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UNBIASED INFORMATION FOR CHILD PSYCHIATRISTS

Glen Elliott, MD, PhD
Editor-in-Chief

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IN THIS ISSUE

Conduct Disorder in Children and Adolescents

Learning Objectives

After reading these articles, you should be able to:

1. Discuss the significance of a conduct disorder diagnosis for understanding and treating at-risk youths or those already within a juvenile detention setting.
2. Describe the difference between conduct disorder and oppositional defiant disorder in children and adolescents. **3.** Identify the risk for later psychiatric issues for kids who were bully victims as well as perpetrators.

Conduct Disorder and Oppositional Defiant Disorder: A Primer

Michael B. Kelly, MD, clinical assistant professor and the assistant director for the Program in Psychiatry and the Law, Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine

Dr. Kelly has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Vignette:
Richie was a 15-year-old boy referred for evaluation after multiple run-ins with the police for drug possession, fighting, and shoplifting. Richie was the oldest of three boys and looked up to a gang-involved cousin who was in prison for drug trafficking. The patient was enrolled in multisystemic therapy (MST) for both treatment and further evaluation. Richie's MST therapist met with his family 3 to 4 times per week

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In Summary

- Although conduct disorder (CD) and oppositional defiant disorder (ODD) are both disruptive behavior disorders, CD involves more serious violations of rules and social expectations that can include physical aggression and deliberate property destruction.
- Most young people with either CD or ODD have at least one other psychiatric diagnosis such as ADHD, a learning disorder, major depression, or an anxiety disorder.
- Effective treatment for CD may include psychosocial interventions such as parent management training and multisystemic therapy as well as medication to potentially help with aggression or a comorbid diagnosis.

Q&A With the Expert

Understanding Conduct Disorder
Akeem Marsh, MD

Clinical assistant professor, New York University School of Medicine; child psychiatrist, Bellevue Juvenile Justice Mental Health Team, New York

Dr. Marsh has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CCPR: Dr. Marsh, please tell us a little bit about your background.
Dr. Marsh: Sure. I'm formally trained in both general psychiatry and child and adolescent psychiatry but always had an interest in law. In my current position, I work in a juvenile detention setting in New York City as a psychiatrist providing diagnostic evaluations, medication management, individual therapy, and treatment planning. The age range can be from ages 11 through 18, but the average age of the youth that I see is between the ages of 13 and 16.
CCPR: Can you tell us your impression about how the diagnosis of conduct disorder originated and how it's evolved over time?
Dr. Marsh: The diagnosis of conduct disorder started with patients who were

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Conduct Disorder and Oppositional Defiant Disorder: A Primer

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over the first three months of treatment. The therapist encouraged the family to increase their level of supervision over their boys, prevent Richie from smoking marijuana at home, and limit his access to problematic peers. Over the course of treatment, Richie's parents established regular communication with teachers and helped him get involved with a local boxing team after school. Richie's therapist reduced the frequency of visits over the final two months of treatment. At the conclusion of treatment, Richie was meeting curfew consistently, completing school assignments, and no longer testing positive for marijuana. Richie's younger siblings also began doing their school work more consistently and behaving better on the playground.

What is conduct disorder? Are there different types? And more importantly, how can we best treat these patients?

This month's Q & A with Dr. Marsh touches on these issues, and I recommend you read that interview first to give you a basic foundation. In this article, I'll go through the topic in a more structured and systematic way, so that you can get a lay of this complicated land.

Defining terms: Conduct disorder and oppositional defiant disorder

Both conduct disorder (CD) and oppositional defiant disorder (ODD) are under the larger umbrella category of "disruptive behavior disorders."

ODD is defined by a pattern of angry, argumentative, irritable, defiant, and/or vindictive behavior for 6 months or greater. In order to meet full DSM-5 criteria for the disorder, a young person must display 4 or more cardinal symptoms that relate to mood, defiance, and retaliatory behavior (see the table "DSM-5 Criteria for Oppositional Defiant Disorder and Conduct Disorder" on page 4).

