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Conduct disorders in children – from diagnosis to therapy

Abstract: Conduct disorders in children and adolescents are associated with the risk of developing criminal behavior in the future. They negatively affect the child's development as well as the functioning of its social environment – parents, teachers and peers. For these reasons, they require early diagnosis and intervention. The data on the limited effectiveness of therapeutic interventions are worrying, especially if they are undertaken in the context of already established disorders. Specialists propose a variety of influences aimed at strengthening the relationships in which children participate, correcting children's beliefs about themselves, other people and the world, and changing undesirable behaviors. The article describes the essence of behavioral disorders, their types, diagnostic dilemmas, etiology and selected therapies.
Key words: conduct disorder, risk group, conduct disorder therapy.

Introduction – about the symptoms of conduct disorders

Conduct disorders in children have aroused the interest of researchers for years: their immediate ailment and expected negative consequences mobilize the search for educational and therapeutic solutions aimed at their regulation.

The term "conduct disorder" is sometimes used in different contexts; 1. colloquial, in which case it usually means rule-breaking, 2. as a jurisprudential category in the field of education law (Kołakowski 2020a), covering a variety of

difficult behaviors of children and, finally, as 3. a diagnosis made on the basis of strict diagnostic criteria of classification systems, primarily DSM[1] and ICD[2]. The inclusion of conduct disorders in classification systems reflects the commonly accepted scientific understanding of these behaviors, in terms of etiology, essence and therapeutic perspectives – while it is free from moral evaluation of these problems, which is not obvious when other perspectives are adopted to analyze the issues (Morrison 2016).

Classification systems of mental disorders indicate that the essence of the problems discussed here are difficulties in regulating emotions and behavior (Morrison 2016).

In the DSM V, which is the system most often cited in clinical research and more widely, in the literature, the category of disorganization, impulse control and conduct disorders includes oppositional defiant disorder (ODD). These range, depending on the intensity, from relatively mild transgressions of norms based on cultural expectations of defying authority figures or educators(Morrison 2016), to serious violations of laws and social rules. It is necessary to distinguish, although sometimes it is difficult, the developmental pursuit of independence and self-determination of young people from the noncompliance behavior of children and adolescents, which already enters the realm of psychopathology. The criteria for this distinction are rooted in a particular culture, social rules, sometimes difficult to verbalize.

Easiness to become irritated or angry, provocative or argumentative behavior, vindictiveness – these are the most important areas of characteristics of emotions and behavior that may suggest the ODD. In the process of making a diagnosis, other evaluation criteria should be taken into account, related, for example, to the timing and severity of symptoms. If the diagnosis is made, it means that the child has established patterns of negative, rebellious, provocative and/or destructive behavior (Kołakowski 2020a).

ODD is most often diagnosed at school age (Kołakowski 2020a), although the first symptoms appear as early as preschool. Resolving the dilemma: ODD or "rebellious child"[3] is easier to grasp *post factum*, when it is apparent whether difficulties in sticking to rules were a predictor or early symptom of the disorder, or whether they were merely a manifestation of a difficult temperament or parenting problems related, for example, to the child's personality or family characteristics.

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[1] As of May 2013, the fifth version of the classification proposed by the American Psychiatric Association is in effect.

[2] In May 2019, the preparation of the 11th version of the ICD was completed (this classification is the result of the work of experts invited by the WHO), it will be effective from January 2022, currently the current version is still the 10th one, although due to the change in the way disorders are included in clinical practice and research, many specialists already refer to the ICD 11.

[3] By this I mean a child defying his/her parents, but one whose behavior falls within the developmental norm area.

Another diagnostic category in the same group of diagnoses, proposed by DSM V, is conduct disorder (CD), which is expressed by an established pattern of aggressive, rebellious and/or antisocial behavior. These behaviors are also characterized by significant stability (Schaffer 2013) over the course of life, which, however, does not determine the ineffectiveness of the treatment and therapy undertaken (Nelson, Finch, Ghee, 2010). One can distinguish between CD with an early (less promising) or late (relatively more favorable) onset. CD predictors are usually observable even in very young children, for example when they get angry quickly in an uncontrollable manner, show signs of angry affect, blame others (Kołakowski 2020a).

