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Case Report

The Importance of Subtypes of Conduct Disorders in Clinical Practice

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Abstract

Introduction: Contemporary diagnostic classification of mental disorders classifies antisocial behavior in children and adolescents under the age of 18 as conduct disorder. Based on the age of onset, there are two subtypes of conduct disorder: Childhood and adolescent onset.

Aim: Aim of the stady reports was to show different aetiologies and developmental courses of conduct disorder in two male patients, age 10 and 16 years, as well as differences in applied treatments and prognosis in the afore-mentioned cases. Individual, family and psychosocial factors related to the disorder in these patients were discussed and brought the obtained results into the context of exsisting literature.

Conclusion: Despite the similar clinical symptoms that led to the diagnosis of conduct disorders, the patients differed in developmental courses of disorder, individual characteristics, individual and family history, family and social conditions, as well as treatment and prognosis. It was emphasized that the existence of subtypes of the conduct disorder according to the onset of disorder, contributes to an easier orientation in clinical work and the choice of more efficient treatments directed to the specific needs of young people with conduct disorders.

Keywords: Adolescent-onset conduct disorder; Childhood-onset conduct disorder

Introduction

Contemporary diagnostic classification of mental disorders classifiesantisocial behaviour in children and adolescents under the age of 18 as conduct disorder [1,2]. This diagnostic category refers to persistent and general forms of antisocial behaviour with significantly impaired family, social and school or work functions, which may or may not include delinquent and criminal activities.

Many biopsychosocial factors contribute to development of the conduct disorder. There are individual factors-genetic factors, personality traits, impulsivity, hyperactivity [3,4], factors related to the family-upbringing, parental conflicts, parental psychopathology, poor quality child care, parental separation and single-parent families [5,6], socio-economic status of the family as well as wider contextual factors-association with deviant peers or exposure to violence in the community. When it comes to personality traits, the greatest risk are callous-unemotional traits which refers to callousness, lack of concern about the feelings of others and lack of remorse [7]. Based on the age of onset, there are two subcategories of conduct problems: Childhood-onset when individuals show at least one symptom characteristic of conduct disorder prior to age 10 years and adolescence-onset conduct disorder with the onset of symptoms during adolescence [2,8].

The aim of the stady reports was to show different aetiologies and developmental courses of conduct disorder in two male patients, age 10 and 16 years, as well as differences in applied treatments and prognosis in the afore-mentioned cases. Individual, family and psychosocial factors related to the disorder in these patients were discussed and brought the obtained results into the context of exsisting literature.

Case Report

Case report 1

Patient NN, aged 10, from an urban environment. He lives with his parents and two younger brothers. The parents live in an extramarital community. He has two adult half-brothers from the mother's first marriage. Reported to a psychiatrist accompanied by his mother, through a referral from the school authorities. The patient behavior included various symptoms: Fights with children, intimidation and cruelty towards other children; property destructiveness (in one school incident, he "tried to burn through a classroom door using a lighter"), theft, lying, disobedience, violation of rules. Behavioural problems have been present from the earliest age-defiant and disobedient behaviour towards authority, verbal aggression towards peers, a low threshold for manifesting physical aggression among peers, violation of school rules and poor motivation for school achievement. He has been a smoker since the age of 10. Frequent interventions by the school counsellor/school psychologist because of the boy's "haughty behaviour and disrespect of authority", school theft and lying. A significant problem was intimidation and extortion of money from children at school. This was why the parents of the "damaged" children addressed the school authorities on several occasions. He went to school irregularly, spending time on the street or in the company of older adolescents, at the bookie's or gaming rooms. The parents did often not know where and with whom the patient spen this time when not at home. He had been caught shoplifting at sports equipment stores several times, which was reported to the competent institutions.

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He did not verbalize the feeling of guilt or remorse in relation to the consequences of his actions, and there was no capacity for deeper emotional attachment and empathy towards others. Insensitive to the suffering of others.

The parents have elementary school education and are not permanently employed. The father has convictions for minor thefts and disturbance of public peace and order i.e. causing fights in the social environment. He was allegedly a volunteer in the regional war events and reports irregularly to the Department of Addictive Disorders for polytoxicomania. The relationship between the parents is disturbed by frequent conflicts and separation, with suspected partner violence. Inconsistent parenting styles, the mother too permissive on the dimension of behaviour control, while the father often used harsh physical violence. The socioeconomic status of the family was extremely low (users of social welfare).

