DOWNLOAD PDF CONDUCT DISORDERS IN CHILDREN AND ADOLESCENTS

Chapter 1 : Conduct Disorder Symptoms

Foreword. Conduct disorder in children and adolescents may be expressed in the form of any of a range of diverse behavioural patterns, from the frequent and intense temper tantrums and persistent disobedience of the difficult child to the delinquent's serious acts of aggression, such as theft, violence and rape.

Three or more of the following would be present in the last year, with at least one in the most recent 6 months: They are published in the Diagnostic and Statistical Manual of Mental Disorders fourth edition, , and available in the public domain. Diagnoses for mental health remain dominated by the medical model in this country. A diagnosis is necessary for insurance coverage for services, and for determining a proper treatment plan. The onset can be detemined to be Childhood Onset, with at least one symptom present prior to age 10, or Adolescent Onset, with a lack of symptoms before age The severity of the disorder may be Mild, if there is only minor harm to others; Moderate, if the effect on others is between mild and severe; or Severe, where behavior causes considerable harm to others. The patterns of behavior are usually found in a variety of settings. Children or adolescents with a Conduct Disorder may display bullying, threatening behaivor, or intimidate others. They frequently start fights. They may use a weapon such as a bat, brick, broken bottle, knife or gun. They may smash car windows, or vandalize schools, homes or public property. They may break into homes or cars. They may frequently lie or break promises for personal gain or favors, or to avoid debts or obligations. They may engage in shoplifting or forgery. Usually children before the age of 13 with this disorder stay out late at night in violation of parental rules. They may run away overnight, or for extended periods of time. Running away due to physical or sexual abuse does not qualify for this criterion. They are often truant from school. The Childhood onset type is usually a male. They have highly conflicted peer relationships. They are more likely to develop an Antisocial Personality Disorder than those with the Adolescent onset. Those with the Adolescent onset type tend to have more normal peer relationships, although their disruptive behavior is often in the company of others. Females are more frequently diagnosed with the later onset type than males. Children and adolescents with a Conduct Disorder may have little empathy or concern for others. The more aggressive individuals may misperceive the intentions of others as hostile and more threatening than is the case, which prompts them to respond with aggression they feel is justified. They may lack guilt or remorse. If they do exibit remorse, it is hard to tell if it is sincere since it may be to avoid punishment. They may easily inform on others, or blame others for their behavior. Like most bullies, their self esteem is usually low, though they act tough. They have poor frustration tolerance, are easily irritated, have temper outbursts, and are frequently reckless. They may have more accidents. A Conduct Disorder is often associated with early sexual behavior, smoking, drug use, and risk taking. These individuals are often suspended or expelled from school and have legal problems. Sexually transmitted diseases, unplanned pregnancies, and physical injuries from accidents or fights are more frequent. Many will require placement in foster homes or residential schools and treatment centers. Intelligence and academic achievement are often lower than average, particularly with reading and verbal skills. Common elements of the environment predispose children or adolescents to having a CD. A Conduct Disorder is not simply a reaction to a social context, where the behavior may be protective, such as in a threatening, impoverished, or high crime environment. It is not applied to immigrant youth from war ravaged countries, where aggressive behaviors may have been necessary for survival. Less severe behaviors tend to emerge first, and the more severe later, although this can vary by individual. This condition is much more common in males. Males engage in more confrontational aggression. It can occur as early as age 5, and onset is rare after age A majority of children and adolescents stop this disruptive behavior by adulthood. Early onset predicts a worse prognosis. There is evidence of both genetic and environmental components in this disorder. It seems to be more common with a parent with Antisocial Personality Disorder or a sibling with a CD. Children and adolescents with a Conduct Disorder receive early attention from authority figures and agencies due to the aggressiveness and severity of

their disruptive behaviors. They usually require court ordered and supervised treatment in individual or group settings. Residential treatment is common. Counseling at the first signs of these behaviors has the best chance of being effective and of minimizing the course of the disorder. Family treatment is almost always indicated, but seldom started or followed through on. Outpatient psychotherapy should be considered when possible. See the Cranberry Counseling, P.

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Chapter 2 : Conduct Disorders in Children and Adolescents - At Health

A Conduct Disorder in children or adolescents is characterized by a repetitive and persistent pattern of behavior where the basic rights of others or major age appropriate or social norms or rules are violated.

A Systematic Review and Meta-Analysis. Children with attention-deficit hyperactivity disorder ADHD may have oppositional behaviour, conduct problems, and aggression. These symptoms vary in severity, and may be related to a comorbid diagnosis of oppositional defiant disorder ODD or conduct disorder CD. Critical evaluation of the efficacy of ADHD medications may guide the clinician regarding the usefulness of medications for these symptoms. We performed a systematic review and meta-analysis of psychostimulants, alpha-2 agonists, and atomoxetine for oppositional behaviour, conduct problems, and aggression in youth with ADHD, ODD, and CD. The quality of evidence for medications was rated using the Grading of Recommendations Assessment, Development and Evaluation approach. Two systematic reviews and 20 randomized controlled trials were included. There is high-quality evidence that psychostimulants have a moderate-to-large effect on oppositional behaviour, conduct problems, and aggression in youth with ADHD, with and without ODD or CD. There is moderate-quality evidence that guanfacine has a small-to-moderate effect on oppositional behaviour in youth with ADHD, with and without ODD. Evidence indicates that psychostimulants, alpha-2 agonists, and atomoxetine can be beneficial for disruptive and aggressive behaviours in addition to core ADHD symptoms; however, psychostimulants generally provide the most benefit. Attention-deficit hyperactivity disorder is the most common neuropsychiatric disorder of childhood, with a prevalence of 4. In addition to these core features, many children with ADHD and their families struggle with oppositional behaviour, conduct problems, and aggression. In children with comorbid ODD, these guidelines advise optimization of pharmacotherapy of ADHD, as well as psychosocial treatments, including parent and other behavioural treatments. For children with comorbid CD, the guidelines state that while medications are usually effective in reducing the symptoms of ADHD and impulsive aggression, these children usually benefit from multimodal treatment, and may require additional pharmacotherapy with antipsychotics or mood stabilizers. Until now, the relative benefits of using ADHD medications rather than adding an antipsychotic or mood stabilizer have been unclear. Clinical Implications Among the medications used for the treatment of ADHD, psychostimulants have the most evidence for efficacy in the treatment of oppositional behaviour, conduct problems, and aggression. There is evidence to support the use of guanfacine and atomoxetine for oppositional behaviour, though effect sizes are small to moderate. The effect of clonidine on oppositional behaviour and conduct problems may not be clinically significant. Limitations There are a very limited number of studies of guanfacine and clonidine for the treatment of oppositional behaviour, conduct problems, and aggression. In light of the disability related to oppositional behaviour, conduct problems, and aggression in youth with ADHD, and the high rate of comorbidity between ADHD, ODD, and CD, a critical evaluation of the efficacy of ADHD medications in treating these types of behaviours can help guide the clinician regarding pharmacotherapy for these target symptoms. The objective of this systematic review is to assess the efficacy and safety of ADHD medicationsâ€”psychostimulants, alpha-2 agonists, and atomoxetineâ€”for oppositional behaviour, conduct problems, and aggression in youth with ADHD that is comorbid with ODD or CD. A companion article in this 2-part series provides a systematic review of antipsychotics and mood stabilizers for the same purpose. Studies had to include outcomes on oppositional behaviour, conduct problems, or aggression, and had to include a placebo phase or group. We searched for studies regardless of publication type. Given the high rate of comorbidity between these disorders and both subaverage IQ and chronic tic disorders, we did not exclude studies that included children with these comorbidities. Types of Interventions Psychostimulants methylphenidate and amphetamine at any dosage or formulation for example, short- or long-acting medications. Alpha agonists clonidine and guanfacine at any dosage or formulation. Atomoxetine at any dosage. Oppositional behaviour, conduct problems, or aggression

