Characteristics and treatment of conduct disorders

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Characteristics and treatment of conduct disorders

Abstract
Conduct Disorder is the most diagnosed condition in both outpatient and inpatient mental health facilities for children in the United States. Behavior problems such as aggression, destruction of property, theft and violation of basic rules are concerns for parents, teachers, peers and other adults. In an effort to help increase the reader's understanding of the Conduct Disorder population and their treatment, the author of this paper will describe and characteristics of this population. The author will also address specific mental health concerns as found in a review of the literature, and the status of mental health treatment.
CHARACTERISTICS AND TREATMENT OF CONDUCT DISORDERS

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Clinicians commonly hear complaints of a child's aggressive and antisocial behavior. The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1995) (DSM IV) described the condition of Conduct Disorder as being the most diagnosed condition in both outpatient and inpatient mental health facilities for children in the United States. Behavior problems such as aggression, destruction of property, theft and violation of basic rules are concerns for parents, teachers, peers and other adults. These same behaviors are also problematic for parents and teachers of children who are not seen in clinical or legal settings (Kendall & Hammen, 1995).

In addition to the fact that behavior disorders among children are common, when they exist in extreme and persistent forms they are problematic for society at large. The seeming persistence of these behaviors over time, perhaps from early childhood through adult life, also highlights their importance DSM IV (American Psychiatric Association, 1995).

In 1987, there were about 28 million 10 to 17 year-olds in the United States, of whom there were one-half million more boys than girls (Bureau of Census, 1987). Estimates of the prevalence of Conduct Disorder in the general population vary. Loeber, Keenan, Lahey, Green, and Thomas (1993) reported that in the general population the number of persons with Conduct Disorder is 4 to 6 percent. Hayes (1997) reported that as many as 1 in 10 children and
adolescents in the United States may have a Conduct Disorder. Kardin (1986) found estimates of Conduct Disorder ranging from 4 to 10 percent of all children.

In an effort to help increase the reader's understanding of the Conduct Disorder population and their treatment, the author of this paper will describe and characteristics of this population. The author will also address specific mental health concerns as found in a review of the literature, and the status of mental health treatment.

The Conduct Disorder Population

The DSM IV Approach

According to the DSM IV (American Psychiatric Association, 1995), the essential feature for the diagnosis of Conduct Disorder is a persistent pattern of behavior that violates the basic rights of others and major age-appropriate social norms. Conduct Disorders are part of the larger DSM IV, (American Psychiatric Association, 1995) category of Disruptive Behavior Disorders which also includes Attention-Deficit Hyperactivity Disorder, and Oppositional-Defiant Disorder. Conduct Disorder occurs as early as 5 or 6 years of age and is usually diagnosed in late childhood or adolescence, but rarely after age 16. The list of characteristics given by the DSM IV (American Psychiatric Association, 1995) to describe manifestations of Conduct Disorder are as follows:
At least three of the following are present as part of a conduct disturbance lasting at least six months.

1. Steals without confronting the victim.
2. Runs away from home overnight at least twice.
3. Often lies.
4. Deliberately sets fires.
5. Often truant from school (absent from work).
6. Breaks into a house or car.
7. Deliberately destroys another person's property.
8. Physically cruel to animals.
10. Uses a weapon in more than one fight.
11. Often initiates physical fights.
12. Steals with confrontation of victim.

The DSM IV, (American Psychiatric Association, 1995) describes two sub-types of Conduct Disorders based on the age at onset of the disorder (i.e., childhood-onset type and adolescent-onset type). The childhood-onset type is defined by the presence of at least one criterion characteristic of Conduct Disorder prior to age 10 years. Individuals in the childhood onset-type are usually males, frequently display physical aggression toward others, have strained peer relations and may have
met the criteria for Oppositional Defiant Disorder during childhood. According to the DSM IV, (American Psychiatric Association, 1995) these youth will usually meet a majority of the criteria for Conduct Disorder prior to puberty. Quay (1986) noted that individuals in the childhood onset type will also be more likely to develop Adult Antisocial Personality Disorder than will the adolescent-onset type.

Adolescent-onset type Conduct Disorder is defined by the DSM IV, (American Psychiatric Association, 1995) as the absence of any criteria for Conduct Disorder prior to 10 years of age. These youth are less likely to display aggressive behavior and tend to have more appropriate peer relationships than do individuals who meet the criterion for childhood onset. The ratio of males to females is lower for the adolescent-onset type than for the early childhood-onset type (American Psychiatric Association, 1995; Quay, 1986).

