

About 5% of youth suffer from Conduct Disorder

Juvenile delinquency is a lay term for a condition that psychologists call Conduct Disorder (CD). The purpose of this brief newsletter is to describe this childhood disorder and to make some general comments about how it may be assessed and treated.

Estimate on the incidence of CD vary from 1% to 10%, with the best estimate being 5%; this adds up to about three million American youth. About 1/4 to 1/3 of the youth with CD are children, with boys far outnumbering girls. The remaining 3/4 to 2/3 of the youth are teens, with a fairly equal distribution among males and females.

Not all children with CD show behavioral problems in the same way. Studies suggest that



behaviors can be subdivided into three groups: destructive/overt, destructive/covert and non-destructive

Conduct Disorder

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tive/covert (the non-destructive/overt behaviors tend to define a milder disorder called Oppositional Defiant Disorder). The non-destructive/covert group includes behaviors called “status violations” (e.g., behaviors like running away, truancy, substance abuse, etc.). The destructive/overt category includes behaviors such as assaulting others, being spiteful, being cruel, getting into fights, etc., while the destructive/covert category usually involves damaging property, hurting animals and lying. The behavior within each group can range from mild to serious, from aggravating to life threatening.

The average age of onset of CD is nine. A group of studies suggest that a childhood onset type is different, and more serious, than an adolescent onset type. It appears that a childhood onset of CD is affiliated with underarousal in the cortical region of the brain, low reactivity to stimulation and social processing deficits. Theoretically speaking, it appears that these biologically

based difficulties interfere with a child’s ability to be influenced by typical consequences; adults respond in a way designed to reduce negative acting out, but these responses do not tend to work with this group. The failure of adult interventions then facilitates considerable stress and a worsening of both child and adult symptoms.

Childhood onset CD seems to be different from teen onset CD

The social processing deficits appear to interfere with a child’s ability to adequately read social cues and to come up with effective solutions to social problems; these deficits also appear to cause these children to attribute hostile intent to neutral social situations and to believe that aggressive behavior will lead to a successful outcome. These children also appear to live in families that have more problems. These family problems appear to exist for two reasons. First, there appears to be a genetic component to childhood onset CD, thus these families are more likely to have fathers who meet criteria for the adult version of CD, or Antisocial Personality Disorder,

Youth with Conduct Disorder typically need a range of services.

and mothers who are clinically depressed. Second, the stress caused by the child's acting out can facilitate an assortment of additional problems including marital problems and child abuse.

When the onset of CD is in adolescence, it appears that a higher proportion of the behaviors may have been brought on by family problems. Stress both within and upon the family seems to place a considerable burden on the youth. Because the family is already overwhelmed, the youth is not monitored well. The teen then gravitates towards a group of peers that is disenfranchised and disposed to act out. A number of studies, which cut across class and race, have demonstrated that the amount of monitoring in these teens' lives correlates highly with how much trouble they get into.

Most children with CD will suffer from an additional disorder as well. In order of

incidence, these youth can also suffer from AD/HD, Substance Abuse, Mood Disorders and Anxiety Disorders. For instance, most of the children with CD will also meet criteria for AD/HD. Whether or not a youth with CD also has a co-occurring condition will have a considerable impact upon both the treatment planning and the prognosis.

A psychosocial assessment of any child is really a family assessment. These assessments should include a family interview, an interview alone with the youth, a parent interview, a battery of behavior rating scales (parent, teacher and youth) and a comprehensive review of all school, medical, psychological, forensic and welfare records. In some instances, psychological testing, or other specialty evaluations, may also be advisable.

An effective treatment plan will most commonly include the following: (1) an evaluation, and follow up treatment, for any parent problems that are present, (2) behaviorally oriented family therapy, and (3) consultation and coordination of services with the school system. If a child has intense rages, or AD/HD, medication will generally be a critical part of any effective treatment plan. If a child has a mood disorder or an anxiety



disorder which persists through the family treatment, individual therapy may be indicated; medication may also be prescribed at the same

time if the mood or anxiety based symptoms are severe. If a child has a persistent substance abuse disorder they may need education services, 12-step meetings, drug counseling and random urine screens.

The setting that treatment occurs in will typically be determined by the severity of the youth's symptoms, the psychological health of the family and the family's resources. The three most common levels of treatment for this population are outpatient care, day treatment care and residential care.

Parents are well advised to seek out professional consultation whenever their child is persistently acting in a defiant or disruptive manner. As is the case in many service disciplines, if problems are caught sooner, rather than later, the prognosis is generally better.