as measured by validated clinician-, parent-, or teacher-reported scales. Adverse effects, including physical, laboratory, or electrocardiogram abnormalities, and adverse eventâ€”related drop outs. Searches were performed by medication class. Language restrictions were not imposed. Studies were not excluded based on publication status. Data Collection and Analysis Selection of Studies Two authors independently reviewed titles and abstracts from the searches and selected potentially relevant studies. Full-text articles were read in detail to determine if they fulfilled inclusion criteria. Disagreements were resolved through discussion between the reviewers. We did not need to refer any disagreement to an independent arbiter. Data Extraction and Management Two authors independently extracted data from studies and entered them into a predesigned data extraction form. The following data were extracted and entered:

Chapter 3 : Treating Adolescent Conduct Disorder

No. 33; Updated June "Conduct disorder" refers to a group of repetitive and persistent behavioral and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules, respecting the rights of others, showing empathy, and behaving in a socially acceptable way.

The phenotypic covariance between exteriorised and internalizing problems is predominantly environmental. In addition to these common global factors, there are on the one hand, supplementary genetic contributions in ADHD and in the temperamental trait of the seeking of novel experiences, and on the other hand, specific environmental components in conduct disorder and substance abuse. These consistent findings justify looking for vulnerability genes. The functional approach involves selecting candidate genes and testing their links with the various disorders. Many such molecular genetics studies have been undertaken, giving highly disparate results. Of the mono-amine-based neurotransmitter systems, attention has focused on the dopamine system, which is known to be involved in motor excitability and concentration. Also, psychostimulants that target dopaminergic neurotransmission have been used to manage ADHD. Recent meta-analyses show a link between ADHD and the genes that encode dopamine receptors D4 and D5, although the correlations are weak and do not by any means fully account for the epidemiological picture with the presence of each of the alleles associated with ADHD increasing the risk by a factor of just 1. However, most of these studies have been category-based and have not been conducted on enough subjects to yield information about comorbid forms, although these are the most heritable. Finally, the most recent studies have sought to define cognitive profiles and drug response patterns in children with ADHD in order to identify phenotypes that are particularly tightly linked to certain candidate genes. An alternative way of identifying genes that predispose to conduct disorder involves the holistic investigation of multiple risk factors. Genetic factors are all the more difficult to define because their frequency varies in parallel to the variability of environmental factors. Exposure to a particular type of environment might exacerbate the situation in a genetically predisposed child to a greater extent than would result from the simple addition of risk factors. Moreover, certain genetic or environmental factors might be protective. There are many reasons for studying interactions between genes and the environment. Firstly, that such interactions do indeed occur is illustrated by the fact that the same genetic factors are associated with conduct disorder, ADHD, and ODD, whereas the relevant environmental factors are specific to each of these conditions. Such studies also point to a link between disruptive behaviour and biological history emerging only if the child is removed from the adoptive home. It is therefore logical that interactions between genes and environment be taken into account when we are looking at the genetics of conduct disorderâ€”and such approaches are yielding valuable information. The allele that is associated with reduced monoamine oxidase A activity appears to be associated with the development of antisocial behaviour, but only in subjects who have been mistreated during childhood. This does not correspond to a simple superimposition of risk factors but rather a synergistic effect between different vulnerability factors. Taking interactions between life events and genes into account could help shed light on why the results of different studies are so divergent and could reveal the type of susceptibility conferred by genes in multifactorial problems such as disruptive behaviour, making it a potentially useful approach to the genetics of behaviour. Temperament and personality may be factors that predispose to conduct disorder For many years, the impact of personality and temperament were neglected in favour of sociological explanations for conduct disorder and delinquency. However, many studies have shown that personal variables such as temperament and personality are key factors in the development, maintenance, and severity of conduct disorder. In children, the existence of a set of traits that collectively constitute a difficult temperament e. A difficult temperament is especially predictive of conduct disorder if the child comes from a dysfunctional family. However, it is not specific to conduct disorder because it is also found in ADHD and internalised problems such as anxiety and depression. In fact, a difficult temperament seems to be a common precursor for mental problems in general. Impulsiveness is also predictive of this type

