Conduct Disorder: Causes and Prevention

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ABSTRACT

Conduct disorder (CD) is characterized by a pattern of behaviour that violates the basic rights of others or age-appropriate norms and rules of society. CD is extremely challenging for parents, teachers, and mental health professionals. The common symptoms of CD are aggression, theft, lying, destruction, vandalism and violation of societal norms and basic rights of others. The cause of CD is believed to be a combination of genetic vulnerability, environmental and family factors. Certain children have a genetic vulnerability to this disorder. When that vulnerability is combined with certain high-risk environmental factors, such as poverty, violence exposure, media, peer effects and some family factors such as parental neglect, marital discord, parental illness, parental alcoholism, and having a parent with antisocial personality disorder, chances of CD increase. The selection of treatment depends on severity of problems. If situation demands and for better effective treatment a combination of treatment can be used. Among all the available therapies psychological therapy is considered the most effective therapy.

Conduct Disorder: Causes and Prevention

In the modern era traditional patterns of guiding the relationships and transitions between family, school and work are being challenged. Social relations that ensure a smooth process of socialization are collapsing; lifestyle trajectories are becoming more varied and less predictable. The restructuring of the labour market, the extension of the maturity gap (the period of dependence of young adults on the family) and, arguably, the more limited opportunities to become an independent adult are all challenges influencing relationships with family and friends, educational opportunities and choices, leisure activities and lifestyles. Developed countries as well as developing countries both are facing this situation. The pressure is more on developing countries because there are new pressures on young people undergoing the transition from childhood to adolescents. Rapid population growth, the unavailability of housing and support services, poverty, unemployment and underemployment among

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youth, the decline in the authority of local communities, overcrowding in poor urban areas, the disintegration of the family, and ineffective educational systems are some of the pressures young people must deal with.

It is not uncommon for children and teens to have behavior-related problems at some time during their development. However, the behavior is considered to be a CD when it is long-lasting and when it violates the rights of others, goes against accepted norms of behavior and disrupts the child’s or family’s everyday life. CD is a group of behavioral and emotional problems in children and adolescents. The term ‘conduct disorder’ is generally used to describe a pattern of repeated and persistent misbehavior. This misbehavior is much worse than would normally be expected in a child of that age. CD is one of a group of behavioural disorders known collectively as disruptive behaviour disorders, which include oppositional defiant disorder (ODD) and attention deficit hyperactivity disorder (ADHD).

**DSM-IV Diagnostic Criteria**

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

**Destruction of Property**
- Has deliberately engaged in fire setting with the intention of causing serious damage.
- Has deliberately destroyed others’ property (other than by fire setting).

**Deceitfulness or theft**
- Has broken into someone else’s house, building or car.
- Often lies to obtain goods or favors or to avoid obligations (i.e., “cons” others).
- Has stolen items of nontrivial value without confronting the victim (e.g., shoplifting, but without breaking and entering; forgery).

**Serious violations of rules**
- Often stays out at night despite parental prohibitions, beginning before age 13 years.
- 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).
- Is often truant from school, beginning before age 13 years.
Factors Affecting Conduct Disorder

Child Factors

Genetic/Heredity- Genetic or hereditary factors also play an important role in the occurrence of CD. Limited baseline autonomic nervous system activity, resulting in a need for greater stimulation to attain optimal arousal may be inherited by a child. In a research by Kraft and Rice (1994) it was found that high level of sensation-seeking activity is associated with the CD. Crowell et al. (2006) revealed the role of autonomic under arousal of CD in adolescents. Beauchaine et al. (2001) and Beauchaine (2003) revealed that both elementary children and adolescents who were diagnosed with CD were having reduced sympathetic and parasympathetic linked cardiac activity.

