Identification, Diagnosis and Treatment of Conduct Disorder: Implications for School Counsellors in Nigeria

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Abstract

The purpose of this paper is to present a literature–based view of conduct disorder as a major problem which could disrupt children’s academic, social and psychological development and indeed, the stated objectives of the school system. The paper discusses the diagnostic criteria for conduct disorder as defined by the Diagnostic and Statistical Manual of Mental disorders (DSM-V, APA, 2013). It also discusses the aetiology of conduct disorder, symptoms, prevalence among Nigerian adolescents and some psychological/behavioural interventions that can be employed by the professional school counsellor and other mental health practitioners. Implications for professional school counsellors are discussed. This paper recommends that Nigerian school counsellors, brace up to challenging new roles by recognizing societal changes, assessing changing needs and developing the necessary skills to enable them effectively reduce conduct disorder in the school system and in the society.

Key words: Conduct Disorder, School Counsellors, Diagnostic and Statistical Manual of Conduct Disorder (DSM)

Introduction

Conduct disorder has been identified as a psychiatric syndrome occurring in childhood and adolescence and characterised by a persistent pattern of violations of rules and antisocial behaviour. The American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorder (DSM –IV TR) defined conduct disorder as a repetitive and persistent pattern of behaviour in which the basic rights of others or major age appropriate social norms and rules are violated as manifested by the presence of three or more of the following characteristic symptoms: aggression to people, destruction of property, stealing and serious violation of rules in the past twelve months with at least one criterion present in the last six months of behaviour. In the same vein, the America Academy of Child and Adolescent Psychiatry (AACAP) in Egbochuku and Oizimende (2013) defined conduct disorder as a complicated group of behavioural and emotional problems in youngsters. Children and adolescents with these disorders have great difficulty following rules and behaving in a socially acceptable way.
In the process of acquiring formal education, some students manifest behaviours which often are detrimental to their education, social and interpersonal relationship. Some of these behavioural problems which are common among school children today are consequent upon societal, peer and family influences while others reflect the frustrations and confusions in the students. These behavioural problems range from stealing, aggression, violent protest, fighting, rules violations, vandalism, other property crime and assaults which are aspects of conduct disorder (Kolo, 1997). The fact that these problems are common and disruptive makes them a concern for those who work with adolescents. High prevalence of conduct disorder has been found among secondary school children in Nigeria (Oizimende 2011; Frank- Briggs & Alikor, 2008). Children with conduct disorder display difficulties adjusting to classroom environment, exhibit poor social skills, low academic achievement and high aggression. They often have low self-esteem even though their actions make them appear tough or self-assured. These children also have a higher probability of dropping out or being expelled from school than other children if they are not identified and assisted by the professional counsellor or mental health professional. Stair, Campbell and Herrick (2002) opined that young people who do not receive adequate therapeutic treatment for their mental health issues do not reach their full potentials. According to Lahey, Loeber, Burke & Applegate (2005), boys are more likely to be diagnosed with conduct disorder than girls. Boys are also more likely to show aggressive behaviour, threats, vandalism and confrontational behaviour than girls. School children with mental disorders have great needs; often they require psychotherapy, special education and sometimes medication. Counselling, in this regard, would involve help given to an individual (the client) by a professionally trained person (the counsellor), in order to bring out those qualities in the client that conform to the norms of the society while discouraging anti-social tendencies. School counsellors have generally received training similar to clinical psychologists but with emphasis on helping people with more normal life problems, for example, helping individuals make educational and career decisions. However, there is a new trend towards counsellors becoming more involved in helping individuals with more serious mental health problems including some conditions addressed by clinical psychologists, such as depression. The first step in rendering this help is proper diagnosis of the need of the client.

**Diagnosis of Conduct Disorder**
The DSM-V (APA, 2013) defined conduct disorder as a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate social norms are violated. Conduct disorder is diagnosed by the presence of three or more of the following characteristic symptoms in the past twelve month. The diagnostic criteria for conduct disorder (APA, 2013) are listed below:

**DSM-V Diagnostic Criteria for Conduct Disorder**

A. A repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three or more of the following criteria in the past twelve months with at least one criterion present in the last six months:

**Aggression to people and/animals**

1. Often bullies, threatens or intimidates others
2. Often initiates physical fights
3. Has used a weapon that can cause serious physical harm to others (e.g., broken bottle, knife, gun, brick)
4. Has been physically cruel to people
5. Has been physically cruel to animals
6. Has stolen while confronting a victim
7. Has forced someone into sexual activity (rape)

**Destruction of property**

1. Has deliberately engaged in fire setting with intention of causing damage
2. Has deliberately destroyed other people’s property (other than fire-setting), for example, destroying other children’s project work, school furniture and other equipments.