of problem, as well as delinquency insofar as this paediatric temperamental dimension may inhibit socialisation processes, e. Although impulsiveness is far from specific to conduct disorder it is also associated with ADHD and ODD , it is particularly marked in the more severe forms e. Impaired behavioural control has been shown to be involved in conduct disorder and antisocial behaviour in both boys and girls. But this type of temperamental trait is involved in a non-specific way and is broadly predictive of exteriorised problems such as ADHD. However, it seems that it is mostly the coupling of a strong need for behavioural activation with weak behavioural inhibition that is predictive of conduct disorder. In terms of emotional dimensions, it has been shown that a lack of guilt feelings in a child is strongly predictive of physical aggression, delinquency, and conduct disorder. The individuals concerned are less empathetic, less able to recognise emotions such as anger and sadness in others, and have a lower level of affective morality. Self-esteem does not seem to be a significant risk factor for conduct disorder insofar as it is not specific to a type of trait. On the other hand, egocentrism the tendency to relate everything to oneself and narcissistic personality could be typical of certain forms of conduct disorder with physical aggression. Some experts believe that all these emotional characteristics express a personality trait defined by affective coldness, insensitivity, and a tendency to charm. This trait associated with conduct disorder might correspond to a specific group which constitutes a predictor of psychopathy in adulthood, especially if the subject exhibits high impulsiveness. The profileâ€"combining both temperament and characterâ€"that would be specifically characteristic of conduct disorder would be one of strong "novelty seeking" exploratory excitability, impulsiveness, extravagance coupled with relatively low levels of "pain avoidance" dimensions i. Psychoticism tough-mindedness, interpersonal hostility, self-centredness, affective coldness seems to be predictive of conduct disorder and antisocial behaviour in both boys and girls insofar as this dimension reflects a tendency toward antisocial attitudes and impulsive behaviour. Extraversion and neuroticism seem to be particularly important in delinquent girls and less serious delinquent behaviour, whereas people who commit extremely violent acts are usually relatively introverted. A longitudinal study has shown that character traits such as affective coldness, a tendency to manipulate, cynicism, and aggression could significantly influence the age at which aggressive behaviour is manifested, the stability of conduct disorder through adolescence, and antisocial personality disorder in adulthood. A number of studies have set out to analyse links that might exist between the temperament of the child and parental attitudes. To a greater or lesser extent, all findings point to the centrality of the "goodness of fit" phenomenon between parents and child in the development of conduct disorder. Thus, a boy with a "resistant" temperament who has trouble concentrating, a tendency to oppose, and little capacity for inhibition would only be susceptible to conduct disorder if his parents adopt a broadly "permissive" child-raising style, and the outcome would be quite different if they were to exert adequate control. The involvement of personality and temperamental traits in the occurrence and maintenance of conduct disorder should be situated in a dynamic developmental perspective in which physiological and environmental factors interact with one another. Perinatal events might be involved in the pathogenesis of conduct disorder Various antenatal and perinatal events have been proposed as possibly exacerbating the risk of conduct disorder. Nevertheless, it seems unlikely that such events would have any very specific impact; rather, interactions with other risk factors notably genetic would determine the form of the disorder. In this context, a large number of studies have consistently shown that the offspring of mothers who smoke are more likely to develop conduct disorder; a significant correlation has emerged in several longitudinal studies between maternal smoking and the occurrence of conduct disorder, especially in boys. In longitudinal studies, a correlation has been observed between cannabis smoking during pregnancy and behavioural problems in the child, notably impulsiveness and impaired concentration. An increased level of exteriorised problems has also been reported, especially in boys whose mothers took cocaine during pregnancy: Premature birth and low birth weight have both been suggested as possible risk factors for conduct disorder, and a relationship has been identified between health problems in premature babies and the incidence of exteriorised problems at the age of 5, notably oppositional behaviour and hyperactivity. Similarly, low birth weight correlates with ADHD and antisocial behaviour.

Complications during delivery can also lead to neurological deficit which itself is associated with neuro-behavioural problems. Recent studies conducted on large populations have shown that there is a correlation between obstetric complications and antisocial behaviour in childhood or adolescence. Among the various problems that may arise during delivery, experts have singled out foetal asphyxia as a specific risk factor for conduct disorder. In a study conducted at a special centre, it was shown that pregnancy at a young age before 20 and to an even greater extent before 18 directly correlated with the number of symptoms of conduct disorder in sons between the ages of 6 and If the mother had a history of conduct disorder, the likelihood of her becoming pregnant at a young age was higher, as was the incidence of the diagnosis of conduct disorder in her children. In addition, it emerged that head injury, even mild, during early childhood may be associated with an increased rate of ADHD and conduct disorder between 10 and 13 years of age. Other risk factors, such as maternal smoking and complications during delivery have been identified in methodological robust studies however they seem to be relatively non-specific, and the correlations with pathology in later life could involve other parameters, such as disturbance of the mother-child relationship or parameters related to the family environment in general. The pathogenesis and persistence of conduct disorder are affected by familial and environmental factors Various contextual factors, essentially related to family or psychosocial environment, are associated with conduct disorder in adolescence and adulthood. Adverse environmental conditions are all the more important in that they are commonly systematic, long term, and associated with other risk factors. Poverty in itself is not a risk factor, but extreme poverty is associated with multiple risk factors, which have impact on parenting behavior. Quite a lot of studies have addressed the impact of parental problems, be it behavioural problems in the father or mother, dysfunction in the couple, maternal post-natal depression, parental alcoholism, or other forms of dependence. These studies have consistently identified a link between conduct disorder in the offspring and antisocial personality disorder in one of the parents. The children of fathers who are substance dependent, particularly to alcohol, and also have an antisocial personality are at higher risk of both conduct disorder and ADHD; and the sons are at greater risk of themselves becoming addicted. Similarly, if the mother has an antisocial personality, the likelihood of the children developing conduct disorder is enhanced, a fact that was underestimated for a long time. Maternal depression is known to have an effect on the development of the child although the magnitude of such effects in conduct disorder remains controversial. The children of mothers who experience post-natal depression may constitute a specific high-risk group. Adolescent pregnancy is associated with conduct disorder in the offspring. The risk of conduct disorder with aggressive behaviour is particularly high among boys whose mothers were very young and whose educational level is low. In several longitudinal studies of a high risk population, insecure attachment and disturbances or disruption of relationships within the family significantly exacerbated the risk of behavioural problems among children. Insecure attachment between child and both parents seemed to increase the risk of conduct disorder substantially, specifically if associated with temperamental difficulties, adverse family events, and disturbances in parent-children relationships. A child whose relationship to principal attachment figures has been disrupted at a very young age tends to exhibit aggressive and directive behaviour toward their parents, particularly if the child has been subjected to violence or sexual abuse. Disorders of attachment, compounded with other dimensions e. Many experts have drawn attention to a link between disruption of the family structure, through divorce and subsequent aggressive behaviour, conduct disorder, and delinquency. However, it has been shown in longitudinal studies that this factor acts long before the actual separation of the parents, and it may be more closely related to the conflict between the parents rather than to the divorce itself. Thus, the long-term impact of a divorce on subsequent problems in the child may be more due to conjugal discord than to the eventual separation. If one of the parents has an antisocial personality or is substance dependent, or if there is conjugal violence, the separation may help protect the child. Various studies have shown that deleterious parental attitudes and inappropriate child-raising strategies emerge as a family characteristic linked to delinquency. Parenting style seems to be more important when it comes to predicting aggressive and oppositional behaviour patterns than for ADHD.