The latest version of the classification system proposed by the WHO, the ICD 11, proposes the category of destructive and dissocial behavior to describe the above problems. It includes oppositional defiant disorder and dissocial behavior disorder, and these categories can be applied to all age groups.[4] These diagnoses do not, of course, exhaust the possible causes of aggressive behavior, which can occur in the course of many diseases or disorders. Compared to the ICD 10, which is still in effect, this proposal is simpler, not requiring a distinction between types of conduct disorders (limited or not to the family environment, with a normal or abnormal socialization process) – which, in any case, reflects one of the main assumptions underlying the revision of this classification system. Hereinafter, the term "conduct disorders" will be used implicitly to mean a set of behaviors from the field of psychopathology, diagnosable using DSM or ICD criteria.

Conduct disorders understood as a psychiatric diagnosis should therefore be distinguished from aggressive behavior or lawbreaking (Kołakowski 2020a). Colloquially, these terms are sometimes used interchangeably, for the reason that conduct disorders include, among other things, aggressive behavior and often result in breaking the law. However, it is worth remembering that, on the one hand, we distinguish different types of aggression (Kołakowski 2020a), and lawbreaking occurs for a wide variety of reasons; conduct disorders are only one of them, on the other hand, conduct disorders involve the specific functioning of a person on many levels: of neurological basis, characteristic way of experiencing emotions and constructing an image of the world, and finally at the level of behavior, available for direct observation. Therefore, they are not limited to aggression.

The above-mentioned behaviors of children causing difficulties for caregivers can be determined by a variety of causes, so the process of diagnosis goes beyond stating and describing them – it also includes the so-called differential diagnosis, which involves ruling out other possible causes of symptoms.

[4] ICD-11 Mental, behavioral or neurodevelopmental disorders: innovations and managing implementation, Wolfgang Gaebel, Ariane Kerst, Archives of Psychiatry and Psychotherapy, 2019; 3, 7–12

Diagnosis – selected issues

The diagnostic process itself is subject to a high risk of error: for example, oppositional defiant disorder and conduct disorder are sometimes diagnosed in a situation of unclear symptoms (e.g., getting irritated easily, sensitivity), which, as it turns out, in adolescence preceded the full expression of bipolar disorder. The course of mania in children and adolescents includes difficulties with behavioral control – which may suggest CD and often this diagnosis is made as the more likely one.

There is also possibility that behaviors suggestive of ODD or CD represent children's reactions to extremely difficult situations they have witnessed or been forced to participate in. Post-traumatic stress syndrome, which is a possible response to such situations, increases the risk of mental health problems, in this case conduct disorders. Thus, a diagnosis of PTSD does not exclude other diagnoses: it may happen that the symptoms of PTSD are misinterpreted as symptoms of ODD or CD, but it may happen that PTSD becomes part of the process of psychopathology, becomes a trigger for it, an environmental risk factor leading to the development of conduct disorders.

When children are raised in conditions that cause them to be insecure, in a situation of constant danger, violence, neglect or other factors related to the failure to meet children's vital needs, they may develop what is known as Complex-PTSD. This diagnosis, included in the ICD 11, covers the entire spectrum of possible symptoms, with the key being problems with regulation in three spheres: intrapersonal, including, among others, the area of self-esteem, problems in regulating emotions, and varied problems in interpersonal relationships. Analysis of the individual developmental paths of children experiencing Complex PTSD indicates that difficulties with anger regulation, the occurrence of aggressive behavior is one of the variants of Complex PTSD expression.

