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3. The Diversity and Challenge of Conduct Disorder

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Introduction

The diversity and challenge of conduct disorder arises in different ways not least the way in which it is understood and perceived by parents and carers. While parents in the US and UK may accept a referral to child mental health services for this problem, parents in the Indian subcontinent for example do not access services as they view such behaviours very much as a problem of discipline. Both views have credence when we consider risk factors as well as interventions. Diversity also arises in views about what conduct disorder represents in terms of psychopathology. Is it the sum of different risk factors i.e.cumulative risk with some risk factors carrying more weight than others? Or is it a disorder where there are different patterns of risks contributing to disorder. A further idea is that there are different causal processes liked to different patterns of behaviour, which nevertheless fall within the diagnostic framework of conduct disorder. On the other hand perhaps conduct disorder should be part of a broader conceptual framework resembling more the concepts used for adult personality disorder. The empirical evidence contributing to these various views have been comprehensively reviewed by Jonathan Hill earlier this year (Hill 2002).

How conduct disorder may be conceptualised in terms of research reflects how clinicians may view the disorder. It is a categorical diagnosis in both major classification systems—the ICD 10 and DSM IV. Such categorical specificity may be necessary in terms of distinguishing levels of clinical need. Earls and Mezzacappa (2002) in a recent review point out that in terms of psychopathology conduct disorder has close links with oppositional disorder and appears to share the same genetic risk factors. Hence it could be viewed in a dimensional manner. In terms of understanding the genesis of the disorder and also what may be pathways to intervention a dimensional approach may in fact be more useful. For the clinician this approach is of value as it highlights the importance of planning interventions for a child with oppositional disorder as preventive measures for conduct disorder.

Diagnostic issues

There are diagnostic challenges in the ways in which conduct disorder may be identified across

cultures. There will be common aspects about what constitutes acceptable behaviour and also socially disapproved behaviour among children and this was highlighted in a cross cultural study done by me and colleagues in South London. However there is also considerable evidence that the extent to which some behaviours such as defiance towards parents, aggression in the playground are accepted or disapproved may vary according to sociocultural norms. Hence where sociocultural norms favour compliance and controlled behaviour frustration may be expressed in ways described as 'internalising' or emotional symptomatology. In these contexts oppositional behaviour, defiance to family elders, may in fact represent a more serious level of disturbance. However in such contexts there may also be a lower tolerance of such behaviour. A trainee working with me who was from a traditional Islamic culture in the Middle East said that on a screening questionnaire boys scored very high in the caseness range for conduct disorder when rated in the school setting. In the country in question fathers favour oppositional behaviour especially to females such as teachers and the screening questionnaire was not weighted to take these sociocultural factors into account. On the other hand different values existed for females within the family system. She and I discussed a weighting which also looked at what would be considered socially disapproved for boys within the family context.

Both ICD 10 and DSM IV advocate the need for considering sociocultural norms when diagnosing a disorder such as conduct where psychosocial factors play an important part but the level of guidance available for clinicians is still insufficient.

It is not my intention in this paper to go into detailed diagnostic issues. However in terms of intervention accurate diagnostic assessment is required not only in terms of diagnosis of disorder but of patterns of behaviour, and of associated risk factors. It is essential to look for comorbid factors the commonest being ADHD. The clinician has to be mindful of the need to obtain details of academic competence, language ability and IQ (at least approximate through academic attainment) and to obtain information on behaviour from at the very least home and school i.e. multiple informants (Earls and Mezzacappa 2002). An appreciation of associated risk and psychosocial context is essential for there to be meaningful intervention.

Assessment of children needs also to consider their emotional state. Children with oppositional or conduct problems often have a low self esteem and little belief that they can have a more positive outcome. Consideration of a child's emotional state is another important assessment component. A 7 year old came to see me with a history of very aggressive behaviour in school although far more compliant at home. He lives with a great aunt and her teenage children having been moved between mother (who lives abroad) and this great aunt since he was 11 months old. He was very clear he was bad, did'nt think he could be better but was also clear that coming to see me increased his badness because he felt labelled.

