Received: 25 November 2018 | Revised: 2 May 2019 | Accepted: 8 May 2019

DOI: 10.1002/npr2.12071

ORIGINAL ARTICLE

NEUROPSYCHOPHARMACOLOGY REPORTS WILEY

Moral competence and conduct disorder among Filipino children in conflict with the law

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Abstract

Aims: The numbers of children in conflict with the law continue to rise in Asia, yet few studies have been conducted regarding factors associated with it. It has been theorized that children with conduct disorder represent majority of children in conflict with the law, and that poor moral competence mediates the association between conduct disorder and antisocial behavior. This study aimed to present a profile of Filipino children in conflict with the law, determine the prevalence of conduct disorder in the sample, and investigate variables associated with conduct disorder.

Methods: This was a cross-sectional study conducted at a conflict with the law Custodial Care Center in the Philippines. The procedure entailed a diagnostic interview and questionnaire administration conducted by psychiatrists. Questionnaires administered included the Moral Competence Test and Parental Warmth and Acceptance Scale. Statistical analyses of data included descriptive statistics, chi-square tests, and independent *t* tests. SPSS v.23.0 was used for data encoding and analysis.

Results: Twenty-three participants were included in the study, with 10 participants with conduct disorder and 13 controls. Majority were male adolescents between the ages of 16 and 18 years. Conduct disorder was associated with commission of multiple violations, particularly theft and homicide, the presence of a substance use disorder, and a history of abuse. Participants with conduct disorder had lower moral competence levels compared to participants without conduct disorder.

Conclusion: Conduct disorder was associated with high-risk antisocial behavior and lower levels of moral competence.

KEYWORDS

children in conflict with the law, juvenile delinquency, moral competence

1 | INTRODUCTION

In Asian countries, young people constitute the most criminally active segment of the population, with rising numbers of violent acts being committed by adolescents and young adults.[1] In the Philippines, the number of children in conflict with the law (CICL) has increased in the recent decades. From 1986 to 1992, there were more than 4000 cases of offenses committed by CICL in Metro Manila alone, and in 2009, there were more than 11 000 children in conflict with the law nationwide.[2–6] Despite these rates, this subset of the population has remained understudied, with majority of local studies qualitatively focusing on CICL profiles.[2–4]

1.1 | Moral competence, conduct disorder, and children in conflict with the law

Child-related, parent-related, and social factors have been associated with increased risk for conflict with the law. Child-related factors include temperament, attachment styles, and psychiatric conditions such as conduct disorder.[7–10]

Conduct disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major societal norms or rules are violated.[11,12] It is a common childhood psychiatric disorder, with a median prevalence rate of 4%-7% in the general population[11,12] and 73%-77% in Western juvenile justice institutions.[13,14] Children with conduct problems are at increased risk for developing severe antisocial behaviors in adult life.[7,9,11,12,15] Hence, it is not uncommon for children with conduct disorder to come into contact with the criminal justice system for engaging in illegal behavior.

Juvenile delinquents have been found to have lower levels of moral competence compared to their nondelinquent counterparts.[16–19] It has been found that delinquent children have significantly lower performances for moral judgment and cognitive development tasks compared to controls.[17–19] Lower levels of moral competence have also been associated with conduct disorder with psychopathic traits, particularly in males.[20–22] Empathy is linked to moral competence, which in turn has been associated with cognitive, social, and emotional development in children.[23] Hence, a lower capacity for empathy may lead to impaired judgment when it comes to moral tasks.[24–27]

However, other studies fail to support the presence of a relationship between delinquency, psychopathy, and moral competence. Three studies have observed that the ability to cognitively classify moral acts was not significantly influenced by psychopathic traits.[28–30] Hence, cognitively mature psychopathic offenders may have conventional moral competence, but abnormal regulation of moral behavior.[29,30]

Due to these conflicting findings, two meta-analyses on the moral reasoning of juvenile delinquents were reviewed. The first meta-analysis conducted in 1990 included 15 studies, while the second meta-analysis conducted in 2006 included 50 studies with a sample size of 4814 subjects (n = 2316 delinquents and n = 2498 nondelinquents). Both meta-analyses demonstrated that moral reasoning of juvenile delinquents was significantly lower compared to that of controls, with an overall effect size of $d = 0.76$.[31,32]

