PERSPECTIVES IN TREATMENT OF CONDUCT DISORDER IN CHILDREN AND ADOLESCENTS

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ABSTRACT

Conduct disorder is by many centuries the oldest of the diagnostic categories used in contemporary child and adolescent psychiatry; long before psychiatry and psychology were born people agonized about what to do about out-of-control children. Childhood conduct disorder casts a long shadow over adulthood, often leading to antisocial personality, drug misuse, increased rates of psychosis and earlier death. This article reviews a short history of this disorder and its impact on society, range of effective treatments, and shows what is ineffective. The common theme underlying interventions that work is that they change the environment around the young person, with parent training emerging as the most effective. The task now is to enable more of these interventions to be available at a reasonably early age.

Keywords: conduct disorder, treatment, family, child and adolescent.

HISTORY

Conduct disorders became established as a medical diagnosis in 1968. There were three distinct periods in the history of conduct disorders:
- The first period begins in 1880 where the origins of conduct disorder lie within the social and legal problem of delinquency. This period is characterized by the initial recognition of delinquency and antisocial behavior as a medical and educational problem.
- In the second period from 1910 until 1968 there was increased research interest in conduct problems of children as researchers attempted to identify the causes of inappropriate behaviors. This culminated with the first categorization of Conduct Disorder as an official category in 1968;
- Thus the final period begins in 1968 and is marked by a rapid accumulation in the knowledge around conduct disorders and an increasingly holistic perception of the causes and treatment of conduct disorder, taking into account the individuals’ interaction with the environment.

WHAT IS CONDUCT DISORDER?

Conduct disorder (CD) is one of the most difficult and intractable mental health problems in children and adolescents.

Conduct disorder is a severe condition characterized by hostile and sometimes physically violent behavior and a disregard for others. Children with CD exhibit cruelty, from early pushing, hitting and biting to, later, more than normal teasing and bullying, hurting animals, picking fights, theft, vandalism, and arson. Since childhood and adolescent conduct disorder often develops into the adult antisocial personality disorder, it should be addressed with treatment as early as possible; the earlier treatment starts, the better the outlook [2].

Conduct disorder is a major health and social problem [3]. There are two subtypes of CD, according to DSM IV, including childhood and adolescent-onset forms of CD [4]. ICD-10 describes three subtypes of CD: confined to the family context, unsocialized, and socialized.
Some researchers have emphasized the importance of overt (characterized by confrontation and fighting) and covert (typified by deception, such as stealing and lying) symptoms which overlaps with the aggressive - nonaggressive distinction. There are data showing that two different types of covert antisocial behavior may exist: property violations (e.g., stealing) and status offenses (truancy, running away) [5]. Although the greatest damage to society is done by delinquent adolescents, the disorder usually starts below the age of 7 years with the oppositional defiant subtype [3]. Childhood behavior problems are linked to later delinquency and criminality and lead to adulthood antisocial personality disorder in about 50% of cases [6]. A prognosis of childhood-onset CD may be related to the impairment of academic and social performance during a period of mental and behavioral maturation [7].

CD is a stable diagnosis over time and is associated with unfavorable outcomes. A 7-year longitudinal study of children with conduct disorder showed that less than 15% of the sample recovered by mid-to-late adolescence. Other longitudinal studies have reported that 45% to 90% still met diagnosis criteria 3 to 4 years later. According to other research reports, 40% of patients with CD are diagnosed with antisocial personality disorder as adults and may have a criminal record. Of those who do not, most manifest significant functional impairments in their relationships and at work. These patients are also at great risk for developing substance use and mood, anxiety or somatoform disorder [7]. CD confers increase risk for substance initiation across all substance classes at age 15 with greater relative risk for illicit substances compared to licit substances [8]. Comorbid disorders should be identified in making the diagnosis because their existence can influence presentation and treatment options [9]. The management of this disorder requires input from the education sector, social services, the police and health service [3].

PREVALENCE

In the United States, prevalence rates for conduct disorder (CD) are estimated at 2-9%, 5 out of every 100 teenagers and are complicated by relatively high rates of co-occurrence or comorbidity with other disorders [10].