Temperament- Temperament is the combination of mental, physical and emotional traits of a person. These characteristics are consistent for a time. Some characteristics are shown at the time of birth while some occurred later during development. Guerin, Gottfried and Thomas (1997) concluded in a longitudinal research that temperamental difficulty correlated significantly, pervasively, and to moderate magnitudes with parent reports of behaviour problems from 3-12 years. Those children who do not have empathy, guilt feeling and emotional attachment may have CD. The key to diagnosing these children is to identify the origin of CD which is found in (1) difficult temperament and (2) ineffective socialization (Van Goozen et al., 2007).

Environmental Factors

Cultural Factors- CD often occurs in social settings in which the norms for acceptable behaviour have broken down. Under such circumstances many of the common rules that prevent people from committing socially unacceptable acts may lose their relevance for some members of society. They respond to the traumatizing and destructive changes in the social reality by engaging in rebellious, deviant or even criminal activities. The social, economic and cultural conditions prevailing in a country play an important role in determining the intensity and severity of juvenile offences. In many cases street children later become young offenders, having already encountered violence in their immediate social environment as either witnesses or victims of violent acts. The causes of and conditions for juvenile crime are usually found at each level of the social structure, including society as a whole, social institutions, social groups and organizations, and interpersonal relations.

Violence Exposure- The link between exposure to violence in the home and community is a crucial risk factor for CD (Fergusson & Horwood, 1998; Kaplan et al., 1998). Violence exposure can take place in many places within the child’s environment including: (1) victimization and witnessing child abuse; (2) community violence; (3) parental abuse (McCabe et al., 2005). The child who faces the violence at society or in family or is the witness or victim of child abuse, have greater risk for CD.

Urbanization- Countries with more urbanized populations have higher registered crime rates than do those with strong rural lifestyles and communities. This may be attributable to the differences in social control and social cohesion. The basic features of the urban environment foster the development of new forms of social behaviour deriving mainly from the weakening of primary social relations and control, increasing reliance on the media at the expense of informal communication,
and the tendency towards anonymity. These patterns are generated by the higher population density, degree of heterogeneity, and numbers of people found in urban contexts.

**Economic and Social Factors** - CD is driven by the negative consequences of social and economic development, in particular economic crises, political instability, and the weakening of major institutions (including the State, systems of public education and public assistance, and the family). Socio-economic instability is often linked to persistent unemployment and low incomes among the young, which can increase the likelihood of their involvement in criminal activity.

**The Media** - Television and movies have popularized the violence for taking revenge and to prove oneself. Many researchers have concluded that young people who watch violence tend to behave more aggressively or violently, particularly when provoked. Mainly 8- to 12-year-old boys are vulnerable to such influences. Media bring an individual to violence in three ways. First, movies that demonstrate violent acts excite spectators, and the aggressive energy can then be transferred to everyday life, pushing an individual to engage in physical activity on the streets. This type of influence is temporary, lasting from several hours to several days. Second, television can portray ordinary daily violence committed by parents or peers (the imposition of penalties for failing to study or for violations of certain rules or norms of conduct). It is impossible to find television shows that do not portray such patterns of violence, because viewer approval of this type of programming has ensured its perpetuation. As a result, children are continually exposed to the use of violence in different situations—and the number of violent acts on television appears to be increasing. Third, violence depicted in the media is unreal and has a surrealistic quality; wounds bleed less, and the real pain and agony resulting from violent actions are very rarely shown, so the consequences of violent behaviour often seem negligible. Over time, television causes a shift in the system of human values and indirectly leads children to view violence as a desirable and even courageous way of re-establishing justice.

**Peer Influences** - Children and adolescents have a deep impact of their friends. They usually spend time with them and adopt their habits. Interaction with a delinquent gang influence the mind set of the children to adopt same pattern. Sometimes adolescents wants to be part of such gang because they feel that these gang will provide them safety and security. By becoming members of such gang they feel, they can dominate the society and can influence people. A number of studies have shown that juvenile gang members consider their group a family. For adolescents constantly facing violence, belonging to a gang can provide protection within the neighbourhood. In some areas those who are not involved in gangs continually face the threat of assault, oppression, harassment or extortion on the street or at school.