1.2 | Family-related factors, conduct disorder, and children in conflict with the law

Family-related factors associated with conduct disorder and juvenile delinquency include child abuse or neglect, harsh parental discipline, absence of parental warmth, parental psychopathology, and family disruption.[8,15,31–34]

While parental warmth has been associated with secure attachment, psychological health, and social competence, children experiencing the opposite are more likely to present with aggression, hostility, negative self-esteem, and emotional instability.[34–36] Inconsistent, distant, or abusive parenting may lead to insecure attachment, causing children to view themselves as unlovable and the world as untrustworthy.[35] By middle childhood, children with insecure attachment tend to misinterpret others' behaviors as antagonistic and react accordingly, leading to the hostile behavior characteristic of conduct disorder.[11,23]

Parental influences on the development of antisocial behavior may be mediated by moral competence, as parents are often the basis upon which children learn to judge moral dilemmas. Pro-social behaviors, as mediated by moral competence, may be enhanced by parental warmth and guidance, while the opposite may hold true for antisocial behavior.[23,30] A study which compared the moral judgment of delinquent and nondelinquent adolescents and their mothers found that the delinquent adolescent-mother pairs had significantly lower levels of moral judgment compared to controls.[37] Another study found that psychopathic delinquent children were more likely to view their fathers as less nurturing compared to nonpsychopathic delinquent children. The psychopathic delinquent children also had lower levels of moral development, suggesting that moral competence, parental warmth, and conduct disorder may be associated.[38]

Majority of the studies in this field have been conducted in Western settings. While one Asian study demonstrated that male juvenile delinquents had less mature moral reasoning compared to controls,[39] there is a dearth of similar studies in the Philippine setting. It is hoped that this study can be useful in providing information regarding children in conflict with the law as well as in broadening the scope of service delivery for them.

1.3 | Objectives

This study aimed to present a demographic profile of Filipino children in conflict with the law, determine the prevalence of conduct disorder among the study sample, and investigate other child- and family-related variables associated with conduct disorder, such as the presence of a stepfamily, history of abuse, moral competence, perceived parental warmth and acceptance, and the presence of comorbid psychiatric conditions.

2 | METHODS

2.1 | Study design and setting

This was a descriptive cross-sectional study conducted at the government-run Kanlungan ng Kabataan Village children in conflict with the law (CICL) Custodial Care Center, Antipolo City, Philippines, from April to December 2017. The Kanlungan ng Kabataan Village is directed by the City Social Welfare and Development Office, while the Custodial Care Center is jointly managed by a social worker and a social welfare assistant, with houseparents serving as temporary caregivers of the children.

2.2 | Study participants

The target population was the residents of the Custodial Care Center whose ages were below 18 years at the time of their offense. Participants were recruited as they presented in the center within the study duration (convenience sampling). Inclusion criteria were referral to the center due to conflict with the law, informed assent from the participant, and informed consent secured from a competent adult guardian. Exclusion criteria included history of any psychiatric illness and the inability to understand the English or Tagalog languages. Withdrawal criteria included removal from the center during the course of data gathering due to legal proceedings or withdrawal of informed assent/consent.

2.3 | Study procedure

The diagnosis of conduct disorder, together with assessment of moral development, was done through face-to-face, in-depth interviews by a trained psychiatrist. The presence of conduct disorder and possible comorbid psychiatric conditions was determined through the use of diagnostic criteria for conduct disorder as specified in the Diagnostic and Statistical Manual for Mental Disorders, 5th edition (DSM-5). Assessment of moral development was done through the use of the Moral Competence Test—Filipino version, and perceived parental warmth and acceptance was measured using the Parental Warmth and Acceptance Scale—Filipino version.

Once the participant's eligibility for the trial was assessed and informed assent/consent was secured, information on the child's demographics, type of offense, history of abuse, and family constellation was gathered. This was followed by the diagnostic interview and questionnaire administration.

2.4 | Tools/measures

Aside from the DSM-5, other study measures included the Moral Competence Test, Philippine version, and the Parental Warmth and Acceptance Scale, Filipino version.

