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Impact of Rational-Emotive Behaviour Therapy (REBT) on Adolescents with Conduct Disorder (CD)

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The present study is to examine the impact of Rational-Emotive BehaviourTherapy on adolescent students with conduct disorder. It was hypothesized that the REBT Psychotherapy would have a positive impact on adolescents' conduct disorder symptoms. The Youth Self Report (YSR) was distributed to 1142 students and they were instructed to fill the forms.The sample included 200 students (100 girls and 100 boys), which 100 was taken as control group (50 girls and 50 boys), and other 100 was taken for experimental group (50 girls and 50 boys) from the schools and colleges in Mysore.The intervention program was given on experimental group for 7 sessions, in seven weeks. There were 10 groups, with 10 subjects in each group. The intervention program consisted of Cognitive, Emotive and Behavioural techniques of REBT. Subjects were thought the techniques of REBT and how to apply it on their problems. One month later the last intervention program and the post test, to assess the impact of REBT. Data analysis involved the use of GLM repeated measure of ANOVA to measure the impact of REBT on Conduct Disorder Symptoms of subjects. Significant impacts were found on the reduction of conduct disorder symptoms experienced by subjects. The results revealed that the treatment decreased the symptoms of conduct disorder. The results showed that REBT has a positive impact on conduct disorder and other emotional and behavioural disorders co morbid with conduct disorder experienced by adolescents.

Keywords: REBT, Conduct disorder,

Adolescence is the stage in a person's life between childhood and adulthood. It is the period of human development during which a young person moves from dependency to independence, autonomy and maturity, from being part of a family group to being part of a peer group and to be independent as an adult (Mabey & Sorensen, 1995). With the onset of adolescence the nature and behaviour of the adolescent also changes. Many of the behaviours of adolescents appear unsocial and unsympathetic. Buhler (1927) defined this period as a negative phase. Chronologically, adolescence comes roughly in between the years from 12 to the early 20s. World Health Organization defines adolescence as the period between 10-19 years. The onset of adolescence varies from culture to culture depending on the socio economics of the country. During adolescence great changes occur in all developmental aspects of the individual.

Children and youngsters with emotional and behavioural disorders (EBD) are a vulnerable group in society. Their disorder proofs to be stable and long-term (Fergusson & Horwood 1992). These children run a high risk of being placed in special education (Lyon 1996) or in semi-residential specialized care (Eme & Kavanaugh1995). More boys than girls are affected (3:1 or 4:1) (American Psychiatry Association 1987; Fagot & Leve 1998) and boys show a more violent behaviouristic pattern and more externalizing behaviour (Eme & Kavanaugh 1995).

Types of mental, emotional, and behavioural disorders that may occur during adolescence are generally known as:Anxiety

Disorders, Severe Depression, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Autism, Schizophrenia, Learning Disorders, Conduct Disorder, Eating Disorders and so on. All can have a serious impact on overall health of adolescent. Some disorders are more common than others, and conditions range from mild to severe. Often, an adolescent has more than one disorder (U.S. Department of Health and Human Services, 1999).

Although adolescent health has gained increasing prominence in India's national health policies, the focus has been on reproductive and sexual health concerns. Despite reports showing that suicide is a leading cause of death in young people in India (Aaron, Joseph, Abraham, Muliyil, George, Prasad, Minz, Abraham, & Bose, 2004), mental health has been a low priority in health policy for adolescents. The few published studies from India have reported prevalence of mental disorders from 2.6% to 35.6% (Srinath, Girimaji, Gururaj, Seshadri, Subbakrishna, Bhola, & Kumar, 2005); (Verghese & Beig, 1974). Although comparability between the findings of these studies is limited owing to methodological factors (Ford, Goodman, & Meltzer, 2003), one reason for the wide variation in rates could be the strong influence of social, cultural and environmental factors on the risk of mental disorders in adolescents.

