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Monograph: Conduct Disorder

University of Utah, High Incidence Grant

Definition and Classification of Conduct Disorder

Conduct disorder is typically more common in males than females and the current rates of diagnosis are between 1 and 4 % of 9-17 year olds (U.S. Department of Health and Human Services, 1999). The behaviors that are exhibited with children with this disorder can be dangerous and detrimental to themselves and others.

The criteria for a diagnosis of conduct disorder has been clearly defined in the Diagnostic and Statistical Manual for Mental Disorders; Fourth Edition, Text Revision (APA, 2000). In order to meet the criteria for diagnosis, one must meet the following criteria:

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 last 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
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 stole 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 18 years or older, criteria are not met for Antisocial

Personality Disorder

Beyond these criteria, the person making the diagnosis must specify age of onset and severity because this helps to make the classification and resulting interventions more effective. There is a different diagnosis for early onset conduct disorder and late onset conduct disorder. Oppositional Defiant Disorder must also be ruled out before a diagnosis of Conduct Disorder can be given.

Another consideration that may be helpful in determining diagnosis and interventions is to determine if behavior is “proactive” or “reactive” and whether it is “overt” or “covert” behavior. Overt behaviors are those that confront or disrupt the environment (e.g., aggression, temper tantrums, arguing) and covert behaviors are those that may not be directly noticed by a caregiver (e.g., stealing, fire starting, lying).

The requirements for a special education classification of conduct disorder varies from the DSM-IV-TR in that conduct disorder falls under the educational classification of emotional disturbance. The definition for Emotional Disturbance in the State of Utah (Harrington, Gray, & Arbogast, 2007) is:

A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a student’s educational performance:

1. An inability to learn that cannot be explained by intellectual, sensory, or health factors.
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
3. Inappropriate types of behavior or feelings under normal circumstances.

4. A general pervasive mood of unhappiness or depression.
5. A tendency to develop physical symptoms or fears associated with personal or school problems.

Emotional disturbance includes schizophrenia. The term does not apply to students who are socially maladjusted, unless it is determined that they have an emotional disturbance.

“Emotional disturbance” is a term that covers the following two types of behavioral difficulties, which are not mutually exclusive and which may adversely affect a student’s educational performance.

1. Externalizing refers to behavior problems that are directed outwardly by the student toward the social environment, and usually involve behavioral excesses.
2. Internalizing refers to a class of behavior problems that are directed inwardly, and often involve behavioral deficits.

There is a high rate of comorbidity with conduct disorder and Attention Deficit/Hyperactivity Disorder (ADHD), Anxiety, Depression, Somatization, low academic achievement, substance abuse, and risky sexual behavior (Fossum, Morch, Handegard, Drugli, & Larsson, 2009; Gardner, Burton, & Klimes, 2006; Dretzke et al., 2005).

Longitudinal Studies

In a longitudinal study of children with depressed mothers (Morrell & Murray, 2003), the researchers were attempting to determine the effects of

parenting and infant characteristics on the development of conduct disorders later in life. One of the results found was that the outcome of a diagnosis of conduct disorder is related to gender. Also, it was found that emotional dysregulation in infancy may contribute to a diagnosis of conduct disorder later in life. Another conclusion of this research was that children are vulnerable to environmental variables, including parenting factors, between 2 and 4 months old, but after that, the parenting style may not have an effect on their later behavior. This is an important study, in that, it determined some possible moderators and mediators of conduct disorder and it identified a time frame that might be more influential in the development of conduct disorder.

In a review of past research in the area of conduct disorder, Eyberg, Nelson, and Boggs (2008) concluded that the caregivers' management skills and the child's deviant peer association contributed to worse outcomes of conduct disorder later in life. Also, possible moderating effects were found with maternal depression, marital adjustment, parental substance abuse, and child comorbidity with anxiety and/or depression. This study contributes some possible risk factors contributing to conduct disorder.

Patterson & Forgatch (1995) found that if there is a high level of deviance prior to treatment, then it might indicate worse outcomes following interventions, but this finding was not consistent in other studies of similar treatments.

