



Born to be wild?

Ashley Seaford reveals the implications for practice of conduct disorder

Introduction

In 2002, in an attempt to effectively manage the difficulties presented by young serious offenders, the government launched the Youth Offending Strategy. Through its legislative responsibilities Child, Youth and Family has an integral role in juvenile justice and augmented the Youth Offending Strategy with its own Youth Justice Plan. In the past few years there has been an increase in the profile of youth justice with the Reducing Youth Offending Programme pilot, the recent opening of the country's largest juvenile justice facility, and a review of youth justice capability, and later this year a residential unit in Wellington for young people with severe conduct disorder will open. While youth justice practitioners need to be aware of these strategic initiatives, they also need to understand fundamental constructs such as conduct disorder and keep up to date with criminological research.

Nature

Young people who engage in frequent and serious offending attract a variety of explanatory labels from professionals, the public and the media. They may be termed juvenile delinquents, deviants, bad, evil, mad or anti-social. Behind each of these epithets lies implicit assumptions. Young people who engage in anti-social activities

are either viewed as rational actors who make a deliberate choice or, in the case of 'mad', seen as not responsible for their behaviour. How a person and his or her behaviour is perceived and understood is important because it has a direct impact on how society responds. At the heart of the issue is personal responsibility for versus medicalisation of anti-social behaviour (Conrad and Schneider, 1994).

Diagnostic criteria

Bad, mad and evil are pejorative, anti-social is imprecise and juvenile delinquency is an American legal term that is not included in any New Zealand legislation (Rey, 1995). The best organised conceptualisation of young people who have engaged in what may be considered anti-social activities and/or serious criminal offending is conduct disorder. This construct appears in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, more commonly referred to as the DSM IV. It is published by the American Psychiatric Association and is this organisation's classification system for all currently known mental health difficulties. The first edition was published in the early 1950s and was produced because of the confusion created by the existence of a number of different systems (Shorter, 1997). As a diagnostic entity conduct

disorder arrived in 1968. The criteria for diagnosing the disorder have changed over time and the current construct is simpler than previous incarnations (Earls, 1994).

The American Psychiatric Association's diagnostic criteria for conduct disorder include: repetitive and persistent patterns of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. This is indicated by the presence of three or more of the following criteria in the previous 12 months, with at least one criterion present in the previous six months:

- bullied, threatened or intimidated others
 - initiated physical fights
 - used a weapon that can cause serious physical harm to others (eg, a bat, brick, broken bottle, knife or gun)
 - physically cruel to people
 - physically cruel to animals
 - stole while confronting a victim
 - forced someone into sexual activity
 - deliberately engaged in setting fires with the intention of causing serious damage
 - deliberately destroyed others' property
 - broken into someone else's house, building or car
 - lied to obtain goods or favours or to avoid obligations
 - stole items of value without confronting a victim
 - stayed out at night despite parental prohibitions, beginning before reaching the age of 13
- ran away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
 - was truant from school on a frequent basis, beginning before reaching the age of 13.

Another criterion is that the disturbance in behaviour causes clinically significant impairment in social, academic or occupational functioning.

From the definition come seven pertinent points:

1. The syndrome is identified by behaviour.
2. A categorical diagnosis is employed, so a young person either meets the criteria to attract a diagnosis or does not.
3. Some of the behaviours set out as criteria are illegal in any circumstances, others may be illegal depending on the situation and others would be seen by many as unacceptable. The construct is not synonymous with criminal activity, but there is substantial overlap (Rutter, Giller and Hagell, 1998).
4. Generally young people cannot be diagnosed with this syndrome if they are over 18 years of age.
5. Due to the criteria, it is relatively easy for this diagnosis to be given. It is likely that many young people involved with the youth justice system would qualify for the diagnosis, but the requirement for significant impairment may exclude others. To differentiate between serious and less serious cases, a dimensional approach is utilised based on the number and intensity of symptoms. Therefore a young person may be said to have mild, moderate or severe conduct disorder.