**Deceitfulness and theft**

1. Has broken into someone else’s house, building or car
2. Often lies to obtain goods or favour or to avoid obligations (i.e. “cons” others)
3. Has stolen items of non-trivial value without confronting a victim (e.g. shoplifting but without breaking and entering; forgery)

**Serious Violation of Rules**

1. Often stays out at night without parental permission beginning before age thirteen years.

2. Has run away from home overnight at least twice while living in parental or parental surrogate home or once without returning for a long time.

3. Is often truant from school, beginning before the age of thirteen years.

B. The disturbance in behaviour causes clinically significant impairment in social, academic or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for anti social personality disorder.

In diagnosing conduct disorder, the following should be specified:

**Childhood onset type** – This type is defined by the presence of at least one criterion for characteristic of conduct disorder before the age of ten years. Conduct disorder appears in early or middle childhood as oppositional defiant behaviour and nearly a half of children with early oppositional defiant behaviour have an affective disorder, conduct disorder or both by adolescence (Bernstein, 2011). A careful diagnosis to exclude irritability due to unrecognised internalising disorder is important in childhood cases.

The individuals who are typically boys (Bernstein, 2000), display high levels of aggression, have poor peer and family relationships and the problems tend to persist through adolescence to adulthood. They are more likely to develop adult antisocial personality disorder than individuals with the adolescent onset type.

**Adolescent onset type** – This is defined by the absence of any characteristic criterion of conduct disorder before age ten years. They tend to be less aggressive than persons with the childhood onset type, and have more normative peer relationship. They often display conduct disorder in the company of peer group and are far less likely to develop adult antisocial personality disorder. The prognosis for individuals with this onset type is much better than for persons with the childhood onset type.
The characteristics reflect the individual’s typical pattern of interpersonal and emotional functioning over a period and not just occasional occurrence in some situations. Multiple information sources are therefore necessary. In addition to individual’s self-report, reports from others who have known the individual for extended periods of time should be considered e.g. parents, peers and extended family members.

**Aetiology of Conduct Disorder**

Research on causal factors for conduct disorder suggests a combination of psychological and biological factors (Harris 2004). In the same vein, Searight, Rottnek and Abby(2001) stated that the aetiology of conduct disorder involves an interaction of genetic constitutional, familial and social factors. Conduct disorder has a multi-factorial causation which includes biologic, psychosocial and issues within the family (Busari, 2013). Negative combination of several factors may predispose children to conduct disorder. A number of risk and protective factors exist that can influence and change outcomes and in most cases, conduct disorder develops due to the interactions of risk factors (Murray & Farrington, 2010). The aetiology of conduct disorder involves an interaction of genetic/ constitutional, familial and social factors.

Regarding genetic or constitutional factors, children with conduct disorder may have inherited decreased baseline autonomic nervous system activity requiring greater stimulation to achieve optimal arousal. Impairment in the frontal lobe of the brain has been linked to conduct disorder (Fairchild, Hagan, Walsh, Passamonti, Caulder & Goodyer, 2013). The frontal lobe of the brain regulates emotions and is home to the personality. The frontal lobe of a conduct-disordered person does not function properly causing, among others:
- reduced ability to plan future achievement
- a lack of impulse control
- a reduced ability to learn from past negative consequences of behaviour

The impairment of the frontal lobe may be hereditary caused by damage to the brain from injuries. The hereditary factor may account for the high level of sensation-seeking activity associated with conduct disorder. Smoking during pregnancy can have serious behavioural outcomes in children (University of Chicago Medical Centre as cited in Busari, 2013). Conduct disorder has also been linked to child abuse; drug or alcohol use in parents, family conflicts, and poverty. Socio economic status: Though conduct disorder is found
among adolescents and children across socioeconomic status, it appears to be overrepresented in lower socioeconomic groups (AACAP, 1997). Dysfunctional family is repeatedly identified as a crucial factor for conduct disorder in adolescents. Poor parental supervision is a predictor of violence and vandalism committed by boys. Parents who were diagnosed with conduct disorder predispose their own children to conduct disorder. Low socioeconomic skills and the number of the siblings in the home are associated with greater probability of children exhibiting delinquent behaviour (Busari and Adejumobi, 2012). According to Somerstein (2007), a common family dynamic in the history of male terrorists is authoritarian parenting style. A correlation between unhealthy parenting styles and child psychopathology has been established (Tunde-Ayinmode and Adegunloye, 2011). Besides poor parenting skills, other characteristics and qualities of family life also influence children’s behaviour. Many studies have shown that children exposed to violence subsequently become aggressive (Moffitt and Caspi, 1998). Marital conflict also influences children’s behaviour due to its effect on emotion regulation.

