Disproportionately high rates of Conduct Disorder are diagnosed in African American and Latino youth of color. Diagnostic bias contributes to overdiagnosis of Conduct Disorder in these adolescents of color. Following a diagnosis of Conduct Disorder, adolescents of color face poorer outcomes than their White counterparts. These negative outcomes occur within mental health and juvenile justice settings. The aims of this article are to: (a) identify the factors that contribute to overdiagnosis of Conduct Disorder in adolescents of color, (b) discuss the associated negative outcomes, and (c) provide recommendations for culturally sensitive diagnosis of adolescents of color with conduct problems in order to reduce overdiagnosis. Clinical and research implications will also be presented.

**KEYWORDS** Conduct Disorder, diagnostic bias, ethnic minority, juvenile justice, race

Researchers have called for revision of the diagnosis of Conduct Disorder in the next edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V). Specifically, they have underscored the need to reduce overdiagnosis of Conduct Disorder among African American and Latino youth (Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1996; Kilgus, Pumariega, & Cuffe, 1995; Mandell, Ittenbach, Levy, & Pinto-Martin, 2007; Moffitt et al., 2008; Wu et al., 1999). Once diagnosed with Conduct Disorder, these adolescents of color experience more negative outcomes in juvenile justice and mental
health systems than do their White counterparts (Pottick, Kirk, Hsieh, & Tian, 2007; Seagrave & Grisso, 2002), heightening the clinical importance of this topic. The aims of this article are to: (a) identify the diagnostic biases that contribute to overdiagnosis of Conduct Disorder in adolescents of color, (b) discuss the associated negative outcomes, and (c) provide recommendations for culturally sensitive diagnosis of adolescents of color with conduct problems in order to reduce overdiagnosis. Clinical and research implications will also be presented.

Conduct Disorder is defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) as a recurring set of behaviors that are harmful to others and must include 3 or more of the following criteria to be present within the past 12 months to qualify for the diagnosis: aggression to people and animals, destruction of property, deceitfulness or theft, and serious rule-breaking or defiance. Symptoms must persistently interfere with functioning in academic, social, or occupational roles. The diagnosis of Conduct Disorder is characterized by antisocial behavior and is a prerequisite to the adult diagnosis of Antisocial Personality Disorder.

**DIAGNOSTIC BIAS**

A number of studies have documented historic diagnostic bias with the use of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000). One study found overdiagnosis of schizophrenia in African Americans as compared to White Americans (Neighbors, Trierweiler, Ford, & Muroff, 2003). Another study found Latinos were overdiagnosed with depression in contrast to their White counterparts and underdiagnosed with psychotic disorders (Minsky, Vega, Miskimen, Gara, & Escobar, 2003). A third study found that African Americans were diagnosed more frequently with severe behavior disturbance disorders, while White Americans were diagnosed more frequently with more mild adjustment disorders (Feisthamel & Schwartz, 2009). These are among the few examples of a wide range of studies that have documented higher rates of stigmatizing diagnoses assigned to populations of color (Lopez, 1989; Neighbors et al., 2003).

Conduct Disorder is one disorder in particular that has been found to be overdiagnosed among populations of color (Cameron & Guterman, 2007; Cuffe et al., 1996; Fabrega, Ulrich, & Mezzich, 1993; Kilgus et al., 1995; Wu et al., 1999). Specifically, Conduct Disorder has been overdiagnosed in urban, low-income, adolescents of Latino and African American backgrounds (Mandell et al., 2007; Mota-Castillo, 2004). In one study of adolescents in a large U.S. residential treatment facility ($N = 1,173$), racial proportions of those who were diagnosed with Conduct Disorder were 43.3% Latino, 34.4%
African American, and 24.4% White American (Cameron & Guterman, 2007). Within this sample, African American youth were particularly overrepresented. In contrast, White American children with comparable behaviors tend to be diagnosed with mood, anxiety, or developmental disorders (Mandell et al., 2007). A study of 406 children found African American children were 2.4 times more likely than White American children to receive what is considered to be the more stigmatizing diagnosis of Conduct Disorder than Attention Deficit-Hyperactivity Disorder (ADHD; Mandell et al., 2007).