6. The criteria have a focus on behaviour that affects others. This contrasts to other DSM IV disorders where the focus is on the sufferer.
7. The behaviour must be repetitive and persistent and lead to difficulties across a range of domains.

Conduct disorder has two developmentally related diagnoses: oppositional defiant disorder and anti-social personality disorder. Oppositional defiant disorder is defined as “a recurrent pattern of negativistic, defiant, disobedient and hostile behaviour towards authority figures that persists for at least 6 months” (DSM 1V, 2000). The primary difference between this syndrome and conduct disorder is that none of the diagnostic criteria are illegal and it is probably best thought of as a much milder form. It has been suggested that oppositional defiant disorder is a stepping stone to conduct disorder (Burke, Loeber and Birmaher, 2002). Anti-social personality disorder is one of ten personality disorders listed in the DSM IV. Although a controversial diagnosis (Stevens, 1993; Blackburn, 1988), anti-social personality disorder is in many ways the adult version of conduct disorder, albeit with fewer illegal behaviours as diagnostic criteria. Research suggests that 50 per cent of those with conduct disorder go on to develop anti-social personality disorder as adults (McGeorge, 1997).

The main subtypes of conduct disorder are childhood onset and adolescent onset. Those with the first exhibit at least one criterion prior to the age of ten, whereas the adolescent onset type is defined by the absence of any criteria before this age.

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There are several critics of the DSM IV (Caplan, 1995; Kutchins and Kirk, 1995) and some sociologists have warned about the possible implications of applying labels to people. Although occupying a range of positions, one seemingly shared assertion is that if a person accepts a label then a self-fulfilling prophecy occurs (Muncie, 1999). Another viewpoint is that a diagnostic label is simply a description of a person’s situation at a given time and no judgements or assumptions are made about causality (Scott, 2002).

Origins of conduct disorder

McGeorge (1997) provides an overview of the immediate and wider family environmental factors that have been associated with conduct disorder and notes that research has highlighted the following factors: parental criminality, child abuse, marital discord, large families, economic deprivation, parental mental health difficulties, harsh and inconsistent discipline, lack of supervision and monitoring, low parental warmth, peer influence, and the neighbourhood. Due to reliance on similar studies, the same associated factors are recounted in work that focuses on the causes of aggressive or solely criminal behaviour.

Some biological factors have also been proposed. It is suspected that genetic inheritance may play a role in anti-social behaviour, and it is possible that children may receive some predisposition, including a tendency to be aggressive or impulsive, that could influence potential offending behaviour (Farrington, 1994). Another revelation is that those with conduct disorder

experience lower levels of physiological arousal such as heart rate and sweating than control groups. Such physiological reactions may be connected to anxiety, which may regulate the involvement in anti-social activities (DSM IV, 2000). Neurotransmitters are the chemicals that enable the brain to communicate, and it is hypothesised that serotonin, which plays a central role in mood and emotion, may influence aggression (Lemonick, 1997). Research indicates that high levels of the brain enzyme monoamine oxidase A protects against the onset of violent behaviour (University of Otago, 2002). Finally, evidence suggests that there may be causal links between brain regions and aggression (Davidson, Putnam and Larson, 2000).

It is important to remember that because the above factors are statistically associated with conduct disorder or aggressive/antisocial behaviour, causality should not be assumed. Biological, psychological and social-cultural factors interact and influence one other in complex and, as yet, unclear processes.

Co-morbidity

Medical science has found that if one part of the body exhibits some difficulty this increases the chance of other associated difficulties. The most common psychiatric conditions that exist alongside conduct disorder include substance abuse, depression, anxiety disorders and attention deficient hyperactivity disorder (Loeber, Burke, Lahey, Winters and Zera, 2000).

Prevalence

Prevalence refers to the measure of the occurrence of an illness within the total population over a certain period of time (Disley, 1997). The Christchurch Health and Development

Study estimated that 10.8 per cent of 15-year-olds met the criteria to be given a diagnosis of either oppositional defiant disorder or conduct disorder. At 18 years of age, 4.8 per cent met the criteria for solely conduct disorder. The Dunedin Multidisciplinary Health and Development Study found similar rates for these ages groups (Fergusson, Horwood and Lynskey, 1997). Of importance is the finding that those diagnosed with conduct disorder have high rates of suicidal ideation and suicide attempts (Ruchkin, Schwan-Stone, Kuposov, Vermeiren and King, 2003).

