Indian Journal of Social Sciences and Literature Studies
Vol. 8, Issue 3, December 2022
ISSN 2349-5634 (Print) ISSN 2455-0973 (online)

Conduct Disorder : Diagnosis and Management

Dr. Samyak Makwana

Assistant Professor,

Dep. of Psychology,

M.P. Shah Arts and Science College,

Surendranagar, Gujarat

Conduct disorder is a psychiatric syndrome occurring in childhood and adolescence, and is characterized by a longstanding pattern of violations of rules and antisocial behavior. As listed in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV),[1] symptoms typically include aggression, frequent lying, running away from home overnight and destruction of property. Approximately 6 to 16 percent of boys and 2 to 9 percent of girls meet the diagnostic criteria for conduct disorder. The incidence of conduct disorder increases from childhood to adolescence.

DSM-IV Diagnostic Criteria for Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past six months:

Aggression to people and/or animals

1. Often bullies, threatens or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
7. Has forced someone into sexual activity.

Destruction of property

1. Has deliberately engaged in fire setting with the intention of causing serious damage.
2. Has deliberately destroyed others' property (other than by fire setting).

Deceitfulness or theft

1. Has broken into someone else's house, building or car.
2. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
3. Has stolen items of nontrivial value without confronting the victim (e.g., shoplifting, but without breaking and entering; forgery).

Serious violations of rules

1. Often stays out at night despite parental prohibitions, beginning before age 13 years.
2. Has run away from home overnight at least twice while living in a parental or parental surrogate home (or once without returning for a lengthy period).
3. Is often truant from school, beginning before age 13 years.

Family physicians who treat pediatric patients frequently encounter this disorder and should be knowledgeable about it for several reasons. First, family physicians are increasingly treating a broader array of psychiatric conditions,[2] including common pediatric mental health problems. Second, primary care physicians often serve as referral sources for mental health treatment. Thoughtful differential diagnosis of conduct disorder enables clinicians to refer patients to appropriate subspecialists. Third, conduct disorder increases the risk of several public health problems, including violence, weapon use, teenage pregnancy, substance abuse and dropping out of school. Thus, it is important to identify conduct disorder and begin intervention as early as possible.

Clinical Features of Conduct Disorder

Four types of symptoms of conduct disorder are recognized:

- (1) Aggression or serious threats of harm to people or animals;
- (2) Deliberate property damage or destruction (e.g., fire setting, vandalism);
- (3) Repeated violation of household or school rules, laws, or both; and
- (4) Persistent lying to avoid consequences or to obtain tangible goods or privileges.

DSM-IV emphasizes that there should be at least three specific conduct disorder behaviors present for at least six months to make the diagnosis. Isolated behaviors (e.g., shoplifting, experimentation with marijuana or alcohol) are common, and specific antisocial acts may occur in up to 80 percent of youth in the United States.By contrast, a diagnosis of conduct disorder requires a persistent history of multiple problem behaviors.

Associated features of conduct disorder include an inability to appreciate the importance of others' welfare and little guilt or remorse about harming others. Adolescents with conduct disorder often develop skills in outwardly verbalizing remorse to obtain favor or avoid punishment, but do not experience any apparent guilt. Patients with conduct disorder often view others as threatening or malicious without an objective basis. As a result, these children and adolescents may lash out preemptively, and aggression may appear unprovoked.

Practical Interventions for Management of Patients with Conduct Disorder

- Assess severity and refer for treatment with a subspecialist as needed.
- Treat comorbid substance abuse first.
- Describe the likely long-term prognosis without intervention to caregiver.
- Structure children's activities and implement consistent behavior guidelines.
- Emphasize parental monitoring of children's activities (where they are, who they are with). Encourage the enforcement of curfews.
- Encourage children's involvement in structured and supervised peer activities (e. organized sports, Scouting).
- Discuss and demonstrate clear and specific parental communication techniques.
- Help caregivers establish appropriate rewards for desirable behavior.
- Help establish realistic, clearly communicated consequences for noncompliance.
- Help establish daily routine of child-directed play activity with parent(s).
- Consider pharmacotherapy for children who are highly aggressive or impulsive, or both, or those with mood disorder.

Conduct disorder has varying degrees of severity. Parental abuse, onset of problem behavior in early childhood, financial hardship and lack of supervision are all associated with more severe conduct disorder. Additionally, a poorer prognosis is associated with an increase in the number and severity of specific DSM-IV criteria. Risk also increases with comorbid ADHD and substance abuse. These dimensions should guide treatment Subclinical conduct disorder symptoms or those of recent onset may be amenable to physician-parent counseling. However, more serious, longstanding behavior involving aggression, illegal acts, substance abuse or other harmful acts should prompt referral to a mental health specialist. With comorbid substance abuse, the focus of initial treatment should be cessation of drug use and may include medical detoxification before rehabilitation.

Monitoring of children's activities and whereabouts by adult caregivers is critical. Compliance with the evening curfew is essential. For working parents, telephoning to check on the child or having another responsible adult ensure that the child is in an appropriate setting during nonschool hours is important. Monitoring becomes particularly important during early adolescence when peer group influences increase. Vulnerable youth are susceptible to peer influences such as smoking, sexual risk-taking, and alcohol or other substance abuse. Organized, supervised activities, such as sports, Scouting, the arts or recreational programs provided by churches, schools or agency youth clubs often protect teenagers from negative peer influences.

COUNSELING PARENTS ABOUT CLEAR COMMUNICATION

A reasonable initial intervention for family physicians is parental instruction in communication for achieving improved compliance. Parents should communicate clear, direct and specific requests (“I would like you to set the table for dinner now.”). Importantly, requests should not be negative or qualified (“Don't waste all your life in front of the television. Maybe

you could be useful and help with dinner."). If the requested activity is not initiated within five seconds, a verbal reminder should follow. When the request is made for a third time, a clear, reasonable consequence should be added ("If you have not finished setting the table in fifteen minutes, you will lose one-half hour of free time with your friends tonight."). The chosen consequences should be restrictions that the parent can realistically implement rather than those that are vague and unenforceable ("You never do what I ask; you just love to make me mad. Well, you're grounded for the rest of the year.").

REINFORCEMENT OF POSITIVE BEHAVIOR

While adverse consequences may be necessary periodically, parent-child interactions should also include rewards. Positive reinforcement for desirable behavior will reduce reliance on punishment. Importantly, rewards should be concrete, specific and always provided promptly when the child meets the criteria ("If you set the table by 6 p.m. each night this week, you can choose a video to rent on Saturday night."). Parents of children with conduct disorder typically rely on inconsistent coercion, rather than reinforcement, in a family climate high in negative exchanges.

Because television, movies and video games are reinforcing to many children and adolescents, they are often used as rewards. Children who are at risk for conduct disorder, however, may be more likely to exhibit aggressive behavior in response to viewing violence. Therefore, access to these reinforcers should occur with parental supervision.

In two-parent households or other family situations in which multiple adults set rules, consistency between caregivers is particularly important. In single-parent households, particularly those with multiple children, parental availability and energy may be limited. Physicians should inquire about the availability of other responsible adults to assist with carrying out rules under the parent's guidance.

A useful directive to improve the emotional climate in families with preteens and younger children is to set aside 15 minutes every day for parent and child to play together. The child chooses a cooperative activity each day (e.g., playing catch, reading or drawing together). Structuring such exchanges ensures regular reinforcing contact between parent and child.