

CONDUCT DISORDER

TOWARDS A DEFINITION OF CONDUCT DISORDER

Conduct disordered youth are known by many names. Horne and Sayger (1990) have suggested the following labels to describe individuals with conduct disorder, as they appear in varying environments: in the medical field they are the hyperactive, hyperkinetic child, in correctional services they are the delinquent or young offender, in social services they are known as a social deviant, antisocial child, or victim of abuse; and, in the education system, they are often labeled a discipline or management problem, and emotionally handicapped youth, or a behavior disordered student.

While a number of formal definitions and subsequent diagnostic criteria exist for the condition, despite the considerable work that has been done in terms of understanding the profile of conduct disordered individual, there remains a lack of clarity in the field regarding specifically “who” is the conduct disordered child. Indeed, it is well recognized that conduct disorder is neither a well defined nor a homogenous construct and that there remains much confusion about the terminology and categories used to describe the same cluster of behavior (Dodge, 1990; Gardener,

1992). Dodge (1990) in fact argues that conduct disorder is a diagnosis often made by default and maintains that the term conduct disorder is at best “a heuristic term to describe the heterogeneous phenomenon with differing etiologies and causes” (p. 699).

While perhaps this fact confounds the process of seeking an accurate diagnosis of the condition, and thus complicates the task of both assessing and planning for treatment programs it is nevertheless, a critical point to acknowledge and to integrate into one’s understanding of conduct disorder. This disagreement, in itself, points to one of the key characteristics of the disorder and is perhaps the most important thing to keep in mind when working with such individuals: conduct disorders constitute a complex and heterogeneous set of antisocial behaviors and therefore the term belies “remarkably broad and diverse patterns of functioning ... which can vary markedly in severity, chronicity and frequency” and which can manifest themselves in a variety of combinations (Kazdin, 1993, p. 277). Recognition of this fact will place the professional, whose task it is to assess and develop an appropriate treatment plan for individuals with conduct disorder, at a solidly realistic, albeit challenging, starting point.

While definition and subsequent diagnosis of this condition remains controversial in North American literature, a uniform diagnosis of conduct disorder has evolved with a consistent or compatible set of characteristics that are understood as such. In its broadest sense; a conduct disorder is commonly agreed to constitute externalizing or “acting out” problems which refer to a constellation of behaviors characterized by noncompliance, aggression, destruction, attention problems, impulsivity, hyperactivity and “delinquent” types of behavior (McMahon, 1994). The connecting thread in the array of behaviors that make up this disorder is the violation of social norms and basic rights of others (Davison and Neale, 1990). A conduct disorder is frequently evidenced by a significant impairment in everyday functioning, be it at home or at school, or when the child’s behaviors are regarded as unmanageable by significant others (Kazdin, 1987).

What separates conduct disordered behavior from normal behavior problems of aggression and defiance, which research suggests have relatively high prevalence at specific ages of development (i.e. defiance at age two or lying at age six), is that the child or adolescent with conduct disorder experiences problems that are “persistent and extreme patterns ... which reflect a serious clinical problem with broad personal and social impact” (Toth, 1990, p. 9). That is, the conduct-disordered child does not “outgrow” these antisocial behaviors (Toth,

1990). Rather, they are increasingly brought to the attention of professionals in many fields because of their frequency, intensity, repetitiveness and chronicity.

This is the starting point. However, before considering the formal diagnostic criteria most commonly used, this author contends that there are several complicating issues that the careful practitioner must keep in mind. Already mentioned is the fact that conduct disorders are heterogeneous and that different agencies know them by different names and in their different manifestations as dictated by setting and by application of differing criteria. Further, there has been increasing recognition of specific issues surrounding the confounding factors of differing developmental courses and degrees of conduct disorder, gender, and comorbidity and their relation to formal criteria. It is critical that the implications of each of these issues be carefully considered when assessing and/or acknowledging a diagnosis of conduct disorder; and more importantly, when considering treatment for these individuals.

PREVALENCE

Schlebusch made the statement in 1979 that “it would be difficult for any student of the problem to arbitrarily answer the question of exactly how prevalent conduct disorders are at any given period due to various difficulties, both practical and theoretical” (p.25). The overlap of this condition with other conditions and

confounding issues such as gender, age, stage of development and potentially differing etiologies and subtypes, further complicates the issue. Nevertheless, there appears to be a general consensus in the literature to indicate that conduct disorders make up one of the most significant types of psychological disorder in children (Davison & Neale, 1990; Kazdin, 1987) Schelbusch (1979) suggests that although statistics vary considerably and we do not yet have a reliable index of the incidence of psychopathology in adolescence, we can get some ideas from a few selected studies.