Statistical discrimination may be contributing to clinicians’ assumptions about the differing rates of diagnoses like Conduct Disorder among ethnic groups (Balsa & McGuire, 2001). In addition, clinicians may be interpreting disruptive and aggressive symptoms of African American children differently than White American children, leading to differences in diagnosis and appropriate treatment (Mandell et al., 2007). Many of these clinicians may hold stereotyped views toward clients of color resulting in differential treatment and assessment (Vasquez, 2007).

Is Conduct Disorder being diagnosed while problems with mood or anxiety are overlooked? Research findings suggest Conduct Disorder diagnoses are often accompanied by depression, separation anxiety, and adjustment disorders (Drrerup, Croysdale, & Hoffman, 2008; Kazdin & Whitley, 2006). This data suggests the possibility that many youth may express conduct problems in response to underlying mood or anxiety disorders. For example, research has found depression to be a precursor to conduct problems (Beyers & Loeber, 2003; Renouf, Kovacs, & Mukerji, 1997). Youth with depression or anxiety may also use substance abuse as a way to cope (Deykin, Levy, & Wells, 1987; Wells, Klap, Koike, & Sherbourne, 2001). Additionally, substance abuse may lead to behavioral misconduct (Drrerup et al., 2008). Hence, conduct problems may in fact be a behavioral response to depression, anxiety, or substance abuse as opposed to a sign of underlying antisocial pathology implied in the diagnosis of Conduct Disorder.

Mota-Castillo (2004) described the tendency for clinicians to misperceive Conduct Disorder in adolescents of color who present with behavioral symptoms of other psychological disorders. Adolescents with Obsessive-Compulsive Disorder may exhibit strong opposition to rigid rules in the classroom and at home. Children with Bipolar Disorder as well as ADHD may engage in destructive behavior. Those with Social Anxiety Disorder often refuse to attend school and express defiance toward teachers in the school setting. Mota-Castillo described working with an adolescent of color with schizophrenia who was misdiagnosed with Conduct Disorder. The author believed diagnostic bias had occurred in this case, mislabeling the adolescent’s behavioral symptoms as conduct problems as opposed to psychosis, and resulting in incorrect medication. In this case and in many others, clinical misperception may interfere with detecting true etiology in adolescents of color and lead to inappropriate treatment.
OUTCOMES OF CONDUCT DISORDER

Mental Health Outcomes

Adolescents of color frequently experience more harmful outcomes following overdiagnosis of Conduct Disorder than White American adolescents (Pottick et al., 2007). African American adolescents diagnosed with Conduct Disorder are more likely to be hospitalized (Lapointe, Garcia, Taubert, & Sleet, 2010; Pavkov & George, 1997; U.S. Department of Health & Human Services, 2001). Both African Americans and Latino Americans have limited access to mental health care in general and on the outpatient basis, which contributes to poorer mental health care service delivery once diagnosed (Alegría et al., 2002; Classen et al., 2000; Merritt-Davis & Keshavan, 2006). Therefore, adolescents of color diagnosed with Conduct Disorder are less likely to receive appropriate mental health treatment following diagnosis.

In addition, adolescents with Conduct Disorder diagnoses are often stigmatized, affecting outcome of treatment quality and appropriateness of services provided. For example, clinicians may label adolescents of color with conduct problems and make more pessimistic predictions toward their recovery (Salekin, 2002). Also suggestive of therapeutic pessimism was a study of 109 juvenile justice clinicians that found clinicians gave higher ratings of risk for future criminality to adolescents with Conduct Disorder diagnoses (Rockett, Murrie, & Boccaccini, 2007). These pessimistic predictions for the mental health outcomes of adolescents of color may lead to less effective treatment from mental health providers (Salekin, 2002).

Juvenile Justice Outcomes

Labels such as Conduct Disorder increase the likelihood that adolescents of color who have been improperly diagnosed will be transferred to adult courts or be ordered to serve longer sentences (Petrila & Skeem, 2003; Seagrave & Grisso, 2002). Moreover, youth with Conduct Disorder diagnoses are prevalent in the juvenile justice system. In a study of 597 court-involved adolescents, Conduct Disorder was the most common diagnosis (Drerup et al., 2008). Another study estimated Conduct Disorder and Oppositional Defiant Disorder rates in juvenile justice system as high as 40% (Teplin et al., 2002). The American Academy of Pediatrics (AAP; 2001) found 20%–60% of juvenile detainees were diagnosed with Conduct Disorder, and many of these juvenile detainees were adolescents of color who were more likely to receive formal prosecution and harsher treatment than White American detainees.

