of social learning the deficit has arisen (Schloss et al, 1986; Simpson, 1986). A better understanding of this issue would promote the development of more efficient treatment methods for Behaviour Disorder. To identify and concentrate upon difficulties in the learning process may ultimately be more effective than reshaping each individual defective or excessive behaviour.

The most robust social learning feature nominated by the present respondents, for both Behaviour Disorder and Severe Behaviour Disorder, was a 'poor perception of cause/effect around own behaviour', which suggests that this factor is highly relevant to treatment. Whether this is literally a perceptual deficit or originates in the processes of discrimination, cognition or response generation is beyond the scope of this study. However, Mischel (1973) has hypothesised that Behaviourally Disordered children show a diminished sensitivity to changing situations and consequences, resulting in indiscriminate responding. Further research into this area is needed.

Externalised vs. Internalised Behaviour Disorder

Respondents in this study reflected a local community perception that Behaviour Disorder is an externalised, rather than internalised, disorder (Mitchell, 1985; Mulligan et al, 1981). At the same time, if reduced social learning ability is accepted as the central factor in Behaviour Disorder, there is a theoretical argument for including both types within a definition of Behaviour Disorder, even though internalised clients attempt to cope in a behaviourally very different (and socially less prominent) way. There is a need for theoretical clarification on this issue, and this can only be provided by further research and documentation.

Conclusions

The survey results strongly indicated that Behaviour Disorder is a disorder in its own right, resulting in chronically disruptive behaviour that is not appropriate for diagnosis and management in a psychiatric setting (other than where psychiatric disorder also exists) and is not likely to respond either to conventional therapies or to traditional correctional service rehabilitation. The strongest aetiological hypothesis offered is that Behaviour Disorder results from a deficit in social learning ability, with or without concomitant intellectual deficit. There is a pressing need for research into the early identification and treatment of Behaviour Disorder and for the funding of services geared to the particular problems presented by this group.

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