Gardner, Burton, and Klimes (2006) aimed at identifying the outcomes of parent training and the mechanisms that fostered change for children with conduct disorder. The key factor found to be a mechanism for change in child behavior was

the level of parenting skills. This is an important implication that substantiates prior research indicating that parent training programs are effective in reducing the deviant behaviors of children with conduct disorder.

Assessment of Conduct Disorder

There are many methods that can be used to diagnose conduct disorder. Some of the most common are behavior rating scales, such as, the BASC, CBCL, ASEBA, and ECBI. These are commonly used questionnaires that teachers, parents, and the children can easily and quickly complete to give multiple aspects of the child's behavior. These measures are based on the individual's report and therefore, should be used with caution and in conjunction with other measures in order to get a more comprehensive report.

Another common practice when considering the diagnosis of conduct disorder is using a functional behavior assessment (FBA). FBA's are used to identify the behavior of the child, the antecedent for that behavior, the consequences the child is receiving for that behavior and any possible replacement behavior that could be introduced to take the place of the disruptive behavior. As a part of completing the FBA, behavioral observations are conducted, but behavioral observations are often completed regardless of whether or not a complete FBA is done.

Personality tests are also an effective measure to aid in determining if a child has conduct disorder. The most common used for adolescents are the MMPI-A and the MACI. These measures provide scores on a number of scales that give information about behavior and personality patterns. These measures are both self-report

questionnaires that should be interpreted cautiously as they are based on the information provided by the child.

Other information that may be helpful in developing a comprehensive assessment would include a structured interview with the parents and/or child and obtaining a developmental and/or medical history. By using multiple sources of information, the clinician is better able to formulate the possibility of the child having a conduct disorder.

Possible Causes and Contributory Factors of Conduct Disorder

There are many factors that have been identified as contributory factors to the development of conduct disorder (Mash & Barkley, 2006; Frick, 2001). Some of these factors include the child's individual vulnerabilities, the child having a difficult temperament, neuropsychological impairments, problems in child rearing (substance abuse, marital distress/divorce, parental antisocial behavior, low social support), and stressors in general social ecology. It is highly common that a number of these contributory factors are present prior to the diagnosis of conduct disorder.

Interventions for Conduct Disorder

There are many treatments that have been used for the treatment of conduct disorder. Some of these treatments have been found to be effective and some have been found to be ineffective, sometimes even having detrimental effects. The treatments used for conduct disorder are types of family-based interventions, skill training, community-based programs, school-based treatment, "get tough" approaches, attachment therapies, or psychopharmacological treatment.

Family-based interventions are primarily focused around a parent training component (Mash & Barkley, 2006; Frick, 2001). Some of the programs included in this type of intervention include: Helping the Non-compliant Child (HNC), Parent-Child Interaction Therapy (PCIT), Incredible Years, Triple P- Positive Parenting Program, OLSC Training Program, and Multisystemic Therapy (MST), Functional Family Therapy (FFT). These programs are found to be effective, but the effects are short-term.

Skill training is a form of treatment that involves teaching skills to the children diagnosed with conduct disorder. These interventions include: Skill Training, Social Skills, Cognitive Behavioral Skills Training, Problem-Solving Skills Training, Anger Management, Coping-Competence Programs, and Multicomponent Skills Training (Mash & Barkley, 2006; Frick, 2001).

Community-based programs include interventions that are more intensive (Mash & Barkley, 2006; Frick, 2001). These interventions include: The Achievement Place Program (Teaching Family Model), treatment foster care, case management, and day treatment. These interventions are based out of community agencies that meet specific community needs.

In the 2007 Biennial Report: Effective psychosocial interventions for youth with behavioral and emotional problems, they determined which interventions were the most and least effective for delinquency and disruptive behavior. The best support for these behaviors is Parent Management Training, Multisystemic Therapy, Contingency Management, Social Skills, CBT, and Assertiveness Training. Good supports included teaching components, such as, problem-solving, communication

skills, anger control, and relaxation. This seems to be consistent with what a majority of the research is indicating. Many of the treatments are have multiple components and include a parent training component.