The term conduct disorder (CD) refers to a persistent pattern of antisocial behaviour in which the individual repeatedly breaks social rules and carries out aggressive acts that upset other people. DSM-IV mentions CD as one of the most frequently diagnosed conditions in outpatient and inpatient mental health facilities for children. CD has been separated from the adult diagnosis of antisocial personality in order to acknowledge what psychiatrists believe to be a greater potential for change in the young. CD has been classified along with oppositional defiant disorder and attention-deficit hyperactivity disorder (ADHD) in the attention-deficit and disruptive behaviour disorders section of DSM-IV-TR. The essential feature of CD is a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. Since its inception in DSM-III, the diagnosis of CD has undergone several modifications. DSM-IV-TR lists 15 criteria grouped into 4 major categories: (i) aggression to people and animals; (ii) destruction of property; (iii) deceitfulness or theft; and (iv) serious violations of rules. Three (or more) of the criteria should have been present for the last 12 months, with at least one criterion present in the past 6 months.

The disturbance in behaviour should cause clinically significant impairment in social, academic, or occupational functioning. If the individual is 18 years or older, the criteria for antisocial personality disorder should not be met. Since the criteria for the diagnosis of CD vary widely, its manifestations at different developmental stages differ and because the databases of different studies are not uniform, the prevalence estimates reported in various studies vary widely. At one end lies the study of Esser and colleagues (1990), reporting a prevalence of 0.9%, while at the other end is the study by Kashani *et al* (1987), reporting a prevalence of 8.7%. DSM-IV reports prevalence in males of 6%-10% and in females of 2%-9%.

Among Indian studies, Deivasigamani (1990), has reported the prevalence of CD to be 11.13%, Sarkar, Kapur and Kaliaperumal *(1995),* reported the prevalence rate of antisocial behaviour to be 7.1% while recently Srinath *et* al (2005), have reported prevalence as low as 0.2%.

Several common childhood psychiatric conditions have features similar to those of conduct disorder, and comorbid conditions are also common. The differential diagnosis should include attention-deficit/hyperactivity disorder (ADHD), oppositional defiant

disorder, mood disorder (major depression, dysthymia, and bipolar disorder), substance abuse and intermittent explosive disorder.

Rational emotive behaviour therapy (REBT) is an active-directive, solution-oriented therapy which focuses on resolving emotional, cognitive and behavioural problems in clients, originally developed by the American psychotherapist Albert Ellis. REBT views that emotional suffering result primarily, though not completely, from our evaluations of a negative event, not solely by the events per se. In other words, human beings on the basis of their belief system actively, though not always consciously, disturb themselves, and even disturb themselves about their disturbances.

REBT helps clients to replace absolutist philosophies, full of 'musts' and 'shoulds', with more flexible ones; part of this includes learning to accept that all human beings (including themselves) are fallible and learning to increase their tolerance for frustration while aiming to achieve their goals. Although emphasizing the same 'core conditions' as person-centred counselling — namely, empathy, unconditional positive regard, and counsellor genuineness — in the counselling relationship, REBT views these conditions as neither necessary nor sufficient for therapeutic change to occur.

Conduct disorder in adolescents is a serious and common mental disorder. There are very limited data on adolescents with conduct disorder in India and no adequate research studies have been reported on the treatment of adolescents with conduct disorder and other emotional and behavioural problems experienced by them.

This study was designed to assess the effectiveness of Rational Emotive Behavioural Therapy (REBT) on the treatment of adolescent students suffering from conduct disorder and other emotional and behavioural problems they experience along with conduct disorder. The findings may help us develop a better treatment for adolescents with conduct disorder.

Hypotheses

H1. Rational Emotive BehaviourTherapy (REBT) has a positive impact on treatment of Conduct Disorder.

H2.Rational Emotive Behaviour Therapy (REBT) has a positive impact on the treatment of additional variables of DSM Scale.

Method

Sample:

A stratified random sample of 200 (100 boys and 100 girls) students with conduct disorder between the age group of 11 and 18 years was selected. They were from different schools and colleges located in Mysore City.