The Moral Competence Test (MCT) is a tool developed to assess moral judgment and competence. Based on Kohlbergian theory, but created for research and evaluation studies, the MCT requires the participant to deliberate on moral dilemmas as well as arguments and counterarguments designed around the dilemma.[40] The tool's advantages are its ease of administration, lack of nonscorable cases, and use in younger populations.[41] Due to its deviation from classical test structure, reliability and validity of the MCT cannot be assessed using standard measurements,[41,42] though a test-retest correlation of $r = 0.90$ has been reported.[43] The Philippine version has been certified valid by the original author,[41] and permission for its use was secured via electronic mail.

Another measure used was the Parental Warmth and Acceptance Scale (PWAS) by Greenberger and Chen, a six-point Likert-type scale containing twenty-six items, with the first part measuring perceptions of maternal warmth and acceptance and the second, paternal warmth and acceptance. The final score for parental warmth and acceptance is attained through the combined scores of both parts. The original scale was found to be highly reliable, with a Cronbach's alpha of 0.91.[44,45] Use of the same scale in Filipino college-age students revealed an acceptable internal consistency score, with a Cronbach's alpha of 0.87.[46] For the study, the Filipino version of the PWAS was used. This version has been found to be valid and reliable in another Philippine study, with Cronbach's alpha scores of 0.90 and 0.92 for maternal and paternal components, respectively.[47]

2.5 | Data analysis and statistical plan

Following data collection, results were encoded and summarized using descriptive statistics and measures of central tendency. Statistically significant differences between groups (those with conduct disorder and those without) in terms of moral competence, parental warmth and acceptance, the presence of abuse, family disruption, and comorbid psychiatric conditions were assessed using independent *t* tests. Other associations between the study variables, moral competence, and conduct disorder were determined using chi-square tests. SPSS v.23.0 was used for all statistical analyses of data.

2.6 | Ethical considerations

In consideration of the participants' vulnerability, assent was secured from all participants, and informed consent was secured from a legally authorized representative of each child prior to the conduct of the study. Participant anonymity and confidentiality were afforded due to consideration through the use of codes for data encoding and processing.

There were no external funding sources for the conduct of this study. Ethical approval was secured from the UERMMMCI Research Institute of Health Sciences (RIHS ERC Code 0345/I/H/17/04).

3 | RESULTS

A total of 23 participants were included in the study, with 10 conduct cases and 13 controls comprising 43.5% and 56.5% of the sample, respectively. The demographic and clinical characteristics of the total, conduct-disordered, and control groups are presented in Table 1. There were no significant differences between groups for the variables of gender, age, educational attainment, and the presence of a stepfamily.

As shown in Table 2, more conduct-disordered children had a history of abuse or neglect (LR = 7.76, $df = 1$, $P = 0.005$). The type of abuse experienced by the children was associated with the presence of conduct disorder (LR = 10.725, $df = 4$, $P = 0.030$). Specifically, children with conduct disorder had histories of verbal abuse (n = 1), sexual abuse (n = 1), and neglect (n = 3), whereas none in the control group experienced such types of abuse.

TABLE 1 Demographic characteristics of the study participants

Study variable	Conduct disorder		Total	Test statistic	*df*	Sig. (*P*-value)
	Present	Absent				
Number of subjects (n)	10	13	23			
Gender						
Male (n)	10	11	21	LR = 2.43	1	0.12
Female (n)	0	2	2			
Age						
Mean	17.60	17.00	17.26	t = 0.68	21	0.50
SD	1.51	2.44	2.07			
Educational attainment						
Grade 1-3 (n)	2	0	2	LR = 3.67	3	0.30
Grade 4-6 (n)	4	6	10			
Grade 7-9 (n)	2	4	6			
Grade 10-12 (n)	2	3	5			
Presence of stepfamily						
Yes (n)	7	6	13	LR = 1.33	1	0.25
No (n)	3	7	10			

Results for the subsequent data are presented in Table 3. The most common violation committed was theft or robbery (n = 9, 39.13%), followed by illegal substance use or trade (n = 6, 26.08%). Less common violations were sexual offenses (n = 5, 21.74%) and homicide (n = 3, 13.04%). Children with conduct disorder were significantly more likely to have committed theft and homicide. There was a significant association between the types of violations committed and the presence of a conduct disorder (LR = 14.63, *df* = 3, *P* = 0.002).

