Conduct Disorder

April 17, 2013

Conduct Disorder (CD): Definition

- DSM IV: A repetitive and persistent pattern of behavior in which the basic rights of others or major age appropriate social norms or rules are violated, as manifested by three or more of the following criteria in the past 12 months with at least one criteria present in the past 6 months:

CD Definition 2

- Aggression to people and animals
  - often bullies or intimidates others
  - often initiates physical fights
  - has used a weapon that can cause serious harm
  - physically cruel to people
  - physically cruel to animals
  - stolen while confronting victim
  - forced sexual activity

CD Definition 3

- Destruction of property
  - Fire-setting with intent to cause serious harm
  - Other serious property destruction
- Deceitfulness or theft
  - breaking and entering
  - lying and conning
  - non-trivial stealing without confrontation

CD Definition 4

- Serious violations of rules
  - often stays out at night despite parental prohibition beginning prior to age 13
  - has run-away from home overnight at least twice or once without returning for lengthy period
  - often truant beginning prior to age 13

Epidemiology

- Very common disorder:
- 1.5-15% (1.5-3.5% using interview methods)
- Gender distribution: Male:Female 3-5:1
- Some evidence of increased rates in recent years
- Peak rate of onset in late childhood to early adolescence
- DSM-IV recognizes two sub-types: a childhood onset and an adolescent onset type (age 10)

Epidemiology 2

- Childhood onset mostly male with worse prognosis and more aggression.
- Adolescent onset CD has more even sex ratio. Girls may have more health issues and may have more anxiety/depression as adults. Rates of female CD tend to be low through early childhood and increase at adolescence.
- Relationship to ASPD: only about 40% or less go on to adult ASPD (primarily from childhood onset group).

Oppositional Defiant Disorder

- DSM-IV: A pattern of negativistic, hostile, and defiant behavior lasting at least six months, during which four (or more) of the following are present:
  - Often loses temper
  - Often argues with adults
  - Often actively defies or fails to comply
  - Often deliberately annoys people
  - Often blames others for mistakes or misbehavior
- Prevalence of 2-16% and approximately twice as common in males as females though gender difference is less consistent.

ODD Diagnostic Issues and Patterns of Co-morbidity

- Relationship to Conduct Disorder
  - Cannot be diagnosed together as the majority of CD patients meet ODD criteria
  - Some ODD patients go on to CD others do not
    - Greater severity and early onset
    - Frequent physical fighting
    - Parental substance abuse
    - Low SES
- Relationship to Mood Disorder and Psychosis
  - Oppositional behavior is very common in mood and psychotic disorders. The issue is the relationship between mood/psychotic symptoms and ODD behaviors. For some, the mood and psychotic symptoms precede the oppositional behavior that then abates with treatment of mood/psychosis.

ODD Continued

- Rates of diagnosis tend to be higher in childhood and fall with age (as long as DSM-IV constraint on not diagnosing with CD is followed)
- However, rates of actual oppositional behaviors tend to increase overall with age through adolescence.
- Co-morbid anxiety and cognitive issues may be more closely related to oppositional symptoms in CD.

Etiology-Risk Factors

- Biological Factors
  - Genetic liability likely but genetic data stronger in adult anti-social personality.
    - Traits with gene linkage include: inattention, hyperactivity, aggressiveness, novelty seeking.
    - Cross situational CD behaviors have strong genetic component—chromosomes 2 and 19 have been implicated.
    - Enhanced rates of s/s variant of serotonin transporter gene
    - Low MAO A activity in some CD patients (found to increase CD risk only in presence of childhood adversity
  - CNS damage CD patients have higher rates of head and face trauma
  - Autonomic hypo-arousal (or possibly excessive reactivity with adolescent onset type)