Measures:

Youth Self-Report for Ages 11-18 (2001), to measure conduct disorder, Designed by ASEBA, (Achenbach System of Empirically Bused Assessment, 2001), research center for Children, youth, and families. (Using YSR DSM-Oriented Scales for Boys and Girls and YSR Syndrome Scales). The "Youth Self-Report" (YSR) (Achenbach, 2001) is a well-known psychopathological instrument designed to obtain adolescent reports of their competencies and behavioural/ emotional problems. The emotional/behavioural part contains 112 items, scored from 0 ("not true") to 2 ("very true or often true"), according to the behaviour displayed during the last six months. From this set of items a "Total problem" score (103 specific problem items) can be derived. The total problem scale is a measure of perceived general maladjustment level.

Procedure:

A sample of 1142 students, boys and girls, aged 11 to 18 years old, was administered to complete theYouth self Report (YSR). Out of this sample 200 adolescents diagnosed of conduct problems by the help of DSM-Oriented Scale, were selected for the

study. Out of 200 students, 100 were taken as experimental group (consist of 50 boys and 50 girls), and another 100 (50 boys and 50 girls) were taken as control group. Following the selection, a teachers report on students' behaviour was given by the teachers. Each experimental group went under seven session of REBT in duration of seven weeks. Four stages were presented in systematic order:

Stage 1: Introductory session:

Stage 2: Using Cognitive Techniques of REBT

I: Active Disputing; II: Rational Coping Self Statements; III: Cognitive Homework.

Stage 3: Using Emotive Techniques of REBT

I: Rational Emotive Imagery; II: Role-Playing; III: Reverse-Role Play.

Stage 4: Behavioural Techniques of REBT

I: Skill Training; II: Use of Reinforcement; III: Use of Penalties

No treatment was given to control group but it was kept under observation. One month after the last REBT session, post-test is taken from experimental and control group. Results were analyzed and hypothesizes were tested.

Results

Table 1 shows that Between pre-test to post-test scores a significant difference was observed (F=26.939; P=.000) in conduct disorders where a decrease of 1.12 (pre-10.91, post-9.79) scores was noticed irrespective of the groups. However, when the decrease in conduct disorders were analyzed group wise, (experimental v/s control) again a significant F value (F=38.782; P=.000) was obtained. From the mean scores it is evident that experimental group decreased its mean by 2.56 (Pre- 10.77 – Post-8.21) scores compared to control group, which changed its scores by only 0.32 scores (pre 11.04 – Post 11.36).

Table 1 Mean scores on conduct problems of male and female subjects in experimental and control groups in pre and post test sessions

Groups	Gender	Age	Pre-Test	Post-Test		Change
		Mean	S.D	Mean	S.D	
Experi	Early	10.71	2.06	8.86	2.27	1.85
	Late	11.86	2.32	9.33	2.63	2.53
	Total	11.7	2.30	9.26	2.56	2.44
Female	Early	10.3	3.45	7.47	3.92	2.83
	Late	9.15	1.66	6.70	3.33	2.45
	Total	9.84	2.90	7.16	3.68	2.68
Total	Early	10.38	3.21	7.73	3.68	2.65
	Late	11.00	2.47	8.49	3.09	2.51
	Total	10.77	2.77	8.21	3.33	2.56
Control	Early	12.49	2.68	12.87	2.65	0.38
	Late	11.09	1.70	11.27	2.10	0.18
	Total	12.18	2.55	12.52	2.60	0.34
Female	Early	9.98	1.95	10.29	2.14	0.31
	Late	8.00	0.00	8.00	0.00	0.00
	Total	9.90	1.95	10.2	2.15	0.30
Total	Early	11.1	2.61	11.45	2.70	0.35
	Late	10.62	1.94	10.77	2.28	0.15
	Total	11.04	2.53	11.36	2.65	0.32
Total	Early	12.22	2.66	12.26	2.95	0.04
	Late	11.70	2.21	9.72	2.63	1.98
	Total	11.94	2.43	10.89	3.05	1.05
Female	Early	10.10	2.61	9.21	3.24	0.89
	Late	9.05	1.62	6.82	3.19	2.23
	Total	9.87	2.46	8.68	3.36	1.19
Total	Early	10.89	2.81	10.34	3.46	0.55
	Late	10.93	2.38	8.88	3.08	2.05
	Total	10.91	2.65	9.79	3.39	1.12