There were no significant associations between the presence of conduct disorder and the presence of a dual diagnosis, except for substance use disorders (Table 3). When the presence of any substance use in the sample was considered, fifteen of twenty-three children (65.22%) had a high likelihood of having a substance use disorder, with more conduct-disordered children having such a diagnosis (LR = 5.27, *df* = 4, *P* = 0.022).

Means, standard deviations, and independent *t* test results are shown in Tables 4 and 5. Children with conduct disorder were more likely to have committed more violations compared to the control group (*t* = 2.33, *df* = 21, *P* = 0.030). However, mean parental warmth and acceptance scores were not significantly different between groups. The mean Moral Competence Test (MCT) scores of the participants were 16.97 ± 6.10. Statistically significant differences between groups were noted, with conduct-disordered children having lower MCT scores compared to controls (*t* = −2.99, *df* = 21, *P* = 0.007).

TABLE 2 Associations between conduct disorder and presence/type of abuse

Study variable	Conduct disorder		Total	LR	*df*	Sig (*P-value)*
	Present	Absent				
History of abuse						
Present (n)	6	1	7	7.76[b]	1	0.005[b]
Absent (n)	4	12	16			
Total (n)	10	13	23			
Type of abuse						
None (n)	4	12	16	10.725[a]	4	0.030[a]
Physical (n)	1	1	2			
Verbal (n)	1	0	1			
Sexual (n)	1	0	1			
Neglect (n)	3	0	3			
Total (n)	10	13	23			

*Significant at *P* < 0.05.
**Significant at *P* < 0.01.

TABLE 3 Associations between conduct disorder and clinical variables

Study variable	Conduct disorder		Total	LR	*df*	Sig (*P-value*)
	Present	Absent				
Type of violation						
Theft/robbery (n)	6	3	9	14.63[b]	3	0.002[b]
Substance use (n)	1	5	6			
Rape (n)	0	5	5			
Homicide (n)	3	0	3			
Total (n)	10	13	23			
Presence of dual diagnosis						
Present (n)	8	11	19	0.083	1	0.773
Absent (n)	2	2	4			
Total (n)	10	13	23			
Type of dual diagnosis						
None (n)	1	2	3	6.002	4	0.199
Mood/adjustment (n)	2	7	9			
Anxiety/trauma (n)	2	0	2			
Substance use (n)	3	3	6			
ADHD/impulse control (n)	2	1	3			
Total (n)	10	13	23			
Substance use disorder as dual diagnosis						
Present (n)	9	6	15	5.274[a]	1	0.022[a]
Absent (n)	1	7	8			
Total (n)	10	13	23			

*Significant at $P < 0.05$.
**Significant at $P < 0.001$.

4 | DISCUSSION

Majority of participants were between 16 and 18 years old, male, and had an educational attainment between Grades 4-6. Furthermore, more than half of them did not belong to a single, nuclear family. These closely echo findings from a qualitative study on Filipino juvenile delinquency, which describes a typical participant to be a 14- to 17-year-old male with an elementary educational attainment belonging to a "broken" family.[2]

The predominance of male participants is in line with Western research, which note that delinquency rates are consistently higher for males. Adolescent males are also more likely to develop conduct disorder, commit more serious crimes, and demonstrate lower levels of moral competence compared to age-matched females. This may explain why more male youths come into serious conflict with the law.[20–22,32]

Most participants were late adolescents, a finding supported by studies which note a rise of delinquent behavior during this stage. Moral judgment deficiencies become more pronounced with age, and the gaps between the moral competence between delinquent and nondelinquent children reach maximum levels during late adolescence.[32] Youth at this stage also start spending more time with deviant peers, which may also account for increased rates of antisocial behavior.[8] Low school attainment was evident for most participants, a finding likewise supported by research. The association between low educational attainment and delinquency may be explained by lower levels of cognitive development leading to poor moral competence.[16,17,19,32]

The most common violation committed by the participants was theft or robbery, followed by illegal substance use or trade. This is consistent with Philippine statistics, where crimes against property, including theft, robbery, qualified theft, and car-napping, represented majority of the offenses of youth institutionalized for conflict with the law.[5]

