Bad Conduct, Defiance, and Mental Health

The majority of youth in detention have a pattern of aggression, oppositionality, and/or defiance of authority that meets the criteria for a diagnosis of conduct disorder (CD), oppositional defiant disorder (ODD), or both. As a society, our approach to dealing with these young people appears to be based on the presumption that they are "bad"—willfully and perhaps even irredeemably so. Yet we know that between 40% and 70% of youth in the juvenile justice system have mental health problems *other* than CD or ODD. Conduct disorder has a rate of high co-morbidity (co-occurrence) with a host of other mental health and substance abuse diagnoses including depression, bipolar disorder, post-traumatic stress disorder, attention-deficit/hyperactivity disorder, and attachment disorders. CD is also often co-morbid with neurodevelopmental disorders caused when a fetus has been exposed to alcohol, drugs, or other toxins.

When we start to see "conduct disordered" young people as individuals and begin to explore their unique histories, it becomes more difficult to maintain the image of them as essentially "bad." Often their stories reflect a skewed developmental process, complicated or ruptured relationships with families and community, traumatic experiences, and/or underlying complex mental health issues. If we build our understanding of problematic conduct around these facts, we are more likely to see these young people as deserving our compassion and our best efforts to help them.

Some of the reasons juvenile offenders are misunderstood can be found in the failings of our system for diagnosing youth. Most psychiatrists have become comfortable with the criteria-based Diagnostic and Statistical Manual (DSM), which since 1973 has been heralded as an objective, scientific document. In reality the diagnostic criteria create a false notion that mental health disorders described in the DSM are well bounded, discrete, and applicable to people of all ages. In fact most disorders are defined with criteria that apply best to adults. CD and ODD are artifacts of this system. They both have clear criteria allowing for reliable diagnosing. In other words, clinicians presented with the same information will reliably make the same diagnosis. But does the diagnosis mean anything? In the terms of those who seek to define things scientifically, are CD and ODD "valid" disorders?

Many clinicians, myself included, doubt that there is any substance to either of these two diagnoses. Both CD and ODD are known to be extremely heterogeneous (have many causes), and both have high rates of co-morbidity with other diagnoses. Furthermore, a diagnosis of CD or ODD offers no guidance for treatment. Some of us believe that the behavior that is highlighted in the CD and ODD diagnoses is usually an unrecognized manifestation of a co-morbid condition. For example, it is not uncom-

mon to find that a child who meets the criteria for CD is suffering from post-traumatic stress disorder, anxiety disorders, or bipolar disorder. However, the diagnostic criteria for these other conditions were derived from clinical experience and research with adults. Adolescents and children with these disorders are often misdiagnosed because their symptoms—expressed as "bad" conduct—are different from the symptoms typical of an adult with the same disorder. A more appropriate view might be that these youth are not actually "conduct disordered with co-morbid disorders," but rather that they have some developmentally understandable manifestations of a disorder that has been defined in terms of adult behavior and symptoms.

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When disruptive behavior is ascribed to CD, there is often little effort to diagnose other disorders or conditions that may be quite amenable to treatment. When treatment focused on CD is pursued, it may well be ineffective, since the root cause of the behavior—the undiagnosed co-occurring condition—remains unaddressed. Worse, the consequences of a CD diagnosis can be quite destructive to a young person's life chances, due to the stigma attached to the conduct disorder label. Conduct disorder in children and adolescents is linked in the DSM to the adult diagnosis of antisocial personality disorder (APD). Having APD is widely (and incorrectly) understood to be synonymous with being a sociopath, that is, having a criminal mind that is fixed and irredeemable. Due to the association between CD and APD, children and youth with CD are often (and incorrectly) presumed to be juvenile sociopaths and thus not worth the effort to treat.