Another disorder that often co-occurs with ODD or CD and is sometimes confused with them is attention deficit hyperactivity disorder. ADHD and ODD/CD are placed in a single group in the American Psychiatric Association's classification: externalizing behavior (Kołakowski 2020a), reflecting not only some similarities in symptoms, but also those in terms of etiology and, in part, treatment. The co-occurrence of these disorders worsens a child's prognosis, not only those relating to the intensity and duration of symptoms over time, but also those relating to his or her future at school, at work, and related to functioning in intimate relationships or social relationships more broadly(Kołakowski 2020a). Risks regarding substance abuse or trespassing are also multiplied (Kołakowski 2020a).

Conduct disorders are associated with the risk of developing personality disorders, especially antisocial personality disorders. Personality disorders are generally diagnosed in adulthood, as before then the personality remains in the

process of intensive development. In recent years, perhaps due to the widespread acceptance of the assumption that the process of personality development actually lasts a lifetime, the position in psychopathology that personality disorders can be diagnosed earlier has become increasingly clear. There is no doubt that traits such as sensitivity to rejection, a tendency to attribute hostile intentions to others, occurrence of violent behavior, inability to maintain stable and enduring emotional relationships (Lenkiewicz, Srebnicki, Bryńska, 2015) can be either a predictor or an early symptom of these disorders.

Above mentioned are only a few possible problems from the field of psychopathology, which enter into various relations with personality disorders: they are confused with it, co-occur with it, are their predictor. The full differential diagnosis is, of course, much more complex.

Conduct disorders are one of the most important reasons for reporting to psychiatrists, psychologists, educators. "Acting-out" disorganizes family, preschool or school life, and indicates that children who behave like this fall within the risk group for other externalizing or disorganizing disorders (Nelson, Finch, Ghee, 2010) and, to a lesser extent, internalizing disorders. It foreshadows aggressive behavior in adulthood and can, importantly from the point of view of social functioning, be a predictor of criminal behavior. Moreover, in the course of development, difficult behaviors accumulate and "pile up" (Lochman., Powell, Whidby, FitzGerald, 2010) the risk of addictions and poorer academic performance increases, which is associated with reduced career prospects (Johnson, McGue, Iacono, 2005), premature parenthood, various law-breaking behaviors or truancy (Lochman, Powell, Whidby, FitzGerald, 2010).

The aforementioned factors enter into a feedback system with each other (Johnson, McGue, Iacono 2005) which negatively affects therapeutic prospects if treatment is already implemented at the time of secondary consequences of conduct disorders. As some (Kołakowski 2020b) point out, in the case of full-blown conduct disorders, there are no "good and effective ways to deal with them" if the problem persists. It is therefore advisable to diagnose children at risk for conduct disorders as early as possible and provide multifaceted therapy as early as preschool age.

It is easy to conclude that behavioral problems so difficult to correct, are associated with significant costs incurred for their treatment and therapy, but – what is even more important from the point of view of pedagogical and psychological science – it also means a high probability of losing the sense of security of other children sharing space, experience of education or life with those who show aggressive behavior. The negative psychological effects of these behaviors also occur for parents and teachers struggling with these issues (Nelson, Finch, Ghee 2010). Adults report low effectiveness of educational and therapeutic interventions – as reflected in the persistence of aggressive behavior over the years (Schaffer 2013). Frequently, the result is a sense of helplessness in educators, their anger and sadness.

Etiology

The etiology of conduct disorders is complex; many risk factors co-occur and enter into multidirectional relationships with each other. In fact, "for both CD and ODD, the fundamental questions of etiology and mechanisms of onset remain unresolved" (Kazdin 2020). Genetic factors and those related to the quality of the family environment, but also peer and educational environment can be distinguished as the most significant (del Valle, Kelley, Seoanes 2001).

Studies aimed at determining the genetic significance of the etiological factor of these behaviors lead to the conclusion of its relevance (Johnson, McGue, Iacono 2005). The contribution of the genetic factor to these disorders is likely to be stronger in children in whom the expression of the problem occurs as early as early childhood (Johnson, McGue, Iacono 2005). It has been established that children who are easily angered, show difficulty in maintaining attention, and who are impulsive are more prone than others to externalizing disorders, including attention problems (Barkley 1997). However, it should be noted that the mentioned traits can be regarded as predisposing to disorders or already constituting a disorder; depending on their intensity and extent. However, one can look for specificity within dopamine, adrenaline and serotonin metabolism as characteristic of children with the problems described.

