

The Relationship of Attention Deficit Hyperactivity Disorder and Conduct Disorder to Juvenile Delinquency: Legal Implications

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Attention deficit/hyperactivity disorder (ADHD) and conduct disorder (CD) are both disorders of childhood and adolescence that all too frequently extend into adulthood. But just what is the relationship between these two disorders? This study explores the overlap between these two disorders as they relate to juvenile delinquency; both are significant risk factors for the development of antisocial behavior. But there is more significance to the presence or absence of ADHD or CD in later antisocial behavior. Higher levels of defiant and/or aggressive behavior lead to antisocial acts as compared with lower levels of defiance and antisocial acts. Boys diagnosed with ADHD have higher felony rates than normal control boys, yet ADHD is not nearly as strong a predictor of offending behavior as is CD in study subjects. The presence of both CD and ADHD contributes to illegal behavior, and it is likely that early intervention in both disorders will reduce the prevalence of antisocial behavior.

Fifty-five percent of all crimes are committed by juvenile delinquents.^{1,2} The 1987 statistics from the Federal Bureau of Investigation reported juvenile arrests made up 15 percent of all violent crimes and 33 percent of all property crimes.³ Juvenile delinquency is an important so-

cial concern. Attempts to remediate this concern include efforts that work toward an understanding of the factors that predispose children to commit crime.^{1,3} Conduct disorder (CD) and attention deficit hyperactivity disorder (ADHD) are two childhood disorders that are commonly associated with juvenile delinquent behavior.¹ For example, in a sample of incarcerated juvenile offenders ages 11 to 17 years, 87 percent met the criteria for CD.⁴ Another study, by Zagar *et al.*,¹ involved 1,056 delinquents and

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found that 55 percent of them had either attention deficit disorder (ADD, an older term for ADHD) or ADHD, which is a much higher prevalence than is found in the nondelinquent population. Ultimately the question becomes, what are the factors that are predisposing children to develop these disorders that seem to lead to offending behavior? As will be discussed later in the article, there seem to be several predisposing factors that contribute to the development of CD, ADHD, and delinquency in children; these include familial, social, environmental, and biological/genetic factors as well as the interactions among them.⁵

Brief History of ADHD and CD

ADHD and CD are not solely disorders of childhood. Barkley *et al.*⁶ reported results from an eight-year follow-up study indicating that over 80 percent of the subjects still had ADHD symptoms in adolescence. Gittelman *et al.*⁷ followed ADHD children for 10 years into adulthood and found that 31 percent still had ADHD symptoms. However, there exists a sparsity of scientific studies investigating such continuity of ADHD into adulthood. When CD-type symptoms are seen in adults, the symptoms are commonly diagnosed as antisocial personality disorder, although diagnostically these adults must have had a conduct disorder as children in addition to the adult symptoms.

Criteria for ADHD and CD

Often ADHD and CD co-occur, making it sometimes difficult to distinguish between the two psychopathologies. The DSM-IV states that the key difference

between ADHD and CD is found in the type of behavior exhibited. While the behavior of ADHD children may be disruptive, it does not "violate age appropriate societal norms." Children with CD, by definition, do break societal norms. (See *Appendix I* and *II* for the DSM-IV criteria of ADHD and CD).

Basic Studies About CD and ADHD Predicting Juvenile Delinquency

Several studies have linked CD and ADHD to juvenile delinquency. Conduct disorder is the most common DSM diagnosis associated with delinquency, particularly with more serious and persistent delinquency.⁸ Approximately 90 percent of juvenile offenders fulfill the criteria for CD.^{4,9} Male adolescents with ADHD have higher numbers of later arrests (36–58%) for delinquent behavior than male adolescents without ADHD.¹⁰ Barkley *et al.*⁶ reported that those diagnosed with ADHD and CD in adolescence had considerably higher rates of antisocial acts than healthy control subjects, with the most common antisocial acts being stealing, theft outside the home, and fire setting.

