Conduct Disorder

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Abstract

'Externalizing behaviors' persistently prevalent in the behavioral repertoire of a child can result in the development of disruptive behavioral tendencies. Conduct disorders are a subtype of Disruptive, Impulse Control and Conduct Disorders, which are understood as a consistent pattern of law-violating behaviors that occur due to the cumulative impact of a multitude of factors. These factors can be either endogenous i.e. neurological/biological or exogenous i.e. psychological, familial and social. According to the 'epigenetic approach', the endogenous factors only come into effect after their interaction with exogenous factors, thus, the current investigation attempts to evaluate the role of 'exogenous' factors in conduct based problems in children. For this purpose, data was collected from five children having conduct based disorders in the form of case histories which were further analyzed to identify differences in the factors contributing to the manifestation of psychopathology. As per the literary review it became evident that children with such disruptive behavioral tendencies are at a major risk for developing antisocial personalities and delinquent traits later in adulthood. The paper, therefore, suggests preventive strategies for reducing such rule-breaking behavior in children.

Keywords: *conduct disorder, precursors, case reports*

1. INTRODUCTION

Psychopathology is the scientific study of mental disorders with efforts to understand their biological, psychological, social and cultural causes, manifestations, classifications and treatment combinations. 'Psychopathology' is defined as the scientific study of origin, development and manifestation of a mental disorder [1]. According [2] 'Child Psychopathology' is, thus, understood as the study of the causes, treatments and preventive strategies of psychological disorders amongst children and adolescents.

Although, there is a broad array of disorders prevalent in children and adolescents, the current study primarily focuses on the category of 'Conduct Disorders' which is a subtype of 'Disruptive, Impulse Control and Conduct Disorders' of DSM V [3]. Disruptive, Impulse Control and Conduct disorders are categorized as disorders with characteristics of disobedient and rule breaking behavior with little regard for others. Wherein, disruptive behavior is understood as the violation of social norms and rules resulting in interference in the child's routine functioning.

Conduct Disorders are understood as a severe mental condition in which the child shows reluctance tow[1]ards both social norms and personal mores. According to American Psychiatric Association's DSM V [3] Conduct Disorder is defined as a repetitive and persistent pattern of age inappropriate and rule breaking behavior. This rule breaking

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behavior, wherein, may be associated with problems in emotional regulation and emotional reactivity, which are common in children having conduct based problems.

1.1. According to DSM V [3] the symptoms required for diagnosing Conduct Disorder are as follows:

A) A repetitive pattern of behavior involving violation of rights of others and social norms, with at least 3 of the following 15 criteria present during the previous 12 months:

Aggression to people and animals:

1. Threatening or intimidating others.
2. Initiating physical fights with others.
3. Used a weapon to incur harm to others (e.g., gun, knife, bat, brick, broken bottle etc).
4. Physical cruelty towards people.
5. Physical cruelty towards animals.
6. Indulged in forcible sexual activity with others.
7. Stolen while confronting the victim.

Destruction of Property:

8. Indulged in fire setting activity with the intention to harm the other.
9. Has destroyed others property other than by fire setting activity.

Deceitfulness or Theft:

10. Broken into someone else's building, car or house.
11. Often cons others to avoid obligations.
12. Stolen items of non trivial value without confronting the victim (e. g., shoplifting, forgery etc.).

Serious Violation of Rules

13. Stays out at night before 13 years of age despite parental prohibitions.
14. Has run away from parental or parental surrogate home at least twice overnight or at least once, without returning for a long period of time.
15. Truancy from school before the age of 13 years.

B) The disturbance causes clinically significant impairment in one or more important areas of functioning.

C) Criteria are not met for Antisocial Personality, if individual is 18 years or above.

