Good Psychiatric Management for Conduct Disorder

A comprehensive inpatient adaptation for adolescents with trauma, attachment insecurity, and conduct disorder

World GPM Congress

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This presentation covers

- Definition + risks if untreated
- Current treatment evidence
- Comorbidities and medication logic
- Interpersonal hypersensitivity in CD
- Hospital, family, and community alignment

Good Psychiatric Management is used here as a pragmatic framework for explaining, coordinating, and delivering care — not as a substitute for evidence-based family, behavioral, or trauma treatment.

What is conduct disorder?

A diagnosis defined by pattern, persistence, and impact

DSM framework

A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms are violated.

At least 3 of 15 criteria in the past 12 months

At least 1 criterion present in the past 6 months

Symptoms cluster in 4 domains and must be impairing

Aggression to people/animals

Threats, fights, intimidation, cruelty

Property destruction

Vandalism, fire-setting, deliberate damage

Deceitfulness / theft

Lying, stealing, manipulation, breaking trust

Serious rule violations

Truancy, running away, repeated major rule breaches

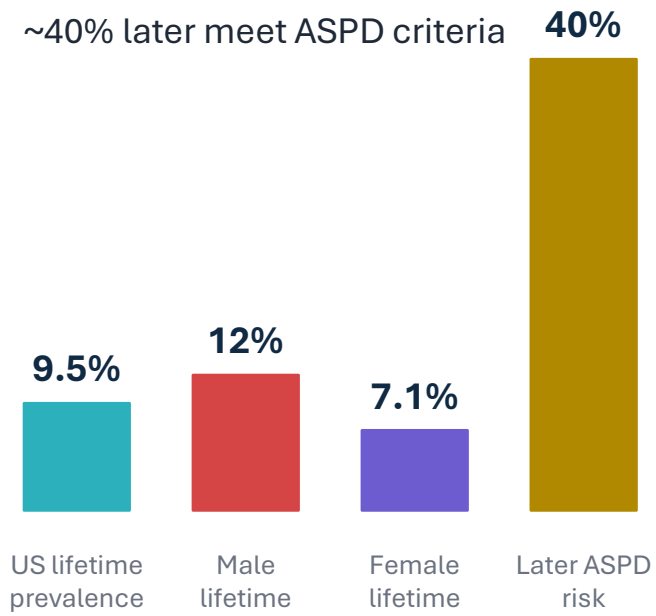
DSM-5-TR criteria summary; AAFP 2018

Why early treatment matters

Conduct disorder is common, impairing, and associated with long-term risk if symptoms persist

Selected epidemiology and risk markers

9.5% = estimated U.S. lifetime prevalence
12% males vs 7.1% females
~40% later meet ASPD criteria



Up to 40% — Looked-after / abused youth in UK surveys had a conduct disorder

16–20% — Youth with conduct disorder also have ADHD in AAFP review

Untreated course — Associated with school failure, substance use, and criminal behavior

Clinical point: untreated conduct disorder predicts a worse developmental trajectory; even when symptoms improve, the longer the pattern is rehearsed, the harder it becomes to restore school attachment, family trust, and safe peer relationships.

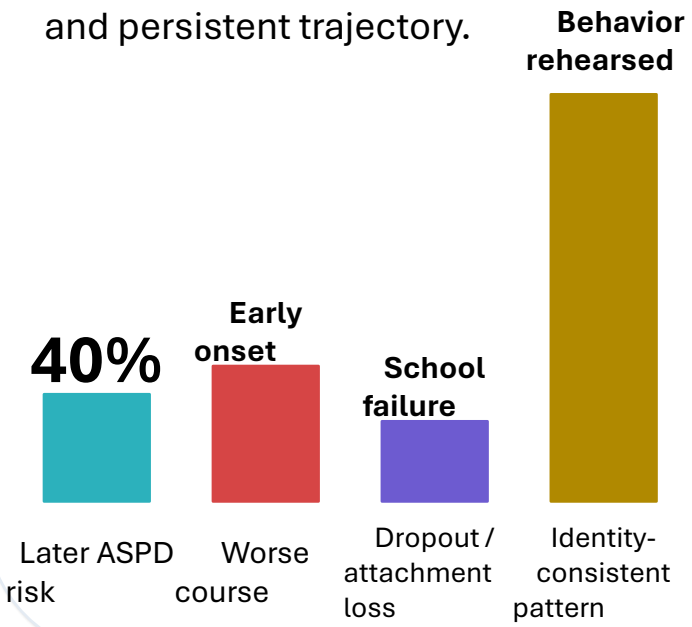
AAFP 2018; APA patient page; NICE guideline intro

Risks of untreated conduct disorder

Developmental trajectory: why early treatment changes outcome

Selected developmental risks

~40% later meet criteria for Antisocial Personality Disorder; earlier onset predicts a more severe and persistent trajectory.