The CD diagnosis is frequently made under sub-optimal conditions. Picture a mental health professional who is charged with evaluating an angry, stubbornly mute youth in a juvenile justice facility. The evaluator has only 15 minutes, no cooperation from the youth, and a long rap sheet of the youth's alleged offenses. It is easy to see why, with the data available, the diagnosis is CD. There is no opportunity to look deeper for other symptoms or to understand family conflicts or social factors including poverty and racial discrimination. These are supposed to be considered before one makes such a diagnosis. So either the CD or ODD diagnosis—the only diagnoses for which available data easily fit criteria—becomes the assigned diagnosis and the youth is unwittingly branded as a juvenile sociopath or an incorrigible. It is then easy to rest with the statistics indicating no specific treatment has been found to treat CD or ODD. We forget to take into account that the causes of CD are variable. No one treatment could ever fit all cases. As a result, many youth felt to have "behavioral problems" (as opposed to mental health problems) are not considered good subjects for mental health treatment. Instead, these youth are seen as "bad" and deserving of juvenile "rehabilitation" in a jail-like facility. If more classic symptoms of a mental health diagnosis emerge during their juvenile justice placement, these will be handled separately, on the side, and won't alter the presumption that the youth is primarily bad and in need of "correction."

As adults, we may have difficulty seeing defiant, problematic behavior in a social-developmental context. During adolescence, youth begin to define their social identities, and to understand that the choices they make have important consequences for their current and future social and economic position in society. Making these choices can be exhilarating for youth as they seek to realize personal ambitions, explore talents, and build new kinds of relationships. Making choices, however, can also bring enormous social and psychological stress. This stress is compounded for youth who have some form of social disadvantage, including a mental illness. Given that the developmental task of adolescence is to find one's place in the social order, it makes sense that youth who encounter difficulties in that task will communicate their frustration, anger, or sadness in socially meaningful ways and behavior—either verbal or action-oriented. Troubled or angry behavior is a prime means by which individuals express social distress. When we look at the behavior of troubled adolescents, be it self-harm, self-starvation, shoplifting, or graffiti, we are well advised to

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try to read the behavioral message the young person is communicating.

Troubling behaviors can also be understood as a young person's effort to find relief from emotional distress. Many youth say that "acting out"—cutting, gorging and purging, drugging, drinking, shoplifting, or stealing cars—is primarily a way to escape pain. Some of these behaviors offer distraction or temporary relief from the problem at hand, and extreme antisocial acts may serve to replace distress with excitement or drama. Despite the risk and the possibility of further pain or other negative consequences in the future, these behaviors are reinforcing because they do provide immediate relief, distraction, or escape from pain.

As adults, we react in confused and angry ways when confronted with behavior that we do not understand. Blaming the youth may be easier for us than acknowledging the social ills that the behavior highlights: alienation, oppression, or a lack of opportunity or social justice. Our own anger leads us to try to contain, repress, and control the behavior. But this response, however natural, serves to exacerbate the alienation, despair, and anxiety that young people often feel. Most adults are unaware of the angst that underlies adolescents' behavior. Unwittingly, we engage with them in an angry dance, and by participating in that dance, we may aggravate the problems.

The juvenile justice system has a dual mandate: protecting society from dangerous youth and rehabilitating youth so that they will no longer be dangerous. It is clear that our current systems are not satisfying this mandate and that they are particularly unsuccessful in the area of rehabilitation. One strategy for improvement is to get away from the idea that noncompliant youth have a series of separate behavior, mental health, or substance abuse problems that require separate (though possibly coordinated) services. Fragmented care plans reflect a poor understanding of these youth and their needs. Instead, when we understand each youth in terms of his or her unique story, context, and communications, we can develop a comprehensive plan that fits with his or her needs. We can also do better by integrating the meaning of socially offensive behavior into our understanding of youth, and then by building a relevant treatment plan that responds to their underlying emotional pain and social alienation.

Let me illustrate how these concepts play out in a case example. Andre is a thoughtful, introverted 17-year-old boy with an exceptional artistic talent. A high school art teacher recognized Andre's talent, and she facilitated his receiving a scholarship to attend an art school. However, a pattern of "tagging" on the sides of buildings all over town led to six arrests and time in juvenile detention for graffiti. Approaching his 18th birthday, Andre had a series of missed court appearances and a bench warrant for his arrest. He was told that any new charge would lead to a remand to adult court, a long sentence, and transfer to an adult jail at age 18.