Prevalence

Estimates from several large scale community studies done in the US (Costello et al 1996), UK (Meltzer et al 2000) and Canada (Offord et al 1987, 1991,) give a prevalence rate of 3-6% in children between the ages of 9-13 years. All the studies reported a marked geneder discrepancy with upto fourfold increases in boys. While community based studies from developing countries are few it is clear that conduct disorder is relatively common as demonstrated in Kerala India (Hackett et al 1998). But the overall rate of disorder was far less than that reported in developed country settings. Cross national studies of child behaviour symptoms indicate a marked gender difference for externalising behaviour although the prevalence of conduct disorder may vary depending on the ways in which socio cultural norms encourage/discourage expressions of frustration/disobedience. In the clinic where I work in a socioeconomically deprived and culturally diverse area of South London, oppositional and conduct disorder are the commonest diagnostic groups between 6-14 years. The male female ratio is 3 : 1 but as we found in a cross cultural study in the area, far commoner among White and African Caribbean groups than among Asian children.

Risk factors

I propose to discuss these in terms of clinical relevance. There are multiple risk factors and correlates. Understanding these are important in terms of early recognition and also identifying appropriate intervention.

There are some risk factors that have been identified as causal. It is useful to look at these in terms of risk factors relevant through the developmental trajectory and others which are more specific at certain stages. The most important causal risk factors relevant throughout the developmental trajectory are quality of caregiver involvement, disciplinary practices, experience of abuse.

Maternal smoking for example is a prenatal risk factor. Perinatal complications associated with maternal rejection have also been implicated in some studies (Hill 2002). Deficits in language based verbal skills independent of IQ have been implicated in a number of studies. Impairment of executive function has also been identified as linking to increase in aggression (Lynam and Henry 2001). Both these problems will have relevance once a child starts school. Social group acceptance, peer relationships are more important in preadolescence. There is evidence that peer relationships operate in different ways—association with more deviant peers could be the result of rejection by non aggressive children and this may occur in primary school age. On the other hand deviant children may get more positive acceptance from other deviant peers and are hence drawn into relationships which reinforce the conduct disordered behaviour. In older children association with deviant peers may lead to conduct problems. None of these risk factors however operate individually but are mediated by other environmental influences. For example I saw a girl of 14 years who is currently defiant, staying out all night and at risk. She is a girl I have known for years as she has a conduct disordered brother and a schizophrenic mother. She has always been socially appropriate but her current vulnerability has in part due to her resentments at her brothers aggressive behaviour and mothers very rigid and unreasoning stance about her more socially acceptable peer relationships.

There is particularly strong evidence of links between parental psychopathology, parent child rearing practices with early onset aggressive conduct disorder. Low income is another factor identified in several studies but again this is not an absolute criterion but relative to context. In developing countries where a large proportion of the population is poor by absolute standards poverty may have to be defined in terms of level of poverty i.e. abject and whether associated with degrees of family and social dysfunction. The poverty situation may also determine the meaning of the behaviour. In my experience when working in developing countries appreciation of the meaning of delinquent behaviour in children had to be linked to context. Where for example children stole food in situations of abject poverty they were brought into the social care system as 'delinquent' rather than as children in need. This was in my opinion inappropriate. Furthermore these children did not display other conduct disorder symptoms.

Genetic and other factors

There is evidence of hereditability for conduct disorder but the identification of risk families at present are behavioural and hence will be discussed in these terms.

There are risk factors which are physiological but again not at present clinically relevant.

Effective interventions

The greatest challenge in my view arises in what we do for children with conduct disorder. It is the commonest disorder seen in generic child mental health services in the UK certainly and it carries relatively the greatest risk of long term problems. In terms of intervention there remain considerable limitations particularly where the problem is more persistent and severe. Prevalence of conduct disorder does not necessarily correlate with delinquency rates. However long term risks of conduct disorder are increased antisocial behaviour in adolescence, increased substance misuse rates as well as crime and this is particularly so for boys. There is also evidence that suggests that timing of symptoms play a part with poorest outcome associated with early severe aggressive behaviour (Earls and Mezzacappa 2002).

Effective interventions will include preventive approaches as well as interventions for children with oppositional or conduct disorder.

The clinical relevance of an understanding of risk is linked closely to preventive intervention. When considering risk and prevention there continues to be the debate as to whether measures should be targeted generally or for high risk groups. If we consider maternal smoking there is a need for widely prevalent health education in this regard about a number of risks particularly where there is a high incidence of smoking in the female population. In the UK for example where there is a high prevalence of smoking among school children and of teenage pregnancy in inner city areas there is also an argument for targeting specific interventions for a potentially high risk group.