1.2. Specify if:

Childhood-Onset type (at least 1 symptom prevalent before 10 years of age)
Adolescent-Onset type (no symptom prevalent before 10 years of age)
Unspecified-Onset (no specific information if symptoms were prevalent before or after 10 years of age)

Apart from the above specifier, DSM V [3] also provides a severity specifier i.e. mild, moderate and severe as well as a specifier concerning 'with limited Prosocial emotions'. Those children who fit into the latter category are said to show a weaker prognosis and are at a higher risk for other psychopathologies.

1.3. Factors related to Conduct Disorder:

Behaviour fluctuates as the child learns; therefore, it becomes essential to consider temporal relationships between emerging concerns for various disorders in their early

childhood. The sequence and timing of particular behaviours and the possible relationships between those behaviours over time i.e. the developmental pathways involved in Conduct Disorders are, therefore, essential to understand various factors involved in conduct based disorders:

1.3.1 Childhood-Onset Type

Literary review in relation to Childhood-Onset Conduct Disorder depicts that conduct based problems early in childhood are a result of a multitude of factors such as genetic or neurological deficits, impulse control problems and emotional regulation problems [4]. Other researches reveal that children with early onset of CD start showing troublesome, oppositional defiant, tantrum throwing behaviour right from pre-school which continues throughout adolescence and adulthood [5]. While [6] depicts that children with early onset CD have a family history of parental psychopathology and inconsistent disciplinary strategies resulting in development of disruptive behavioural tendencies in them. Further, [4] & [6] also reveal that such children show academic problems early in childhood along with difficulty in establishing peer relationships.

1.3.2 Adolescent Onset Type

In contrast, in adolescent onset CD unlike early onset CD, the child starts having behavioural difficulties since childhood, but they become manifest only on the onset of adolescence. According to [4] adolescent onset CD emerges due to lack of supervision by parents and deviant peer affiliations of the child. [6] Reveal that neurological deficits which were evident in childhood onset CD are not evident in adolescent onset CD. While, [7] in their study reveal that adolescent onset CD has a lesser role of cognitive and neurological factors while behavioural factors such as rebellious, carelessness regarding norms and rule breaking behaviour are more prominent for their onset.

1.4. Importance for evaluating and preventing 'Conduct Disorders':

- Children with conduct problems have delinquent tendencies and are, therefore, at risk of indulging in criminal activities [8].
- Due to aggressive tendencies children with conduct disorders are at risk of getting into fights with peers resulting in expulsions and suspensions from school and further academic failures [9].
- Children having conduct problems are at a higher risk to experience anxiety problems, suicidal tendencies, depressive disorders and legal difficulties as compared to other children [10, 6].
- Children with conduct disorders show psychopathic deviations in their behavior putting them at risk for developing antisocial personalities in future [11, 5, 12, 4].

Conduct problems serve as a 'diathesis' for difficulties in social, occupational, academic and legal areas of life, therefore, it becomes essential to evaluate various factors contributing to the conduct based problems in children in order to prevent the same [12].

2. CASE EXAMPLES

2.1. Case Example 1

- **Symptoms present**: Initiates physical fights with others
- Has destroyed others property other than by fire setting activity
- Stolen items of non trivial value without confronting the victim
- Truancy from school before the age of 13 years

An 11 year old male, belonging to low socioeconomic status group was referred to a clinician after he 'burned three of his fingers while lighting a cracker". The chief complaint of his parents was that the client misbehaves and they often get complains from his school about his misbehavior. They quoted instances of the same reported by his teachers i.e. 'he lies very often', 'he's poor in academics', 'he doesn't share his things with others', 'he has a habit to steal things from his classmates' etc. His parents further reported that they often find others belongings in his bag and marks on his arm as if he has cut himself several times deliberately. His mother, wherein, reported that he has always been a difficult child since his childhood i.e. has a short temperament, stubborn outlook and tantrum throwing behavior. He often prefers to be by himself and doesn't get along with his siblings or age mates. His parents also revealed that his friends have always been elder to him in age and those that are less interested in academics and indulgent in pornography, which they attribute as a cause of such behavior. His behavior, however, has worsened since the past few months, wherein, he refuses to listen to parental commands and breaks things when home especially when his demands are not fulfilled by others. His mother pointed out that his hatred for school has increased, wherein; he recently missed school consecutively for 10 days and ran away from school a few days back. In those ten days he refused to have any interaction with other family members and sat alone the entire day with his room closed. He hasn't received any treatment for his behavior in the past; although there is a family history of depression (paternal grandmother had it).