In the pedagogical and psychological literature, the awareness of the importance of the quality of the family environment for the course of the processes of formation of a person is widespread and has been established for years (Goldenberg, Goldenberg 2006; Twardowski 2012; Nowak 2016). Many researchers link children's conduct difficulties (disobedience, norm breaking, aggression) to certain characteristics of the home environment (Mash, Barkley 1998). It has been noted that behavior in the parent-child system is based on escalating cycles of coercion and resistance, which sometimes results from ineffective issuance of commands, requests to the child or rulet (del Valle, Kelley, Seoanes 2001). It has also been found that ODD is associated with numerous negative messages directed from mothers toward their children (Mash, Barkley 1998) (such a correlation was also confirmed by the author of the text with regard to children with ADHD) (Kubiak 2005). It is impossible to determine whether the primary cause in such situations is the child's temperamental traits, difficulties with biological regulation on the child's part, or the parent's lower competence regarding empathetic support for the child on the one hand and setting limits on the other[5].

Adopting this perspective of the possible etiology of conduct disorders is consistent with an analysis of the beliefs of children experiencing them.

[5] I describe a similar mechanism in the book Być matką dziecka nadpobudliwego, Poznań 2007.

Specifics of functioning of children with conduct disorders

As early as the 1950s, researchers (Shapiro 1957) analyzed the beliefs of children demonstrating inappropriate[6] behavior: they believed, among other things, that direct means of achieving goals were more effective than any other means, that is, assuming mediation or negotiation. It was also pointed out that a sense of rejection and insecurity is present in the inner experience of children (McCord, McCord, Howard 1961). Later studiem (Lochman, Powell, Whidby, FitzGerald 2010) provide a better understanding of the inner world of children and adolescents with the described problem, but do not contradict the cited findings.

It has been established that aggressive children, including those with conduct disorders, differ from others in terms of their characteristic cognitive style. The biggest differences relate to different perceptions of social reality (Lochman, Powell, Whidby, FitzGerald 2010). And so, they may interpret neutral signals from the environment as hostile, resulting in increased levels of anxiety and anger that are inadequate to external events, but adequate to the children's internal reality[7]. In addition to over-sensitivity to signals of hostility[8], they also underestimate their own aggressiveness and ignore it (Nelson, Finch, Ghee 2010). Children perceive the world as hostile, which is sometimes the impetus for them to engage in thoughts and then actions related to pre-emptive attack. They tend to resolve situations not with negotiation or even verbal aggression, but with physical aggression directly aimed at harming the partner in the interaction (Lochman, Lampron 1986). This is the result of, among other things, misjudging one's own arousal as anger (Nelson, Finch, Ghee 2010) (rather than choosing among possible multiple interpretations: arousal can, after all, mean excitement, joy, fear, anger, etc.), but also social deficits, including, among others, a lack of ability to ask for help, to negotiate, to apologize. When experiencing frustration (which is very likely when surrounding signals are interpreted as hostile), children reach for direct, aggressive solutions not only in interactions with peers, but also with teachers (Nelson, Finch, Ghee 2010).

In summary, the dissimilarities in the functioning of children with conduct disorders and also oppositional defiant behaviors relate to emotions (repeated anger-anxiety cycles), cognitive patterns, as well as behaviors included in

[6] This contradicts children's perceptions of adult expectations.

[7] We deal with the so-called logic of disorder in the course of all mental disorders – emotional reactions are usually not "suspended in a vacuum" and are a response to our thoughts – cf. Alford, Beck 2005.

