Conduct disorders: An overview of common childhood behavioural problems

PIA De Silva[1,2], ILAN Darshana[3]

[1]*American National College, Colombo, Sri Lanka.*
[2]*Nothern Arizona University, United State of America.*
[3]*Department of Community Medicine, Faculty of Medicine, University of Ruhuna, Galle, Sri Lanka.*

Correspondence: Ms. P. I. A. De Silva
e-mail*: desilvaisuri519@gmail.com*
https://orcid.org/0009-0001-6900-5497
Submitted on 10.10.2025 and accepted for publication on 20.11.2025

Introduction

Conduct Disorder (CD) is a complex mental health condition that is observed in children and adolescents. It is characterised by persistent patterns of antisocial and destructive behaviours. According to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), destructive behaviours are defined as aggression, property damage, deceitfulness, theft, and rule violations (1). Literature indicates that CDs affect approximately 2 to 10 percent of the population. When signs of conduct disorder appear before the age of 11, it is identified as childhood onset, while signs appear during an individual's teen years, 14 to 17, it is identified as adolescent onset (2). CDs are often mistaken for a phase of childhood misbehaviour or bad parenting rather than a significant mental health concern (3). However, it can affect an individual's relationship with loved ones and society, as well as their physical, mental, and emotional development. So, it is important to understand the causes, impacts, and effective interventions for conduct disorder. This article explores the nature of conduct disorders, their underlying causes, their effect on a child's development, and evidence-based intervention strategies for their management.

Impacts of conduct disorders on childhood development

Children with conduct disorder often struggle with academic performance. Poor concentration, disruptive behaviour, and negative interactions with teachers and peers are experienced by these children, which will lead to the inability to achieve their academic goals (4), increasing the risk of the child dropping out of school. Individuals with CDs typically display aggression, and they do not listen to or comply with societal norms and rules, which makes it harder for them to maintain healthy relationships with others. So, most of the time, individuals with CDs live an isolated life. Due to this reason, signs of low self-esteem are widely shown, which eventually increase the risk of developing other mental health conditions such as depression and anxiety. Literature shows that children who suffer from CDs are at high risk of smoking, alcohol, or substance abuse, as well as getting involved in delinquent gangs. If the conduct disorder is left untreated, there is a high chance that these symptoms will be carried into adulthood. Further, these individuals will be unemployed and involved in criminal activities (5). Apart from the individual, other family members might also be affected by conduct disorder. Especially, parents may have a higher caregiver burden (6), while siblings might feel neglected, as much attention is going toward the child with

CD (7). Further, the cost of treatment for CDs can cause a financial burden on parents. Hence, conduct disorder among children cannot be neglected.

Causes and risk factors

CDs can be caused due to some biological factors. It is implied that antisocial behaviours, impulsivity, temperament, and aggression can be heritable (8). Neurological abnormalities are associated with children with CDs, including structural and functional differences in the brain regions such as the amygdala, ventromedial prefrontal cortex, insula, and prefrontal cortex (9). These children have impaired emotional regulation and decision-making due to these neurological abnormalities.

Apart from biological factors, some environmental factors also contribute to the development of CDs. Child abuse, poverty, getting associated with delinquent peers, parental substance abuse behaviour, community violence, and limited access to education increase the risk of developing CDs, according to the literature (10). Apart from them, being male, having a family history of CDs, having other psychiatric disorders, and having a history of experiencing traumatic events also increase the risk of developing CDs (10).

The poor parental supervision, poor parental discipline, poor parental attitude, parental conflict, disrupted families, large families, low-income families, antisocial parents and peers, and high crime neighborhoods (11) are also identified as risk factors for CDS in the literature. Children with CDs show comorbid conditions such as attention deficit hyperactivity disorder, anxiety, and substance use disorders. These comorbidities make it harder to treat these children with CDs.

Clinical Presentation and Diagnosis

Signs and symptoms of conduct disorder develop gradually over time. Aggressive behaviours are shown by children with CDs towards others, such as bullying, physical violence, sometimes with a weapon, verbal fights, hurting animals, threatening, and forcing sexual activities. They also show signs of destruction toward property by intentionally setting fires, vandalizing, destroying others' properties, deception and lying, including stealing, breaking into houses, and lying to get a favor or to avoid responsibilities. Breaking rules, not going to school, and running away from home are not uncommon among them (8). Apart from the above-mentioned signs and symptoms, heavy alcohol drinking or substance use, engaging in risky sex, becoming easily frustrated, not showing remorse for their actions, and difficulty making and maintaining friendships are also common signs of CDs (12).