2.2. Case Example 2

- **Symptoms present:** Initiates physical fights with others
- Has destroyed others property other than by fire setting activity
- Indulged in forcible sexual activity with others

A 15 year old male (in tenth grade) had to be referred for professional help due to his increasing 'anger issues' since the past one year. The client's parents reported that they had started having regular arguments with him due to his diminishing academic interest. His teachers complained that 'he picks fights with others in class and provokes teachers deliberately by instigating an argument'. In the ninth standard he was accused of eve teasing and got suspended from the school for the same reason. His friendships with senior boys and his rule breaking behavior, however, started posing a serious concern for both the parents and the teachers since the past one month. When asked, his parents reported that he hardly stays at home and whenever home, he tries to provoke his siblings and parents to engage in a verbal battle or physical fight (breaking things) with him. He maintains a poor hygiene and keeps playing games, watching adult videos (as reported by the mother) and chatting with random unknown people online. The client' has had a normal delivery with no developmental delays as reported by the parents. However, his mother reported that he has had a problem of bed wetting till the age of 8 years and an aggressive temperament since his early childhood. He is over pampered by his father, which is disliked by his mother, and the two experience dissonance in their disciplinary strategies to be used with the client. The client's father consumes excessive alcohol regularly and has a short temper, as reported by the mother, which is a reason of major fights at their home.

2.3. Case Example 3

- **Symptoms present:** Threatening or intimidating others
- Has destroyed others property other than by fire setting activity
- Initiates physical fights with others
- Stolen items of non trivial value without confronting the victim

The client i.e. a 15 year old male started exhibiting behavioral problems since the past few months, wherein, his parents felt a need to seek professional help for the same. His parents reported that he started blackmailing them in order to get his demands fulfilled since the last two-three months. Since then, he experiences sudden outbursts of anger and becomes violent on petty issues. When angry, he breaks articles at home and indulges in fights with siblings without any feelings of guilt/remorse. He has a short temperament, poor sleep and a habit of lying to his parents as well as friends. He has been involved with a girl three years senior to him and spending large sums of money on her (7000 rupees/month) without asking his parents' permission (also taking parental belongings without seeking approval). His father works as a lieutenant general in the army and his mother is a homemaker. He indulges in verbal battles with his parents as well as siblings on a daily basis on petty issues. He has no past history of a medical/psychiatric illness and has no family history of the same. There has not been any developmental delay or prenatal complications as reported by the mother of the client.

2.4. Case Example 4

- **Symptoms present:** Stolen items of non trivial value without confronting the victim
- Often cons others to avoid obligations
- Physical cruelty towards people

A 15 old male (class X^{th}), had to be referred to a psychologist due to his increasing 'behavioral issues' as reported by his mother and teachers. His mother (being the chief informant) reported that his behavior had become problematic particularly from the past few months, wherein, he tries to seek 'negative attention' from the others (especially when a guest visits them). His interest in studies has been diminishing and he has started consuming alcohol on a regular basis with his friends. He doesn't have a fixed peer circle, so it's difficult to identify how and with whom did he start drinking alcohol. His teacher complained that he was caught 'stealing money from his classmate' last week but when confronted he refused and showed no guilt for doing so. Similar instances have been occurring at home as described by the mother. During the family history it became evident that his mother is his single caretaker, as his father expired due to alcohol overdose, eleven years ago. Since then his behavior has been more problematic, wherein, he spends the entire day either outside with friends or playing monopoly or video games. He belongs to a poor socioeconomic background so his mother is unaware of his 'financial sources' for playing monopoly. He likes privacy and being by himself most of the times. He often expresses a desire to have a lot of money (from any source i.e. legal/illegal), buy a home in Spain and eventually settle down in Brazil (since it has a lot of money/alcohol and opportunity to gamble, as reported by the client) as reported by the mother. The client, however, has had a normal delivery and no developmental delays and is the only child of his parents.