Practice implications

The implications of this research are:

- Conduct disorder provides a model for understanding the origins, prevalence, prognosis and treatment of a young person's mild to severe anti-social/criminal behaviour.
- Youth justice workers and social workers are not responsible for diagnosing conduct disorder or any co-morbid conditions – this is the task of specially trained mental health staff. However, youth justice practitioners need to understand the concept of co-morbidity and be alert to the possible existence of serious psychiatric disorders in the young people they work with. Staff should consistently use the provided screening tools. Because of the well-understood link between depression and suicide, youth justice social workers need to be familiar with the signs and symptoms of depression and be on the lookout for these in their interactions with clients.
- The ability to recognise an existing co-morbid psychiatric condition is not enough – youth justice staff must take an appropriate form of action.
- Where appropriate, youth justice staff should utilise the Department's suicide monitoring programme.

- The disciplines of academic psychiatry, psychology and criminology continue to uncover important information in relation to young people with conduct disorder and young people who offend. Youth justice social workers and National Office policy makers need to keep up to date with research findings.
- The family factors that are associated with the later development of conduct disorder have been briefly set out. Social workers who work with families may be able to recognise and influence some of these factors.

Conclusion

Gathered behind the term conduct disorder is a large amount of robust scientific research that can enhance the services offered to those in the juvenile justice system and their families. The pain that serious youth offending brings to victims and society, coupled with the narrowed life opportunities for offenders, makes it imperative that research and theory are continually incorporated into youth justice social work practice and policy.

REFERENCES

- Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)* (2000) American Psychiatric Association. Washington DC.
- Blackburn, R. (1988) "On Moral judgements and Personality Disorders: The myth of psychopathic personality revisited". In *British Journal of Psychiatry* (153). Pp 505-512.
- Burke, J, Loeber, R and Birmaher, B. (2002). "Oppositional Defiant Disorder and Conduct Disorder: A review of the past 10 years, Part II". In *American Academy of Child and Adolescent Psychiatry Journal* (41:11). Pp 1275-1293.
- Caplan, P. (1995) *They Say You're Crazy: How the world's most powerful psychiatrists decide who's normal (the inside story of the DSM)*. Addison-Wesley Publishing Company. Reading, Mass.
- Conrad, P and Schneider, J. (1994) "Medicine as an Institution of Social Control: Consequences for society". In S Traub and C Little (eds). *Theories of Deviance (Fourth Edition)*. F E Peacock Publishers, Inc. Illinois.
- Davidson, R, Putnam, K and Larson, C. (2000) "Dysfunction in the Neural Circuitry of Emotion Regulation: A possible prelude to violence". In *Science* (289). Pp 591-594.
- Disley, B. (1997) "An Overview of Mental Health in New Zealand". In P Ellis and S Collings (eds) *Mental Health in New Zealand from a Public Health Perspective*. Ministry of Health. Wellington.
- Earls, F. (1994) "Oppositional Defiant and Conduct Disorders". In M Rutter, E Taylor, L Hersov (eds) *Child and Adolescent Psychiatry: Modern approaches. (Third Edition)*. Blackwell Science. Oxford.
- Farrington, D. (1993) "The Psychosocial Milieu of the Offender". In J Gunn and P Taylor (eds) *Forensic Psychiatry: Clinical, legal and ethical issues*. Butterworth Heineman. England.
- Fergusson, D, Horwood, J and Lynskey, M. (1997) "Children and Adolescents". In P Ellis and S Collings (eds) *Mental Health in New Zealand from a Public Health Perspective*. Ministry of Health. Wellington.
- Kutchins, H and Kirk, A. (1995) "Pathologising Everyday Behaviour". In *Making US Crazy (DSM: The Psychiatric Bible and the Creation of Mental Disorders)*. The Free Press. New York.