After several arrests a court psychiatrist diagnosed Andre with CD based on a pattern of property destruction with graffiti, stealing art supplies from stores, and chronic truancy. A new probation officer requested a more in-depth evaluation with a therapist familiar with the wraparound process. Clinical evaluation revealed a severe anxiety disorder and depression, both of which were partially helped by medications. Andre essentially lived alone in a trailer. His mother was often gone with boyfriends, drinking for weeks. An outreach to Andre's mother and maternal uncle was made, and both agreed to be on his wraparound team. The team supported Andre's uncle in his effort to get Andre's mother into a chemical dependency treatment program. Andre was terrified to be at school, except for his art class where he felt cared for by the art teacher. She saw his strengths and was delighted to be on the wraparound team. The team arranged for Child Protective Services to place Andre briefly in a group home so that he could qualify for an Independent Living Skills program. This program helped him find housing with good supports. Several of those involved in his transitional housing program joined Andre's wraparound team, as did his probation officer. A peer-to-peer outreach worker was able to help his fellow taggers understand their friend's legal peril and they too supported Andre in abstaining from graffiti. One of these peers agreed to be on the wraparound team. The team found money to buy art supplies on the condition that Andre would use them in legal and responsible ways.

The team was able to convince the court not to place Andre in detention on the condition that he complete his GED and enroll in art school. Once in that program Andre was able to lead a project creating a mural on the side of a county building.

Andre escaped the dreadful dance with the court that could have led him into a criminal lifestyle. Committed professionals, including a probation officer, a teacher, and a mental health counselor, helped Andre get beyond the dead-end CD diagnosis and get adequate treatment for his anxiety disorder and depression. Friends and family joined the professionals on Andre's wraparound team, and as a group, they facilitated a series of individualized family and social interventions that were developmentally sensitive and that honored his peer connections and recognized his peer support. The team supported his mother as she addressed a problem that had left Andre prematurely on his own, thus giving him additional peer and adult supports.

Andre's situation highlights a possible resolution of the often-colliding forces from deferent child-serving systems: courts, social services, mental health, and schools. The wraparound process focused on practical issues. This boy was not seen as a walking diagnosis, even though getting medication for his chronic anxiety disorder was a part of the resolution of his problems. As the professionals working with Andre came to understand the meaning of his behavior, they were able to join family and peers in addressing Andre's challenging behavior. "Conduct disorder" was not mentioned by his wraparound team. That term was not helpful and did not offer guidance for planning. The appropriate diagnosis of his anxiety disorder did lead to treatment that contributed to his successful outcome. However, the primary factor underlying this success was that the people around Andre were able to see him as an individual, and to respond in a manner that acknowledged his strengths, his needs, and his adverse social and family circumstances. A practical planning process based on this perspective helped Andre give up his behavioral distress signals and helped the professionals around him avoid branding him as a sociopath.

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DIAGNOSIS OF CONDUCT DISORDER

According to DSM-IV criteria, conduct disorder is a repetitive and persistent pattern of behavior in which the basic rights of others, or major rules and values of society are violated, as shown by the presence of three (or more) of the following behavior patterns in the past 12 months, with at least one behavior pattern present in the past 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 (for example, a bat, brick, broken bottle, knife, gun).

4. Has been physically cruel to people.

5. Has been physically cruel to animals.

6. Has stolen while confronting a victim (for example, mugging, purse snatching, extortion, armed robbery).

7. Has forced someone into sexual activity.

Destruction of property:

8. Has deliberately engaged in setting fires with the intention of causing serious damage.

9. Has deliberately destroyed others' property (other than by fire setting).

Deceitfulness or theft:

10. Has broken into someone else's house, building, or car.

11. Often lies to obtain goods or favors or to avoid obligations (in other words, "cons" others).

12. Has stolen items of nontrivial value without confronting a victim (for example, shoplifting without burglury; forgery).

Serious violations of rules:

13. Often stays out at night despite parental prohibitions, beginning before age 13 years.

14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).

15. Is often truant from school, beginning before age 13 years.

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