CONDUCT DISORDER IN FEMALES: GENDER DIFFERENCES EVERY YOUTH CARE WORKER SHOULD KNOW

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Abstract: Conduct Disorder can be a very difficult problem for professionals to deal with. Although the DSM-IV describes the presenting symptoms and diagnostic criteria, there are no specific criteria presented for girls. The research literature also emphasizes studies of boys with conduct disorder. How do girls differ from boys in the formation of conduct disorder? What are the long-term effects on girls who have conduct disorder? This article examines the current literature concerning conduct disorder in the female population.

Key words: conduct disorder, gender differences, child and youth care work

INTRODUCTION

Conduct disorder (CD) is a child and adolescent behavioral problem that affects girls and boys under the age of 18. It is a widespread phenomenon that permeates our society in a variety of ways. As conduct disorder escalates in individuals, there may be increasing difficulties with school officials, parents, and even the law enforcement community.

According to the Diagnostic and Statistical Manual of Mental Disorders, "conduct disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated" (American Psychiatric Association, 1994). Most of these behaviors present in four distinct areas: aggressiveness, property damage, deceitfulness or theft, and what the DSM-IV describes as serious violations of rules.

Clearly, as stated by Kazdin (1995), conduct disorder refers to a clinical problem among children and adolescents that can involve aggressive acts, theft, vandalism, fire setting, running away, truancy, defying authority, and other problems that are considered antisocial. Throughout this article, another term, oppositional-defiant disorder (ODD) will be used several times, as there is an on-going relationship between the two disorders in the classification of antisocial behavior disorders in children. The DSM-IV (Atkins, McKay, Talbot, 1996), describes oppositional-defiant disorder as a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months (Criterion A) and is characterized by the frequent occurrence of at least four of the following: losing temper, arguing with adults, actively defying or refusing to comply with the requests or rules of adults, deliberately doing things that will annoy other people, blaming others for his or her own mistakes or misbehavior, being touchy or easily annoyed by others, being angry and resentful, or being spiteful or vindictive.

Although conduct disorder and oppositional-defiant disorder are two distinct disorders in the DSM-IV, the two are seen as being hierarchical in their relationship. Indeed, most children with CD have early histories of ODD. Many adults who have had a history of antisocial personality disorder in their adult lives also have a history of CD. Conduct disorder remains a very frustrating problem for parents, because they feel that their children are out of control, and that their own methods of dealing with the problem have been largely unsuccessful. School officials must also deal with children and adolescents with a multitude of disciplinary and school-related problems. It also poses a problem for mental health practitioners; youth care workers and foster parents.

In a study conducted by Atkins, McKay, & Talbot (1996), it was found that "aggression and oppositional behavior are the most common reasons for referral to a school mental health team for special education services" (p. 277). They go on to state that

> many of the symptoms of CD and ODD are apparent in school interactions. For CD, this includes symptoms related to aggression toward peers (e.g., bullies, initiates fights) and truancy. Other items related to stealing, destruction of property, and cruelty often are apparent in school interactions (p. 277).

Prevalence

Conduct disorder has been described as one of the most significant and frequent disorders in children and adolescents. Reid, Eddy, Fetrow, & Stoolmiller, (1999) found that there are between "1 million and 4 million children and adolescents in the United States exhibiting a conduct disorder at any given time" (p. 484). According to Reid, et al., "it is one of the most frequently diagnosed conditions in outpatient and inpatient mental health facilities for children" (p. 278). The DSM-IV (1994) reported prevalence rates of 6 percent to 16 percent for males under age 18, and rates of 2 percent to 9 percent for females. Other studies report the same figures, which are lower for females, but still represent CD as the most significant disorder among adolescent females (Keenan, Loeber, & Green, 1999).

As pointed out in a study by O'Keefe, Carr & McQuaid (1998) "conduct disorder is more prevalent among males than females" (p. 369). Many research studies support this significantly higher prevalence rate in males, (Webster-Stratton, 1996; Keenan, Loeber, & Green, 1999; Fergusson, & Woodward, 2000; Kann and Hanna, 2000; Pajer, 1998). However, one study reported that the prevalence rates for juvenile delinquency was approximately the same for both sexes at the time of adolescence (Hoyt & Scherer, 1998).

While the statistics point to the fact that males are diagnosed with conduct disorder more often than females, there are a number of other significant differences between males and females regarding CD.

Gender Differences

According to researchers, there are many differences between males and females with conduct disorder and other behavioral problems. There has been very few adequate studies that have examined conduct disorder in females. This article will examine these gender differences.

While there have been many studies conducted on CD itself, studies of females with CD are few. Most of the research has centered on the male population. In fact, it has been reported that the research for the DSM-IV manual on CD was done mostly with males, rather than females. A number of researchers have called attention to this problem. Kann & Hanna (2000) point out that in the DSM-IV field trials, only one third as many girls as boys were represented in the sample (p. 268).