Adolescents of color overdiagnosed with Conduct Disorder face racial disparities of the juvenile justice system. Youth of color are overrepresented in juvenile detention centers, incarcerated more than White youth who
committed similar crimes, and are frequently arrested for minor status offenses that pose no serious safety risk to society (W. Haywood Burns Institute, 2011). In particular, they are more likely to be arrested and enter into the juvenile justice system (Fite, Wynn, & Pardini, 2009; Hanson, Henggler, Haefele, & Roddick, 1984; Lahey, Waldman, & McBurnett, 1999). Subjective risk assessment procedures may contribute to these racial disparities in juvenile justice decision making (Steinberg, 2008; Steinhart, 2006).

CULTURALLY SENSITIVE DIAGNOSIS

The DSM-IV-TR (American Psychiatric Association, 2000) description of Conduct Disorder indicates that clinicians should not assign the diagnosis if conduct problems are a response to a negative environment, as opposed to an internal psychological dysfunction (Wakefield, Pottick, & Kirk, 2002). However, adolescents of color often experience disparities in environmental stressors due to higher rates of poverty and experiences of racial discrimination (Gonzalez, 2005). Overdiagnosis among adolescents of color may diminish with a more thorough assessment of environmental factors that may contribute to conduct problems (Beauchaine, Webster-Stratton, & Reid, 2005; Fite et al., 2009; Jaffee, Belsky, Harrington, Caspi, & Moffitt, 2006; Tiet et al., 2001). In this section, the environmental stressors that may account for conduct problems among adolescents of color are outlined in order to facilitate thoughtful diagnosis of Conduct Disorder.

Socioeconomic Status

Socioeconomic status (SES) has been linked with expression of conduct problems among adolescents of color (Beiser, Hou, Kaspar, & Noh, 2000; Jaffee et al., 2006; Sampson & Groves, 1989; Tiet et al., 2001). One study found conduct problems were negatively correlated with income, with diagnosis rates increasing as absolute income of immigrant families decreased (Beiser, Hou, Kaspar, & Noh, 2000). Children who are reared in neighborhoods that are impoverished and disorganized (i.e., disrupted social networks) are at additional risk for conduct problems and being charged with criminal behaviors (Sampson & Groves, 1989; Tiet et al., 2001). A study of 246 families in a 30 year cohort found children with parents with low SES in addition to a history of conduct problems and relationship violence were more likely to have children with conduct problems (Jaffee et al., 2006). Additional diagnostic consideration is needed to assess the stressors of poverty and exposure to violence in a high crime environment. These stressors might contribute to acting out behaviors among adolescents living below the poverty line that would rule out the diagnosis of Conduct Disorder.
Violence

Violence exposure has been linked to the expression of conduct problems among adolescents of color in particular. In a study of urban African American adolescents, witnessing violence was a primary factor in predicting conduct problems (Durant, Cadenhead, Peendergrast, Slavens, & Linder, 1994). In another study, witnessing of and victimization by community violence led to development of conduct problems over the course of a 1-year period (Pearce, Jones, Schwab-Stone, & Ruchkin, 2003). An additional study found experiences of violence in school contributed to conduct problems for teens living in high crime communities (Flannery, Wester, & Singer, 2004). Violence exposure and victimization appear to be significant precursors to the development of violent behavior. This tendency further highlights the need to consider the environmental context of the adolescent of color with conduct problems prior to assigning Conduct Disorder.