Developmental momentum

Escalation from oppositionality to aggression to entrenched antisocial behavior becomes more likely over time.

Functional impact

School failure, loss of prosocial peers, and rupture with caregivers and institutions accumulate.

Clinical point

We are not only treating behavior in the moment — we are interrupting a developmental trajectory.

The longer the pattern is rehearsed, the harder it becomes to restore school attachment, family trust, and safe peer relationships.

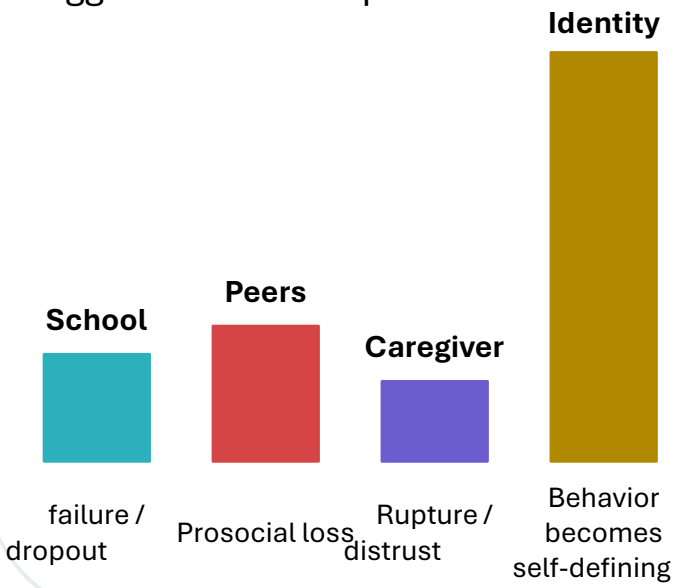
AAFP 2018; APA; NICE; AHRQ 2025; JAACAP 2025

Risks of untreated conduct disorder

Developmental trajectory: how untreated symptoms change identity and function

Selected developmental risks

Untreated conduct disorder narrows school, peer, and family pathways while strengthening aggressive or deceptive solutions.



Identity risk

Aggression, deceit, and major rule-breaking can become part of how the adolescent understands self and status — not just a situational reaction.

Why timing matters

Early coordinated intervention changes trajectory more than late intervention after antisocial behavior is already entrenched.

Clinical point

The goal is not symptom perfection on the unit — it is trajectory shift.

This is why early, coherent inpatient, family, school, and community action matters.

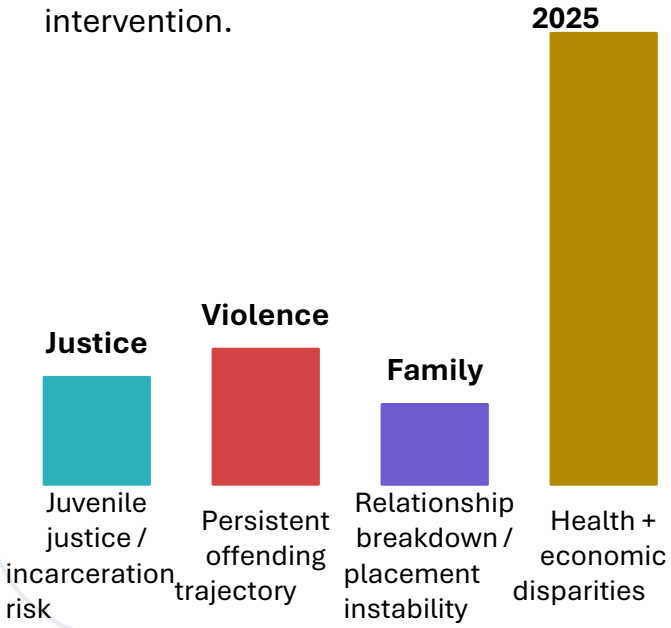
AAFP 2018; NICE; AHRQ 2025; JAACAP 2025

Risks of untreated conduct disorder

Public health and systems impact: conduct disorder becomes a multi-system burden

Selected public health risks

Persistent disruptive behavior disorders are linked to long-term health, legal, and economic burden; earlier intervention changes trajectory more than later intervention.



Systems

Untreated CD predicts downstream involvement across schools, emergency settings, courts, probation, and residential care.

Costs

Healthcare, legal, educational, and lost-productivity costs accumulate across adolescence and adulthood.

Clinical point

Untreated conduct disorder is one of the strongest predictors of system involvement in child psychiatry.

CD is not simply a family or school problem; it is a public-health problem with developmental, legal, and economic consequences.

