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Conduct Disorder

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DESCRIPTION OF CONDUCT DISORDER

Conduct Disorder (CD) is characterized by behavior that violates either the rights of others or major societal norms, and begins in childhood or adolescence (American Psychiatric Association [APA], 2013). Individuals with CD are generally considered to be deceitful, hostile, and destructive. The symptoms categories associated with CD include (a) physical harm to people or animals, (b) destruction of property, (c) deceitfulness and theft, and (c) breaking societal norms. The severity of CD can be determined based upon the individual's lack of empathy; greater lack of empathy across a variety of settings indicates more severe CD. In order to diagnose a child or adolescent with CD, the enduring and repetitive symptoms of CD must cause significant impairment in social, academic, and occupational functioning, occur more than once per week, and be present for at least three months (APA).

The onset of CD can occur during childhood or adolescence (APA, 2013). Typically, individuals with childhood onset are first diagnosed with Oppositional Defiant Disorder (ODD; a less severe behavioral disorder; Murray & Farrington, 2010). However, individuals can have both ODD and CD; in the *DSM-5*, the disorders are not mutually exclusive (APA, 2013). Children who display mildly oppositional behaviors such as lying, stealing, and fighting might receive a CD diagnosis in adolescence if the symptoms persist, increase in significance, and impair everyday academic and social tasks (Kazdin, 2001; Murray & Farrington, 2010).

Risk factors for CD can be divided into three categories: individual, family, and societal (Murray & Farrington, 2010). Individual risk factors include (a) low IQ, (b) low self-control, (c) inability to plan ahead or risk-taking, and (d) impulsiveness, also described as hyperactivity. Forty to Seventy percent of children diagnosed with CD are also diagnosed with ADHD (Kazdin, 2001). Next, family risk factors include (a) poor parental supervision and low levels of discipline, (b) abuse, (c) parent separation within the first 5 years of life, and (d) antisocial behavior by parents. Finally, societal risk factors include (a) socioeconomic status, (b) peer group factors, and (c) low achieving schools.

Protective factors related to CD are those variables that offset the effects of risk factors (Bassarath, 2001). Although it is judicious to focus upon risk factors, protective factors reduce the risk of delinquency and therefore may assist in identifying successful interventions (Keenan et al., 2003). Bassarath (2001) stated that there are three types of protective factors (a) individual protective factors, (b) social factors, and (c) societal factors. Individual protective factors include being female, high intelligence, positive social orientation, and resilient temperament. Social factors include supportive relationships with adults, involvement in extracurricular activities, and increased economic equality across society (Bassarath, 2001; Keenan et al., 2003). The proportion of protective factors to risk factors has a significant influence on child delinquency, so interventions should focus on reduction of risk factors and an increase in protective factors (Burke, Loeber, & Birmaher, 2002: Keenan et al., 2003).

Males are more commonly diagnosed with CD than females, and males tend to display more aggressive symptoms than females (APA, 2013). The onset of CD in females is generally later than males, with the median age at onset of 8 to 10 years for males and 14 to 16 years of age for females (Murray & Farrington, 2010). Children diagnosed with CD are more likely to experience dysfunctional behaviors in adulthood (APA, 2013; Kazdin, 2001; Murray & Farrington, 2010). There is significant overlap between young individuals with CD and adults with Antisocial Personality Disorder (ASPD). As such, ASPD is listed in the *DSM-5* twice, once with CD under disruptive disorders and again under personality disorders (APA, 2013).

IDENTIFICATION/ASSESSMENT STRATEGIES

Because CD symptoms manifest in a variety of forms, assessment can be challenging (McMahon & Frick, 2005). The issues of gender, age of onset, ethnicity, and culture must be taken into consideration (Barry, Golmaryami, Rivera-Hudson, & Frick, 2013; Mash & Hunsley, 2005). Barry et al. (2013) offered four practical implications for choosing an assessment tool: (a) the tool must assess a wide range of problems and levels of severity; (b) the tool must screen for comorbidity; (c) the treatment target, risks, and protective factors must be considered; and, (d) the tool must consider key constructs. Possible assessment options include (a) unstructured diagnostic interviews; (b) structured diagnostic interviews including the Diagnostic Interview Schedule for Children (DISC; Fisher, Lucas, Lucas, Sarsfield, & Shaffer, 2006); (c) broad band behavior rating scales, including the Behavior Assessment System for Children (Reynolds & Kamphaus, 2002), and the Achenbach System of Empirically Based Assessment (ASEBA, 2013); (d) behavioral observations; and (e) performance-based measure (Barry et al., 2013).