The Ontario Child Health Survey has provided a comprehensive picture of Conduct Disorder in the general population (Offord et al., 1987, 1991). In this study of children between ages 4 and 16 sampled throughout the province of Ontario, a diagnostic method was produced that conformed to criteria established in the DSM III, (American Psychiatric Association, 1980). From this survey it was concluded that the frequency of symptoms of less serious behaviors declined with age while those of more serious nature increased with age. Males exceeded females in prevalence for most symptoms.
Conduct Disorder continues for a period of six months or more, so isolated acts or one time acts of antisocial behavior do not count. The DSM IV, (American Psychiatric Association, 1995) stated that children with Oppositional Defiant Disorder may behave much like children having Conduct Disorder: exhibiting temper outbursts, violating of curfew, playing hooky, being spiteful and vindictive, and generally showing disobedience and opposition to authority figures. However, these children do not violate the basic rights of others or major age-appropriate societal norms or rules, as do children with Conduct Disorder (American Psychiatric Association, 1995; Loeber, et al., 1993).

Many youth having Conduct Disorder also have a second, or dual diagnosis. It is estimated that 8 to 10 percent of elementary school age boys and 2 to 3 percent of elementary school age girls have Attention Deficit Hyperactivity Disorder, (ADHD) (Miller, Palker, & Stewart, 1973; Szatmari, Olford, & Boyle, 1989). ADHD has been closely related to Conduct Disorder and learning disabilities (Barclay, 1990). The possibility of subtypes of ADHD is gaining attention, and there seem to be important differences between ADHD youth with and without comorbid Conduct Disorder and aggression (Fergusson, Horwood & Lloyd, 1991). As many as 50 percent of ADHD youth also meet the diagnostic criteria for Conduct Disorder or Oppositional Defiant Disorder (Weiss, Minde, Werry, Douglas, & Nemeth, 1971).
Prevalence

The exact prevalence of Conduct Disorder is difficult to establish and estimates vary among studies and among differing segments of the general population (Loeber, et al., 1993). Dryfoos (1990) stated that there is no way to estimate the prevalence in any given population as defined by psychiatrists. Kazdin's (1986) review of the literature on this subject found estimates of the syndrome ranging from 4 to 10 percent of all children. Differences in definition as well as socioeconomic and familial factors influence the number and kinds of problems reported (Kazdin, 1995). Nonetheless, aggression, as well as antisocial, oppositional, and similar behaviors certainly are among the most common childhood problems as reported by Wells & Forehand (1985). In their review of prevalence studies, Wells and Forehand (1985) noted that 33 to 75 percent of clinic referrals were for Conduct Disordered behavior.

Gender differences in the numbers of persons having Conduct Disorders are evident. Kendall and Hammen (1995) discussed how the precise gender ratio in the prevalence of this disorder is difficult to determine because of the varying types of assessments that have been used. Quay (1986) estimated that in most cases the reported ratio is at least 2:1 or 3:1 (males-females). Earles (1994) reported that estimates varying from 3:1 to 5:1 (males-females) are common.
Gender differences are also apparent in the age of onset for Conduct Disorders (Kazdin, 1990). According to Kazdin's findings, boys more frequently have an onset before age ten and exhibit more antisocial behaviors such as theft than do girls before age 10. Kazdin (1990) further reported that the onset of Conduct Disorders for girls is concentrated in early teens years (age thirteen to sixteen) in the acting out of sexual misbehavior.

**Contributing Factors**

**Organic.** There is evidence to support the relationship between Conduct Disorder youth and organic abnormalities. The Harvard Medical School Mental Health Letter, Part I (1989) found that children and adolescents with the most severe Conduct Disorder, were often mentally retarded or neurologically impaired. This finding was most evident among the violent individuals. This source further states that the same kind of behavior that is regarded as a sign of organic pathology in young children is often interpreted as simply antisocial or criminal behavior in adolescents. The source further states that these organic problems can be difficult to detect (The Harvard Medical School Mental Health Letter, Part I, 1989).

Negative affect and constraint were also considered by Coninger, (1987) to have specific neurobiological undertones (Coninger, 1987).
Past research has explored a possible connection between the rate at which the brain expands its neurotransmitter substances and the dimension of personality. For example, abnormally low levels of a metabolite by-product from the neurotransmitter called serotonin have been found in the cerebrospinal fluid of prison inmates whose criminal history is habitually violent and impulsive (Linnoila, Virkunnem, Nuutila, Rimon, & Frederick, 1983; Virkunnen et. al, 1987). These findings have led many theorists to outline the neural mechanisms by which low serotonin levels in the brain could simultaneously produce impulsivity and greater negative affect (Depue & Spoot, 1986; Spoot, 1992).