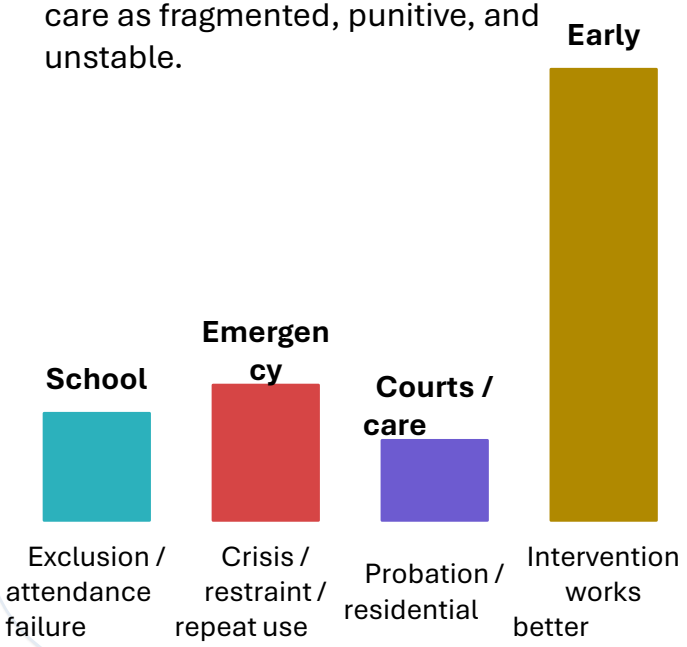
AHRQ 2025 systematic review; JAACAP 2025 meta-analysis; NICE; AAFP 2018

Risks of untreated conduct disorder

Public health and systems impact: why alignment across hospital, family, school, and community matters

Selected public health risks

The more systems become involved without one coherent therapeutic story, the more the adolescent experiences care as fragmented, punitive, and unstable.



Alignment need

Hospital, family, school, and community should use one trigger map, one behavior plan, and one crisis script whenever possible.

Research message

Recent syntheses support early, coordinated, caregiver-involved intervention and are less optimistic about late-stage change in entrenched adolescent conduct problems.

Clinical point

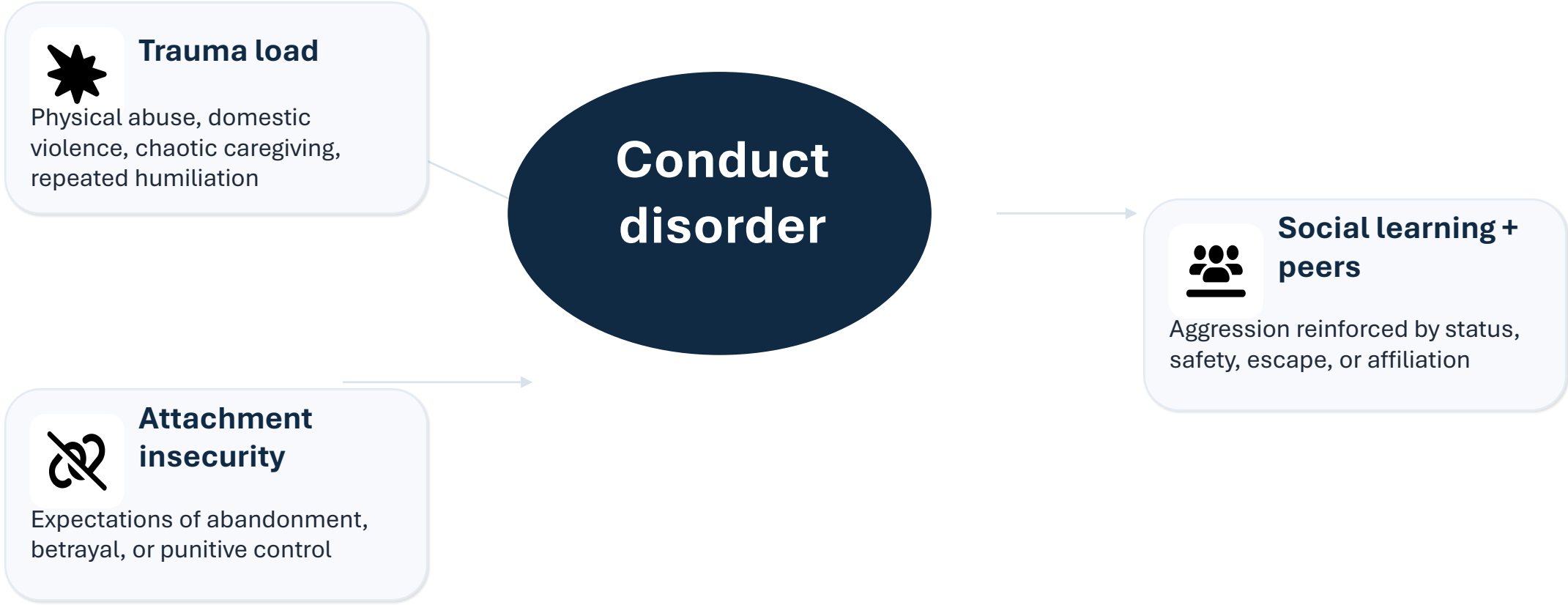
A world-conference message: CD is a public-health problem that requires integrated systems action.