According to Kann & Hanna (2000),

> There is a primary difference in the way boys and girls present symptoms of disruptive behavior disorders. Externally directed behaviors, generally associated with boys, are acts that are harmful to others or the environment, such as stealing, lying, fighting, and destructiveness. Behaviors that are internally focused are more common in girls and include anxiety, shyness, withdrawal, hypersensitivity, and physical complaints (p. 268).

This fact is also represented in a number of other studies (Hoyt & Scherer, 1998; Keenan, Loeber, & Green, 1999; Webster-Stratton, 1996; and O'Keefe, Carr, & McQuaid, 1998), which point to more aggressiveness in males overall.

Sexual Abuse and Conduct Disorder

Studies show that even though there are some similarities in the etiology, diagnosis, and treatment of boys and girls with CD, it is quite obvious that little attention has been given to females (Hoyt & Scherer, 1998; Keenan, Loeber, & Green, 1999; Webster-Stratton, 1996; and O'Keefe, Carr, & McQuaid, 1998; Kann & Hanna, 2000). According to Green, Russo, Navratl, and Loeber (1999), girls who have been sexually abused will have a much higher risk of behavioral disorders. Since female sexual abuse is such a problem in our society, (it occurs more than three times the rate for males), it must be taken into account for the high number of girls being diagnosed with CD (p.152).

Green, Russo, Navratl, and Loeber (1999) gathered data through arranging structured interviews with 49 girls. Findings indicated that the prevalence of CD and major depression were higher for abused girls. They identified symptoms for girls who were sexually abused, physically abused, and dually abused (sexually and physically). It was also found that truancy was twice as high as normal girls for those that had been sexually and physically abused. Internalization of symptoms was also highest for the dually abused groups (p. 164). According to these studies, the trauma from sexual and physical abuse is at the forefront of a large

amount of conduct disorders in girls. While it is yet unclear why this reaction occurs in the female population, it is widely known that the long-term effects of child sexual abuse produces a number of different psychopathologies and problems, ranging from anxiety and depression to sexual problems in adulthood. According to Briere (1992), girls may form a negative self-evaluation of the maltreatment after the abuse, leading to self-deprecating conclusions about themselves. Briere also reports that children's aggressiveness toward others (fighting, bullying, or attacking other children) is a frequent short-term sequel of various types of maltreatment, including sexual and physical abuse (p. 57).

Academic Differences

One other notable difference between girls and boys with CD is academic and school performance. In a review of the literature by Kann & Hanna (2000), it was noted that girls with CD typically have higher rates of academic difficulty (p. 278). This is also found to be true in studies by O'Keefe, Carr, & McQuaid (1998). The authors took 20 male and 20 female conduct disordered adolescents and tested for gender differences on a number of issues. They reported that while boys showed higher rates of cruelty, bullying, destructiveness, weapon-carrying and initiating fights, girls were more likely to internalize their symptoms with depression and anxiety, and showed lower IQ scores and more academic failure (p.376).

Age of Onset

Other important studies show that the course of CD for girls and boys is also very different. According to O'Keefe, Carr, & McQuaid (1998), "for girls, the onset of CD is typically in adolescence and recovery is more frequent, whereas for boys the onset is typically in childhood and CD is more likely to persist into adulthood (p. 369).

Co-morbidity Of Symptoms

A number of studies have determined that there are major differences between boys and girls with regard to comorbidity, (the simultaneous occurrence of two or more unrelated conditions,) as it relates to CD. Stahl and Clarizio (1999) conducted an exhaustive literature review concerning comorbidity in children with CD and found that while CD is in itself a complex disorder, there is a high likelihood of comorbid conditions.

Most studies have shown that girls who have CD have more susceptibility to having a coexisting condition of anxiety, depression, and somatization, and that boys have more occurrences of ADHD (Keenan, Loeber, & Green 1999; O'Keefe, Carr, & McQuaid, 1998; Green, Russo, Navratil, & Loeber, 1999; and Stahl, & Clarizio, 1999).

Spencer & Oatts (1999) suggest that African-American males may actually be misdiagnosed with CD, when they are really afflicted by ADHD due to the similar occurrences within the disorders (p. 515). In

another exhaustive review of the literature, Abikoff and Klein (1992) pointed out that "comorbidity among the disruptive disorders is extremely common," stating that in their study of clinical samples, estimates of co-occurrence of ODD and CD among children with ADHD range from 20% to 60%, and even at 90% for those already diagnosed with CD (p. 881).

Finally, a study conducted by Walker, Lahey, Hynd, & Frame (1987) shows numerous connections between CD and ADHD, especially in boys. The authors studied a sample of 21 children diagnosed with CD and ADHD and compared them to a group of 14 children with a diagnosis of CD, but no subsequent ADHD. The results showed that children with both CD and ADHD showed more physical aggression and a greater variety of behavioral problems than the children who had conduct disorder only" (p. 911). O'Keefe, Carr, & McQuaid (1998) also showed in their studies of 20 girls and 20 boys, all with CD, that boys were more likely to show a comorbidity with ADHD, and that girls were more likely to show a comorbidity with anxiety and depression disorders (p. 381).