Parental indifference to truancy from school or to the absence of the child from the family home is predictive of antisocial behaviour and delinquency, particularly in underprivileged settings. The influence of siblings cannot be ignored. Various studies have shown that a child with a brother or sister especially if he or she is older who has been convicted for an act of delinquency is significantly more likely to come before the courts. It may be that, in a family in which there is already a child with conduct disorder, his or her siblings may be directly influenced, independently of any other risk factors. This association is significantly amplified in underprivileged settings. Similarly, the fact of having older brothers or sisters who perform well at school may be protective. Many experts agree that the type of aggressive and violent behaviour patterns that are common in underprivileged settings depend on the concurrence of diverse risk factors. Concentrations of gangs of children and adolescents with conduct disorder in certain neighbourhoods tend to attract other young people from the same neighbourhood, and mixing with delinquents doubles the risk of aggressive or delinquent behaviour patterns being sustained through adolescence. The available data suggest that schooling experiences need to be taken into account when evaluating risk factors for conduct disorderâ€"truancy, rudeness at school, and academic failure have all been related to conduct disorder and delinquency. When children are presenting symptoms of both ADHD and early-onset conduct disorder, they are very likely to fail at school. Numerous studies have revealed a significant link between exposure to media violence and aggressive behaviour in young people. Recent studies have confirmed that 8-year-old children who watch violent shows on television are far more likely to act aggressively in the long term 11 to 22 years later. This correlation is independent of intelligence quotient IQ and socio-economic status. Televised violence may not only lead to real violence but it also leads to desensitisation, entailing trivialisation and habituation, resulting in a passive reaction to and tolerance of violent acts. In certain children, playing violent games enhances physiological excitation, exacerbates aggressive attitudes, and inhibits positive social behaviour patterns. The inundation of childrenâ€"who might already be vulnerable by virtue of their family or social environment, or who might already be presenting signs of nascent conduct disorderâ€"with violent stimuli such as are so ubiquitously and continuously dispensed via television and video games, enhances the attraction of violence, all the more so because the violent behaviour is at best trivialised or exempted of any feeling of guilt, and at worst glamorised and encouraged. It is nevertheless important to remember that it is children who already have problems with real violence who are the most affected by exposure to virtual violence in the media. Neurocognitive deficits are associed with conduct disorder Two types of neurocognitive deficit seem to be associed with conduct disorder in children and adolescents, namely impaired verbal skills and impaired executive inhibition mechanisms.

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Chapter 4 : Conduct Disorder | Mental Health America

Introduction. Conduct disorders or related behaviours in children and adolescents are important issues in current times. The excessive presence of non-compliance in a child, with or without aggression, produces enormous challenges to parents and teachers.

Destructive conduct may include arson and other intentional destruction of property. Violation of Rules Violation of rules may include: Girls are more prone to deceitful and rule-violating behavior. Additionally, the symptoms of conduct disorder can be mild, moderate, or severe: Mild If your child has mild symptoms, it means they display little to no behavior problems in excess of those required to make the diagnosis. Conduct problems cause relatively minor harm to others. Common issues include lying, truancy, and staying out after dark without parental permission. Moderate Your child has moderate symptoms if they display numerous behavior problems. These conduct problems may have a mild to severe impact on others. The problems may include vandalism and stealing. Severe Your child ha severe symptoms if they display behavior problems in excess of those required to make the diagnosis. These conduct problems cause considerable harm to others. The problems may include rape, use of a weapon, or breaking and entering. Genetic and environmental factors may contribute to the development of conduct disorder. Genetic Causes Damage to the frontal lobe of the brain has been linked to conduct disorder. The frontal lobe is the part of your brain that regulates important cognitive skills, such as problem-solving, memory, and emotional expression. The frontal lobe in a person with conduct disorder may not work properly, which can cause, among other things: A child may also inherit personality traits that are commonly seen in conduct disorder. Environmental Factors The environmental factors that are associated with conduct disorder include: If your child is showing signs of conduct disorder, they should be evaluated by a mental health professional. For a conduct disorder diagnosis to be made, your child must have a pattern of displaying at least three behaviors that are common to conduct disorder. Your child must also have shown at least one of the behaviors within the past six months. The behavioral problems must also significantly impair your child socially or at school. How Is Conduct Disorder Treated? Children with conduct disorder who are living in abusive homes may be placed into other homes. If your child has another mental health disorder, such as depression or ADHD, the mental healthcare provider may prescribe medications to treat that condition as well. Since it takes time to establish new attitudes and behavior patterns, children with conduct disorder usually require long-term treatment. However, early treatment may slow the progression of the disorder or reduce the severity of negative behaviors. Children who continuously display extremely aggressive, deceitful, or destructive behavior tend to have a poorer outlook. The outlook is also worse if other mental illnesses are present. Once treatment is received for conduct disorder and any other underlying conditions, your child has a much better chance of considerable improvement and hope for a more successful future. Without treatment, your child is likely to have ongoing problems. They may be unable to adapt to the demands of adulthood, which can cause them to have problems with relationships and holding a job. Your child may even develop a personality disorder, such as antisocial personality disorder, when they reach adulthood. This is why early diagnosis and treatment are critical. The earlier your child receives treatment, the better their outlook for the future will be. Medically reviewed by Timothy J.

Chapter 5 : Conduct Disorders in Children and Adolescents

Conduct disorder is the most prevalent emotional disorder in children and adolescents, and therefore requires special attention from clinicians.

What help is available for families? Although conduct disorder is one of the most difficult behavior disorders to treat, young people often benefit from a range of services that include: Training for parents on how to handle child or adolescent behavior. Training in problem solving skills for children or adolescents. Community-based services that focus on the young person within the context of family and community influences. What can parents do? Some child and adolescent behaviors are hard to change after they have become ingrained. Therefore, the earlier the conduct disorder is identified and treated, the better the chance for success. Most children or adolescents with conduct disorder are probably reacting to events and situations in their lives. Some recent studies have focused on promising ways to prevent conduct disorder among at-risk children and adolescents. In addition, more research is needed to determine if biology is a factor in conduct disorder. Parents or other caregivers who notice signs of conduct disorder or oppositional defiant disorder in a child or adolescent should: Pay careful attention to the signs, try to understand the underlying reasons, and then try to improve the situation. If necessary, talk with a mental health or social services professional, such as a teacher, counselor, psychiatrist, or psychologist specializing in childhood and adolescent disorders. Get accurate information from libraries, hotlines, or other sources. Talk to other families in their communities. Find family network organizations. All the fact sheets listed below are written in an easy-to-read style. Families, caretakers, and media professionals may find them helpful when researching particular mental health disorders. To obtain free copies, call or visit http: Many children have mental health problems. These problems are real and painful and can be severe. Mental health problems can be recognized and treated. Caring families and communities working together can help.