That is exactly where a GPM framework becomes useful: it gives teams one language and one plan across settings.

AHRQ 2025; Lee 2024; Hunkin 2025; NICE

A developmental formulation is more useful than a moral one

Conduct disorder is best understood as an adaptation to chronic threat, disrupted attachment, and maladaptive reinforcement



Framing implication: understanding a behavior as adaptive in its original context does not remove accountability; it tells the team where to intervene.

AAFP 2018 risk factors; NICE introduction and principles of care

Common co-morbidities change how conduct disorder looks

Co-occurring disorders often determine the trigger, tempo, and treatment priorities

ADHD

Impulsivity, reward-seeking, poor inhibition, rapid retaliation

AAFP: about 16–20% of youth with CD also have ADHD; NICE notes ADHD as a key complicating factor.

PTSD / trauma-related symptoms

Hypervigilance, hostile attribution bias, shutdown or fight

PTSD is a complicating factor in NICE guidance; trauma exposure is a major risk factor in AAFP.

Mood / anxiety disorders

Irritability, shame, hopelessness, suicidal risk, social withdrawal

Mood and anxiety symptoms increase shame, hopelessness, and overall psychiatric burden.

Substance use disorders

Disinhibition, intoxication-related aggression, peer contagion, legal risk

SUD magnifies risk-taking, peer contagion, and community harm.

AAFP 2018; NICE QS59 / CG158

ADHD + conduct disorder: the fastest route to reactive aggression

When attention and inhibition problems combine with coercive or antisocial learning, fights happen faster and consequences matter less in the moment

Mechanism

Poor inhibition	**More rapid retaliation**
High reward sensitivity	**More rapid retaliation**
Low frustration tolerance	**Less pause before aggression**
Rapid action before reflection	**Less pause before aggression**

Medication logic when ADHD is present

- No FDA-approved medication for conduct disorder itself
- Treat ADHD first: methylphenidate or atomoxetine within licensed indications
- AHRQ 2025: stimulants and/or antipsychotics outperform placebo for short-term aggression response, but evidence beyond that is sparse

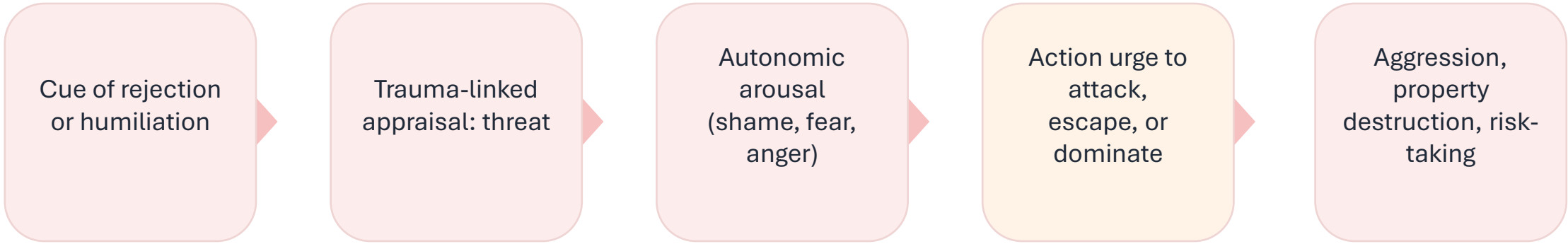
Practical inpatient implication

If the unit is trying to manage “conduct disorder aggression” in a youth whose untreated ADHD is driving impulsive fights, treatment will look punitive and feel ineffective. A more accurate formulation reduces blame and improves sequencing.

NICE 1.6.1–1.6.3; AAFP 2018; AHRQ 2025

Trauma / PTSD + conduct disorder: when threat is everywhere

Trauma does not excuse aggression — but it does change the trigger map



Clinical pearl

Many adolescents with trauma histories misread neutral peer or staff behavior as contempt, exclusion, or impending control. In that moment, aggression can feel like self-protection rather than “bad behavior.”

Treatment implication

Use trauma-informed de-escalation in the moment; treat full PTSD with trauma-focused therapy once safe enough; keep accountability intact throughout.