In contrast to ODD, CD is identified on the basis of behaviors that often violate the rights of others and break social rules—as opposed to simply being defiant and angry. In order to meet DSM-5 criteria for conduct disorder, a person must meet 3 of 15 diagnostic criteria spanning four separate domains (see the table on page 4). DSM-5 further divides conduct disorder into two subtypes based on age of onset (ie, before or after 10 years of age). Youth who develop conduct disorder prior to age 10 tend to have a less favorable long-term prognosis.

Finally, DSM-5 also includes a "with limited prosocial emotions" specifier for youth with CD who have 2 or more of the following traits: lack of remorse or guilt, callousness or lack of empathy, absence of concerns about performance, and a shallow or deficient affect. Like early age of onset, this specifier implies a poorer prognosis. The limited prosocial emotions specifier is often more colloquially termed psychopathic traits, and these are not unique to CD. Psychopathic traits also occur in ODD and, as in CD, are correlated with worse treatment outcomes.

According to the Centers for Disease Control, around 3.5% of youth between the ages of 3 and 17 years have a behavioral problem such as ODD or CD at any given time. Disruptive behavior disorders are more common in boys than girls by a margin of roughly 2:1 (Perou R et al, *MMWR Surveill Summ* 2013;62(Suppl 2), 1–35). About 40% of youth with ODD go on to develop CD (Loeber R et al, *J Am Acad Child Adolesc Psychiatry* 2000;39(12):1468–1484).

CD and ODD rarely occur as isolated conditions. Most kids with either diagnosis have at least one other psychiatric disorder, the most common being learning disorders, depression, bipolar disorder, anxiety disorders, substance use disorders, and attention-deficit/hyperactivity disorder (ADHD) (Maughan B et al, *J Child Psychol Psychiatry* 2004;45(3):609–621). The combination of ADHD and CD is especially troublesome, since it's associated with substance use disorders and persistent antisocial behavior in adulthood. By the way, adults can also have either CD or ODD—with the provision that those who meet criteria for antisocial personality disorder can't also have CD.

Hot vs. cold aggression

While not incorporated into DSM-5, recent research has found that there are two types of aggression: hot vs. cold. Understanding this distinction will help you in your treatment of patients with CD.

Hot aggression has a defined trigger and is essentially losing one's temper. It is also referred to in the literature with the mnemonic RADI: **R**eactive, **A**ffective, **D**efensive, and **I**mpulsive. A good example from popular culture of hot aggression is the Incredible Hulk.

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EDITORIAL INFORMATION

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This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists, and other health care professionals, with an interest in the diagnosis and treatment of psychiatric disorders.

Conduct Disorder and Oppositional Defiant Disorder: A Primer

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Bruce Banner is a mild-mannered scientist who morphs into "the Hulk" whenever he is threatened or becomes angry. The Hulk's rage is nearly impossible to control.

Cold aggression, by contrast, is more similar to what many people think of as psychopathic aggression. A common mnemonic for it is PIP: **P**lanned, **I**nstrumental, and **P**redatory. An extreme portrayal of cold aggression is Dr. Hannibal Lecter from the book and movie *Silence of the Lambs*. Dr. Lecter coldly calculates and plans violence of all sorts to satisfy his desires, and he is devoid of empathy and remorse.

Youth with a propensity for cold aggression often have reduced biologic reactivity to dangerous and stressful situations. They also tend to be less biologically responsive when observing fearful facial expressions in others and are relatively undeterred by punishment. Cold aggression identifies youth who qualify for DSM-5's specifier, "limited prosocial emotions." Other terms often used for these kids include "callous-unemotional" or "psychopathic" personality traits.

Youth with CD often display mixtures of hot and cold aggression. Understanding a patient's aggression profile is important in terms of your treatment decisions. Youth with CD and hot aggression are more responsive to therapy and medications (Steiner H et al, *Child Adolesc Psychiatry Mental Health* 2011;5:21). Those with cold aggression usually need structured, longer-term, intensive services—a type of care that generally is hard to find.