**Symptoms of Conduct Disorder**

Common behaviour associated with conduct disorder include aggression to people and animals (Baker and Scarth, 2002), vandalism and or destruction of property, deceitfulness or theft, serious violation of rules. The clinical features of conduct disorder as listed in DSM-V (APA, 2013) include serious threats of harm to people and/animals, deliberate property destruction/ damage such as in fire setting and vandalism, repeated violation of household or school rules, laws or both and persistent lying to avoid consequences or to obtain tangible goods. These are behavioural symptoms of conduct disorder. Other symptoms may be physical in which the individual has injuries or burns got from being involved in fights and from fire setting respectively. The presence of sexually transmitted diseases in adolescents may also signal behavioural problems. The symptoms may also be cognitive in which the individual has poor decision-making skills, lack concentration and has lower than average intellectual behaviour. Associated features include psychosocial maladjustment manifested in the inability to appreciate the importance of others’ welfare and little or no guilt or remorse about harming others (Evans, 2012). Adolescents with conduct disorder often develop skills in outwardly verbalizing remorse to obtain favour or avoid punishment but do not experience any apparent guilt. Conduct disordered persons often view others as threatening or malicious without an objective basis.
Thus, many of them lash out preemptively and exhibit unprovoked aggression. Many symptoms seen in conduct disordered persons also occur in children and adolescents without conduct disorder but in children with conduct disorder, the symptoms are more frequent and persistent and interfere with learning, school adjustment and peer relationship. Caregivers should be able to distinguish between normal adolescent risk taking and enduring antisocial behaviour.

Prevalence and Incidence in Nigeria

Conduct disorder, according to Evans (2003), is a steady pattern of harming others or their property, lying, stealing or breaking rules of behaviour. Most children normally exhibit instances of poor judgement or bad behaviour during childhood. This must not be confused with conduct disorder which has the characteristics of persistence aggression and lack of empathy. In Nigeria, a good number of adolescents are in different correctional centres mainly due to conduct disorder offences but accurate figures of the prevalent level and degree of severity of the conduct disorder is comparatively unknown (Adeusi, Gesinde and Adekeye, 2015). A pilot study carried out by Egbochuku and Oizimende (2013) among secondary school students in Benin City, Nigeria showed prevalence of conduct disorder among the secondary school adolescents as manifested in the much risk-taking behaviour engaged in by the students. These include serious violation of school rules, assault, threatening and intimidating others, destroying others’ property, truancy. Prevalence of conduct disorder has also been reported in Ibadan, Nigeria (Olley, 2006). In the same vein, Achinike, Alikor, Frank-Briggs and Okoh (2015) confirmed the prevalence of conduct disorder in Port Harcourt, Nigeria. They particularly found a prevalence of attention deficit hyperactivity disorder among school-age children. This is worrisome because conduct disorder interferes with learning, not just that of the individual who is conduct-disordered but also of the schoolmates who are in contact with him/her. Accurate figures of prevalence are imperative as they would serve as baseline data for preventive and remedial strategies. However the results obtained through the research work done on conduct disorder in Nigeria so far indicate a prevalence of conduct disorder in the adolescent population.

Treatment of Conduct Disorder

For treatment to be successful, it must begin early. Also, treatment of conduct disorder requires an approach that addresses both the child/adolescent and his/her
environment. If possible, interventions should address specific contexts as it cannot be assumed that success in one area will generalise to another. For instance, improvement in the home arising from successful parent training programme may not necessarily lead to less anti-social behaviour at school (Scott, 2007). The Nigerian Government has established juvenile courts, special schools and correctional centres to re-educate and re-orient the individuals in conflict with the law, cater for children in conflict with their parents and to prevent delinquency. Parents, caregivers and the society at large often refer cases of adolescent behaviour disorder to juvenile courts, remand or correctional homes but these measures are not sufficient in correcting conduct disorder (Adeusi, 2013). Different psychological interventions like Cognitive Restructuring, behaviour rehearsals, token economy, thought –stopping self-management, reinforcement, modelling and family therapy are measures put in place by professional counsellors and psychologists to treat or correct conduct disorder. Behavioural therapy and psychotherapy can help a child or adolescent with conduct disorder control his or her anger and develop new coping techniques and social skills training can help improve his/her relationship with peers. Family group therapy may also be effective in some cases. In such cases, parents can be counselled on how to set appropriate limits for their children and to be consistent and realistic while disciplining. Family-based interventions have been demonstrated to positively alter behaviour (Bernstein, 2000). A family-based approach is the parent management training (PMT).