AAFP 2018 differential and risk factors; NICE complicating factors and engagement principles

Mood disorders, anxiety, suicidality and substance use complicate the picture

These syndromes increase volatility, shame, suicidality, and legal risk — and they need direct treatment

Mood / anxiety/suicidality

- May present as irritability instead of sadness
- Can intensify shame after aggressive episodes
- Treat when a full syndrome is present; do not collapse everything into “behavior”
- Adolescents with conduct disorder have a **5-fold increased risk of suicide attempts**

Substance use

- Intoxication and withdrawal lower inhibition
- Peers, access, and probation pressures increase relapse risk
- Integrated SUD treatment is part of the conduct-disorder plan, not an “extra”
- Adolescents suffering from CD, the risk of suicidal behavior is considerably increased by co-morbid alcohol dependence

AAFP 2018; NICE QS59 complicating factors

Current psychosocial treatment options

What is evidence-based, for whom, and what each model tries to change

Intervention	Best fit	Core target
Parent management training / parent-only	Younger children; family can participate regularly	Reduce coercive cycles; strengthen reinforcement, routines, monitoring
Parent + child multicomponent programs	Preschool and school-age youth	Combine parent skill building with child social/problem-solving work
CBT / problem-solving skills training	School-age and some adolescents	Hostile attribution bias, anger regulation, perspective-taking, choice points
Multisystemic therapy (MST)	Older adolescents; justice/system involved	Home, school, peers, legal context, supervision, community ecology
FFT / family-focused adolescent work	Adolescents with entrenched family conflict	Reduce blame/escalation; improve communication, supervision, alliance
Treatment Foster Care Oregon / intensive placement-based models	Youth whose home setting cannot currently sustain safety	Structured behavior support with parallel family work

Bottom line: the evidence base is strongest when an intervention changes the caregiver system and the child's decision-making environment — not just the child's insight.

AHRQ 2025 systematic review; NICE CG158; AAFP 2018

What the latest synthesis actually says

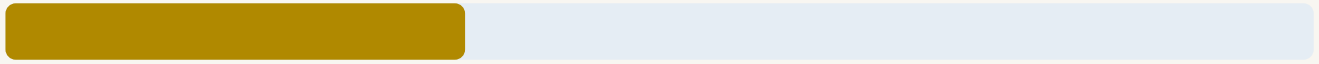
Evidence is meaningful — and also more mixed in adolescents than many presentations imply

Preschool / school-age parent-only — Moderate evidence

Better than usual care/waitlist immediately post-treatment

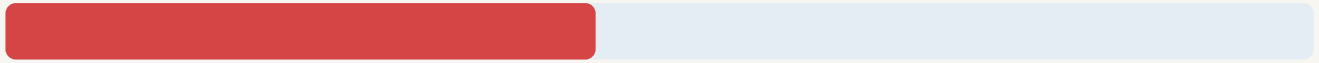
Preschool / school-age multicomponent — Moderate evidence

Also better than usual care/waitlist immediately post-treatment



Adolescent multicomponent / child-only — Low / insufficient

Results mixed; heterogeneity high; not one clear winner



Pharmacotherapy for aggression — Low / short-term only

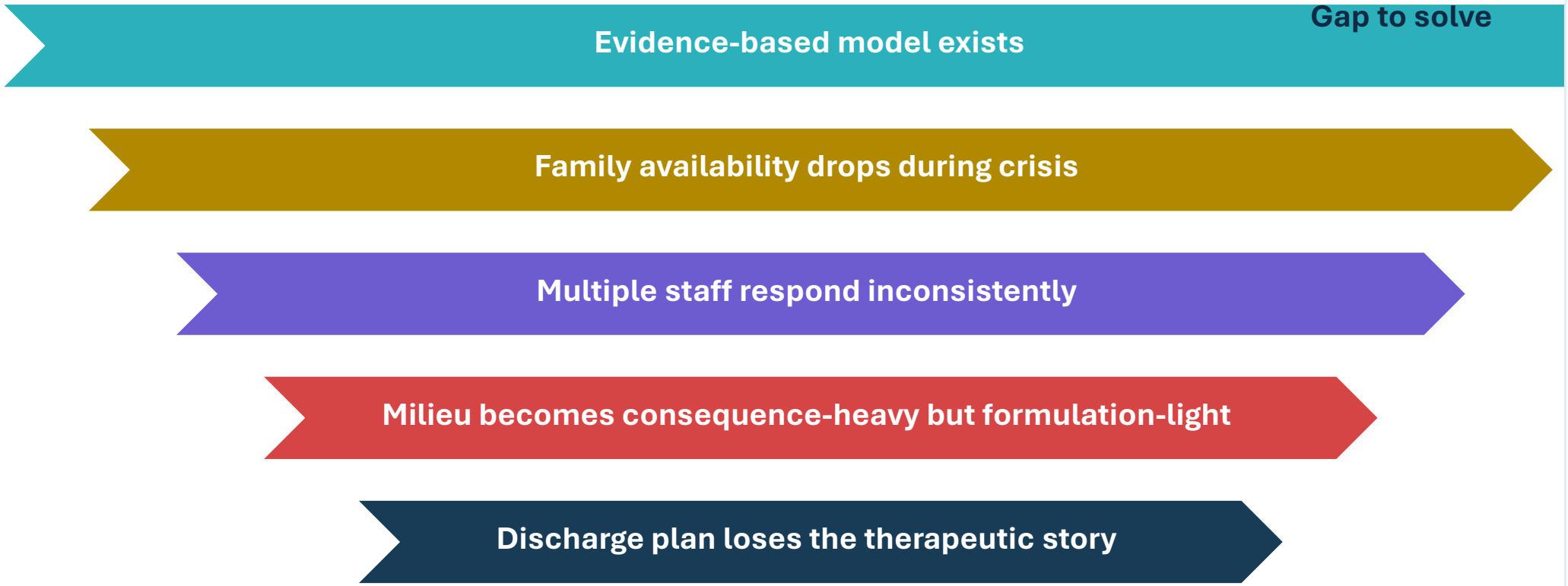
Stimulants and/or antipsychotics better than placebo for short-term aggression response