Chapter 6 : Conduct Disorder

Conduct disorder is known as a "disruptive behavior disorder" because of its impact on children and their families, neighbors, and schools. Another disruptive behavior disorder, called oppositional defiant disorder (ODD), may be a precursor of conduct disorder.

The findings support that if a caregiver is able to respond to infant cues, the toddler has a better ability to respond to fear and distress. If a child does not learn how to handle fear or distress the child will be more likely to lash out at other children. If the caregiver is able to provide therapeutic intervention teaching children at risk better empathy skills, the child will have a lower incident level of conduct disorder. The first is known as the "childhood-onset type" and occurs when conduct disorder symptoms are present before the age of 10 years. This course is often linked to a more persistent life course and more pervasive behaviors. Specifically, children in this group have greater levels of ADHD symptoms, neuropsychological deficits, more academic problems, increased family dysfunction, and higher likelihood of aggression and violence. The characteristics of the diagnosis are commonly seen in young children who are referred to mental health professionals. It is also argued that some children may not in fact have conduct disorder, but are engaging in developmentally appropriate disruptive behavior. The second developmental course is known as the "adolescent-onset type" and occurs when conduct disorder symptoms are present after the age of 10 years. Individuals with adolescent-onset conduct disorder exhibit less impairment than those with the childhood-onset type and are not characterized by similar psychopathology. Research has shown that there is a greater number of children with adolescent-onset conduct disorder than those with childhood-onset, suggesting that adolescent-onset conduct disorder is an exaggeration of developmental behaviors that are typically seen in adolescence, such as rebellion against authority figures and rejection of conventional values. Specifically, research has demonstrated continuity in the disorders such that conduct disorder is often diagnosed in children who have been previously diagnosed with oppositional defiant disorder, and most adults with antisocial personality disorder were previously diagnosed with conduct disorder. However, this is not to say that this trajectory occurs in all individuals. In fact, the current diagnostic criteria for antisocial personality disorder require a conduct disorder diagnosis before the age of Associated conditions[edit] Children with conduct disorder have a high risk of developing other adjustment problems. Children with conduct disorder have an earlier onset of substance use , as compared to their peers, and also tend to use multiple substances. Despite the complexities, several domains have been implicated in the development of conduct disorder including cognitive variables, neurological factors, intraindividual factors, familial and peer influences, and wider contextual factors. A number of interactive risk and protective factors exist that can influence and change outcomes, and in most cases conduct disorder develops due to an interaction and gradual accumulation of risk factors. Co-variation between two variables can arise, for instance, if they represent age-specific expressions of similar underlying genetic factors. Thus, the genes that dispose the mother to SDP may also dispose the child to CD following mitotic transmission. Indeed, Rice et al. Thus, the distinction between causality and correlation is an important consideration. These findings hold true even after taking into account other variables such as socioeconomic status SES , and education. However, IQ and executive function deficits are only one piece of the puzzle, and the magnitude of their influence is increased during transactional processes with environmental factors. Compared to normal controls, youths with early and adolescent onset of conduct disorder displayed reduced responses in brain regions associated with social behavior i. Lastly, youths with conduct disorder display a reduction in grey matter volume in the amygdala, which may account for the fear conditioning deficits. These reductions are associated with the inability to regulate mood and impulsive behaviors, weakened signals of anxiety and fear, and decreased self-esteem. Intra-individual factors[edit] Aside from findings related to neurological and neurochemical profiles of youth with conduct disorder, intraindividual factors such as genetics may also be relevant. Having a sibling or parent with conduct disorder

increases the likelihood of having the disorder, with a heritability rate of. For instance, antisocial behavior suggestive of conduct disorder is associated with single parent status, parental divorce, large family size, and young age of mothers. Peer influences have also been related to the development of antisocial behavior in youth, particularly peer rejection in childhood and association with deviant peers. Hinshaw and Lee [1] also explain that association with deviant peers has been thought to influence the development of conduct disorder in two ways: In a separate study by Bonin and colleagues, parenting programs were shown to positively affect child behavior and reduce costs to the public sector. For instance, neighborhood safety and exposure to violence has been studied in conjunction with conduct disorder, but it is not simply the case that youth with aggressive tendencies reside in violent neighborhoods. Transactional models propose that youth may resort to violence more often as a result of exposure to community violence, but their predisposition towards violence also contributes to neighborhood climate. Similar criteria are used in those over the age of 18 for the diagnosis of antisocial personality disorder. Therefore, it is important to exclude a substance-induced cause and instead address the substance use disorder prior to making a psychiatric diagnosis of conduct disorder. Additionally, treatment should also seek to address familial conflict such as marital discord or maternal depression. For those that do not develop ASPD, most still exhibit social dysfunction in adult life. Females are more likely to be characterized by covert behaviors, such as stealing or running away. Moreover, conduct disorder in females is linked to several negative outcomes, such as antisocial personality disorder and early pregnancy, [45] suggesting that sex differences in disruptive behaviors need to be more fully understood. Females are more responsive to peer pressure [46] including feelings of guilt [47] than males. United States[edit] Research on racial or cultural differences on the prevalence or presentation of conduct disorder is limited. However, it appears that African-American youth are more often diagnosed with conduct disorder, [48] while Asian-American youth are about one-third as likely [49] to develop conduct disorder when compared to White American youth.

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Chapter 7 : Child and Adolescent Mental-Health Disorders - Encyclopedia of Social Work

Conduct disorder is repetitive and persistent aggression toward others in which the basic rights of others are violated. Disruptive, impulse control and conduct disorders appear to have addictive properties as they tend to have strong aspects of compulsion, craving, loss of control, and hedonistic release.