Researchers have investigated genetic factors as a possible force in Conduct Disorders (Plomin, Nitz, & Rowe, 1990). When examining aggressiveness in studies of twins, these researchers found hints that aggressiveness shows no consistent pattern of genetic influences. However, Dilalla and Gottesman (1989) and Wicks-Nelson and Israel (1991) reported on research that has suggested a genetic relationship to criminal activity. It should also be noted that the relationship between genetic factors and antisocial behavior is higher with adult (crime) than with youth (delinquency), (Dilalla & Gottesman, 1989; Wicks-Nelson & Israel, 1991).

Family Environmental Factors. Gardner (1994) described how the relationship between deprivation of parental affection and the
development of psychogenic pathology in the child has a direct correlation with the diagnosis of Conduct Disorder. Although Gardner considered a wide variety of parental deficiencies, most of his clients had a common basic impairment in the parent's capacity to provide the child with love, guidance, affection, nurturance and protection.

Other research findings have supported the notion that the family is a contributing factor in the development of Conduct Disorders (Jouriles, Bourg & Farris, 1991). Hetherington and Martin (1986), cited in Kenall and Hammen (1995), listed four alternative patterns they believe are common in the families of youngsters with Conduct Disorder: parental deviance, lack of discipline or supervision of children, parental rejection and coerciveness, and marital conflict and divorce. Kendall and Hammen (1995) described how extreme permissiveness, inconsistent discipline, and harsh discipline have been associated with Conduct Disorder. They further reported how extremes in parental control, too much or none at all, seem to contribute to the appearance of aggressive and defiant behavior. In three additional studies West (1982), Gabel and Shinslederker (1992), and Kendall and Hammen (1995), reported how the parents of Conduct Disorder children were often found to be deviant, to display maladjustment, anger, criminal behavior, and alcoholism. These factors often put the child at greater risk for the disorder.
Patterson, Chamberlain, and Reib (1982) claimed that family environment has a pervasive influence on parents and on the personality development of their children, particularly on the development of antisocial behavior. Other factors shown to predict late aggression include harsh, inconsistent disciplinary practices and a chaotic home environment (Loeber & Stouthamer-Loeber, 1986). For these youth, living under the constant threats of emotional or physical harm increases the negative affects more than does a simple perceptual bias. The youth's view is that the harsh realities of their everyday living is a constant reinforcer of their need for defensive coping skills.

Constraint may also affect family dynamics. For example, parental conflict has been found to predict children's scores on constraint at age eighteen (Vaughn et al., 1988). Thus, a personality configuration involving high levels of negative affects and low levels of constraints may develop when children grow and learn in a discordant family environment in which parent-child interactions are harsh and inconsistent.

Patterson (1986) summarized his findings from three interlocking structural equation models. These models defined a set of relations between stress and family management skills and between parental discipline and antisocial child behavior. In the third model, it was hypothesized that inept parenting skills set a process in motion that
causes the child to be rejected by peers, to fail academically, and to have low self-esteem.

The risk for a child having a Conduct Disorder increases in children whose biological or adoptive parents are Antisocial Personality Disorders or who have a sibling with Conduct Disorder (American Psychiatric Association, 1995; Rutter & Quinton 1984). This disorder is also common in children who's biological parents are alcohol dependent, have a mood disorder, are Schizophrenic, have Attention-Deficit/Hyperactivity Disorder or have Conduct Disorder (American Psychiatric Association, 1995). There appears to be a relationship between alcoholism and antisocial personality in the fathers, in combination with low socioeconomic status and unsocialized Conduct Disorder in children (Earls et al., 1988). Robin (1966) and West (1982) found that criminal behavior and alcoholism, particularly in the father, put the child at high risk for Conduct Disorder.

Garder (1994) explained how parents can overtly or covertly sanction a child's antisocial behavior. This may be overtly accomplished by direct instruction or covertly accomplished by parental modeling that supports the antisocial behavior and by parental failure to properly guide, and provide structure, proper discipline and consequences for their antisocial child. The result of overtly or covertly sanctioning a child's antisocial behavior is the same. There is parental support for the child's acting out. Finally, parents of Conduct
Disorder children tend to respond coercively and often negatively to their children. Loeber (1990) stated that, although measuring parental practices is difficult, there seems to be a strong association between a negative parent-child relationship and antisocial conduct between children.

According to Patterson, Chamberlain, & Reid (1982), the parents of children with Conduct Disorder tended to reward positive and negative behaviors inconsistently. In particular, the parents reinforced (by attention or laughter) coercive child behaviors such as demanding, defy, yelling, and arguing. Meanwhile, positive behaviors were often ignored or responded to inappropriately. Thus, according to Patterson, families with children with Conduct Disorder are characterized by coercive interactions. Poor parenting skills, he argued, produce and promote antisocial behavior.