Risk factors for CD and ODD

While causes of CD of ODD are far from established, there are certain well-known risk factors. These include those you would suspect—poverty, growing up in dangerous neighborhoods with increased risk of exposure to trauma and abuse, inconsistent parenting practices, lack of appropriate supervision, parental incarceration, and associating with delinquent peers. For both CD and ODD, evidence suggests that temperamental factors such as poor emotional regulation during infancy and early childhood are key, especially with inconsistent or ineffective parenting with ODD and harsh, punitive parenting with CD (Manglio R, *Trauma Violence Abuse* 2015;16(3):241–257).

Treatment of CD and ODD

The main treatments available for CD and ODD involve psychosocial interventions and, in some cases, medication for symptom relief. We've put together a table, "Potential Treatments for Conduct Disorder and Oppositional Defiant Disorder," below outlining these interventions.

Psychosocial interventions

Parent management training (PMT) aims to empower parents to retake the reins within the family system, set clear expectations, and incentivize appropriate behavior, all while providing healthy doses of positive reinforcement. In PMT, parents are initially tasked with observing their children's behavior closely so they can create explicit goals and then monitor progress. Parents learn to incentivize positive behaviors through social reinforcers (eg, praise, hugs) and tokens (eg, gold stars, points) that can be exchanged for special activities (such as going out for ice cream or to a baseball game). Parents learn to provide discipline promptly, calmly, and consistently in this approach. PMT has been shown to be quite effective for ODD and ADHD and somewhat effective for CD. This approach works best with school-aged children, although it has been used effectively in conjunction with individual approaches in teens.

Multisystemic therapy (MST) is an approach designed for a subset of conduct-disordered youth who are entrenched in the juvenile justice system and often also have comorbid substance use problems. The technique targets environmental factors that perpetuate juvenile delinquency and substance abuse. MST therapists are on call 24 hours a day to help families stay on track. Over a typical four- to five-month treatment course, MST teaches parents how to better monitor their kids for problematic behaviors. MST therapists also help parents work effectively with

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Potential Treatments for Conduct Disorder and Oppositional Defiant Disorder

Intervention	Details
Psychosocial interventions	
Parent management training (PMT)	Teaches parents how to: • Set clear expectations • Incentivize appropriate behavior • Give consistent, positive reinforcement
Multisystemic therapy (MST)	Teaches parents how to: • Monitor for problematic behaviors • Work effectively with teachers, probation officers, case workers, etc.
Medications *(No medications are FDA approved for the treatment of CD or ODD)*	
Lithium	For aggression
Anticonvulsants • valproic acid • carbamazepine	For aggression
Atypical antipsychotics • risperidone • aripiprazole	For aggression
Stimulants	For impulsivity

Expert Interview
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generally labeled as "bad kids"—juvenile delinquents, so to speak—and then professionals came to the realization that these kids are not necessarily "bad" but that there may be some kind of psychiatric pathology underlying their actions. Over time, mental health professionals developed the criteria we use now, which describe certain patterns of behavior. As per the DSM-5 definition, the behaviors involve violations of age-appropriate societal norms or basic rights of others. Aggression to people and animals, destruction of property, deceitfulness or theft, and serious violations of rules are among the categories used. Three of 15 items listed within the categories must be present for a year, with at least 1 of those items present within the past 6 months. There are also specifiers based on current severity, age of onset, and whether or not limited prosocial emotions are present.

CCPR: Do you find the name of the diagnosis accurate?

Dr. Marsh: I believe that conduct disorder is somewhat useful as a basic description, but the diagnosis doesn't really get at the underlying core issues. The term tries to capture an assortment of signs and symptoms that distinguishes these individuals from ones with other behavioral problems.

CCPR: There are those who say, "Well, of course the original term was juvenile delinquent. All we've done by saying these kids have a conduct disorder is that we've turned a legal term into a mental disorder one." Is this criticism valid?