2.5. Case Example 5

- **Symptoms present:** Truancy from school before the age of 13 years
- Initiates physical fights with others
- Has destroyed others property other than by fire setting activity

A 13 year old male ($VIII^{th}$ grade) started bunking school and being aggressive with his parents and friends since the past few months. His mother reported him of being adamant and short tempered as well as picking fights on petty issues (breaking things) with everybody. He doesn't listen to instructions and has a problem with 'following rules'. His interest in academics has been diminishing and he finds studies boring. He has one sibling, who he doesn't get along with. His mother reported him to have a habit to

provoke others and defy rules. He has no past medical/psychiatric history, whilst, his mother has been on medication since the past two years for 'depression'. He had a normal delivery with no delay in developmental milestones. The client has always been a difficult child as per the mother; however, the client disagrees of the same and does not admit to any of the above issues listed by the parent.

3. FINDINGS & SUGGESTIONS

As evident from the above literary review and case examples conduct disorder is a result of the interaction of various 'exogenous' factors. A multitude of factors interact so as to result in conduct based problems. The findings from the current study, therefore, are as follows:

- Conduct based problems involve the role of inadequate 'parenting styles' i.e. those involving reprimand and a lack of warmth towards the child.
- Conduct disorder is more prevalent in males as compared to females.
- Conflict in terms of 'disciplinary strategies' amongst parents can contribute in the development of conduct based problems.
- Parental psychopathology or family history of a psychiatric illness poses a risk for developing conduct disorder.
- Lack of supervision upon the daily routine of the child, results in, absent or weak emotion regulation and reactivity within the child which further may take the form of conduct based problems.
- Developmental delay, which is an essential aspect of other childhood disorder, is usually absent in conduct based problems.
- Poor family dynamics and a non-conducive family environment serves as an antecedent for conduct based problems.
- Lack of interest in academics is predominant in children having conduct based problems. Such children instead invest time in 'extraneous activities' that may be dangerous or inappropriate for their age group.
- Peer influences, further, interact with the already present triggers in the environment and reinforce conduct based problems in the child.
- Aggressive and rule breaking behavior is evident since the early childhood of the child.
- Late identification of the fact that 'conduct based problems' are a clinically recognizable condition is usual that further delays the implementation of the interventional program and therefore, weakens the rate of prognosis.

3.1. In lieu of the above mentioned findings, the following suggestions are proposed to manage and prevent conduct based problems in the child (due to exogenous factors):

- Parents should be educated regarding appropriate parenting styles to be used with a child i.e. one involving a balance between parental warmth and control by holding awareness campaigns in school.
- Child should be made aware of the consequences of rule breaking and defiant behavior in a firm but non-punishable manner.
- Parent and child relationship building skills should be taught to parents so as to rebuild their rapport with the child and reduce his oppositional and defiant behavior.
- Contingency management techniques should be suggested to the parents i.e. the ones involving rewarding the appropriate behavior and ignoring the inappropriate behavior of the child.