Table 2 shows that Between pre-test to post-test scores a significant difference in affective problems was observed (F=16.164; P=.000) where a decrease of 0.66 (pre-10.04, post-9.38) scores was noticed irrespective of the groups. However, when the decrease in affective problems were analyzed group wise, (experimental v/s control) again a significant F value (F=27.015; P=.000) was obtained. From the mean scores it is evident that experimental group reduced its mean by 1.61 (Pre- 10.44 – Post-8.83) scores compared to control group, which changed its scores by only 0.3 scores (pre 9.63 – Post 9.93).

Table 2 Mean scores on affective disorders of male and female subjects in experimental and control groups in pre and post test sessions

Groups	Gender	Age	Pre-Test		Post-Test		Change (Pre-Post)
			Mean	S.D	Mean	S.D	
Experi	Male	Early	6.57	3.21	5.14	2.12	1.43
		Late	10.51	3.49	8.91	3.35	1.60
		Total	9.96	3.69	8.38	3.45	1.58
	Female	Early	11.07	3.3	8.67	3.06	2.40
		Late	10.7	2.47	9.75	2.99	0.95
		Total	10.92	2.97	9.28	3.02	1.64
	Total	Early	10.22	3.7	8.24	3.25	1.98
		Late	10.57	3.18	9.17	3.24	1.40
		Total	10.44	3.37	8.83	3.26	1.61
Control	Male	Early	9.97	4.76	10.41	5.00	0.44
		Late	7.64	5.14	7.73	5.41	0.09
		Total	9.64	4.89	9.82	5.16	0.18
	Female	Early	9.94	2.98	10.19	3.42	0.25
		Late	6.5	0.71	6.50	0.71	0.00
		Total	9.8	3	10.40	3.43	0.60
	Total	Early	9.65	3.85	10.29	4.18	0.64
		Late	7.46	4.72	7.54	4.96	0.08
		Total	9.63	4.04	9.93	4.36	0.30
Total	Male	Early	9.46	4.69	9.61	5.04	0.15
		Late	9.93	4	8.67	3.83	1.26
		Total	9.71	4.32	9.10	4.43	0.61
	Female	Early	10.37	3.13	9.72	3.32	0.65
		Late	10.32	2.66	9.45	3.00	0.87
		Total	10.36	3.02	9.66	3.24	0.70
	Total	Early	10.03	3.8	9.68	4.03	0.35
		Late	10.04	3.65	8.89	3.61	1.15
		Total	10.04	3.73	9.38	3.88	0.66

Table 3 shows that In anxiety problems a non-significant difference was observed (F=2.134; P=.146) where a decrease of 0.14 (pre-4.78, post- 4.64) scores was noticed irrespective of the groups. However, when the decrease in anxiety problems were analyzed group wise, (experimental v/s control) a significant F value (F=11.148; P=.001) was obtained. From the mean scores it is evident that experimental group reduced its mean by 0.53 (Pre- 4.94 – Post-4.41) scores compared to control group, which changed its scores by only 0.25 scores (pre 4.62 – Post 4.87).

Table 3 Mean scores on anxiety problems of male and female subjects in experimental and control groups in pre and post test sessions