Conduct Disorder What is Conduct Disorder? Conduct disorder is a repetitive and persistent pattern of behavior in children and adolescents in which the rights of others or basic social rules are violated. The child or adolescent usually exhibits these behavior patterns in a variety of settingsâ€”at home, at school, and in social situationsâ€”and they cause significant impairment in his or her social, academic, and family functioning. What are the signs and symptoms of Conduct Disorder? Behaviors characteristic of conduct disorder include: Aggressive behavior that causes or threatens harm to other people or animals, such as bullying or intimidating others, often initiating physical fights, or being physically cruel to animals. Serious rule violations, such as staying out at night when prohibited, running away from home overnight, or often being truant from school. Many youth with conduct disorder may have trouble feeling and expressing empathy or remorse and reading social cues. These youth often misinterpret the actions of others as being hostile or aggressive and respond by escalating the situation into conflict. Conduct disorder may also be associated with other difficulties such as substance use, risk-taking behavior, school problems, and physical injury from accidents or fights. How common is Conduct Disorder? Conduct disorder can have its onset early, before age 10, or in adolescence. Children who display early-onset conduct disorder are at greater risk for persistent difficulties, however, and they are also more likely to have troubled peer relationships and academic problems. Among both boys and girls, conduct disorder is one of the disorders most frequently diagnosed in mental health settings. What does the research say about Conduct Disorder? Recent research on Conduct Disorder has been very promising. For example, research has shown that most children and adolescents with conduct disorder do not grow up to have behavioral problems or problems with the law as adults; most of these youth do well as adults, both socially and occupationally. Researchers are also gaining a better understanding of the causes of conduct disorder, as well as aggressive behavior more generally. Conduct disorder has both genetic and environmental components. That is, although the disorder is more common among the children of adults who themselves exhibited conduct problems when they were young, there are many other factors which researchers believe contribute to the development of the disorder. For example, youth with conduct disorder appear to have deficits in processing social information or social cues, and some may have been rejected by peers as young children. Despite early reports that treatment for this disorder is ineffective, several recent reviews of the literature have identified promising approaches treating children and adolescents with conduct disorder. The most successful approaches intervene as early as possible, are structured and intensive, and address the multiple contexts in which children exhibit problem behavior, including the family, school, and community. Examples of effective treatment approaches include functional family therapy, multi-systemic therapy, and cognitive behavioral approaches which focus on building skills such as anger management. Pharmacological intervention alone is not sufficient for the treatment of conduct disorder. Co-occurring conduct disorder and substance abuse problems must be treated in an integrated, holistic fashion. Why are assessment and treatment important? Accurate assessment and appropriate, individualized treatment will assure that all children are equipped to navigate the developmental milestones of childhood and adolescence and make a successful adaptation to adulthood. Treatment must be provided in the least restrictive setting possible. Learn more about conduct disorder, including recent research on effective treatment approaches. Contact NMHA for additional resources on conduct disorder or other emotional or behavioral disorders of childhood. Explore the treatment options available. Treatment must be individualized to meet the needs of each child and should be family-centered and developmentally and culturally appropriate. Find a family support group or organization in your community. Practice parameters for the assessment and treatment of

children and adolescents with conduct disorder. Diagnostic and Statistic Manual of Mental Disorders 4th edition. This Fact Sheet is one in a series of Fact Sheets that Mental Health America has produced on major childhood emotional and behavioral disorders, including bipolar disorder, depression, and anxiety disorders. This Fact Sheet is intended to generally inform the reader about this disorder and is not intended to be a substitute for proper assessment by a trained mental health professional.

Chapter 8 : Conduct Disorder in Children and Adolescents

Conduct disorder is the most prevalent emotional disorder in children and adolescents, and therefore requires special attention from clinicians. It addresses the biological, psychological, and interpersonal aspects of aggressive behavior and conduct disorders, and includes the most current clinical research.

Effective interventions, however, are available. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR defines conduct disorder as a "persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. These subtypes differ in regard to prognosis, age of onset, and severity of symptoms. Childhood-onset type is characterized by the presence of one criterion characteristic of conduct disorder before age ten. The prognosis tends to be poor for this subtype, which appears to be genetic. At age of eighteen, the adolescent is more likely to be diagnosed with antisocial personality disorder as compared to those developing a later onset variety of conduct disorder. It is common for the child-onset type to have non-normative peer relationships. Although they can be very charismatic, they tend to be loners. Adolph Hitler is an example of this type of presentation. History indicates he suffered from child-onset conduct disorder. In later life, he exhibited symptoms of bipolar disorder. With childhood onset, the style of aggression may be predatory. For example, reduced anxiety in the face of danger, lack of empathy, high degrees of stimulus seeking, high drive, and low-frustration tolerance are genetically influenced temperament traits and complicate the clinical presentation. This adolescent is going to be more interested in immediate gratification, as opposed to working hard for future gain such as going to college. Why work your way up the employment ladder when you can sell drugs or steal? Adolescent-onset type is defined by the absence of any criterion characteristic of conduct disorder prior to age ten. These individuals tend to be less aggressive and have more normative peer relationships. Often, their aggressive tendencies come out while involved in a group action. The prognosis for an individual with adolescent-onset type is much better than for someone with the childhood-onset type. Because these adolescents have shown the ability to bond to a group, the use of self-help and group therapies can be effective. The adolescent-onset type generally diminishes by adulthood. Conduct disorder symptoms may emerge in someone as young as five or six years old. Generally, the disorder appears during late childhood or early adolescence. Less severe symptoms such as lying and stealing tend to emerge first. As the child grows older and sexually matures, more severe problems such as rape and burglary can appear. It must be remembered that each adolescent is different. It is also important to view the social and economic context of the behavior. Do the adolescents come from a war-ravaged nation or are they constantly exposed to violence and harm in their families and communities? Symptoms that fit a conduct disorder diagnosis might be perceived as survival skills in the above contexts. Because individuals diagnosed with conduct disorder tend to tell lies, the use of "observers" is often necessary. Noncompliance with authority figures creates child-teacher and child-parent interaction problems that may result in less cognitive stimulation as the individual gets rejected both at home and at school. Continued aggression makes the conduct-disordered preadolescent and adolescent unattractive to peers. This occurs during a development period where social and physical status is critically important. Aggressive and noncompliant actions in the classroom create an environment where teachers and other school staff reject the individual. The above is a recipe for continuing and exaggerated problems. Because of school and parental lack of interest, the individual has more unstructured and unsupervised time, time which may be spent with those of similar mind and experience. The individual has been alienated from family culture, successful school orientation, and socially oriented peers. The individual with conduct disorder may now join a gang or hang out with others who have demonstrated failure in school and other social endeavors. The affiliation with a deviant peer group provides a different type of education. Peer modeling of criminal and delinquent behavior, including substance abuse, is the norm. If the adolescent is arrested and incarcerated, experiences with other deviant peers in the juvenile justice setting create advanced learning opportunities in deviant behavior. Promising Treatments A number of