Societal. Barclay and Hoffman (1990) researched how societal contributions also influences the likelihood of a youth being diagnosed with a Conduct Disorder. Conduct problems are more prevalent among those of low socioeconomic status, and of urban (8 percent) rather than rural (4 percent) youth. DSM IV (American Psychiatric Association, 1995) described how the prevalence of Conduct Disorders seems to have increased over the last decades and may be higher in urban than in rural settings. Estimated rates range from 6 percent to 16
percent for males under the age of eighteen and from 2 percent to 9 percent for females, under the age of eighteen.

Kendall and Hammen (1995) speculated regarding different reasons put forth for gender differences in the diagnosis of Conduct Disorder. One speculative explanation these authors give is that the socialization process, in both families and schools, shape boys and girls differently. Kendall and Hammen (1995) concluded that aggressiveness is tolerated more in boys than in girls and boys are encouraged to discharge their frustrations more physically than are girls.

Whether the diagnosis for Conduct Disorders is influenced by organic, genetic, family, societal factors or by a combination of two or more of these factors, diagnosable youth are difficult children to raise, teach and interact with. They are challenges in the school systems and in the communities. Without proper treatment, these children are likely to grow up to be challenging adults. Understanding the possible reasons for Conduct Disorders would facilitate development and implementation of appropriate treatment procedure to produce positive change in these young people.

Theoretical Perspectives of Conduct Disorders

Psychodynamic:

The Harvard Medical School Mental Health Letter (1989) described the two most familiar types of individual therapy as psychodynamic (psychoanalytic) and cognitive behavioral
approaches. The first to be addressed is psychodynamic.

Psychodynamic theory postulates that children and adolescents with Conduct Disorders are "acting out" or discharging tension through action instead of fully expressing inner conflicts and allowing them to be resolved (Harvard Medical School Mental Health Letter, Part II, 1989). According to these authors' psychodynamic interpretation, acting out is a defense against anxiety or even a roundabout way of receiving punishment for guilty unconscious destructive wishes. The Harvard Medical School Letter states that the therapist must try to prevent the acting out and then interpret its source and meaning.

Kernberg and Chazan (1991) viewed psychoanalytic thinking as offering the appropriate framework within which to view Conduct Disorder children, revealing them as deficient in the basic personality structures and relationships that lead to healthy integration. In Kenberg and Chazan's (1991) view, throughout their development, children with Conduct Disorders tend to internalize negative parental images associated with negative feelings. Thus, the children come to perceive others as they themselves have been perceived.

In another version of psychodynamic theory, acting out is not a defense against inner turmoil, but the result of deficient emotional development that makes it difficult to delay action (Harvard Medical School Mental Health Letter, Part II, 1989). According to Kenberg and Chazan (1991), in structural psychoanalytic terms, Conduct
Disorder children have ego deficits in the following areas: cognitive functioning, attention, impulse control, judgment, modulation of affect, language, and tolerance for anxiety and frustration. In relationships, they are often encumbered by primitive organizational principles that govern their perception of themselves and others. Kenberg and Chazan further describe how these youth find it difficult to understand that peers have motivations, characteristics, and desires different from their own, tending instead to attribute to others their own feelings and thoughts. They tend to be immature and have poor social skills and when their need to control others is unsuccessful, they act out, unable to contain their feelings of frustration.

According to the Harvard Medical School Mental Health Letter, Part II (1991), traditional psychotherapy alone usually proves to be insufficient or unhelpful for youth with Conduct Disorder. The youths lack of interest in psychotherapy or active resistance to it is frequently evidenced by their failure to comply with therapy and a failure to attend sessions. These authors further stated that psychotherapy is useful only when the child has an underlying psychiatric disorder, such as depression. They consider psychotherapy useless for treating undersocialized aggressive behavior or gang aggression.

Kenberg and Chazan (1991) however support the use of psychotherapy. They state that with a combination of different
therapeutic approaches psychotherapy can be a useful strategy to use with Conduct Disorder children. They use individual play therapy, which seeks to strengthen the child's ego. The use of parent-training serves as a model of good parenting behavior and in play group therapy which helps with peer interaction and enhance the child's sense of mastery and self-control.

**Cognitive Behavioral**

Corey (1991) described the cognitive behavioral approach as including Albert Ellis's Rational-Emotive Therapy (RET), Albert T. Beck's cognitive therapy and Meichenbaum's cognitive behavior modification (CBM). Cognitive therapies have a number of basic similarities. They are active, directive, time-limited, structured approaches. Corey further states how these approaches are insightful therapies that emphasize the recognition and changing of negative thoughts and maladaptive beliefs.