Dr. Marsh: I think that criticism speaks to two types of groups: First, a certain percentage of kids in the criminal justice system actually do meet criteria for conduct disorder; and second, many kids are labeled as juvenile delinquents just because they are in the detention setting, but they don't necessarily have the pattern of behavior associated with a conduct disorder diagnosis.

CCPR: So there are kids in the criminal justice system who do not have conduct disorder?

Dr. Marsh: Oh, absolutely—many kids, actually. Some kids just made one mistake; others were caught in the wrong place at the wrong time or got involved in the system but didn't actually do anything that would warrant them being in a juvenile facility.

CCPR: DSM distinguishes different subtypes of conduct disorder—childhood onset, adolescent onset, and unspecified onset. Do you think these subtypes are helpful?

Dr. Marsh: These distinctions are useful in one way: Research has shown that kids who have childhood-onset conduct disorder have a poorer prognosis. But this classification doesn't really change treatment approaches for those with a conduct disorder diagnosis. Then there is the recently added qualifier about limited prosocial emotions, which also may be useful. However, I believe the kids who have conduct disorder actually fall into different categories.

CCPR: Can you elaborate on this?

Dr. Marsh: A lot of these kids have complex trauma as a result of experiencing multiple traumatic events over time that may desensitize or predispose them to developing conduct disorder. And there are also kids who have ADHD—often undiagnosed or under- or untreated—that can promote impulsive behaviors over time that eventually result in conduct disorder. Then there is a very small percentage of kids with "pure" conduct disorder, and I'm using quotes because I don't really know how else to describe it. These are kids who have nothing else clearly identifiable and are more likely to have the limited prosocial emotions category. So clinically I see three main categories: first, those who developed the disorder from trauma; second, those who developed it from ADHD; and third, a pure form of conduct disorder with no other clear diagnosis.

CCPR: With younger kids, oppositional defiant disorder is a much more common diagnosis than conduct disorder. Do you think many of these kids go on to develop conduct disorder?

Dr. Marsh: It is something that we see for sure. But not all of the kids who have conduct disorder start with oppositional defiant disorder—though they may have some of the features.

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DSM-5 Criteria for Oppositional Defiant Disorder and Conduct Disorder

Diagnosis	*Oppositional defiant disorder*	*Conduct disorder*
Usual Age of Onset	Ages 2 through 10	Ages 7 through 15
Key Diagnostic Features	**Irritable or angry mood** 1. Loses temper; 2. Touchy; 3. Resentful **Defiant or argumentative behavior** 4. Argues with adults; 5. Defiant; 6. Deliberately annoys; 7. Blames others **Vindictiveness** 8. Repeatedly spiteful	**Aggressive with people or animals** 1. Bullies; 2. Fights; 3. Uses weapons; 4. Physically cruel to people; 5. Physically cruel to animals; 6. Steals while confronting victim; 7. Forces sexual activity **Destructive of property** 8. Fire setting; 9. Other deliberate property destruction **Deceitful and thieving** 10. Breaks into another's property; 11. Tries to con others; 12. Steals valuable items without confronting victim **Seriously violates rules** 13. Stays out at night despite parental rules; 14. Runs away from home; 15. Often truant from school
Minimum Criteria for Diagnosis	At least 4 of above 8 recurrently for at least 6 months	At least 3 of above 15 in past 12 months and at least 1 in past 6 months

Source: Adapted from *American Psychiatric Association Diagnostic and Statistical Manual,* 5th Ed., 2013.

