Running head: A REVIEW OF CONDUCT DISORDER

A Review of Conduct Disorder

William U Borst

Troy State University at Phenix City

Abstract

Conduct disorders are a complicated set of behavioral and emotional problems that afflict between nine percent of male boys and two percent of female girls. The disorder is characterized by persistent aggression, theft, lying, destruction, vandalism, and most of all the child or adolescent violates societal norms and the basic rights of others (Appendix). The etiology of the disorder is still in debate. Some theories relate the disorder to inconsistent home lives, an predisposition to the disorder, modeling and operant conditioning theory, and environmental factors. Treatment is centered around helping the child control their anger, parent interaction training, cognitive problem solving skills, and medications (mostly for the other diagnosed disorders that accompany conduct disorder). Prognosis is poor for this type of disorder especially if it is Child-onset type (having 1 criteria before the age of 10), rather than Adolescent-onset type (no criteria before the age of 10) in which the prognosis is guarded.

A Review of Conduct Disorder

Conduct disorder is a complicated group of behavioral and emotional problems in children and adolescents. The major feature of conduct disorder is a "repetitive and persistent pattern in which the basic rights of others or major age-appropriate societal norms or rules are violated" (American Psychiatric Association [APA], 1994, p.85). Children and adolescents diagnosed with this disorder display aggression towards peers and adults, destroy property, engage in vandalism, theft and truancy. Studies indicate that conduct disorders are the largest group of psychiatric illnesses in adolescents. Often beginning before the teens years, conduct disorders afflict approximately nine percent of boys and two percent of girls under the age of 18. Because the symptoms are closely related to socially unacceptable, violent or criminal behavior, many people confuse the illness with either juvenile delinquency or the turmoil of the teen years. Symptoms and criteria for conduct disorder include intimidating others, initiating fights, using weapons while confronting a victim, being physically cruel to people or animals, forcing sexual activity. Other criteria include setting fires, destroying property, consistently lies, breaking into homes or cars, truancy, and running away from home at lest twice or once if for a length period. Three or more of these criteria must be present in the last 12 months, with at least one criterion present in the past six months. When making a diagnosis of conduct disorder, one must also specify either childhood-onset type or adolescent-onset type. Childhood-onset type is given if at least one criterion characteristic is present before the age of 10. Adolescent-onset type is given if absence of any criterion prior to age 10. The severity of the disorder is also given; ranging from mild to severe. Mild severity is stated if there were only just enough of the criterion present to diagnose the disorder and the child's conduct only causes minor harm to others. Moderate is given if several conduct problems exist and the effect

on others is between mild and severe. Severe severity should be given if many criterion are met and they cause considerable harm to others (APA).

Researchers have not yet discovered what causes conduct disorder, but they continue to investigate several psychological, sociological, and biological theories. Psychological and psychoanalytical theories suggest that aggressive, antisocial behavior is a defense against society, the result of maternal deprivation, or a failure to internalize controls. While other psychological theories (behavioral) suggest children use modeling and operant conditioning to develop and maintain this disorder. Sociological theories suggest that conduct disorders result from a child's attempt to cope with a hostile environment or to gain social status among friends. Other sociologists argue that inconsistent home life contribute to the development of the disorder, whereas, biological theories suggest some children have a predisposition to the disorder linked to their parents (APA, 1992). Cadoret & Yates (1995) studied such a combination of the previous mentioned theories. The researchers used multiple regression analysis to measure separately genetic and environmental effects on 95 male and 102 female adoptee and their adoptee parents. They found that (1) a biological background of antisocial personality disorder predicted increased adolescent aggressiveness, conduct disorder, and adult antisocial behaviors, and (2) adverse home environments (parents who had martial problems, were divorced, separated, or had anxiety conditions, depression, and substance abuse) independently predicted increased antisocial behavior. Other factors may lead to a child developing conduct disorder, including brain damage, child abuse, defects in growth, school failure and negative family and social experiences. The child's "bad" behavior causes a negative reaction from others, which makes the child behave even worse (American Academy of Child and Adolescent Psychiatry [AACD], 1996). Most likely, an inherited predisposition and environmental and parenting influences all play part in the etiology of the disorder.