Kendall and Hammen (1995) described how cognitive processing targets as being the deficient and distorted thinking tied to Conduct Disorders. Their position is based on the premise that cognitions or self-statements are the major determinants of how people feel and act. According to Albert T. Beck cited in Kovacs and Beck (1977), cited in Kendall and Hammen (1995) psychological problems are not necessarily the product of mysterious impenetrable forces, but may result from common-place processes such as faulty learning, making
incorrect inferences on the basis of inadequate or incorrect information, or not distinguishing adequately between imagination and reality. Beck suggested that early in life individuals begin to formulate rules about how the world works, and that, for depressed persons, these rules are based on erroneous ideas. A youth continues to distort experiences through characteristic errors in perceiving and thinking about event outcomes, personal attributes, and interpersonal relations. Kendall and Hammen (1995) describe how cognitive behavioral therapy aims to teach children and youth to stop, think, and engage in reflective problem solving. This is supported by The Harvard Medical School Mental Health Letter, Part II (1989), which reported that behavior therapists believe the Conduct Disorder child's inadequate learning of social rules must be corrected by altering the reinforcements (rewards and punishments) in his or her environment.

Many of the programs in place for delinquency prevention interventions such as school programs, family and parent training, combine different forms of cognitive behavioral therapy (Dryfoos, 1990). Many use behavior modification programs that focus on enhancing problem-solving skills by teaching means-ends and causal thinking. Dryfoos described many of these techniques as trying to increase sensitivity to and empathy with other people's problems and feelings.
Family Therapy

Dryfoos (1990) stated that a major determinant of Conduct Disorders and delinquency is the lack of parental support and guidance. Dryfoos further stated his opinion that children act out because their parents do not know how to control them. Family therapy or family management training with Conduct Disorder youth corresponds to problem-solving skills training for parents and children and is also based on behavioral social learning theory. (Harvard Medical School Mental Health Letter, 1989). Family therapy or family management trainings purpose is to teach the parents to notice and reward good behavior instead of ignoring it and to substitute effective discipline for inconsistent harshness. Harvard Medical School Mental Health Letter (1989) described how parents of children with Conduct Disorder are trained in family therapy to reinforce consistent, stable rules, issue clear, positive commands, negotiate compromises with older children, and use mild forms of punishment (e.g., insisting that children apologize, depriving them of privileges or sending them to their rooms). This is done by the family therapist modeling the behavior and rehearsing the parents. In the research reviewed (Alexander & Parsons, 1982; Kazdin, 1995) many of the parent and family work is based on cognitive and behavioral therapy techniques which will be
described in the paper under family interventions and functional family therapy headings.

Treatment for Youth with Conduct Disorders

School Based Intervention

Dryfoos (1990) reported that despite the number of individual and family attributes that have been linked to delinquent behavior of youth, another set of attributes relates to the quality of that school. Dryfoos described certain characteristics of schools that are associated with high delinquency rates. These include large school size, absence of individual attention, ability grouping and negative labeling, low teacher expectations, lack of structure, and inconsistent treatment by teachers and administrators. Hawkins and Lam (1987) concluded that the strong effects of school environments and the probability of misbehavior called for required delinquency prevention strategies directed at bringing about improvements in academic achievement accompanied by emphasis on positive peer influence strategies.

Dryfoos (1990) concluded that there are few evaluations of school-based interventions specifically designed to influence social behavior and delinquency. The examples of school-based interventions cited here fall into five broad categories: classroom management (teacher training), cooperative (student-staff) learning arrangements, school
team approaches, alternative schools, and special services and counseling.

When looking at classroom management, Hawkins and Lam (1986) conducted an experimental study of 7th graders in Seattle Washington. They tested instructional strategies intended to promote greater bonding of the school, increase achievement, and lessen antisocial behavior. Strategies included: proactive classroom management, interactive teaching, and cooperative learning. At the end of the first year very few positive results were found in improved bonding among students and they did not do any better in school. There was, however, some evidence that students were more likely to engage in learning activities, did more home work, did better in math classes, and upgraded their educational expectations. Students whose teachers were trained in classroom management, interactive teaching and cooperative learning were less likely to be suspended or expelled from school, but there was no difference in self-reported truancy, theft, or the frequency of getting in trouble at school for drugs or alcohol.

Dryfoos (1990) discussed cooperative learning arrangements as being beneficial in helping in the prevention of delinquency among youth. The first primary intervention of this approach is a participatory decision-making process which staff, parents, and student groups can be involved in decision making concerning management issues, which include discipline policies. The second intervention is student team
teaching in which heterogeneous students were put together to work on academic tasks in a cooperative atmosphere.

