Nosology and subtypes of conduct disorder

Sir,

Attention-deficit hyperactivity disorders (ADHDs) remain the most debated psychiatric diagnosis, while conduct disorders (CDs) still remain enigmatic. While ADHDs result in functional impairment of the individual, CDs are regarded as public health problems. There are differences in classification of these disorders in the two major diagnostic systems of International Classification of Diseases-10 (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition. While the diagnostic criteria are being still worked on, recently, the American Psychological Association has included a subtype of CD, the callous unemotional type in DSM-5 “with limited prosocial emotions” as specifier. Other subtypes of CD which include aggressive/nonaggressive CD, reactive/proactive aggression, and physical/relational aggressions remain under investigation.

Little is known about Indian children with these disorders. The article by Jayaprakash et al. is a commendable effort in this direction. While the authors have documented that 45% of children had comorbid hyperactivity, whether this subgroup fulfilled criteria for hyperkinetic CD or had comorbid hyperkinetic disorder as per the ICD-10 Diagnostic Criteria for Research is not clear. As per the ICD system, a diagnosis of hyperkinetic disorder is given priority over CD. The higher prevalence of hyperactivity in younger age group as compared to the adolescent age group might have been due to the fact that this belonged to the different category of hyperkinetic CD which is marked by younger age of onset and more severe symptomatology, which is in line with the findings of an earlier study.

The validity of findings in the present scenario could have been increased using a standardized and validated scale: Child Behaviour Checklist which remains the gold standard for measuring child and adolescent emotional/behavioral problems and social competencies. The instrument has three versions for parents, youths, and teachers with two sections: one section for social/adaptive functioning and the second section for problem behaviors. The behavioral profile section comprises of 118 items scored as 0 (not true), 1 (somewhat or sometimes true), or 2 (very true or often true). These items provide score on eight narrow scales: withdrawn/depressed, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior. The CD symptoms could have been rated on aggression and nonaggression dimensions using this scale.

There is an inherent problem of misreading the features of disinhibition, inattention, and distractibility of hyperkinetic disorders as lying, serious aggression, and illegal behavior. The overlap in symptoms of hyperactivity and conduct is so pronounced that a clear distinction between the two is often difficult.

In spite of the aforementioned limitations of the study, much of which can be due to the nature of the two major
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externalizing disorders of childhood, this is the first prospective study which throws light on the symptom profile, contributory family stressors, and the resulting functional limitations. The most common subtype reported in the study was CD in family context followed by oppositional defiant type which is quite a heartening finding.

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Conflicts of interest
There are no conflicts of interest.

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