McMahon and Frick (2005) support the use of clinical interviews and structured diagnostic interviews to assess for CD. McMahon and Frick noted that clinical interviews assist in understanding parent-child interactions, as well as the type, severity and impairment of CD. Structured interviews are more reliable and valid, according to the authors, in relation to the information collected. McMahon and Frick also point to the DISC as a popular structured interview; behavior rating scales can be used to assess peer relations, academic performance, and specific behaviors. Behavioral Coding Systems (McMahon & Forehand, 2005) and Dyadic Parent-Child Interaction Coding System (Eyberg, Nelson, Ginn, Bhuiyan, & Boggs, 2013) are examples of popular coding systems (MCMahon & Frick, 2005).

INTERVENTION STRATEGIES

Multisystemic Therapy

Multisystemic therapy (MST; Henggeler, Cunningham, Schoenwalk, Borduin, & Rowland, 2009) is one of the most evidence-based approaches for use in treating CD. MST is a comprehensive model that integrates aspects of treatment approaches that have the most empirical support for use with those who have CD. Aspects of CBT, behavior therapy, and pragmatic family therapy are integrated into MST. MST aims to empower caregivers to make changes in a youth's environment including disengagement from deviant peers and improved school performance (Henggeler & Sheidow, 2012). MST is typically conducted by a group of counselors who carry a small caseload of four to six clients for three to five months. When working in this treatment model, counselors are readily available to clients and meet in settings where the client spends most of his or her time. According to Henggeler and Sheidow (2012) if an intervention is not successful, the team redesigns and implements new interventions.

Scott (2008) suggested that engaging the family by forming positive relationships and alliances increases the success of therapeutic interventions. A lack of family engagement correlates with significant treatment dropout rates. Scott also suggested that the counselor needs to select interventions that are tailored to the client's unique needs. Scott also suggested that building upon the strengths of the family and client encourages pro-social activities; families should be encouraged to engage in scholastic learning (e.g., doing the child's homework together) and in social skills learning (potentially provided by the counselor). Finally, Scott also suggested that treating clients for co-morbid conditions in their natural environment, rather than in residential settings, supports successful outcomes.

Behavioral Interventions

Frick (2001) suggested that contingency management programs, parent management training, and cognitive-behavioral skills training are useful interventions in treating CD. Contingency management programs focus on enhancing the consistency of living environments and aim to increase reinforcement of positive behaviors and provide consequences for negative behaviors. These programs can be useful when applied across environments (e.g., school, home, residential treatment).

Parent management training focuses on helping parents to develop and implement structured management programs in the home (Frick, 2001). Training focuses on parent-child interactions, changing behavior, and supporting parents' ability to monitor, supervise and improve discipline. Parent management training can be used with the parents of children age 3 to 12. Well-validated parent management training interventions include Helping the

Non-Compliant Child program (McMahon & Forehand, 2005), Incredible Years Parent training (Drugli, Fossum, Larsson, & Morch, 2010), and Parent-Child Interaction Therapy (Eyberg, Nelson, & Boggs, 2008). One important limitation for parent management training programs is premature termination and parental non-compliance with the training.

Cognitive-Behavioral Skills Training (CBST) focuses on social cognition and social problem solving for clients with CD (Frick, 2001). CBST targets impulsivity and aggressive behaviors and encourages the use of problem solving steps. Different CBST programs target different issues. Problem-solving skills training (Mpofu & Crystal, 2001) focuses on developing impulse control skills while Anger Coping Programs (Mpofu & Crystal, 2001) focus on enhancing perspective taking. Scott (2008) noted that Problem-Solving Skills Training (PSST-P; Kazdin, 2001) supported a decrease in deviant behavior while increasing pro-social behavior, and the Coping Power Program (Lochman & Wells, 2002) reduced aggression and substance abuse while improving social competence. Promoting Alternative Thinking Strategies Curriculum (PATHS) is another CBST that focuses on developing social skills and emotional awareness (Frick, 2001)

Pharmacological Interventions

Forty to ninety percent of clients with CD have co-morbid ADHD (Berkout, Young, & Gross, 2011; Frick, 2001; Gregg, 2009). Prescribed stimulant medication can reduce ADHD symptoms and aid in impulse control; however, there is little evidence that it treats CD per se. Scott (2008) stated that "no pharmacological intervention is currently approved for conduct disorder" (p. 67). Scott also noted that there is insufficient evidence that stimulants cause reduction in aggression when ADHD is not comorbid in CD clients.

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