**Parent Management Training**

This is designed to improve parents’ behaviour management skills and the quality of parent-child relationship such as development of positive parent-child relationship, using praise and rewards to increase desirable behaviour, giving clear directions and rules, using consistent and calmly executed consequences of unwanted behaviour. Group treatment has been shown to be effective and offers parents opportunity to share their experiences with others who are struggling with disruptive children. According to Scott (2015), some behaviour management program are now teaching parents to read with their children with the idea of targeting multiple risk factors for anti-social negative factors associated. If the home is abusive, effort must be made to move the child to a more supportive environment.
Cognitive Behaviour Therapy and Social Skills Therapy

The four targets of CBT and Social Skills Therapy are to reduce children’s aggressive behaviour, increase pro-social interaction such as entering a group, starting a conversation, participating in group activities, sharing, co-operating, asking questions politely, listening to others and negotiating (Scott, 2007). Other targets include to correct the cognitive deficiencies, distortions and inaccurate self-evaluation exhibited by many of these children and to ameliorate emotional deregulation and self-control problems. This helps to reduce emotional liability, thus enabling the child to be more reflective and able to consider how best to respond in provoking situations.

Cognitive Behaviour Therapy (CBT) is a structured form of psychotherapy that is designed to rapidly and effectively reduce and eliminate psychological symptoms. CBT is effective in treating a wide range of psychological difficulties including depression, anxiety phobia, obsessive compulsive disorder, social anxiety and shyness. CBT challenges adolescents to make conscious choices and to accept full responsibility for their choices. Mathye in Busari (2013) and is effective in treating antisocial behaviour such as stealing (Obalowo, 2004). Cognitive Behaviour Therapy originally was used mainly with school-age children and adults but more recently have been successfully adapted for pre-school-age children. They may be delivered in individual or group therapy.

Social skills training (SST) is a fundamental factor in relationship formation. Social skills represent a set of skills and techniques used to harmonize or develop a positive interpersonal relationship among individuals. It is a constructive process that involves assertive communication, modelling and management of feelings. Social skills training have been successfully applied by Cook (2003) in helping adolescents become more competent in social skills. Azimah and Khairani (2009) used Social Skills Training successfully in changing students’ unacceptable behaviour.

Self-management skills (SMS) involve the use of three basic skills of self-assessment, self-monitoring and self-reinforcement. Using self-assessment, the student assesses on behaviour to determine whether it should be reinforced or not. In self-monitoring, the student monitors own progress in order to modify and control his/her behaviour in response to environmental demands while self-reinforcement enables the student reinforce own behaviour when appropriate. Self-management has been successfully used by researchers in reducing conduct disorder. Self-management has been found to be effective in reducing
conduct disorder (Aderanti & Hassan, 2011), preventing substance abuse, delinquency and violence among adolescents (Straton and Taylor, 2007), reducing stealing, lying and relational aggression (Martin, 2008). Egbochuku, Oizimende and Oliha (2015) found self-management and social skills training effective in reducing adolescents’ conduct disorder. They recommended that school counsellors use these techniques more often.

Implications for School Counsellors

Conduct disorder is a common childhood psychiatric problem that has increased incidence in adolescence. The overriding feature of conduct disorder is the repetitive and persistent pattern of the behaviour that violates age-appropriate societal norms and the rights of other people.

These behaviours are often referred to as antisocial behaviour and could indeed be precursors to antisocial personality disorder. The professional School counsellors should be able to identify and classify the socio-emotional and psychological needs of the adolescents and children in the school in order to adequately cater for them. It is probable that many the children in the various correctional centres in Nigeria would not have ended up there if they had received timely help from the school counsellor. School counsellors therefore need to be familiar with the DSM classification and interpretation of different behaviour disorders.

This information may be helpful to counsellors struggling to understand their clients’ experiences. This understanding may in turn, enable effective planning of counselling psychotherapy and mental treatment strategies or referral to other mental health practitioners.

However, since the DSM is an instrument foreign to the Nigerian culture, the Nigerian school counsellor needs to take into consideration the cultural milieu of the clients in making diagnosis with the DSM. Keeping of accurate record or bio data files of each student is important and care should be taken not to treat reports of misbehaviours, no matter how severe, in isolation of previous records. Regular meetings with parents should be part of the School’s counselling programme as parents’ cooperation is paramount to successful interventions to conduct disorder.

Conclusion and Recommendations

Counselling practice has evolved over the years from being primarily concerned with educational and career adjustment to being involved in helping people with more serious mental health problems. Conduct disorder in children and adolescents hampers the achievement of the goals of the school system. The DSM provides information that will
enable the counsellor offer comprehensive and collaborative services to clients. It therefore means that counsellors who want to remain relevant in the system must forge the new paths though their training may not have included the range of elements in the new school counselling models. They must recognise that the society is changing, assess the changing needs and acquire and develop the necessary professional skills to meet the needs of clients and reduce conduct disorder in the school system and in the society.

References