Recent reviews sharpen the message: treat early, involve caregivers, and be honest that outcomes for severe persistent adolescent conduct problems are less robust than the field often implies.

AHRQ 2025; Lee et al. 2024 scoping review; Hunkin et al. 2025 meta-analysis

Why this still fails in real-world inpatient care

Evidence-based outpatient models often fragment when adolescents move into crisis settings

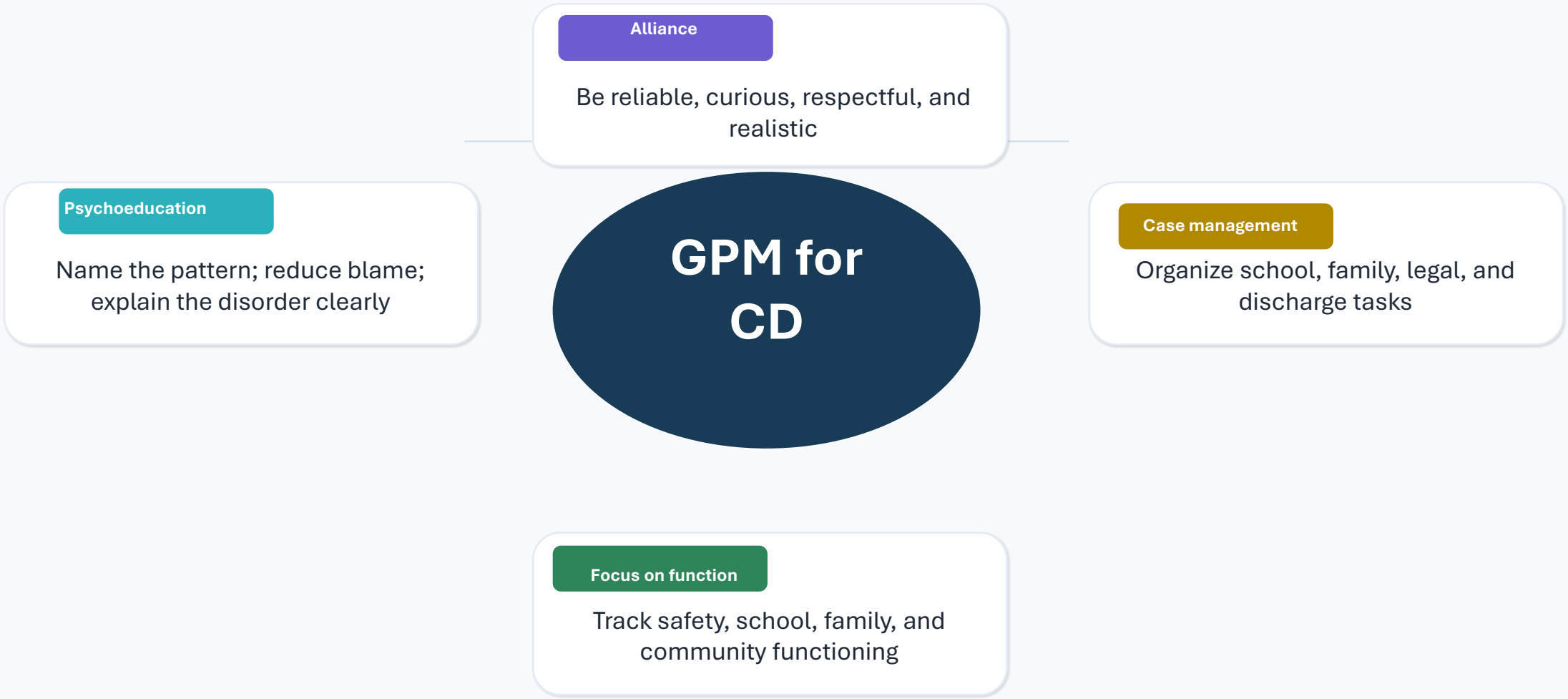


How do we keep one coherent formulation, one language, and one behavior plan across all staff and across discharge?