- Parents should be educated, not to use unnecessary reprimands or getting over-involved with the child, if the behavior is not interfering with the child's routine.
- Peer relations should be monitored regularly by parents, as peers are a significant factor for an increase in conduct based problems. Parents can be suggested to become a part of the child's inner circle, which will not only help them to keep a track of the child's friendships but also give them an opportunity to better their relation with the child.
- 'Special time' technique should be used i.e. a technique in which the parent spends alone time with the child without involving any extraneous distracters or interferences on a regular basis.
- In case of severe problems, 'time out' technique should be used, wherein; the child is moved out of a stimulated environment and kept in an isolated setup for a span of few minutes so as to reduce his inappropriate behavior.
- Value-based exercises should be administered with the child regularly in the form of fun school based activities in which the importance of rules and norms can be reinforced.
- In terms of diminishing academic interest, teachers should be guided to set short term, modest goals for the child and follow the completion of a task or an attempt to do complete a task with a reward.
- Awareness campaigns should be conducted in schools with parents and other staff members regarding 'identification' signs of conduct disorder so that children with conduct based problems can be identified at an early stage and consequently treated early.
- The child should be equipped with techniques of anger management so as to constructively give an outlet to their aggressive and violent behavior e.g. deep breathing exercises, distraction techniques, counting techniques etc.

References

[1] *American Heritage Dictionary of the English Language 5th ed, Houghton Mifflin, Boston,* ***(2011).***

[2] *E. J. Mash and R. A. Barkley, "Child Psychopathology", Guilford Publishers, New York,* ***(2003).***

[3] *American Psychiatric Association, "Diagnostic and statistical manual of mental disorders (5th ed.)", American Psychiatric Publishing, Arlington, VA,* ***(2013).***

[4] *T. E. Moffitt, "Life-course persistent versus adolescence-limited antisocial behavior" Edited In D. Cicchetti and J. Cohen, Wiley Publishers, New York,* ***(2006),*** *pp. 570- 598.*

[5] *P. J. Frick and E. M. Viding, "Antisocial behavior from a developmental psychopathology perspective" Development and Psychopathology, vol. 21,* ***(2009),*** *pp. 1111–1131. doi:10.1017/S0954579409990071*

[6] *D.L. Odgers, T.E. Moffitt, J.M. Broadbent, N. Dickson, R. J. Hancox, H. Harrington and A. Caspi, "Female and male antisocial trajectories: From childhood origins to adult outcomes", Developmental Psychopathology, vol. 20,* ***(2008),*** *pp. 673–716. doi:10.1017/S0954579408000333*

[7] *D. M. Dandreaux and P. J. Frick, "Developmental pathways to conduct problems: A further test of the childhood and adolescent-onset distinction", Journal of Abnormal Child Psychology, vol. 37,* ***(2009),*** *pp. 375–385. doi:10.1007/s10802-008-9261-5*

[8] *P. J. Frick, T. R. Stickle, D. M. Dandreaux, J. M. Farrell, and E. R. Kimonis, "Callous-unemotional traits in predicting the severity and stability of conduct problems and delinquency", Journal of Abnormal Child Psychology, vol. 33,* ***(2005),*** *pp. 471–487. doi:10.1007/s10648-005-5728-9*

[9] *P. J. Frick, "Developmental pathways to conduct disorder: Implications for future directions in research, assessment, and treatment", Journal of Clinical Child and Adolescent Psychology, vol. 41,* ***(2012),*** *pp. 378–389. doi:10.1080/15374416.2012.664815*

[10] *D. L. Odgers, A. Caspi, J. M. Broadbent, N. Dickson, R. J. Hancox, H. Harrington. . . and T. E. Moffitt, "Prediction of differential adult health burden by conduct problem subtypes in males", Archives of General Psychiatry, vol. 64,* ***(2007),*** *pp. 476–484. doi:10.1001/archpsyc.64.4.476*

[11] *K. A. Dodge and G. S. Pettit, "A biopsychosocial model of the development of chronic conduct problems in adolescence", Developmental Psychology, vol. 39,* ***(2003),*** *pp. 349–371. doi:10.1037/0012-1649.39.2.349*

[12] *P. J. Frick, J. V. Ray, L. C. Thornton and R. E. Kahn, "Annual research review: A developmental psychopathological approach to understanding callous-unemotional traits in children and adolescents with conduct problems", Journal of Child Psychology and Psychiatry, vol. 55,* ***(2014),*** *pp. 632–548. doi:10.1111/jcpp.12152*