In a review of the current literature, Kazdin (1993) assessed that, conservatively, estimates in prevalence range from 2 to 6%. Shamsie (1990) points to findings of a study based in Ontario that suggests the rate to be 5.5%. The DSMIV (1994) suggests that the incidence of conduct disorder appears to have increased over the last decade and may now be as high as 6 to 16% in males under 18 and 2 to 9% in females. An interesting point raised by Phelps and McClintock (1994) suggests that there may be differing prevalence rates not only for different genders, but also for different subtypes, with moderate cases representing 12% and severe cases representing 4%. Further, Kazdin (1987) found that rates are significantly elevated for specific ages and behavior when youths report on their activities. For example, he found that 50% of youth between 13 and 18 admit to theft, 35% to assault, 45% to property

destruction, and 60% to aggressiveness, drug abuse, vandalism and arson (p. 16).

Another measure for the prevalence of conduct disorder is the extent to which referrals to clinical services include antisocial behavior. Estimates have indicated that referrals to out-patient clinics for aggressiveness, conduct problems and antisocial behaviors encompass from one-third to one-half of child and adolescent cases (Kazdin, 1987; Horne & Sayger, 1990; Shamsie, 1990) and Mash & Barkley (1989) suggest that 33 to 75% of clinic referrals consist of individuals with conduct disorder. Still, as estimates are typically based primarily on referral rates they may be somewhat on the low side if one considers that a large number of children, particularly girls, with this condition may never formally be referred for mental health services (Phelps & McClintock, 1994).

GENDER ISSUES

Robins (1991) points out that one of the most stable of all observations in the literature on conduct disorder is the “high rate of conduct disorder in boys as compared to girls” and that “why this occurs, to what extent it is biological and to what extent it is a culturally determined factor is yet to be settled” (p. 204). Zahn-Waxler (1993) echoes a similar concern indicating that “we are still some distance from answers regarding the etiology of conduct disorder in males and females, linkages between theories, empirical data and diagnostic

outcomes” (p. 84). But while we may not yet have all the answers, what is more important is that the questions are being raised and that these questions flag yet another significant consideration for those who work with conduct disordered children and youth.

A common estimate of the comparative prevalence of conduct disorder in boys versus girls is typically reported to be 9% in boys under age 18 and 2% in girls (Toth, 1991). Schwartz (1989) suggests that the likelihood for boys to develop conduct disorders is four to eight times greater than for girls; whereas, Kazdin (1987) reports that conduct disorders are at least three times more common among boys and that sex differences further affect the age of onset. Girls tend to engage in conduct-disordered behavior starting between ages 14 and 16; whereas, for boys, many have become engaged in antisocial behavior before the age of 11.

These differences have been linked to research on early and late starter models of conduct disorder, and the suggestion is made that conduct disorder may have a different developmental course in females. McMahon (1994) and Hinshaw, Lahey and Hart (1993) point out that components of the early-onset pathway for boys have failed to find similar support in girls and that girls may be more likely to enter the late starter pathway. In support of this, the DMS IV (1994) also makes a vague reference to the fact that “childhood

onset type is much more common in males,” implying that for girls, adolescent onset may be more common (p. 86). But are males somehow more predisposed to an earlier and more severe form of conduct disorder than are females? McMahon (1994) suggests that of the few studies that have examined developmental causes of conduct disorder in girls, contradictory findings have been reported concerning whether there is a differential prognosis for boys and girls with respect to later display of conduct disorder. Walker, Colvin and Ramsey (1995) along with Zahn-Waxler (1993) make the argument that, despite gender differences, there is “considerable overlap between males and females on problems of conduct” (p. 81). In order that this female population of conduct disordered girls is no longer ignored or sidestepped in issues surrounding classification, assessment and intervention, it is imperative that prospective care givers attempt to understand why these girls have not been recognized in the past. Several reasons for the vague understanding of female conduct disorder have been proposed.

THE ISSUE OF COMORBIDITY

The effort to define conduct disorder is further complicated by mounting evidence in recent research that, while in itself it constitutes a cluster of behavioral problems and can be seen as a syndrome, this disorder is most often not found in isolation. Indeed, there has been a plethora of studies in the past five years that

focus on and which indicate that there is considerable overlap of conduct disorder with other conditions. More specifically, conduct disorders have been found to coexist with the two other major types of externalizing behavior: oppositional defiant disorder and attention deficit/hyperactivity, along with anxiety and depression, substance abuse and learning problems (Forness, Kavalc, King and Kasari, 1994). In addition to these comorbid conditions, Fetal Alcohol Syndrome, Fragile X syndrome and traumatic brain injury are recognized to produce symptoms of conduct disorder and thus might also been seen as types of occurring conditions.

Reference List is available upon request.

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It contains excerpts from a paper Lisa Marie wrote on Conduct Disorder.