AHRQ 2025; NICE care-pathway recommendations; Lee 2024

GPM in one slide

A management model that prioritizes alliance, function, and coherent explanation



GPM conceptual adaptation by presenter

Adapting GPM specifically for conduct disorder

The adaptation shifts the focal problem from “instability of self and relationships” to “interpersonal threat, control, and rights violations”

Accountability + empathy

Understand why the behavior happens without excusing it

Structure as treatment

Predictability reduces chaos and clarifies consequences

One story across staff

Prevent splitting, bargaining, and mixed messages

Function over confession

Target safety, school, family, and discharge readiness

Developmental hope

The goal is a trajectory shift, not a perfect unit stay

GPM adaptation by presenter, consistent with NICE engagement and pathway principles

Interpersonal hypersensitivity model: a useful bridge from BPD to conduct disorder

In conduct disorder, perceived abandonment, humiliation, disrespect, or loss of control can rapidly activate retaliatory behavior

Trigger themes

Rejection
Abandonment
Humiliation
Status loss
Adult control

Internal appraisal

“I’m being disrespected.”
“They are against me.”
“I have to act now.”

Action tendency

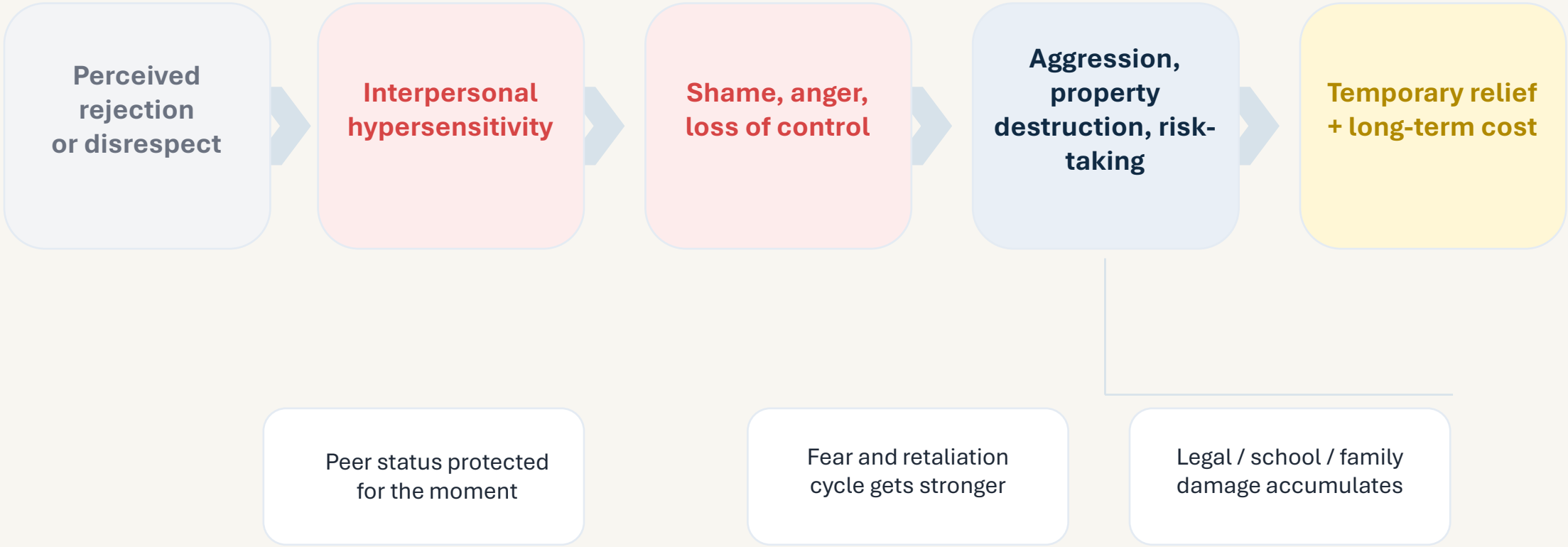
Attack
Dominate
Damage
Escape
Recruit peers

This model matters because it changes the staff question from “How do we stop defiance?” to “What interpersonal cue just made aggression feel necessary?”

GPM-informed adaptation by presenter; consistent with trauma and engagement principles in NICE / AAFP

How hypersensitivity becomes aggression in conduct disorder

The short-term function is usually relief, control, or restored status; the long-term cost is escalating harm



Conceptual model adapted by presenter; clinical logic supported by AAFP/NICE risk and engagement principles

Clinical vignette: the same event through two lenses

A GPM frame changes what staff notice, say, and prioritize

Typical reading

Peer laughs after basketball game. Patient says, “You think I’m a joke?” He shoves the peer, punches the wall, and kicks a chair when staff intervene.

- “He is manipulative and refusing limits.”
- Staff react to the aggression only.
- Intervention becomes consequence-heavy and relationship-light.

Likely outcome: brief compliance, persistent resentment, repeated replay

GPM reading

Same event, different formulation: perceived humiliation → shame/anger spike → urgent need to restore status. Staff name the feeling, set a limit, offer a choice, and return later for repair.