The study also sought to determine the prevalence of conduct disorder among the participants. As one of the most common psychiatric disorders of childhood, conduct disorder occurs in up to 77% of incarcerated youth in Western and Latin American countries.[11,13,14] However, current study results contrast with Western rates, with only 43.5% of the sample meeting DSM-5 criteria for conduct disorder. This lower prevalence may be explained by cultural differences, with one prior study noting that Asians were significantly less likely to have conduct disorder compared to Caucasians. The same study demonstrated that in the Asian sample, conduct disorder was strongly associated with substance use, a finding also supported by this study.[48]

TABLE 4 Means and standard deviations between groups with or without conduct disorder

Study variable	Conduct disorder	N	Mean	Std. deviation	Std. error mean
Age	Yes	10	17.60	1.51	0.48
	No	13	17.00	2.45	0.68
Number of violations	Yes	10	2.00	1.15	0.37
	No	13	1.15	0.55	0.15
Number of dual diagnosis	Yes	10	1.60	0.84	0.27
	No	13	1.15	0.69	0.19
PWAS score (mother)	Yes	10	47.30	6.91	2.19
	No	13	49.39	7.23	2.00
PWAS score (father)	Yes	10	47.30	5.03	1.59
	No	13	47.08	7.29	2.02
PWAS score (both)	Yes	10	94.60	10.20	3.23
	No	13	96.46	13.15	3.65
MCT (C-score)	Yes	10	13.26	6.96	2.20
	No	13	19.83	3.40	0.94

Abbreviations: MCT, Moral Competence Test; PWAS, Parental Warmth and Acceptance Scale.

TABLE 5 Independent *t* test results between groups with or without conduct disorder

Study variable	*t*	*df*	Sig.	Mean difference	Std. error difference
Age	0.68	21	0.50	0.60	0.88
Number of violations	2.33[a]	21	0.03[a]	0.85	0.36
Number of dual diagnosis	1.40	21	0.18	0.45	0.32
PWAS scores (mother)	−0.70	21	0.49	-2.08	2.98
PWAS scores (father)	0.08	21	0.94	0.22	2.70
PWAS scores (both)	−0.37	21	0.72	−1.86	5.04
MCT (C-score)	−2.99[a]	21	0.007[a]	−6.57	2.20

*Significant at $P < 0.05$.
**Significant at $P < 0.001$.

In the current study, conduct disorder was not associated with age, gender, and the presence of a stepfamily. However, participants with conduct disorder had an increased number of violations compared to controls. This is supported by Western findings which estimate that over 90% of juvenile delinquents with multiple offenses and recidivism had conduct disorder.[8–11]

Most participants had a comorbid psychiatric disorder, such as mood, adjustment, and attention-deficit/hyperactivity disorders. In the study, conduct disorder was associated with the presence of a substance use disorder, but not with other comorbid psychiatric disorders. In general, juvenile offenders have a higher risk for multiple substance use disorders and problems associated with substance use.[11,48,49] A comorbid substance use disorder has also been associated with severe functional impairment, recidivism, and poorer treatment outcomes.[48–50] The relationship between conduct and substance use disorders may be bidirectional, with early substance use being a risk factor for the future development of a conduct disorder.[50]

More conduct-disordered participants had a history of abuse or neglect compared to controls. This is in line with previous research which identifies harsh physical or verbal discipline, abuse, and neglect as significant predictors of conduct-disordered behavior and juvenile delinquency. Negative interactions with parents have a detrimental effect on the emotional and psychological development of children, increasing their risk for aggression, delinquency, withdrawal, and other behaviors symptomatic of conduct disorder.[51–60]

Most studies on child maltreatment and subsequent antisocial behavior have been conducted in Western countries. The US National Comorbidity Survey demonstrated that physically punished children were 1.3 times more likely to develop psychological problems and antisocial behavior compared to controls.[55] These findings were supported by a study which demonstrated a causal link between physical punishment and antisocial behavior, including juvenile delinquency and substance use problems.[55] Similarly, a Danish study found that harsh physical punishment was associated with internalizing and externalizing symptoms in youth, as well as elevated risk for antisocial conduct.[55,56]

There may be bidirectional and interactive effects between negative parenting and externalizing behavior.[53–55] Specifically, negative dyadic interchanges between a parent with abusive tendencies and a child with externalizing behavior promote

aggressive behavior in both parties, leading to conduct problems in the child.[56–58]