**Family**

**Divorce and Marital Discord** - The family as a social institution is currently undergoing substantial changes; its form is diversifying with, for example, the increase in one-parent families and non-marital unions. The absence of fathers in many low-income families can lead boys to seek patterns of masculinity in delinquent groups of peers. These groups in many respects substitute for the family, define male roles, and contribute to the acquisition of such attributes as cruelty, strength, excitability and anxiety.
Substance Abuse and Criminality in Parents- The “criminalization” of the family also has an impact on the choice of delinquent trajectories. The researchers propose maternal smoking is a significant factor in CD because nicotine may interrupt fetal brain development. Nigg and Breslau (2007) examined prenatal smoking exposure and low birth weight as risk factors for attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and CD in a population-based longitudinal design from ages 6 to 17 years. Results showed that prenatal smoking exposure contributed to ODD and via that route to later CD.

Parenting Style- Parenting style is associated also associated with CD. Family dysfunction is repetitively identified as one of the crucial factor for CD in adolescence. Poor parental supervision is the predominant predictor of violence and vandalism committed by boys. A longitudinal survey of children suggests ineffective parenting style is the strongest predictor of delinquent behavior in children between the ages of 8 and 11 years. In addition, aversion tactics, low socioeconomic status and the number of siblings in the home are associated with higher probability of children exhibiting CD (Stevenson, 1999). The parents’ adoption of authoritarian parenting style (extremely restrictive and demanding rules) lead children to believe that they are not responsible for their actions and they believe that there is no need to answer for their faults and mistakes. Somerstein (2007) reveals the common family dynamic in many individuals’ histories of male terrorist is authoritarian parents. Hoeve et al., (2008) concluded that there is a strong link between parenting styles and delinquency trajectories.

Intervention for Conduct Disorder

Treatment of children with CD is difficult because the causes of the illness are complex and each youngster is unique. Apart from the difficulties, there are uncooperative attitudes of children, fear and disrupts of adults are also major challenges in preventing CD. Early treatment of conduct is important and it is helpful in developing a healthy adult. The selection of treatment depends on severity of problems. If situation demands and for better effective treatment a combination of treatment can be used. Sometimes a team based approach can be used in many cases. The team can include family, school professionals and other professionals who hold the children responsible for his/her behavior and help the child in avoiding many problems related to his/her conduct.

Pharmacotherapy

Pharmacotherapy is an adjunct treatment for CD. Though there is no formally approved medication for CD but few medications can be used to remove some specific features of CD. Methylphenidate, Dextroamphetamine etc. are some medication which can be given to children with CD but all of these have some side effects like anorexia, nervousness, sleep delay, restlessness, dysrhythmias, palpitations, tachycardia, anemia leucopenia etc. It is found that alone pharmacotherapy is not enough to treat CD. The presence of aggression is associated with one or more psychiatric conditions such as CD, oppositional defiant disorder, disruptive behaviour disorder and ADHD. In a research inpatients aged 10-17 years with aggressive CD received lithium or placebo over 4 weeks. Final mean dosage of lithium was 1425 mg/day. When its effectiveness was studied it was found that lithium significantly reduced the subjects’ aggression according to specific and global measures, and hospital staff also agreed that in subjects clinical improvement has occurred (Malone et al., 2000). A Study by Robin (2003) revealed the efficacy of the stimulant methylphenidate, the mood
stabilizer lithium, typical anti-psychotic, and the atypical antipsychotic risperidone in treating aggressive behavior in children and adolescents. Pappadopulos et al. (2006) studied and largest effects were noted with methylphenidate for co-morbid aggression in ADHD (mean ES = 0.9, combined n = 844) and risperidone for persistent behavioral disturbances in youth with CD and sub-average IQ (mean ES = 0.9, combined n = 875). Study supported the use of certain medications for managing pediatric aggression.