different interventions have been used to treat youth with conduct disorder. Cognitive therapy, behavioral therapy, and combination cognitive-behavioral therapy are most frequently utilized. The greatest difficulty arises from the fact that conduct disorders impacts not only the adolescent but also his or her family, school, and community. Family-based interventions have consistently demonstrated the ability to positively alter behavior. Two approaches to the treatment of conduct disorder that have gained empirical support are briefly discussed below. Parent Management Training Considerable evidence supports the use of parent training techniques based on social and behavioral learning theory for youth with conduct disorder. These interventions have been successfully implemented in the clinic and in the home using individual or group sessions. Parent management training is more effective in reducing behavior problems in younger children than in older adolescents. Multisystemic Therapy Multisystemic therapy conceptualizes behavior as being linked with the various aspects of the multiple systems in which the adolescent is embedded. This includes the family, peers, schools, and neighborhood. Interventions are designed for all levels to 1 promote disengagement from deviant peers, 2 build stronger bonds to the family and school, 3 enhance family skills such as monitoring and discipline, and 4 develop greater social and academic competence in the adolescent. Conduct disorder is difficult to treat. In many ways the role of a parent is appropriate. Being fair these are the rules , being consistent you interpret the rules the same way every time , and being available a positive role model are the greatest and most needed gifts you can give these adolescents. For many, these gifts have never been experienced before. Excerpted from Nuckols, C. Professional Development Our online courses will help you expand your knowledge about alcohol and drug addiction and mental health disorders. Each of these models of therapy has been proven successful when used in community addiction treatment programs. Cognitive-Behavioral Therapy, utilizes cognitive-behavioral therapy CBT principles to address the most common psychiatric problems in both mental health and addiction treatment settings.

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Chapter 9 : Conduct: Disorder in children and adolescents - INSERM Collective Expert Reports - NCBI Boo

Conduct disorder is a serious behavioral and emotional disorder that can occur in children and teens.A child with this disorder may display a pattern of disruptive and violent behavior and have.

Under the terms of the applicable license agreement governing use of the Encyclopedia of Social Work accessed online, an authorized individual user may print out a PDF of a single article for personal use, only for details see Privacy Policy and Legal Notice. This entry provides an overview of some of the most commonly seen disorders in children and adolescents: The prevalence, course, diagnostic criteria, assessment guidelines, and treatment interventions are reviewed for each disorder. In addition, the key role of social workers in the identification and intervention of these disorders, as well as ways social workers can support the children and families experiencing these disorders, is discussed. There is not a clear distinction between childhood and adult disorders because disorders commonly diagnosed in childhood often continue into adulthood, and adult disorders are typically rooted in early childhood conditions and experiences. However, DSM-5 APA, no longer includes this category, and so disorders formerly included in the category have been moved to categories more reflective of related symptomology, presentation, and etiology. These new categories include neurodevelopmental disorders and disruptive, impulse control, and conduct disorders. This entry focuses on some of the most commonly diagnosed and recognized mental-health disorders in children and adolescents, including attention deficit hyperactivity disorder ADHD , oppositional defiant disorder ODD , conduct disorder CD , separation anxiety disorder SAD , and specific learning disorders. This entry provides a broad overview of these diagnoses and is not meant to be used for diagnostic purposes. When making a diagnosis, the DSM-5 APA, should be consulted for a listing of full diagnostic criteria related to each disorder. This encyclopedia also contains other entries that deal with mental-health issues in children and adolescents, including autism spectrum disorder; youth suicide; intellectual disabilities; mental health, adolescents; and mental illness, children. The behaviors are severe enough to cause problems at home, in school, and with peers. One major limitation is that few studies of high quality have been conducted to explore the prevalence of ADHD across racial and ethnic groups. In the prior edition, ADHD was included in the diagnostic category disorders usually first diagnosed in infancy, childhood, or adolescence, which has been removed as a category. The DSM-5 APA, diagnostic criteria for ADHD specify that there must be six or more symptoms of inattention or hyperactivity and impulsivity that interfere with functioning and are inconsistent with developmental level for at least six months. Common symptoms of inattentiveness include difficulty sustaining attention in tasks or play activities, difficulty following instructions and failing to finish schoolwork, and difficulty organizing tasks and activities. Additionally, symptoms should not be better accounted for by another mental disorder and should not occur exclusively within the course of pervasive developmental disorder, schizophrenia, or another psychotic disorder. Attention deficit hyperactivity disorder, combined type, is diagnosed if there are six or more inattentive symptoms and six or more hyperactive or impulsive symptoms. Attention deficit hyperactivity disorder, predominantly inattentive type, is diagnosed if there are six or more inattentive symptoms but hyperactiveâ€”impulsive symptom requirements are not met. Attention deficit hyperactivity disorder, predominantly hyperactiveâ€”impulsive type, is diagnosed if there are six or more hyperactive and impulsive symptoms but inattentive symptom requirements are not met. Specification is also required to describe symptoms as mild, moderate, or severe. Course Although symptoms of ADHD, such as excessive physical activity, are often reported by parents in children as young as toddlers, ADHD is typically not diagnosed until children begin elementary school. The symptoms of ADHD tend to be consistent through early adolescence. For many children with ADHD, the motor hyperactivity subsides somewhat during adolescence but impulsivity, inattention, restlessness, and difficulty planning remain persistent APA, With treatment, symptoms of ADHD can be managed successfully, but the disorder often persists into adulthood. Assessment Evaluation for ADHD should include information from multiple sources