- “That felt disrespectful. Throwing chairs is not okay.”
- “You can step out with me now, or we move to a higher level of containment.”
- Later: reconnect, review the trigger, plan a better move next time.

Likely outcome: less escalation, preserved alliance, better learning window

Illustrative clinical vignette by presenter

Hospital staff are the intervention

On an inpatient unit, the treatment is not one clinician; it is the consistency of the whole system

Psychiatry / NP	Diagnosis, medication sequencing, shared formulation
Nursing	Moment-to-moment regulation, predictable limits, observation
Milieu counselors	Relationship continuity, coaching, consequence delivery
Social work	Family alignment, systems coordination, discharge bridge
Psychology / therapy	Skills, repair, behavior analysis, trauma work when ready
School / recreation	Restore mastery, routine, and prosocial identity

Shared stance Calm • brief • non-punitive • consequence-based • one story across shifts

NICE staff competence, supervision, and integrated pathway principles; team photo: Advisory Board

What staff actually do on the unit

These are small moves — but they only work when everybody makes them the same way

Keep it brief	Long lectures usually strengthen opposition or shame
Name the trigger	“That felt disrespectful to you.”
Set the limit	“Threatening or hitting is not okay.”
Offer structured choice	“Step out now or we move to a higher level of containment.”
Return for repair	After safety is restored, revisit the cue and plan another move

Sample language

“You can be angry here. You cannot threaten staff.”

“I’m not arguing with you. I’m telling you the next safe step.”

“We will talk more after you’re regulated enough to use words.”

“This consequence is about safety and repair, not about punishment.”

Presenter framework for unit language and stance

Flow chart: how to respond in the moment

The sequence matters more than eloquence

Common failure mode: trying to process while the adolescent is still mobilized to fight, flee, or dominate.

Presenter algorithm grounded in NICE safety / engagement principles

Align the family without blaming the family

Families are more likely to engage when the team names the burden, explains the rationale, and offers one coordinated plan

What families need to hear

- This is not your fault alone
- We need your help because change happens across settings
- We will explain the logic of every recommendation

Unit team

What schools / community need

- A clear trigger map
- One behavior plan and one crisis script
- Rapid communication when risk rises

Family

School / community

Goal: family + unit + community tell the same therapeutic story

NICE engagement, parent/carer support, and pathway recommendations

Align family and community before discharge

A safe discharge is a coordinated handoff, not a hopeful referral list

Before discharge

1

- Family meeting
- School / probation contact
- Medication and behavior plan

First 7 days

2

- Outpatient appointment
- Crisis contact
- Home supervision plan

30 days

3

- School attendance
- Substance-use check
- Family follow-through

90 days

4

- Violence / police contact
- Placement stability
- Skills generalization

NICE transfer, care-pathway, and coordinated communication recommendations

Medication: important, limited, and often misunderstood

There is no FDA-approved medication for conduct disorder itself

Do not routine-medicate "behavior problems" in CD. Use medication to treat a co-occurring syndrome or short-term severe aggression when psychosocial treatment alone has not been enough.

ADHD present

Stimulants or atomoxetine within usual indications

Best medication-supported route when impulsivity is a major driver of aggression

Severe explosive aggression

Consider short-term risperidone only after psychosocial work and ADHD treatment are addressed

Monitor metabolic, movement, cardiovascular, and prolactin risks; review at 3–4 weeks and stop by 6 weeks if no important response

Mood / PTSD / SUD

Treat the diagnosed syndrome with its own evidence-based protocol

Medication choice follows the co-morbid disorder, not the conduct-disorder label

NICE 1.6.1–1.6.7; AAFP 2018; AHRQ 2025

What better outcomes could look like

Inpatient success is a trajectory shift, not symptom perfection

During admission

- Fewer assaults / restraints
- More usable recovery time after triggers
- Clearer trigger map and behavior plan

30–90 days

- School re-entry or attendance improves
- Family follows one consistent plan
- Less justice / police contact

Longer-term

- Reduced harm to others
- Improved supervision and attachment
- Safer peer and community functioning

Outcome framework by presenter, aligned with NICE pathway emphasis on measurable goals

Key takeaways

- Conduct disorder is defined by persistent rights violations and major rule-breaking — not simply “noncompliance.”
- Untreated symptoms are associated with school failure, substance use, justice involvement, and later antisocial personality disorder risk.
- Current evidence supports psychosocial treatment first; medication mainly targets co-morbidity or short-term severe aggression.
- A GPM frame helps inpatient teams keep one coherent formulation: accountability with empathy, function over blame, and one story across staff.
- The interpersonal hypersensitivity model explains how abandonment, humiliation, and status loss can become aggression, property destruction, or high-risk behavior.
- Outcomes improve when hospital staff, family, school, and community are aligned before discharge.

Selected references

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Full URLs and source notes embedded in slide notes