ETIOLOGY

The etiology of conduct disorder involves an interaction of genetic/constitutional, familial and social factors. Children who have conduct disorder may inherit decreased baseline autonomic nervous system activity, requiring greater stimulation to achieve optimal arousal. This hereditary factor may account for the high level of sensation-seeking activity associated with conduct disorder. Current research focuses on defining neurotransmitters that play a role in aggression, with serotonin most strongly implicated.

Parental substance abuse, psychiatric illness, marital conflict, and child abuse and neglect all increase the risk of conduct disorder. Exposure to the antisocial behavior of a caregiver is a particularly important risk factor. Children with conduct disorder, while present in all economic levels, appear to be overrepresented in lower socioeconomic groups. Another common feature appears to be inconsistent parental availability and discipline. As a result, children with conduct disorder do not experience a consistent relationship between their behavior and its consequences [1, 9].

TREATMENT

Treatment includes a variety of psychological, behavioral, or pharmacological approaches, alone or in combination, targeting the child and/or the family. Professionals largely believe that therapy is of limited effectiveness, particularly in the patients with CD typically seen in mental health settings (more chronic, more disturbed, and usually with comorbid conditions) [5].

General principles to keep in mind when treating CD are:

CDs tend to be a chronic condition and treatment should be tailored accordingly.

Most guidelines concur that structured psychosocial interventions should be the first line of treatment and should be continued even if medications are subsequently initiated.

Treatment is more likely to be effective when administered early in the course of the
disorder. Typically, maladaptive behaviors are continually reinforced; over time, negative perceptions, emotions, and patterns of relating become deeper and more entrenched. Once CD is established, it becomes more resistant to intervention.

Treatment should involve the parents. In almost all instances, improving parenting skills and parent-child interactions are core goals.

Comorbid conditions (ADHD, depression) ought to be identified and, if appropriate, treated.

Parental depression, psychosis, or substance abuse should also be noted and treated.

It is very useful to ascertain children's and families' strengths and build on them in addition to focusing on their problems.

Dealing with the stress, anger, and hopelessness that many of these families experience and achieving some calm and control is often a necessary initial step.

The goals of treatment need to be realistic and modified as progress occurs. For example, preventing or minimizing drug use or involvement in delinquent activities in adolescents with CD may be a more appropriate initial step than seeking symptom resolution.

Because these young people usually show disturbance in a variety of settings (e.g., school, home) and impairment in several aspects of functioning, addressing their multiple needs in the various domains is likely to increase effectiveness (multimodal treatment).

Association with deviant peers is a well-established factor that increases the likelihood of conduct problems, delinquency, and drug use, particularly in adolescence. A goal should be to enhance participation in activities with well-functioning peers [5].

**PARENT MANAGEMENT TRAINING**

CD is often associated with a range of parent and child problems including harsh and controlling parenting, lack of child compliance, increased aggression toward parents, and coercive parent-child interaction patterns. Parenting training interventions are the most widely researched and effective intervention strategies available for the treatment and prevention of CD in young children [11,12].

Involvement of parents and interventions directed at enhancing their knowledge and use of effective parenting strategies is a critical component in the treatment of CD. Although these programs differ in their focus on teaching behavioral management techniques versus skills such as parental reflective capacity and sensitivity, which foster secure attachment it is possible that enhancement of the quality of parent-child relationships remains a key factor that determines treatment impact. Furthermore, teaching parents behavioral management techniques in the absence of addressing issues in the parent-adolescent relationship may result in parents attempting to enforce greater control over their adolescents, that inadvertently exacerbates rather than solves problems [6,11,13].

Parent management training (PMT) is based on the principles of operant conditioning and social-learning theory. In PMT parents are encouraged to use positive reinforcement, to adopt more effective discipline strategies, and to learn how to negotiate with their children. PMT has been the most extensively researched therapy in this field. It has the potential to produce improvements in child behavior to within the nonclinical range at home and, sometimes, at school. Further, these effects can be maintained, together with indirect improvement in other areas such as sibling behavior, maternal psychopathology, marital satisfaction, and family cohesion. Key limitations of PMT include the substantial number of parents who do not complete the program, their frequent ineffectiveness in the most dysfunctional families, and that it has been targeted to younger children [5].