One of the most important causal risk factors relates to family factors which include exposure of children to conflict, parental psychopathology, child rearing practices. Within the developmental trajectory it is important to look at what may be effective at preschool as well as at school age. Nurse home visitation for high risk mothers has proved to be effective and the impact established

in follow up to adolescence (Olds 1998). Preschool education such as in the Perry preschool project which also worked with families again have proved effective as well as cost effective in the long term (Barnett 1998).

There are a number of initiatives used for school age children with parents alone or where there are multiple inputs in terms of parent management combined with remedial reading help for children and work with teachers. There are also programmes which target children specifically using either a single component approach, multiple components, competency enhancement. Effects vary as do resource intensity required for these programmes (Offord 2002).

In terms of successful interventions there is accumulating evidence of the effectiveness of parent management programmes which mediate parent child relationships and promote more effective parenting including use of appropriate discipline. Issues relate however to the ways in which parents can be encouraged to access such parenting programmes and relate also to issues about the availability of resources. Initiatives such as Sure Start in the UK are a mean of targeting high risk families early but are not available in all areas. Furthermore the more dysfunctional families are less easy to engage. Programmes may be for parent and child or delivered in the form of parent group approaches. There may need to be far greater involvement of services such as health visiting. This is certainly an issue for developing countries to consider as health workers engaged in child health work are the most likely sources of information about high risk families. An important issue is the extent to which known positive aspects of child rearing and parenting can be incorporated into parent education that is generally available and how effective this will be as a preventive measure for poor parenting. Scott highlighted ingredients of successful parent management programmes which include techniques for promoting a child centred approach, teaching ways of increasing acceptable behaviour in the child, setting clear expectations, reducing unacceptable behaviour (Scott 2002). It is reasonable to suppose that this type of approach could be incorporated into general parenting education particularly in situations where this is the only way of changing parent attitudes about what are effective parenting strategies and alternative disciplinary approaches. This is certainly an issue for many sociocultural contexts where coercive disciplinary practice may be favoured. Available evidence suggests that targeting high risk groups remains an effective strategy but it is resource intensive. Working with Health workers in Sri Lanka I had to suggest only that they did allow more time for working with the more dysfunctional families in their area and also try different strategies of engaging them. More intensive work was not possible under the prevailing resource constraints.

Many of the approaches discussed thus far rely on inputs which involve joint work within primary and secondary care agencies. For example in the UK early screening of high risk groups will be done by primary care and child health services and hence there needs to be close working and consultative support between these agencies and child mental health services as well as with schools. There also needs to be liaison with adult mental health since mentally ill parents are a particular high risk group often forgotten.

Parenting issues are not the only risk factors relevant for intervention. Mention has been made of the links between executive function, language skills and later conduct disorder. This requires

attention given to those children who display impulsivity and poor planning skills even although these problems may not on themselves result in a diagnosis. I am aware of the need in our service to provide intervention for these children who may have been referred for diagnosis of ADHD which they do not have. Recognition that this is a group requiring preventive help for later conduct disorder is not universal by any means.

Another high risk group in early school age are those children who present with poor frustration tolerance, tending to respond more aggressively in conflict who are then isolated in terms of positive peer relationships.

Interventions for these groups require co-operation between screening agencies which will be school, school health and child mental health services. Approaches found to be effective to some degree include anger management skills, training on appropriate assertiveness development of problem solving skills to promote adaptive outcomes in conflict rather than confrontation.

While these approaches all focus on the child or adolescents behaviour, there is also an emphasis on considering attachment theory and hence encouraging the child to develop more positive relationships. This is based on the assumption that children with conduct disorder may have become disconnected from significant others possibly as a result of their behaviour but poor attachment may also be an antecedent risk linked to poor parenting. On the other hand the development of positive relationships can occur with other significant adults—a teacher, a mentor, extended family member.

An important ingredient of working with children and young people with conduct disorder is not only motivating them to consider change but to instil the belief that change is possible and that problems can be overcome. This is an aspect of intervention that may be a positive outcome of programmes mentioned above but particularly with older children it is my experience that discussion of these aspects can facilitate engagement of the child or adolescent.

Conclusion

This presentation is not a comprehensive summary of conduct disorder or of interventions that may be used. The presentation has attempted to highlight some of the challenges in considering this very common disorder. Firstly is the issue of diagnostic assessment, which is sensitive to sociocultural norms, and looking at what may be risk and comorbid factors. Secondly the identification early of high risk groups and the use of feasible affordable as well as effective intervention strategies. Thirdly the use of effective interventions for the child with established problems. Finally the need for planned and coordinated approaches which involve multiagency planning and joint work.

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