Children with ADHD and CD in childhood are also more likely to go on to commit crimes as adults. For example, a 14-year follow-up longitudinal study found that ADHD and antisocial behavior (i.e., behavior meriting criminal conviction) in childhood were among the most important predictors of later offending behavior at age 32.¹¹ A study of adult inmates by Eyestone and Howell¹² con-

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cluded that 25.5 percent of them had ADHD symptoms as children and still had them as adults. One study, in which the findings were in contrast to those above,⁵ was done with formerly hospitalized child psychiatric patients. It did not find that a prior diagnosis of CD was correlated to adult criminality, since 57 percent of the children diagnosed with CD had no prison record. The authors fail to mention, however, that apparently 43 percent did have a prison record.

In addition to being associated with externalizing problems such as delinquent behavior, childhood problems of CD and ADHD are also significantly associated with internalizing problems, which may lead to depression.¹³ For example, male adolescents with diagnosed ADHD have been found to have higher rates of institutionalization than male adolescents without ADHD.¹⁰

In general, the above evidence supports the hypothesis that CD and ADHD are both significant risk factors for the development of adult antisocial behavior. However, several carefully done studies have questioned the idea that ADHD alone is a strong predictor of juvenile delinquency. Klein and Mannuzza¹⁴ reviewed several longitudinal studies that found that the link between childhood hyperactivity and criminality was not straightforward. They concluded that only a portion of those children diagnosed with ADHD actually go on to develop antisocial behavior. This conclusion was based on their finding that some ADHD individuals also develop antisocial personality disorder; it is members of this small group that have an increased risk of

offending behavior, not the portion of the population that suffers from ADHD alone. Another extensive review of longitudinal studies¹⁵ found consistent evidence that ADHD leads to subsequent antisocial behavior. However, those studies that controlled for the effects of comorbid CD found that it was actually the CD that was related to later antisocial behavior, not ADHD. In other words, when childhood ADHD is not accompanied by conduct problems or aggression, it is not strongly related to adult antisocial behavior. Fergusson *et al.*¹⁶ also found that ADHD was not correlated to offending behavior when comorbid CD effects were controlled.

Another study, by Satterfield *et al.*,¹⁷ demonstrated the heterogeneity of ADHD. They studied two different groups of ADHD individuals and found that those subjects with high aggression and defiance ratings had higher offending rates than those ADHD individuals with lower aggression and defiance ratings. However, this study also found that even the ADHD boys with lower aggression and defiance ratings still had higher felony rates than normal control boys. Barkley *et al.*⁶ also reported that those diagnosed with ADHD alone tend to have more antisocial acts than healthy control subjects. However, the important conclusion is that ADHD does not seem to be nearly as strong a predictor of offending behavior as CD, when the studies are controlled for comorbidity.

Differential Diagnosis

Many people have questioned whether CD and ADHD are truly different disor-

ders. It is true that the two disorders do commonly co-occur. Conduct disorder has been reported to be present in as many as 50 percent of people diagnosed with ADHD.⁸ Despite this high comorbidity rate, there is much research evidence supporting the belief that these are indeed two separate disorders.

One study demonstrated some ways in which the disorders differ in terms of the long-term behavior outcome. Fergusson *et al.*¹⁶ found that early conduct problems at ages 6, 8, and 10 years were highly continuous with offending behavior at age 13 but were unrelated to academic achievement when accounting for comorbid ADHD effects. Similarly, this study also found that ADHD was correlated to academic difficulties but not to offending behavior when CD effects were controlled. Another study¹⁸ also found differences of an academic type between the two disorders. ADHD children more often have cognitive and achievement deficits than CD children. They are also more often "off task" in classroom and play situations, but they were not found to be at significant risk for behavioral deviance in adolescence. Conduct disordered children, on the other hand, are on task and have better volitional control and social skills, but their behavioral and social outcomes are far worse. Furthermore, school expulsion rate was found by one study to be "considerably higher" in boys with diagnosed CD than in those with either ADHD only or normal controls.⁷ All of the above is evidence of the differentiation of CD and ADHD. An extensive review of the literature similarly concluded that differences in terms of vali-

dating criteria, course, and family history all strongly suggest that ADHD and CD are two etiologically different disorders.¹⁵