**Psychotherapy**

The main evidence-based individual therapy for the youth with CD is cognitive behavioural therapy, problem-solving skills training. More successful treatment methods require the active participation of the young person, are oriented toward solving social problems and are relatively intense and long-term. Cognitive behaviour therapy helps in suppressing undesirable behaviour and promoting desirable behaviours and helps in developing positive relationships. Problem solving skills training helps the child in managing cognitive deficiencies which contribute in antisocial behaviour. Problem-solving skills training helps in improving communication skills, problem skills, impulse control and anger management (Kazdin, 1995).

**Family Intervention**

In the family therapy entire family is treated. Family intervention is an essential component for treating CD. There are two primary strategies for family intervention: 1. Focus on the parents’ education about the cycle of events that leads to problems related to conduct. 2. Focus on the parents’ management training for the improvement of parenting skills. It has been proved by many studies that parenting skills training and training for the improvement of child’ behaviour, peer relationships, academic achievement reduces the aversive interactions (McCord et al., 1994). Family members are encouraged to make explicit contracts or agreements to build reciprocity among family members. There is an emphasis on clear communication, both in the expression of personal needs and in the constructive process of finding solutions to interpersonal problems. Family members identify desirable behaviors in each other and these are put into a system of rewards that promote adaptive behaviors throughout the family. A study was done to determine whether family and parenting interventions benefit children and adolescents with CD and delinquency. Meta-analysis of eight randomized controlled trials involving 749 children and adolescents (aged 10–17 years) with CD and/or delinquency was done. Family and parenting interventions significantly reduced the time spent by juvenile delinquents in institutions (weighted mean difference 51.34 days). There was also a significant reduction in the risk of a juvenile delinquent being rearrested (relative risk 0.66) and in their rate of subsequent arrests at 1–3 years (standardized mean difference “0.56). The family and parenting interventions for juvenile delinquents and their families have beneficial effects on reducing time spent in institutions and their criminal activity (Woolfenden, Williams & Peat, 2002).

**School Intervention**

For children and adolescents with CD, school is a place where they face only failure which results in frustration. They show poor academic performance and teachers dislike such students and they also dislike their teachers. Sometimes to prove their presence and to gain the attention such students involve in such acts which ethically and morally are not permissible in the society. Children
with CD may be treated effectively in day treatment programs, but good follow-up and transition planning is necessary if treatment gains are to be maintained in regular classrooms. A research by Ialongo et al., (2001) evaluated the long-term impact of two first-grade preventive interventions on the occurrence of conduct problems and disorder and mental health service needs. The two interventions were: The classroom-centered (CC) intervention, designed to enhance teachers’ management of the classroom and children’s social skills in first grade; and the Family-School Partnership (FSP) intervention, designed to promote communication between the parent and teacher, and improve parent’s management of the child’s behavior. CC and FSP children were rated by teachers as exhibiting lower levels of conduct problems in sixth grade than control children. FSP intervention girls were significantly less likely to have been suspended in sixth grade than control girls. Overall, the CC intervention appeared to be the more effective of the two in reducing the prevalence of conduct problems and disorder at age 12 and in reducing mental service need and utilization.

**Peer Intervention**

Since adolescents have deep impact of their friends on their personality. They trust their friends more than they do their parents and teachers. For the effective treatment it is necessary that focus should be given on peers. If child becomes the part of antisocial group then he/she involve in antisocial activities. To avoid CD it is necessary to remove the child from such groups and should help him/her to form a new peer group. The child must be taught the social interaction skills and should encourage joining positive activities and organizations in the community. Vitaro et al. (1999) studied the three competing models regarding the role of deviant friends in the trajectory linking early disruptiveness with later conduct problems through the use of a preventive intervention program. The program was implemented during the second and third grade. The results showed that the program’s effects on later conduct problems were mediated by the reduction in disruptiveness and by the association with less deviant friends.

CD is far more serious problem than it seems. Parents should be aware about the behaviour that is showing by child. If its symptoms are found in any child then proper care and prevention programs should be used to prevent it at its mild stage because once it is developed it would be turn into anti-social behaviour. For the betterment of individual as well as society it is necessary that children should be healthy not only physically as well as mentally also.

**REFERENCES**