School-based treatments are provided in the schools for children classified in special education under the classification of emotional disturbance. The services provided include classroom management and involvement in multicomponent treatments.

Popular Non-Validated Techniques for Conduct Disorder

There are some treatments that are considered scientifically questionable treatments (SQT's). Peer-group interventions have been found in past research to not only be largely ineffective, but also to have detrimental effects in some cases (Lilienfeld, 2005). In this type of treatment, it was found that the children in these groups learned undesirable behavior from the other children instead of learning desirable behavior.

“Get tough” approaches are also found to be largely ineffective (Lilienfeld, 2005). These programs include the boot camp programs and the Scared Straight program. Scared Straight is a program that has people who are currently incarcerated come and talk to children at risk of delinquency in order to scare them into changing their behavior. Both of these programs have been proven largely ineffective, although no detrimental effects have been found in the current research.

Attachment therapies have been deemed ineffective, but possibly deadly as there have been multiple reports of children dying as a result of this treatment (Lilienfeld, 2005). Attachment therapies are based on the belief that children must

express rage that is within them in order to make improvement. Once the therapy has begun, the child is not able to stop the experience because the child is usually uncomfortable, but that is seen as necessary. This type of therapy is extremely intrusive and are sometimes referred to as "rebirthing therapy", "compression therapy", "corrective attachment therapy", "reparenting therapy", "the Evergreen model", "holding time", "rage-reduction therapy" or "prolonged parent-child embrace therapy".

The final treatment that is considered to be an SQT is psychopharmacological treatment when it is used as a stand-alone treatment. Medication may be effective in conjunction with other therapies, but it is not recommended as the only treatment for conduct disorder. The most common psychopharmacological treatments are the use of antipsychotics and mood stabilizers.

Prevention

Along with intervention techniques, there are also a number of preventative techniques that can be used to address early symptoms of conduct disorder and hopefully prevent the development of the disorder as defined in diagnostic criteria. The majority of prevention for conduct disorder is a response to the behavior that is already present, so prevention can be very similar to intervention.

The two main subcategories of prevention techniques would be early intervention for infants and preschoolers and prevention for at-risk children through adolescence (Mash & Barkley, 2006). These programs can be developed as a broad intervention for all children or specified for children who are already displaying deviant behavior.

Positive Behavior supports is an example of a school-wide prevention program that addresses all students in the population and then narrows the focus for children who may need more intensive support. This program is a tiered approach to providing the appropriate support individual students need, but as a whole school.

Another program, the Seattle Social Development Project (Mash & Barkley, 2006) is a program implemented in elementary schools for grades 1-6. The intervention is a combination of teacher training, parent training, and social-cognitive skills training for children. The program is tailored to the individual's developmental level to ensure the highest level of effectiveness.

The Fast Track project (Conduct Problems Prevention Research Group, 1992) is another program that targets deviant behavior. This program is intended for children to participate from 1st grade through 10th grade. It takes place in multiple settings and incorporates many components. This program includes parent training, home visits, social skills training, academic tutoring, and a teacher-based classroom intervention.

Standard Case Study of Conduct Disorder

A study conducted in Norway (Fossum, Morch, Handegard, Drugli, & Larsson, 2009) attempted to identify the predictors and mediators of treatment for children with conduct disorder or oppositional defiant disorder. The subjects in this study were between the ages of 4 and 8 who were referred by their parents for conduct problems. For inclusion in this study, the children could not have a debilitating physical impairment, and the children's behavior had to be in the clinical range on the Eyeberg Child Behavior Inventory (ECHI) as determined by Norwegian norms.

If the children did not meet DSM-IV criteria for ODD or CD, they were still included if they displayed severe conduct problems.