Comorbidity of CD and ADHD

As mentioned above, about 50 percent of those diagnosed with ADHD also have CD and antisocial behavior.^{6, 8} Forehand *et al.*³ report that the comorbidity of CD and ADHD is associated with more arrests and more antisocial behavior, which start at a younger age than in individuals diagnosed with CD alone. Perhaps this occurs because those with ADHD as well as CD are more likely to get caught or because their impulsivity somehow leads to more arrests. The comorbidity group reportedly also were found to have lower levels of intellectual and academic skills.³ Barkley's⁶ report of the higher than normal rate of antisocial acts among people with ADHD is especially prevalent when CD also is present. The comorbidity of the two disorders seems to combine the worst features of both disorders.¹⁸

It has been hypothesized that those whose ADHD continues into adulthood are at increased risk of developing CD, which also commonly leads to substance abuse and antisocial personality disorder. This may be one reason that ADHD is noted as a significant risk factor for the development of adult antisocial behavior.⁷

Predisposing Factors for Developing CD, ADHD, and/or Delinquency

As previously mentioned, there appear to be several predisposing factors that not only contribute to the development of CD

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and ADHD, but also often exist comorbidly with these disorders in the manifestation of delinquency. Generally, these include familial, social, environmental, and biological/genetic factors; this article will address specific variables such as parenting, peer relations, socioeconomic status (SES), personal characteristics, and heredity. Each of these factors can exert its influence individually or in the form of multiple interactions.

There are a number of studies that focus on parenting, which seems to be the most researched of the factors that may lead to delinquency problems. Simons *et al.*¹⁹ emphasized the important contribution of poor parenting to early delinquency, echoing the views of Nagin and Farrington,²⁰ who pointed out a similar positive association with early onset, but not late onset, delinquency. Similarly, conduct problems, as defined by Farrington *et al.*,²¹ were also found to be related to poor parenting as well as inadequate parental supervision. Stouthamer-Loeber and Loeber²² added poor marital relations to the list, while Loeber *et al.*,²³ pointed out the contributions of negative parent-child interactions and lack of parental involvement, in addition to poor supervision, as correlates of delinquency. Primary trauma of physical and/or sexual abuse results in girls, in particular, developing symptoms of delinquency and pathology.²⁴ The behavior of these girls is hypothesized to be a modeling of what had been done to them by continuing to violate the rights of others. Furthermore, another study found that children who were abused severely enough to have been removed from their parents showed

a significantly greater prevalence of ADHD and CD.²⁵ Finally, Brown *et al.*²⁶ classified many of these negative parenting qualities under general family disorganization, which often precedes and likely contributes to the onset of delinquency.

The influence of parental qualities, meaning the personality characteristics of the caretakers, has drawn nearly the same research attention as methods of parenting. Additionally, these personality traits are frequently associated with the argument for the influence of heredity on delinquent behaviors. Barkley *et al.*⁶ reported on risk factors that are associated with ADHD in particular, although he did not control for the possible comorbidity of CD. He found that the children diagnosed with ADHD as compared with a normal population had parents with three times more divorce, four times more changes of residence, and twice the number of fathers who had repeatedly committed antisocial acts; also 11 percent of the fathers had an antisocial personality disorder. Similarly, another study concluded that children with CD had parents with relatively greater rates of psychopathology.²⁷ They had both mothers and fathers who were diagnosed with APD, and fathers who abused substances. In contrast, however, ADHD was not associated with any parental disorder in this study. In relation to the evidence of comorbidity, those diagnosed with CD and ADHD had fathers with greater levels of aggression, arrests, and imprisonment than those with CD alone. In addition, Nagin and Farrington,²⁰ and Stouthamer-Loeber and Loeber²² concluded that the

parents' criminality is significantly correlated with late onset delinquency in their children, while Farrington *et al.*²¹ related this characteristic to the development of a child's hyperactive-impulsive-attention problems. In combination, these results suggest that CD, ADHD, and/or delinquency may have a family etiology that could be the result of heredity, social learning, or some other mode of familial transmission. Coffey,²⁸ however, emphasized the former: "heredity and genetics contribute significantly to the development of antisocial or criminal behavior" (p 378).