**FAMILY FUNCTIONING**

Functional family therapy, multisystemic therapy, and treatment foster care aim to change a range of difficulties which impede effective functioning of teenagers with conduct disorder [14, 15].
Functional family therapy addresses family processes that need to be improved, such as better communication between parent and young person, reducing interparental inconsistency, tightening up on supervision and monitoring, and negotiating rules and the sanctions to be applied for breaking them. Functional family therapy has been shown to reduce reoffending rates by around 50 per cent [8,15].

MST focuses on youth with serious clinical problems (e.g., violent juvenile offenders, juvenile sexual offenders, substance abusing juvenile offenders, youth with serious emotional disturbance and so forth) and their families [16]. In multisystemic therapy, the young person’s and family’s needs are assessed in their own context at home and in their relations with other systems such as school and peers. Following the assessment, proven methods of intervention are used to address difficulties and promote strengths. Several randomized controlled trials attest to the effectiveness, with reoffending rates typically cut by half and time spent in psychiatric hospitalization reduced further [15].

Treatment foster care is another way to improve the quality of encouragement and supervision that teenagers with conduct disorder receive. The young person lives with a foster family specially trained in effective techniques; sometimes it is ordered as an alternative to jail. While the young person is living with the specially trained foster careers, the families of origin are trained in effective methods. Outcome studies following return to the birth family show useful reductions in rates of reoffending [8,15].

**INDIVIDUAL INTERVENTIONS**

Problem solving skills training is the best studied and it results in a clinically significant improvement. Children are taught to understand interpersonal problems and find adaptive solutions using various techniques including games, structured activities, stories, modeling, role play, and reinforcement. Studies have also demonstrated at least modest benefits for other individual interventions. Individual assertiveness training, anger control/stress inoculation, and rational emotive therapy are probably efficacious. Child CBT-based interventions showed a small to moderate effect in decreasing antisocial behavior [5].

**PHARMACOTHERAPY**

Pharmacotherapy is not the mainstay of treatment of CD. Psychotropic drugs may be used for the treatment of CD symptoms only when psychosocial and educational interventions have failed and as a part of a comprehensive management plan, although medication is often used for those individuals who have coexisting conditions, such as ADHD, and in emergency situations.

Some principles should be followed when prescribing medication for CD:

- The dosing strategy of “start low, go slow, taper slowly” should be followed, particularly when using antipsychotic drugs.
- Caution and careful monitoring should be exercised when prescribing stimulants to adolescents with CD, given the high rate of substance abuse in this population.
- Adherence, side effects, and drug interactions should be monitored routinely and systematically. In particular, it is important to ascertain whether patients are concurrently using psychoactive substances or complementary therapies that may interact with prescribed drugs.

Before switching, augmenting, combining, or discontinuing medications because of a lack of response, it should be ensured that patients have received adequate trials (dose and duration) as well as psychosocial interventions. Polypharmacy should be avoided whenever possible.

Antipsychotic drugs (atypical antipsychotics are to be preferred initially) are often prescribed to reduce aggressive symptoms. Antipsychotic drugs have often been prescribed to manage disruptive behavior in individuals with mental retardation. Recent controlled trials suggest these medications, particularly risperidone, are beneficial in this population, at least in the short term. Careful consideration of benefits and risks is required before deciding long-term (longer than 6 months) use of antipsychotics CD because of the side effects. Mood stabilizing and antiepileptic drugs (lithium, valproate, carbamazepine) have been used to treat Romanian Journal of Child and Adolescent Psychiatry
aggression. There are controlled studies suggesting that stimulants, clonidine, and atomoxetine are of assistance, particularly in children with comorbid ADHD or hyperkinetic conduct disorder [4,5,7].

REFERENCES