Racial Discrimination

Experiences with racism at individual and systemic levels may enhance risk factors for conduct problems among youth of color (Piquero, Moffitt, & Lawton, 2005). In one study of African American adolescents, racial discrimination among teachers and peers predicted conduct problems and low academic performance (Wong, Eclles, & Sameroff, 2003). In fact, poor academic achievement is one of the most significant contributors to conduct problems (Fite et al., 2009). Adolescents of color may experience prejudice from these adults whose roles are intended to mentor and support. Taking into account environmental stressors such as academic discrimination is essential to understanding the context of the child with conduct problems more fully, prior to assigning a Conduct Disorder diagnosis. These considerations of environmental stressors can help differentiate conduct problems from Conduct Disorder, potentially reducing racial disparities in diagnosis.

CLINICAL AND RESEARCH IMPLICATIONS

Clinical Training

How can clinicians become more aware of these problems in the diagnosis of Conduct Disorder for youth with conduct problems? Various barriers may prevent culturally sensitive diagnosis from occurring. These barriers include the lack of availability of and training in culturally sensitive diagnostic tools, lack of cultural competence training of clinicians, and tendencies to pathologize communities of color in mental health institutions (Park-Turner, Ventura, & Ng, 2010). Offering providers with didactic and experiential training to better understand the intersections of race, SES, gender, and other
variables of social identity may improve culturally sensitive diagnosis with adolescents of color (Kress, Eriksen, Rayle, & Ford, 2005; Neighbors et al., 2003; Roysircar, 2005).

In general, more psychoeducation is needed for clinicians in training as well as continuing education in conducting culturally sensitive diagnosis and treatment of conduct problems (Pottick et al., 2007). Roysircar (2005) recommended culturally sensitive diagnosis to be improved with: (a) examination of a clinician’s own cultural biases, (b) gathering information about clients’ cultural backgrounds, (c) awareness of the cultural biases of any diagnostic assessment measures being used, and (d) careful differentiating of the client’s culture from mental disorder. These skills can help clinicians to avoid participation in the overuse of Conduct Disorder as a label for adolescents of color.

In a social context of racial bias, youth of color who act out are often perceived as dangerous and disobedient (Mandell et al., 2007; Mota-Castillo, 2004). Mental health providers can enhance their awareness of the larger systemic issues that contribute to conduct problems among adolescents of color. Increasing culturally sensitive diagnosis among clinicians is likely to enhance effectiveness of treatment for clients of color (Roysircar, 2005). Diagnosticians can improve their efforts to assess the experience of the adolescent of color with conduct problems to enhance culturally sensitive treatment.

Diagnostic Revisions

Revision of the Conduct Disorder diagnosis in DSM-V may assist clinicians in taking into account environmental stressors more consistently when working with adolescents of color (Moffitt et al., 2008). Clinicians often overlook the textual commentary at the end of the criteria list for Conduct Disorder related to environmental stressors (Wakefield, Pottick, & Kirk, 2002). This commentary indicates exclusion of the diagnosis if conduct problems are a response to environmental stressors. Clinicians may consider this diagnostic guideline more consistently if it were included in the core criteria list in order to avoid overlooking this critical aspect of differential diagnosis.

Future Research

Additional research is needed to further explore the incidence of conduct problems in association with exposure to community violence (Weaver, Borkowski, & Whitman, 2008). Investigation is also needed to assess differences in diagnosis of Conduct Disorder resulting from clinical bias (Pottick et al., 2007). More field-based research is required to further delineate the outcomes following diagnosis of conduct problems of adolescents of color (Cameron & Guterman, 2007; Mandell et al., 2007). Finally, further research is needed to provide empirical evidence of the impact of cultural sensitivity training on diagnostic practices.
CONCLUSION

Conduct Disorder is overdiagnosed among adolescents of color. Diagnostic bias that occurs among clinicians contributes to racial disparities in diagnosis. Diagnostic bias may occur due to statistical assumptions about rates of diagnosis among populations of color, lack of cultural sensitivity training, and lack of consideration of environmental stressors that may differentially affect adolescents of color. Following diagnosis of Conduct Disorder, adolescents of color often face poorer outcomes in mental health and juvenile justice settings. Culturally sensitive diagnostic skills can assist clinicians in making more accurate assessments of conduct problems among adolescents of color, potentially reducing overdiagnosis rates. Research can help clarify successful strategies for improving diagnostic assessment of clinicians working with adolescents of color to ensure culturally appropriate and effective mental health treatment.

REFERENCES