Another area of predisposing factors includes the child's personal characteristics, among which the development of a learning disability appears paramount. Crawford²⁹ recalled the findings of two studies, each reporting a strong relationship between learning-disabled children and delinquency. In these studies, the probability of delinquency for adolescents with learning disabilities was twice as great as for their peers without learning disabilities, prompting Crawford to call learning disabilities "one of the important causes of delinquency" (p 23). More recently, Williams and McGee³⁰ focused specifically on reading disabilities, and they found a significant association with the later manifestation of CD in boys and increased police contact among both boys and girls. Other personality traits related to delinquency include negative emotions and weak constraint. Caspi *et al.*³¹ explained that "in low constraint individuals, negative emotions may be translated more readily into action" (p 187).

In addition to intrapersonal character-

istics, interpersonal variables also have been shown to influence the manifestation of delinquency, particularly in the form of peer relations. Lawrence³² analyzed this factor along with school performance and found that association with delinquent peers weighed more heavily than school attachment in predicting delinquent behavior. This leads to the question of whether delinquent behavior attracts similar peers, or do delinquent peer relations cause the individual behavior? Thornberry *et al.*³³ attempted to answer this question and concluded that the two factors have an interactional effect, each influencing the other in important ways, without one necessarily preceding the other.

Finally, environmental predisposing factors have received some attention, with SES at the forefront, inviting conflicting and controversial explanations. On the one hand, Williams and McGee³⁰ attribute the source of delinquency to early antisocial behavior and "background disadvantage," specifying that "later disadvantage is predictive of delinquency" (p 455). Alternatively, Stouthamer-Loeber and Loeber²² found SES to be "only weakly related to delinquency" (p 344), and Simons *et al.*¹⁹ saw only an "indirect" relationship between SES and delinquency (p 270). Furthermore, "competent mothers seem to insulate a child against criminogenic factors even in deteriorated neighborhoods" (p 411), according to McCord.³⁴ Consequently, it appears that the power of SES has yet to be determined in the manifestation of juvenile delinquency.

Loeber and Dishion³⁵ reviewed predic-

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tion studies on delinquency and rank ordered the principle predictors as follows: parental family management techniques, child's problem behavior, reports of child's stealing, lying or truancy, family members' criminality or antisocial behavior, child's poor educational achievement, SES, and separation from parents. Although each of these factors has been repeatedly linked to the development of CD, ADHD, and/or delinquency, Huizinga *et al.*³⁶ caution against pointing to a single path to delinquency, emphasizing instead the heterogeneity of this group of individuals. With respect to ADHD, the DSM-IV³⁷ affirms this position by providing criteria for three distinct subtypes: Combined Type, Predominantly Inattentive Type, and Predominantly Hyperactive-Impulsive Type. However, research seems to be lacking regarding the differential developmental patterns of each of these subtypes.

Legal Implications Beyond Delinquency

While juvenile delinquency tends to be the usual medium through which adolescents with ADHD and CD clash with the law, in recent years the court system has been faced with other complications of these disorders, specifically ADHD. Cases have arisen in connection with the Americans with Disabilities Act in the workplace as well as the use of ADHD in court defense.

Conroy³⁸ recently called for an improved system for the determination of disabilities under the Americans with Disabilities Act. This plea has come in

response to the wide range of applications for which the Americans with Disabilities Act has begun to be used, including as a defense for persons with ADHD. Conroy specifies "reasonable accommodations for ADHD's in the workplace" (p 465), which includes a long list of possible alternatives to assist such employees in completing their tasks. However, Conroy points out that, according to the Americans with Disabilities Act, "the employer is neither required to change the 'essential functions' of the job nor to provide an accommodation that would be an undue burden" on the employer (p 466). This appears to open the door to further ambiguity, as terms such as "essential functions" and "undue burden" seem potentially troublesome.

