

HOSPITAL PHYSICIAN®

PSYCHIATRY BOARD REVIEW MANUAL

STATEMENT OF EDITORIAL PURPOSE

The *Hospital Physician Psychiatry Board Review Manual* is a study guide for residents and practicing physicians preparing for board examinations in psychiatry. Each quarterly manual reviews a topic essential to the current practice of psychiatry.

PUBLISHING STAFF

PRESIDENT, GROUP PUBLISHER
Bruce M. White

EDITORIAL DIRECTOR
Debra Dreger

SENIOR EDITOR
Bobbie Lewis

ASSISTANT EDITOR
Tricia Faggioli

EXECUTIVE VICE PRESIDENT
Barbara T. White

EXECUTIVE DIRECTOR OF OPERATIONS
Jean M. Gaul

PRODUCTION DIRECTOR
Suzanne S. Banish

PRODUCTION ASSISTANT
Kathryn K. Johnson

ADVERTISING/PROJECT MANAGER
Patricia Payne Castle

SALES & MARKETING MANAGER
Deborah D. Chavis

NOTE FROM THE PUBLISHER:

This publication has been developed without involvement of or review by the American Board of Psychiatry and Neurology.



Endorsed by the
Association for Hospital
Medical Education

Conduct Disorder

Series Editor:

Jerald Kay, MD

Professor and Chair, Department of Psychiatry, Wright State University School of Medicine, Dayton, OH

Contributors:

Christina G. Weston, MD

Assistant Professor of Psychiatry, Associate Director, Division of Child and Adolescent Psychiatry, Wright State University, Dayton, OH

Jacqueline Countryman, MD

Assistant Professor of Psychiatry, Wright State University, Child and Adolescent Psychiatry Training Director, Wright Patterson Medical Center, Dayton, OH

Table of Contents

Introduction	2
Diagnosis	2
Screening Tools	2
Comorbid Conditions	3
Risk Factors	4
Management	6
Conclusion	10
References	10

Cover Illustration by mb cunney

Copyright 2004, Turner White Communications, Inc., 125 Stafford Avenue, Suite 220, Wayne, PA 19087-3391, www.turner-white.com. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, mechanical, electronic, photocopying, recording, or otherwise, without the prior written permission of Turner White Communications, Inc. The editors are solely responsible for selecting content. Although the editors take great care to ensure accuracy, Turner White Communications, Inc., will not be liable for any errors of omission or inaccuracies in this publication. Opinions expressed are those of the authors and do not necessarily reflect those of Turner White Communications, Inc.

Conduct Disorder

Christina G. Weston, MD, and Jacqueline Countryman, MD

INTRODUCTION

Conduct disorder (CD) in children and adolescents is commonly seen in mental health and community clinics. The disorder frequently results in significant costs to patients, their families, and society through the personal loss of life and property when crimes are committed.¹ Prevalence estimates vary based on criteria and measurement instrument used.² Studies have shown an increase in nonaggressive CD behaviors from childhood through adolescence.³ Studies have also shown that CD is 3 to 4 times more likely to occur in boys than in girls across different ages.⁴ However, CD is relatively common among girls in clinical settings, with prevalence ranging from 2% to 9%.⁵ Approximately 6% to 16% of boys meet diagnostic criteria for CD. There is some evidence that the gender differences have narrowed in recent years.

DIAGNOSIS

A diagnosis of CD is a clinical decision. The diagnostic criteria are listed in **Table 1**. The essential feature of CD is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated.⁶ A person must meet 3 or more of the criteria listed in Table 1 in the past 12 months with at least 1 criterion present in the past 6 months. The diagnostic criteria for CD have been shown to be accurate for both males and females.⁷

Information from parents, teachers, and the child should be obtained. Children are essential informants because their covert acts may not be noticed by adults. The correlation between different informants' recall of the relative ordering of symptoms has been high.⁸ Evidence for subtyping of CD between overt and covert behaviors also exists in the literature. Of the symptoms of CD, physical fighting together with a diagnosis of oppositional defiant disorder (ODD) is the best predictor of the onset of CD.⁹

Another distinction made in the literature is that of youths exhibiting callous-unemotional (CU) traits. These are defined as absence of guilt, constricted display of emotion, failure to display empathy, and use of others for

one's own gain. It has been shown that the presence of CU traits in children with CD may designate an important subtype of conduct problems in children. Children with both CD and CU traits show a greater number and variety of conduct problems. They also are more likely to show high levels of proactive aggression (ie, aggression that is used for instrumental gain and dominance).¹⁰ They also have shown a lack of behavioral inhibition.¹¹ In contrast, youths with CD but without CU traits tend to be highly reactive to emotional and threatening stimuli.¹¹ They also tend to respond more strongly to provocations in social situations, and their aggressive and antisocial behavior is more strongly associated with dysfunctional parenting practices¹² and with deficits in intelligence.¹³ Making this distinction may be helpful in identifying those youths at greatest risk of future CD problems.

A detailed history is necessary to distinguish between childhood-onset type CD (onset of symptoms before age 10) and adolescent-onset type CD (after age 10). Also, a severity specifier is given based on the number of conduct problems and the effect these behaviors have on others. It has been shown that the age of onset is related to the number of aggressive behaviors.¹⁴ Earlier onset has significant implications for later outcomes and is related to poor future functioning in social relationships, education, and work.¹⁵ Children with early-onset conduct problems are characterized by more aggression, greater impulsivity, and more dysfunctional family backgrounds.¹⁶ The second, larger, subgroup of delinquent youths demonstrates later onset of antisocial behavior in adolescence and is thought to represent an exaggerated pattern of the rebellious behavior commonly observed during this phase of development. Higher rates of psychopathology have also been noted in early-onset CD youths.¹⁷ Factors associated with early-onset conduct problems in youths include social and familial disadvantages, poor parenting, and impulsivity and attention problems.¹⁸

SCREENING TOOLS

The assessment of CD typically has been accomplished by means of questionnaires or interviews conducted with parents, teachers, or other adult observers,