According to Dryfoos (1990), the school team approach is a joint problem solving process. Teams consist from six to eight people, including parents, students, school staff and community residents. Teams are trained in a two-week session to deal with problem behaviors in the school by acting as a group and developing a plan of action. Dryfoos described interventions as including setting up a time-out room for disruptive students in lieu of suspension, making home visits to problem students, and using students as monitors and advisors.

Grant and Cappell (1983) reported on the school team approach that was implemented in 200 schools over a two-year period. Evaluation results were more favorable in the middle school than in the high schools. School crime and disruptive behavior were reduced in middle schools, attributed by the evaluators to improved parent-teacher relations and successful handling of discipline and security problems within the schools. In the high schools the most effective school teams appeared to improve communication between students and teachers through joint student-teacher problem-solving groups. The largest decreases in school crime occurred early in the program, described by the evaluators as a honeymoon effect.

Alternative schools offer another approach Dryfoos (1990) discussed as a way to help behavior problem youth. In this approach
troubled youth are to separated from other youth and placed in separate classes or schools. Self-paced individual instruction, intensive counseling, paid employment, an open "rec room," and "contingency contracting" for behavioral modification are among strategies used.

Special services and counseling is the fifth approach (Dryfoos, 1990) suggested. Dryfoos described this approach by the Primary Mental Health Project (PMHP) as being used for approximately three decades in hundreds of schools throughout the United States. Repeated evaluations have demonstrated that this training has resulted in decreased antisocial behavior among those who are shy and withdrawn, but with less successful among very aggressive children.

In this approach, children at high risk of school maladjustment are identified by teachers in the early grades. Targeted children meet with a trainer either individually or in small groups for approximately 25 sessions. Children are taught to recognize feelings and set limits on their own behaviors.

Residential Treatment

Conduct Disorder is one of the leading reasons for admission to child psychiatric inpatient units and to residential treatment centers (Kashani & Cantwell, 1983). This was true in 1983, and nothing more recent has been found in the literature by this writer. The admission for treatment may some be based on the need to determine detailed differential diagnosis, to establish the presence of other psychiatric
disorders, and for immediate control of aggressive behavior or threats of such behavior (Earles, 1994). The impatient setting also allows the psychiatrist a greater opportunity for more intensive observation of the youth than could be allowed in an outpatient setting. Earles (1994) reported that residential treatment is usually reserved for youth who are so seriously disturbed that they require intensive, long-term management.

Family Intervention

The family environment often has a large influence on the personality development of children and on the development of antisocial behavior. (Patterson et al., 1982). This may be due to a impairment in the parent's capacity to provide love, guidance, affection, nurturing and protection (Gardner, 1994). Hetherington and Martin (1986) report on how the parents' inability to supply discipline, supervision or marital conflict may also influence the risk on Conduct Disorder. Do to these factors several therapeutic techniques will be reviewed: parent management training, functional family therapy, multi-systemic therapy, cognitive problem-solving skills training and parent training.

Parent management training. Parent management training (PMT) refers to procedures in which parents are trained to alter their child's behavior in the home (Kazdin, 1995). Parents meet with a therapist or trainer who teaches them to use specific procedures to alter interactions
with their child, in order to promote prosocial behavior, and to
decrease deviant behavior (Kazdin, 1993). Training is based on the
general view that conduct problem behavior is inadvertently developed
and sustained in the home by mal-adaptive parent-child interactions.
The training focuses on developing several different parenting
behaviors such as establishing the rules for the child to follow,
providing positive reinforcement for appropriate behavior, delivering
mild forms of punishment to suppress inappropriate behavior,
negotiating compromises, and other procedures. Kendall and Braswell
(1993) supported Kazdin regarding the importance of parent training
and the teaching of discipline practices. Inept discipline practices and
coercive exchanges have direct implications for intervention (Kendall
& Braswell, 1993).

According to Kazdin (1995), PMT is probably the best researched
therapy technique for the treatment of Conduct Disorder youths.
Scores of outcome studies have been completed with youths varying in
age and degree of severity of dysfunction (e.g., oppositional, conduct
disorder, delinquent youth) (Kazdin, 1993; Miller & Prinz, 1990;
Patterson, Dishion, & Chamberlain, 1993). The effectiveness of
treatment has been evident in marked improvements in child behavior
on a wide range of measures, including parent and teacher reports of
deviant behavior, direct observation of behaviors at home and at school, and various institutional records (e.g., arrests) (Kazdin, 1993; Miller & Prinz, 1990; Patterson, Dishion, & Chamberlain, 1993). It has also been shown to bring problematic behaviors within the normative levels of their peers who are functioning adequately. Follow-up assessments have shown that gains are often maintained for 1 to 3 years after treatment. Longer follow-ups are rarely used, although one program reported maintenance of gains 10 to 14 years later (Forehand & Long, 1988; Long, Forehand, Wierson, & Morgan, 1994).

