**CASE Study**

**Case 15.1 Doesn’t Know the Rules**

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Kyle was a 12-year-old boy who reluctantly agreed to admission to a psychiatric unit after getting arrested for breaking into a grocery store. His mother said she was “exhausted,” adding that it was hard to raise a boy who “doesn’t know the rules.”

Beginning as a young child, Kyle was unusually aggressive, bullying other children and taking their things. When confronted by his mother, stepfather, or a teacher, he had long tended to curse, punch, and show no concern for possible punishment. Disruptive, impulsive, and “fidgety,” Kyle was diagnosed with attention-deficit/hyperactivity disorder (ADHD) and placed in a special education program by second grade. He began to see a psychiatrist in fourth grade for weekly psychotherapy and medications (quetiapine and dexmethylphenidate). He was adherent only sporadically with both the medication and the therapy. When asked, he said his psychiatrist was “stupid.”

During the year prior to the admission, he had been caught stealing from school lockers (a cell phone, a jacket, a laptop computer), disciplined after “mugging” a classmate for his wallet, and suspended after multiple physical fights with classmates. He had been arrested twice for these behaviors. His mother and teachers agreed that although he could be charming to strangers, people quickly caught on to the fact that he was a “con artist.” Kyle was consistently unremorseful, externalizing of blame, and uninterested in the feelings of others. He was disorganized, was inattentive and uninterested in instructions, and constantly lost his possessions. He generally did not do his homework, and when he did, his performance was erratic. When confronted about his poor performance, he tended to say, “And what are you going to do, shoot me?” Kyle, his mother, and his teachers agreed that he was a loner and not well liked by his peers.

Kyle lived with his mother, stepfather, and two younger half-siblings. His stepfather was unemployed, and his mother worked part-time as a cashier in a grocery store. His biological father was in prison for drug possession. Both biological grandfathers had a history of alcohol dependence.

Kyle’s early history was normal. The pregnancy was uneventful, and he reached all of his milestones on time. There was no history of sexual or physical abuse. Kyle had no known medical problems, alcohol or substance abuse, or participation in gang activities. He had not been caught with weapons, had not set fires, and had not been seen as particularly cruel to other children or animals. He had been regularly truant from school but had neither run away nor stayed away from home until late at night.

When interviewed on the psychiatric unit, Kyle was casually groomed and appeared his stated age of 12. He was fidgety and made sporadic eye contact with the interviewer. He said he was “mad” and insisted he would rather be in jail than on a psychiatric unit. His speech was loud but coherent, goal directed, and of normal rate. His affect was irritable and angry. He denied suicidal or homicidal ideation. He denied psychotic symptoms. He denied feeling depressed. He had no obvious cognitive deficits but declined more formal testing. His insight was limited, and his judgment was poor by history.

**Diagnoses**

* Conduct disorder, childhood-onset type, severe, with limited prosocial emotions
* Attention-deficit/hyperactivity disorder

**Discussion**

Kyle is a 12-year-old boy who was brought to a psychiatric unit after getting caught breaking into a grocery store. He has a lengthy history of behaviors that violate the rights of others. These behaviors deviate significantly from age-appropriate societal norms and have caused social, academic, and functional impairment. He has a disorder of conduct.

In DSM-5, the criteria for conduct disorder (CD) are organized into four categories of behavior: aggression to people and animals, destruction of property, deceitfulness or theft, and serious violations of rules. A CD diagnosis requires three or more specific behaviors out of the 15 that are listed within these four categories. The behaviors must have been present in the last 12 months, with at least one criterion present in the prior 6 months. Kyle has at least seven of the 15: bullying, fighting, stealing (with and without confrontation), break-ins, lying, and truancy.

Kyle also has a history of comorbid DSM-5 ADHD, as evidenced by persistent symptoms of hyperactivity, restlessness, impulsivity, and inattention. ADHD is found in about 20% of youth with CD. The criteria for the two disorders are relatively distinct, although both entities present with pathological levels of impulsivity.

DSM-5 includes multiple specifiers that allow CD to be further subdivided. Kyle’s behavior began before age 10, which places him in the category of childhood-onset type as opposed to adolescent-onset type. There is also an unspecified-onset designation, used when information is inadequate to clarify whether the behaviors began before age 10. When trying to identify the age at onset, the clinician should seek multiple sources of information and recall that estimates are often 2 years later than actual onset. People with an early age at onset—like Kyle—are more likely to be male, to be aggressive, and to have impaired peer relationships. They are also more likely to have comorbid ADHD and to go on to have adulthoods marked by criminal behavior and substance use disorders. In contrast, CD that manifests between ages 10 and 16 (onset is rare after age 16) tends to be milder, and most individuals go on to achieve adequate social and occupational adjustment as adults. Both groups have an elevated risk, however, of many psychiatric disorders.

The second DSM-5 specifier for CD relates to the presence (or absence) of callous and unemotional traits. The “limited prosocial emotions” specifier requires the persistent presence of two or more of the following: lack of remorse or guilt; lack of empathy; lack of concern about performance; and shallow or deficient affect. Kyle has a history of disregard for the feelings of others, appears unconcerned about his performance (“What are you going to do, shoot me?”), and shows no remorse for his actions. This label applies to only a minority of people with CD and is associated with aggression and fearless thrill seeking.

A third specifier for CD relates to the severity of symptoms. Lying and staying out past a curfew might qualify a person for mild CD. Vandalism or stealing without confrontation might lead to a diagnosis of moderate CD. Kyle’s behaviors would qualify for the severe subtype.

Multiple other aspects of Kyle’s history are useful to understanding his situation. His father is in prison for substance use and/or dealing. Both of his biological grandfathers have histories of alcohol abuse. His mother and stepfather are underemployed, although details about the stepfather are unknown. In general, CD risk has been found to be increased in families with criminal records, conduct disorder, and substance abuse, as well as mood, anxiety, and schizophrenia spectrum disorders. Environment also contributes, both in regard to chaotic early child-rearing and, later, to living in a dangerous, threatening neighborhood.

Kyle’s diagnosis of conduct disorder is an example of how diagnoses can evolve over the course of a lifetime. His earlier behavior warranted a diagnosis of DSM-5 oppositional defiant disorder (ODD), which is characterized by a pattern of negative, hostile, and defiant behaviors that are usually directed at an authority figure (e.g., parent or teacher) and may cause significant distress in social or academic settings. However, ODD cannot be diagnosed if CD is present. As he enters adolescence, Kyle is at risk for many psychiatric disorders, including mood, anxiety, and substance abuse disorders. Of particular concern is the possibility that his aggression, theft, and rules violations will persist and his diagnosis of conduct disorder will shift in adulthood to antisocial personality disorder.

**Suggested Readings**

1. Buitelaar JK, Smeets KC, Herpers P, et al: Conduct disorders. Eur Child Adolesc Psychiatry 22 (suppl 1):S49–S54, 2013 PubMed ID: 23224151
2. Maughan B, Rowe R, Messer J, et al: Conduct disorder and oppositional defiant disorder in a national sample: developmental epidemiology. J Child Psychol Psychiatry 45(3):609–621, 2004 PubMed ID: 15055379
3. Nock MK, Kazdin AE, Hiripi E, Kessler RC: Prevalence, subtypes, and correlates of DSM-IV conduct disorder in the National Comorbidity Survey Replication. Psychol Med 36(5):699–710, 2006 PubMed ID: 16438742
4. Rowe R, Maughan B, Moran P, et al: The role of callous and unemotional traits in the diagnosis of conduct disorder. J Child Psychol Psychiatry 51(6):688–695, 2010 PubMed ID: 20039995