[8] I am referring to the aforementioned interpretation of neutral signals as hostile and the overinterpretation of actually occurring hostile signals as more hostile, more threatening, than would be perceived by people without externalizing disorders.

symptoms for the purpose of classification. This means that effective therapeutic management should target changes in all these areas. Traditionally, therapy for externalizing disorders has mainly addressed the behavioral sphere (Kednall 2010).

Conduct disorder therapy

It was mentioned above that a crucial problem is the limited effectiveness of therapeutic interventions aimed at children with conduct disorders. Thus, there is a need to reach for solutions that already involve families at risk and not just those raising children with already-established problems. It is also worth noting that introducing single interventions (e.g., drawing consequences for behavior, setting limits, etc.) is not only ineffective, but may worsen the behavior of the child/teenager (Kołakowski 2020b) – so it is advisable to use long-term therapeutic programs, assuming the persistence and internal dynamics of the change process – which means accepting temporary deterioration during treatment. Guidelines have been developed for the work, which can be read as postulates for standards of treatment of behavioral disorders (Kołakowski 2020b), which take into account, among other things, the need to treat comorbid disorders, the focus on strengthening parents in their parenting role, including in terms of perceived self-efficacy, the assumption of long-term treatment, the inclusion of work on social relations, school problems, striving to establish and maintain cooperation between the home environment, school environment, in many cases also the judicial system. Also, in certain cases, pharmacotherapy and hospital treatment are recommended.

As can be seen from this, the treatment of conduct behavior and oppositional defiant behaviors is a complex, costly and lengthy process. It is aimed not only and not primarily at symptoms: on the contrary, it is now believed that from the point of view of the short- and long-term development of children with externalizing disorders, it is much more important to work in the area of their functional limitations than to focus on symptom reduction (Pelhram, Gnagy, Greiner i in. 2020). Secondary consequences of conduct disorders, such as difficulties in the peer group, functioning in it only vertically (treating people as occupying a position 'below' or 'above' the subject, not as people, colleagues, friends equal in essence to the subject), school problems, occupational problems, inability to solve problems without any conflicts – can leave an adverse mark on the lives of individuals and entire communities, despite the fact that they are not symptoms of disorders according to the definition.

Some of the most commonly used therapeutic interventions are briefly described below, divided into:

- relationship-oriented therapies, which as a principle should be applied as early as possible, preferably to parents and their young children, during the period when attachment patterns are still forming;

— therapies based on cognitive-behavioral theories – while this strand of work with children and adolescents with conduct disorders and oppositional defiant behaviors can be considered the dominant category of psychopedagogical interventions.

The described interventions are, of course, not the only ones in use, on the contrary, numerous and varied therapeutic interventions are currently proposed – the choice of interventions mentioned here is subjective, and made primarily on the basis of the criterion – whether the therapy is "evidence-based" (Metody… 2020).

According to the commonly used in pedagogy division of parental behavior into authoritarian, authoritative and permissive (Baumrind 1966), the authoritative parenting style, combining warmth and readiness to make demands, can be considered the most beneficial for children at risk of conduct disorders. A child raised in such an atmosphere has the chance to experience a safe, supportive relationship with someone they perceive as stronger and therefore providing support and security.

In the search for effective methods of supporting children at risk, programs have been developed to support parent-child interaction. Their assumptions are based on attachment theory. An example of such an intervention is Video Training (VIPP-SD) (Lambermon, van IJzendoorn 1989; Mesman, Stolk, van Zeij i in. 2008). This intervention is intended to ensure the emotional availability of parents to the child, increase their sensitivity to the child's needs, teach an attitude of following these needs, strengthen the ability to support the child in conjunction with making demands on the child, arising from the need for safety or respect for others. This strand of relationship-oriented therapy is applicable to a wide range of developmental and clinical problems, including in the course of aggressive behaviors and conduct disorders or more broadly – when there is a risk of their occurrence (Van Zeijl, Mesman, Koot i in. 2006). Assumptions of therapy based on attachment theory, aimed at supporting relationships, are implemented in various therapeutic programs. In addition to the VIPP-SD mentioned above, interaction therapy (PCIT), based on behavioral reinforcement, is very popular in the treatment of children with disorganizing behavior, and includes a didactic part during which parents are taught parenting skills and then a practice part during which they have the opportunity to practice them (Zisser-Nathenson, Herschell, Eyberg 2010). Parents learn what to do when a child behaves aggressively, breaks rules, exhibits destructive behavior. As early as the 1980s (Zisser-Nathenson, Herschell, Eyberg 2010), the effectiveness of these interventions was proved in a group of children with the behavioral problems described.