Group	Gender	Age	Pre-Test		Post-Test		Change(Pre-Post)
			Mean	SD	Mean	SD	
Exp	Male	Early	0.40	1.63	3.57	1.51	0.43
		Late	4.67	2.26	4.16	2.27	0.51
		Total	4.58	2.19	4.08	2.17	0.50
	Female	Early	5.17	1.78	4.57	1.85	0.60
		Late	5.50	1.76	0.50	1.81	0.50
		Total	5.30	1.76	4.74	1.83	0.56
	Total	Early	4.95	1.79	4.38	1.82	0.57
		Late	4.94	2.14	4.43	2.15	0.51
		Total	4.94	2.01	4.41	2.03	0.53
Control		Early	4.18	1.99	4.54	2.42	0.36
		Late	0.40	2.65	4.27	2.90	0.27
		Total	4.14	2.12	4.48	2.50	0.34
	Female	Early	4.98	1.71	5.15	2.04	0.17
		Late	0.80	1.41	0.80	1.41	0.00
		Total	5.10	1.79	5.26	2.09	0.16
	Total	Early	4.62	1.87	4.87	2.22	0.25
		Late	4.62	2.87	4.85	3.02	0.23
		Total	4.62	2.01	4.87	2.33	0.25
Total	M	Early	4.15	1.92	4.39	2.31	0.24
		Late	4.54	2.34	4.19	2.38	0.35
		Total	4.36	2.15	4.28	2.34	0.08
	Female	Early	5.05	1.73	4.92	1.98	0.13
		Late	5.73	1.86	5.27	1.96	0.46
		Total	5.20	1.77	0.50	1.97	0.20
	Total	Early	4.72	1.85	4.73	2.12	0.01
		Late	4.88	2.26	4.50	2.31	0.38
		Total	4.78	2.01	4.64	2.19	0.14

Table 4 shows that Between pre-test to post-test scores a non-significant difference was observed (F=.145; P=.704) in somatic problems where a decrease of 0.02 (pre-3.57, post-3.59) scores was noticed irrespective of the groups. However, when the decrease in somatic problems were analyzed group wise, (experimental v/s control) a significant F value (F=4.371; P=.038) was obtained. From the mean scores it is evident that experimental group reduced its mean by 0.16 (Pre- 3.63 – Post-3.47) scores compared to control group,

which increased its scores by 0.20 scores (pre 3.51 – Post 3.71).

Table.4 Mean, SD on somatic problems of male and female in experimental and control groups in pre and post test sessions

Gender	Age	Pre-Test		Post-Test		Change
		Mean	S.D	Mean	S.D	
Experimental						
Male	Early	2.43	2.30	2.26	2.06	0.17
	Late	3.60	2.65	3.33	2.36	0.27
	Total	3.44	2.61	3.18	2.33	0.26
Female	Early	4.33	2.70	4.24	2.64	0.09
	Late	3.05	2.24	3.05	2.24	0.00
	Total	3.82	2.58	3.76	2.53	0.06
Total	Early	3.97	2.70	3.86	2.63	0.11
	Late	3.43	2.52	3.24	2.31	0.19
	Total	3.63	2.59	3.47	2.43	0.16
Control	MEarly	0.40	2.87	4.31	2.90	0.31
	Late	3.82	2.57	4.18	2.96	0.36
	Total	3.96	2.81	4.28	2.89	0.32
Female	Early	3.15	2.27	3.23	2.28	0.08
	Late	0.10	1.41	0.10	1.41	0.00
	Total	3.06	2.27	3.14	2.29	0.08
Total	Early	3.53	2.57	3.71	2.62	0.18
	Late	3.38	2.75	3.69	2.98	0.31
	Total	3.51	2.58	3.71	2.65	0.20
Total	MEarly	3.76	2.82	0.40	2.87	0.24
	Late	3.65	2.64	3.5	2.49	0.15
	Total	3.70	2.71	3.73	2.67	0.03
Female	Early	3.60	2.49	3.62	2.46	0.02
	Late	2.86	2.23	2.86	2.23	0.00
	Total	3.44	2.45	3.45	2.42	0.01
Total	Early	3.66	2.61	3.76	2.61	0.10
	Late	3.42	2.54	3.32	2.42	0.10
	Total	3.57	2.58	3.59	2.54	0.02

Table 5 shows that In ADHD, the intervention did not have any significant change from pre to post test situation irrespective of the groups, as the obtained F value of.084 was found to be non-significant (P=.772). No differential change for both groups – experimental and control groups- were observed from pre to post test session (F=.300; P=.584). The changes for both the groups were found to be statistically same.