Long Term Effects of Conduct Disorder in Females

Many studies have been done regarding the long-term effects of CD on children. They do not paint a positive picture of the after effects of CD on adult lives. Some of the studies are concerned with the health outlook of the adult who was diagnosed with CD as a child. Bardone, Moffit, Caspi, Dickson, Stanton, & Silva (1998) studied the long-term health effects in women. The authors conducted a very impressive longitudinal look at a cohort of subjects known as the Dunedin Multidisciplinary Health and Development Study. The children were born between April 1, 1972, and March 31, 1973 in New Zealand. A total of 1,037 children (52% males and 48% females) participated in the study. At age 15 (1987-1988) mental health data was collected for 461 girls (92% of the cohort). Again, at the age of 21 (1993-1994) data was collected for 470 women (94% of the original cohort). Complete medical exams were conducted, and extensive measurements were taken to assess medical problems.

The results of the study were astounding. In relation to substance dependence: 25% met the criteria for substance dependence at age 21, and tobacco use was more prevalent among girls with CD. Seventy four percent were smokers by age 21. Also, more of the girls with CD (46%) were pregnant by the age of 21, and more sexually transmitted disease cases were reported.

Kathleen Pajer (1998) conducted a study of the adult outcomes of girls with CD. Her reports were similar. Her conclusion was that girls with CD would not fare well as adults. Pajer revealed that girls with CD would have a 10% higher mortality rate than the normal population. They will also have more psychiatric difficulties, as well as higher rates of criminality. Girls with CD also marry earlier (age 17) than normal girls, and have higher rates of divorce and extramarital activity. Forty percent of the girls in the study did not finish high school. Pajer also found that girls who

had conduct disorder ended up on welfare more often. Over half of the subjects utilized social service agencies, or were involved with Child Protective Services. Another striking finding by Pajer was the issue of parenting behavior. Mothers who had CD as children tended to have children with CD difficulties more often than normal mothers.

Zocolillo & Rogers (1991) studied the long-term effects of CD on those girls who had been treated in psychiatric hospitals. This study was conducted by a 2-4 year follow up after their release from the psychiatric hospital. He studied a sample of 55 girls. The 55 girls in the study had been admitted to a locked adolescent short-term psychiatric unit during two time periods in 1987 and 1988. The precipitating events for their admission into the hospital were: suicide attempts (38%), suicide threats (16%), running away (20%), family conflict (9%), and the others were a potpourri of depression, alcohol intoxication and substance abuse.

The results from this study were indeed eye opening in relation to the long-term effects of CD. Of the 55 girls studied, it was learned that three were dead. As far as education went, out of 49 girls, 13 were still in high school, 7 graduated, 20 dropped out permanently, 5 dropped out but returned, 4 were expelled and did not return, five girls obtained a GED, and 12 were expelled or suspended. Fifty percent of the girls had been arrested, 38% were re-hospitalized, 16 were placed in children's homes, or long-term treatment facilities, eleven had attempted suicide, and 24 ran away. Of the girls that had jobs (39), 8 had been fired. Fifty-two percent were in motor vehicle accidents requiring medical care. Twenty-five were pregnant, 16 of those before the age of 17 years.

CONCLUSION

Girls differ greatly from boys in the symptomology of behavioral disorders. We know that there has been some evidence of sexism in the classification of CD by the experts who formulated the criteria in the Diagnostic and Statistical Manual for Mental Disorders. In that regard, females have largely been ignored in the research of CD.

There are significant gender differences in the way that males and females exhibit symptoms of CD. Boys tend to externalize their highly volatile emotions, often becoming aggressive and hostile. Females will show more internalization of the same emotions, turning their hostility inward. They exhibit much more depression and anxiety than boys as a result.

Another observation must be made about females with conduct disorder. Since they internalize their behaviors, it is highly probable that they may be misdiagnosed with borderline personality disorders because of the self-injurious behaviors, (including eating disorders), which may accompany their symptoms.

Implications for Practice

While conduct disorder is difficult to deal with, professionals must continue to make progress in the treatment of this disorder with both genders. However, it is imperative that females be given individual consideration in determining the diagnostic criteria and treatment of behavioral difficulties. It is also important for more research to be conducted in the area of female conduct disorder. Researchers need to ensure that future studies that are conducted on such widely accepted genres as the Diagnostic and Statistical Manual of Disorders are not biased in their sample selection.

Recent progress in the treatment of conduct disorder has been demonstrated by utilizing social skills training curriculums, problem-solving methods, and cognitive therapy techniques. More studies need to be done to measure the effect these tools have on diverse populations with behavioral disorders.

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