In the Philippines, approximately 8.5% of children have reported receiving severe corporal punishment.[53,59] While there was a significant association between the presence of abuse and conduct disorder, there were no significant associations between parental warmth and acceptance scores and conduct disorder, a finding which may have been due to the limited sample size of the study. However, cross-cultural aspects must be considered. Prior findings demonstrate that Filipino parents report themselves to have higher warmth and acceptance compared to the global mean. Specifically, while Filipino parents emphasize obedience regardless of the form of discipline, they also tend to be affectionate and indulgent.[35,53,61] Hence, it is possible that no significant associations were demonstrated since Filipino parents may have been able to demonstrate affection toward their children despite the presence of harsh discipline and abuse.

Finally, the results demonstrated lower moral competence means for children with conduct disorder compared to controls, supporting the theory that moral competence mediates the relationship between conduct disorder and delinquency.[16,19,32] In a previous meta-analysis, the effect size for the relationship between moral competence and juvenile delinquency was largest for studies involving incarcerated male, late adolescent juvenile delinquents with psychopathic disorder, which closely reflects the demographic characteristics of the study sample.[32]

Conduct-disordered children are high risk for the commission of more crimes, violent crimes, recidivism, and the development of antisocial personality disorder, making them an important population to consider when developing programs geared toward reducing juvenile crime.[8,11,12,32] The finding that children with conduct disorder have decreased levels of moral competence suggests that increasing moral competence can be a strategy for such interventions.

4.1 | Limitations and recommendations

The study sample was small, which may have led to limited statistical power to detect differences with regard to other variables examined. Furthermore, the findings may be culturally specific, with differences in rates observed in the study compared to Western research. While this may limit generalization of the data to a wider population, the results provide much-needed information regarding the situation of Philippine children in conflict with the law. This may also have an impact on proposed interventions, since psychosocial programs should be needs-oriented in order to achieve desired results.

Recommendations include extension to larger populations in order to replicate and validate results. It may also be of benefit to make consistent psychological care available for these children, since majority were found to have comorbid psychiatric conditions which may be amenable to treatment. Finally, the development and evaluation of an intervention program which aims to improve moral competence, with the eventual goal of reducing offense rates and recidivism, is recommended.

In sum, the present study aimed to determine the demographic characteristics and the prevalence of conduct disorder in Filipino children in conflict with the law. Variables hypothesized to be associated with conduct disorder, such as family background, history of abuse, perceived parental warmth and acceptance, psychiatric comorbidities, and moral competence, were likewise examined. Results demonstrated that majority of the participants were between 16 and 18 years old, male, and had an educational attainment between Grades 4-6. More than ninety percent had a comorbid psychiatric disorder, but only 43.5% met the clinical criteria for conduct disorder, a finding which could be explained by cultural differences. Participants with conduct disorder were more likely to have committed multiple violations, to have committed theft and homicide, to have a comorbid substance use disorder, and to have had histories of abuse or neglect. Finally, children with conduct disorder were found to have lower moral competence levels, a finding which supports majority of the previous research in the field. Recommendations include replication and extension of the study and the development of a local intervention program geared toward increasing the moral competence of children in conflict with the law in conjunction with consistent psychological care.

ACKNOWLEDGMENTS

The author would like to thank the psychiatrists and the children who participated in the study. The author would also like to acknowledge Dr. Georg Lind for the permission to use the Moral Competence Test (Philippine version).

CONFLICT OF INTEREST

Preliminary results were presented as an oral presentation at the 23rd World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions, through a travel grant from the UERMMMCI Research Institute of Health Sciences.

AUTHOR CONTRIBUTIONS

MPM is the sole author of this study.

DATA REPOSITORY

The author agrees to publish part of the data as Supporting information.

ETHICAL APPROVAL

Ethical/institutional review board approval was secured from the UERMMMCI Research Institute of Health Sciences (RIHS ERC Code 0345/I/H/17/04).

INFORMED CONSENT

Informed consent/assent was secured from all study participants and their legal guardians.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

How to cite this article: Mariano MPV. Moral competence and conduct disorder among Filipino children in conflict with the law. *Neuropsychopharmacol Rep*. 2019;39:194–202. https://doi.org/10.1002/npr2.12071