In Ventura County, CA alone, three defendants have recently attempted to use ADHD as a defense.³⁹ While none of these cases resulted in an acquittal, trial and appeal courts have offered little formal opposition to defense attorneys use of ADHD in this manner. In fact, in one of the California cases, it is believed that the sentence was diminished to a degree as a result of the ADHD defense, although the judge in the case did not explicitly state this. Coffey²⁸ warns that with the growing literature on the genetic association to criminal behavior, the judicial system must decide to what extent each possible factor will be assigned causal precedence. Overall, most experts in the field believe that "ADHD's best courtroom use is as a minimizing factor in sentencing or during the punishment phase of a death penalty case" (p 2).³⁹

Treatment and Outcome

Both ADHD and CD are correlated with an adult diagnosis of antisocial personality disorder especially if onset occurs before age six. In terms of early identification, those who commit a greater number of crimes and more serious crimes are the ones who are more likely to go on to commit crimes in adulthood.¹⁰ Because early onset is such a strong predictor of long-term criminal offending behavior, it is important to be able to identify which children will commit crimes as adults by looking for predictors and starting interventions while they are young.^{40, 41} Similarly, the comorbidity of CD with ADHD should alert the therapist to intensify treatment or to begin the treatment as soon as possible.³

Early onset ADHD and CD are particularly resistant to treatment.⁸ There does not seem to be any significant advantage of one system over another when therapeutic and correctional treatment strategies for these disorders are compared; all of them seem to have similar outcomes.^{8, 42} Satterfield *et al.*¹⁷ found that intensive psychological and medication treatment did not change offender rates in the highly aggressive defiant ADHD children compared with the same type of group that was treated with only medication and brief counseling.

Some treatment success has been found by teaching boys with ADHD to relax by using relaxation tapes and electromyographic biofeedback or a combination of the two. After this training, the boys with ADHD showed significant improvement on psychological tests that required the

ability to concentrate and their parents reported significant positive change in behavior.⁴³ Based on the above discussion of predisposing factors, biological and family environmental influences seem to be possible targets for intervention.

Conduct Disorder and ADHD in Females

CD is the second most common psychiatric disorder found in adolescent girls.⁴⁴ However, there are very few outcome studies that include females in their sample population. The few that do include females do not examine them separately from the male population. Zoccolillo and Rogers⁴⁴ propose that the criteria for CD in girls should be different from the current criteria, which apply to both boys and girls. They propose that for females, the criteria should be less weighted to violence and criminality and that the current criteria underdiagnose CD in females. A new set of criteria to be used for females was validated by their study finding that by using the new criteria they were able to predict poor outcome. It also found that female CD was associated with a high comorbidity of depression and anxiety. These results are similar to those in studies that have found a high comorbidity of antisocial personality disorder in women with depression and anxiety. In general, it seems as though girls need to exhibit very few symptoms in order to be at increased risk for a poor outcome, a point of which clinicians should be aware.⁴⁴

In terms of ADHD in women, Klein and Mannuzza¹⁴ could not find a longitudinal study on ADHD females; however,

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they were able to conclude that ADHD girls seem to be as vulnerable to developing CD as boys.

Conclusion

Researchers are working toward improving our ability to predict delinquency, hoping to serve two goals. On the one hand, it would help parents, teachers, court officials, and therapists to be aware of the warning signs of delinquency so they could take action as soon as possible. Increasing our predictive powers would also help increase our understanding of the origins of delinquency. It would be useful to know the earliest age at which problems become predictors so that preventive efforts could be made before the problem behaviors become entrenched. Loeber and Dishion³⁵ suggest that future studies should use intercorrelations between different factors to try to improve predictability as well as to establish variables that are predictive of the absence of delinquency despite certain environmental risk factors.