Kazdin (1995) claimed the impact of PMT is relatively broad. The effects of treatment are evident for child behaviors that are not a direct focus of treatment. Kazdin saw this as an important effect because siblings of Conduct Disorder youth are at risk for severe antisocial behavior. In addition, maternal psychopathology, particularly depression, has been shown to decrease systematically following PMT (Kazdin, 1993). These changes suggest that PMT alters multiple aspects of dysfunctional families.

Functional Family Therapy

Functional family therapy (FFT) reflects an integrative approach to treatment that has relied on systems, behavioral, and cognitive views of dysfunction (Alexander & Parsons, 1982). Clinical problems are
conceptualized from the standpoint of the functions they serve in the family as a system, as well as for individual family members. The assumption is made that problem behavior evident in the child is the only way some interpersonal functions (e.g., intimacy, distancing, support) can be met among family members (Kazdin, 1995). FFT requires that the family see the clinical problem from the perspective of relational functions it serves within the family. The therapist points out interdependencies and contingencies between family members in their day-to-day functioning with specific reference to the problem that has served as the basis for seeking treatment. Once the family sees alternative ways of viewing the problem, the incentive for interacting more constructively is increased. The main goals of treatment as summarized by Kazdin are to increase reciprocity and positive reinforcement among family members for behaviors that are desired from each other. Other goals are to negotiate constructively, and to help identify solutions to interpersonal problems.

Relatively few outcome studies have evaluated FFT (Alexander et al., 1982). These author have examined the processes in therapy to identify in-session behaviors of the therapist and how these influence responsiveness among family members (Alexander, Barton, Schiavo, & Parsons, 1976; Newberry, Alexander, & Turner, 1991).
Multi-Systemic Therapy

Multi-Systemic Therapy (MST) is a family systems-based approach to treatment (Henggeler & Borbuin, 1990). Family approaches maintain that clinical problems of the child emerge within the context of the family, therefore the focus of treatment is at the family level. MST expands on that view by considering the family as one, albeit a very important, system (Kazdin, 1995). Because multiple influences are entailed, many different treatment techniques are used. Thus, MST can be viewed as a package of interventions that are deployed with children and their families. Treatment procedures are used on an "as needed" basis directed toward addressing individual, family, and system issues that may impact the individual. This approach method serves as a basis for selecting multiple and quite different treatment procedures.

Central to MST is a family-based treatment approach (Kazdin, 1995). Several family therapy techniques (e.g., joining, reframing, enactment, paradox, and assigning specific tasks) are used to identify problems, increase communication, build cohesion, and alter how family members interact. Among the goals of treatment are to help the parents develop behaviors of the adolescent, to overcome marital difficulties that impede the parents' ability to function as parents, to eliminate negative interactions between parent and adolescent, and to
develop or build cohesion and emotional warmth among family members (Henggeler, Melton, & Smith, 1992).

Several outcome studies are available for MST and are consistent in showing that treatment leads to change in adolescents and that the changes are sustained (Henggeler et al. 1992; Henggeler, Rodick, Borduin, Haanson, Watson, & Urey, 1986; Mann, Borduin, Hengeler, & Blaske, 1990). A strength of the studies is that it includes youth that are treated who are severely impaired (e.g., delinquent adolescents with a history of arrest). Another strength or rational of the study is the conceptualization of conduct problems at multiple levels-namely, as dysfunctional in relation to individual, family, and extra-familial systems and the transactions among these (Kazdin, 1995). In fact, youths with Conduct Disorder experience dysfunction at multiple levels, including individual repertoires, family interactions, and extra-familial systems (e.g. peers, schools employment among later adolescents). Alternative treatment approaches invariably identify one of these as the main treatment focus (Henggeler et al. 1992). MST begins with the view that many different domains are likely to be relevant; these domains need to be evaluated and addressed in treatment (Mann et al., 1990).

