Clarification in the nosology of conduct disorder

Sir,

Thanks to the detailed and objective observations and critical comments about the study titled “Determinants of symptom profile and severity of conduct disorder (CD) in a tertiary level pediatric care set-A pilot study.” The majority of study population (55%) was relatively smaller children (6–11 years), since the study setting was behavioral pediatrics unit, which is an exclusive center for providing child and adolescent mental health service under Pediatric Department. Many smaller children with externalizing disorder were being referred to. Experiences showed that the attributed stigma attached to availing mental health service to children and adolescents were less in the pediatric background.

Conduct disorder is the most common child psychiatric disorder.[1] It is also one of the most difficult and intractable mental health problems in children and adolescents, and is characterized by marked chronic conflict with parents, teachers, and peers. In the International Classification of Disease-10 (ICD-10) (WHO, 1992),[2] CDs are included in the section called disorders of childhood and adolescence (F90–98) and coded as F91. When CD presents with co morbid hyperkinetic disorder, they are coded as F90.1. Hyperkinetic CD. Comparative nosology shows that ICD-10 diagnostic guide lines for CD are descriptive, but Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition Text Revision (DSM-IV-TR)[3] is categorical. Another difference is that, ICD-10 diagnoses only CD and subtype it as oppositional defiant disorder (ODD) only, if less severe symptoms were present. However, DSM-IV-TR treats each disorder separately, may either diagnose ODD or CD. DSM-IV-TR divides the CD into two groups namely childhood onset and adolescent onset based on the age of onset, before or after the age 10 years. The ICD-10, diagnostic criteria for research (ICD-10, DCR)[4] provides a symptom list of 23 items for DCR on CD as given in DSM-IV TR. The symptom list is divided into 8 less severe items and 15 more severe items. However ICD-10, DCR also diagnose only CD and subtype it as ODD, if only less severe symptoms were
Letters to Editor

Letters to Editor

ICD-10, DCR gives specification for childhood or adolescent onset based on the age of onset before or after the age of 10 years as in DSM-IV-TR. Specification for possible subdivisions is given, based on hyperactivity, emotional disturbances and severity of CD. The severity of CD is graded as mild, moderate and severe. In the present study, we used ICD-10, DCR for defining the study population.

The main critical points or comments raised for clarifications were three namely:

- Does the children with CD having comorbid hyperkinetic disorder fulfilled the criteria for hyperkinetic CD?
- “The validity of findings in the present scenario could have been increased using a standardized scale child behavior checklist (CBCL)”
- The inherent problem of misreading of symptoms of hyperkinetic disorder and CD.

Regarding the first point, the 45% of the children with CD also had fulfilled the diagnostic criteria for comorbid hyperkinetic disorder in the present study. Hence, it could be coded as F90.1 Hyperkinetic CD as per ICD-10. That is, both conduct and hyperkinetic symptoms were adequately present which satisfied the diagnostic guideline for hyperkinetic CD.

Regarding the second point, the scale we used in the study was revised behavior problem checklist (RBPC).\(^2\) RBPC is an 89 item scale with each item having weighted scoring as 0, 1 and 2. The RBPC is developed and standardized for use in screening and clinical assessment of school-age children in kindergarten through 12\(^{th}\) grade. The RBPC is widely used for the purpose of screening and quantification behavioral symptoms among children with behavioral disorders in the school. It is used as an aid in clinical diagnosis and for measurement of behavior change following psychological and pharmacological change.

Revised behavior problem checklist contains seven subscales namely CD having 22 items, socialized aggression (SA) having 17 items, attention problems (AP) having 16 items, anxiety-withdrawal (AW) having 11 items psychotic behavior (PB) having 6 items, motor tension-excess (ME) having 5 items and not relevant (NR) having 12 items. The NR items were retained in the RBPC because they are often useful for item level and qualitative analysis and interpretation. The CD subscale focus on behavioral problems of physical aggression, difficulty in controlling anger and open disobedience, defiance and oppositionality. The SA subscale focus on adolescent CD. It taps the behaviors in the company with others such as stealing, lying, gang membership, truancy from school and substance abuse. Hence, one is aggressive, and other is nonaggressive as pointed out.

In order to use the tool RBPC for symptom rating of the CD among children in Indian culture and language (Malayalam), it was validated before the present study. The validation process included translation, back translation, comparison, pretesting, content validity testing, rating of symptoms using the refined and finalized Malayalam version RBPC, reliability assessment including internal consistency and stability and construct validity. In the internal consistency, the Cronbach’s \(\alpha\) is 0.67 for CD; 0.86 for SA; 0.85 for AP; 0.77 for AW; −0.80 for PB and 0.89 for ME. Stability was assessed by analyzing the inter-rater and test-retest reliability. These data which were given in the present article had agreed with the conceptual understanding of the psychopathology of CD. Hence, it was concluded that the psychometric properties of the tool RBPC and its validated Malayalam version showed good validity and reliability measures in our culture.

In short RBPC gives complex behavioral domains of heterogeneous CD. Hence, it was used in the present study. However, as pointed out CBCL is a time tested and validated scale for assessing the behavioral problems of children and adolescents.

Regarding the third point, children with hyperkinetic disorder were excluded from the study population by judiciously applying the diagnostic criteria. As pointed out it is a difficult task. However in the clinical scenario one can very well point out pure hyperkinetic disorder without behavioral problems.

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Conflicts of interest
There are no conflicts of interest.

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Letters to Editor

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Sir,

Article titled "Age of onset of dependence-Does it help our understanding of opioid dependence by generating categories or by acting as a useful dimension? A critical examination of the classic debate in psychiatry" [1] made an interesting reading. The debate about the categorical versus dimensional approach to diagnosis in psychiatry was termed as the classical debate by Kraemer et al.,[2] the debate that would help us to understand the nature and etiology of psychiatric disorders. Using the case of age of onset of opioid dependence (AOOD) authors have attempted to analyze this debate. As suggested by the authors, AOOD is indeed a very simple and clinician friendly variable. Previously De et al.[3] also used the same variable to classify the patients into two subtypes: Early onset (EO) with a mean AOOD 21 years and late onset (LO) with mean AOOD 27 years. Based on this finding, authors divided the study sample into two groups: EO <20 years and LO >22 years, omitting the year 21 just because the study by De et al.[3] showed that AOOD tended to peak around age 21 years. This omission brings in a methodological issue of creating "categories" out of a continuous variable of age. Recall bias is a common problem, and when two groups have almost no gap, that is, 20 years versus 22 years, one can easily fall into the "other" category. Table 4 of the article [1] depicts this nicely and also points out the problem of recall bias, that is, age of onset of opioid use and AOOD are not very different, especially for EO group. Further such narrow (age wise) categories were bound to yield no difference. It is very understandable that age gap of 1 or 2 years would not affect the variables under study. Wider age gaps probably would have given us more insight into the issue at hand, as well as a very simple variable AOOD, would have settled the classical debate.

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