

Disruptive and Conduct Disorders



Fact Sheet

What are Disruptive and Conduct Disorders?

At some stage in their lives, all children and young people can exhibit defiant, disobedient or impulsive behaviours. Behaviour is related to a child's developmental stage and environment and is also influenced by the individual's own personality. In most cases, occurrences of disruptive behaviour are mild or infrequent and will resolve over time. However in some instances, children and young people may have persistent negative and challenging behaviours, beyond their developmental stage, that can cause concern for their care giver, families, teachers or the community.

This fact sheet outlines key points about two disorders associated with disruptive behaviour: Oppositional Defiant Disorder and Conduct Disorder. A separate fact sheet is available about Attention Deficit Hyperactivity Disorders at www.responseability.org/AttentionDeficitHyperactivityDisorder.

Oppositional Defiant Disorder

Oppositional Defiant Disorder (ODD) is a recurrent pattern of defiant, disobedient and hostile behaviour towards others, occurring frequently over a period of at least six months. The problem behaviour will be more common than expected age-appropriate levels, resulting in significant impairment of functioning.

A child or young person with this disorder frequently loses his or her temper, argues with authority figures such as parents or teachers, refuses to follow requests or rules and may deliberately do things to annoy others. For example, a person with ODD may frequently:

- be defiant or refuse to cooperate;
- have a negative attitude;
- be irritable and easily annoyed;
- be stubborn;
- show low self-esteem;
- get frustrated easily;

- shift the blame for their misbehaviour or mistakes to others or try to justify their inappropriate behaviour;
- use drugs and alcohol excessively;
- have trouble becoming independent from their primary carer; and
- speak harshly, unkindly or aggressively.

The causes of ODD are unknown, but may include a range of biological and environmental factors. Behaviours associated with ODD may be strengthened through excessive negative reinforcement for example, parents or teachers drawing attention to the inappropriate behaviours.

It is difficult to be sure how many children or young people are likely to be affected by ODD. Estimates vary from 2% to 16%. Before puberty, ODD is more common in males, but after puberty it occurs equally in boys and girls. Age of onset is usually between five and eight years of age.

ODD is more likely in families where a parent has a history of depression, ODD, conduct disorder, attention deficit hyperactivity disorder (ADHD), antisocial personality disorder or a substance related disorder.

Conduct Disorder

Conduct Disorder (CD) is a recurrent and chronic pattern of behaviour over 6-12 months in which the person shows a serious and blatant disregard for social norms or rules, or for the rights of others.

CD usually involves more persistent patterns of serious behaviour than ODD, and is usually diagnosed at a later age than ODD. For diagnosis to occur, these behaviours must cause significant dysfunction in a variety of settings as opposed to being a reaction to social situations.

Children with CD experience a high rate of school drop-out, delinquency and imprisonment.

Behaviour may include aggression or cruelty towards people or animals, property damage, serious violation of rules, deceitfulness or theft. It normally affects all aspects of the person's life, such as home, school or work, and the



community. A diagnosis of CD often occurs when such behaviour has come to the attention of law enforcement services.

A person diagnosed with CD may:

- have lower-than-average intelligence;
- have poor reading and verbal skills;
- have problems adjusting to work;
- be regularly absent from school or work for no good reason;
- run away from home regularly or for prolonged periods or stay out late without parental permission;
- only display guilt to reduce the likelihood of being punished;
- have a troubled family life that involves regular conflict;
- have low self-esteem, but put on a tough exterior;
- be restless or easily frustrated;
- be dishonest for their own personal gain;
- be reckless;
- unfairly label others, blame others for their own wrongdoing;
- show little empathy or compassion for others;
- initiate physical attacks or bullying;
- be threatening or intimidating;
- be hostile and/or defiant;
- misinterpret the actions of others as hostile or react aggressively to others;
- begin engaging in sexual activity and/or substance use at a young age;
- be more likely to contract sexually transmissible infections (STI) or have unplanned pregnancies;
- engage in illegal activity such as theft, arson, break and enter, assault or rape;
- have legal difficulties; or
- have suicidal ideation or attempt suicide.

