

# Conduct Disorder: An Overview

Tejo Chandra Vanteddu\*

Department of Nano Science, Dublin City University, Dublin, Ireland

**ABSTRACT:** *Conduct disorder (CD) is a psychological problem analysed in childhood or adolescence that introduces itself through a redundant and steady example of conduct in which the essential privileges of others or significant age-appropriate norms are violated. These behaviours are often referred to as "antisocial behaviours."*

**KEYWORDS:** *Conduct Disorder, Delinquency, Risk Factors, Protective Factors, Genetics, Subtype.*

## INTRODUCTION

Conduct disorder (CD) is 1 of 3 disruptive behaviour disorders, the others being oppositional defiant disorder (ODD) and attention-deficit hyperactivity disorder (ADHD). As indicated in the DSM-I V, CD connotes a severe externalizing disorder comprising serious aggressive and anti-social behaviours such as fighting, bullying, cruelty, robbery, forcing sexual activity, fire setting, theft, conning, truancy, and other rule violations. Anti-social behaviour describes actions contrary to the rights of others and rules of society. Adolescent anti-social behaviour that breaks the law (and gets caught) may result in contact with police and the courts; the terms delinquent and young offender would then apply (Yeager & Lewis, 2000). Thus, CD represents a constellation of anti-social behaviours; a subgroup of youths with severe CD will be delinquents. We will also use the terms aggression and violence in this overview. Aggression is defined as outward destructive behaviour that results from the confluence of longer-term factors (for example, biological, psychological and personality, family, peer, school, and community), short-term influences (for example, internal states of anger, boredom, or intoxication) and situational opportunity. Violence—a particular form of overt and intentional aggression—uses or credibly threatens to use physical force such as beating, kicking, choking, using a weapon, forcing sex, and throwing objects (Lewis & Yeager, 2000).

## EPIDEMIOLOGY

CD is the most common reason for psychiatric evaluation

of children or adolescents. Between 30% and 50% of all child psychiatry referrals tend to involve CD. The Ontario Child Health Study indicated that for ages 4 to 16 years, 5.5% suffered from this condition.

Not all youths with CD have a criminal record, and not all youths with a criminal record have CD. Crime statistics therefore can be informative but extremely controversial. Inflated statistics could result from population growth, police reporting practices, or growth of police forces. Equally possible, underreporting may occur. This could be due to the existence of special youth crime units and more community-based policing, along with conflict resolution strategies rather than formal prosecution. In any event, Statistics Canada data indicate that youth offences increased steadily until 1991 but have declined since. In 1986, there were 136 787 charges laid against youth in Canada; in 1991, there were 171 673; by 1994, these had declined to 143 337. By 1998–1999, courts heard 106 665 adolescent cases in Canada (Kazdin, 2000). While this decline in overall numbers is comforting, another disturbing trend is occurring. The proportion of youth charged with violent offences seems to be increasing. In 1986, 408 youths per 100 000 were charged with a violent crime (that is, homicide, attempted murder, assault, sexual offences, abduction, and robbery). In 1995, the rate was up to 938, representing a growth rate of 13% per annum. We expect a 31% increase in the juvenile population over the next 2 decades (9). Accordingly, CD is and will continue to be a fairly significant public health problem, warranting much attention from both the mental health community and the juvenile justice system (American Psychiatric Association, 1994).

\*Correspondence regarding this article should be directed to:  
tejochandra@gmail.com

## **PROTECTIVE FACTORS**

Protective factors are not simply the absence or opposite of risk factors, although this is sometimes the case. In fact, despite exposure to multiple known risk factors, many children avoid serious anti-social behaviour. Protective factors are best defined as those variables that offset the effects of risk factors. Research, however, has largely ignored these factors in favour of elucidating risk. It is quite likely that more emphasis on these variables could significantly influence practice and policy (Werry, 1997).

### **INDIVIDUAL PROTECTIVE FACTORS FEMALE SEX**

Being female may be protective via different parenting or socialization patterns; also, girls generally mature and acquire skills more quickly.

### **HIGH INTELLIGENCE**

This is as measured by standard IQ testing. Such testing, however, has been criticized as too limited with respect to types of intelligence and cultural diversity (Zoccolillo et al. 1992).

### **POSITIVE SOCIAL ORIENTATION**

This would likely include the absence of anti-social attitudes and cognitive biases, such as interpreting social cues as necessarily hostile or threatening (Kazdin, 1985).

### **RESILIENT TEMPERAMENT**

This usually means possessing good coping skills and the ability to endure stress, hardship, or trauma without mental de-compensation. Competence at a Skill attaining at least 1 area of good ability at a skill, hobby, or interest has been noted to be protective, perhaps leading to other pro-social activities and interactions.

### **ANXIETY**

According to some research, having anxiety, worry, and guilt tends to protect against the development of anti-social behaviour. Social Factors Warm, Supportive Relationships with Adults. Positive interactions, warmth, or mentorship from adults has been found to be greatly beneficial in influencing away from CD (Offord et al. 1989).

Individual and Family Commitment to Social Values Such As Pro-social Norms or Academic Achievement. Aspiring to universal values such as positive social interactions with others and school success helps children decrease their risk of conduct problems and increases their achievements and opportunities (Pagani et al. 1999).

Recognition for Involvement in Positive Extracurricular Activities. Not just being involved in pro-social activities but

actually being acknowledged, and even rewarded, helps perpetuate such positive behaviour. Societal Factors Increased Economic Equality and National Social Program Support. Developed countries with larger social-program spending tend to have lower homicide rates (Moffitt, 1993).

## **SOCIAL ORGANIZATION**

Strong and stable community in situations (for example, church, neighbourhood organizations, and extended families), as opposed to disorganized, chaotic, and crumbling communities, tend to be protective.

## **GENETIC CONTRIBUTIONS**

It is well known that psychiatric disorders often run in families. Simple Mendelian inheritance, however, is not found with such complex conditions. Given the diagnostic heterogeneity of CD, a more appropriate phenotype, such as aggressively or violence, is used in research. Genetic studies can be Socially Organized (in 21 types) (3-12) (with)-162)6(e adoption, or familial methods, and those using molecular biology methods. Discussing the science behind these is beyond the scope of this article. One excellent representative twin study looked at the relation between child behavior checklists (CBCL) syndromes such as mood and anxiety disorders, attention deficits, anti-social behavior, and aggressive behavior and temperament ratings using the Emotionality, Activity, and Sociability Temperament Survey (Nagin, & Tremblay, 2001)