Table 5 Mean, SD on ADHD of male and female in experimental and control groups in pre and post test sessions

Gender	Age	Pre-Test		Post-Test		Change
		Mean	SD	Mean	SD	
Experimental						
Male	Early	0.60	0.10	0.60	0.10	0.00
	Late	6.86	2.78	6.79	2.56	0.07
	Total	6.74	2.62	6.68	2.41	0.06
Female	Early	6.67	2.32	6.43	2.25	0.24
	Late	5.50	2.01	5.45	2.06	0.05
	Total	6.20	2.26	6.04	2.21	0.16
To	Early	6.54	2.14	6.35	2.07	0.19
	Late	6.43	2.63	6.37	2.48	0.06
	Total	6.47	2.45	6.36	2.32	0.11
Control	MEarly	0.60	2.48	6.21	2.85	0.21
	Late	6.73	2.87	6.82	3.16	0.09
	Total	6.16	2.26	6.34	2.90	0.18
Female	Early	5.88	2.55	5.69	2.42	0.19
	Late	5.50	0.71	5.50	0.71	0.00
	Total	5.86	2.50	5.68	2.38	0.18
Total	Early	5.93	2.50	5.92	2.62	0.01
	Late	6.54	2.67	6.62	2.93	0.08
	Total	6.01	2.52	6.01	2.66	0.00
Total	MEarly	0.60	2.31	6.17	2.64	0.17
	Late	6.83	2.77	6.80	2.66	0.03
	Total	6.45	2.59	6.51	2.66	0.06
Female	Early	6.18	2.48	5.97	2.37	0.21
	Late	5.50	1.92	5.45	1.97	0.05
	Total	6.03	2.38	5.86	2.29	0.17
Total	Early	6.11	2.41	6.05	2.47	0.06
	Late	6.45	2.61	6.41	2.54	0.04
	Total	6.24	2.49	6.18	2.50	0.06

Table 6 shows that Between pre-test to post-test scores a non-significant difference was observed (F=.005; P=.942) in ODD where a decrease of 0.01 (pre-4.10, post-4.09) scores was noticed irrespective of the groups. However, when the ODD were analyzed group wise, (experimental v/s control) a significant F value (F=5.153; P=.024) was obtained. From the mean scores it is evident that experimental group reduced its mean by 0.28 (Pre- 4.21– Post-3.93) scores compared to control group, which increased its scores by 0.22 scores (pre 3.98 – Post 4.20).

Table 6 ***Mean scores on ODD of male and female subjects in experimental and control groups in pre and post test sessions***

Gender	Age	Pre-Test Mean	S.D	Post-Test Mean	S.D	Change
Experimental						
Male	Early	4.29	2.21	4.14	2.41	0.15
	Late	4.65	2.27	4.40	2.08	0.25
	Total	04.6	2.24	4.36	2.11	0.24
Female	Early	03.9	2.12	3.70	1.60	0.20
	Late	03.7	1.26	3.45	1.19	0.25
	Total	3.82	1.81	3.60	1.44	0.22
Total	Early	3.97	2.11	3.78	1.75	0.19
	Late	4.35	2.04	4.10	1.89	0.25
	Total	4.21	2.07	3.93	1.84	0.28
Control						
Male	Early	3.79	1.73	4.10	2.01	0.31
	Late	4.91	2.39	5.27	2.10	0.36
	Total	4.04	1.93	4.36	2.07	0.32
Female	Early	3.81	2.12	3.94	2.53	0.13
	Late	06.5	2.12	6.50	2.12	0.00
	Total	3.92	2.17	4.04	2.37	0.12
Total	Early	03.8	1.95	4.01	2.19	0.21
	Late	5.15	2.34	5.46	2.07	0.31
	Total	3.98	2.04	4.20	2.22	0.22
Total						
Male	Early	3.87	1.80	4.11	2.05	0.24
	Late	04.7	2.27	4.57	2.10	0.13
	Total	4.32	02.1	4.36	2.08	0.04
Female	Early	3.85	2.11	3.85	2.08	0.00
	Late	3.95	1.53	3.73	1.52	0.22
	Total	3.87	1.99	3.82	1.97	0.05
Total	Early	3.85	1.99	3.94	2.07	0.09
	Late	4.49	2.10	4.33	1.98	0.16
	Total	4.10	2.05	4.09	2.04	0.01