Common practice in diagnosing conduct disorder is by use of diagnostics interviews and the use of the DSM-IV. Not only must a practitioner evaluate the child by the criteria, but also consider the context in which the behavior is occurring. The DSM-IV cautions practitioners to give the diagnosis "only when the behavior in question is symptomatic of an underlying dysfunction within the individual and not simply a reaction to the immediate social context" (APA, 1994, p. 88). The practitioner must also understand the comorbidity of conduct disorders. It is not uncommon for the child to also satisfy other Axis I diagnosis if they are diagnosed as conduct disorder. Burket and Myers (1995) conducted a study to investigate psychotic comorbidity in male and female adolescents with conduct disorder. Twenty-five adolescents (11 females, 14 males) with conduct disorder were evaluated using structured diagnostic interviews for Axis I and personality disorders. The most common Axis I comorbid diagnosis were depressive disorders, 64 %; anxiety disorders, 52 %; substance abuse, 48 %; and attention-deficit hyperactivity disorder, 28 %. The most common Axis II disorder was borderline personality disorder found in 32 % of the children. Other studies have found that there were no significant differences in the incidence comorbidity between younger (aged 10 to 13) and older (above 13) youth. Among youth who met criteria for conduct disorder, 52 % also met criteria for a substance abuse disorder (Reebye, Moretti, & Lessard, 1995).

Research shows that the future of children diagnosed with conduct disorders are likely to be very unhappy if they and their families do not receive early, ongoing and comprehensive treatment. The prognosis for child-onset type is very poor, whereas adolescent-onset type is usually guarded. Without treatment many children become unable to adapt to the demands of adulthood and continue to have problems with the legal system and maintaining a job.

Even if treated, the children may go on to develop anti-social personality disorder. Treatment of children with conduct disorder is difficult because the causes of the illness are complex and each youngster is unique. Adding to the challenge of treatment are the child's uncooperative attitude, fear, and distrust of adults (AACAP, 1996). Davidson and Neale (1996) go on to say that "just as precious little in the way of effective treatment has been fund for psychotherapy, so are there few ways to reach young people who commit violent and antisocial acts with little remorse or emotional involvement" (p. 427). However, behavior therapies and psychotherapies are usually necessary to help the child appropriately express and control anger. The clinician might also concentrate on parent interactions strategies, and cognition problem solving skills. Remedial education may be needed for children with learning disabilities. Parents often need assistance in devising and carrying out special management and educational programs in the home and at school. Treatment may also include medication in some children, such as those with comorbid diagnosis like depression or ADHD (AACAP, 1996). Campbell, Kafantaris, and Cueva (1995) reviewed the use of Lithium Carbonate with children diagnosed with conduct disorder. They found only a few double-bind and placebo-controlled studies that show a wide range of results. The authors conclude by stating that differences in duration of treatment, subject status, and subject selection may account for the effectiveness of Lithium's ability to reduce aggression. The children who evade help, often end up in the legal system and are constantly incarcerated or shifted from psychiatric hospital to group home.

Lewis and Lovely (1994) comment that in group homes the children are exposed to more people who are not criminals, and, since they had to take responsibility for their living instead of simply following prison rules, they internalize some standards and develop some self-control. Children who went to prison, the authors say, come out angry, ignorant, and unprepared for the life on the outside.

They conclude by saying these type of treatments (group homes) often work better than just simply throwing the children in prison. In conclusion, conduct disorder is difficult to diagnose properly and treatment is rarely brief since establishing new attitudes and behavior patterns take time. However, treatment offers a good chance for considerable improvement in the present and hope for a successful future.

References

American Academy of Child and Adolescent Psychiatry (1996). Conduct disorder. [On-line]. Available: http://www.psych.med.umich.edu/edu/web/aacap

American Psychiatric Association (1992). Let's talk about facts: Childhood disorders. [On-line]. Available: http://www.ihr.com/apa/children.htm

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Burket, R. C., & Myers, W. C. (1995). Axis I and personality comorbidity in adolescents with conduct disorder. [On-line]. Available: America On-line, Medline Record.

Cadoret, R. J., & Yates, W. R. (1995). Genetic-environmental interaction in the genesis of aggressivity and conduct disorders. [On-line]. Available: America On-line. Medline Record.

Campbell, M., Kafantaris, V., & Cueva, J. (1995). An update on the use of lithium carbonate in aggressive children and adolescents with conduct disorder. [On-line]. Available: America On-line, Medline Record.

Davidson, G. C., & Neale, J. M. (1994). Abnormal Psychology (6th ed.). New York: Wiley and Sons, Inc.

Lewis, D., & Lovely, Y. (1994). A clinical follow-up of delinquent males. [On-line]. Available: http://www.mentalhealth.com/mag1/p5h-boys.html

Reebye, P., Moretti, M., & Lessard, J. C. (1995). Conduct disorder and substance abuse disorder: Comorbidity in a clinical sample of preadolescent and adolescents. [On-line]. Available: America On-line, Medline Record.