Cognitive Problem-Solving Skills Training

Kazdin (1995) provided his view of problem-solving skills training (PSST) that consists of developing interpersonal cognitive
problem-solving skills. Although many variations of PSST have been applied to Conduct Disorder youth, Kazdin suggested that several characteristics usually shared. First, the emphasis is on how children approach situations. Although it is obviously important that children ultimately select appropriate means of behaving in everyday life, the primary focus is on the thought processes rather than the outcome or specific behavioral acts that result. Second, children are taught to engage in a step-by-step approach to solve interpersonal problems. They make statements to themselves that direct attention to certain aspects of the problem or tasks that lead to effective solutions. Third, over the course of treatment structured tasks involving games, academic activities, and stories are used. Fourth, therapists usually play an active role in treatment. They model the cognitive process by making verbal self-statements, applying the sequence of statements to particular problems, providing cues to prompt the use of the skills, and delivered feedback and praise to develop correct use of the skills. Finally, treatment usually combines several different procedures, including modeling and practice, role-playing, reinforcement and mild punishment (loss of points or tokens) (Kazdin 1993; Shapiro & Hynd, 1993).

Several outcome studies which would support programs such as PSST have been completed with impulsive, aggressive, and Conduct Disorder
children and adolescents (Baer & Nietzel, 1991; Durlak, Fuhrman & Lampman, 1991; Kazdin, 1993). Findings in several of these studies have indicated that cognitively-based treatment has led to significant reductions in aggressive and antisocial behavior at home, at school, and in the community, and that these gains are evident up to 1 year later. Also, some evidence suggests that older children profit more from treatment than younger children, perhaps due to their cognitive development (Kazdin, 1993).

**Parent Training**

Kendall and Hammen (1995) described another approach called "parent training." They suggested that there is an association between Conduct Disorders and ineffective, punitive, and inconsistent parenting. Patterson, Chamberlain, and Reid, (1982) described action-oriented family therapy as an approach in which parents are taught skills for managing their children. This type of treatment is aimed at undermining the coercive family interactions associated with antisocial behavior (Kendall and Hammen, 1995). Treatment uses interventions such as written manuals, practice with the therapist, and homework assignments. Parents learn to identify problem behaviors and to properly reward or stop wanted or unwanted behaviors (Patterson, Chamberlain, & Reid, 1982).

Patterson's (1974) studies have indicated that action-oriented family therapy can lead to improvements in children's functioning, including
reductions in antisocial behaviors and continuing improvement for at least brief follow-up periods. Patterson (1974) studied documented that after treatment the frequency of a target behavior dropped to a level within the range found in nondeviant families.

**Medication**

Campbell, Ganzatez, and Silva (1992) stated that use of drug therapy for Conduct Disorder youth is also a source of treatment for acting out, defiant behaviors. According to their research, Neuroleptics are the most commonly used psychotropic drugs in the treatment of aggressive children and adolescents, particularly with children who are hospitalized consistently or are mentally retarded. According to these authors, the Neuroleptics that are most commonly used are haloperidol, thioridazine and chlorpromazine. Campbell et al. (1992) stated that lithium may also be useful in reducing aggression. If a therapeutic dosage is used and careful clinical and laboratory monitoring is maintained, this drug is effective and has less frequent side effect than do other such drugs. Anticonvulsant carbamazepine and propranolol and beta-blockers also have psychoactive properties for both antiaggressive and antimanic behaviors, which are promising agents for these youth. Campbell et al (1992) did point out that stimulants should be considered the first
choice of drug treatment in coexisting Conduct Disorder and ADHD or in milder forms of aggression.

Conclusion

Characteristics of youth with Conduct Disorder and the possible factors that may contribute to this population have been examined. Many different types of treatment have been applied to this population, but unfortunately, little outcome evidence exists for most of the approaches. Eight different treatments with the most promising evidence to date have been highlighted: school based programs (Dryfoos, 1990), residential treatment (Earles, 1994), parent training (Kazdin, 1995), functional family therapy (Alexander & Parsons, 1982; Kazdin, 1995), mult, systemic therapy (Kazdin, 1995; & Henggeler & Borbough, 1990), cognitive problem-solving skills training (Kazdin, 1995), parent training (Kendall & Hammen, 1995), and medication (Campbell, Ganzates, & Silva, 1992).

As good as much of the evidence is, at this time one cannot say that any one intervention can ameliorate Conduct Disorder and overcome the present poor long-term prognosis. The breadth of dysfunction of Conduct Disorder youth and their families makes the task of developing effective treatments demanding. Significant issues remain to be addressed to accelerate advance in the area of treatment. The magnitude of change and durability of treatment effects raise multiple
issues about how to evaluate treatment and the conclusions reached about any particular intervention.

The fact that only a few promising treatments have been identified is not cause for despair. An alternative, or rather complementary, approach to have impact on the problem is to use a combination of the above approaches and intervene early, before the full disorder or constellation of symptoms has formed. Kendall and Hammen (1995) noted that early intervention is important because once the problematic behavior patterns become entrenched, the youth are resistant to treatment.
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