The children were randomly assigned to one of three conditions; parent training, parent training combined with child training, or wait-list condition. The children in the two active treatment conditions had a mean age of 6.6 years (SD=1.3), 28 children lived in a one-parent home, there was a step-parent involved in 18 families, 6 children were living in foster care, and 2 families were not native-speaking Norwegians.

The children were all given a number of assessments, including; the Eyeberg Child Behavior Inventory (ECBI), the Kiddie-SADS diagnostic interview with mother, teacher questionnaires, the Dyadic Parent-Child Interaction Coding System-Revised (DPICS-R) to observe parent-child interactions, the Preschool Behavior Questionnaire (PBQ), Teacher Report Form (TRF), Parental Stress Index (PSI), Beck Depression Inventory (BDI), and the Parenting Practices Interview (PPI) (adapted version).

The manualized program used for the treatment conditions was the Incredible Years (IY) intervention program (Webster-Stratton & Reid, 2003). The BASIC parent training condition aimed to strengthen families and promote parent competencies by increasing their positivity and self-confidence in parenting, reduce negative parenting practices, improve parents' problem-solving skills and anger management, and improve school involvement. The participants were divided into groups of 10-12 parents (parents of approx. 6 children). The groups met two hours weekly for 12-14 weeks with two accredited therapists. The parents watched 250

video vignettes of parent-child interactions followed by the therapists leading discussions about different aspects of the vignettes. At each session, the parents received home tasks and parents shared experiences from these tasks at the beginning of the next session. There was a high attendance rate, with parents attending an average of 92% of the meetings.

The second treatment condition was the IY program and the "Dinosaur School" (Webster-Stratton & Reid, 2003). The "Dinosaur School" is a child training that they combined with the same parent training (IY) described previously. The groups met simultaneously at the clinic, but the groups were run separately. Approximately 6 children were in a group that met for two hours weekly with two therapists for 18-20 weeks. The child training program also involves watching about 100 video vignettes, but they are clips of children in multiple settings. Along with the video vignettes, the program involves fantasy play with life-size puppets (a girl, a boy, and various animals). The children were given exercises to take home with them. The children also had a high rate of attendance, averaging 91%.

There were fifteen therapists who ran the parent training groups and nine therapists who ran the child training groups. All of the therapists were well-trained and all of them followed the treatment manual for both conditions. The sessions were videotaped for peer, self, and trainer evaluation to ensure that the treatments were conducted properly.

The outcome variables measured were child functioning at home, independent observation of negative parenting, and child behaviors in day care or school. In the area of child functioning, 39.8% were considered responders to the

treatment and 60.2% were considered non-responders to the treatment. It was also concluded that 34.1% of the mothers achieved 30% or greater reduction in their observed negative parenting. The teacher ratings of behavior did not result in a significant effect, but 32.6% of children were at a level below the behavioral cut-off score at the end of treatment.

The researchers also conducted logistic regression analyses with the results indicating that the independent variables of having ADHD, being female, and maternal stress predicted worse outcome in the subjects. The treatment effects were lower than the original study on this program (Webster-Stratton & Reid, 2003), but this is not an uncommon result. At post-treatment, two-thirds of the children were found to score within behavioral norms. Also, there were no child or family variables that were found to predict unfavorable outcomes.

The authors did not control for any parental factors. It was also observed that the parents in this study had more neutral interactions during the observation periods than U.S. parents have.

Overall, this study did substantiate the efficacy of the Incredible Years parent and child training modules. This is also notable, given that the study was conducted in Norway, showing some possible application in various cultures and with differing groups of families.

Conclusions

Conduct disorder is a very complex, multi-faceted disorder with many possible mediators, moderators, and contributing factors. It is important to be mindful of the vast possibilities. Looking at the current research available can aid

parents and professionals in choosing the best options for prevention, treatment, assessment.

The assessments available can assist in this process also. Many of the assessments discussed offer information about the types of interventions that may be most appropriate and effective for individual children. It is important to look at all contributing factors, including parent-child interactions, deviant peer influences, and parenting techniques when determining interventions to be implemented with the child.

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