A diagnosis of CDs can be made by a mental health professional, such as a psychiatrist or a licensed clinical psychologist, based on DSM-5 criteria, which is provided by the American Psychiatric Association. Usually, CDs in children or adolescents are diagnosed by the criteria, which state children or adolescents who have demonstrated three or more destructive behaviours in the previous 12 months, including at least one in the previous six months. These behaviours include aggression towards people or animals, destruction of property, deception, lying, stealing, and serious violations of parental rules. These behaviours must be serious enough to affect relationships at home or school and disrupt the child's normal functioning(1). If a child is showing these symptoms on a more severe scale, the child should be referred to a child and adolescent psychologist or a psychiatrist as soon as possible to minimise the harm.

Management

When considering prevention strategies, parent training programs, and providing tools for parents to manage their child's behaviours would be beneficial. Anti-bullying programs can be implemented by schools to promote prosocial behaviour in children. Community-based programmes could also implement campaigns to reduce poverty and provide safe places for children to play, learn, and socialize (8).

When considering interventions, negative and disruptive thought patterns can be identified and modified by cognitive behavioural therapy(CBT). Multisystemic therapy(MST) is used as a family-centered approach that addresses multiple ways

of influencing a child's behaviour, including their family, community, and school environment, which covers CBT, behavioural therapy, and pragmatic family therapy. Hence, MST has been identified as one of the most evidence-based approaches used for treating CD (13). There is no specific pharmacological management for CDs, but there are some treatments targeting comorbid conditions like ADHD or other disorders that can indirectly improve symptoms of CDs (14). However, these should be given under the authority of a mental health professional.

Children who have moderate to severe levels of symptoms of CDs require individualized and specialized education programmes that are designed for children with disabilities and behavioural disorders. The child's unique needs are accommo--dated and fostered by a more supportive and growth-based learning environment. Involvement of appropriate health care professionals along with educators, family members, and social workers in the management of children with CDs may ensure a comprehensive approach to intervention, which will benefit them immensely.

Conclusions

CDs affect the academic performance, physical and mental well-being of the child and family members, and social relationships, putting proper childhood development at risk. Early identification of CDs and addressing root causes will be beneficial for mitigating and adjusting dysfunctional behaviours of the child and improving outcomes for their future by ensuring healthy and productive lives.

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed., text rev. Washington, DC: American Psychiatric Publishing; 2022.
2. Silberg J, Rutter M. Age of onset and the subclassification of conduct/dissocial disorder. *J Child Psychol Psychiatry.* 2014; **55**(4): 403-410.
3. Coghill D. Editorial: Do clinical services need to take disorders more seriously? *J Child Psychol Psychiatry*. 2013; **54**(9): 921-923.
4. Gitonga MK, Muthomi S. Determine the effect of conduct disorder on students' academic performance and their correlation: Case study of Kamukunji and Olympic Secondary. *Int J Curr Res.* 2022; **14**(5): 4463-4469.
5. INSERM Collective Expertise Centre. Conduct disorder in children and adolescents. Paris: Institute national de la santé et de la recherche médicale; 2005.
6. Meltzer H, Ford T. The burden of caring for children with emotional or conduct disorders. *Int J Fam Med.* 2011; **2011**: 801203.
7. Raising Children Network. Conduct disorder: Children & teenagers. 2024 Nov 6 [cited 2025 April 5]. Available from: https://raisingchildren.net.au/guides/a-z-health-reference/conduct-disorder-children-teenagers
8. Mohan L, Yilanli M, Ray S. Conduct disorder. In: Stat Pearls. Treasure Island (FL): StatPearls Publishing; 2025 [cited 2025 April 10]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK560876/
9. Passamonti L, Fairchild G, Goodyer IM, Hurford G, Hagan CC, Rowe JB, *et al.* Neural abnormalities in early-onset and adolescence-onset conduct disorder. *Arch Gen Psychiatry.* 2010; **67**(7): 729-738.
10. Kivi R. Conduct disorder. [Internet] Healthline; 2022 Jan 6 [cited 2025 April 10]. Available from: https://www.healthline.com/health/conduct-disorder
11. Murray J, Farrington DP. Risk factors for conduct disorder and delinquency: Key findings from longitudinal studies. *Can J Psychiatry.* 2010; **55**(10): 633-642.
12. Cleveland Clinic. Conduct disorder [Internet]. Cleveland Clinic; 2022 Apr 8 [cited 2025 April 18]. Available from: https://my.clevelandclinic.org/health/diseases/23924-conduct-disorder
13. Gillen M, Rotheram E. Description of conduct disorder. Center for Counseling Practice, Policy, and Research; 2014.
14. Yale Medicine. Conduct disorder [Internet]. [cited 2025 April 18]. Available from: https://www.yalemedicine.org/conditions/conduct-disorder