Discussion

The results clearly indicate that REBT is highly effective in reducing emotional and behavioural problems of the adolescents in affective problems, anxiety problems, somatic problems, Oppositional defiant problems and conduct problems except for ADHD. The main findings of the present study are:

1. Experimental groups showed a reduction of 8.61% on conduct disorder. The finding supports hypotheses #1 that states Rational Emotive Behaviour Therapy (REBT) has a positive impact on treatment of Conduct Disorder. The finding is consistent with the study by Morris (1993), who conducted an experiment to compare adolescents diagnosed with Conduct Disorder (CD) and adolescents diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) for group effectiveness. He used "a 12-weeks treatment program… based on the principles underlying REBT and designed for 'at risk' adolescents (Morris, 1993). Significant differences were found for the CD subjects, who overall reported higher levels of anger and frustration at the outset of the study. There are very limited studies on the effectiveness of REBT on conduct disorder.

2. Considering the sub-variables on DSM-Oriented Scale, REBT had the highest effectiveness of reduction in Affective Problems with 6.57 % after the Conduct Disorder. The third effect was on Anxiety Problems with 2.92% of reduction. REBT also had a 0.56% of reduction on scores with Somatic problem and 0.24 % with ODD Problems. This finding supports the hypothesis # 2 that states Rational Emotive Behaviour Therapy (REBT) has a positive impact on treatment of additional variables of DSM Scale.

Conclusion

Over time, the consequences of conduct disorder are severe and pervasive. When identified in childhood, this condition can be a predictor for chronic problems in many areas of adolescent and adult functioning (Kazden, 1996; Kazden, 1993; Kazden, 1987). For example, many conduct disordered children as they develop over the lifespan tend to: be at greater risk for becoming juvenile delinquents than their non-conduct disordered peers; be at high risk for exhibiting chronic antisocial behaviour and criminality as adults; experience poor interpersonal functioning and marital difficulty; drop out of school; remain chronically unemployed; become financially

dependent as adults; developmental and/or physical health problems with greater frequency; have higher rates of alcoholism and drug abuse as adults; (as parents) be likely to pass along antisocial behaviours to their children who continue this cycle,(Srorm-Mathisen and Vaglum, 1994; Kazdin, 1996, 1993, 1987). Literature from Indian studies shows a high level of emotional and behavioural problems among adolescents. Deivasigamani (1990) has reported the prevalence of conduct disorder to be 11.13%, further, Sarkar, kapur and Kaliaperumal (1995) reported the prevalence rate of antisocial behaviour to be 7.1%, while recently Srinath *et al* (2005) have reported a prevalence as low as 0.2%. In a study in the state of Goa, by Pillai *et al* (2008) out of 2684 adolescents, they found the most common diagnosis which was anxiety disorder (1.0%), depressive disorder (0.5%), behavioural disorder (0.4%) and ADHD (0.2%). Paul (2006) in his study on Delhi adolescents using the YSR scale reported that Social problems (34.41%) rank the highest compared to the other problems, such as anxiety/ depression (19.74%), somatic complaints (19.12%), thought problems (14.13%), delinquent behaviour (10.75%), attention behaviour (10.52%), aggressive behaviour (8.29%) and withdrawn behaviour (6.91%). The present study also revealed the emotional and behavioural disorders, adolescents are facing. Considering the literature it should be concluded that majority of adolescents are struggling with emotional and behavioural problems. For these reasons alone, the development of more effective methods of treatment for conduct disordered children is indicated as a means of preventing such negative outcomes. For Rational Emotive Behaviour Therapy (REBT), a host of studies were compiled by Engles, et al (1993) and Lyons and Woods, (1991) in their meta-analysis report which examined the efficacy of REBT. Results indicate that REBT is useful for a large range of clinical diagnosis and clinical outcomes; REBT is equally efficient for clinical and non-clinical populations, for a large age range (9-70), and for males and females. It is high time now the counselors, social workers, psychiatrists, psychologists, and sociologists to plan proper treatment packages to avoid psychological morbidity among adolescents since it is a serious mental health concern.

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