CD is one of the most common conditions present in children who are regular clients of mental health services, juvenile justice facilities and child welfare organisations.

The symptoms of CD can be exacerbated by increasing age and the development of physical strength, cognitive ability

and sexual maturity. Young people who exhibit CD are more likely to have additional problems in later life, such as depressive or anxiety disorders, antisocial personality disorder and substance use problems.

CD is more common in males than females, with less confrontational behaviour seen in females with CD. The estimated prevalence is thought to be between 6-16% for males and 2-9% for females. Onset is usually from middle childhood through to middle adolescence and is rare after 16 years of age.

Both genetics and the environment have been implicated in the development of CD. Children are at greater risk if one or both parents have one of the following: alcohol dependence, depression, schizophrenia, antisocial personality disorder, ADHD or CD.

CD appears to be more common in children whose parents employ below optimal parenting practices, communicate poorly or with hostility, or are abusive or neglectful. Some evidence suggests that CD occurs more frequently in rural populations than in metropolitan settings.

Impact on school and academic performance

Children with these disorders often develop a non-productive relationship with teachers. Staff may avoid interacting with the student for fear of confrontation, unpleasantness, or concern about heightening the disruptive behaviour. Other children are often aware of the disruptive behaviours and either become alienated from the student, or develop alliances with them. This can lead to groups engaging in negative behaviour such as bullying. Refer to the Bullying fact sheet for more information at www.responseability.org/bullying.

Research shows a strong correlation between disruptive behaviour and academic under achievement. It is generally believed that academic problems are related to attention deficit, negative teacher and student relationships, regular absence from school and an overall lack of commitment to rules and conventions. There is also some suggestion that



the frustration and alienation experienced by a child with these disorders in a school environment may actually result from academic underachievement. Either way, a child with ODD or CD is often significantly disadvantaged in terms of achieving academic success.

What can teachers and schools do?

Early intervention

Teachers play an important role in identifying and monitoring disruptive behaviours. A child or young person diagnosed with ODD or CD will usually have significant difficulty coping with school life. The disorder can affect social interactions, learning, self-esteem and the overall wellbeing of the child. The difficulties caused by behavioural disorders also impact on others in the school community. When disruptive behaviours do occur (with a frequency or severity that is more than would be expected for that child's developmental stage), it is helpful for the family to receive specialised, professional support as early as possible. ODD, CD and other disruptive disorders are usually treated with individual counselling, family therapy and sometimes medication (usually for those displaying more aggressive behaviours). Parents can also undertake training to help manage their child's disruptive behaviours.

There is debate about whether these disorders can or should be diagnosed in pre-school aged children. Transient disruptive or defiant behaviours are common to some extent in this age group and there is a wide variation of 'normal' behaviour. Some research suggests that many children who are diagnosed with CD in the middle years or adolescence displayed pre-school behaviours that indicated a risk e.g. lack of control, negative social interactions and difficulty achieving developmental milestones.

If you are concerned about the behaviour of a young person in your care, a good first step is to discuss the behaviour with your supervisor or principal to determine the best course of action. For example, this may mean talking to your Year Advisor, School Counsellor, Manager or Principal.

You could then find a quiet place to share your observations in a compassionate way with the young person's parent or caregiver. Give them an opportunity to talk about their own observations or concerns. Be conscious of not discussing the problem behaviours in front of the young person or other children. The parent or caregiver may ask for further support, this would be a good time to refer them to health professionals or their GP for support (see page 5 for more detail). Parents could also deny there is a problem. If this occurs it is important to continue to monitor the young person's behaviour and keep your supervisor informed of any changes.

Behaviour management

These disruptive disorders are frequently associated with aggressive behaviour. A child with ODD or CD tends to interpret the communications and attitudes of others as hostile or negative. This fuels a variety of behaviours ranging from coercion or domination to physical aggression or destruction. Deficits in social skills may also contribute to aggression.

The use of pro-active behaviour management skills is more effective than reactive strategies. Pro-active management does not require staff to wait for the actual occurrence of disruptive behaviour. Pro-active strategies require you to be conscious of how you teach as well as what you teach, and to be aware of the broader school climate and policies.