across settings including parents, schools, and the child, if possible. Several commonly used behavior rating scales are used in the assessment of ADHD. In addition, clinicians should consider cultural factors when conducting an assessment because various cultural groups have differing norms regarding child behavior APA, These include Adderall, Ritalin, Concerta, and Strattera. If none of the approved medications results in satisfactory improvement, the Practice Parameters recommend a review of the diagnosis and then consideration of behavior therapy or use of medications not approved by the Food and Drug Administration for ADHD treatment. These may include antidepressants such as bupropion, imipramine, nortriptyline, or 2-adrenergic agonists such as clonidine or guanfacine. Dosages should be adjusted to ensure the child is obtaining the greatest benefit from the medication with minimal adverse side effects American Academy of Pediatrics, For many children, pharmacological treatment combined with behavioral therapy is more effective than either one alone Power et al. Behavioral interventions typically include components such as token economies, time-outs, and other incentives and interventions to which the child is individually responsive. Classroom behavioral interventions are also often required to assist children with ADHD in managing their behaviors at school and improving academic performance. Barkley has observed that ADHD treatment tends to be most helpful when it is directed at behaviors at the point of performance in the natural environment. Parent training is most likely to be helpful when combined with psychopharmacological and behavioral therapies in a holistic fashion. Oppositional Defiant Disorder Children with ODD typically display an irritable or angry mood, are frequently defiant or argumentative, and are vindictive toward others APA, The behavioral manifestation of ODD often makes it difficult for a child to perform at his or her full potential. The average prevalence rate appears to be approximately 3. Oppositional defiant disorder seems to be more common in males than in females during early childhood, but in adolescence it appears equally prevalent in males and females APA, In the prior edition, ODD was included in the diagnostic category of disorders usually first diagnosed in infancy, childhood, or adolescence, which has been removed as a category. The DSM-5 APA, criteria for ODD specify that there must be a pattern of negativistic, hostile, and defiant behavior operationalized by the presence of four or more symptoms that occur for at least six months. These symptoms include often losing temper, frequently defying or refusing to comply with adult requests, and deliberately annoying others. For children under the age of five, the behaviors should occur on most days, and for individuals older than five, the behaviors should occur at least once per week. These behaviors should occur more frequently than is typical for the age and developmental level of the individual. The DSM-5 APA, also specifies that these behaviors must be causing clinically significant impairment in social, academic, or occupational functioning and must not occur exclusively during a psychotic or mood disorder. Risk Factors Oppositional defiant disorder is believed to stem from a mix of biological, psychological, and social factors. It does appear that various temperamental factors, such as limited frustration tolerance and emotional reactivity, are related to ODD. In addition, inconsistent or harsh child-rearing practices may contribute to the development of ODD. Certain neurobiological markers have been associated with ODD as well, but again, those markers have not been distinguished from those of CD APA, Course Oppositional defiant disorder is usually manifest by age eight Connor, and is relatively stable over time. With increasing age, comorbidities with diagnoses such as ADHD, learning disorders, communication disorders, anxiety disorders, and mood disorders begin to appear APA, ; Lavigne et al. Assessment A wide range of interviews and instruments are available for assessing oppositional behavior and aggression in children and adolescents in different settings. A number of assessment batteries have also been developed to aid in assessment. One of the challenges of assessment is that children often do not display the same behaviors during a clinical interview as they do in their natural environments. Therefore, the reports of parents, teachers, and other appropriate observers are particularly critical to obtaining a complete clinical picture APA, In preschool children, programs such as Head Start Connor, and home visitation to high-risk families have produced positive outcomes Eckenrode et al. In school-age children, parent management strategies have strong empirical support for disruptive behavior. In general, these approaches focus on the following four principles: Conduct Disorder Conduct disorder is

characterized by a persistent pattern of behavior that violates age-appropriate social norms and interferes with the basic rights of others. Behaviors typically observed in CD include aggression and violence to others, property damage, deceitfulness, and serious rule violations APA, These behaviors exceed what is developmentally appropriate and interfere with social, school, and occupational functioning. Conduct disorder is typically seen more frequently as children enter adolescence and boys have higher prevalence rates of CD than girls. Rates of CD appear relatively stable across countries that differ with respect to race and ethnicity APA, In the prior edition, CD was included in the diagnostic category of disorders usually first diagnosed in infancy, childhood, or adolescence, which has been removed as a category. The DSM-5 APA, criteria for CD specify that there must be a repetitive pattern of behavior that violates the basic rights of others or major age-appropriate societal norms as evidenced by the presence of three or more of the identified symptoms in a period of 12 months, with at least one of the criterion present in the past 6 months. Those symptoms include aggression to people or animals, destruction of property, and serious rule violations such as running away repeatedly and school truancy. The behavior must be causing clinically significant impairment in social, academic, or occupational functioning. The disorder is considered to have childhood onset if behavior occurred prior to age 10 and adolescent onset if behavior did not occur until after age There is a diagnostic specifier included in the DSM-5 APA, for callousâ€"unemotional presentation, which is given if the person displays at least two of the following traits in the past 12 months: Severity is specified as mild, moderate, or severe. Conduct disorder shares similar symptoms with ODD, but can be distinguished by the severity of the symptoms presented in CD. Risk Factors A variety of factors have been associated with an increased risk of developing CD. There does appear to be a genetic component to CD. Children with a parent or sibling previously diagnosed with CD are more likely to develop it themselves APA, Child temperament also appears to play a role in the formation of CD, with children who display aggression at very young ages being more likely to manifest CD in adolescence Mandel, Difficulties forming friendships and peer rejection have also been linked to CD Holmes et al. At the community level, high rates of violence are a risk factor as well APA, Course Conduct disorder can develop as early as the preschool years, but symptoms most typically begin to present during the middle childhood years through adolescence APA, The course of CD varies significantly. It is common for many individuals diagnosed with CD, particularly those with an adolescent onset and mild symptoms, to become adjusted adults with stable social and occupational functioning. However, individuals with an early onset and more severe behaviors have a worse prognosis and are at risk of criminal behavior, substance-related disorders, and a variety of additional psychiatric disorders as adults APA, For those individuals whose CD extends into adulthood and involves continued aggression, violence, deceitfulness, and rule violation at home and work, a diagnosis of antisocial personality disorder may be appropriate APA, Assessment The assessment of CD requires a comprehensive evaluation. In addition, various assessment scales, such as the Conners Rating Scale parent and teacher versions Conners et al. All sources of information should be considered when completing the assessment. Treatment Intervention with children and adolescents diagnosed with CD is generally most effective when it takes a biopsychosocial approach, is multimodal, and is multisystemic Gerten, Primary components of treatment for CD include the development of prosocial skills and prosocial peer relationships. A combination of behavioral therapy and psychotherapy is often needed to assist children and adolescents with CD in learning to express emotions and manage their behaviors. Social skills training can also be used to develop problem-solving abilities and form supportive relationships AACAP, For some children, medication may also be used to address impulse-control problems and stabilize aggressive outbursts AACAP, Separation Anxiety Disorder Prevalence Separation anxiety disorder is one of the earliest and most common mental-health disorders of childhood Kessler et al. Research regarding the prevalence of SAD among girls and boys has yielded mixed results. Generally, SAD appears to be equally common among girls and boys in clinical samples, whereas it is more frequently seen in females in community samples APA, Diagnosis The DSM-5 APA, diagnostic criterion for SAD requires the existence of developmentally inappropriate and excessive anxiety concerning separation from those to whom the individual

is attached. This anxiety is evidenced by at least three symptoms such as the following: In addition, the fear, anxiety, or avoidance must be persistent for at least four weeks in children and adolescents. The anxiety must also cause clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.