Etiology-Risk Factors 2

- Biological factors continued
  - neurohormonal (cortisol, serotonin, testosterone)
    - Diminished salivary cortisol
    - Low CSF 5-HIAA
    - Elevated testosterone (not simple relationship, may reflect dominance behavior primarily)
  - Gender effects
    - Boys with more direct aggression
    - Girls with higher levels of indirect aggression and higher levels of internalizing comorbidity. Poor adult health
  - Difficult temperament
  - Pre-natal toxin exposure—nicotine and FAS

Etiology-Risk Factors 3

- Psychosocial factors
  - Poverty (may be related to large family size, overcrowding and poor parental supervision)
  - Abuse, neglect and positive family attitude of acceptance toward violence and egocentricity
  - Persecutory cognitive bias
  - Impaired executive function—may be more closely related to co-morbid AD/HD
  - Learning disability/low IQ, performance IQ> verbal IQ
  - Delinquent peers

Etiology-Risk Factors 4

- Psychosocial variables continued
  - Unsupportive family interactions
  - Families with impaired management of transitions and change
  - Divorce has been associated with development of CD but may be related through intermediate variables of parental ASPD and high levels of parental conflict

Resilience Factors

- High IQ (generally)
- Positive temperament
- Good social skills
- “Islands of competence” outside school
- Positive relationship with at least one supportive adult
- Relationships with pro-social peers

Co-morbidity

- AD/HD: May be important sub-type with combination yielding worse prognosis. These patients tend to be more aggressive and to be more anti-social generally than those with conduct disorder alone. Rates of co-morbidity at about 50%
- Substance abuse: Extremely common affecting 60-80 % of CD youth. Childhood aggression is risk factor for adolescent SA. May reflect temperament as well as direct effects

Co-morbidity 2

- Mood Disorders
  - Depressive co-morbidity shows variable course. May be relatively independent from CD symptoms. Related to maternal depression, paternal anti-social behavior, and high parent-child conflict.
  - Bipolar Disorder: high rate of CD in juvenile bipolar patients. Manic symptoms can directly contribute to anti-social behavior.

Co-morbidity 3

- Psychosis
  - Some patients who subsequently develop schizophrenia have demonstrated years of anti-social and aggressive behaviors prior to developing psychosis. Some evidence of familial link between anti-social behavior and schizophrenia—basis unknown.
- Trauma spectrum disorder
  - Patients often have extensive exposure histories as victims, witnesses, and perpetrators of violence. Elevated risk of PTSD and likely more so among females.
- Anxiety disorders—mixed evidence

Conduct Disorder: A Transactional Model

- Underlying biological/temperamental features dispose to behavioral characteristics that then give rise to a range of environmental responses that then provoke further behavioral responses.
- Later in development, the individual may then more actively seek particular environments with which to interact.

Assessment

- Utilize information from multiple sources
- Structured interviews and rating scales
  - DISC
  - CBCL
  - Iowa Conners Aggression Factor
  - Children's Aggression Rating Scale
- Monitor one's own attitude and be aware of counter-transference feelings as these can become intense. Try to avoid therapeutic nihilism.
- Be ready to seek consultation particular if issues of dangerousness become prominent

Treatment

- Psychopharmacology--may be effective for symptoms of aggression and exacerbating co-morbidities (AD/HD, bipolar mood disorder, schizophrenia, etc.)
- Ecologically based multi-modal interventions--Multi-systemic therapy, Functional Family Therapy. Some of these have good empirical support for their effectiveness

Treatment 2

- Inpatient and residential treatment--Acute care may be helpful as crisis response to co-morbid conditions but residential care has little overall empirical support.
- Bottom line is that intervention must work to increase the relative value of pro-social behavior and will likely have to focus on multiple contributing factors.

Conclusion

- Conduct disorders represent a complex and heterogeneous family of conditions that share a broad range of contributing factors. May represent a "final common pathway" characterized by a deterioration in the re-enforcing quality of pro-social relative to anti-social behavior.
- Effective treatment planning requires a careful assessment of this range of contributing variables and co-morbidities as well such that the patient experiences more net reward for pro-social relative to anti-social behaviors.