Ensure that you are aware of the behaviour management policy and procedures that apply in your school. Ideally there should be a structured behaviour management system that clearly describes the range of acceptable and unacceptable behaviour, with a step-by-step list of consequences (such as warnings, time out, referral to the Assistant Principal, Deputy Principal or Principal, contacting parents, suspension, etc.). All staff and students should understand the behaviour management process and need to enforce it consistently.

Classroom strategies

Children of all ages tend to notice and copy the behaviour of others, so always try to demonstrate positive behaviour in your own interaction with the class. A well-structured



classroom environment, a clear lesson plan and a well-defined behaviour management approach will help you to minimise classroom uncertainty and conflict for all students, including those with challenging behaviour.

Suggested classroom strategies include:

- be very clear and explicit about rules and consequences;
- let older students have some input into defining class rules;
- enforce rules consistently and calmly; remind students of consequences;
- do not tolerate put-downs, negative comments or arguments in the group;
- communicate clearly and allow time for instructions to be understood;
- as far as possible, always be patient, fair, positive and calm;
- show respect for all students and be sensitive to their needs;
- accommodate a range of learning styles to encourage success;
- use a range of learning tools, e.g. visual, auditory, tactile, etc.;
- explicitly teach children about developing social skills and managing emotions – look for resources that you can use, adapt, or integrate into your existing curriculum; and
- acknowledge the positive contribution of all students, including those who tend to display challenging behaviour.

In general, it is helpful to reward and encourage desirable behaviours and to remove attention from undesirable behaviours. Where desirable behaviours are not occurring, consider rewarding lower rates of the undesired behaviour. Rewards should be removed if the behaviour becomes disruptive again.

Some examples of rewards for primary school age children include:

- verbal praise;
- positive attention;

- thanks;
- nods and smiles;
- pat on the shoulder;
- writing a letter or making a phone call to student's parents/carers;
- present a certificate to take home;
- in-class student of the week award;
- extra computer time;
- allowing the student to choose an activity;
- implement a point system with points or stickers for good behaviour where child receives a small gift after so many points are collected e.g. a book;
- time for special interests work;
- get a fun worksheet;
- first pick of recess equipment;
- help the librarian;
- sit at the teacher's desk;
- have lunch with the teacher or principal;
- be a helper in a room with younger children; and
- homework pass.

Many of these rewards are still appropriate for students as they enter high school for example social rewards such as verbal praise, thanks and acknowledgment are useful and help to affirm the young person's sense of worth. Also, time for special interests work, computer time, homework pass and recognition of achievements via certificate, in-class acknowledgment or communication to parents/carers are suitable. In addition some teachers use 'contracts' with older students. These are written agreements about behaviour signed by the student and teacher. For some, having a formal and binding agreement helps to reinforce the value of desirable behaviours.

Techniques that seem to be less effective in managing children with behavioural disorders include constant overcorrection and verbal reprimands, the use of physical reprimands, and seating or segregating the student away from others.

Tip – For students of all ages it is helpful to tailor rewards to the individual, knowing the students interests will help.



Sources and Links

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Tips for referral - Why refer families to their GP?

A general practitioner (GP) is a good place to start if there are concerns about a child's development or behaviour. He or she can perform an initial assessment and refer the child and family to other professionals if needed for additional assessment, treatment and support. A GP referral is needed to access specialists such as a paediatrician or psychiatrist. A referral is not needed to see a psychologist however seeing a GP in the first instance is still useful to see if this is the type of support needed and to recommend a professional.

Description of specialists:

Paediatrician: a doctor who specialises in treatment and care for babies, infants, children's and adolescents. Paediatricians have specialised knowledge of the illnesses and diseases affecting children and young people.

Psychiatrist: a doctor who has undertaken additional training to become a specialist in mental illness and can prescribe medications as well as providing or referring people to other forms of treatment and support, e.g. counselling.

Psychologist/clinical psychologist: a professional trained in assessing people's behaviour and abilities and who specialise in mental health problems and illness. A psychologist does not prescribe medication but can provide a range of other therapies.