Expert Interview
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CCPR: Does that kind of progression have a different outcome than kids who solely present as conduct disorder?
Dr. Marsh: I think so. Kids who initially had oppositional defiant disorder but later develop conduct disorder may actually do better overall, because it started out as less severe.
CCPR: That's good to know, and it brings us to the topic of treatment. Based on your experience, what advice do you have for the average clinician who's thinking that they may have a patient with conduct disorder?
Dr. Marsh: When I see somebody presenting with those kinds of behaviors, I try to screen them for other things that may be going on as well. A lot of times these kids have some other comorbid condition such as PTSD, depression, or ADHD. If you can treat the comorbidity, then those conduct-type symptoms may improve, oftentimes markedly.
CCPR: Would you say that most kids with conduct disorder need more help than an individual clinician typically can provide?
Dr. Marsh: Yes, absolutely. The child is going to need some wraparound services, if available. Problems in the family unit are often associated with conduct disorder, so family work is usually the number one thing to address. Oftentimes these kids also need some type of educational intervention because if they are going to school, they're usually not doing well academically or may not be in the right setting. And, although I know this sounds really basic, just getting these kids involved in something like an afterschool program or some kind of hobby can be really helpful because it will decrease their idle time so they're not going to be doing other things that they shouldn't.

"Many kids are labeled as juvenile delinquents just because they are in the detention setting, but they don't necessarily have the pattern of behavior associated with a conduct disorder diagnosis."

Akeem Marsh, MD

CCPR: Do you see any differences in the way conduct disorder presents in terms of males versus females?
Dr. Marsh: Absolutely. Of the females who actually end up in detention, there's a higher likelihood of conduct disorder. To be clear, females tend to have lower rates in general, but prevalence in detention may be skewed because there is a much smaller population of girls overall.
CCPR: Interesting. I think many of us have the impression that these kids don't want help or are not likely to accept it. Is this true, in your experience?
Dr. Marsh: On the surface, yes, these kids appear to reject help. Part of the diagnosis, after all, is being oppositional towards authority. Many of these kids have had bad experiences with authority figures and may have had bad experiences with mental health systems. For example, a clinician may have said or done something that was not conducive to the therapeutic relationship. So that's where the resistance comes in. Despite that, I find in general that the kids who are referred for help are much more accepting and willing to engage than most would expect. With this group, you have to take a unique approach; you have to meet them where they are. If you are able to do that, you can work with them.
CCPR: So this is not a population where you want to take a passive stance and wait for them to seek help. It sounds like you need to be more active and show you care.
Dr. Marsh: Exactly.
CCPR: What's your sense of the percentage of kids with conduct disorder that have good outcomes as adults?
Dr. Marsh: If I had to estimate, I'd say about one-third of them would go on to have good outcomes. Right now, the main treatment options are psychosocial interventions, plus the medication interventions with comorbid conditions, but these are all limited as far as effectiveness.
CCPR: How about within the setting of the kids you work with?
Dr. Marsh: Our initial effort focuses on at least getting an accurate diagnosis and determining if they have disorders that are likely to respond to medications and, if so, getting appropriate treatment started. We'd like to think that as a result of our interventions we reduce recidivism, but, of course, learning if that is actually true takes time. We hope that once they leave here, their life circumstances improve or maybe the next treatment team they see on the outside will be able to build on our progress. But despite the lack of objective proof, I do believe we are making a difference, at least in the beginning stages.
CCPR: What is the main ingredient of your psychosocial interventions?
Dr. Marsh: I'd say that a key goal of our intervention is addressing the underlying trauma that many of these youths have become accustomed to. That comes in the form of screening most of the children for trauma-related disorders, providing trauma-informed cognitive behavioral therapy groups, and incorporating trauma-informed care into the milieu.
CCPR: Is trauma something that you recognize in the kids you work with?
Dr. Marsh: Yes. All of the kids who are referred to mental health are thoroughly screened for past traumatic events because that's one of the recommendations for best practices in a detention setting. And we have started looking preliminarily at the data we have, and there appears to be a link between trauma symptoms and conduct disorder.
CCPR: Could you elaborate a bit about how you believe trauma sensitizes kids to conduct disorder?
Dr. Marsh: Many people who end up in the justice system have had exposure to different types of experiences compared to the general population and unfortunately, most often these traumas have never been addressed. You have situations that may have

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Research Updates IN PSYCHIATRY

BULLYING

Getting Bullied as a Kid: Not Good for Your Mental Health

(Sourander A et al, *JAMA Psychiatry* 2016;73(2):159–165)

Previous studies have shown that children who are bullied or who bully others are at higher-than-normal risk to have psychiatric disorders as adults. It's tempting to blame the bullying—but it's possible that the development of adult problems was driven not by bullying, but rather by preexisting psychiatric disorders in childhood. Prior studies have not answered this basic question because of problems with study design, such as not following subjects for a long enough time period. This is the first comprehensive study to address these limitations.