Accurate prediction would allow a focus on the group with the highest risk, and then interventions could be focused on that group. If it were possible to predict with a 70 percent accuracy rate, and if intervention was successful with 25 percent of that group, then the intervention would be cost effective.⁵

There is ample evidence, as garnered from the cited articles, that both CD and ADHD contribute to illegal behavior. With 55 percent of all crimes being committed by juveniles, the legal implications of ADHD and CD become more apparent. Certainly, crime should not be toler-

ated in a society regardless of who commits it. Prevention is the obvious deterrent.

These findings suggest the importance of early diagnosis and treatment of ADHD. If more than 25 percent of adult criminals have ADHD, as Eystone and Howell¹² found (and practically none of the inmates in their study had ever been treated as children), that suggests that early treatment of ADHD may be an effective deterrent. To accomplish this, more education of teachers, physicians, and parents is needed.

Similarly with CD, early detection, diagnosis, and treatment may well reduce resulting crime, although studies are lacking to support this theory. Unfortunately, too many teenagers and other people are having children when they are ill-equipped to properly rear these children. Once again early detection, education, and help offered to potential parents may reduce the high incidence of pregnancies and of children who are likely to have problems as they grow and develop.

Appendix I

DSM-IV Diagnostic Criteria for Attention Deficit/Hyperactivity Disorder (p 83–85)³⁷

A. Either (1) or (2):

- (1) Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

- (a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities;
- (b) Often has difficulty sustaining attention in tasks or play activities;

- (c) Often does not seem to listen when spoken to directly;
 - (d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions);
 - (e) Often has difficulty organizing tasks and activities;
 - (f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework);
 - (g) Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools);
 - (h) Is often easily distracted by extraneous stimuli;
 - (i) Is often forgetful in daily activities.
- (2) Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

- (a) Often fidgets with hands or feet or squirms in seat;
- (b) Often leaves seat in classroom or in other situations in which remaining seated is expected;
- (c) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness);
- (d) Often has difficulty playing or engaging in leisure activities quietly;
- (e) Is often "on the go" or often acts as if "driven by a motor;"
- (f) Often talks excessively.

Impulsivity

- (g) Often blurts out answers before questions have been completed;
- (h) Often has difficulty awaiting turn;
- (i) Often interrupts or intrudes on others (e.g., butts into conversations or games).

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

- C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).
- D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Type:

Attention Deficit/Hyperactivity Disorder, Combined Type: if both criteria for A1 and A2 are met for the past 6 months.

Attention Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if criterion A1 is met but criterion A2 is not met for the past 6 months.

Attention Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if criterion A2 is met but criterion A1 is not met for the past 6 months.

Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

Appendix II

DSM-IV Diagnostic Criteria for Conduct Disorder (p 90-91)

- A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals

- (1) Often bullies, threatens, or intimidates others;
- (2) Often initiates physical fights;
- (3) Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun);
- (4) Has been physically cruel to people;

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- (5) Has been physically cruel to animals;
- (6) Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery);
- (7) Has forced someone into sexual activity;

Destruction of property

- (8) Has deliberately engaged in fire setting with the intention of causing serious damage;
- (9) Has deliberately destroyed others' property (other than by fire setting);

Deceitfulness or theft

- (10) Has broken into someone else's house, building, or car;
- (11) Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others);
- (12) Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering, forgery);

Serious violations of rules

- (13) Often stays out at night despite parental prohibitions, beginning before age 13 years;
- (14) Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period);
- (15) Is often truant from school, beginning before age 13 years.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 or older, criteria are not met for Antisocial Personality Disorder.

Type based on age of onset:

Childhood-Onset Type: onset of at least one criterion characteristic of Conduct Disorder prior.

Adolescent-Onset Type: absence of any criteria characteristic of Conduct Disorder prior to age 10 years.

Severity:

Mild: few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others.

Moderate: number of conduct problems and effect on others intermediate between "mild" and "severe."

Severe: many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others.

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