Case report 2

Patient NN, aged 16, from the suburban environment. He reported to a psychiatrist through a referral from the school authorities, accompanied by a teacherfrom the Social Protection Centre. The picture included violation of house rules, occasional thefts, beatings, lying, lack of authority, absence from school. Heteroanamnesis revealed that such behaviour had been present for about 8 months. He also had frequent and prolonged periods of irritability. Verbalised feelings of shame and remorse for individual actions, low level of self-esteem, with insight into his own maladjusted behaviour. During the early years in the elementary school, the adolescent was of "inconspicuous" behaviour, well-adapted and accepted in the peer group. During the lower and upper elementary school grades he regularly attended school and achieved weaker school results. Joined a "risky" peer group at high school-prone to drinking alcohol, shoplifting and causing fightsin the peer environment. Absent from school to the extent that school authorities considered his exclusion from regular schooling. Sometime earlier, he had escaped from the social protection institution, which was reported to the police by the educators.

At the age of 12, after the mother's death, the patient was placed in a foster family following the decision of the social service. According to the data, he had changed three foster families. He has a younger brother who also lives in a foster family. At the age of 15, the patient was placed in a social protection institution. Family history showed that the patient's mother had died of a malignant disease. The father was without permanent employment, performed seasonal jobs, often absent from home, abused alcohol. The father's parenting style had been rated as indifferent and neglecting, which was the reason for separating the children from the biological family.

Discussion

Both patients meet the diagnostic criteria for conduct disorders in accordance with the current diagnostic classifications "at least three of the 15 criteria in the past 12 months, with at least one criterion present in the past 6 months" with significantly impaired social and school functioning [1,2]. The diagnosis was confirmed using Schedule for Affective Disorders and Schizophrenia for School Age Children Present and Lifetime Version (1.0) (K-SADS-PL) [9]. The first patient's medical history reveal edearly-onset conduct problems expressed through defiant, disobedient and hostile behaviour towards the social environment. The results of one study [10], indicated that physical aggression in kindergarten is the best and only predictor of later delinquency. Early-onset conduct disorder is more commonly associated with severe family dysfunction, antisocial problems in parents, hereditary load, perinatal complications, neurocognitive deficit, lower intelligence, hyperactivity, neglect, impulsivity, difficulties at school and problems with peer relationships [11,12]. Some studies indicate that adverse psychosocial factors and early measures of temperament control in the first year of life are strongly related to the childhood-onset conduct disorder and a persistent course in both sexes, while neurodevelopmental deficits have no impact on it [13].

On the question of upbringing, in the first patient report, there was an inefficient parenting style reflected in strict, physical punishment by the father and anoverly permissive dimension of behavioural control by the mother. Some of the risks for the development of conduct disorders, aggression and secondary forms of psychopathy [14,15], include ineffective parenting, broken home as well as educational styles characterized by emotional coldness on the dimension of affection, and excessive strictness or indulgence on the dimension of control [16,17]. Parental conflicts and partner violence are also predictors of antisocial behaviour in children [18].

The first patient's family history revealed the existence of polytoxicomania and psychopathic patterns of behaviour of the father. Studies emphasize that parental history of antisocial behavior, alcoholism and substance abuse increase the risk of conduct disorders in children, through genetic or environmental influence (modeling, parenting) [19,20]. The influence of the father's criminal history as an independent predictor for the development of delinquency in the son is very significant. This transmission of antisocial behaviour across generations is explained by many factors: Continual exposure to many risk factors such as poverty, poor living conditions, disrupted families, choosing a partner similar to oneself, poor children monitoring and inconsistency in the upbringing, genetic transmission mechanisms as well asstigmatization and labelling marking of families whose members are criminals [20].

Although at a younger age character dimensions are not finally formed and differentiated like inolder individuals, one particular characteristic of the patient from the first case report is the lack of guilt and remorse for the consequences of his actions as well lack of concern about the feelings of others. Some authors claim that key psychopathic features (such as dishonesty, lack of guilt and manipulation) can be encountered even in children [21,22]. Callous-unemotional traits in children are considered crucial in determining psychopathy [7]. Despite the notion that the concept of child and adolescent psychopathy is accompanied by numerous controversies [23,24], one advantage of classifying young people with antisocial behavior patterns based on psychopathic traits is to identify risk groups for developing serious criminal careers and developing more effective preventive programs and treatments [25].