In 1989, researchers randomly selected a sample of 5,034 Finnish 8-year-olds and determined how many were bullying perpetrators or bullying victims. They got this information by interviewing the children, their parents, and their teachers. They also evaluated psychiatric symptoms in these children using a behavior scale that was filled out by parents and teachers. Eight years later, when the kids were 16 years old, the researchers started gathering data about who had been diagnosed with a psychiatric disorder. They gathered these data continually from ages 16 through 29, and then they did some statistical analyses.

Here's what they found: The vast majority of kids—90%—had never been exposed to bullying, either as perpetrators or victims; of those individuals, only 11.5% went on to develop a psychiatric disorder as adults. Bullying increased the risk substantially, with the following adult rates of psychiatric disorders in three different bullying categories: Bullying perpetrators: 19.9%; victims: 23.1%; and kids who were both perpetrators and victims: 31.2%. Being bullied was specifically associated with developing depression.

In order to separate the effect of bullying from the effect of having had a psychiatric problem as a child, the researchers re-ran the analysis among those who were psychiatrically healthy when young. Among this group, being a perpetrator did not lead to later psychiatric disorders—but being a victim or a combo victim-perpetrator did increase the risk.

TCPR's Take: This is likely the most thorough study on the long-term effects of bullying. It's no surprise that kids who were bullying victims were more at risk for later psychiatric issues, even controlling for childhood diagnoses. The implication is that bullying is a form of abuse and is similar to trauma, humiliation, and neglect—all of which have been associated with later depression and other problems. This reinforces the importance of asking about bullying during our evaluations of children.

—Bret A. Moore, Psy.D, ABPP

Dr. Moore has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

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teachers, probation officers, case workers, etc. to ensure that the benefits of MST continue after treatment is terminated. MST has been shown to reduce recidivism and substance abuse and also appears to reduce the likelihood of conduct problems in the siblings of MST clients (Wagner DV et al, *J Consult Clin Psychol* 2014;82(3):492–499).

Medications

There are no FDA-approved medications for the treatment of CD or ODD. However, there's some evidence for the effectiveness of valproic acid, especially for curbing hot aggression (Padhy R et al, *Child Psychiatry Hum Dev* 2011;42(5):584–593). Atypical antipsychotic medications are also effective in reducing hot aggression when used judiciously, while stimulants can improve both CD and ODD when they are comorbid with ADHD (Connor DF and Doerfler LA, *J Atten Disord* 2008;12(2):126–134). There are no hard-and-fast dosing guidelines for treating hot aggression. In general, medications should only be used when behavioral interventions aren't enough. As always in child and adolescent psychiatry, we recommend that you "start low and go slow" when initiating meds on kids, especially those prone to hot aggression. However, medications don't seem to touch kids with cold aggression.

Conclusion

In sum, CD and ODD are serious, often chronic disorders that can produce major problems for the individual, family, and society more broadly. Too often, individuals with these diagnoses are dismissed as "bad apples" and may well end up in the legal system, where effective treatment is unlikely to be available. Accurate diagnosis and intervention, especially of ODD and some subtypes of CD, can be life-changing.

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CME Post-Test

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Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning Objectives are listed on page 1.

