

Knowledge Notes

What are the current Best Practices for Conduct Disorder within the Adolescent Population? George Harris, RPN

Objectives

This review will inform health care managers and supervisors (in particular, those in the former Palliser Health Region (PHR) in decision-making as they make long range plans to look at potential change in delivery of services for this patient population.

Background

The purpose of this systematic literature review is to determine if the existing literature identifies more appropriate treatment modalities for adolescents who experience Conduct Disorder (CD). CD is a diagnostic category characterized by a pattern of behaviour that violates the basic rights of others or age-appropriate norms and rules of society. CD can be extremely challenging for parents, teachers, and mental health professionals. The clinical experience of children's mental health staff indicates that children with early-onset CD are the most resource-intensive population to serve. Early identification, accurate assessment, and effective treatment are essential to reduce the burden of suffering associated with CD for children, families, and society.

Prevalence

The estimated prevalence of CD is between 1.5% and 3.4% of the general child and adolescent population. Although only 3-5% of all youth with CD experience onset before adolescence, these young people appear to consume the most resources in the mental health system and are responsible for at least half of the illegal offenses committed by juveniles. CD appears from 3 to 5 times more often in boys than girls, but the gap between boys and girls closes at adolescence. By mid-adolescence, girls surpass boys in the onset of CDs. Boys are more likely to exhibit aggressive behaviour and girls more likely to commit covert offenses and prostitution, but gender differences in behaviour types tend to disappear in the most severely disturbed youth.

Clinical Characteristics

CD involves a pattern of disturbed behaviour that causes significant impairment in social, academic, or occupational functioning. CD behaviours include aggression to people and animals, deliberate destruction of property (including fire-setting), stealing, lying, and truancy from school. Research shows that there are different profiles for CD based on age of onset and severity.

Children living with CD are more likely to have attention-deficit disorder/hyperactivity disorder (ADHD), learning disabilities, and poor academic achievement. In terms of developmental progression, ADHD tends to be followed by Oppositional Defiant Disorder (ODD) and then by CD. Children with childhood-onset CD tend to be male and the incidence is not strongly related to socioeconomic class or ethnic group.

In adolescent-onset CD, sociocultural factors, such as the influences of poverty and peer groups, appear to be largely responsible for the resulting behaviours. Youth with adolescent-onset CD usually do not have serious problems before adolescence.

Protective factors include higher levels of intelligence, good social skills, relaxed temperament, positive work habits in school, areas of competence outside school, and a positive relationship with an adult. Given the strong association of environmental and family factors in CD, some children and youth may adopt CD traits as a protective strategy. It is important, therefore, that clinicians consider the client's socioeconomic status when assessing the presence of CD.

Assessment

A diagnosis of CD is made when DSM-IV-TR target symptoms are present or reported in the child's history, and other disorders have been eliminated. Target symptoms include aggressive behaviour, deliberate destruction of property, deceitfulness and theft, and serious violations of society's rules (e.g., truancy). It is important to know that DSM-IV-TR does not consider one specific criterion alone as necessary for diagnosis and that any combination of three or more criteria are sufficient. The number of conduct problems and the harm they cause to others determines the severity of CD.

Since CD is a complex mental health problem affecting multiple domains of functioning and showing a high rate of comorbidity with other disorders, suspicion of CD requires a comprehensive assessment. Assessment information should be obtained from multiple sources, including the child, family, school, peers, and community. Information from these sources will help the clinician determine: whether the child has CD; identify the type of CD (childhood- or adolescent-onset); determine if a psychiatric or medical problem is causing the disorder; and detect if there is an additional comorbid disorder

Comorbid Disorders

Comorbid disorders are often an issue with CD. Between half and three-quarters of children with CD also have ADHD at the same time. About half of the children with CD also have an internalizing disorder such as depression or anxiety disorder. Children with CD and comorbid depression are at higher risk of suicide than children with depression alone. They also are more likely to harm themselves without intending suicide. As many as 90% of drug abusing young offenders have CD.

Results

Current consensus in research and practice indicates that optimum outcomes from treatment must address multiple domains in a coordinated manner over a period of time. Treatment involves an integrated approach with the adolescent, family, school and peer group. Successful interventions are developmentally and gender sensitive. Therapy alliance from adolescents/families appears to promote positive and significant behavior changes regardless of treatment modality. There remains insufficient evidence that pharmacotherapy alone can ameliorate this disorder, although some psychiatric medications are used to treat adolescents with a comorbid disorder. Research identifies and supports the evidence of Cognitive Behavioral Therapy (CBT) for treating CD, especially Problem Solving Skills Training. CBT interventions assist to control antisocial behaviors and strengthen pro-social functioning. Family intervention is an essential conduit in treating CD. Well-coordinated supports services through parent counseling, parent education, family therapy, and parent management programs and collaboration with other systems can ensure optimum, safe, environment.

That continued research for effective treatment programs and interventions for adolescents with CD or behavior related disorders be coordinated through national and provincial partnerships.

Creative partnerships between mental health settings and other resources, wrap-around service delivery models should be strongly encouraged and researched.

Recommendations:

Local recommendations and plans are included in the larger review by George Harris, which is available by clicking [here](#).