The second patient's medical history did not show any early and persistent behavioural problems, but the symptoms of conduct disorder developed in the later period of adolescence. The influence of a risk peer group is evident. Peer influence appears later in relation to individual and family factors. It does not have to be the primary cause of conduct disorders but does represent a risk factor for children who already have high-risk individual and family factors. A larger number of studies find that adolescent subtypes of conduct disorders are

influenced by an association with antisocial peers or seeking social status through delinquent behaviour, even in the absence of personality or family problems. Because of the need for belonging to a peer group, such children are prepared to intensify maladaptive behaviour to the extent that they violate the rights and property of others in order to gain a "sense of belonging and acceptance". The frequency of their anti-social behaviour as well as the extent of violence and delinquency throughout teenage years may be even greater than in permanently antisocial individuals. Persisting problems in adulthood can be the result of antisocial behaviour in adolescence (criminal records, leaving school and addiction to psychoactive substances) [8,11].

The patient from the second report comes from a dysfunctional family burthened by the mother's severe illness and father's alcoholism. A large meta-analysis of studies dealing with the correlation between parental behaviour (especially the emotional relationship of parents towards children) and the children's externalizing behaviours indicates a significant correlation between parental rejection and externalizing problems in children [26]. It was found that aversive family structure variables (the father's absence, divorce, family size, parental unemployment, low socioeconomic status etc.) positively correlate with children's conduct disorders. Parental rejection of the child has proved to be a significant mediator of this correlation [27].

Accoding to the treatment the first patient received a multicomponent treatment. This included an individual social skills training which typically comprises instruction, modeling, rehearsal, role playing with peers, feedback, and discussion [28,29], as well as a Cognitive behavioural anger management training which helps an individual regulate intense emotions and modify cognitive distortions and promotes pro-social behaviours [30]. At the same time, family interventions were conducted through parental counseling, improvement of parent family management and communication skills, and parental training for the consistent monitoring of the child's behaviour [31]. The father was required to continuously engage in the treatment of polytoxicomania at the Department of Addictive Disorders, Clinic for Mental Health Protection. Family interventions had some limitations due to the varying motivation of both the patient and the parents. In cooperation with the school, a mentoring system was introduced and the child's behavior monitored at school. A professional social service team started regular home visits to help improve family functioning. At the initial stage of the treatment, we used pharmacotherapy with small doses of atypical neuroleptic Risperidone. Most research indicates that risperidone is a therapy of choice in the treatment of conduct disorders due to a better profile of adverse effects [32]. Short-term use (up to 4 months) in low doses (up to 1-1.5 mg risperidone daily) is recommended but only in cases of extreme aggression followed by poor emotion control.

Interventions that focus on encouraging personal identity development and increasing contact with prosocialally oriented young people through programs that provide structured after-school activities [33], are beneficial for patients with adolescent-onset conduct disorders. The adolescent from the second case report was subjected to personal development interventions for anger management. These interventions emphasize the need to address issues of motivation, self-esteem, and identity to enable adolescents to make effective use of techniques for self-control [34]. Cooperation with the school counsellor/school psychologist was established to aid with studying. For irritability and depressive equivalents, lower doses of sertraline were included into the pharmacotherapy. Although some theoretical approaches do not explain depression in the antisocial population, empirical findings have unambiguously demonstrated a significantly higher incidence of co-morbidity of antisocial behavior and depression in the young in comparison to individual occurrence of these disorders [35].

In general, taking into account the data related to the patient from the first report, we can expect a worse prognosis related to the outcomes of antisocial behavior [36]. However, the prognosis for adolescence-onset conduct disorders is not as good as it used to be believed. They develop more internalizing problems and life stress and it is not clear whether their problems disappear during adulthood [37]. According to some research [38], members of the adolescent subtype had higher rates of drug and property-related criminal offenses at the age of 26, and more symptoms of depression and anxiety on self-assessment scales compared to those without a history of anti-social behavior in childhood and adolescence.

Conclusion

Case reports of ten and sixteen year-old patients with a diagnosis of conduct disorders resulted from clinical work with young people with conduct disorders. Conduct disorders cover a wide range of behaviour, which makes this diagnosis "very easy to make and very difficult to avoid", especially for inexperienced or overly busy clinicians. It was evident that in spite of similar clinical symptoms leding to the diagnosis of conduct disorder, our patients showed differences in developmental courses of disorder, individual characteristics, life and familial history, family and social factors, as well as treatment and prognosis. It can be concluded that the existence of subtypes of the conduct disorder, based on the onset of disorder, in the diagnostic classification contributes to an easier orientation in clinical work, better understanding of the etiology of disorders and the choice of more efficient treatments directed to the specific needs of young with this disorder.

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