1. Which of the following is not a diagnostic symptom of oppositional defiant disorder (ODD)? (Learning Objective #2)
   [ ] a. Frequently losing one's temper [ ] b. Being easily annoyed
   [ ] c. A tendency to be spiteful or vindictive [ ] d. Shoplifting or theft

2. Which of the following comorbid conditions is often present in children and adolescents with conduct disorder (CD)? (LO #1)
   [ ] a. Eating disorders [ ] b. Sleep disorders
   [ ] c. Attention-Deficit/Hyperactivity Disorder [ ] d. Obsessive-compulsive disorder

3. Which of the following statements about CD is true? (LO #2)
   [ ] a. Youth with CD tend to underachieve academically and have less healthy relationships as adults
   [ ] b. Youth with hot aggression tend to be less biologically responsive when observing facial expressions in others and are relatively undeterred by punishment
   [ ] c. Adults can have ODD with the provision that those who meet the criteria for antisocial personality disorder must also have CD
   [ ] d. Disruptive behavior disorders occur equally in males and females

4. Over 50% of those diagnosed with oppositional defiant disorder as children will develop conduct disorder in adolescence. (LO #1)
   [ ] a. True [ ] b. False

5. According to a recent study, what percentage of children who were victims of bullying developed psychiatric disorders as adults? (LO #3)
   [ ] a. between 10% and 15% [ ] b. between 20% and 25%. [ ] c. between 30% and 35% [ ] d. between 40% and 50%

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Expert Interview

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started during early years such as domestic violence, physical abuse, sexual abuse, severe neglect, and community violence. I've heard some children describe their neighborhood as a warzone. Factor in disrupted attachments that can happen as a result of parental absence, abandonment, incarceration, mental illness, or substance use, and you really have someone with insurmountable odds toward healthy psychological development.

CCPR: Could you give some specific examples of the types of trauma you see in these kids?

Dr. Marsh: Kids actually witnessing firsthand other people getting assaulted. Sometimes it's gun violence. They see these things happen and it becomes their language, their way of navigating through the world. So this normalizes violence and normalizes oppositional behaviors.

CCPR: What about issues of ethnicity, socioeconomic status, those kinds of things? Do they play a role in conduct disorder?

Dr. Marsh: From what I see, it appears that true conduct disorder exists across different racial and socioeconomic lines. But the reality is that not everyone ends up in the juvenile justice system. So within the system, it tends to be kids from lower socioeconomic status and the ethnic minority groups, because those are the ones who are less likely to have access to strategic types of resources such as bail or private attorneys.

CCPR: I assume that for these kids, being in the juvenile justice system is not the ideal place for treatment?

Dr. Marsh: Correct. I mean, it is an imperfect system; ideally, it would be set up to be more therapeutic. Talking about therapeutic interventions, it would be far better if we could start with having interventions for youth considered at risk before they become involved in a system. For example, if you have a sibling involved in the system or if you come from a community where there are high rates of incarceration, then you could be considered at risk.

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This Issue's Focus:

Conduct Disorder in Children and Adolescents

Next Time in *The Carlat Child Psychiatry Report:* Eating Disorders in Children and Adolescents

Expert Interview

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CCPR: So more of a preventative model rather than waiting until they're already involved in some legal action. What about gangs? Where do they fit in in all of this?

Dr. Marsh: I would say gangs definitely factor in heavily. What I believe to be the case with the gangs is that they often attract kids who have dysfunctional family units. And because of the organization itself—the gang—kids end up doing certain things that would be considered deviant and as a result will get into trouble somehow.

CCPR: It's certainly difficult to disentangle, but what do you think of the genetics of conduct disorder versus environmental effects?

Dr. Marsh: That's a good question and definitely a tough one. I see a lot of kids as vulnerable, many who suffer from disorders like anxiety and depression. I'd say that, while there is a genetic component, it's probably not obvious for the majority of the kids. Many have some sort of general predisposition more because whatever environment they are in will play a role. However, it's not at all uncommon for a child with conduct disorder to be living with one parent in a high-risk environment and also have an absent parent with a history of conduct disorder. Given that kind of situation, it's really hard to say how much is genetic and how much is environmental—or a combination of both.

CCPR: Thank you for your time, Dr. Marsh.

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