The use of interaction-oriented therapy, while it may be considered the treatment of choice in the prevention and management of conduct disorders that are not yet entrenched, may be more justified for younger children[9]. In terms of

[9] Reasons for this include the greater flexibility of attachment patterns during their formation, but also the fact that older children and adolescents may show resistance to such therapy.

older children, programs are used aimed at 1. developing their social skills and skills of coping with problems (Kazdin 2020), 2. strengthening the competence and involvement of parents (Kazdin 2020).

At their core is usually a cognitive-behavioral view of the human being, which implies the assumption that in working with children with externalizing disorders one should aim to change behavior and the cognitive basis of it, that is, basic beliefs about the world (e.g., threatening versus safe, bad versus good people). Cognitive-behavioral therapy is a problem-focused, structured, collaborative therapy (Ambroziak, Kołakowski 2020). A prerequisite for its success is an accurate conceptualization of the problem, updated on an ongoing basis. The standard is to work simultaneously with children affected by the disorder, in the form of individual and/or group therapy, and their parents and teachers, in the form of parenting skills training.

To date, a number of therapeutic programs have been developed and positively verified for effectiveness – among them, for example:

- "The incredible years" (Webster-Stratton, Reid 2020), developed as an in-depth prevention and behavior correction program aimed at parents, teachers and children from their earliest years, with age-appropriate messages (various versions of the program);
- Oregon model of parenting skills training for parents of at-risk children, repeatedly modified (Forgatch, Gerwitz 2020);
- "Coping power", a contextual cognitive-behavioral model of prevention, aimed on the one hand at teaching social competence or developing problem-solving skills in children, and on the other hand at strengthening parental involvement and confidence in implementing discipline (Powell, Lochman, Boxmayer i in. 2020).

These and similar programs are based primarily on behavioral analysis of conduct, with a special place in the analysis of so-called antecedents (what precedes a child's behavior) in how parents relate to their child. The therapist also aims to trigger planning related to problem solving. Since in the case of children with conduct disorders, both they and their parents manifest deficits in coping with problems, especially those of an interpersonal nature, so the whole family can benefit from the program, not just the child/adolescent delegated as a patient.

Sometimes there are reasons to include family therapy in the treatment process as well (Jagielska 2020). This happens, among other things, if the family is found to have disorders in its structure (reversal of hierarchy, entanglement, or intergenerational coalitions), relationships saturated with anxiety and anger, and other serious problems in family functioning. They may have a role in the development of conduct disorders, but given the complex and, to this day, inconclusively described etiology, we can consider these family problems as risk factors, triggering psychopathology, while not their causes in the literal sense.

Summary

In summary, conduct disorder and oppositional defiant disorder are a category of behavior problems of very high social importance. They are sometimes predictors of criminal behavior, including interpersonal violence and psychoactive substance abuse. They represent a significant burden on the family, school, and peers of the person who presents them. They are an obstacle to building relationships, the essence of which is mutual understanding and support. It is not uncommon for these disorders to become enmeshed in a cycle of developing psychopathology that leads to the use of the aforementioned violence or intimidation, destructive to the victim, but also to the perpetrator. Children and then adolescents with behavioral disorders require support, which, however, is difficult to give them – because the way they think and perceive reality makes it difficult to receive it. This type of disorder requires early diagnosis and therapy; otherwise, interventions are ineffective and costs borne by the education, health care, judicial systems are very high.

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